SOCIODEMOGRAPHIC FACTORS AND THEIR INFLUENCE ON SCHOOL HEALTH AND HIV PROGRAMMES: THE CASE OF LESOTHO

By

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DECLARATION

I, Puleng Relebohile Letsie declare that the Doctoral research thesis thatmplesa I herewith submit at the University of the Free State, is my independent work and that I have not previously submitted it for qualification at another institution of higher education.

Puleng Relebohile Letsie **Date**

TO WHOM IT MAY CONCERN

This is to state that the Doctoral thesis: 'Sociodemographic factors and their influence on School Health and HIV programmes…" (text only), submitted to me by Ms. P R Letsie (student no: 1997220767) of the University of the Free State, South Africa, has been language edited by me, according to the tenets of academic discourse.

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LISTS OF ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
AU	African Union
CDA	Critical Discourse Analysis
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CSE	Comprehensive Sexuality Education
CRC	Convention on the Rights of the Child
ESA	East and Southern Africa
FGD	Focus Group Discussion
ICPD	International Conference on Population and Development
LBSE	Life-skills Based Sexuality Education
MOET	Ministry of Education and Training
POP-FLE	Population and Family Life Education
SADC	Southern African Development Community
SCT	Sociocultural Theory
SGBV	Sexual and Gender-Based Violence
SRGBV	School Related Gender Based Violence
SSA	Sub Saharan Africa
STI	Sexually Transmitted Infections
UFS	University of the Free State
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNESCO	United Nations Educational, Cultural and Scientific Organisation
UNFPA	United Nations Fund for Population
UNICEF	United Nations International Children's Emergency Fund
WHO	World Health Organisation

CLARIFICATION OF CONCEPTS

Adolescent: The World Health Organisation (WHO) defines an adolescent as a person aged between 10 and 19 years, while youth refers to 15–24 years. The term, young people refers to the 10–24-year-old age group, as does the composite term adolescents and young adults. This study will refer to adolescents and young people, which encompass boys and girls between the ages of 10 and 24.

Community: people living in one particular area or people who are considered as a unit because of their common interests, social or cultural group, or nationality**.** Mannarini and Fedi (2009) in Titz, Cannon & Krüger (2018:18) define community as a valid concept that describes people's connectiveness and cohesion, provides members with shared codes, representations, and norms, and fulfils members' practical needs in serving as an often well-organised structure to which they can turn for dealing with both ordinary and extraordinary tasks.

Comprehensive Sexuality Education: a curriculum-based process of teaching and learning about the cognitive, emotional, physical and social aspects of sexuality (UNESCO 2018).

Culture: socially shared beliefs, values, norms, expectations, and practices within a group. Culture manifests itself as a part of external reality: as artefacts and cities, and as forms of social organisation and institutions (Mironenko and Sorokin 2018:337).

Gender: Gender is not a synonym for sex, but rather refers to the widely shared expectations and norms within a society about appropriate male and female behaviour, characteristics, and roles. UN Women (online) defines gender as the social attributes and opportunities associated with being male and female and the relationships between women and men and girls and boys, as well as the relations between women and those between men. These attributes, opportunities and relationships are socially constructed and are learned through socialization processes. They are context/ time-specific and changeable.

School Health: School health is a cross-disciplinary field of study and a fundamental strategy that can be used to improve both health and education outcomes (Kolbe 2019:443).

School Health Programmes: multicomponent programmes implemented collaboratively by health, education, and often other organisations to improve both health and education (Kolbe 2019:444).

Social Determinants of Health: the conditions in which people are born, grow, develop, live, work, and age (World Health Organisation).

Sociodemographic factors: of, relating to, or involving a combination of social and demographic factors, such as age, gender, sexual orientation, race, religion, income, marital status, birth and death rates, average size of family, heritage, education, and medical history. Salahuddin & Talukder (2017:17) define the term 'sociodemographic' as a group defined by its sociological and demographic characteristics.

SUMMARY

Key Terms: Adolescents, Comprehensive Sexuality Education, Culture, Gender, HIV, School Health, Sociodemographic factors.

Many adolescents and young people approach adulthood faced with conflicting and confusing messages about sexuality, gender, and culture. These are often exacerbated by embarrassment, reprimanding, silence, and disapproval of open discussion of sexual matters. These young people, often school-going, are affected by many challenges, and in various ways. Some of these challenges include HIV, high morbidity, premature deaths, orphan hood and early and unintended pregnancy (EUP), among other challenges. These are more pronounced in Lesotho, as the country has the second highest HIV prevalence globally. Moreover, they are exacerbated by the high levels of other communicable and non-communicable diseases, social inequalities, and economic challenges.

The education sector is facing considerable challenges due to the high HIV prevalence among adolescents and youth, increasing levels of school-related gender-based violence, as well as the large number of teenage pregnancies among school-going adolescents and young people. In Lesotho, and in most countries in Southern Africa, young people are reported to have their sexual debut from as early as 12 years. School settings therefore provide an important opportunity to reach large numbers of young people with HIV prevention, treatment and impact mitigation programmes through integrated school health and Comprehensive Sexuality Education (CSE) programmes, offering an appropriate structure through the formal curriculum.

Although the education sector has been responding to these challenges, glaring gaps continue to surface. These are mainly related to the social and cultural dynamics about educating young people about health, sex, sexuality, HIV and other social issues. Among the various sociodemographic factors, this study critically analyses how gender and culture specifically, affect and influence school health and HIV programmes, with a specific focus on comprehensive sexuality education (CSE) within schools. It highlights the key health issues and challenges, as well as other critical social issues facing adolescents. Furthermore, it continues to narrate the nature and

scope of school-based health and HIV prevention programmes in Lesotho. It draws special attention to the relationship between sociodemographic factors and the education sector; and highlights how the selected sociodemographic factors influence and affect school health and HIV programmes, specifically sexuality education. It then concludes with recommending a culturally sensitive and gender transformative implementation framework that can be adopted to contextualise responses to the HIV epidemic and enhance CSE implementation, as it emphasises what is required for effective health and HIV programmes in schools.

The findings revealed that the roles, attributes, behaviours, and level of comfort of parents / guardians and teachers highly affect the success of school health and sexuality education programmes. The curriculum content should be informed by prevalent, gender transformative and culturally sensitive materials and issues, with learners and communities also contributing to the development of the curriculum and strategies to roll it out. Emphasis is placed on the need for deeper and more meaningful content within the curriculum, as well as the continuous updating of key health topics, such as menstrual health management (MHM), which is a glaring gap in the current curriculum.

Finally, for school health and sexuality education programmes to be effective, meaningful, and efficient, they should be implemented alongside youth-friendly health services. For them to have considerable impact, these programmes should look beyond the individual to the society, addressing not only safer sexual practices, but underlying contextual issues, such as gender inequality and culture. These factors include parental involvement in school-based health and HIV programmes; community involvement in the review of curricula; and stakeholder perceptions about the key issues around sexuality and related challenges.

CHAPTER 1: ORIENTATION, RESEARCH OVERVIEW AND STRUCTURE OF THE RESEARCH

1.1 INTRODUCTION

The health status of children is one of the factors used to measure the development of countries. Crespo (2018:61) affirms that children's health might be affected by overall level of development in their residential area or country; with Galasso, Weber & Fernald (2019:141) in agreement that low socioeconomic status is also a risk factor for poor child development outcomes such as language, cognition, and behaviour; as children of parents with less income or education have been found to perform worse than children whose parents have more income or education.

However, amidst these critical affirmations, other researchers (Ford and Stein 2016; Grantham-McGregor, Cheung, Cueto, Glewwe, Richter & Strupp 2007) indicate that many children younger than 5 years in developing countries are exposed to multiple risks, including poverty, malnutrition, poor health, and unstimulating home environments, which adversely affect their cognitive, motor, and social-emotional development. This is due to the fact that it is deemed that the healthier the children in a country are, the better the health systems, often leading to better development outcomes. Many countries in Southern Africa, including Lesotho, South Africa, Zambia and Zimbabwe to mention a few, have signed several conventions and declarations on children's rights and protection, labour and education (Govender, Masebo, Nyamaruze, Cowden, Schunter & Bains 2018; Verhellen 2015; September 2014; Oladiji 2012; Rosa & Dutschke 2006). Specific reference is made to the Convention on the Rights of the Child (CRC), which Lesotho ratified in March 1992 following its adoption in 1990.

In light of the HIV, health and other development challenges facing Southern Africa, including Lesotho, the promotion of health in schools has become more of a necessity than an option. This does, however, need strong political commitment for HIV and school health programmes to be effectively coordinated and implemented. For this to happen, families and communities need to be involved, and it is critical to note the sociodemographic factors which influence the way people live and make decisions

around their lives and those of their offspring or children in their care. For instance, Guzzo and Hayford (2018:38) are of the opinion that adolescent views and experiences set a precedence for long-term patterns in that the behaviours and dynamics in romantic relationships in adolescence affect the formation and character of adult intimate relationships. This is in alignment with Odimegwu & Somefun (2017:3) as they emphasise that societal norms and gender-power relations influence behaviour, which may allow positive or negative changes.

All these are illustrated by that in different societies, norms and beliefs of suitable roles for men and women are enforced by that society's institutions and practices, highlighting that gender, family structure, ethnicity, knowledge, and attitudes are primary factors related to adolescents' health behaviours (Ozbay, Shevorykin, Smith and Sheffer 2019:2). It therefore becomes apparent that there is a need to thoroughly understand how some of these sociodemographic factors influence and affect health and HIV programmes in schools, so that effective measures can be developed and implemented. For purposes of this study, specific focus will be on the cultural aspects, as well as social relationships, which will be explored from a 'gender' lens.

The Human Immunodeficiency Virus (HIV) pandemic, gender-based violence and other communicable and non-communicable diseases, such as cardiovascular diseases, cancer, chronic respiratory diseases and diabetes are some of the health issues which have been more challenging to countries and most directly to community values and capabilities, especially in Southern Africa (Doherty, Jackson, Zarowsky and Sanders 2019:2). The huge impact of the global HIV pandemic on the social, economic, and demographic stability of countries and communities across the world is a major development challenge. Even though UNAIDS (2017:1) indicated that new HIV infections declined by 29% between 2010 and 2016 globally, the 2018 global report indicates that there were some good gains against HIV, especially in eastern and southern Africa in 2017 a region that is home to more than half (53%) of the world's 36.9 million people living with HIV. In sub-Saharan Africa, adolescent girls and young women (aged 15–24 years) bear the brunt of HIV prevention shortcomings (one in four HIV infections in 2017), despite being just 10% of the population. Women aged 15 and older represented 59% of new infections among adults in the region; with the increased vulnerability to HIV infection being linked to intimate partner violence, which

is more common among younger women and women who are economically dependent on their male partners (UNAIDS (2018:9).

Although strongly linked to HIV prevention, my observation is that issues of sexuality are seldom discussed with and emphasised to young people in preparing them for adulthood and even for higher learning. Research (de Haas & Hutter 2019; Boraiah & Yeliyur 2013; UNESCO 2009) indicates that many young people approach adulthood faced with conflicting and confusing messages about sexuality and gender. This is often exacerbated by embarrassment, silence, and disapproval of open discussion of sexual matters by adults, including parents and teachers, at the very time when it is most needed. In Lesotho specifically, young people are reported to have their sexual debut from as early as 12 years (National AIDS Commission 2009:15). This therefore reinforces the need for school health and other proven HIV programmes, such as comprehensive sexuality education (CSE) in schools, especially in sub-Saharan Africa, including Lesotho where the burden of HIV and the impact of AIDS are the highest. Active leadership from the education sector is required to develop and implement relevant frameworks and a curriculum for school health and CSE in this instance. These need to be contextualised and delivered by the schools and teachers in alignment with their particular settings. All these efforts will, however, not be successful if the social environments, including the social, cultural and gender issues and dynamics within those settings are not incorporated in such frameworks and curricula.

To affirm its commitment, the Government of Lesotho has signed and ratified several international and regional conventions that identify the rights of children and young people, and these are being used to guide programming for both education and health. They include the Africa Charter on Child Rights and Welfare; the Convention on the Rights of the Child; the Convention on the Elimination of Child Labour; the fourth World Conference on Women UN 1995 Platform for Action and Beijing Declaration; the International Conference on Population and Development (ICPD) Programme of Action; the Organisation of African Unity Charter on the Right and Welfare of the Child; the SADC Protocol Article 17 on Child and Adolescent Health; the SADC Regional Conceptual Framework for Psychosocial Support for Orphans and Other Vulnerable Children; the SADC Minimum Package of Services for Orphans, Vulnerable Children

and Youth ; the UN Convention on the Elimination of all forms of Discrimination against Women (CEDAW), as well as the Eastern and Southern African (ESA) Commitment on Comprehensive Sexuality Education and Sexual and Reproductive Health Services for adolescents and young people.

It is therefore evident that the high rate of HIV infection among youth in Africa has prompted both national and international attention. Education and prevention programmes should be viewed as the primary way of decreasing the HIV incidence among young people. However, these cannot be sustained on their own within the health care settings; hence the need for comprehensive school-based programmes. In addition, health and other social challenges happen, and are addressed within homes and communities. This then calls for the need to consider the social settings and interrogate how sociodemographic factors, such as culture and gender influence health and HIV prevention programmes, specifically focusing on those implemented within the schools.

1.2. BACKGROUND TO THE STUDY

Adolescents acquire extensive information related to sexuality, which may be misguiding and can have a significant negative impact on their sexual behaviours. Sexuality is a complex human behaviour, which is largely influenced by factors such as physical appearance, psychological factors, social factors, cultural norms, and past experiences (Kar, Choudhury and Singh 2015:73). Even though these authors highlight that the extensive sexuality related information can be misguiding, it is generally assumed that the more information adolescents receive, the more informed and empowered they will be (UNESCO 2018). This empowerment will enable them to make informed choices, hence the need to highlight what influences their access to, and comprehension of the information and education related to their health and sexuality, as this study intends to.

Kar *et al.* (2015:74) continue to emphasise that sexual exposure during adolescence is a matter of serious concern due to the risk of transmission of sexually transmitted infections including HIV, early and unintended pregnancy (EUP), and adolescent parenthood. They assert that in many developing and underdeveloped countries, early sexual exposure, early marriage leading to early sexual exposure and pregnancy also have adverse consequences on the reproductive health of adolescents and young people. This is affirmed by Sodik (2018:496) who states that teenagers who are in puberty are curious about issues regarding sexuality, which could trigger the behaviour of unsafe sex resulting in unwanted pregnancy, HIV and Sexually Transmitted Infections (STIs).

Given the strong links between health, HIV and education, it is essential to continuously acknowledge this relationship and make deliberate efforts to integrate and harmonise school health and HIV programmes, especially sexuality education, within the efforts and programmes of the education sector. This is affirmed by Kelly (as quoted by Maritz and Lessing 2004:107) who states that,

> *"Education in a world with AIDS must inevitably differ from education in a world without AIDS. Schools are traditionally expected to communicate knowledge,*

instil values and promote behaviours that will enable students to protect themselves against HIV protection".

This reinforces the need for comprehensive HIV programmes in schools, with a focus on prevention, treatment, impact mitigation and social protection. However, even where available, some of these programmes are hindered and thwarted by the strong cultural and gender issues within and across schools, communities and countries, especially in sub-Saharan African countries, such as Lesotho where the burden of HIV is among the highest. Bhana, Crewe & Aggleton (2019:362) concur as they emphasise that good quality sexuality education is a vital resource to provide adolescents and young people with knowledge and information to address sexual and reproductive health and to prevent adverse social, health and educational outcomes. Furthermore, they note that when sexuality education is delivered within a human rights, gender, and sexual justice framework, it has the potential to address and challenge gender inequality, oppressive heteronormativity, and relationship dynamics.

There are several barriers to educating young people about sex and HIV, and these include cultural, religious, political, legal, individual, and limitations of programmes and the quality of education (Pariera & Brody 2018; Qiao, Zhang, Li & Menon 2018; Kamangu, John & Nyakoki 2017; UNESCO 2008). The Ministry of Health (2015:7) affirms that comprehensive knowledge of HIV prevention in Lesotho seems to be static, as 39% of women and 29% of men were found to have comprehensive knowledge in 2009, while the 2014 Lesotho Demographic and Health Survey (LDHS) showed 38% and 31% for women and men respectively; illuminating the urgent need for the country to implement strategic programmes to manage HIV prevalence, especially among young women and girls to mitigate their vulnerability and risks of acquiring HIV.

Since the advent of HIV in eastern and southern Africa in the early eighties, various prevention, treatment, and impact mitigation programmes have been implemented, scaled up and replicated within and across communities, countries and regions. Their implementation has however been marred by various institutional, financial, social and cultural challenges and barriers over the years (Phanuphak, Seekaew and Phanuphak 2019; Whiteside 2019; Khau 2016; Poku and Bonnel 2016). This is highlighted by the notion that amidst the evidence that exists (Jagadish & Yeliyur 2013; UNFPA 2008;

UNAIDS 2006) affirming the effectiveness of sexuality education as a vital part of HIV prevention and critical to achieving Universal Access targets for reproductive health and HIV prevention, treatment, care and support, there is still some resistance and barriers to its implementation. These challenges and barriers are mainly due to the various social, cultural and gender issues and norms. While it is not realistic to expect that an education programme alone can eliminate the risk of HIV and other Sexually Transmitted Infections (STIs), unintended pregnancies, coercive or abusive sexual activity and exploitation, my belief is that if properly designed and implemented, school based health and HIV programmes can reduce some of these risks and underlying vulnerabilities.

HIV remains a critical challenge to socioeconomic development in many countries in sub-Saharan Africa (SSA). The HIV pandemic represents a priority for all health authorities in all countries and it also represents serious added socioeconomic challenges for societies over the world (Mgwaba & Maharaj 2019; Trapero-Bertran & Oliva-Moreno 2014; Obure, Nyambedha & Oindo 2011). The HIV epidemic has created a multidimensional crisis that is challenging national management structures including the education, social development, and healthcare systems. Research (Nakkeeran & Nakkeeran 2018; Stangl & Grossman 2013) therefore calls for more rigorous efforts across sectors, but more importantly within families and communities, as these will affect and influence school health and HIV programmes within the schools. This is signified by that HIV-related stigma and discrimination are often deeply interwoven with other forms of discrimination based on gender, sexual orientation and gender identity, race, disability, and other social, migratory and health factors.

Some social and cultural issues continue to manifest through violations of women's rights, including gender-based violence, which in turn exacerbate women and girls' vulnerability to HIV and prevent them from accessing services and care (Bharati 2017; Borges 2017). These are in turn, fuelled by the structural barriers such as discriminatory laws and practices that restrict women's equal access to decision-making, education, employment, property, credit and / or autonomy. Hammack (2018:48) alludes to this, by stating that women's well-being is profoundly influenced by social structures (policies, laws, cultural practices) that infringe on their human rights. These structures create damaging social conditions, encompassing several

forms of discrimination that may occur in overt or subtle ways. This kind of discrimination therefore limits women's abilities to achieve well-being and positively enjoy life, as their gendered experiences of discrimination are shaped by some other sociodemographic factors.

Effective HIV programmes that incorporate sexuality education are important because of the impact of cultural values and religious beliefs on all individuals, especially on young people. Scholars (Govender, Masebo, Nyamaruze, Cowden, Schunter, and Bains 2018; Kirby, Obasi & Larisa 2006; Robinson, Bockting, Simon Rosser, Miner & Coleman 2002) have continuously indicated that school settings provide an important opportunity to reach large numbers of young people with HIV prevention, treatment and impact mitigation programmes under the umbrella of sexuality education before they become sexually active, as well as offering an appropriate structure through the formal curriculum, within which to do so.

Within the various sociodemographic factors, this study will specifically explore how gender and culture affect and influence school health and HIV programmes, with an emphasis on comprehensive sexuality education (CSE) within schools. Research (Rwafa, Shamu & Christofides 2019; Robinson, Narasimhan, Amin, Morse, Beres, Yeh & Kennedy 2017; Andersson, Cockcroft & Shea 2008) indicates that unequal gender power relations are a fertile underlying cause of HIV and Gender Based Violence (GBV), as some of the critical dynamics of unequal power are intergenerational sex and transactional sex. USAID (2009:1) also postulates that the public health and development communities have known for nearly two decades that gender influences people's vulnerability to HIV, and how societies respond to the epidemic. Although gender norms vary among societies, there are several common ways in which they affect the spread of HIV and people's coping mechanisms.

This is further asserted by other researchers (Manji 2018; Alexander-Scott, Bell & Holden 2016) as they highlight that around the world, especially in Africa, gender norms discourage women from asserting control over the timing and circumstances of sex, including negotiating HIV protection. Some of these social norms around masculinity simultaneously put men at risk of HIV by encouraging them to have multiple partners and unprotected sex, while also discouraging their routine use of

healthcare. These factors often even encourage male domination of women's sexuality, leading to instances of violence and sexual coercion.

Sorokin (2016:18), complimented by Barnett and Casper (2001:465) highlight that, human social environments encompass the immediate physical surroundings, social relationships, and cultural milieus within which defined groups of people function and interact. This highlights the notion that the education sector makes significant contributions to the responses to HIV at all levels. Through formal and informal education settings, this sector is able to reach children and youth with information and education on sexuality, HIV, and other critical issues, beyond the standard school curriculum. It is due to these relations and linkages between health and education that one can assert that education on health and HIV is a critical factor and an avenue for addressing deeper sociodemographic factors, including the cultural and development issues, such as gender inequalities, social and cultural norms.

The Lesotho School Health and Nutrition Policy by the Ministry of Education and Training and Ministry of Health (2017:7) indicates that the HIV epidemic has significantly affected life expectancy in Lesotho. It indicates that the leading cause of death in Lesotho is HIV-related complications, followed by pulmonary tuberculosis (TB), meningitis, pneumonia and other acute respiratory infections (ARI), violence, diarrheal diseases, cancer, anaemia, stroke, diabetes, neonatal disorders and ischemic heart disease, amongst others. The Government of Lesotho (2013:13) continues to highlight that the HIV epidemic in Lesotho is fuelled mainly by behavioural, social and structural drivers. It asserts that the country has made significant strides in the bio-medical prevention of HIV, but the social and structural drivers and factors that influence the epidemic remain a critical challenge.

Khau (2016:99) postulates that it is crucial to understand how young people in Lesotho receive information regarding sexuality, HIV and AIDS. This has therefore led to the several efforts to incorporate HIV- and AIDS-related education programmes in schools in Lesotho. In the late seventies and early eighties, Population and Family Life Education (POP-FLE) was, for instance, implemented in Lesotho; followed by the incorporation of Life Skills Education (LSE) in August 2005 as a compulsory subject in

the school curriculum, as a way of preventing HIV and curbing its spread (Monyake 2019; Chabela 2010).

The need for integrated health and HIV information, education and communication calls for concerted efforts to ensure that there are functional school health and HIV programmes. However, as research (Hamadziripi 2017; Ansell 2009) points out, life skills programmes have not been straightforwardly implemented in Lesotho due to practical difficulties in integrating the form of education envisaged into a very conventional, didactic style of schooling.

1.3. RESEARCH PROBLEM, RESEARCH QUESTIONS, AIM AND OBJECTIVES

Even though the number of new HIV infections globally continued to decline in 2017, progress is far slower than what is required to reach the 2020 milestone of less than 500 000 new infections. Notwithstanding the reductions in AIDS-related mortality, and in new HIV infections between 2010 and 2017 in sub-Saharan Africa, women continue to account for a disproportionate percentage of new HIV infections among adults (aged 15 and older) in the region, as they represented 59% of the 980 000 new adult HIV infections in 2017. This is in on contrast to other parts of the world, where men accounted for 63% of the 650 000 new adult HIV infections in 2017 (UNAIDS 2018:6). However, in all regions of the world, punitive laws, policies, and practices continue to violate human rights and maintain structural conditions that leave people without access to HIV and other health services (UNAIDS 2016:14). Adolescents and young people in Lesotho and in the Southern African region are faced with myriad health and other challenges including sexually transmitted infections (STIs), HIV, maternal morbidity and mortality, sexual abuse, orphanhood and increasing vulnerability (Ezeh, Bankole, Cleland, García-Moreno, Temmerman & Ziraba 2016:31). These call for concerted and multi-sectoral efforts to address the needs of young people, especially

within the school settings, thus effective school health and HIV programmes are needed now more than ever.

Evidence indicates that Lesotho has made strides in the education sector as an HIV and AIDS policy was developed in 2012. The Government undertook a comprehensive review of the curriculum using UNESCO's International Technical Guidance on Sexuality Education through the adoption of the revised Life-skills Education (LSE), which incorporates gender-transformative, comprehensive sexuality education that is scientifically accurate, age-appropriate, and culturally relevant for Grade 4 (9-year-olds) to Grade 10 (15-year-olds) (Monyake 2019; Rakolobe 2017; Khau 2016). However, the adoption and implementation of comprehensive sexuality education (CSE) has been limited to only Grades 4 to 10 since its introduction, starting at about nine years of age to fifteen years. This decision by the Government of Lesotho left out a critical mass of young people below the age of nine and those beyond Grade 10. My view is that the implementation of the curriculum has had challenges as some students, teachers, parents and stakeholders believe that comprehensive sexuality education is culturally inappropriate and not gender-sensitive within the Lesotho context.

Despite the development of the Lesotho school health policy in 2005 and reviewed in 2016 into a School Health and Nutrition policy, the implementation of the policy has been met with challenges including limited coordination between the Ministry of Health (MoH), civil society organisations (CSOs) and other implementing partners, as well as the Ministry of Education and Training (MoET). The need for functional school health and HIV programmes is further emphasised by Chutuape, Muyeed, Willard, Greenberg & Ellen (2014:3) as they highlight that opportunities to control risk factors that contribute to HIV transmission and acquisition, extend far beyond individuals and include addressing social and structural determinants of HIV risk. This therefore emphasises the need for the integration of sociodemographic factors in school health and HIV programmes.

1.3.1. Research Questions

The previous section highlights the rational and importance of this study, and therefore the questions posed are:

1.3.1.1. **Primary Research Question:** What is the influence of culture and gender as specific sociodemographic factors on school-related HIV and health programmes?

1.3.1.2. Secondary Research Questions

1. What are the key health issues and challenges facing adolescents in Lesotho?
2. What are the critical social challenges facing adolescents in Lesotho?
3. What is the nature and scope of school-based health and HIV prevention programmes in the Southern African region and in Lesotho specifically?
4. What is the relationship between sociodemographic factors and the education sector?
5. How do the specific sociodemographic factors (gender and culture) influence and affect school health and HIV programmes, with a specific focus on comprehensive sexuality education (CSE)?
6. What is required for effective health and HIV programmes in schools?

1.3.2. Aim of the study

The aim of this study is to critically analyse the influence of gender and culture as specific sociodemographic factors on school health and HIV programmes in Lesotho.

1.3.3. Research Objectives

1.3.3.1. To explore the key health issues and challenges facing adolescents.

1.3.3.2. To discuss the critical social challenges facing adolescents.

1.3.3.3. To investigate the nature and scope of school health and HIV programmes.

1.3.3.4. To highlight the relationship and connections between the specific sociodemographic factors and education.

1.3.3.5. To critically analyse the influence of gender and culture on school health and HIV programmes, with a specific focus on comprehensive sexuality education (CSE); and

1.3.3.6. To provide a framework highlighting key sociodemographic factors essential for effective school health and HIV programmes.

1.4. THEORETICAL FRAMEWORK

Owing to the complexity of the HIV pandemic and its inter-relations with the key variables within the research, which include sociodemographic factors, adolescent health as well as HIV and school health programmes, a combination of models and theories will be used to anchor the theoretical framework of this study. This study will therefore be grounded within the Biopsychosocial Framework, which Shields (as quoted by Farber 2018:2) believes to highlight the application of a cultural intersectionality perspective. This takes into account the convergence of sociodemographic characteristics, such as gender, race/ethnicity, nationality, age, socioeconomic status and sexual orientation that uniquely influence individual identity, psychological experience, and health-related attitudes and behaviours. This view is corroborated by Borrell-Carrió, Suchman and Epstein (2004:578), as they highlight the importance of specific sociodemographic factors and how they can influence health and HIV programmes within the school system. This will be beneficial for this study as the biopsychosocial approach systematically stipulates that biological, psychological, and social factors exist along a continuum of natural systems, and therefore have links to some specific sociodemographic factors.

The Social-Ecological model will be used within the ecological framework for adolescent health as outlined by Blum, Bastos, Kabiru and Le (2012:1567). The framework emphasises the fact that there are various factors that contribute to the social construct of adolescence as a distinct period of life, as it provides a useful overview of the factors affecting adolescent health in line with the life cycle, from preconception to old age.

Finally, the Sociocultural Theory on the other hand, places the emphasis of the theory on the influence that social interactions and language, embedded within culture have on people's cognitive development and therefore highlights the critical need to ensure that learning and educational strategies are socially and culturally responsive. This can be done by, among other things, integrating socially and culturally acceptable language in the classroom, and using teaching methods and strategies that integrate students' cultural and community contexts to recognise the social interactions to which learners are exposed. Kanaʻiaupuni, Ledward, and Jensen (2010:17) suggest that one

approach is to increase teacher sensitivity and pedagogical knowledge for working with the cultural diversity of all students, as culture-based educational practices encourage instruction and learning that is rooted in cultural and linguistically relevant contexts.

The above-mentioned theories will be used to highlight the links between the specific sociodemographic factors affecting health and HIV programmes within schools as they all have strong social aspects. These theories also complement one another as they provide the linkages between gender, culture, education and school health.

1.6. RESEARCH DESIGN AND METHODOLOGY

Owing to the social and people-centred nature of the research, qualitative research methods are used. As Rahman (2017:103) indicates, the term 'qualitative research' means any type of research that produces findings not arrived at by statistical procedures or other means of quantification. He indicates that qualitative research can refer to research about persons' lives, lived experiences, behaviours, emotions, and feelings, as well as about organisational functioning, social movements, cultural phenomena, and interactions between nations; thus, it is safe to conclude that qualitative research is not statistical, and incorporates multiple realities. It is interested in analysing subjective meaning or the social production of issues, events, or practices by collecting non-standardised data and it is basically associated with multiple aspects, is multi-method in focus, and involves an interpretive, naturalistic approach to its subject matter (Paley 2017:5).

An extensive literature review was carried out on key sociodemographic factors, especially gender and culture, and their linkages and relationships with HIV and school health programmes. This was done to collate information to support the research assumptions and conclude the research. Appropriate primary and secondary sources including books, journals, documents, electronic media and research reports among others, were studied to gather relevant information on school health, HIV, and sociodemographic factors, specifically culture and gender. Garbers (1996:290) stipulates that the difference between theoretical studies and empirical studies is that the evidence produced by the researcher to support their argument can be acquired

either from existing facts or information, or from new empirical data or information; thus, my decision to specifically use qualitative methods. To complement the literature review and acquire an in-depth exploration of the social issues, dynamics and environments influencing the acceptance and implementation of school health and HIV programmes, such as comprehensive sexuality education, data were collected through focus group discussions.

Due to the qualitative nature of the study, seven focus groups were constituted, with the participants clustered by their social classification. These social clusters comprised 8 community health workers, 32 community members including parents, 12 faith and community leaders, 10 government officials, 21 students, 12 teachers, as well as 9 development partners supporting school health, HIV and sexuality education programmes in Lesotho. The data from the focus group discussions were used to substantiate and, in some instances, annul some of the theoretical assumptions regarding school health and HIV programmes, such as comprehensive sexuality education (CSE), specifically in Lesotho. The focus groups highlighted the social issues and attributes that either facilitate or hinder the implementation and success of the school health and HIV programmes.

The research will highlight the positive influences of the key concepts or variables that can be beneficial to the implementation of health and HIV programmes in schools. Finally, recommendations will be made on how these can be used to promote and enhance the acceptability and the successful implementation of school health and HIV programmes in Lesotho, as well as possibly being replicated in other countries in the region and beyond.

1.6.1. Data analysis

For the theoretical chapters, a historical review of the health and HIV challenges facing the Education sector will be made, complemented by a theoretical review which will trace developments in the sector with regard to health and HIV, highlighting how the various theories are being supported by empirical evidence regarding HIV and school health. An epistemological orientation was then used to analyse the data from the focus groups' transcribed data, through using social constructivism. Steward (2006:112) indicates that social constructivism broadly suggests that much of reality

and the meaning and categories that frame everyday life are essentially social creations. This therefore resonates with this study; hence the use of social constructivism as it tends to emphasise how people and/ or group members collaborate on an issue; how they achieve or fail to reach consensus in some cases; and how they construct shared meanings about social concerns and environments influencing HIV and school health programmes in Lesotho.

In addition, critical discourse analysis (CDA) has been used, as it employs language to reveal the kinds of discourses used to maintain power and sustain existing social relations (Bouvier & Machin 2018:179). This is relevant to this study as CDA highlights the connections between discourse practices, social practices, and social structures, which may otherwise be connections that might be complicated or not very clear to ordinary citizens or community members. It was instrumental in highlighting the connections between the current perceptions on school health and other HIV programmes, such as CSE with social relations, as well as the gender and power dynamics within Lesotho.

All these were then synthesised with an integrative review noting the status quo, and provide a context review focusing on school health and comprehensive sexuality education (CSE) as some of the key strategies to curb HIV, gender-based violence, including school-related gender-based violence (SRGBV), and other health and social challenges in schools, within the broader sectoral, national and regional perspective.

1.7. VALUE OF THE RESEARCH

There is limited research which determines how sociodemographic factors, specifically culture and gender can influence the acceptability and successful implementation of school health and other proven programmes, such as HIV and comprehensive sexuality education (CSE) within a specific country. Thus, it is my intention to critically analyse the influence of these on the acceptability and implementation of school health and HIV programmes in Lesotho. Most studies have focused on relationships between health, HIV and the education sector, without necessarily exploring the key variables

and environments that may be influencing and perpetuating the current challenges in relation to health and HIV programmes in schools.

The study will also contribute to the refinement of the Education sector's health and HIV programmes by highlighting some of the challenges posed by the health issues and HIV in the sector, and their relationship to sociodemographic factors. Finally, the study will recommend modalities with policy direction and imperatives that the education sector, which Lesotho and other countries can implement, to effectively and successfully implement school health and the CSE curriculum within conducive social and cultural environments.

1.8. ETHICAL CONSIDERATIONS

Ethical considerations were adhered to as participation in the research was voluntary. Information, people's identities and views obtained through the study were treated with utmost confidentiality as coding was used for recording respondents' names. Data were stored in a password-locked computer with hard copies in a locked cabinet to ensure safety and confidentiality. After the research has fulfilled its objectives all the collected data will be properly disposed of to avoid the duplication of information. Ethical clearance was acquired from the University of the Free State (Ethical Clearance number: UFS-HSD2019/0380/2207), as well as from the Lesotho Ministry of Education and Training (MoET) to undertake the research.

1.9. CONCLUSION

Reducing HIV incidence, gender-based violence and other health and social challenges amongst young people in eastern and southern Africa requires a gender-responsive, culturally sensitive and evidence-based approach that is grounded in human rights principles. However, these cannot be attained if the key issues and variables that affect health and HIV programmes within schools and communities are not acknowledged, and deliberate efforts made to address them or at least promote harmonisation. This study will therefore provide a framework to highlight the critical

sociodemographic factors, specifically gender and culture, that influence school health and HIV programmes in Lesotho.

1.10. LAYOUT OF CHAPTERS

The research chapters will be as outlined as follows:

Chapter 1: Orientation, research overview and structure of the study
Chapter 2: Selected paradigms and theories in psychology and social research
Chapter 3: Research design and methodology
Chapter 4: HIV and health among adolescents and youth
Chapter 5: School health, HIV programmes and sociodemographic factors in the education sector
Chapter 6: Research results
Chapter 7: General conclusions and recommendations

CHAPTER 2: SELECTED PARADIGMS AND THEORIES IN PSYCHOLOGY AND SOCIAL RESEARCH

2.1 INTRODUCTION AND LITERATURE OVERVIEW

The relationship between education and health has been established over time, as education is critical to social and economic development and has a profound impact on population health (Zimmerman, Woolf & Haley 2015:1). Some of these health conditions that have a dramatic effect on education and education outcomes include the human immuno-deficiency virus (HIV), gender-based violence, early and unintended pregnancy, and other non-communicable diseases. The challenges brought about by these are further exacerbated by social environments and practices that happen within these environments, such as gender roles, norms and some harmful practices, such as child marriage. Therefore, there is the need to understand the educational and macro-level contexts in which the association between health and education occurs (Zajacova & Lawrence 2018:274). The selected paradigms and theories will be outlined within the context of Lesotho, and efforts will be made to link them to the sociodemographic factors affecting school health and HIV programmes, with a specific emphasis on gender and culture.

Lesotho has a very young population, and this coupled with high unemployment levels lead to a high dependency ratio on those with some earnings, and at the same time, predisposes adolescents and young people to risky behaviours, such as substance abuse, transactional sex and early marriages. Orphans and vulnerable children (OVC) are at the highest risk as poverty and food insecurity put them at risk of harassment, violence, and child labour, as well as rape (Ministry of Education & Training 2018:8). With an HIV prevalence of 25%, Lesotho ranks as the second country most affected by HIV and TB globally (Ministry of Health 2015:4).

Lesotho is landlocked by the Republic of South Africa, and has a surface area of 30,355 square kilometres, with a predominantly female and young population, with 51% women; 49% men and 58% of the population aged under 19 (Bureau of Statistics 2016:1). HIV has become the single largest threat to sustainable socio-economic

development in Lesotho, exacerbating the depth and breadth of household poverty, and threatening to roll back progress made in human development in Lesotho over the past three decades (Thabane 2017; Coburn, Okano & Blower 2013). The Government of Lesotho has been implementing programmes and initiatives to curb HIV and other health and social challenges over the years, but progress seems to be slow.

There is compelling evidence that the HIV epidemic and other health issues and challenges are fuelled mainly by behavioural, social and structural drivers (Pantelic, Sprague and Stangl 2019; Gleeson, Rodríguez, Hatane & Hart 2018; Ordóñez & Marconi 2012). This is further confirmed by the Ministry of Health (2013:13) by its assertion of the strides made by the country in preventing HIV, although the social and structural drivers of the epidemic remain a critical challenge. In an effort to respond to the epidemic within the Education sector, there have been several efforts to incorporate HIV and AIDS-related education programmes in schools in Lesotho. Chabela (2010:11) highlights that in the late seventies and early eighties, Population and Family Life Education (POP-FLE) was implemented in Lesotho, followed by the incorporation of Life Skills Education (LSE) in August 2005 as a compulsory subject in the school curriculum. This was viewed as a way of preventing HIV and curbing its spread, as well as addressing other social challenges facing adolescents and children in Lesotho.

Research (Palombi and Moramarco 2018; Kebede, Andargie, Gebeyehu, Awok, Yitayal, Mekonnen, Wubshet, Azmeraw, Lake and Alemu 2017; Kasprowicz, Achkar & Wilson 2011; World Bank 2005) indicates that HIV and AIDS are the leading causes of death in Africa and the continent's greatest challenge to making progress in economic and social development. The pandemic is unique in that it affects all sectors, makes all groups potentially vulnerable, and reaches from villages to national capitals; yet HIV is preventable, more so if the young are reached early enough with the right messages and education. They further assert that the education sector touches all parts of society, particularly young people, and has the potential to play a critical role in the response to HIV, gender related and other health and social challenges, but the sector has not exploited this potential effectively. The abovementioned authors assert that this is highlighted by the fact that most projects and programmes in Education

rarely include a comprehensive response to HIV, with most focusing only on prevention and not comprehensive enough to include other key issues.

The need to consider the influence of sociodemographic factors and social environments, including social capital, culture and structural issues within countries is further buttressed by Wood and Pillay (2016: 130) as they opine that the literature suggests that there is a need to adopt a holistic view of HIV in the curriculum. Therefore, a stand-alone module, if used, needs to be supplemented by some form of curricular infusion at programme level to ensure adequate coverage and the avoidance of duplication. However, the current models and theories that are used to inform the curriculum in South Africa, where HIV is a social issue with a complex aetiology are rarely suitable. These authors assert that with Sub-Saharan Africa being the epicentre of the pandemic, local knowledge, based on local experiences and interpretations, should serve as the starting point to “develop indigenous theories that will diminish the epistemic injustice that seems to exist, judging by the lack of home-grown theories to explain the phenomenon”. This affirmation continues to place more focus on the importance of social environments in school health and other HIV programmes, in order for them to be effective.

Consideration of social environments will also be beneficial for the adolescents and young people, as Hussey, Kanjilal and Okunade (2013:75) reiterate that evidence suggests that an adolescent's perceived support from school and parents is an important predictor of their mental well-being, with the estimated effects of school support and parental support, suggesting that schools and parents are very important to them during the years involving the transition into high school and young adulthood. Swarts, Rens and de Sousa (2018:64) express this need by postulating that in order to enable learners to attain relevant knowledge, values and skills, teaching and learning should be based on local realities. This provides opportunities for critical and productive interaction between the classroom and the learners’ living environment. They do however caution that life skills-oriented curricula, such as CSE should also focus on educating learners that they are connected to other human beings, with teachers also being able to connect knowledge, values and skills to what learners are familiar with, or have experienced in their local environment.

To emphasise the critical relationship between education and sociodemographic factors, especially gender and culture, Hlalele and Letsie (2011:162) highlight the fact that despite the impressive advances made by women in educational attainments, unequal gender relations are still a dominant feature in Lesotho. With regard to gender, although there have been some strides in the empowerment of women through enacting empowering legislation, such as the Sexual Offences Act 2003 and the Legal Capacity of Married Persons 2011, among others, the Lesotho society's patrilineal and patriarchal system continues to subordinate women to men, with the customary laws continuing to classify women as minors, and perpetually subjected to the guardianship of their male counterparts. These dynamics usually spill over to the school, and manifest in students' chores and duties within the school. Girls are usually assigned the 'feminine' tasks of sweeping and cleaning, while boys will be assigned roles such as digging and other tasks deemed to be 'tough'. This means that the school curriculum also continues to perpetuate gender stereotypes. Consequently, women's rights are marginalised and their educational advantage over men does not translate into economic, political, and social empowerment.

Concerning health and with specific reference to school health, it is worth noting that as is the case in Lesotho, there are some improvements in addressing HIV and the impact of AIDS in schools, but there have been very slow and lengthy realisation, acknowledgement and implementation of effective school health and HIV programmes. However, as Robinson, Smith, and Davies (2017:334) indicate, children's sexuality education in schools and in families continues to be inundated with tensions and controversies. They indicate that these social anxieties mainly emanate from "cultural discourses that perpetuate the perspective that sexuality is irrelevant, developmentally inappropriate, risky and dangerous to pre-pubescent children". These then lead to serious compromises when it comes to children's sexuality education, especially in terms of the age at which this education should begin, the time dedicated to the topic, the content that can be addressed with children and how it is taught and by whom.

It is my understanding that school health programmes, specifically HIV and sexuality education programmes are designed to ensure that the rights of young people to be informed about their sexuality and to make responsible decisions about their sexual

and reproductive health (SRH) are upheld. Although these programmes have demonstrated some successes in promoting healthy behaviours and habits, delaying sexual debut, reducing the frequency and number of sexual partners, and increasing condom and contraceptive use, they continue to face a number of implementation challenges within schools, communities and other institutions. My observation is that after many years of masking issues of sexuality and sexuality education under different names and titles, the schools and media are finally publicly discussing the long-kept ‘taboo’ topic of sexuality, especially in African settings. This is affirmed by Ferfolja and Ullman (2020:43) in that even though many gender and sexuality diverse teachers are constrained by the prevalent heteronormativity and heterosexism culture within their workplaces, this is beginning to change due to media and other forms of publicity.

Owing to the fact that adolescent and youth reproductive health (AYRH) outcomes and behaviours are influenced by various sociodemographic factors and social norms which are beyond the individual’s control, it is worthwhile advocating for, and implementing interventions for adolescents and young people’s health that go beyond individual behavioural change. Rather, it should be to seek to shift the negative normative environments that affect adolescents’ and young people’s health and well-being (Nguyen, Costenbader, Plourde, Kerner & Igras 2019: S17).

It therefore becomes apparent that school health, especially HIV and sexuality education interventions and programmes need to be all encompassing in their design and implementation. They should consider the various sociodemographic factors in acknowledging that schools, communities, and countries are not homogenous. This is affirmed by various researchers (Guba & Lincoln 1994; Krauss 2005; Lincoln, Lynham, & Guba 2011) in Dean (2018:3) as they highlight that while positivists uphold that there is one reality, interpretivists believe reality is subjective, multiple and socially constructed. This therefore necessitates linking all these to the selected paradigms and theories.

2.2 SELECTED PARADIGMS IN PSYCHOLOGY AND SOCIAL RESEARCH

There are various paradigms used in education, but this study will focus on those specifically utilised in psychology and social research. The reason for exploring these

from the psychology and social research perspectives is mainly due to the nature of this study, which is anchored within the Psychology of Education field but highlights the relations and linkages between the psychology of education and social aspects. Sarokin (2017:2) defines a paradigm as a central conceptual framework for how one views the world around one, and it can be so ubiquitous or widespread and well accepted that it can be almost unnoticed. In addition, Abdulkareem, Ismaila and Jumare (2017:25) indicate that the term paradigm refers to a research philosophy with a set of beliefs, values, and assumptions that a researcher has in common, concerning the nature and conduct of research. They emphasise that a paradigm is not a theory but provides a lens that guides the choice of theory and methods in research; simply meaning that it is an approach to thinking about and doing research.

There are several research paradigms in psychology and social research, but for purposes of this study, the interpretive paradigm will be used as it allows me, as the researcher, to make meaning of my data through my own thinking and cognitive processing of the data informed by my interactions with the study participants. It allows the researcher to construct knowledge socially as a result of their personal experiences of the real life within the natural settings and social environments in this case. In summary, Kivunja and Kuyini (2017:34) emphasise that the Interpretivist paradigm posits that social environments cannot be fully comprehended from the standpoint of an individual, as people's and learners' realities are multiple and socially constructed based on their context. This resonates well with my belief that social environments are vital for knowledge and learning; thus, the need to clearly acknowledge and understand how social environments influence school health and sexuality education programmes. This will then enable the research to recommend how these contextual factors can or should be taken into consideration in the systematic pursuit of functional and effective school health, HIV and sexuality education programmes in Lesotho.

As this is a qualitative study, the use of the interpretive research paradigm will further enable me to conclude this study by recommending a framework to integrate social environments in school health and sexuality education programmes. Taking an interpretive angle means highlighting the fact that I will take an epistemological position of co-creating and sharing knowledge, while also creating relationships

between the variables of social environments, school health and sexuality education through using rich, qualitative data. This notion is further affirmed by Kivunja and Kuyini (2017:33) by noting that the key principle of the Interpretivist paradigm is that reality is socially constructed, hence also referred to as the Constructivist paradigm. It will therefore enable the study to suggest and specify requirements for effective and results-based sexuality education and school health programmes; create alternative solutions; and build what can be referred to as a prototype for such programmes which will be grounded within the social environments that affect them.

2.3 THEORETICAL FRAMEWORK

Based on the above research paradigm and research grounding, a framework and theories that have a direct relationship with the key concepts will be highlighted. The bio-psychosocial framework will position the study within the psychological frame, with the intention of explaining and predicting health behaviours by focusing on the attitudes and beliefs of individuals, of learners, teachers and school leadership, including community leaders and policy makers. It will then be complemented by the Sociocultural Theory, as well as the Socio-Ecological model.

2.3.2 The Biopsychosocial Framework

Melchert (2007:9) indicates that even though this approach is referred to as the 'biopsychosocial model,' this perspective is not considered a model or a theory because it applies at a very general level and does not attempt to explain specific phenomena related to either physical or mental functioning but describes an essential and fundamental characteristic of human beings. The biopsychosocial integrative framework is based on the perspective that people are inherently biopsychosocial organisms in which the biological, psychological, and social dimensions are inextricably intertwined (Black and Hoeft 2015; Meyer 2008). It interprets human health as a product of social environments in the form of the shared influences of biological, psychological, interpersonal, and macrosystem contextual dynamics that unfold over personal and historical time. The model intertwines biological, psychological, and sociological factors: physical or chemical alterations to the body (biological factors), personal development and psychological/mental health factors, as well as social determinants.

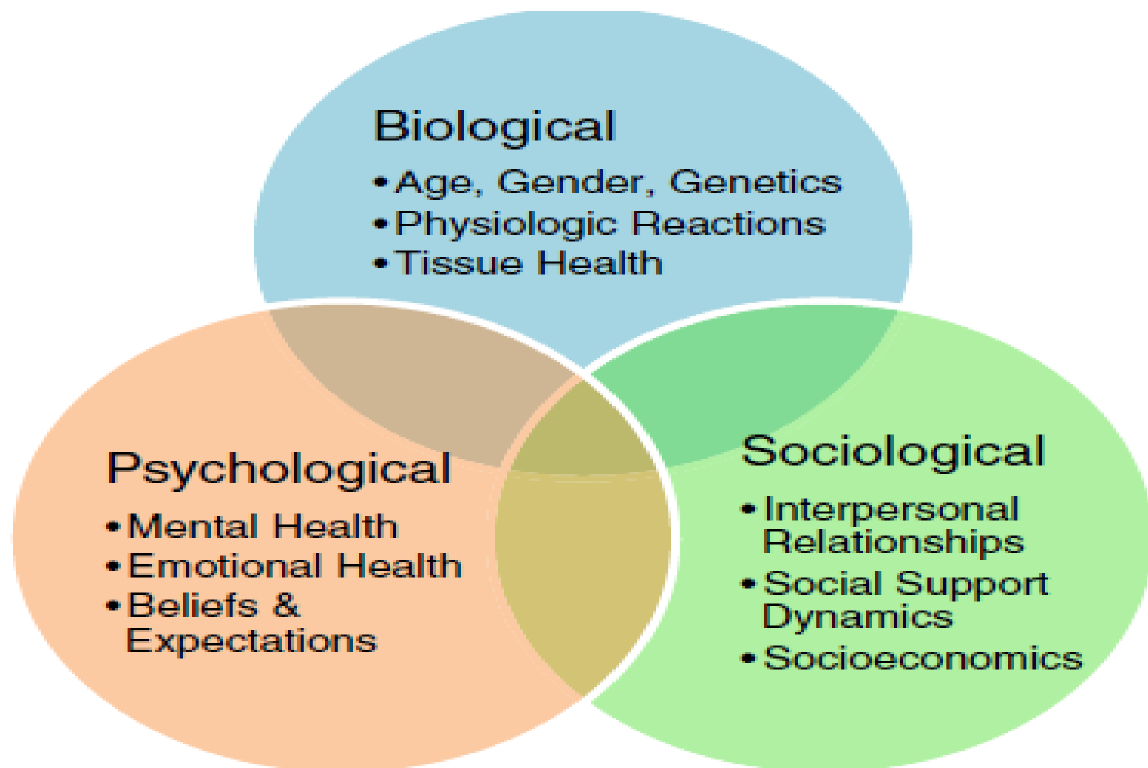


Figure 2.1 The Biopsychosocial Model (Gliedt, Schneider, Evans, King & Eubanks 2017:2)

This model clearly explains the relationship between the physical attributes, the psychological, as well as the social environments, thus its relevance to the study. These relations have, for a long time not been taken into consideration in the development and implementation of school health and HIV programmes. In emphasising the relationship between the biological, psychological and sociological factors, this model continues to highlight the fact that school health and HIV programmes, especially sexuality education programmes, will be affected by the biological development of learners, as the content and approaches will resonate with the developmental and psychological stage and state of the learner. The implementation and success of these programmes will further be greatly influenced by the leaners' beliefs, interpersonal relationships including with family and society, as well as by their socioeconomic status; hence the need to continuously acknowledge these relations if school health and HIV programmes are to be successful.

2.3.3 Sociocultural Theory (SCT)

In an effort to emphasise and entrench the cultural components of the study, the Sociocultural Theory will be used. As illustrated by Muller, Buchheister and Boutte 2017:14), socio-cultural theorists view the learner as an active interpreter of information within a structured society, as they are of the view that "cognition is culturally mediated by material and semantic artifacts such as tools and signs, it is founded in purposive activity". This then leads to cognitive development being influenced and shaped by a person's cultural environment, which includes their participation in social and cultural situations and events.

Lev Vygotsky (1896-1934) is one of the Russian psychologists whose ideas have influenced the field of educational psychology and education as a whole. For him, although biological factors constitute the necessary pre-requisite for elementary processes to emerge, sociocultural factors are indispensable for elementary natural processes to develop. Through the Sociocultural Theory, Vygotsky focused on the relationships between an individual's psychological aspects and the social and culturally produced contexts and artefacts that transform the individual's cognitive or mental functions (Turuk 2008:244).

Lantolf in Zubaidi (2015) clarifies that though the name Sociocultural theory may imply the meaning of the theory, it is not necessarily a theory of the social or cultural aspects of humanity, but rather a "theory of mind" that recognises the central role played by culture and social relationships in people's ways of thinking. This is critical for this study as it clarifies the importance of culture and social capital in the way learners, parents, teachers and leaders think and comprehend health and HIV programmes within the school and community settings.

The main components or ideas of the Sociocultural theory on cognitive development are:

- **Internalisation**: Vygotsky encourages teachers not to concentrate too much on teaching concrete facts but also to guide their students into an abstract world as a means to assisting them to develop multiple skills that will enable them to deal with complex learning tasks.

• **Zone of Proximal Development (ZPD)**: highlights the distance between a child's actual developmental level and the higher level of potential development.
• **Scaffolding**: is an instructional structure whereby the teacher models the desired learning strategy or task, then gradually shifts responsibility to the students.
• **Mediation:** refers to the part played by other significant people in the learners' lives.
• **Dynamic Assessment:** outlines that what children can do with assistance, better reflects intelligence, than what a child can do alone.

The above components denote that certain sociodemographic factors, especially culture and gender play a critical role in the way people, and learners in this regard behave and think; hence the need to link culture to the learners' cognitive development, as well as their relations with others for school health and sexuality education programmes to be effective. According to Vygotsky (in Linton & Rueda 2015:4), Sociocultural theory as outlined in Figure 2.2 posits that interpersonal interactions can be understood only with reference to historical and cultural forms. People obtain information through the combination of signs, internally oriented activities and tools, as well as externally oriented human influence. This theory, therefore, affirms the relationship between the cultural ways of living, which are explained as social interactions, as well as their impact on the way people develop cognitively and the way they comprehend issues. This highlights the need for cultural awareness and the recognition of sociodemographic factors in general, in education and other health programmes and initiatives.

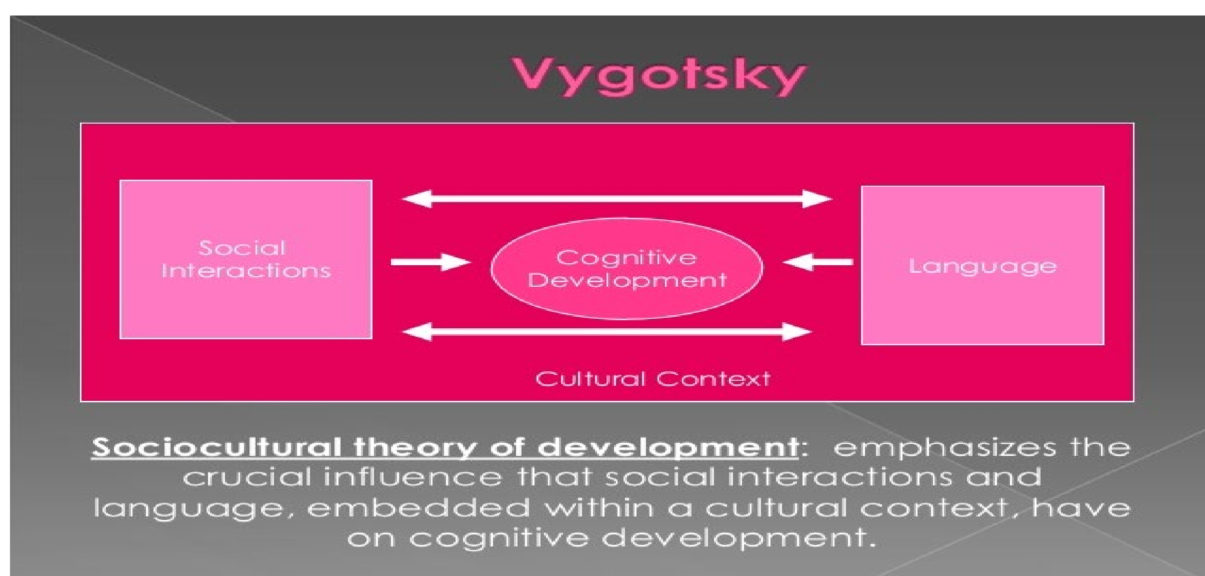


Figure 2.2 Vygotsky's Sociocultural Theory of Development (Osborne 2012:2)

The emphasis of the theory on the influence that social interactions and language - embedded within culture - have on people's cognitive development highlights the critical need to ensure that learning and educational strategies are socially and culturally responsive. This can be done by, among other things, integrating socially and culturally acceptable language in the classroom, and using teaching methods and strategies that integrate students' cultural and community contexts to recognise the social interactions to which learners are exposed. Kanaʻiaupuni, Ledward, and Jensen (2010:17) suggest that one approach is to increase teacher sensitivity and pedagogical knowledge for working with the cultural diversity of all students, as culture-based educational practices encourage instruction and learning that is rooted in cultural and linguistically relevant contexts.

The assertions by these researchers are in alignment with the Theory's concept of *Internalisation*, which highlights that language is key to the internalisation of complex ideas. Therefore, if ideas, issues and facts are not communicated in a language that is socially and culturally meaningful to the learners, it will not make sense as they understand and remember knowledge based on their own social context. In addition, Parrish and Linder-Vanberschot (2010:1) indicate that the growing multicultural nature of education and training environments make it critical that instructors and teachers develop skills to effectively deliver culturally sensitive and culturally adaptive instruction and education. They further assert that culture forms an expansive middle portion of the thinking pyramid, reflecting its multiple layers of group interactions, for instance, from the national level to the local community.

Furthermore, the Sociocultural theory highlights that *Mediation* is critical for learning. Lantolf and Poehner (2008:7) indicate that human contact with the world is indirect and is mediated by signs and tools – which are psychological, social and cultural tools. This basically means that people represent their thoughts well when they are familiar with the communication form used; thus, the need for community and parental involvement in the design and implementation of school health and HIV programmes is important. This is underscored by the fact that culture shapes individuals and communities, including their norms, values, attitudes and behaviours, and in turn, people shape their own culture, including how they would want programmes and initiatives, even within the education sector, to be managed and implemented.

The above factors are displayed in everyday lives, as decisions made by individuals are strongly influenced by culture, both in their personal lives and specifically around education and related issues. In implementing school health and HIV programmes, and specifically sexuality education, Khau (2012:65) asserts that parents in Lesotho wish for their children to be taught past cultural practices which would instil moral values, resilience and pride in their children. Moreover, they believe that these should be given equal or greater attention within the curriculum, instead of the current sexuality education content. As UNESCO (2003:7) states, “if behaviours need to be changed – as is the case in the time of AIDS – norms, values and attitudes need to change at the same time; hence working on culture, incorporating positive and relevant HIV and related behaviour change messages is of utmost importance”.

These issues highlight the needed advocacy and call for school health, HIV and sexuality education interventions and programmes to be designed and implemented in relation, and in response to the intended or target individuals’ and communities’ social environments for them to be effective, as they will benefit from the much-needed community ownership. In conclusion, the social environment, specifically cultural and ethnic identity can mitigate negative experiences, increase self-confidence, self-esteem, and resilience among children and adults. This could be due to the fact that culture is related to the functioning of social and family networks, leading to the inherent benefits of integrating sociodemographic factors into the delivery of health, social work, education, and other services as summed up by the model in Figure 2.3.

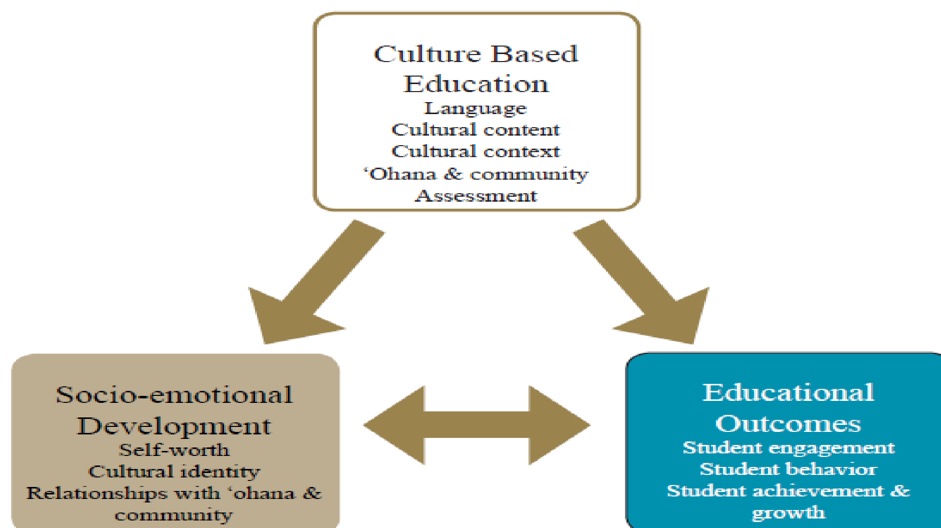


Figure 2.3 Cultural Influences in Education Study Model (Kana‘iaupuni et al. 2010)

To conclude, Mason, Schmidt, Abraham, Walker and Tercyak (2009:347) affirm my choice of the SCT, in that it is a socially informed theoretical model for understanding the impact of adolescents' sociodemographic factors, as it suggests that human behaviour results from the dynamic and ongoing interaction of personal, environmental, and behavioural factors.

2.3.4 The Socio-Ecological model

To sum up the theoretical framework, the socio-ecological model (SEM), which was first introduced as a conceptual model for understanding human development by Urie Bronfenbrenner in the1970s and later formalised as a theory in the 1980s, will inform this study. As Kilanowski (2017:295) postulates, the model works across four levels, being the microsystem, the mesosystem, the exosytem, and the macrosystem. The microsystem is closest to the individual, contains the strongest influences and encompasses the interactions and relationships of the immediate surroundings. The second layer is the mesosystem that looks beyond immediate interactions and includes those the individual has direct contact with, such as work, school, church, and neighbourhood. The exosystem on the other hand, does not directly impact the individual but exerts both negative and positive interactive forces on the individual, such as community contexts and social networks. The macrosystem includes societal, religious, and cultural values and influences. All these are linked by the chronosystem, which contains both internal and external elements of time and historical content; in revised models, this level includes the influence of policy.

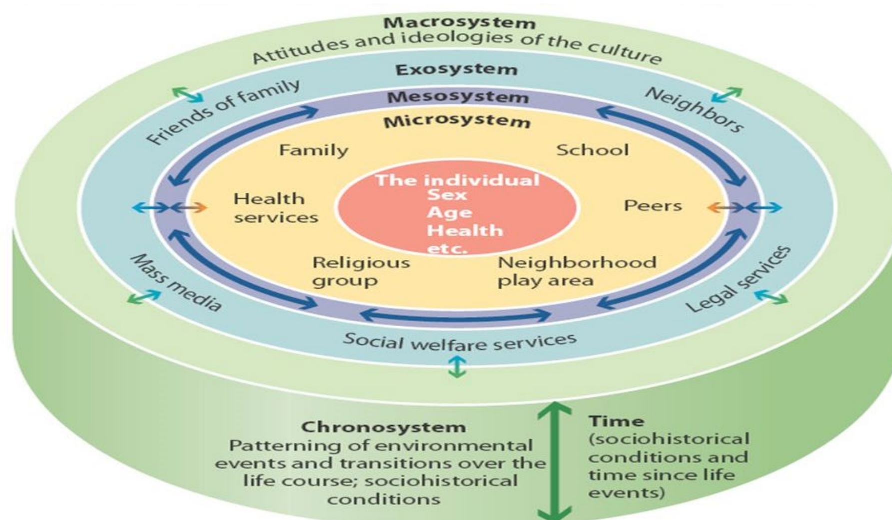


Figure 2.4 Bronfenbrenner's Ecological Theory of Development (Analisah & Indartono 2019:240)

The theory basically emphasises that behaviour is understood to be shaped at multiple levels and by varied forces. Thus, I find the Socio Ecological Model to be useful in the creation of sustainable solutions for at-risk individuals and societies as it is very comprehensive by dealing with the individual, community, institution, and policy. This is further affirmed by Simovska & Kane (2015:6) in that the socio-ecological model also offers sexuality educators and school administrators an avenue to broadly explore how to achieve sexual health through sexuality education, both within and outside the school environment.

This then enables sexuality educators to utilise new ways of addressing structural issues to better serve all students to increase the quality of their sexual health through integrating critical pedagogy and the physical, social, emotional, intellectual and spiritual dimensions. This therefore necessitates the socio-ecological model in school health and HIV programmes, to clearly comprehend the structural, socio-historical and cultural factors influencing sexuality education and its implementation, from the macro (socio political and ecological) to the micro level, which includes the attitudes of parents, teachers, and other community and national stakeholders.

The model resonates with, and highlights the importance of sociodemographic factors and social environments in school health and HIV programmes, as these social environments include all the levels beyond the individual person, with all the decisions made by the individual being influenced by the macrosystem, exosystem, and mesosystem, as well as the microsystem. Townsend and Foster (2011:1102) clearly maintain that the SE model provides two critical concepts, in that behaviour affects and is affected by multiple levels of influence, and that individual behaviour shapes and is shaped by the social environment; hence the study intends to highlight the interaction between, and interdependence of factors related to health behaviours and interventions.

This then demonstrates that learners and related school programmes, should not be viewed in isolation, as they exist within larger social environments, which can either support, and promote school health and HIV programmes, or negatively influence and affect them. It is evident that for school health, especially HIV and sexuality education programmes, the linkages between all these environments and systems should be

taken into consideration, as what the learner does and believes in, is influenced by their social environments.

2.4 CONCLUSION

School-based interventions have been proven to be effective in several areas; for adolescent girls, in particular, investments in comprehensive sexuality education, reproductive health knowledge and related services, sanitary facilities, and iron supplementation are crucial to support school enrolment and retention (Bundy, de Silva, Horton, Jamison & Patton 2018:xi). These necessitate functional school health and sexuality education programmes, especially in Lesotho and in Southern Africa, where the brunt of the HIV pandemic is highest among adolescent girls and young women.

The decision to use the two theories and a model is informed by the fact that multiple theories give varying perspectives on key issues, and this enabled me to define this study philosophically, psychologically, and analytically. These links between the biopsychosocial integrative framework which emphasises that people are complex beings with intricately interwoven human and social dimensions, clearly denoting that school health and HIV programmes, specifically sexuality education programmes need to be as comprehensive as possible.

Finally, the Sociocultural Theory affirms the above theories and model, and connects them by placing emphasis on the relations between social interactions and language, highlighting the need for appropriate and relevant language in the design and implementation of school health programmes. This selection allowed me to research the study variables in a broad manner to reach credible conclusions and limit bias. The theories and model with also be aligned with the study findings, to affirm some of their strengths and highlight how this study can contribute to complement some of them and fill the outstanding gaps, as presented earlier. The next chapter will present the research design and methodology, with emphasis on the paradigm guiding the study, as well as the specific data gathering and analysis processes.

CHAPTER 3: RESEARCH DESIGN AND METHODOLOGY

3.1 INTRODUCTION

This is an interpretive study based on several theories, consisting of qualitative research methodologies aimed at critically analysing the influence of gender and culture as specific sociodemographic factors on school health and HIV programmes, with a specific focus on sexuality education programmes in Lesotho.

The aim of this chapter is therefore threefold: firstly, to compile and to present an overview of the investigation in terms of the processes, and steps used to gather and analyse data in an effort to increase the comprehension of the research topic. Secondly, it will provide an overview of the research design and methodology, while covering the research paradigm, the research methods, strategy of inquiry, data collection tools, sampling, research setting, data analysis. Thirdly, it aims to present specific information around trustworthiness and ethical issues.

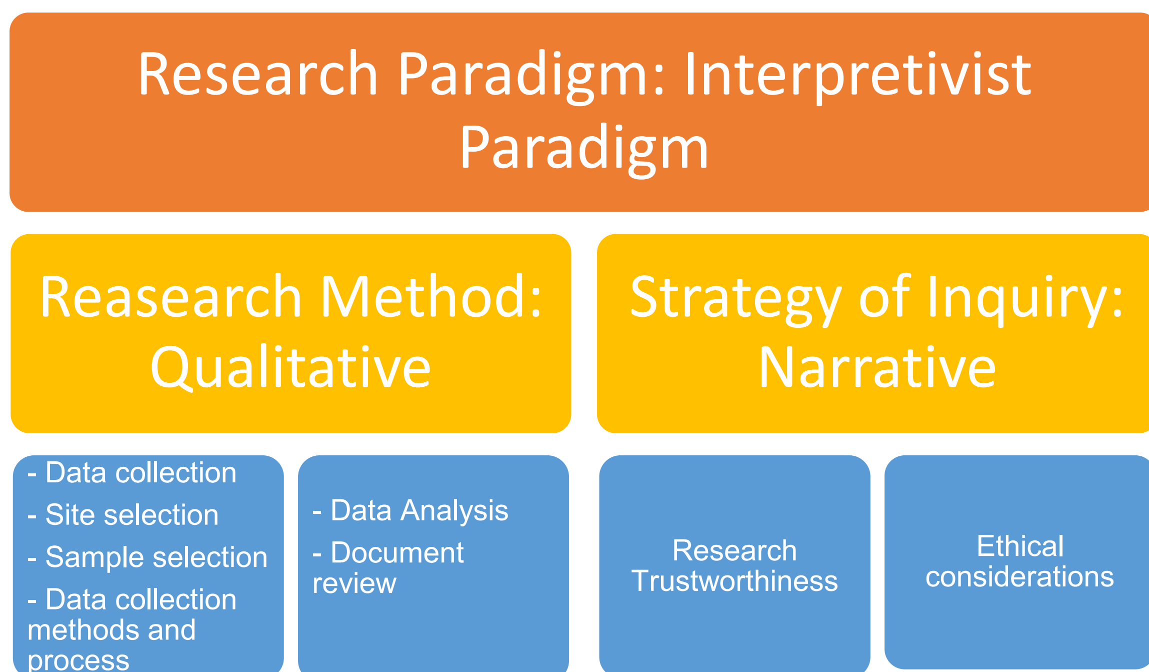


Figure 3.1 Summary of Chapter 3

3.2 RESEARCH DESIGN

As indicated in Chapter 1, this study will use qualitative research methods due to its social and people-centred nature. This decision is also based on the fact that quantitative approaches usually have an objective reality, while qualitative approaches make an effort to identify reality as socially and psychologically constructed. This is affirmed by Gelo, Braakmann and Benetka (2008:270) as they are of the view that quantitative paradigms see reality as single and tangible, whereas qualitative paradigms view reality as a multiple, socially and psychologically constructed phenomenon.

Due to the complexity of sociodemographic factors and their inter-relations with the key variables within the research being school health and HIV programmes, with a specific focus on sexuality education, a combination of paradigms and theories have been used to anchor the theoretical framework of the study.

3.3 INTERPRETIVIST RESEARCH PARADIGM

This research is anchored in the interpretivist research paradigm as various sociodemographic factors are interpreted differently by various social and cultural groups of people and populations, similarly, affecting different people differently. Thanh and Thanh (2015:24) aver that a research paradigm comprises three elements: a belief about the nature of knowledge; a methodology; and criteria for validity. They assert that taking into account the views of different scholars, the interpretivist paradigm allows researchers to view the world through the perceptions and experiences of the participants, as their experiences are used to construct and interpret the researcher's understanding from the data they gather.

This therefore affirms the notion that the realities that happen in the education sector and in various communities are influenced by individuals' perception and understanding of schools and society. However, the challenge is that if parents and communities are not involved in the design and implementation of programmes, their subjective views will shape and control their behaviour towards the health and HIV programmes in schools.

Furthermore, Pham (2018:30) states that since multiple interpretations are developed among humans' relationships, interpretivist researchers should try to understand "the diverse ways of seeing and experiencing the world through different contexts and cultures" and attempt to avoid bias in studying the events and people with their own interpretations. This has enabled this study to directly interrogate and explore the key sociodemographic factors, specifically gender and culture in school health and HIV programmes, such as sexuality education programmes. Instead of generalising, the key gender and cultural issues which influence learners, teachers, parents, policy makers and general communities towards health and HIV programmes in schools will be discussed in a focused manner. This will highlight the various policy and implementation issues to be taken into consideration as global and regional economic communities, governments, institutions and communities make decisions in responding to the challenges faced by adolescents and young people, especially in Lesotho.

Based on the complexity of human behaviours and the various factors affecting beliefs, cultures and values, the interpretivist paradigm will enable me to look into the diverse views on school health, especially HIV and sexuality education programmes, as the study does not look only into these programmes, but aims to deeply understand them within the various social contexts. The other advantage of this paradigm is that the research will be conducted within the participants' natural settings in order to provide more authentic information related to the research objectives. It will also allow me, as a researcher, to probe their thoughts, values, prejudices, perceptions, views, feelings and perspectives, which will provide valuable data for better insights for further action and/or reprioritisation as far as school health programmes are concerned, with a specific focus on HIV and sexuality education programmes.

It is however worth acknowledging that despite its strengths, the interpretivist paradigm also has its limitations. Pham (2018:30) notes that although interpretivists aim to gain a deeper understanding and knowledge of phenomena within their complexity of context, rather than generalise these results to other people and other contexts, this tends to leave a gap in verifying the validity and usefulness of research outcomes by using scientific procedures. Secondly, the paradigm is also criticised for its ontological view, which tends to be subjective rather than objective, as research

outcomes are unquestionably affected by the researcher's own interpretation, own belief system, ways of thinking or cultural preference which may lead to bias.

In addition, interpretivism is thought to be very limited in addressing the political and ideological impact on knowledge and social reality, as it focuses on understanding current phenomena, rather than focusing on the problems related to the empowerment of individuals and societies. I do however aim to overcome this limitation as this study also provides a historical view in terms of school health, HIV and sexuality education programmes, and highlights the gender and cultural issues, with an emphasis on the critical issues of power and agency, which are features of our society.

Finally, Interpretivism provides multiple perspectives on an issue and will lead to a more comprehensive understanding of the sociodemographic factors, especially from the gender and culture perspectives that affect and influence school health, HIV and sexuality education programmes. This paradigm will therefore significantly facilitate more in-depth and insightful information and perspectives from society, to inform these programmes.

3.4 QUALITATIVE RESEARCH

Qualitative research is an umbrella term for a broad range of different approaches and methods, which vary considerably in terms of focus, assumptions about the nature of knowledge and the role of the researcher (Astalin 2013:121). Many efforts and attempts have been made to define qualitative research in the social sciences, and to determine the differences between it and quantitative research, but there is limited consensus. This is mainly because qualitative research is certainly not a unified set of techniques or philosophies, but has grown out of a wide range of intellectual and disciplinary traditions, and is most commonly associated with certain schools which fall broadly within what is known as the interpretivist sociological tradition (Mason 2002:2).

Astalin (2013:118) defines qualitative research as a systematic scientific inquiry which seeks to build a holistic, largely narrative description to inform the researcher's understanding of a social or cultural issue. The definition implies that data and

meaning gradually emerge from the research context. Qualitative research has been seen to work out under a combination of observations, interviews, and document reviews, as it emphasises the value of looking at variables within the natural settings in which they are found. Most importantly, the interviewer or researcher becomes an integral part of the investigation which will be evident in this study, as I will interact with the participants in order to clearly comprehend the key issues being explored.

Abdullahi, Senekal, Van Zyl-Schalekamp, Amzat and Saliman (2012:23) provide another critical historical justification as they indicate that social life and human actions are highly complex, multidimensional and entrenched in meanings. Although the journey to demystify and understand the complex nature of human society and human behaviour began with positivism, leading to the quantitative research approach, over the past few years the emergence of what these authors term, "a dynamic method of investigation in the social sciences widely known as the naturalist, interpretive, constructivist or qualitative research methodology" has come to the fore.

Hoepfl (1997:49) summarises the advantages of qualitative research through eight distinct characteristics, being that qualitative research uses the natural setting as the source of data, as the researcher attempts to observe, describe and interpret settings as they are, maintaining what is called "empathic neutrality". In addition, the researcher acts as the "human instrument" of data collection, and predominantly uses inductive data analysis. Furthermore, the reports in qualitative research are descriptive, incorporating expressive language and the "presence of voice in the text" as it has an interpretive character, aimed at discovering the meaning events have for the individuals who experience them, and the interpretations of those meanings by the researcher.

Other advantages include the fact that within qualitative research, the researcher pays attention to the idiosyncratic, as well as the pervasive, thus seeking the uniqueness of each case, as it has an emergent (as opposed to predetermined) design. Hoepfl (1997:49) concludes by alluding to the fact that it allows researchers to focus on the emerging process, as well as the outcomes/product of the research, as qualitative research is judged using special criteria for trustworthiness, which will be discussed in some detail in a later section. These views are further affirmed by Hammarberg,

Kirkman and de Lacey (2016: 489-499) as they indicate that in psychosocial research, qualitative methods mainly answer questions about experience, meaning and perspective, most often from the standpoint of the respondent.

As initially indicated, in most cases, qualitative data are usually not amenable to counting or measuring. This study has therefore opted for focus group discussions with the participants within the study area. This is facilitated by that these qualitative research techniques include small-group discussions for investigating beliefs, attitudes and concepts of normative behaviour; semi-structured interviews, with the intention to seek views on specific topics or areas to gain background information or institutional perspectives with the key informants; in-depth interviews to comprehend one or more conditions, experiences, or events from a personal perspective; as well as the analysis of texts and documents, such as government reports, media articles, websites or diaries, to learn about distributed or private knowledge.

The various definitions and explanations of qualitative research provide a holistic view of qualitative research and how it links with this study, which is concerned with the sociodemographic factors, specifically culture and gender, affecting school health, HIV and sexuality education programmes in schools. This is derived from the same belief that qualitative research is anchored in value systems, which encapsulate people's values, norms, and culture.

3.4.1 Rationale and Purpose

There have been protracted debates over the years on the relative value of qualitative and quantitative research. Hoepfl (1997:47) avers that while qualitative research uses a naturalistic approach that seeks to understand phenomena in context-specific settings, quantitative research, on the contrary makes use of experimental methods and is usually used to test hypothetical generalisations. He indicates that in instances where "quantitative researchers seek causal determination, prediction, and

generalization of findings, qualitative researchers instead seek illumination, understanding, and extrapolation to similar situations”

These views are affirmed by Peter (2015:1) as she indicates that qualitative research is a situated activity that involves the researcher as a key instrument of data collection, and not as an objective, authoritative, politically neutral observer. As a researcher, I interacted with the participants in the focus group discussions and did not bring my objective views on how school health, especially HIV and sexuality education programmes are supposed to be managed and implemented within schools and communities. This allowed me to collect some richly descriptive data as the naturalistic approach of qualitative research gave me an opportunity to observe, not only the behaviours and activities of humans, but also the physical settings in which these activities take place.

3.4.2 Research Participants

The research participants comprised community health / extension workers, community members, faith and community leaders, government officials, students, teachers, as well as development partners supporting school health, HIV and sexuality education programmes in Lesotho. These participants were mainly from the Maseru and Mafeteng districts which are the capital city of Lesotho and an urban district in the south of Lesotho respectively.

3.4.3 Selection and Sampling

Sampling can be broadly defined as the selection of specific data sources from which data are collected to address the research objectives (Gentles, Charles, Ploeg & McKibbon 2015:1775). In selecting a sample for this study, purposeful or purposive sampling was used. This, as defined by Palinkas, Horwitz, Green, Wisdom, Duan and Hoagwood (2015:534) is a technique “widely used in qualitative research for the identification and selection of information-rich cases for the most effective use of limited resources”. It involves identifying and selecting individuals or groups of

individuals that are especially knowledgeable about an issue or have vast experience on the issue.

The use of purposive sampling is supported by Patton (2015:264) as he asserts that the logic and power of purposeful sampling lie in selecting information-rich cases for in-depth study. It is from these information-rich respondents that I, as the researcher, also learnt a great deal and gained more in-depth comprehension of school health programmes, especially HIV and sexuality education programmes and how they are perceived by the participants and influenced by their sociodemographic factors, especially gender and culture, in this instance.

Within purposive sampling, expert sampling was used to select the development partners supporting sexuality education in Lesotho, as well as the Ministry of Education and Training staff members. This is informed by Etikan, Musa & Alkassim (2016:3) in their articulation that expert sampling calls for experts in a particular field to be the subjects of the purposive sampling. This is a positive tool to use when investigating new areas of research, to establish whether or not further study would be worth the effort. In this instance, even though sexuality education is not necessarily new in Lesotho, following the signing of the Eastern and Southern African (ESA) Commitment on Comprehensive Sexuality Education and Sexual and Reproductive Health Services for adolescents and young people (2013) - usually referred to as the ESA Commitment - the Ministry of Education and Training institutionalised the Lifeskills-Based Sexuality Education (LBSE), as a stand-alone, assessed subject. This process has been led by a core group of officials and development partners, hence their selection.

The Government of Lesotho has rolled out Life Skills Based Sexuality Education across the country including in the two districts of Maseru and Mafeteng, hence their selection. Within the districts, particular communities were selected for the focus group discussions. Their selection was based on the researcher's relations and rapport with the community leaders and members, which is critical for in-depth dialogues and discussions. In Mafeteng, Motse-Mocha within the Mafeteng urban constituency, was selected; while in Maseru, the Abia constituency was used for the data collection due to the good relations with the area chief and some community members. All these

constituencies have within them high schools offering the Life Skills Based Sexuality Education offered by the government of Lesotho.

Although Etikan, Musa and Alkassim (2016:2) indicate that purposive sampling is a non-random technique that does not need underlying theories or a set number of participants, for purposes of this study, the sample of participants was based on my knowledge of local champions and leaders, but also with the guidance from both the community leaders and the Ministry of Education and Training, in order for me to interact with the other stakeholders in the education sector.

For the stakeholders and partners of the Ministry of Education, expert sampling was used as I had only the focus group discussions with the school health, HIV and sexuality education team members, comprising officials from the Ministry of Education and Training (MoET), Ministry of Gender, Youth, Sports & Recreation (MGYSR), Ministry of Health (MoH), and the National Curriculum Development Centre (NCDC), and development partners (UNESCO, UNAIDS, UNICEF). These were selected based on the recommendations of the Ministry of Education HIV Unit, which leads and coordinates school health, HIV and sexuality education programmes in Lesotho; as well as due to their active involvement and leadership as members of the sexuality education and school health technical working group in Lesotho.

3.4.4 Data Collection

A research team comprising two note takers and a subscriber was constituted. As indicated in Chapter 1, the data were collected through seven focus group discussions. Sutton and Austin (2015:227) are of the opinion that regardless of the philosophical standpoint of the researcher, and the data collection method, the process will involve the generation of large amounts of data. In addition to the variety of study methodologies available, there are various ways of recording what is said and done during a focus group discussion, such as taking handwritten notes or audio recording. Both these processes were used to capture and record data from the focus groups and the data were then transcribed afterwards for analysis.

3.5 FOCUS GROUP DISCUSSIONS

Qualitative research methods have traditionally been utilised in two main instances. The first one is when the researcher is interested in understanding the 'why' behind people's behaviours or actions, as qualitative research will then provide avenues to obtain an in-depth understanding of the underlying reasons, attitudes, and motivations behind various human behaviours. Secondly, these research methods are also used when the researcher is interested in better understanding a particular issue from the participants' perspective (Rosenthal 2016:510). These reasons are fully aligned with my intentions to specifically utilise qualitative research methods, with the intentional choice of focus group discussions.

As indicated in Chapter 1, seven focus group discussions were held with the seven groups of adolescents and young people, teachers, community members including parents, faith and community leaders, community health workers, government officials, as well as development partners supporting HIV and sexuality education programmes in Lesotho. The two (2) focus group discussions in Mafeteng comprised students and community members which included parents, and the five (5) focus groups discussions in Maseru comprised students, community members including faith and community leaders, teachers, government officials and development partners. These focus group discussions were used to substantiate and, in some instances, annul some of the theoretical assumptions regarding school health, especially HIV and sexuality education programmes in Lesotho. Specifically, the focus groups highlighted the social issues and attributes that either facilitate or hinder the implementation and success of the school health, HIV and sexuality education programmes.

The number of participants in these discussions is important, and although it is generally accepted that between six and eight participants are sufficient, some studies have reported as few as four and as many as fifteen or more. This is complicated by the uncertainties around focus groups discussions around the lack of guarantee that all those recruited will attend the discussion. (Ochieng, Wilson, Derrick & Mukherjee 2018:24). In this study, the focus groups ranged from nine to nineteen (19) participants. Even though the recommendation is to over- recruit by 10– 25%, the over-

recruitment in the study was due to the mobilisation strategy used by working with the chiefs and community counsellors. My belief, also affirmed by the participants for the over-attendance, is the great interest in health and sexuality education issues by the community members, given the increasing levels of early and unintended pregnancies, HIV incidence, as well as age-disparate sex in Lesotho.

It is however worth noting that this over-recruitment was turned into an opportunity to obtain data saturation. O'Reilly & Parker, 2012; Walker, 2012 in Fusch and Ness (2015:1409) define data saturation as a point "when there is enough information to replicate the study when the ability to obtain additional new information has been attained". They assert that the importance of data saturation cannot be overemphasised as failure to reach data saturation has an impact on the quality of the research conducted and hampers content validity. As Hancock, Amankwaa, Revell & Mueller (2016:2124), the "gold standard" for quality research is data saturation, as instead of relying on the number of participants, qualitative research focuses on different perspectives and opinions of participants. Fusch and Ness (2015:1410) sum it up by postulating that, "a focus group is one way to elicit a number of perspectives on a given topic to reach data saturation, especially if one had a large pool of potential participants to draw from".

Rosenthal (2016:510) does however, caution that the quality of the data received from an in-depth interview or focus group is heavily dependent on the level of thought put into the development of the questions posed to the participants. She provides six primary kinds of open-ended, in-depth focus groups questions: experience or behaviour questions; sensory questions; opinion or value questions; knowledge questions; feeling questions; and background or demographic questions. In analysing these question types, it becomes apparent that experience or behaviour questions are designed to understand a participant's actions, either past or present. Experience questions are often followed by sensory questions, which focus on things that the participant has physically experienced, and therefore can help them to better remember other experiences or behaviours.

In addition, Rosenthal (2016:510) avers that opinion or value questions are designed to elicit a participant's understanding of a phenomenon or experience and then provide

specific insight into their goals and intentions. On the other hand, knowledge questions seek factual information from a participant, and these were specifically appropriate for the teachers, government officials and development partners supporting school health, HIV and sexuality education programmes as they provide the facts on how these programmes have been designed, are being implemented and what some of the key issues and challenges in their implementation are. These are the direct opposite of feeling questions, as they are intended to prompt a description of an emotion from a participant; therefore, it became critical to carefully develop the wording of these questions to get the desired responses. Finally, background or demographic questions were used to facilitate the characterisation of the people participating in the focus groups.

In summary, focus group discussions were useful for obtaining the desired data for this study, as the connection between people's perceptions and their socio-cultural situation is critical to decision-making, as most people derive their notions, mental constructions and interpretations from their immediate surroundings and develop these from their practical knowledge. This process is further outlined by Ochieng,

Wilson, Derrick, and Mukherjee (2018:25) in Figure 3.2. as they provide a detailed flow chart of focus group discussions.

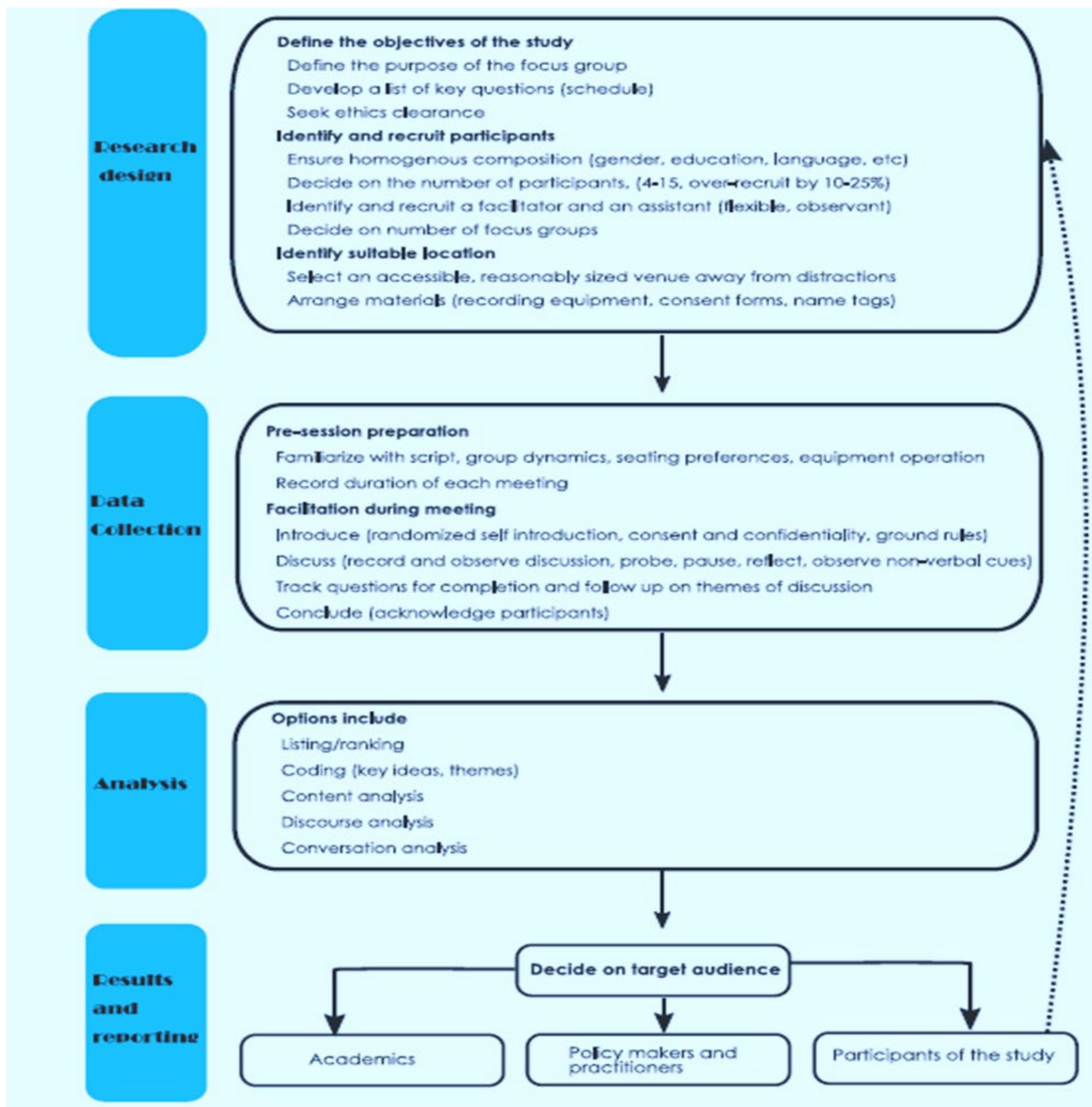


Figure 3.2 Focus Group Discussion Flow Chart (Wilson, Derrick & Mukherjee 2018:25)

Following the data collection, which was done in Sesotho, the information from the notes and recordings was translated by a certified translator, transcribed, and coded. These were derived from the field notes, which were taken to complement the audio recordings, as they were helpful in assisting me to note some of the observations in terms of impressions, environmental contexts, behaviours, and some nonverbal signals that might not have been adequately captured through the notes and recordings.

3.5.1 Advantages and Disadvantages of Focus Group Discussions

There are several benefits and advantages of using focus groups, especially in issues related to sociodemographic factors, thus, my choice of focus groups. Namey (2019: 28) mentions some of their benefits, which include their ability to provide a broad range of perspectives, specifically regarding understanding social norms. They are also beneficial if one is interested in group dynamics, which is my interest due to the nature of school health, HIV, and sexuality education programmes and how gender and culture affect and influence these programmes. Of critical importance is the fact that focus groups can also encourage sharing of sensitive and sometimes personal information if the group dynamics are conducive. This is helpful as frequently there are no genuine, free and honest feedback loops between governments and other stakeholders in school health, HIV and sexuality education programmes as review meetings are not the most conducive settings for such feedback, due to their nature.

Gibbs (1997:2) is of the view that although practically, focus groups can be difficult to assemble, with the challenges of not being able to get a representative sample, and the process itself having the potential to discourage certain people from participating, as well as limited confidentiality or anonymity due to their administration. This said, there are still some benefits including the nature of the interaction between and among the participants, which highlights their view of the world; the language they use about an issue; and their values and beliefs about a situation. This interaction also enables them to interrogate one another, while simultaneously having opportunities to re-evaluate and reconsider their own understandings of their specific experiences.

In addition, focus groups elicit information in a way which allows me, as researcher, to find out why an issue is relevant and prominent within a specific setting, as well as how multiple explanations of the participants' behaviours, attitudes, beliefs, gender and culture will affect and influence school health, HIV and sexuality education programmes. Gibbs (1997:2) continues to emphasise that these benefits also apply to the participants as they are granted an opportunity to be involved in decision-making processes, to be valued as experts, and to be given the chance to work collaboratively with researchers and decision makers; a benefit which can be empowering for many participants. Focus groups can also become a platform or forum for change, and this can either be during the focus group meeting itself and afterwards. In this study, this

was be realised as constant, and regular feedback was provided to the Ministry of Education and Training in Lesotho, and some of the leaders and development partners during the focus groups, instead of waiting for the final data analysis and report.

Although group research focus is open ended and cannot be entirely predetermined, my view and practice were to allow the participants to talk to one another, ask questions and express doubts and opinions, while I was generally keeping them focused on the topic. This enabled them to freely interact, share their views and thoughts within their specific context and culture, without necessarily feeling intimidated by the questions.

Finally, Cox (2018:79) emphasises the benefits of focus groups as being useful for research that aims to explore, pilot or refine a programme concept; identify participants' goals, expectations and views of the efficacy of an existing or proposed programme; document experiences of implementing a programme; or describe differing outcomes across participant groups. They can be very beneficial for discussing ideas about new or existing programmes, for obtaining practitioners' and the local community's views on the perceived enablers and the barriers involved, or to even assess a programme's effectiveness and efficiency across a range of stakeholders. These focus groups were able to provide the much-needed views of these stakeholders and community members on how sociodemographic factors influence school health, specifically HIV and sexuality education programmes in Lesotho. The pros and cons of focus groups are summarised below as explained by Cox and van Gorp (2018:80).

Table 3.1 Advantages and Disadvantages of Focus Group Discussions

Advantages	Disadvantages
▪ Time efficiency	▪ Participation bias: participants' selection purposive sampling and includes a limited number of participants – may lead to findings not generalisable to a wider population.
▪ Cost – consultation with relevant and various stakeholders done consulted during the same session.	▪ Moderator bias: the risk of the moderator intentionally or inadvertently injecting their personal biases into the discussion, leading to inaccurate results.
▪ Group dynamics often draw out information that may not have been anticipated by the researcher and may not have emerged from individual interviews	▪ Social desirability bias: when participants answer questions in a manner that will be viewed favourably by others.
▪ Generation of a wide range of opinions	▪ Groupthink: the tendency for participants to try to minimise conflict and reach a consensus decision without critical evaluation of alternative viewpoints and actively suppressing dissenting viewpoints.
▪ Promotion and exchange of ideas and information, encouraging varying views and beliefs	▪ Lack of anonymity: participants may be more reluctant to disclose sensitive information in a group context.
	▪ Lack of depth

To overcome some of these disadvantages, for possible bias from the purposive sampling, the selection of participants was deliberately broadened to include a wide variety of community stakeholders in the form of community leaders, parents, and community health workers. The inclusion of the adolescents of young people was another way to alleviate the non-representation of those who are most affected and are the direct beneficiaries of school health and HIV programmes in Lesotho. As I was

the main moderator, I refrained from making my views heard, but just focused on facilitating and guiding the discussion. The other team members were also well trained and briefed before the data collection. With the beginning of each discussion, ground rules were done with all to assure the participants that there is no wrong answer, as the responses and discussions should be form each individual's perspective and belief, and not necessarily what the other participants think or believe. This was also emphasised to also addresses issues related to Groupthink, as I and the other members constantly reminded ourselves of the potential dangers that groupthink can pose on the outcome of the discussion by ensuring fair distribution of opportunities to all participants to voice out their perspectives. In addition, to allay their fears about limited anonymity when they wanted to sensitive information in the group context, participants were given the opportunity to write their views on a piece of paper, as pens and paper were provided. During the seven discussions, the participants were free to discuss and respond to each other's perspectives and the pieces of paper were not utilised. Finally, to address, the possible lack of depth, the moderation was anchored on probing and engaging questions, to continue to enhance data saturation.

The three phases of focus groups were used, being the opening, during which I welcomed the group, shared the purpose and context of the focus group, how it was going to flow, and facilitated introductions. The second part was the presentation of the research question and related focus group questions, which was followed by thanking the participants, giving them an opportunity for further inputs, informing them how the data will be used, and explaining when the overall process will be completed.

3.7 DATA ANALYSIS

According to Noble and Smith (2014:2), data analysis is an interactive process, where data are systematically searched and analysed in order to provide an illuminating description of phenomena. It is a recurring process, which is vital for the creativity of the analysis, development of ideas, clarifying meaning and the reworking of concepts as new insights are identified in the data.

Following the review of field notes and compiling the recordings, the data from the recordings were transcribed in order to accurately capture what was said in the focus groups; each recording was transcribed as soon as possible after each discussion, when participants' comments were still fresh in my mind. Following this, the content was then carefully reviewed, and submitted for professional translation, to ensure that the content was not distorted. Content analysis commenced as the data were organised and categorised according to themes, patterns and trends arising from the discussions, while also referring to the notes to highlight the nonverbal communication observed. As outlined by Erlingsson and Brysiewicz (2017:94) a common starting point for qualitative content analysis is usually transcribed interview and discussion texts. This is to analyse the raw data from verbatim transcribed interviews to form categories or themes with the intention to systematically transform a large amount of text into a highly organised and concise summary of key results. For purposes of this study, the transcribed and translated data was then compiled and aligned with the key study themes.

The choice of content analysis is informed by its qualities of being a research technique for the objective, systematic and quantitative description of the manifest content of communication as defined by Bengtsson (2016:10). She underlines this process of analysis as a reliable and learnable method that precludes the personal authority of the researcher, as it is more than a counting process, because it aims to link the results to their context or to the environment in which they were produced. I

therefore used this to also compliment the written data with the other verbal and visual data that was not necessarily documented as discussion questions.

According to Wilkinson (2003:107), it is recommended that following the above process, as data are being explored, the categories will emerge and act as a framework for understanding the collected data, with processes, such as colour coding being used to do the thematic analysis. As indicated in Chapter 1, an epistemological orientation was used to analyse the data from the focus groups' transcribed data. In terms of process, I started by going through the notes and transcribed text to get an overall view and understanding of the points as raised by the participants, then divided the text into smaller parts, and linked them to the study themes, while constantly ensuring that the core meanings were not diluted or lost. Relevant codes were then formulated and then grouped into the categories as outlined in Chapter 6.

This highlights that much of reality and the meaning and categories that frame everyday life are essentially social creations, as the emphasis is on how people collaborate on a specific issue, how they achieve or fail to reach consensus in some cases, and how they construct shared meanings about social concerns. This was helpful in highlighting how the sociodemographic factors, especially culture and gender tend to influence school health, especially HIV and sexuality education programmes in Lesotho.

3.8 RESEARCH TRUSTWORTHINESS

Issues of reliability and validity cannot be overemphasised in research, especially in qualitative research due to its limitations. In ensuring that they are well noted and acknowledged, Noble and Smith (2015:34) advise that in order to assess the reliability of one's study findings, the researcher needs to make judgements about the 'soundness' of the research in relation to the application and appropriateness of the methods undertaken, as well as the integrity of the final conclusions. They broadly define the terms as, "validity refers to the integrity and application of the methods undertaken and the precision in which the findings accurately reflect the data, while reliability describes consistency within the employed analytical procedures". They do, however, note that for qualitative research specifically, alternative criteria for demonstrating rigour that should be considered are the value of truth, consistency, and neutrality, as well as applicability. This is further affirmed by Connelly (2016:435) in that the rigour of a study refers to the degree of confidence in data, interpretation, and methods used to ensure the quality of a study; hence the need to establish the protocols and procedures necessary for a study to be considered worthy of consideration by the readers or end users of the research. She asserts that the above-mentioned criteria are useful though not all procedures are used in each study.

Efforts were made in this study to ensure that the credibility and validity yardsticks were utilised and maintained in order for the research to be valid, reliable and its findings be applicable not just to Lesotho, but to the other countries in the East and Southern Africa implementing sexuality education, school health and HIV programmes. Furthermore, although Hammarberg *et al.* (2016:499) are of the opinion that the terms 'reliability' and 'validity' are contentious among qualitative researchers, as some prefer 'verification', the integrity of research, as well as its robustness are as important in qualitative studies as they are in other forms of research.

Haradhan (2017:73) emphasises that in research, validity has two essential parts being internal (credibility), and external (transferability). Internal validity indicates whether the results of the study are legitimate because of the way the groups were selected, data were recorded, or analyses were performed. It refers to whether a study

can be replicated. On the other hand, external validity shows whether the results given by the study are transferable to other groups of interest.

To ascertain the credibility of this study, I used standard procedures, tools and processes that are typically used in qualitative research, as focus group discussions have been proven to be a reliable data collection method for qualitative research (Baillie 2019; Joshi, Ganjiwale, Varma, Singh, Modi & Singh 2017; Lokanath 2016; Rosenthal 2016; Woodyatt, Finneran & Stephenson 2016). Several techniques to establish credibility that were used include prolonged engagement with the participants before the focus group discussions, before and after they were conducted; with peer-debriefing, especially with the technical working group in the Ministry of Education and Training and colleagues from UNAIDS, UNESCO and UNICEF during and after the data collection.

To ensure external validity, Korstjens and Moser (2018:121) highlight that transferability concerns the aspect of applicability of the study and its findings. In order to be transferable, the links with other programmes, gender and cultural practices and norms in Lesotho, as well as the reference and alignment of the data to the normative guidance in the region, such as the ESA Commitment were used to highlight the applicability of the research in Lesotho. The wide and deep selection of the study participants and how the research was undertaken, will enable the readers and those who will use this research to inform policy and programming, to make the transferability judgment.

It is therefore worth mentioning that when the kind of data being gathered is with the intention of answering questions of personal or social meaning, as is the case in this study, there is need to capture real-life experiences, which are unique and peculiar to each person. As Hammarberg *et al.* (2016:499) continue to clarify that the way people, and participants in this instance explain an issue or phenomenon will vary, based on the sociodemographic factors, such as culture and gender, as well as other religious or social interpretations.

3.9 ETHICAL CONSIDERATIONS

The role of the researcher in qualitative research is to attempt to access the thoughts and feelings of study participants. This is not an easy task, as it involves asking people to talk about things that may be very personal to them. Sometimes, the experiences being explored are fresh in the participant's mind, whereas on other occasions reliving past experiences may be difficult. However, as the data collection is in progress, the researcher's primary responsibility is to safeguard participants and their data (Sutton & Austin 2015:226).

During the data collection, the concepts of anonymity and confidentiality were clarified. This was in line with the recommendations of Oye, Sorensen, Dahl & Glasdam (2019:1232) that overall, research ethics in collaborative qualitative research must be understood as relational, situational, and emerging. This is because researchers cannot predict all future ethical dilemmas and issues, as unexpected ethical issues often occur when there are interpersonal issues. However, this was alleviated through delineating myself as the researcher from the participants and respecting their autonomy; and the principle of shared confidentiality clearly explained before and during the discussions. These mechanisms have been clearly articulated in the research ethics application as approved by the University of the Free State (UFS-HSD2019/0380/2207), as well as the Lesotho Ministry of Education and Training (MoET).

Cox and van Gorp (2018:81) also note that anonymity is perhaps the most ethically contentious aspect of focus groups, though there are efforts and steps that can be taken to minimise the risks. To ensure that these considerations are adhered to, I provided full information about the purpose and uses of the participants' contributions and views, to alleviate any suspicions or feelings of mistrust. The handling of sensitive material and confidentiality, as well as honesty and open communication, is equally important so that expectations are clearly communicated. This is why I included within the focus group guide and questions, an emphasis on respect and confidentiality, as

well as a commitment to maintain the anonymity of the data in the development of the study findings and subsequent publications.

3.10 CONCLUSION

This chapter presented the research design and methodology, which is guided by the interpretivist paradigm, as this is a qualitative study aiming to comprehend how the sociodemographic factors, especially culture and gender affect and influence school health, specifically HIV and sexuality education programmes. The data collection methods were outlined, being focus group discussions, with the selection and sampling techniques outlined. Finally, the trustworthiness of the research and ethical considerations were discussed. The next chapter will present a theoretical review on HIV and health among adolescents and youth.

CHAPTER 4: HIV AND HEALTH AMONG ADOLESCENTS AND YOUTH

4.1 INTRODUCTION

The education sector is facing considerable challenges due to the high HIV prevalence among adolescents and youth, increasing levels of school-related gender-based violence, as well as the large number of early and unintended pregnancies (EUP) among school-going adolescents and young people. These factors are exacerbated by the high levels of other communicable and non-communicable diseases, social inequalities and economic challenges. This is affirmed by Bonella, Blakemore, Fletcher and Patton (2019:437), as they indicate that evidence of health and education being interlinked is transforming investment in adolescent health. This has been evident through the considerable shifts and changes in the health of adolescents and young people globally.

Toska, Pantelic, Meinck, Keck, Haghighat and Cluver (2017:3) reiterate that with increased access to antiretroviral treatment in sub-Saharan Africa, the number of children vertically infected with HIV who survive to adolescence has risen. HIV-positive adolescents and youth are at risk of passing on the virus to their sexual partners and children. They are additionally vulnerable to potential re-infection by HIV and more vulnerable to other sexually transmitted infections (STIs) compared to their HIV-negative peers. These are compounded by that adolescents living with HIV experience a range of vulnerabilities that reduce the efficacy of generalised prevention programmes, including cognitive and mental health issues, family-related challenges, and material deprivation. Both adolescents living with HIV and those who are not yet infected, are particularly vulnerable to these risks due to poor access to healthcare services such as family planning, HIV testing, and treatment. Toska *et al.* (2017:3) continue to note that some studies on adolescents living with HIV in sub-Saharan Africa report high rates of unprotected sex, with high-risk sexual practices being associated with higher odds of becoming infected with HIV among the general adolescent population. Michaud, Namazova-Baranova, Weber and Ambresin (2018:187) further attest to this by indicating that a considerable number of the main

health problems affecting adolescents have changed, with the prevalence of most infectious diseases decreasing, while mental health problems, violence, sexually transmitted infections, unplanned pregnancies and abortions, and substance abuse have increased.

The World Health Organisation (WHO) clearly defines adolescents as those aged from 10 – 19 years; youth as those aged 15 – 24; and young people being all the people aged 10 – 24. However, for the purposes of this study, the terms adolescents and young people will be used. Adolescence is a transitional stage of physical and psychological human development that generally occurs during the period from puberty to legal adulthood. Taghizadeh Maghaddam, Bahreini, Ajilian, Fazli & Saeidi (2016:1423) go on to alert that among the approximately 1.2 billion adolescents (10-19 years) globally, roughly 90% of live in low and middle-income countries. Most are healthy, but there is still significant deaths, illnesses, and diseases among them. Illnesses can hinder their ability to grow and develop to their full potential. Alcohol or tobacco use, a lack of physical activity, unprotected sex and/or exposure to violence, can jeopardise not only their current health, but often their health for years to come.

It cannot be denied that adolescence is one of life's critical stages and transitions. UNAIDS and UNICEF (2015:2) assert that the biological and psychosocial changes that take place during this period affect every aspect of adolescents' lives; with the meaning assigned to this transition being different in different cultures and contexts, though it signifies the move from childhood to adulthood across the board. UNAIDS (2016:3) indicates that among the world population of approximately 7.3 billion, there are about 1.8 billion young people aged between 10 and 24. Many of them (about 600 million) are adolescent girls between the ages of 10 and 19. Of the world's population of people aged 10–24 years, approximately 89% live in less developed countries, with half of the population in 17 developing countries being under 18 years old.

However, there is progress as UNAIDS (2019:2) mentions that globally, new HIV infections among young women (aged 15–24 years) were reduced by 25% between 2010 and 2018. Although this is good news and a considerable milestone, it still remains challenging and "remains unacceptable that 6000 adolescent girls and young

women become infected with HIV every week, as the sexual and reproductive health and rights of women and young people are still too often denied".

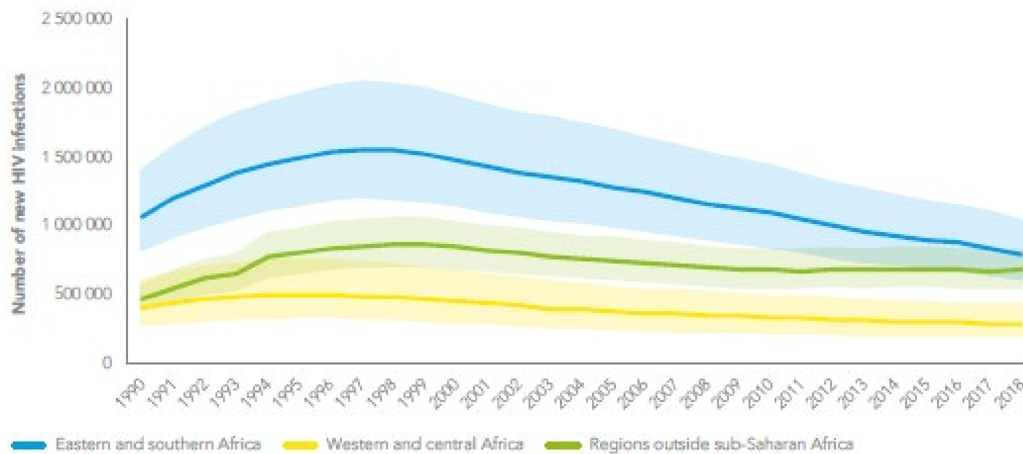


Figure 4.1 Number of new HIV infections by region 1990 – 2018 (UNAIDS 2019:2)

In terms of people living with HIV, UNAIDS (2019:17) continues to highlight that in 2018 there were 37.9 million people living with HIV, of which 18.8 million were women aged 18 and above. About 5000 new infections occur each day, with 61% of these occurring in sub-Saharan Africa, and 4400 being adults aged 15 and older, of which 32% of them are young people aged 15 – 24. There are several factors contributing to these issues as some evidence from locations with high HIV prevalence in sub-Saharan Africa suggests that intimate partner violence (IPV) increases susceptibility to HIV, and that violence (or the fear of violence) is associated with lower treatment access, treatment adherence rates, and rates of viral suppression among women and girls.

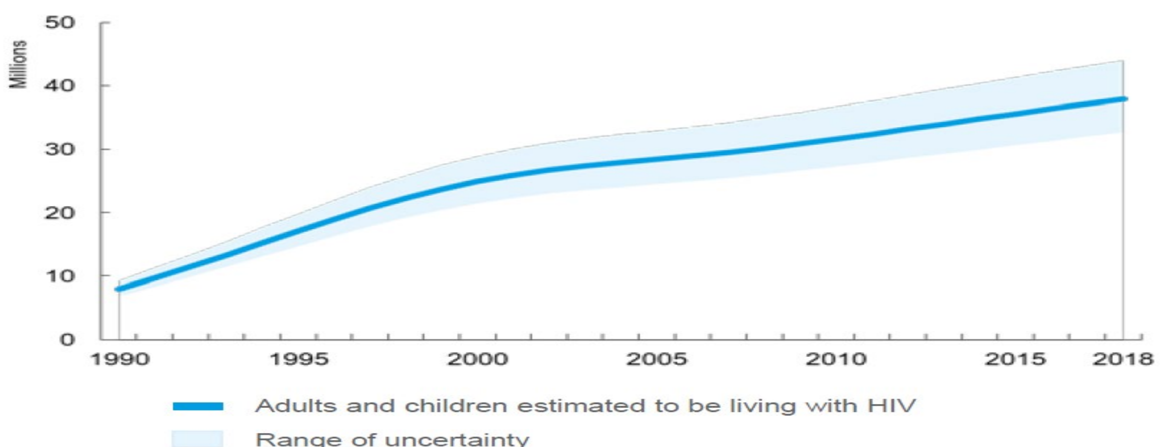


Figure 4.2 Adults and children estimated to be living with HIV 1990–2018 (UNAIDS 2019:3)

Despite the great advancements in antiretroviral therapy (ART) and worldwide progress towards implementation of treatment-as-prevention programmes, approximately 2 million people become newly infected with HIV every year. This situation highlights that evaluations of the HIV burden are integral to the assessment of control approaches, with prospective projections of future HIV burdens being very instrumental to guide resource allocation and policy optimisation (Pandey and Galvani 2019: e810). HIV is a serious threat to global, regional and national developmental goals. The education sector, like all other sectors has been making efforts to the health, socio-cultural and other development challenges over the years. However, it has been evident that HIV continues to deplete financial and human resources meant for educational development, with the pandemic also reversing some of the gains made in the education sector over the years (Sleeman, de Brito, Etkind, Nkhoma, Guo, Higginson, Gomes & Harding 2019; Wong, Murray, Phelps, Vermund & McCarraher 2017.

Bundy (2002) in Cooper, Risley, Drake and Bundy (n.d.:1) describe the paradox of HIV and education as that, education can prevent HIV infection, but HIV can damage and even destroy education systems. The preventive role of education is in teaching children from the earliest school age, the appropriate knowledge of the existence of HIV, and in providing age appropriate life skills to protect themselves. Kelly (as quoted by Maritz and Lessing 2004:107) states that education in a world with AIDS must inevitably differ from education in a world without AIDS. Schools are traditionally expected to communicate knowledge, instil values and promote behaviours that will enable students to protect themselves against HIV infection.

In addition to HIV and sexual and reproductive health issues and challenges, adolescents and young people are faced with other social and health issues, such as obesity, alcohol and substance abuse, depression, and malnutrition, as well as other economic and social issues, such as female genital mutilation, early marriages and other problems, leading to their increased vulnerability and susceptibility to diseases (Santesteban-Echarri, Álvarez-Jiménez, Gleeson & Rice 2018; Baltag and Sawyer 2017; Lassi, Salam & Bhutta 2017). It can safely be said that there have been very few health issues that have been more challenging to sectoral and community values and capabilities than HIV. The impact of the global epidemic on the social, economic,

and demographic stability of regions, countries, communities, and sectors, has posed serious development challenges. These challenges and their impact do however differ according to the various regions, countries, communities, cultures, genders and other socio-economic variables.

Phaswana-Mafuya and Peltzer (2018:7) also reiterate that according to the population health model, health outcomes may vary by race or ethnicity, socioeconomic status, geography and gender; thus, racial or ethnic health differences are at the centre of public health efforts in many parts of the world. This emphasises the need for context-based school health and HIV programmes, as the context is critical for the suitability and efficiency of such programmes. In addition, Irvine, Armstrong, Nagata, Rollins, Schaaf, Doherty, Penazzato and Vicari (2018:S4) are also of the view that to date, despite great advances in prevention, testing, and treatment, HIV in children and adolescents remains a major cause of mortality and morbidity in these vulnerable populations, therefore calling for evidence on how to successfully address their specific health needs, including how best to deliver services to them. This is further affirmed by Armstrong, Nagata, Vicari, Irvine, Cluver, Sohn, Ferguson, Caswell, Njenga, Oliveras, Ross, Puthanakit, Baggaley and Penazzato (2018: 16) who emphase that adolescents are now recognized as a distinct population with different health requirements from children and adults. This prominence is evident in current global health and HIV agendas. Even though HIV programmes have increasingly recognised adolescents as a critical age group, they continue to be underserved by current health and HIV services, and experience increased needs for psychosocial support and sexual reproductive health (SRH) services.

Despite some of the efforts, Wong, Murray, Phelps, Vermund & McCarraher (2017: S192) indicate that there is insufficient evidence on successful efforts to get adolescents and young people into HIV testing and link them to treatment. Some recent research reported that approaches used to reach children and adolescents aged 5 – 14 have not necessarily been tailored to needs of this age group, as they replicate strategies for adults and do not consider the specific barriers that adolescents face. Some of these factors include health providers lack ‘friendliness,’ adolescents’ developmental stage, and the realisation that most efforts and programmes have

focused on addressing individual barriers and not adequately addressing other barriers such as structural and health system issues.

Extensive efforts are therefore still required to understand what works best for adolescents and young people. This evidence is important, and much needed to inform innovative and targeted interventions that inform adolescent health and HIV policy and reach the ambitious targets that the global community has set to achieve an AIDS-free generation by 2030. It is for these reasons that this study will also provide some of the evidence from key stakeholders, communities, and the health and education sectors on how best to provide services for adolescents and young people, based on various sociodemographic factors.

Finally, Toska, Cluver, Orkin, Bains, Sherr, Berezin and Gulaid (2019:10) suggest that through school-based HIV and health programmes, there is potential to identify unreached adolescents living with HIV, through school-based markers of low attendance, repeated grades, frequent sickness, low mood and learning difficulties. They further opine that adolescents living with HIV experience substantial educational difficulties that could benefit from targeted and sensitive support. Schools can reach those affected, by supporting adolescents with physical, emotional, and cognitive difficulties with educational assistance, without requiring the unwanted disclosure of their HIV-status through school health and HIV programmes, such as sexuality education. This can only happen if educational systems are strengthened and capacitated to support adolescents and young people.

4.2 ADOLESCENCE AND THE SOCIAL DETERMINANTS OF HEALTH

The World Health Organisation (2018:1) estimated that 1.2 million adolescents died in 2015, meaning that over 3000 adolescents died every day, with these deaths mostly from preventable or treatable causes. Globally, there are 44 births per 1000 to girls aged 15 to 19 per year; and half of all mental health disorders in adulthood start by age 14, though most cases are undetected and untreated. The main health issues facing adolescents include early pregnancy and childbirth, HIV, other infectious diseases, mental health, violence, alcohol and drugs, and injuries, as well as

malnutrition and obesity. WHO continues to validate this by highlighting that 1 in 6 of the world's population are adolescents aged 10 to 19. It has been noted that most of them are healthy, but there are substantial premature deaths, illnesses, and injury among adolescents, especially in under-developed countries.

Needless to say, illnesses can hinder their ability to grow and develop to their full potential; with alcohol or tobacco use, lack of physical activity, unprotected sex and/or exposure to violence also likely to jeopardise not only their current health, but also their health as adults, and even the health of their future children. It is therefore critical and necessary to ensure that healthy behaviours are promoted during adolescence and steps are taken to better protect young people from health risks through prevention initiatives and programmes, either within schools or out of school.

Brindis & Tebb (2017:4) aver that the social determinants of health are the leading causes of health disparities across the lifespan and have a profound impact on the overall development of adolescents and young adults. These factors can be educational, economic, racial, ethnic, related to employment, sexual orientation, gender identity, and geographic location, as well as the structures and systems that shape the daily conditions of life. This is complemented by Raymond-Flesch, Auerswald, McGlone, Comfort and Minnis (2017:5) in that parents, teachers, and community leaders, as well as health care providers are often challenged in terms of ways to address the social determinants that shape the health outcomes of adolescents, beyond simply developing policies. It is therefore critical to highlight, acknowledge and address social determinants that shape the health and education outcomes of adolescents and move from just developing policies and strategies with the intention and hope of promoting equity.

It is evident that there are many health and social challenges facing adolescents and young people, and these need to be addressed from all angles, from the home to the community and to the school (Berger, Thompson & Joubert 2019; Grieb, Kerrigan, Tepper, Ellen, & Sibinga 2018; Mehra, Daral & Sharma 2018;). This calls for the need to look at adolescent health in a holistic manner in order to effectively respond to the health and social challenges facing adolescents and young people. The future of the global workforce and overall development looks bleak, given the challenges posed by

health, HIV and related issues globally, regionally, in countries and specifically in schools. This necessitates the acknowledgement of the challenges and identification of strategies to overcome the threats brought about by these issues. Therefore sectors, specifically the education sector needs to strongly advocate for and implement programmes to promote good health, prevent HIV and mitigate its impact.

UNAIDS (2019:2) indicates that every week, around 6000 young women aged 15–24 years become infected with HIV. In sub-Saharan Africa, four in five new infections among adolescents aged 15–19 years are in girls, with young women aged 15–24 years being twice as likely to be living with HIV than men. Despite the risks faced by young people, they are often viewed as the 'window of hope' for halting the pandemic. In an attempt to prevent HIV infection among this vulnerable population and save the next generation of Africans, many ministries of education (MOEs) have introduced and are implementing school health programmes and more specifically for HIV prevention, Life Skills education which has later been expanded and strengthened to become Sexuality Education (SE).

Koon, Goudge and Norris (2014:85) highlight that in 2002, the World Health Organisation (WHO) developed the Adolescent Friendly Health Services model. The model focused on providing a package of health services that effectively addressed the specific health needs of adolescents (13 - 19 years of age). In recent years, the package has been broadened to include the health needs of young people aged 10 - 24 years and is now called Youth-friendly Health Services (YFHS). This model addresses complex issues, such as substance abuse, obesity, violence, and psychosocial support, in addition to the sexual and reproductive health services that typically target young people. YFHS consists of a framework in which effective and appropriate health services are delivered in equitable, accessible, and acceptable ways for youth, as illustrated in Figure 4.3.

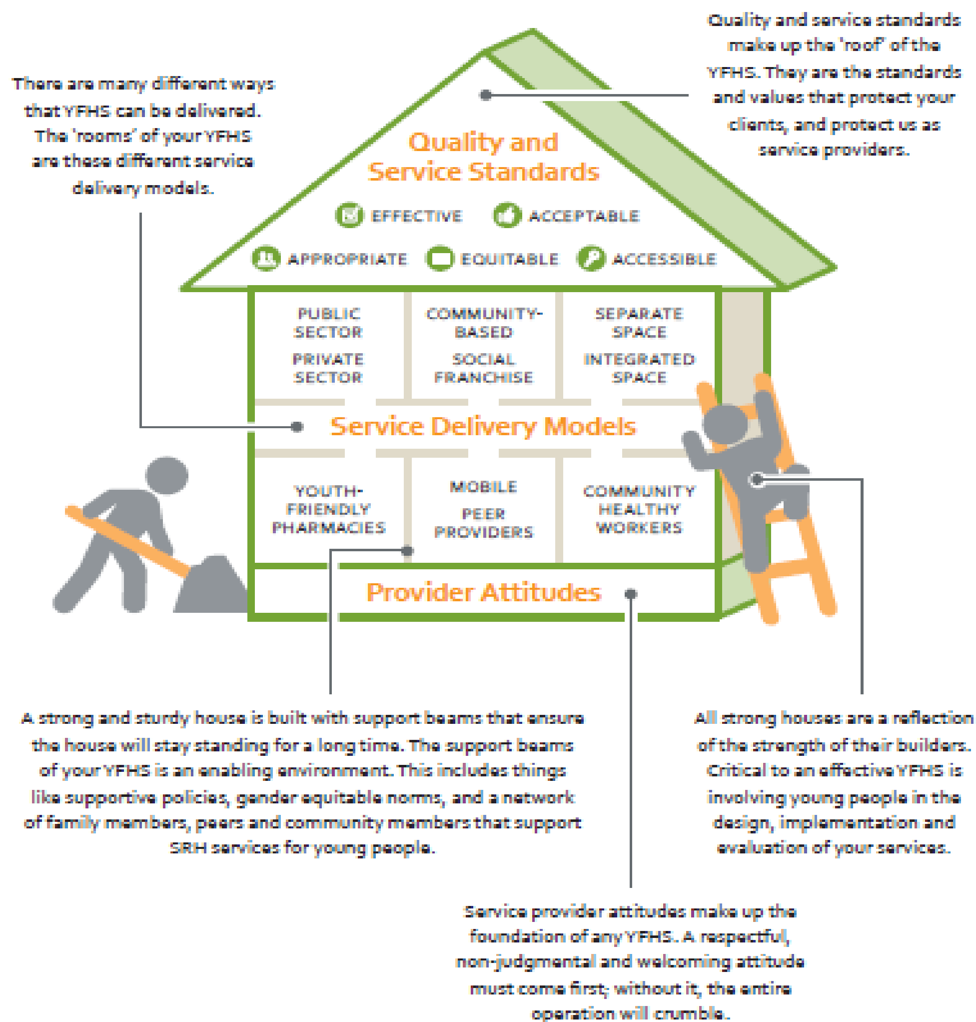


Figure 4.3 Youth Friendly Health Services Model (Population Services International 2014:4)

Kasule (2014:102) emphasises that many adolescent problems are related to sexual behaviour. She partly attributes this to mass media and entertainment outlets as she is of the opinion that they give many sexual messages that affect adolescent sexual behaviour, with this mainly being for economic gains. She maintains that, as and when sexually mature adolescents are “bombarded by sexual messages from the media and entertainment industries”, they are unable to explore and engage in legitimate sexual expressions and end up engaging in risky sexual behaviour, resulting in high levels of adolescent pregnancies and sexually transmitted infections (STIs).

Furthermore, Nagata (2017:131) states that adolescent sexual and reproductive health has come to the forefront of the current global health agenda by its emphasis on two major global strategies: the 2030 Agenda for Sustainable Development, and

the United Nations Global Strategy for Women's, Children's, and Adolescents' Health. Both documents emphasise the reduction of adolescent childbearing through universal access to sexual and reproductive healthcare services.

These challenges highlight the need for proven methodologies and strategies to protect and promote adolescent health; hence Helleve, Flisher, Onya, Mokuma & Klepp (2009:190) emphasise that effective sexuality education is important because of the impact of cultural values and religious beliefs on all individuals, especially on young people. School settings provide an important opportunity to reach large numbers of young people with sexuality education before they become sexually active, as well as offering an appropriate structure through the formal curriculum, within which to do so.

For comprehensive adolescent health responses, Azzopardi, Kennedy and Patto (2017:5) clarify that academics, as well as international institutions, such as the United Nations International Children's Emergency Fund (UNICEF) and the World Health Organisation (WHO) have defined social development and well-being data collection and reporting frameworks for adolescent health. These frameworks are intended to merge several indicators which measure distinct aspects of development and well-being for adolescent health and social development profiling, and they are discussed below.

4.2.1 Physical and mental health

There are various definitions of mental health from different schools and cultures. However, the World Health Organisation does provide a comprehensive and now agreed upon definition as they define mental health as "a state of well-being in which the individual realizes his or her own abilities, can cope with normal stressors in life, can work productively and fruitfully, and is able to make a contribution to his or her community" (Galderisi, Heinz, Kastrup and Sartorius 2015:231).

Adolescents' physical and mental health play a key role in their development, as well as on their ability to make decisions. Their physical activity may also contribute to the development of healthy lifestyles, even into adulthood, which will help with the reduction of chronic diseases. Health and social development decisions are of critical

importance in the lives of adolescents, as these can positively or negatively impact their lives and future endeavours and successes. Research (Sagatun 2009; Paruk & Karim 2016) indicates that it is worth noting that adolescents are prone to mental health problems as well, as they go through various mental health problems, including emotional, behavioural and peer problems, which may severely interfere with their daily lives and functioning.

It is therefore evident that physical and mental health issues in adolescents are associated with significant short- and long-term morbidity and mortality; thus, the urgent need for increased awareness, screening, detection and treatment of mental health issues and challenges among adolescents and young people. This can be done through integrated healthcare systems which include efficient and functional school health programmes.

4.2.2 Economic opportunity and employment

Adolescence is the period between childhood and adulthood, during which one is being prepared for independence and resilience. This includes economic, social, spiritual, physical and overall preparation for roles and responsibilities in adulthood. Call, Riedel, Hein, McLoyd, Petersen and Kipke (2002:71) also allude to the fact that the most significant factors to adolescents' health are found in their environments, and in the choices and opportunities for health-enhancing or health-compromising behaviours available in these contexts. These factors can be for example, exposure to violence, or the availability of supportive families and other social factors. It is worth noting that if these contexts or environments are not supportive of adolescents and their economic and / or employment opportunities, they represent a failure to invest in and protect adolescents, leading to their alienation and limited abilities and opportunities to integrate themselves into society as able economic beings.

Greene and Staff (2012: 25) are in agreement that contrary to popular belief about not exposing youth and adolescents to employment opportunities for fear of academic interruption, research shows that some early work experiences do not undermine academic performance and school activities. Moreover, some jobs can prepare youth for careers in adulthood by providing useful skills, while at the same time facilitating the exploration of potential careers and expanding social networks. It is therefore

important to explore and acknowledge how adolescents' economic or employment activities may contribute to their development or how they affect or hinder their emotional, intellectual and socio-economic prospects, as this might also have an impact on their health, and sexual behaviours and practices.

4.2.3 Protection and safety

For them to prosper and lead healthy lives, adolescents need to be protected and lead healthy and safe lives. Attending school has been proven to be one of the critical factors increasing adolescent protection and safety from risky behaviours and social environments. This is in line with studies conducted by Magnani, Meekers and Ahmed, Meekers and Calves, Raymundo and Laguna, Isarabhakdi and Podhisita *et al*. as quoted by WHO (2005:8) as they indicate that schooling has been widely shown to be a protective factor for sexual debuting across the United States, and Western European countries, as well as in developing countries, as in-school status was significantly related to sexual initiation among adolescents.

This means that adolescents who attend or are at least enrolled in school are deemed to be significantly less likely to engage in sex. Education provides a protective factor for adolescents; thus, the need for the exploration and acknowledgement of the various sociodemographic factors that can positively influence schooling, as well as those which hinder adolescent health and education outcomes. Based on these, it can be postulated that safe and supportive families, combined with safe and supportive schools and supportive peers may lead to adolescents with a positive outlook, as also affirmed by Santhya and Jejeebhoy (2015:194). This is fundamental to helping young people develop to their full potential and attain the best health and education outcomes as they transit to adulthood.

4.2.4 Participation and civic engagement

Adolescents and young people are usually encouraged to take part and be engaged in community development and governance processes within school, and in their communities and countries. Ballard, Hoyt and Pachucki (2018:1) found a pattern of positive associations of voting and volunteering with important aspects of adult development. They concluded that civic activities, such as voting, volunteering, and activism were positively associated with subsequent income and education levels.

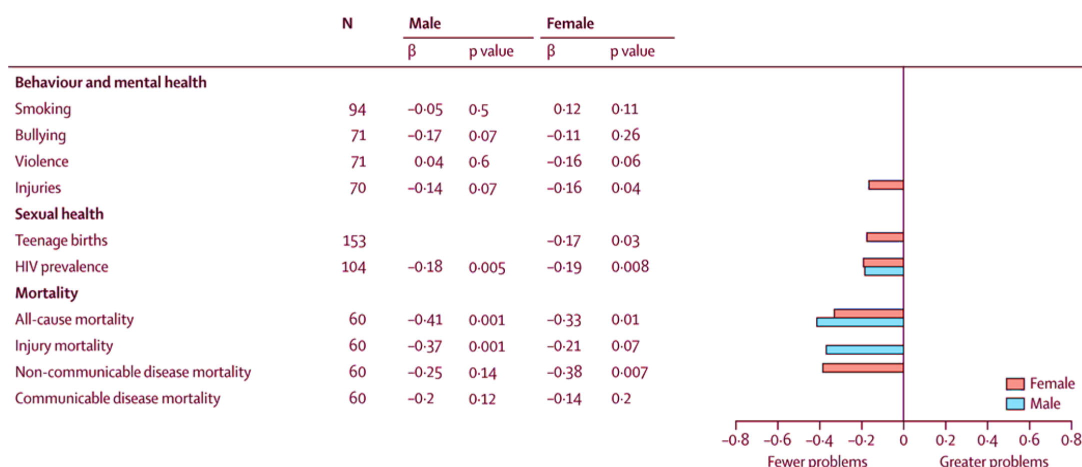
Volunteering and voting were specifically associated with better mental health and fewer risky health behaviours, while activism was associated with higher income and educational attainment in adulthood.

Chan, Ou and Reynolds (2014:1832) attest to this, as they noted that studies suggest that engaging in civic activities during adolescence is associated with greater academic achievement, social and emotional adjustment, and civic development; as well as with fewer problem behaviours. These assertions are therefore in line with the socio-ecological theory elaborated in Chapter 2, as it states that adolescents' daily activities are important developmental occurrences. This is due to the nature of their activities, which can be seen as an important index of psychosocial adjustment, as well as a forum for the socialisation of cultural knowledge and practices (Alessio, Nation, Perkins & Santinello 2007:762). The interrogation of sociodemographic factors, such as gender and culture then become critical for these developments to be realised.

4.2.5 Education and learning

The importance of adolescents' education and training cannot be overemphasised. As indicated above, there are tremendous benefits of education and schooling for adolescents' health and wellbeing. Viner, Ozer, Denny, Marmot, Resnick, Fatusi and Currie (2012:1656) concur with this, as they discovered that the completion of secondary school provides great benefits for adolescents. It improves their health and wellbeing; increases their capacity and motivation to prevent pregnancy, while simultaneously empowering them to take responsibility for their own lives, and for improving the lives of others. They go on to emphasise that education also improves survival of their children in instances of teenage or adolescent pregnancy.

This is elaborated in Figure 4.4 which highlights associations between the national secondary school participation rate and health outcomes. The figure illustrates that countries with a greater proportion of their young people in education have lower male and female mortality, as well as lower male injury mortality and lower female non-communicable disease mortality. In this study, enrolment and participation in higher education was also associated with lower HIV prevalence, and lower injury levels in both sexes, as well as fewer teenage births.



	N	Male β	Male p value	Female β	Female p value
Behaviour and mental health					
Smoking	94	−0·05	0·5	0·12	0·11
Bullying	71	−0·17	0·07	−0·11	0·26
Violence	71	0·04	0·6	−0·16	0·06
Injuries	70	−0·14	0·07	−0·16	0·04
Sexual health					
Teenage births	153			−0·17	0·03
HIV prevalence	104	−0·18	0·005	−0·19	0·008
Mortality					
All-cause mortality	60	−0·41	0·001	−0·33	0·01
Injury mortality	60	−0·37	0·001	−0·21	0·07
Non-communicable disease mortality	60	−0·25	0·14	−0·38	0·007
Communicable disease mortality	60	−0·2	0·12	−0·14	0·2

Figure 4.4 Association of access to education and adolescent health outcomes (Viner, Ozer, Denny, Marmot, Resnick, Fatusi & Currie 2012:1650)

It can therefore be concluded that the strongest determinants of adolescent health are structural factors, such as national wealth, income inequality, and access to education. This is corroborated by Viner *et al*. (2012:1650) by asserting that improving adolescent health requires addressing risk and protective factors in the social environment and focusing on factors that are protective to adolescents across various health outcomes. The most effective interventions are most likely to be the structural changes to improve access to education and economic independence for adolescents and young people; thus, the alignment between sociodemographic factors, school health and HIV programmes becomes critical.

4.3. SPECIAL VULNERABILITIES OF ADOLESCENTS AND YOUTH

There are several definitions of vulnerability which should be based on the context, the population group, and the social environment, as well as the prevalent sociodemographic factors. According to Arora, Shah, Chaturvedi and Gupta (2015:197), vulnerability is a relative state, with its degree and type varying over time and between countries. It is highly contextual and generally refers to the groups of people who are more exposed to risks than their peers. The above authors mention that most work related to vulnerability has been done in the African context, with factors, such as extreme poverty, chronic illness of self or parents, and a lack of social

support and education, found to expose young people to increased vulnerability, especially to abuse, neglect, deprivation and violence.

As mentioned earlier, adolescents and youth are faced with daunting and complex challenges, especially in Sub-Saharan Africa. These are affected by the changing social, economic, cultural, and physical environments of the 21st century. They include economic shocks, the high HIV incidence and prevalence, increasing rates of sexual and gender-based violence including school related gender based violence (SRGBV), high levels of morbidity and mortality, increasing orphan-hood, environmental degradation, high unemployment levels, increasing poverty and food insecurity, and high levels of non-communicable diseases, to mention a few. These then lead to the early assumption of adult responsibilities by adolescents and youth, which then increase their levels of vulnerability.

This is further affirmed by Fischhoff, Nightingale and Iannotta (2001:1) as they indicate that despite the widespread view that adolescents do not necessarily feel personally vulnerable, both scientific evidence and direct discussions with them have shown that most of them have serious concerns. They indicate that these concerns are mainly based on real-life factors which present serious challenges and obstacles in their lives. They include chronic diseases, violence, and interestingly, even if the economy is sound, many adolescents also worry about having a decent and meaningful job or career. In addition to these, racial relations and poverty have been seen to be special concerns.

Although adolescents and youth face countless challenges, it is important to take cognisance of their context and the predominant sociodemographic factors within their environments, if we are to clearly understand and respond to their vulnerabilities and challenges. It is only through recognising and acknowledging those challenges, that we can afford them the respect and support that they deserve. The use of generalised and collective actions and strategies for adolescents continues to undermine their differences, and encourages the adoption and implementation of homogenous interventions, which are not responsive to their needs most of the time. This is why this study places a lot of emphasis on context, especially looking at gender and culture, as the specific factors affecting some of the programmes intended for adolescents.

4.3.1. Underlying Factors of Vulnerability

There are various factors that expose adolescents and young people to vulnerability, but for purposes of this study, focus will be on three fundamental factors which are causal to the vulnerability of adolescents and young people as outlined by the Pan American Health Organisation (2013:10); these are poverty; gender; and ethnic diversity. They allude to the fact that although poverty is measured in different ways at various levels through indicators, such as social and economic development, inequalities and inequities, as well as opportunity, studies have found that lower household economic status is associated with poorer health indicators, especially sexual and reproductive health indicators.

4.3.1.1. Poverty

There is no doubt that poverty is a multifaceted concept, and it includes social, economic, cultural, environmental and political elements. Gordon (2005:3) posits that, in its definition, the United Nations states that,

> *fundamentally, poverty is a denial of choices and opportunities, a violation of human dignity. It means lack of basic capacity to participate effectively in society. It means not having enough to feed and clothe a family, not having a school or clinic to go to, not having the land on which to grow one's food or a job to earn one's living, not having access to credit. It means insecurity, powerlessness and exclusion of individuals, households and communities. It means susceptibility to violence, and it often implies living on marginal or fragile environments, without access to clean water or sanitation*.

Adolescents grow up and live in varying communities with varying levels of success or poverty. Some adolescents and young people are also exposed to hazardous living environments with very limited support systems. Some are from impoverished neighbourhoods which are marred by social and security challenges, such as violence, limited or non-existent social and health resources, as well as high levels of substance abuse. Poverty is linked to several actual and potential problems among adolescents and young people, including chronic health conditions, low educational attainment, and engagement in delinquent behaviours (Fernandes-Alcantara 2018:6).

This is further asserted by several researchers (Hardgrove 2014; McAra & McVie 2016) as they realise that poverty remains one of the gravest threats to young people's lives in various ways. This includes food shortage; lower cognitive achievement; and the fact that poverty is strongly associated with violence and gender issues at the household and community levels. These relationships overlap and even link to issues of risk and protection linked to victimisation, and relationships between children, their caregivers, and school.

4.3.1.2. Gender

There has been some confusion concerning the utilisation of the terms, gender and sex over time. Gender refers more closely to the social constructs and not necessarily the physical or physiological features of a person (Gupta 2000:1). This is further elaborated by Chrisler and Lamer (2016:76), as they assert that gender is a term used to describe individuals' social identity (woman/girl, man/boy) and personality or behavioural tendencies, which include being masculine, feminine, androgynous, or transgender. These definitions will be used in this study as they indicate that gender is not a synonym for sex, but more about the roles and behaviours in terms of the widely shared expectations and norms within a society about appropriate male and female behaviour, characteristics, and roles.

It has been proven that adolescence is the time when young people begin to discover their sexual orientation and gender identities and what it actually means to be male, female or other. As the Pan American Health Organization (PAHO) (2013:16) highlights, there are various social expectations of both adolescent girls and boys, which expose them to various forms of vulnerabilities. For instance, for the men and adolescent boys, traditional expectations related to masculinity are often associated with behaviours that increase their risk of inter alia, HIV infection, sexually transmitted infections (STIs), and early fatherhood; with sexual violence and multiple sexual partnerships being socially accepted in many cultures. For women and adolescent girls, their access to basic information, social pressures, unequal and passive roles in sexual decision-making are often constrained by socio-cultural gender norms and practices. These, therefore, lead to increased risk of early pregnancy, unsafe

abortions, early motherhood, sexual exploitation, sexual abuse, and high levels of STIs and HIV.

All these are evident in most parts of Africa as the feminisation of poverty, HIV and other social challenges have been mainly brought about by vulnerabilities caused by gender and culture. Wathuta (2016:56) alludes to the feminisation of the HIV epidemic, stating that the entrenched economic and gender inequities are driving a globally expanding, increasingly female HIV epidemic. She highlights that according to both UNAIDS and WHO, over half (58%) of those living with HIV in Sub-Saharan Africa are women, who in general acquire HIV infection at least 5 - 7 years earlier than men; with HIV-related complications being the leading cause of death among those of reproductive age in developing countries, in general.

The majority of new HIV infections among young people aged 15 to 24 occur in sub-Saharan Africa. With a broadly generalised HIV epidemic, Lesotho's overall HIV prevalence is among the highest globally, and four times higher among adolescent girls than boys (Moazzami, Ketende, Lyons, Rao, Taruberekera, Nkonyana, Mothopeng, Schwartz and Baral 2020:716). Concurrent with this high HIV prevalence, is widespread violence against women, with 86% of women having experienced gender-based violence, and studies have called for more rigorous evidence on abuse and the exploitation of children (Grosso, Busch, Mothopeng, Sweitzer, Nkonyana, Ntsane, Taruberekera & Baral 2018:4). Evidently gender based violence has been on the increase, especially among adolescent girls and young women.

On the home front, women in and girls in Lesotho are usually tasked with taking care of the household, including ensuring that the basic needs such as food are available for the household. However, the increasing levels of poverty, economic and environmental checks, as well as the high unemployment rates, their vulnerability is further increased. Low, Frederix, McCracken, Manyau, Gummerson, Radin, Davia, Longwe, Ahmed, Parekh, Findley and Schwitters (2019: 10) affirm that the Lesotho Population Based HIV Impact Assessment (LePHIA) found some association between food insecurity and incident infection among adolescent girls and young women (AGYW). In addition, they discovered increasing patterns of risk behaviours associated with HIV infection, including transactional and commercial sex, suggesting

that some women may indeed be relying on sexual favours to survive drought and other economic and social challenges. They further noted that the increase in early sexual debut and reduced educational attainment in girls in rural areas is consistent with adolescent girls being removed from school for transactional partnerships or marriage so that families can benefit from the bride price, referred to as *bohali* in Sesotho. This led to the affirmation that the strong association between marriage and HIV infection suggests that there may be relatively high rates of transmission between married couples, either through infections developed prior to marriage or through infections acquired from extramarital partners in Lesotho.

Fogelman (2017:39-40) argues that the status of women in Lesotho is complex and continues to evolve. This is illustrated by the fact that the majority of primary school students in the country are girls, leading to Lesotho's high ranking in World Economic Forum's Global Gender Gap report. However, on the other hand, married women were legally considered minors until 2006 when the Legal Capacity of Married Person Bill was enacted. The social and economic landscape is also changing as before 2000, a massive number of middle-aged men were mainly working in South Africa's mining sector. This has also since changed as South Africa's labour market has shrunk significantly for Lesotho citizens, with a large number of men retrenched and back home in Lesotho. This coincides with the favourable United States' trade policy that has made Lesotho a source of textile production, in which several American clothing companies produce clothing in Taiwanese and Chinese-owned factories that employ 40,000 people, nearly all of them women. This has now led to women being mostly the main breadwinners, and men being left in the rural households while the women are based in the urban centres, mainly Maseru and Maputsoe in Leribe.

These developments have led to changing dynamics and relations, as there has been a shift from the traditional perception of men as providers and breadwinners. Legally, there have been other developments to protect women and improve their status in society. This is explicated by Fogelman (2017:41) with the recent legislation enabling women to secure their rights to land in the face of threats. These laws include the Local Government Act 1997 (subsequently amended in 2004, 2010 and 2011), which fully moves land allocation power from chiefs to elected local government councils; the Legal Capacity of Married Persons Act 2006, which bestows full citizenship and full

property ownership rights on women, instead of subjugating them as minors to the will of husbands or fathers. In terms of land rights, the legislation culminated in passage of Land Act 2010, which has been a major force in giving women the right to access and own land. These have made a difference in the status of women in society, even though some challenges persist, as indicated earlier.

Adams and Nkuebe (2018:8) are in agreement with the above assertions as they aver that with regard to women's rights in Lesotho, following the ratification of the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) in 1995, which seeks to protect women against all forms of gender-based discrimination, violence, and abuse and calls for review and reform of laws that may discriminate against women, Lesotho established the Child and Gender Protection Unit (CGPU) within the Lesotho Mounted Police services in 2002. The Unit investigates and ensures prosecution of gender-based violence cases, provides services to victims, and does community sensitisations. However, I can attest to the fact that it has been more than eight years of advocacy for the domestic violence legislation, and the process to develop this legislation has stalled even after various attempts by civil society organisations, development partners and government ministries in Lesotho.

These challenges lead to further challenges which continue to exacerbate the impact of HIV among Basotho. Sebastian, De La Ocampos, Daidone, Davis, Pace, Niang and Pellerano (2019:6) emphasise the impact of HIV in that within the sub-Saharan African context, the age of the head of the household is very relevant, as (due to the HIV pandemic), female headed households sometimes consist of elderly women caring for their grandchildren. This is the case in Lesotho, as households face particular constraints caused by the HIV pandemic. Sebastian *et al*. (2019: 23) indicate that in Lesotho, the household structure, and subsequent capacities and constraints of the household play a significant role in influencing gender-differentiated impacts on child and adolescent investments, rather than gender bias. These therefore highlight the dynamism of the evolving family structure and gender dynamics in Lesotho.

To address these challenges, several programmes have been implemented, including school health and sexuality education programmes in Lesotho. However, Mpalirwa

(2017:6) establishes that while many intervention prevention programs continue to invest in increasing HIV education, evidence suggests that young women's vulnerability to new HIV infections does not stem from a lack of knowledge as is often assumed, but rather stems from a lack of behavioural change, hence the need for clear studies to investigate what factors inhibit behavioural change in Lesotho. She does however note that policy makers and development partners operating in Lesotho identified a general frustration "that increasing awareness and knowledge of HIV and AIDS in Lesotho was not being translated into behaviour change". This is attributed to the prevailing myths and perceptions about condoms and having multiple partners that proved difficult to overcome. These continue to emphasise the need for comprehensive school health and sexuality education programmes.

In conclusion, one notes that despite these programmes, there are still some critical gaps in the education sector and related curricula, in Lesotho and elsewhere. For instance, Francis, Reygan, Brown, Dlamini, McAllister, Nogela, Mosime, Muller, and Thani (2018: 25) note that little is known about gender and sexuality diversity in education, or even broadly, in Lesotho, where patriarchy is reinforced by traditional and cultural practices which remain pervasive. She points out that these patriarchal gender ideologies are endorsed in the schooling system where boys find themselves under tremendous pressure to proclaim and display their masculinity or succumb to being humiliated for not upholding this societal expectation, continuing to perpetuate the gender stereotypes and increasing levels of gender-based violence, including school related gender-based violence. These gaps and challenges continue to escalate the necessity for comprehensive gender transformative and culture sensitive school-based health and HIV programmes.

4.3.1.3. Ethnic diversity

Ethnic diversity has been seen to be one of the factors increasing vulnerability. Ethnic minorities are usually neither involved nor consulted and engaged in community, national, regional and even in some global initiatives and research activities. This then leads to most of their not receiving or benefiting from relevant services, including health, education and other social services (PAHO 2013:19). PAHO (2013:20) continue to affirm this as they discovered that ethnic background, together with low

socio-economic status, rural residence, and lower educational levels are associated with lower contraceptive use, lower coverage of prenatal and delivery care, and shorter birth spacing intervals during childbearing. These problems make it apparent that even in the case of adolescents, ethnicity can increase their vulnerability, based on their sociodemographic factors and social environments, hence the need for contextual and adolescent informed planning and programming.

4.4. THE HEALTH AND HIV STATUS OF ADOLESCENTS

The world's social and physical environments confront today's adolescents with exceptional challenges. These changes in turn, transform adolescent development and change adolescents' current and future prospects. Wessely (2012:1565) posits that adolescence is central to global health goals for physical, mental, sexual, and reproductive health; reductions in injuries; HIV incidence; and chronic substance misuse. At least 70% of premature adult deaths reflect behaviours started or reinforced during adolescence. The rapidly increasing challenge of non-communicable diseases linked to obesity, physical inactivity, high blood pressure, tobacco and substance use, and mental disorders pose worldwide threats to health, as two-thirds of deaths are linked to non-communicable diseases.

The importance of focusing on adolescent health is stressed by Salam, Das, Lassi and Bhutta (2016: S91) who note that compromised adolescent health will negatively affect any country's economy, and this is more evident in lower and middle-income countries (LMICs). Failure to invest in the healthcare of adolescents will lead to more dependency and negatively influence the health of future generations. hence it is imperative to work towards improving adolescent health for an improved and brighter future for coming generations.

One in six of the world's population (1.2 billion), are adolescents aged 10 to 19; it is estimated that 1.2 million adolescents died in 2015, translating to over 3000 of them dying every day and notably, these deaths have been mostly from preventable and treatable causes. WHO (2018:1) further highlights that girls are affected more as the leading cause of death for 15 – 19-year-old girls globally is complications from pregnancy and childbirth. This has led to the decision that one of the specific targets

of the health Sustainable Development Goal (SDG 3) to be, that by 2030, “the world should ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes”. CHIVA (2017:4) summarises these challenges as the 11 issues that threaten the health of adolescents and youth in Figure 4.5.

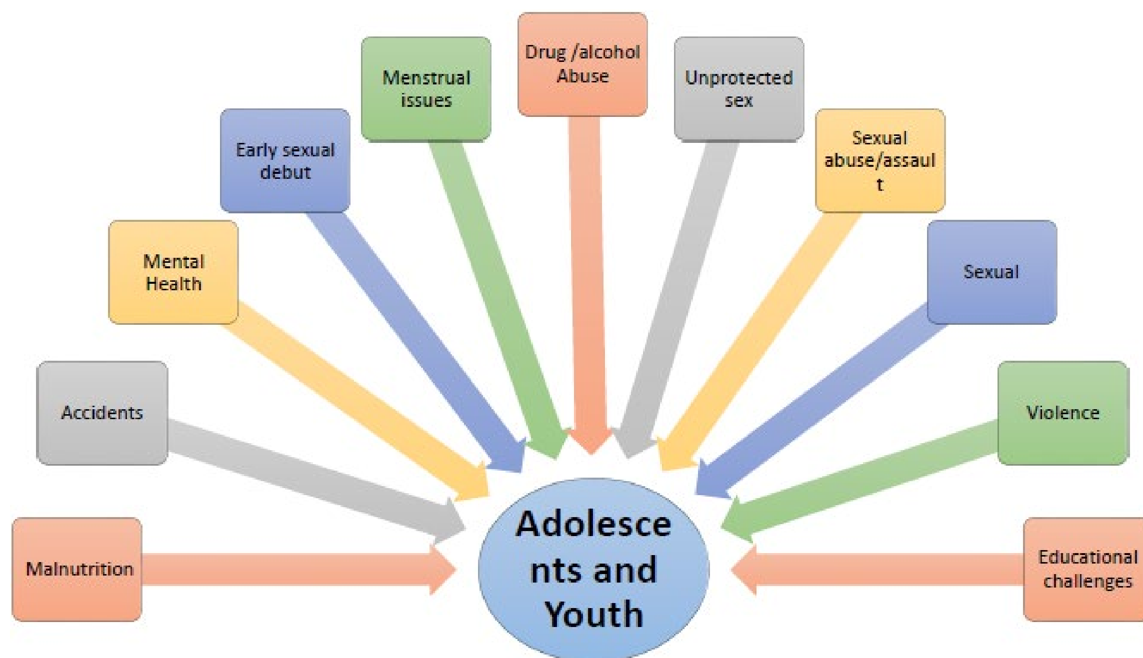


Figure 4.5 Issues that threaten the health of adolescents and youth (CHIVA 2017:4)

4.4.1. HIV

Since recording its first case of AIDS in 1986, the number of HIV infections in Lesotho has increased exponentially. With an adult prevalence rate of 25%, Lesotho has one of the highest HIV burdens globally, with the most affected groups being sex workers (79.1% prevalence), textile factory workers (42.7% prevalence), men who have sex with men (32.9% prevalence), prison inmates (31% prevalence), and pregnant women with a 25.9% prevalence (Mabathoana, Wyk and Adefuye 2019:2). According to Faturiyele, Karletsos, Ntene-Sealiete, Musekiwa, Khabo, Mariti, Mahasha, Xulu and Pisa (2018:2), Lesotho had 330,000 people living with HIV in 2016. The brunt of the epidemic in Southern Africa is further emphasised by Brown, Williams, Kinchen, Saito, Radin, Patel and Voetsch (2018:2), as they highlight that in 2016, an estimated 1.5 million females aged 15–24 years were living with HIV in Eastern and Southern Africa.

Even though the Global AIDS Response Progress Report (Ministry of Health 2015:7) states that in 2013 alone, 5 700 new HIV infections occurred among young women (15-24 years) compared to 3 500 new HIV infections in young men (15-24 years), with about 110 new HIV infections occurring in young girls weekly in the same year, Labhardt, Ringera, Lejone, Amstutz, Klimkait, Muhairwe and Glass (2019:7) argue that it is an encouraging fact that Lesotho is now progressing well towards the UNAIDS 90–90-90 targets. This is affirmed by Green (2018:9) as he notes that the UNAIDS 90-90-90 targets challenge each country to meet three objectives by 2020 - to have 90% of its people who have HIV know of their infection status, 90% of those who know their status on antiretroviral therapy (ART), and 90% of those on ART achieving viral suppression. Among other efforts toward that goal, Lesotho in 2016 became the first country in sub-Saharan Africa to institute the *Test and Start* program, which aims to put all people with HIV on ART.

The Ministry of Education and Training (MoET) Education Sector Strategic Plan: 2005-2015 communicated plans to make schools centres for sexual and reproductive health (SRH) education, including HIV and AIDS to ensure that care and prevention interventions shall particularly target the most severely affected age groups in the school system (6-19 olds), and the most infected sex group (females). Commitments were made to target teachers in an effort to minimise the adverse impact on education service delivery of the very high teacher attrition rates due to HIV. These included the need to design an effective system of attending to the health and emotional needs of the surging number of infected and affected teachers and learners through, inter alia, the facilitation of cost-effective and manageable care and counselling facilities and services; including periodically costing the implications of the high prevalence levels of HIV among education personnel and design appropriate response mechanisms.

These commitments were further strengthened by a pledge by MoET to incorporate HIV education in the school curriculum and conduct studies on the impact of HIV and AIDS on the basic education sub-sector by 2015. Though efforts to incorporate HIV in the school curriculum have borne some results, the HIV impact study on the sector was not done as committed in the sector strategic plan 2005 – 2015. There have been some critical sociodemographic factors, especially culture and gender barriers that

have prevented, and continue to hinder the implementation of school health and related HIV programmes, such as Comprehensive Sexuality Education (CSE) in Lesotho. These, in turn, deter efforts to prevent and curb the spread of HIV and gender-based violence in schools.

The need for the creation of a conducive environment still exists if schools are to be centres for education, good health and wellbeing in Lesotho and elsewhere. Mkumbo (2012:150) asserts that as much as teachers may support the teaching of sexuality education in schools, they may lack the knowledge, skills and confidence to handle sexuality education sessions in a classroom situation; as it has also been observed that the training teachers receive in conventional teacher training colleges may be insufficient in so far as the teaching of sexuality education is concerned.

Furthermore, Low, Thin, Davia, Mantell, Koto, McCracken, Ramphalla, Maile, Ahmed, Patel, Parekh, Fida, Schwitters and Frederix (2019: e613) caution that despite substantial progress in epidemic control of HIV in sub-Saharan Africa, HIV acquisition remains high among adolescent girls and young women (AGYW) aged 15–24 years. They attribute this to both biological susceptibility of adolescent girls and young women, as well as to social vulnerability as the girls transition to adulthood. This is characterised by the fact that it is during adolescence that they leave home and enter employment, marriage, and sexual debut. The high rates of infection in young women have serious implications in terms of individual health as well as lifetime risk of vertical and sexual transmission, particularly in a region where much of the population is younger than 18 years.

For Lesotho specifically, Low, *et al*. (2019: e618) affirm the issues on progress highlighted above. They maintain that even though the Lesotho Population Based HIV Impact Assessment (LePHIA) indicates that prevalence and incidence of HIV in adolescent girls and young women in Lesotho are high, particularly in urban areas, the comparison of the HIV prevalence in LePHIA with prevalence in the Lesotho Demographic and Health Surveys of 2009 and 2014, there has been a decrease in overall prevalence, from 13·6% in 2009 to 11·1% in 2017, and a substantial drop in prevalence in women aged 23–24 years, from 31·6% in 2009 to 19·9% in 2017, suggesting a decrease in HIV acquisition in this population group. They are of the view

that this reduction in HIV infections might be “a result of improvements in protective structural factors such as educational attainment and delayed marriage, as well as expansion of HIV treatment coverage and reduction in population viraemia”. However, given these successes, adolescent girls and young women are still becoming infected at high rates, and they are still at substantially higher risk than young men. They continue to highlight the gender dynamics in Lesotho and the need for effective responses to the HIV epidemic and other challenges, which include comprehensive information regarding factors that put young people at risk for HIV infection. My view is that this information should be strongly anchored in and aligned to the specific gender and cultural dynamics within the specific community or district for contextual and effective responses.

It is evident that there is a strong and urgent need for adolescents and young people to have comprehensive knowledge on how to protect themselves from HIV, and should have the means, skills, and competencies to do so. This should be in the form of availing protective materials and commodities, equipping them with the skills to protect themselves, as well as ensuring that adolescent-friendly services are available in conducive areas including schools. Pettifor, Stoner, Pike and Bekker (2018:267) are in agreement as they justify that programming for adolescents should recognise the need for treating people, especially adolescents in this instance, as individuals and not as a collective. This will mean that their needs will be considered individually but taking cognisance of their peers, sexual and social networks, and families, as well as the sociodemographic factors and sociocultural environments within which the adolescent exists.

4.4.2. Mental Health

Adolescence is a critical and fragile period in the human life cycle as it presents many challenges and changes, physically and psychologically. It is therefore important to note and acknowledge that these changes can present challenges in the lives of young people, especially with the pressures of the 21st century. Vojta, Skivington, Sweeting, Campbell, Fenton and Thomson (2018:30) maintain that this phase encompasses many changes related to biological and psychosocial development and are likely to impact transitions into adulthood. They assert that adolescence is also a time when

most mental health disorders begin, associated in turn, with negative health, behavioural and educational outcomes, which have consequences on relationships with family and friends.

This transition into adulthood is usually more problematic for the most vulnerable and disadvantaged young people, who are at high risk of poor health, educational, behavioural and relationship outcomes and are likely to require additional support to make successful and healthy transitions. This is affirmed by Paruk and Karim (2016: 548) as they also share the view that it is estimated that about 20% of children and adolescents have a mental health disorder and that the risk of mental health issues and challenges are more pronounced in vulnerable environments, with poor social support and socio-economic inequalities, especially in developing countries.

Lelisa (2016:3) reiterates that over and above the high risk of maternal mortality in adolescents who fall pregnant in Lesotho, is the issue of unsafe abortion. Abortion is restricted in Lesotho, as section 45 (2) of the 2010 Penal Code authorises medical abortion only in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the foetus. As a result, adolescent girls who fall regnant in most cases resort to procuring abortions which are not performed by qualified medical personnel and thereby using extremely dangerous methods to terminate unwanted pregnancies. This and other challenges facing adolescent girls and young women in Lesotho, continue to negatively affect their mental and psychological wellbeing.

Given the nature of adolescence and its importance for mental health–related interventions and initiatives which can be beneficial in preventing future distress and reducing the current levels of stress and dysfunction; the school becomes one of the key institutions to curb these. This can be done through initiatives and programmes that aim to build life skills in children and adolescents, while at the same time providing them with psychosocial support to promote good mental health. For early detection and management of mental health challenges among adolescents, there should be strong and functional linkages and collaboration between school health and community programmes. Liu, Gan, Yu, Gao, Lyu, Pang, Cong, Wang, Wu, Cao and Li

(2018:600) affirm that good family relationships in childhood and adolescence have a positive impact on mental health in adulthood.

4.4.3. Violence

Garbarino (2009:538) postulates that over the past 25 years the percentages of children and youth who have mental health and developmental adjustment problems severe and chronic enough to warrant professional intervention, have doubled. He believes that this escalation and spread of youth violence are related to broader development issues. In addition, WHO (2018: online) confirms that violence is a leading cause of death in older adolescent males, while 1 in 10 girls under the age of 20 years, experiences sexual violence globally.

Furthermore, as girls and boys transit through adolescence, they begin to spend more time in an ever-expanding social environment within and beyond their immediate networks, in which they interact with more people. While the broadening of the social world might be beneficial in many respects, it unfortunately also creates situations in which children may be exposed to new forms of violence. As children enter the second decade of their lives, the mortality rate from violence more than doubles what it had been during their first 10 years of life (UNICEF 2017:51), as illustrated in Figure 4.6.

Region	Number of deaths	Rate per 100,000		
		Total	Boys	Girls
Middle East and North Africa	22,000	29.9	35.6	23.9
West and Central Africa	2,000	1.9	2.4	1.3
Eastern and Southern Africa	1,700	1.4	1.8	1.0
South Asia	4,600	1.3	1.6	1.1
Eastern Europe and Central Asia	200	0.4	0.6	0.3
East Asia and the Pacific	400	0.1	0.2	0.1
Latin America and the Caribbean	150	0.1	0.2	0.1
North America	<10	0.0	0.0	0.0
Western Europe	<10	0.0	0.0	0.0
World	**31,000**	**2.6**	**3.1**	**2.0**

Figure 4.6 Number of deaths and mortality rate due to collective violence among adolescents aged 10 to 19 years in 2015 (UNICEF 2017:51)

Adolescents and young people need a safe, nurturing and inclusive environment in which to grow, learn, thrive and succeed. The general expectation is that schools should provide or be regarded as safe havens. However, school-related violence including school-related, gender-based violence (SRGBV) are a reality for many adolescents, which in turn, compromises their ability to fully benefit from educational opportunities.

Garbarino (209:540) is of the view that the increasing levels of violence are a direct result of the social environments in which adolescents grow up. The observations and reporting of increasing levels of violence and other social ills bear testimony to this. Owing to the social influence of violence among adolescents and young people, the responses and approaches should therefore be influenced and informed by relevant sociodemographic factors, which include broad-based prevention perspectives on community life, as well as school-based or institution-based interventions.

4.4.4. Alcohol, tobacco and drugs

Alcohol consumption in Africa is responsible for approximately 6.4% of deaths and 4.7% of disability-adjusted life years lost. It has been found to be a major risk factor for chronic diseases, injuries, HIV infections, adverse women's health outcomes, and interpersonal violence (Amanuel, Morojele & London 2018:306). Alcohol consumption has been common for thousands of years and the drinking of alcoholic beverages is frequently used in social gatherings or to signify some joys, milestones, or celebrations, as is the case in Lesotho as well.

The increasing abuse of alcohol, tobacco and drugs by adolescents has been evident over several years and this is prompted and promoted by the social changes that have been taking place during the past decade. These include advertising for alcohol, tobacco and drugs and thereby enticing adolescents and young people to use them. Access to them has also increased with the elevation of economic independence among adolescents in recent times.

This is confirmed by Nkambule, Bhayat and Madiba (2018:27) as they observe that alcohol consumption and smoking among university students tend to peak between

the ages of 18 and 25 years, with students in these age groups being at a particular risk for increased alcohol consumption, when compared with their peers not at university. They found that the overall trend of alcohol use increases from high school into university and then plateaus off after graduation; though the rate of consumption of alcohol among the general population and heavy intermittent drinking of alcohol among young adults is on the rise in many countries. The use of alcohol among adolescents and young adults remains a prominent public health problem, with the excessive consumption of alcohol being associated with alcoholism, risky behaviours or social immorality, such as unprotected sex. Cancers, liver cirrhosis, epilepsy, vehicle accidents and other traumatic outcomes may result from the abuse of alcohol, as well as disability and the loss of life.

There is a very strong link between alcohol consumption and tobacco, as well as other drugs (Milam, Furr-Holden, Cooley-Strickland, Bradshaw & Leaf 2014; Nkyi 2015; Vaughn, Salas-Wright, Kremer, Maynard, Roberts & Vaughn 2015). In light of the above-mentioned assertions pertaining to increasing levels of alcohol use, it should be noted that among adolescents the effects are much more serious as they are also exacerbated by peer pressure and the desire to belong and be 'part of the group' of adolescents and young people. This calls for schools and communities to work together to develop, implement and jointly monitor prevention and harm reduction programmes through school health programmes and community based and driven programmes which include structural (policies, laws); community; and individual-level interventions.

4.4.5. Malnutrition and obesity

Research and regular updates continue to provide information about the worrisome trends of obesity and malnutrition across communities, population areas, countries, and regions. The irony is that it is deemed that most boys and girls in developing countries enter adolescence undernourished, while at the other end of the spectrum, there are increasing levels of obesity and being overweight among adolescents, in low, middle and high-income countries.

Kotian and Kotian (2010:176) aver that the increasing incidence of childhood obesity in developing countries is an emerging public health threat which results in socioeconomic challenges, as well as straining the public health sector, especially in developing countries. They note that the prevalence of childhood obesity is higher in urban, rather than in rural areas, with its prevalence varying within each country due to the differences in lifestyle, especially in the dietary patterns and physical activity of children and adolescents. These are further worsened by urbanisation and industrialisation, as highlighted by Kelishadi (2007:63) who asserts that although malnutrition is prevalent in African countries, childhood obesity is increasing in some of these countries.

These justify and corroborate the shifting norms and practices in terms of eating habits, and even the availability of food in some instances; hence the need to re-focus strategies aimed at healthy living. As Kelishadi (2007:66) also noted, until recently, most national public health programmes and policies, especially in low and middle-income countries, have focused on undernutrition and its effects on the survival and mortality of mothers and children. I opine that this practice has been overtaken by events, as health promotion in the current context should be more cognisant of the growing levels of childhood and adolescence obesity and its complications, complemented by nutritional deficiencies, given the high food insecurity in Southern Africa and the concomitant unhealthy eating habits.

Nishio, Saito, Tomokawa, Kobayashi, Makino, Akiyama, Miyake & Yamamoto (2018:2) are of the view that adolescence is one of the highest risk developmental phases, especially regarding the initiation of alcohol, drugs, and tobacco use. They found that in Africa, the estimated prevalence of smoking is 9.3% for boys, 3.8% for girls, and 6.6% for both sexes. This developmental period also presents a great opportunity for prevention; therefore, intervention programmes in schools should take the unique advantage of reaching a large number of at-risk youths within a short period of time, making these programmes very promising methods to prevent substance abuse. Such programmes can be several and varied in nature; for instance, the Focusing Resources on Effective School Health (FRESH) initiative by UNESCO, UNICEF, and the World Bank, developed in 2000. These programmes were intended to strengthen health promotion and educational activities in schools and recommend

that governments implement school-based health programmes in efficient, realistic, and result-oriented ways through four key components as outlined in Figure 4.7.

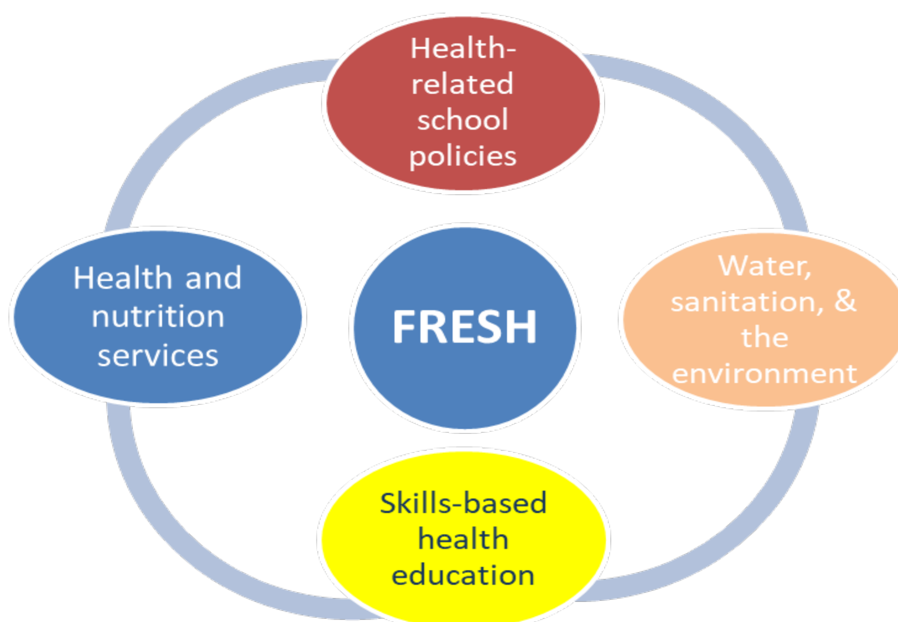


Figure 4.7 Focusing Resources on Effective School Health (UNESCO, UNICEF, and the World Bank 2000)

In the instance that this was implemented across the board, school health programmes, including tobacco prevention, nutrition, healthy lifestyles programmes, as well as comprehensive sexuality programmes would be implemented with the best method, based on scientific evidence throughout the continent and in Southern Africa specifically. Needless to say, this initiative is broad and focuses on various health issues, but its adoption, full implementation and the results therefrom are yet to be realised in a number of countries, as programmes are still fragmented and being managed in isolation, where there are any school health initiatives.

In conclusion, it is worth noting that because there are these multiple health challenges facing adolescents and young people, there is still a lot of work to be done to take care of adolescent health at various levels. In their review, Vojta *et al.* (2018:32) also established that there is a remarkable lack of evidence in respect of individual-level interventions to improve the mental health and well-being of vulnerable adolescents.

4.5. GLOBAL STANDARDS FOR QUALITY HEALTHCARE SERVICES FOR ADOLESCENTS

The World Health Organisation (WHO) and the Joint United Nations Programme on HIV/AIDS (UNAIDS) have defined eight global standards which delineate the required level of quality in the delivery of services as shown in the table below. These organisations emphasise that each standard reflects an important facet of quality services, and if the needs of adolescents are to be met, all these standards should be adhered to and attained.

Adolescents' health literacy	**Standard 1.** The health facility implements systems to ensure that adolescents are knowledgeable about their own health, and they know where and when to obtain health services.
Community support	**Standard 2.** The health facility implements systems to ensure that parents, guardians and other community members and community organizations recognize the value of providing health services to adolescents and support such provision and the utilization of services by adolescents.
Appropriate package of services	**Standard 3.** The health facility provides a package of information, counselling, diagnostic, treatment and care services that fulfils the needs of all adolescents. Services are provided in the facility and through referral linkages and outreach.[1]
Providers' competencies	**Standard 4.** Health-care providers demonstrate the technical competence required to provide effective health services to adolescents. Both health-care providers and support staff respect, protect and fulfil adolescents' rights to information, privacy, confidentiality, non-discrimination, non-judgemental attitude and respect.
Facility characteristics	**Standard 5.** The health facility has convenient operating hours, a welcoming and clean environment and maintains privacy and confidentiality. It has the equipment, medicines, supplies and technology needed to ensure effective service provision to adolescents.
Equity and non-discrimination	**Standard 6.** The health facility provides quality services to all adolescents irrespective of their ability to pay, age, sex, marital status, education level, ethnic origin, sexual orientation or other characteristics.
Data and quality improvement	**Standard 7.** The health facility collects, analyses and uses data on service utilization and quality of care, disaggregated by age and sex, to support quality improvement. Health facility staff is supported to participate in continuous quality improvement.
Adolescents' participation	**Standard 8.** Adolescents are involved in the planning, monitoring and evaluation of health services and in decisions regarding their own care, as well as in certain appropriate aspects of service provision.

Table 4.1 Global Standards for Quality Healthcare Services for Adolescents (WHO & UNAIDS 2015:2)

These standards are quite comprehensive and very useful for the standardisation of the provision of quality health services for adolescents. This is sorely needed as Nair, Baltag, Bose, Boschi-Pinto, Lambrechts and Mathai (2015:289) affirm, that the aspect of quality in healthcare services for adolescents is not well understood. The main challenge is that there is generally no single definition or framework for improving the quality of healthcare, especially for adolescents. They indicate that, “although there is existing knowledge about the factors that could promote or hinder quality improvements in healthcare services, the evidence is scattered in a large number of published and unpublished literature”.

In attempting to critically analyse the key sociodemographic factors affecting school health, specifically HIV and sexuality education programmes, this study makes mention of these standards as they form the basis for programming. The implementation and alignment of programmes to these global standards is not necessarily dictated by the abovementioned guidelines and standards due to the different sociodemographic factors and the relations that determine the decision making, implementation and monitoring of school health, HIV and sexuality education programmes. These dynamics therefore need to be highlighted and acknowledged as this will then provide mechanisms to ensure the implementation of programmes in alignment with global, regional and national standards and guidelines.

4.6. ADOLESCENT HEALTH AND EDUCATION

The school has over time, and also currently been seen as a resource within communities and countries, more so at community level as schools are regarded as a critical resource for knowledge and guidance. It is deemed to be a place and environment trusted to respond to questions about most of the issues faced by communities, especially health issues. These beliefs call for a clear comprehension of the need to overcome some of the existing barriers such as cultural and social differences between the school and the community, in an effort to enhance effective partnerships (Gaztambide-Fernández & Rivière 2019; Lopez 2019). This then explains the need for school health programmes and other social and development initiatives which will have a spill-over effect on the communities served by the school.

This is necessitated by the strong links between health and education, more so among adolescents. This is the main reason for the need for collaborative and functional partnerships and linkages between the education, health, and social development sectors specifically, in order to strengthen coordination between these sectors in policy development, strategic planning, implementation and monitoring processes. In alignment with this, Cutler and Lleras-Muney (2006:1) also observe that there is a well-known large and persistent association between education and health which has been seen in many countries and time periods, and for a wide variety of health measures. These links and relations have been researched and confirmed by various authors over the years (Cutler & Lleras-Muney 2006; Jackson 2009; Mee *et al.* 2018; Patton *et al.* 2012; Wessely 2012).

This relationship between health and education, especially among adolescents is further clarified by Jackson (2009:688) as he purports that health is a contributor to the disparities in educational attainment through various means. These include the need to critically consider health during adolescence, as this is a critical period of educational progress and transition; that interactions between health and socioeconomic status and race or ethnicity are important for educational attainment. He also mentions the fact that adolescents in poorer health are less likely to graduate from high school in a timely manner and less likely to attend college after high school graduation. This suggests that educational participation and performance play meaningful roles in ascertaining the reasons behind adolescents' lower levels of education in instances of poor health.

Brasil, Silva, Rodrigues and Queiroz (2017:2) provide some background that health promotion was internationally highlighted with the Ottawa Charter in 1986, which was a result of the First International Conference on Health Promotion and inspired by the principles of the Alma-Ata Declaration. The declaration prioritised primary healthcare, healthcare for 0 – 6-year-olds, as well as women, maternal and child protection services. However, the Declaration omitted or excluded healthcare for schoolchildren, including children from 7 to 10 years of age. This was later on rectified through the School Health Programme (SHP), which was basically defined as a strategy that integrates education and health actions with the purpose of contributing to the integral education of students through prevention, promotion and healthcare actions. The

intention of the school health programme was also to strengthen actions in the articulation of health and education, in order to address the vulnerabilities in the pre-adolescent and adolescent population groups.

According to Shaeffer (n.d.3), human capital development is critical for economic growth and for development, as research has proven that universal primary education can strongly contribute to growth, especially in the developing world. He indicates that education leads to many other positive developmental effects and is of particular importance in increasing life chances for the most disadvantaged sectors of any population, including girls and women. It is evident in many countries and regions that the education sector is usually the major employer within the public sector, possibly receiving one of the largest shares of government revenue in a country; therefore, the critical need for the sector to acknowledge and play its crucial role in responding to health challenges, including the impact of the HIV pandemic. I am therefore in agreement with the above assertions and in line with the earlier discussions, I aim to utilise this study to highlight some of the underlying causes of the challenges between health and education, especially within the school health setting.

4.7. CONCLUSION

The importance of ensuring a secure and stable social environment for adolescents in order to support their optimal development and success is essential for their social and emotional well-being, even in adulthood. PAHO (2017:4) concur as they go a step further to mention that although the family can provide the primary structure of protection and security during this period, adolescents by nature are exposed to and sensitive to many other influences, such as friends, school, communications media, the community, and the world of work.

These then suggest that the communications media can influence the attitudes, values, and behaviour of the individual more than during any other stage of life, as the digital revolution has also facilitated exposure to new ideas and contacts with like-minded people, while also posing new risks, such as the marketing of unhealthy products and the promotion of unhealthy habits. This calls for some structured ways and means to promote healthy lifestyles for adolescents and young people as

suggested by YouthPower (2018:1) through what they term positive youth development (PYD). This refers to "a broad approach that aims to build the competencies, skills and abilities of youth that they need to grow and flourish throughout life" and illustrated in Figure 4.8.

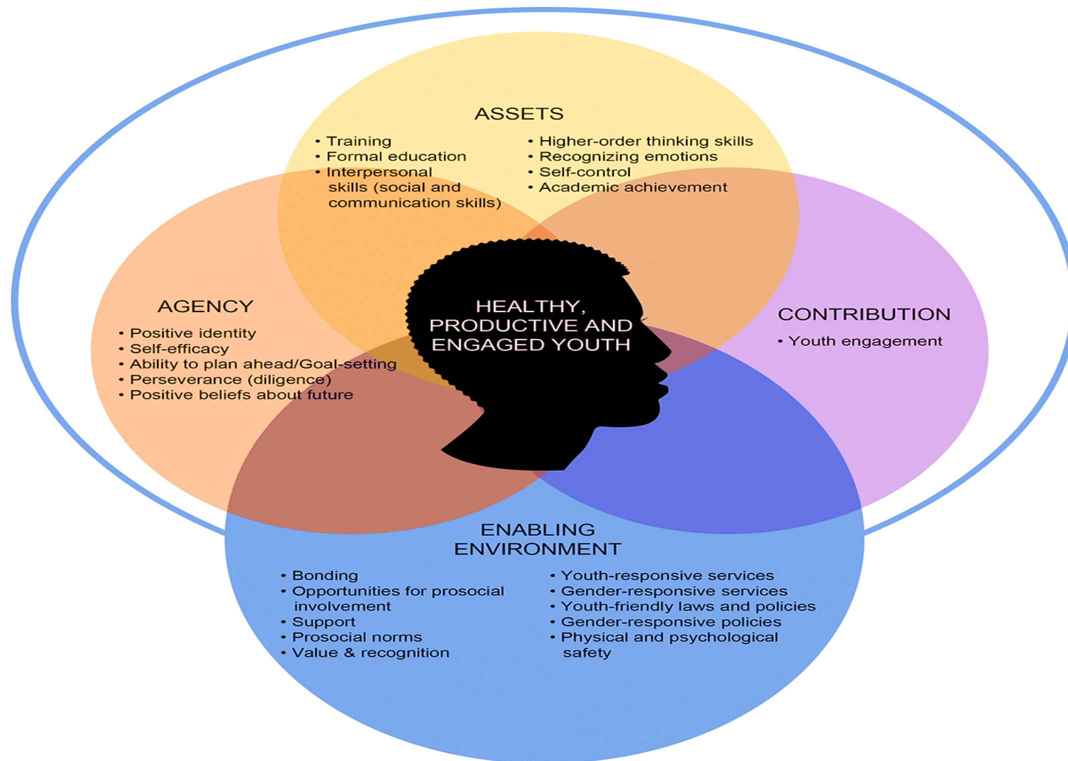


Figure 4.8 PYD Measurement Framework to promote healthy development in adolescence (YouthPower 2018:1)

Finally, adolescents are in transition and are therefore unique in terms of human development. Their specific needs and challenges require specific and unique solutions, which should be heavily and largely driven and informed by the adolescents themselves. This is because over the years, initiatives and projects have been developed and implemented, but considering developments and the adolescent landscape today, it is evident that the desired results have not been attained by most initiatives.

These tailored and context specific packages should take into account specific adolescent needs and comprise a combination of biomedical, behavioural and structural components. As Pettifor *et al.* (2018:265) concur, these age appropriate health and social interventions and initiatives should be bundled and offered in a variety of both school-based and community-based initiatives that are already acceptable to, and endorsed by adolescents in alignment with their gender and cultural

settings. This is the reason this study explores the gender and culture related issues that influence these initiatives within the education and school settings. The next chapter will therefore highlight the linkages between school health, HIV programmes and sociodemographic factors within the education sector.

CHAPTER 5: SCHOOL HEALTH, HIV PROGRAMMES AND SOCIODEMOGRAPHIC FACTORS IN THE EDUCATION SECTOR

5.1 INTRODUCTION

The benefits of education cannot be overemphasised, as education is universally acknowledged to improve the lives of individuals, communities and is instrumental in promoting national development. The education sector has a critical role to play in preparing children and young people for their adult roles and responsibilities, including the transition to adulthood, which requires becoming informed and equipped with the appropriate knowledge and skills to make responsible decisions in their social and sexual lives. Gordon (2008:14) asserts that in most countries, children, particularly those aged between five and thirteen, spend relatively large amounts of time in school. Thus, schools provide a practical means of reaching large numbers of young people from diverse backgrounds in ways that are replicable and sustainable.

As highlighted in Bronfenbrenner's socioecological system and subsequent frameworks discussed in Chapter 2, sociodemographic factors are highly influential in shaping child and youth development. Mansour, Martin, Anderson, Gibson, Liem and Sudmaliset (2016:223) also indicate that there is a wide range of sociodemographic factors that shape adolescent development; these include age, academic orientation, achievement, ethnicity, grade, gender, community, socioeconomic status, school geographic location, and school classifications to mention a few. In this study, sociodemographic factors will be discussed, with a focus on gender and culture, along with their relationship and influence on school health and HIV programmes, such as sexuality education.

These sociodemographic factors can be experienced on multiple scales, often simultaneously, and this can be at the levels of household, family networks, communities, towns and cities, as well as at regional levels (Barnett & Casper

2001:465). Thus, this study explores them from the standpoints of an individual, community, country (Lesotho) and Southern Africa as a region.

Health issues, including HIV and the impact of AIDS have the potential to result in social, demographic, and economic changes in society, and these changes affect the education sector in various ways. Visser (2005:204) confirms that these can influence educational and learning patterns, such as the demand for education, specifically enrolment trends, school attendance, drop-out and repetition rates, as well as increases in the number of orphaned and vulnerable children. Furthermore, the supply of education is also affected as teachers, managers and others responsible for the system become affected by high rates of morbidity and mortality, thus reducing the provision of quality education.

Maritz and Lessing (2004:110) caution that a very important factor to consider is the context of HIV within the cultural discourse of traditional ideas and perceived traditions. School health and HIV programmes, therefore, need to acknowledge and build on the understanding and beliefs of those they seek to influence; therefore making the need to constantly mainstream the sociocultural, economic and gender issues within a particular context very important. This chapter will highlight school and HIV responses and explore the relationship and linkages between those programmes and specific sociodemographic factors within the education sector.

5.2 SOCIODEMOGRAPHIC FACTORS IN EDUCATION

The term 'sociodemographic' refers to a group defined by its sociological and demographic characteristics; these comprise a "combination of sociological and demographic characteristics. Demographic characteristics refer to age, sex, and place of residence, religion, educational level and marital status, while the sociological characteristics are more objective traits, such as membership in organisations, household status, interests, values and social groups" (Salahuddin & Talukder 2017:17). This study is therefore anchored in the sociological aspects, as it explores culture and gender, which are both social constructs. Lee and Schuele (2010), as

quoted by Hanafi and Noor (2016:292) take the definition further as they determine that,

> *The term demographic refers to particular characteristics of a population. The word is derived from the Greek word for people (demos) and picture (graphy) and demographic information provides data regarding research participants and is necessary for the determination of whether the individuals in a particular study are the representative sample of the target population for generalization purposes.*

This chapter therefore focuses on these sociodemographic factors and their relationship with the education sector. The identification of the effects of various demographic, educational and social factors on education and the performance of learners has been the focus of many educators and policy makers (Salem, Al-Mously, Nabil, Al-Zalabani, Al-Dhawi & Al-Hamdan 2013:S85). It is for this reason that it is necessary to explore and investigate some of these sociodemographic factors, but for purposes of this study, gender and culture will be explored in line with their relationship with education, as well as how they influence school health, especially HIV and comprehensive sexuality education programmes.

Ogunlesi and Olanrewaju (2010:384) attest to this as they found that some sociodemographic factors such as maternal age, maternal education, as well as family socioeconomic status are independent predictors of prompt and appropriate care-seeking behaviours for health and other social challenges, including issues and challenges in the education of their children. Thus, community-based, health-education programmes are essential for improving care-seeking behaviours. These underline the powerful influence and impact of sociodemographic factors on school health and HIV programmes.

There are strong relations and linkages between people's gender and culture and the way they relate, participate and behave in the education sector. This is further affirmed by the various researchers who conclude that some demographic factors have a

significant positive effect on the academic achievement of learners (Hanafi & Noor 2016; Tomul & Polat 2013; Nasir 2012).

5.2.1 Culture and Education

Kanaʻiaupuni, Ledward and Malone (2017:311) posit that learners thrive within culture-based education (CBE), especially Indigenous students who experience positive socioemotional and cultural influences. They assert that academic achievement emanates from forward-oriented research and leadership that embraces the cultural advantages of students with diverse experiences. Therefore, there is the need to implement and utilise culturally vibrant and affirming learning environments instead of 'one-size-fits-all' approaches, as this will enable educators to honour and utilise social capital and indigenous knowledge, values, and assets.

It may not always be easy to discuss education in Lesotho without mentioning religion. This is due to the fact formal education was introduced by the Christian missionaries who also introduced the first foreign religion to gain recognition in Lesotho in the 1830s. According to Mokotso (2019:5), missionaries regarded Christian education as an essential ingredient for the propagation of the gospel, hence schools were established alongside Christian churches. Currently, the Christian religion and education are dominant in Lesotho with an approximately 90% Christian population, with about 80% of all primary and secondary schools being owned and operated by different Christian denominations, which include the Roman Catholic Church, the Lesotho Evangelical Church in Southern Africa, the Anglican Church, and the Methodist Church. These church schools are therefore offering mandatory religious education approved by the government, meaning that learners from the minority 10% of the religious groups, including Muslims, Hindus, and Bahai are obliged to learn Christian education in a predominantly Christian education system.

The above historical outline is further affirmed by Pitikoe (2017:106) that Lesotho became a British protectorate between 1868 and 1966. Prior to this period, Basotho like many other African countries practiced traditional education, as a method of promoting the collective philosophy, which brings Africans together. However, the missionaries' arrival in Lesotho brought about a paradigm shift from the traditional

education to a more ‘western’ provision, in the form of Christianity. This led to some strong resistance from Basotho as the missionaries wanted Basotho to abandon their traditional practices. As Mokotso (2015) in Pitikoe (2017: 105) states, in an effort to overcome the resistance, the missionary society relegated the then existing “traditional practices as inferior” and barbaric, recommending the abolishment of traditional institutions such as the initiation school.

Pitikoe (2017:106) goes on to highlight that after the gaining independence in 1966, Lesotho inherited the Western education from the British government, and the Ministry of Education and Training (MoET) became the sole custodian of education provision. She however asserts that even though Lesotho's conventional education brought about an increase in literacy statistics, it still faces some social injustices. These include inequalities in the provision of education where more females than males become literate; the social and cultural duties of boys which lead to them taking more years to complete basic education due to being herd boys; the nature of the curriculum which is more academic than practical; as well as the limited enforcement of the Education Act of 2010 which makes schooling compulsory.

Like in many African countries, Basotho are a patriarchal society characterized by engendered social roles and responsibilities as part of their socialisation to transit into adulthood phase. Most of the learning is acquired informally from their elders, family members and social institutions such as family and initiation schools. For Basotho males, culture influences the social construction of their masculine identity where they learn the socially acceptable roles and responsibilities of ‘Basotho men’. Male socialisation is further reinforced through traditional institutions such as initiation schools and livestock herding where they learn to be providers and protectors of their families at a very young age (Ramakhula 2019; Pitikoe 2017; Rosenberg 2015).

Mohlaloka, Jacobs and de Wet (2016:21) aver that traditional cultural practices, such as initiation and circumcision mirror beliefs and values held by community members for periods often going through different generations. This means that traditional initiation is a generational ritual that is passed from one generation to the next to ensure that the legacy of that community or family is kept alive for a long time. Known as ‘lebollo’ in Sesotho, the traditional cultural practice signifies the transition from

boyhood to manhood as young men are initiated to prepare them for their future roles in their respective communities. This is affirmed by Khau (2016:102) as she indicates that traditional education for Basotho children was both formal and informal. The formal education was through the initiation school led by community elders, local leaders and traditional doctors, and the informal education mainly executed through the socialisation of children as they grew up in the home. Upon reaching adolescence, young boys and girls were expected to join the traditional initiation school, where they would be taught various issues including "how to become real men" and women, sex, what to expect from their partners, with girls also taught how to sexually please their men.

Jerves, Lo´pez, Castro,Ortiz, Palacios, Rober and Enzlin (2014:18) bring in the notion that parents' views regarding sexuality are closely related to the cultural forces and societal traditions that have shaped their experiences. For some parents, sexuality relates to moral values and social mores that do not change over time or from place to place. Parents recognise that religion – both Catholic and Evangelical – had exerted, and still exerts, a fundamental role in setting the parameters of behaviour in the area of sexuality; as they clearly referred to religion, and the rules they had learned in, and promoted by, the church as their immediate point of reference for their understanding of sexuality.

This is further affirmed by Green, Dlamini, D'Errico, Ruark and Duby (2009:289) that traditional African leaders have always played an important role in the lives of the majority of Africans, especially in rural areas. This is the case for Lesotho as traditional leaders are represented in key community structures and decision-making bodies such as the health centre committees for the Health sector, as well as in school boards. The Lesotho Education Act of 2010 indicates that all schools shall be governed by a school board consisting of nine members appointed by the school proprietor and approved by the Minister of Education and Training; and among these is a gazetted chief or their representative under whose jurisdiction the school falls.

These emphasise the critical role played by these leaders, as the custodians of culture as they strongly influence policy and all management decisions made by the school; hence it is critical to involve these leaders through all stages of the programme and

curriculum development as they can become a barrier to school health and sexuality education programmes, if they are not convinced that it is a worthwhile and beneficial initiative in line with their culture and beliefs. In addition, Jerves *et al*. (2014:24) highlight the importance of understanding cultural traditions and religious views on sexuality that may constitute obstacles to the success of sexuality education. They emphasise the need to identify opportunities for sex education in which the cultural characteristics of the population to which it is oriented are recognised, as they are of the view that sex education that is based on scientifically appropriate knowledge may help to overcome myths and taboos about sexuality.

The above assertions clearly highlight the linkages of culture and education, and in the alignment with this study, one notes that these relations and linkages are also relevant for sexuality education and school health programmes. My observation has been that some of the challenges for these programmes include inadequate resources for school health and sexuality education programmes, lack of political commitment, educators' reliance on authoritarian and didactic approaches to teaching, as well as opposition from communities and other leaders, from a cultural perspective. To highlight some of these, Ferreira, Nelas, Duarte, Albuquerque, Grilo, and Nave (2013:221) indicate that attitudes of teenagers towards sexuality are strongly influenced by the organisational culture of the family, institution or community which they belong to, in terms of rules, power relations and control, social objectives, capacity for dialogue, autonomy, organisation and creativity; hence the need for community systems, structures and culture to be entrenched in the delivery of school health and sexuality education programmes.

There are several barriers to educating young people about sex and HIV, and these include cultural, religious, political, legal, individual, the limitations of programmes and the quality of education (UNESCO 2008:2). The above acknowledgements confirm my view that health and HIV issues are mainly exacerbated by social environments which include physical surroundings, social relationships, and the cultural backgrounds of individuals and in this case, of adolescents. In conclusion, the Ministry of Gender (2018:17) asserts that women and girls in Lesotho continue to experience different forms of discrimination and violation of their fundamental freedoms and human rights; with the interface of culture and contemporary forms of masculinities creating new

challenges for men and boys. Gender disparities between men and women continue to prevail, and this is highlighted by realities such as the under-representation of women in political structures and at decision-making levels, increasing gender-based violence, high maternal mortality rates, feminised HIV and poverty, among other issues.

5.2.2 Gender and Education

Education is considered one of the main tools for the consolidation and reproduction of countries' and nations' official ideology and the indoctrination of this ideology on the community. In addition to this, power relations that exist within society and determine the country's character reflect indirectly on the education system. Although they may vary from country to country, education systems under state control continue to harbour elements that instil ideals that embody inequality, gender discrimination, nationalism, racism and marginalisation. Education is of especially decisive influence in the reproduction of gender inequality, and this does not only refer to the inequality of boys' and girls' access to education, but also to the influence of educational curricula and school cultures on the reproduction and consolidation of gender roles (Derince 2012:17).

UNAIDS (2015:57) mentions that gender inequalities place women and girls at greater risk of exposure to HIV, and this greater risk of exposure, combined with biological susceptibility, means HIV continues to disproportionately affect women and adolescent girls. When their cultural, social and economic status is lower than that of men, women and young girls are unable to negotiate protected sex. It is understood that this implies that the lack of decision-making powers, limited access to resources, fear of violence and abandonment, as well as cultural attitudes towards sex, pregnancy and HIV, are all barriers to women and girls accessing HIV services. These assertions therefore remind us to tackle HIV and other health and social challenges in a gender transformative manner because they affect women, men, boys and girls differently. The same analyses, conclusions and decisions should also be made in the development and implementation of school health and HIV programmes in and out of school.

In the presence of all these challenges, Gupta *et al*. (2019:3) aver that the Sustainable Development Goals offer the global health community a strategic opportunity to promote human rights, advance gender equality, and achieve health for all. The inability of the health sector to accelerate progress on various health outcomes illuminates the substantial impact of gender inequalities and restrictive gender norms on health risks and behaviours. They continue to relay that the present is a politically challenging time as the gender transformative agenda demands gender equality for girls and women, and positive gender norms that promote health and wellbeing for all. Within this agenda, there is a wave of grassroots movements, fuelled and democratised by social media, engaged in various advocacy issues including ending sexual harassment in the workplace (#MeToo, #TimesUp); violence against women (#Nirbhaya in India and #NiUnaMenos in South America) and gender-related pay gaps (#EqualPay); advocating against toxic masculinities that underlie male violence (#MenEngage); and promoting lesbian, gay, bisexual, transgender, and queer (LGBTQ) justice (#hrc, #WhereLoveIsIllegal), among others.

It therefore becomes apparent that the need to accelerate responses to the health and social challenges facing women, men, boys, and girls in a comprehensive manner cannot be overemphasised. This is because these movements and campaigns emphasise and exert pressure on the need to have functional and effective school health and HIV programmes. Management Systems International (2008:1) highlight the specific gender benefits of education, as they indicate that educating females and males produces similar increases in their subsequent earnings and expands future opportunities and choices for both boys and girls, though educating girls produces many additional socioeconomic gains that benefit entire societies. These benefits include increased economic productivity, higher family incomes, delayed marriages, reduced fertility rates, and improved health and survival rates for infants and children.

As gender is a social construct, it is interesting to note its influence on school and the whole education sector. This is clarified by Morojele and Muthukrishna (2013:5362) elucidating that over the last three decades, social science research has recognised that childhood is culturally and socially, rather than biologically constructed. This does affect education as Mosia (2017:63) avers that in some developing countries, gender does have an influence on access to education. In the case of Lesotho, even though

Moshoeshoe (2015:34) noted the gender gap in favour of girls, as boys' enrolment was about 13 percentage points lower than that of girls, Lethoko (2019:20) is of the view that some parents still consider their boy children to be only partially educated if they did not go to initiation school, leading to them taking children out of the school to attend initiation school before they can continue their education. This is referred to as rurality by Marrion (2016) in Seotsanyana and Maiketso (2019:54), as they define it as a situation "that involves the keeping of livestock and crop farming in the districts that are mountainous, inaccessible, and sparsely populated". Lethoko (2019:20) goes on to indicate that most parents in Lesotho support male education, with the notion that males will go and seek for employment in the neighbouring South Africa and will be able to maintain their families. This is also aligned to the belief that there are no benefits to educate a girl as they will be married to another family; thus the sex of the child plays a critical role in the education of both boys and girls in Lesotho.

To conclude, as Newman, Chama, Mugisha, Matsiko and Oketcho (2017:4) indicate, the effects of gender on the education of girls in Lesotho and other countries, go beyond the school and well into their employment and economic success. They elucidate that gender status beliefs that involve perceptions of women's lesser worth or inferiority as leaders act as barriers to women achieving positions of power and authority. Beliefs that men have more worth, referred to as male primacy, act as facilitators to power, as well as barriers to their assuming positions of lesser social significance. For instance, a belief in male primacy in Lesotho prevented men from crossing into the female-typed social role of caregiver, because it involved 'free' (volunteer) labour and low-status female-typed tasks, ultimately keeping men out of HIV community-based caregiving, and women almost exclusively leading such activities, and being the main caregivers.

5.3 AN OVERVIEW OF THE EDUCATION SYSTEM IN LESOTHO

Lesotho's formal education system has the provision of five layers of education. The layers include three years of integrated early childhood care and development (IECCD), seven years of primary, three years of junior secondary, two years of senior secondary and four years of tertiary education. In addition, the system includes the technical and vocational education and training (TVET), for skills development at the

post-secondary level, and non-formal and specialised education for those who are excluded from the formal schooling system. Ministry of Education and Training and Ministry of Health (2017:6) indicate that in 2013 there were 338 registered secondary schools of which 28% were owned by the government; 26% by the Roman Catholic Church; and 24% by the Lesotho Evangelical Church in Southern Africa (LECSA), with a total enrolment of 127,121. Of the total enrolled, 7,802 (6.1%) had a disability, and 41.4% of pupils enrolled in secondary school were orphans and vulnerable children (OVC), and with the lower the grade, the higher the proportion of OVC. There was a high rate of repetition in both primary and secondary schools with 18,318 (14%) of enrolled secondary students repeating a grade.

Lekhetho (2013:397) highlights that through the Ministry of Education and Training, evidence suggests that although school enrolment has increased due to free primary education, the low level of output from teacher preparation programmes and high teacher attrition have led to a reliance on unqualified or expatriate teachers. He notes that amidst intense resistance from some of the stakeholders, including the school proprietors, the public and teachers, whose main concern was the anticipated 'unplanned' mass enrolment of children in schools, which they believed would lower the quality of education, the Government of Lesotho introduced Free Primary Education (FPE) in 2000.

Free primary education was introduced in a progressive manner starting from Standard 1, until the cohort reached Standard 7 in 2006. In some cases, the increase led to large classroom sizes, high pupil teacher and pupil classroom ratios, and compromised the quality of teaching and learning. The Ministry of Education and Training and Ministry of Health (2017:7) therefore acknowledge that these low levels of achievement, as well as the high repetition and drop-out rates imply that a large number of children are leaving schools without the basic educational competencies or the knowledge, attitudes and skills to effectively protect themselves and make healthy decisions.

Lekhetho (2013:403) continues to note that although the Government of Lesotho introduced Free Primary Education in 2000 and enacted the Education Act in 2010, which made primary education free and compulsory, many children still do not attend

school because of multiple reasons that include extreme poverty facing many families, the HIV epidemic in Lesotho, as well as some sociocultural practices, such as the tradition of initiation. Of critical importance, is that even though primary education is free, many parents are still unable to pay for the additional educational costs, such as school uniforms and transport due to high levels of poverty and unemployment. This has led to instances of boys dropping out of school to herd livestock in order to meet the pressing family demands, while girls are often made responsible for taking care of siblings and their sick parents and relatives. These challenges are exacerbated by some in-school factors as mentioned earlier.

Following the spikes in enrolment, the trend has changed as United Nations Lesotho (2017:32) indicates that even though the government invests and spends about 14% of public resources on the education sector, Lesotho has not been able to provide quality basic education for all. This is due to several issues including limited education opportunities for the school-aged population, high dropout rates, low retention, compromised quality of education, and the transition from primary to secondary education, especially in the rural areas and among the poor. It notes that the negative trend in enrolment figures in primary education is especially worrisome, given the size of the budget allocated to education in Lesotho, as illustrated in Figure 5.1.

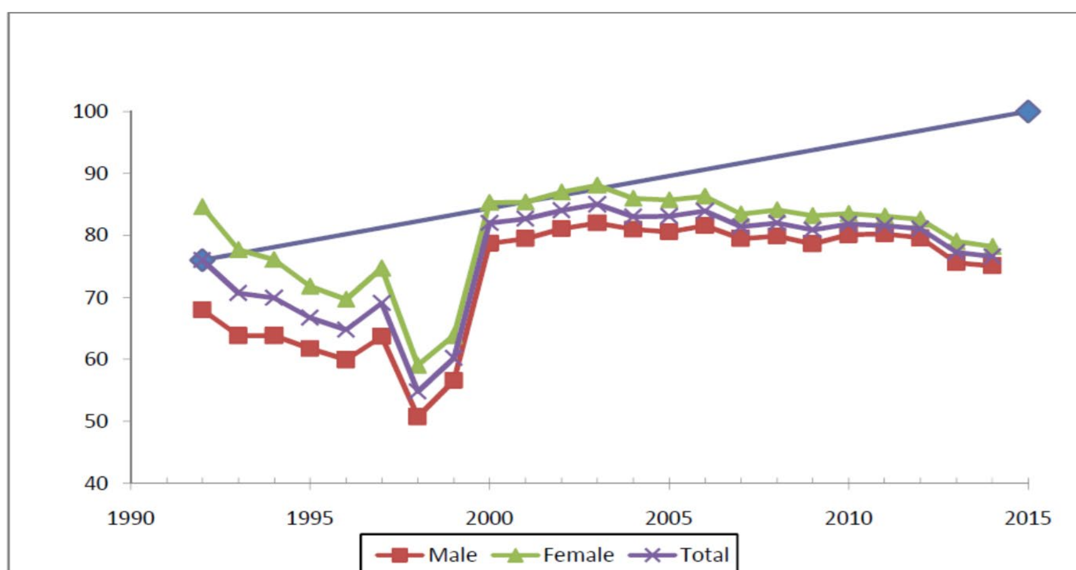


Figure 5.1 Net Enrolment Ratio in Primary Education (United Nations Lesotho 2017:32)

In terms of gender parity, the Ministry of Development Planning (2016:18) notes that in 2013, Lesotho attained gender balance in primary education, as there were almost equal numbers of males and females, with Lesotho ranking 16th globally on the Gender Parity Index with regard to primary education. This indicates some progress as historically, there were more females than males enrolled in primary schools, although in 2014 there was a gender imbalance in favour of males, with a ratio of 98 females to 100 males in primary school. These imbalances continue to highlight the prominent influence on gender and culture as key sociodemographic factors in the education sector in Lesotho; thus, the need to critically explore how these influences can be exploited to benefit the education, health, social development and development planning sectors, as well as the country as a whole.

5.4. SCHOOL HEALTH

School health is a cross-disciplinary field of study and a fundamental strategy that can be used to improve both health and education outcomes (Kolbe 2019:443). Schools are deemed to be an appropriate venue for health interventions, especially because adolescence is the key age at which critical initiatives and interventions should occur. However, these interventions and programmes need to be well conceptualised, well targeted, well implemented, and based on evidence. Horton, Toledo, Mahon, Santelli and Waldfogel (2018:185) affirm this by emphasising that promoting adolescent health requires a broad range of actions across several sectors. Education is key and affects skills and employment opportunities, with several other benefits, including delaying marriage and early childbearing among girls, for instance. They advise that policies and laws that allow flexibility in adolescents' access to health services without necessarily requiring parental authorisation and consent are vital, as are policies and laws controlling their exposure to unhealthy products and activities. Adolescents and young people therefore need to be sufficiently empowered for them to be involved in decisions concerning their well-being, and where feasible, they can even lead some of those efforts.

Schools have a huge responsibility and great potential in health promotion, although there is still a lot to be done to exploit this opportunity and promote school health. Prasla and Prasla (2011:150) are of the same view as they assert that schools are

uniquely positioned to play a significant role in health promotion and advocacy for preventive measures. They indicate that this is mainly because schools offer structured opportunities for learning and reflecting, and learners spend a significant amount of their time in schools during which they are involved in various activities, which include physical and social interactions. This is also recognised by the World Health Organisation (WHO) as they advocate for 'Health Promoting Schools' which are schools which constantly strengthen their capacities and capabilities in setting healthy standards for living, learning, and working.

Of particular interest is the notion shared by Michaud, Namazova-Baranova, Weber and Ambresin (2018:278), who emphasise that most of the main health problems affecting adolescents globally have changed. They note that there are decreasing levels and prevalence of most infectious diseases, with increases in mental health problems, violence, persistent sexually transmitted infections, unplanned pregnancies and abortions, and increases in substance abuse. Despite these improvements in the health of the adolescent global population, several countries, especially in Sub-Saharan Africa continue to face worrisome trends in some of these areas, specifically in sexual and reproductive health; thus functional school health and sexuality education programmes are a critical necessity.

Yakubu and Salisu (2018:3) are also of the view that adolescent girls, particularly in sub-Saharan Africa continue to experience a disproportionately high burden of sexual and reproductive health challenges. They include high adolescent pregnancies, which are usually marred by adverse health and social consequences. These adolescents are likely to have pregnancy complications, including unsafe abortion and more likely to become young mothers more than once. This becomes a vicious cycle as babies born to adolescent mothers face a substantially higher risk of dying than those born to women aged 20 to 24; as they are at an increased risk of malnutrition, low mental and physical development, inappropriate social connection with parents, and poor education. This leads to the adolescents also developing psychological problems from social stigma and suffering physical and domestic violence in their attempt to meet the demands of pregnancy and childbearing. In terms of schooling, they are most likely to drop out and may even not get the chance to return to school.

It is particularly interesting to note that seemingly unique to sub-Saharan Africa, research (Chirwa, Mazalale, Likupe, Nkhoma, Chiwaula & Chintsanya 2019; Habitu, Yalew & Bisetegn 2018; Yakubu & Salisu 2018; Isa & Gani 2012) confirmed the determinants of adolescent pregnancy to be associated with religious factors, early marriages, low level of education, and poverty. In addition to these, the cost of contraceptives, the lack of adolescent-friendly health services, inadequate and unskilled health workers, and the lack of comprehensive sexuality education have further compromised adolescent reproductive health (Yakubu & Salisu 2018:2).

These affirmations are aligned to my view that there are various sociodemographic factors affecting and influencing adolescent health. Due to their nature, community mobilisation and sensitisation play a critical role, and cannot be overlooked if adolescent health within school health and HIV programmes is to be improved. This needs to be complemented by providing accessible and adolescent-friendly health services, as well as high impact adolescent empowerment programmes within school health programmes, including HIV and comprehensive sexuality education programmes. It is therefore imperative that policy makers, especially in sub-Saharan Africa should also understand the determinants of adolescent health within their social environments in order to design pragmatic interventions and programmes that will improve the health outcomes among adolescents.

Michaud, Namazova-Baranova, Weber and Ambresin (2018:278) state that school health services can provide a variety of interventions, such as vaccination, and screening for developmental disability and other lifestyle conditions, such as hypertension, vision or ear defects, and others. They believe that school health programmes have, over the years, mainly focused on mental health, behavioural and health-compromising behaviours through counselling activities and group or class interventions.

Given the current challenges facing adolescents and young people, there is a compelling need to broaden these programmes and strengthen sexuality education and various preventive programmes focusing on the use of contraception, prevention of unplanned pregnancies, violence, and HIV to mention a few. These views and recommendations therefore reinforce and highlight the need and importance of school

health and other innovative programmes, such as Comprehensive Sexuality Education (CSE) in schools, especially in sub-Saharan Africa, including Lesotho where the burden of HIV is among the highest. These will however be effective in the context of favourable and adolescent-friendly sociodemographic factors. UNESCO (2013:7) affirms this as they emphasise the importance of comprehensive sexuality education making links with health, education, and an enabling environment.

In conclusion, it is important to anchor school health frameworks and policies within relevant international, regional and national legislation and frameworks. This strengthens their credibility and facilitates their subsequent implementation, monitoring and evaluation. It is therefore commendable that the South African Integrated School Health Programme (ISHP) is aligned to relevant key education, health and social development policies and programmes, as well as to several acts of legislation including the Constitution of South Africa (Act No.108 of 1996); the amended Children's Act (Act No.38 of 2005); the South African Schools Act (Act No. 84 of 1999); the National Health Act (Act No. 63 of 2003); and the Mental Health Care Act (Act No. 17 of 2002), among others (RSA DBE & DoH 2012:8).

5.4.1. School Health in Lesotho

The Kingdom of Lesotho is a landlocked country with a surface area of 30,355 square kilometres. According to the United Nations Development Programme (2015:15), the country has a population of approximate 2.1 million people and is ranked at 161 out of 188 countries on the Human Development Index (HDI). This indication coupled with the fact that approximately 57% of its population live below the poverty line, highlight that Lesotho is a relatively poor country. In addition, the country is very young demographically, with nearly 40 percent of the population aged between 15 and 35 years, meaning that the country is therefore experiencing a youth bulge.

The Lesotho Government and the Basotho often refer to the education system as a 'three-legged pot'. As Moshoeshoe (2015:1) unpacks it, this means that for the education system to be effective, parents, teachers, and the community should equally contribute to the teaching and learning processes offered through the education sector. This emphasis on the involvement of parents and the community alludes to the critical need for community involvement, with the benefits clearly linked to the

socioecological model as outlined in chapter 2. Learners' education and development outcomes are heavily influenced by the social, cultural and gender norms and practices within their family, community, school environment and experiences. This continues to highlight the need for education policies and strategies to be linked to the sociodemographic factors of the particular community in which education takes place, as the benefits will be realised by both the school and the community from the interactions and influences from both institutions.

However, even though Nthunya, Tuan, Shaw and Jay (2017:259) are in agreement that education in Lesotho is usually symbolically described as a 'three-legged pot', they posit that education is the responsibility of the church, government and community. They further indicate that although communities are mentioned as one of the key stakeholders and represented on the school boards, the people of Lesotho have little control of school management. The government and the church are the main partners who influence what should happen in schools.

As a major player in school education, for several decades, the Government of Lesotho has embarked on projects to address poverty and respond to other challenges, such as HIV and teenage pregnancy. This is so, as improving basic education is considered to be an enabler and key driver of economic growth and poverty reduction. In alignment with this idea, the Constitution of Lesotho changed in 1993 to mandate that education should be available to all citizens, and that secondary education shall be made generally accessible to all, through the progressive introduction of Free Primary Education (FPE) in 2000.

The Ministry of Education and Training and Ministry of Health (2017:17) assert that in terms of school health in Lesotho, the country is "implementing Life-skills based Sexuality Education (LBSE), as the curriculum is integrated in the Personal, Spiritual and Social (PSS) learning area for learners in grades 4, 5 and 6, while it is offered as a stand-alone from Grade 7 to Grade 10. Curriculum packages for Grades 8 - 10 are yet to be implemented. Even though the LBSE curriculum is comprehensive and covers a variety of issues, such as gender, human rights, knowledge and the understanding of self and others, sexually transmitted infections (STIs) and HIV and AIDS; substance use; sexual and reproductive health; together with some elements

on physical activity, nutrition, and religion among others, the health and HIV impact continues to manifest itself in a devastating manner in the country. This could be due to the limited implementation of the school health and other progressive policies and initiatives, such as comprehensive sexuality education – implemented as LBSE in Lesotho.

The Government of Lesotho acknowledges that health services in schools are provided on an ad hoc basis, and this is largely influenced by national priorities and health campaigns, such as the human papilloma virus (HPV) vaccination campaign, or even directed by the priorities of the District Health Management Teams. “There is no clarity as to what or when certain services will be provided, or agreement on what services should be provided for each age group”, as Ministry of Education and Training and Ministry of Health (2017:8) indicate. This therefore means that there are glaring gaps in the implementation of these policies and strategies; hence my assertion that the involvement of communities and community leaders (including faith leaders) is very important if results are to be realised.

School health should not only include the provision of health services to the learners, but should be broad and comprehensive, catering for the social and emotional needs of learners and teachers as well. This includes the school surroundings, infrastructure, and facilities, including extra-mural activities. Lee, Siu Chee Lo, Keung, Kwong and Wong (2019:18) agree with this notion in that the concept of Health Promoting School (HPS), which was initiated by the World Health Organisation (WHO), aims to move beyond individual behavioural change as it also emphasises organisational and structural change, such as improving the school’s physical and social environment, and to complement the curriculum, as well as the teaching and learning or instructional methods.

It is commendable that through the Education sector strategic plan, the Ministry of Education and Training (2016:89) recognised and acknowledged that among the key issues facing the sector, the following were identified as the main challenges for the sector:

- Poor retention rates at primary and secondary levels

- Low student learning outcomes / achievements
- Graduates with inadequate skills for the world of work
- High inefficiency in the system
- HIV and AIDS
- Poor school governance

The Ministry further noted that health has an impact on education as it affects attendance and retention, as well as the quality of education. This is due to several diseases, such as diarrheal diseases and acute respiratory infection (ARI), with the significant ones being early and unintended pregnancy (EUP) and other sexual and reproductive health (SRH) issues leading to high drop-out rates. HIV continues to represent the highest burden of disease in the country; and to break the cycle, the Ministry resolved to access young people before they become sexually active with the knowledge, skills and attitudes they need to protect themselves, through sexuality education. They also highlighted that even though the Life-skills based sexuality education (LBSE) curriculum is being implemented, it does not cover learners in grades 11 and 12 (16-17 year olds), and it is still not clear what exists at institutions of higher learning in terms of the curriculum; thus, the ability of teachers to effectively deliver LBSE in schools is still limited.

To respond to these challenges, the Government of Lesotho has developed several strategies, initiatives, and tools. For instance, in 2012, the Child-Friendly School Standards were developed by the (Ministry of Education and Training 2012:4), and while they aimed at highlighting the fact that priorities and strategies vary in diverse settings, the below dimensions are considered core characteristics of a child-friendly school:

- ✓ ***Inclusive and Rights Based:*** *being proactive about finding out-of-school children to attract children to school and continuously participate in learning activities.*
- ✓ ***Gender Sensitive:*** *promoting school enrolment, access to all educational processes including resources, extra-curricular activities, and personal development regardless of their gender.*

- ✓ ***Effective Teaching and Learning:*** *this entails ensuring that all children develop appropriate life and livelihood skills and knowledge.*
- ✓ ***Safe and Protective:*** *to ensure that all children learn in a safe and inclusive environment taking into consideration their emotional, social, and psychological health and well-being.*
- ✓ ***Healthy and Health-Promoting:*** *promotion of the physical and emotional health of children by addressing key nutritional and health care needs of children.*
- ✓ ***Community Engaged and Participatory:*** *encouraging partnership among schools, communities, parents, and children in all aspects of the education process.*

The emphasis is that child-friendly schools will not be achieved without effective leadership, planning, management, and monitoring in schools; thus, the development of the Lesotho Child-Friendly School Model as depicted in Figure 5.2.

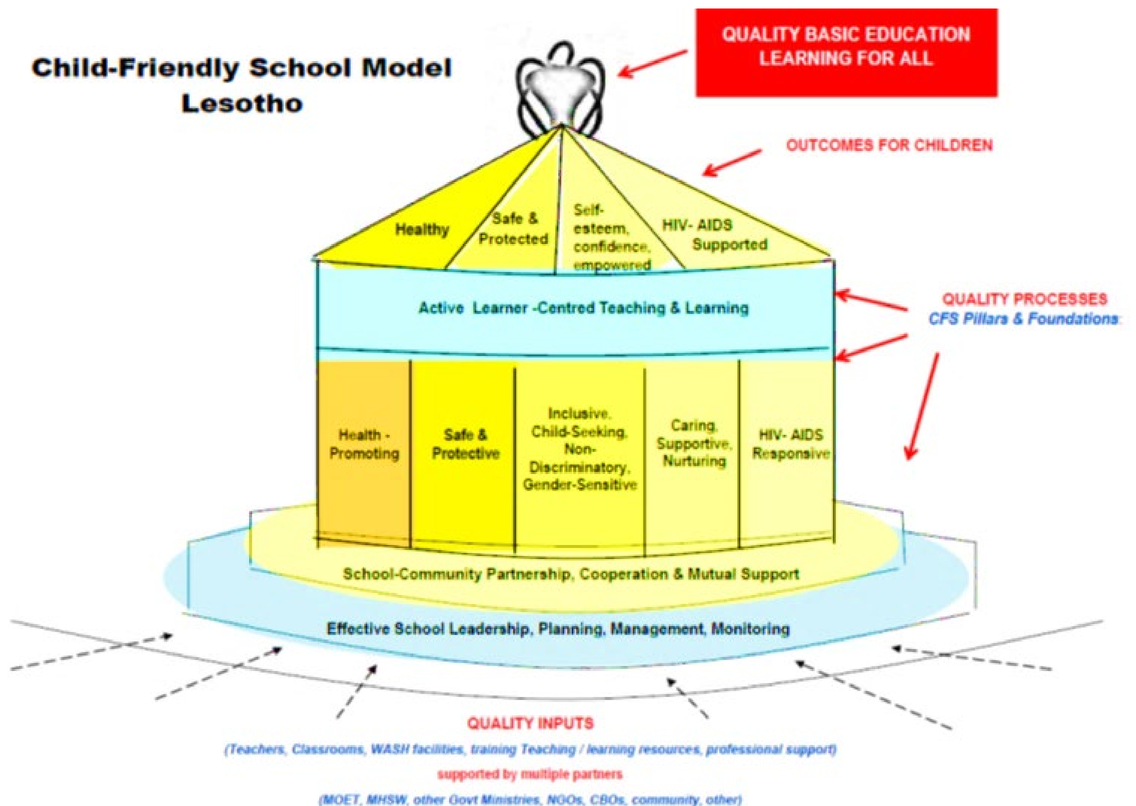


Figure 5.2 Lesotho Child-Friendly School Model (Ministry of Education and Training 2012:4)

This model is unpacked and implemented through the following seven main pillars:

CFS Main Pillars
Pillar 1: Child-Friendly School Leadership, Planning and Management
Pillar 2: Inclusive, Child-Seeking, Access -Enabling
Pillar 3: Learner-Centred Teaching and Learning
Pillar 4: Health, Nutrition and Water, Sanitation and Hygiene (WASH)
Pillar 5: Safety, Protection and Psycho-Social Care and Support
Pillar 6: HIV and AIDS Prevention, Care and Support, and
Pillar 7: School-Community Partnership and Mutual Support.

Gender is cross-cutting and has been integrated throughout the seven pillars and standards (Ministry of Education and Training 2012: iii). The curriculum in Lesotho has been hailed to be strong in both general life skills, HIV and STI-related topics but lacks the essential topics of adolescent reproductive health and sexuality education – such as sexual abuse, gender equality, transmission of STIs and sexual behaviour (UNESCO 2016:6). There have been efforts to address these shortcomings in the newly revised curriculum. To emphasise the importance of sociodemographic factors in the education sector, UNESCO and other partners recommended that the limited sensitisation among school management and communities on the revised curriculum, specifically on school heath and comprehensive sexuality education (CSE) in Lesotho needs to be improved. This is because principals and parents, as well as school proprietors cannot support what they are not aware of. This brings to the fore the importance of gender and culture as influential concepts in the acceptance of new programmes and content, as they shape both the learners' and teachers' behaviours, values, and beliefs.

In conclusion, even though there are plans and strategies in place, the implementation is still very slow and marred with delays, limited leadership and lacking in enthusiasm to implement these by the schools. This therefore calls for some interrogation of, and intelligence on some of the reasons leading to the slow or non-implementation of some of these frameworks, hence the study explores the influence of the gender and cultural dynamics within the schools, national leadership, and communities.

5.5. HIV RESPONSES WITHIN THE EDUCATION SECTOR

Although there are many health and developmental issues and challenges requiring a multi-sectoral response, the ministries of Education are well-positioned to play a critical role in the prevention of HIV, sexual and gender-based violence and other sociocultural and development challenges. This is mainly because schools help to shape social norms, values, and behaviours among young people, especially at the early stages of growth and development.

Traditional public health interventions are often based on issues that adults, in the form of leaders, policy makers, teachers and service providers perceive young people to need (Alegria, Atkins, Farmer, Slaton and Stelk 2010; Johnson, Courser, Holder *et al.* 2007; Decat, Nelson, De Meyer *et al.* 2013). As noted by these researchers, the challenge, is that often, these interventions have usually developed and been supported by evidence adopted from other countries or communities, without necessarily determining the needs of the young people and adolescents within a particular social environment and setting. In most instances, these programmes are usually fragmented, sporadic, short-term, and largely problem focused. This means that most of the time, programme and curriculum developers develop programmes and interventions that focus solely on reducing problems and associated behaviours, without necessarily equipping adolescents and young people with the sexual health knowledge, skills, and services that they need. Most importantly, they neither acknowledge nor provide adolescents and young people with the motivation to avoid health challenges, such as HIV, sexually transmitted infections, gender-based violence, and unintended pregnancies, among others.

Mathews, Eggers, de Vries *et al.* (2015:4) assert that, if effectively implemented and operationalised, most school-based health and HIV programmes and facilities would help to provide comprehensive, multidisciplinary care to many young people and adolescents who would otherwise not be able to access care. However, community engagement, leadership and involvement cannot be overemphasised as critical success factors; hence the need for collaborative efforts and means of engagement with communities. An overview of the current and ongoing responses to some of these

challenges by the education sectors in the region and in Lesotho will therefore be explored.

There have been several programmes aimed at adolescents and young people over the years, especially with the advent of HIV in the early eighties, both in school and out of school. More specifically, peer education programmes were implemented for in school and out of school youth. Frantz (2015:1) indicates that peer-led health education strategies have been recognised as a popular and effective method of providing health education in schools, especially in addressing issues, such as HIV prevention, sexual health promotion and education, as well as other health issues, such as the prevention of smoking. He does, however, allude to the fact that there is limited evidence of peer education programmes being used in schools to address chronic diseases, such as asthma, for instance.

Peer education and other health promotion programmes have been and continue to be implemented in schools. Tolli (2012:905) defines peer education as, “the teaching or sharing of health information, values and behaviours by members of similar age or status”. He goes on to assert that amidst the positive effects of peer education, especially in increasing knowledge and the use of condoms, as well as producing changes in attitudes and community norms, changes regarding sexual behaviour and sexually transmitted infections have not necessarily been consistent. He concludes that from several peer education reviews, although some evidence regarding effectiveness of peer education for the promotion of sexual health has been found, especially concerning the transfer of knowledge and behaviour change, the evidence highlighting their effectiveness is very limited. As Mabuza and Dlamini (2017:3) also state, it can be concluded that this is one of the reasons for the transition from stand-alone peer education programmes to comprehensive sexuality education and integrated school health programmes.

Ministries of Education have a critical role to play in providing strong leadership and mobilising resources for the education sector’s response to HIV and other health challenges. They should therefore take leadership in developing effective policies, programmes and strategies to respond to these challenges. These should be done with the support of national AIDS coordinating authorities, ministries of health, local

government, and civil society organisations, as well as other stakeholders as they all need to acknowledge and be receptive to the sector's critical role in the response. This is also affirmed by Koza and Mushoriwa (2018:114) as they state that education offered in schools is a key strategy and defence against the spread of HIV and other health issues, especially through the empowerment of youth by imparting to them relevant knowledge, attitudes, skills and appropriate sexual behaviour.

However, in order to be effective, the education sector cannot do all these in isolation, hence the need for partnerships and collaboration from other sectors and development partners. This is further confirmed by Bakilana, Bundy, Brown and Fredriksen (2005:25) as they provide an overview of issues that can be considered in the preparation of an effective education sector response to HIV and AIDS, which addresses the following four issues:

a) Education sector policy for HIV and AIDS
b) Education sector management and planning to mitigate the impact of HIV and AIDS
c) Prevention of HIV by the education systems
d) Ensuring access to education for orphans and vulnerable children.

Health and HIV issues, specifically HIV prevention and good health should be taught in schools as early as possible, using age-specific, gender-responsive and culturally appropriate materials and information (Coates, Richter and Caceres 2008; Donovan 1998; Sarma & Oliveras 2013). Learners and all children have the right to information in order for them to prevent HIV, gender-based violence and make informed decisions regarding their lives.

In 2001, countries committed themselves to the *Declaration of Commitment on HIV and AIDS through the United Nations General Assembly Special Session on HIV and AIDS* (UNGASS), in which leaders recognised the importance of education in responding to HIV through reducing the vulnerability of young people to HIV infection. It cannot be overemphasised that adolescents and young people represent the future of every society; therefore, better education and public health measures can be hugely beneficial to their health and development.

The importance of early initiation of health, HIV and sexuality education is further emphasised by Sneed, Tan and Meyer (2015:891) as they allude to the fact that adolescence is also the time when puberty takes place; when many young people initiate their first romantic and sexual relationships, and when risk-taking is heightened and 'fitting in' with peers becomes very important. It can also be a challenging time for young people who are becoming aware of their sexual and reproductive rights and needs, and who rely on their families, peers, schools and health service providers for affirmation, advice, information and the skills to navigate the sometimes difficult transition to adulthood.

Clarke and Aggleton (2012:2) indicate that the Dakar Framework for Action on Education for All (EFA) clearly sets out concerns for young people in the face of a critical global threat from HIV. The EFA Goal 3 advocates for the provision of youth-friendly programmes to protect young people from HIV, with its strategy 7, calling for the urgent implementation of programmes to combat the epidemic. They note that several efforts have been made by education sectors to respond to HIV, but their impact is very hard to disaggregate from the effects of other prevention efforts and interventions due to difficulties in putting in place an adequate framework for tracking progress.

It can therefore be concluded that the integration of HIV and sexuality education, as well as school health within the curriculum needs to be supported and led by government, sectors and schools' management, and should be embedded in the institutional strategic management plans. Needless to say, this requires leadership at all levels, specifically at programme curriculum development levels, and should be complemented with ongoing and regular teacher training, in order to address personal fears and biases, as well as stereotypical discourses around health, HIV and sexuality issues among teachers.

5.5.1. Peer Education

In an effort to respond to the high levels of HIV, sexually transmitted infections and other social and health challenges, peer education programmes were introduced both

within schools and as out-of-school programmes. Ghebreyohans, Khalil, Tsige and Ali (2015: 295) describe peer education as,

> *a popular concept that implies an approach, a communication channel, a methodology, a philosophy, and a strategy. School based peer led education is the most preferred strategy to teach adolescents about reproductive health because they share key characteristics such as behaviour, experience, status or cultural background that makes them more credible source of information than adult.*

They elucidate that peers play an important role in adolescents' lives as they support one another, act as both formal and informal models of behaviours, and as trusted sources of information. This has been demonstrated by the high level of influence the behaviours of their peers have; hence the need to have and effectively implement programmes that will continue to train and educate adolescents and young people, and motivate them to adopt positive, constructive and healthy behaviours. This corroborates my views of acknowledging and taking note of the sociodemographic factors that have a strong influence on some of these programmes, as these will determine the relevance and efficacy of such programmes, including peer education programmes.

Merakou and Kourea-Kremastinou (2006:128) maintain that albeit peer education has a long history as a pedagogical method, its application in health education, especially for HIV prevention started only during the 1980s. In recent years, peer education has been relatively popular in health education and health promotion; a practice which can be attributed to the documented positive characteristics of facilitating interaction between and among peers. Most of the sexuality education and HIV programmes for young people in school and out of school continue to utilise peer education as one of the key strategies.

According to Simoni, Franks, Lehavot and Yard (2011:2), contemporary peer health interventions emanate from the traditions of community-based lay support for health and well-being. This is because one of the common roles of peers has been the provision of social support to enhance health outcomes. In the second instance, peer education is deemed to be a longstanding practice that has been adopted in

contemporary environments, where the value of peers as role models is being recognised and extended beyond didactic functions, as peers engage in participatory learning processes to foster their empowerment. The third and final tradition is that of mutual aid for recovery from health and social ills and addictions, such as alcoholism. In the 20th century, this mutual aid grew from individual assistance to advocacy for system changes, and expanded into HIV care and prevention, mental health care, and breast cancer treatment. This illustrates the transition of peer education over time, as well as its foundations in communities; emphasising the need to note the relationships and influence of sociodemographic factors, especially gender and culture.

In addition, Khong, Berlach, Hill and Hill (2018:206) affirm that peer-led education programmes which are designed using behaviour change theory are effective in addressing people's low levels of knowledge and engagement in prevention strategies. This provides a useful approach for researchers or organisations that are developing prevention education for health education and other social development programmes. In my opinion, this emphasises the links to sociodemographic factors as behaviour is strongly influenced by the social and cultural environments to which adolescents and young people are exposed.

The importance and value of peer education are further elaborated by Swartz and Moolman (2015:2) as they opine that peer education has long been seen as a key health promotion strategy, and an imperative mechanism to challenge and shift youth behavioural norms, especially with regard to sexual behaviour. They emphasise that peer education provides opportunities for frank and genuine inspections and introspections of attitudes and choices and gives adolescents and young people opportunities to learn about the various ways of being healthy from other adolescents and young people. This makes peer education more relevant, making it more fun and credible, while at the same time encouraging creativity and independence among adolescents and young people, especially in issues around sex, sexuality, and health.

Frantz (2015:2) is of similar views as he argues that peer education is deemed to be a process of receiving advice from a friend who is 'in the know'; who has similar concerns, and can identify with an understanding of what it is like to be a young person. He also affirms the empowerment benefits of peer education and advises that if peer

education interventions in schools have been proven to be effective in creating awareness regarding HIV and sexual health, it should be considered as one of the key health promotion strategies to address risk factors for chronic diseases.

According to Ghebreyohans *et al.* (2015: 308), people's behaviour is influenced by the opinions and actions of their close, trusted peers; hence peer educators can communicate and understand among themselves and their fellow peers in a way that the best-intentioned adults may not be able to. This necessitates the need to further explore the benefits of peer educators, as well as the blending of peer education and other health education and promotion strategies and methodologies, especially in the implementation of school health and HIV programmes for adolescents and young people.

5.5.2. Comprehensive Sexuality Education

Concerns about high HIV prevalence and other sexually transmitted diseases among adolescents and young people, the lower age of sexual debut, increasing levels of sexual and gender-based violence, and the persistent high rates of teenage pregnancies are an indication of the high incidence of youth involvement in sex. Early sexual debut and high pregnancy and infection rates show that many teenagers are not only having sex, but also do not adequately protect themselves against unplanned pregnancies and disease. These factors have strong linkages to critical structural factors, such as poverty and rising inequalities (Francis & DePalma 2015:30). Concerted efforts should be made to respond to these challenges and equip adolescents and young people with the skills, competencies and resources to possess the resilience to protect themselves. In my view, this should be in alignment with the specific and relevant sociodemographic factors within the contextual social environments of adolescents and young people, so that the strategies employed will resonate with their gender, social and cultural ideologies, beliefs and practices.

Bhana, Crewe and Aggleton (2019:362) caution that whilst it is important to focus on the very real political, social, health and economic challenges that exist in a country, two major problems concerning sex and sexuality education have emerged. These are the exclusive "framing of sex in the domain of innocence, suffering and risk, with girls

– especially in working class contexts – being largely portrayed as the victims of male sexuality"; while the second issue relates to the conceptualisation of sexuality education as, "a domain of danger and power with little consideration being given to sexualities that encompass desire, pleasure, queer experiences, curiosity and excitement". These authors note that the majority of education interventions continue to emphasise 'risk' over 'desire' and 'shame' over 'pleasure' in their programming; leading to their losing their value, intention and objective to engage young people.

Pettifor (in Francis 2013:1) is of the opinion that sex education is the cornerstone on which most HIV prevention programmes rest, especially given the high HIV prevalence among adolescents and young people. Moreover, Francis (2013:87) states that in South Africa, the HIV and AIDS epidemic has largely shaped the discourse about sexuality. This same belief, though focusing more on the social, political and cultural influences is highlighted by Hawkes and Scott (2005) in Francis (2013:87) as they affirm that,

> *Human sexuality extends beyond that which is preordained, innate, instinctive, or biological. Personal and public discourses are frequently characterised by intense debates about the various meanings of human sexuality. It is generally accepted that human sexuality is rooted in social relations which are contingent on cultural and political influences.*

This shows that issues of sexuality cannot be discussed just as school subjects, without the involvement of parents and the community as they are deeply rooted in social and cultural systems and ethos.

In December 2013, Ministers of Education and Health from twenty-one (21) Eastern and Southern African (ESA) countries affirmed their joint commitment to deliver Comprehensive Sexuality Education (CSE) and sexual and reproductive health (SRH) services for young people through what is now referred to as the ESA Commitment. The commitment was developed based on a Regional Report, "Young People Today: Time to Act Now" which reviewed the trends and status of sexual and reproductive health and HIV among adolescents and young people in the ESA Region, which includes Comprehensive Sexuality Education and service needs.

Fonner, Armstrong, Kennedy, O'Reilly and Sweat (2014:1) are of the view that school-based sex education is an intervention that has been promoted to increase HIV-related knowledge and shape safer sexual behaviours to help prevent new infections among adolescents and young people. It is defined as those programmes designed to encourage sexual risk reduction strategies for HIV prevention delivered in school settings, with the definition including abstinence-only, abstinence-plus, and comprehensive sexuality education programmes.

Van Rooyen and Louw (1994:20) continue to reiterate that , “sexuality education aims at providing the child with knowledge, promoting positive attitudes, positively directing and reinforcing behaviour, inculcating Biblical values and norms, enriching and promoting the child’s personal life, helping the child to eventually be able to make decisions on his own in a responsible manner, and enabling the child to acknowledge, understand and respect his own dignity and that of others within a relationship”. This is affirmed by Fonner, Armstrong, Kennedy, O'Reilly and Sweat (2014:16) that school-based sexuality education is an effective intervention for generating HIV-related knowledge and decreasing sexual risk behaviours among adolescents and young people, including delaying sexual debut, increasing condom use, and decreasing numbers of sexual partners. These resonate with the Lesotho education system, which is mainly led by the Christian Council of Lesotho and other independent churches in collaboration with the government. This partnership was demonstrated by the signature of the Lesotho Gate keepers SRHR Statement signed in October 2017 by church leaders.

Browne (2015:2) emphasises that Comprehensive Sexuality Education (CSE) includes basic health education, but grounds its approach in Rights-based approaches, including gender and power; it has a gender focus; encourages and is anchored in participatory learning; strengthens youth advocacy and civic engagement; and most importantly, it strongly emphasises cultural appropriateness. He indicates that in general, evidence suggests that CSE has positive impacts on behaviour change, such as increased condom use, girls’ empowerment and delayed sexual debut through increasing knowledge and changing attitudes. In the same breath, Browne further notes that the key challenge to CSE identified in the literature is that of cultural resistance, which often takes the form of religious or morality-based

conservatism. The main argument is that teaching CSE encourages young people to have sex earlier and to engage in sexual activity; though he asserts that there is strong evidence to counteract this point of view. It is in line with the above notion that I also intend to contribute to the body of evidence to highlight some of the key challenges in the implementation of school health and HIV programmes, such as CSE that are mainly driven by gender and culture, with the focus on the Lesotho context.

To emphasise the sociodemographic factors that influence comprehensive sexuality education, Hague, Miedema and Le Mat (2017:4) emphasise that there is general consensus on the core elements that should be addressed in CSE programmes. These elements include sexual and reproductive health and behaviours, sexuality and relationships, youth rights, participation and agency, and gender, power, and social norms, as illustrated in Figure 5.3.

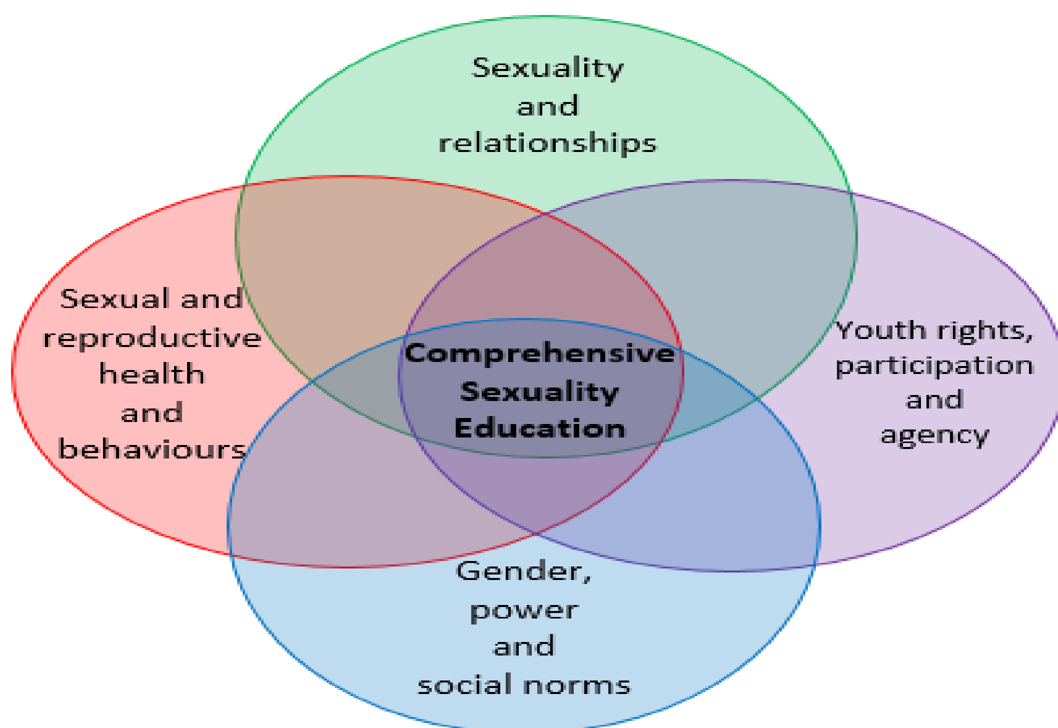


Figure 5.3 Components underpinning Comprehensive Sexuality Education (Hague, Miedema & Le Mat 2017:4)

For sexuality education to be effectively implemented and integrated within the education sector, Van Rooyen (1997:43) emphasises that it should be viewed as an integral part of the school guidance curriculum, as a promotive, developmental and preventative programme. Importantly, it should be contextually sensitive to the democratic ideals and needs of the learner society, which systematically assists the

learner through their personal and social development, in order to play a meaningful role in society. This development and implementation of the core curriculum should be anchored within a multi-sectoral approach, drawing on the resources of other education support services, civil society, the private sector, other government programmes, and teacher organisations, as well as various community structures. This view resonates with the Lesotho education sector model of education being a three-legged pot, comprising the school, parents (community) and the church; as well as my assertion of the need to be aware of the prevalent sociodemographic factors within specific school communities.

In conclusion, despite the good intentions of the ministries and departments of Education to integrate sexuality and HIV education in the school curriculum, there are challenges in its implementation. For instance, questions have been raised about the preparation of teachers to deliver Sexuality Education, together with the lack of uniformity in teacher training; limited capacities of some governments to implement comprehensive sexuality education; limited resources, and some socio-cultural resistance, leading to CSE and school health programmes continuing to face myriad implementation challenges. Other researchers (Francis & DePalma 2015; Browes 2015) are in agreement as they recommend that successful and impactful sexuality and HIV education programmes have to begin with an understanding of the necessary educator characteristics, culture, attitudes and values, not simply their knowledge; and should aim to engage with and involve the wider community, to reduce contradictory messages and increase programme support.

5.6. IMPLICATIONS FOR THE EDUCATION SECTOR

The influence of sociodemographic factors in the education sector have been highlighted in various ways, earlier in this chapter and in the preceding chapters. This section will highlight and strengthen those relationships, linkages, and implications of specifically gender and culture on the education sector, drawing on lessons from Lesotho. Chabela (2010:150) avers that the Ministry of Education and Training in Lesotho is faced with a serious challenge to tailor the education system in response to the challenges of the 21st century. The impact of HIV on adolescents and young people, in particular, challenges the government to restructure the education system

to ensure that young people and their concerns and needs are at the centre of educational activities. Thus, education should enable young people to interrogate their social and cultural contexts and develop insights into the influence of these contexts on their own lives as individuals and as members of society.

5.6.1. Culture and Comprehensive Sexuality Education

There are numerous benefits to creating an educational environment that is relevant to and reflective of student realities, background and culture. Sekese 2002 (in Khau 2012:414), explains that in the past, the Basotho discussed issues of sexuality only with young people considered ready to be married. Such discussions were held in traditional initiation schools, which were situated in mountainous terrains on the outskirts of villages to discourage interference by the community. They were operated by village chiefs with the assistance of elders and traditional healers. The teachers within these schools were outstanding members of communities who were tasked with informing the initiates of their sexual duties within marriage and how to become good men and women.

However, there are reports of increasing sexual and gender-based violence (SGBV) in Lesotho, with some research institutions, such as Women and Law in Southern Africa (WLSA) attempting to research the linkages between initiation and SGBV. This is brought about by allegations that when coming back from initiation school, young men are usually the perpetrators of SGBV, as they now see themselves as men and ready to engage in sexual activities (Khaile 2019; Mhele 2017; Chipatiso, Machisa, Nyambo & Chiramba 2014). This continues to highlight the urgent need for CSE, even for out-of-school youth as its implementation is limited outside the school setting, not even by the health inclined non-governmental organisations (NGOs).

As indicated earlier, for CSE or any other health or behaviour change intervention to be effective, it should be anchored in the recipients' and beneficiaries' cultural ethos so that it is fully embraced. In the case of Lesotho however, Motalingoane-Khau (2010) in Khau (2012:419) argues that the formal sexuality education curriculum is Eurocentric and does not incorporate the Basotho's indigenous ways of knowing, which makes it unacceptable within rural communities. She emphasises that parents

are not necessarily against sexuality education, but are against how it is being taught, and the content of what is being taught.

Furthermore, Letsie and Hlalele (2012:81) insist that HIV prevention interventions cannot be imposed on a population but should rather grow from and be owned by the populations to be reached. They emphasise the need for more social and cultural analyses of the HIV epidemic in Lesotho, through some ethnographic studies aimed at learning and understanding cultural phenomena which reflect the knowledge and system of meanings guiding the life of the Basotho as a cultural group. This socio-cultural analysis is also critical and can be well adapted in the instance of CSE.

Culture has been a powerful prelude for organising knowledge and demarcating people's comprehension of certain appropriate or inappropriate attitudes and behaviours towards sexuality. This is elaborated by Sanjakdar (2011:109) when highlighting that most prominent in the sexuality discourse is how culture functions as an object of a preventative discourse in the learning of sexuality. He posits that culture has been one of the most influential concepts in sexual knowledge through which danger is 'problematised' or organised as a specific problem that can be addressed through strategies and techniques of governance and reform.

One can argue that for school health, especially HIV and Comprehensive Sexuality Education programmes to be effective, acceptable and relevant, teachers should be aware of the cultural beliefs and practices of learners and the communities they serve. This is further confirmed by Helleve, Flisher, Onya, Mukoma and Klepp (2009:197) by that teachers in South Africa argue that the flexibility given to Life Orientation teachers has allowed them to adjust their HIV and AIDS and sexuality teaching in response to the local culture and religion, and to the age and maturity levels of their students.

Regarding language, Helleve *et al*. (2009:198) indicate that teachers experience both personal and cultural contradictions when they teach sexuality issues, especially with regard to the content. In addition to content, the issue of language was cited as a concern related to the practice by which teachers communicate with their students. They indicate that teachers expressed that there were certain norms that people should follow when discussing sexuality with others; as well as certain rules about

which words are appropriate to use, in particular words related to sexual organs and sexuality.

This is also the case in Lesotho, as adults and teachers may use some words which are considered to be softer and culturally sensitive to describe body parts, especially sexual and reproductive health ; a practice which in most instances, simply implies that certain words mean certain body parts – an issue which is highly debatable as it has been realised that even within the same country, different districts and geographical areas use different words to refer to the same issue. This highlights the need for a constant cultural review of language to maintain the credibility and relevance of CSE in Lesotho and elsewhere.

5.6.1.1 Community systems and CSE

The Global Fund (2014:2) defines community systems as, "the structures, mechanisms, processes, and actors through which communities act on the challenges and needs they face. They are made up of different types of entities: community members, formal and informal community organizations and networks, and other civil society organizations. They are usually less formalized and less clearly defined as a system than health systems. What the entities that make up community systems have in common, is that they have close links with communities and, therefore, better understand the issues facing those that are most affected by different health challenges".

Based on this, community systems strongly influence the teaching and acceptance of CSE, and the need to be aware of the specific cultural factors that may influence sexuality education so that they may be taken into account. These systems have the unique advantage of being able to identify, comprehend and respond to the needs of community members, especially those who may be disadvantaged, marginalised and vulnerable within communities. Furthermore, they have the mandate and power to influence whatever happens within their communities. It is therefore evident that these structures need to be involved in the planning for, implementation and roll-out of CSE at all levels, as within these structures, are also the custodians of culture in the form of traditional leaders. Taylor and Ward (1991:123) posit that school-based sexuality

education programmes and family values and beliefs may conflict in complicated ways, as children and adolescents do not only learn about sexuality from school-based sources but also from some cultural groups. Non-school-based sources, such as playgroups, initiation schools and other non-governmental initiatives provide substantial assistance and instruction in this area as well.

Community agencies and health facilities, the staff members of which are more likely to be sensitive to the cultural values of the learners, offer informal sexuality education and/or counselling to young people. It should however be noted that the information disseminated in non-school-based sources may conflict with information disseminated in school-based CSE programmes. This is because most of these non-school-based settings are usually not monitored and regularly empowered with education and information in order to ensure that they deliver standard, relevant and credible content, especially in the Lesotho situation where CSE is not offered for out-of-school youth in an organised manner, as is the school-based initiative.

In conclusion, it is important to note and acknowledge how teachers perceive some of these community and cultural systems. Some teachers use community systems and culture as an argument for avoiding discussions of sex altogether, reflecting a more universal discomfort about talking about sex with young people. DePalma and Francis (2014:558) therefore suggest that to prepare teachers for both culturally sensitive and dialogic pedagogy, teacher training needs to address culture directly in two ways. The first way is to (re)define culture as dynamic, interactive, and responding to, but not determined by, socio-historical realities. Secondly, teachers need to learn how to critically engage with cultural practices and perceptions, though they should be provided with some basic tools to do so; and also realise that this is not only their right, but their duty as educators.

5.6.2. Gender and Comprehensive Sexuality Education

Tadele and Kloos (2013:33) and UNAIDS (2015:57) indicate that education assists in the HIV response and in school health programmes. There is evidence that education reduces the vulnerability of girls to HIV infection, with each year of schooling offering greater protective benefits. They affirm that schools can impart knowledge and skills

that reduce a person's chances of contracting HIV, even in the absence of HIV-specific programmes. In 17 countries in Africa and 4 countries in Latin America, girls with a higher level of education were found to delay first sex and were more likely to use condoms, and in Uganda HIV infection rates declined the most among young women with a secondary school education.

This is further confirmed by Ministry of Health and ICF International (2016:193) as they found that in Lesotho, comprehensive knowledge of HIV rises with education and the wealth quintile among both women and men. This difference by level of education is particularly striking among men as only 13% of men with no education have comprehensive knowledge of HIV, compared to 72% of men who hold more than a secondary education as outlined in Figure 5.4.

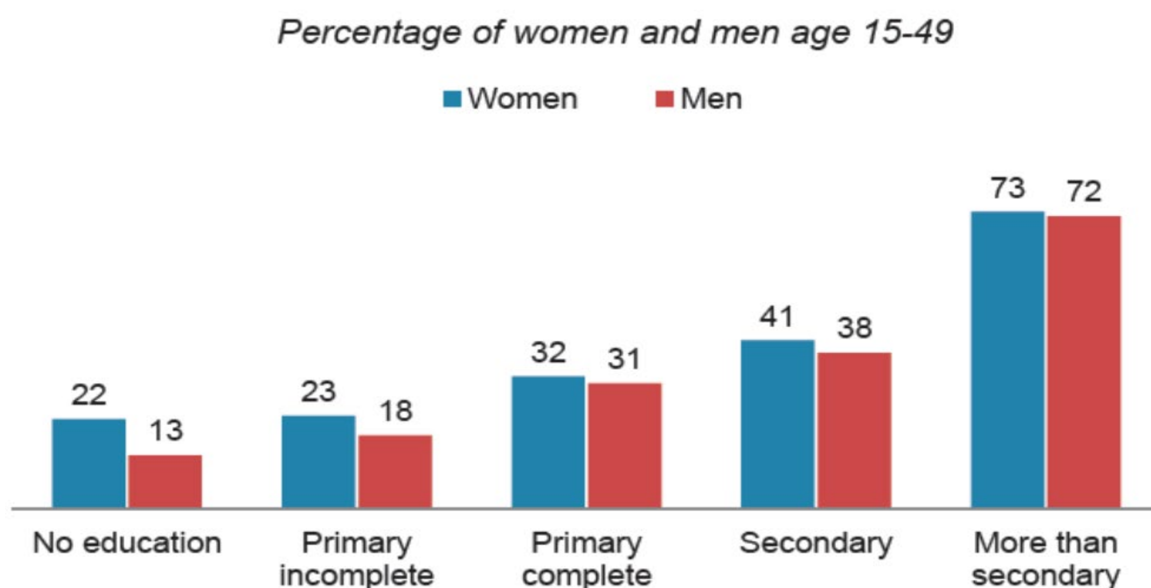


Figure 5.4 Comprehensive knowledge of HIV by Education (Ministry of Health and ICF International 2016:193)

Research (Haberland 2015:32; Meyer 2011:240; Gupta 2000:1) suggests that school health programmes often reflect broader discourses about gender that reinforce and actively produce gender stereotypes. These can influence the way that students engage with sexuality and relationships education, both within schools and communities. Gender discourses in schools can determine which sex, gender, and

sexuality identities are visible and intelligible, and how girls and boys can be represented and constituted.

In alignment with the above notion, gender stereotypes affect the way boys and girls interact with each other, and continue to affect their behaviours, perceptions, thoughts and decision-making. This filters down from the community and family as the majority of sexuality and relationships education in schools are entrenched in notions of sex and gender difference, as well as on ideas about sex-roles. Johnson, Harrison, Ollis, Flentje, Arnold and Bartholomaeus (2016:16) maintain that gender is overwhelmingly used to refer to three binaries: men and women; male and female; and masculinity and femininity. In terms of sexuality and relationships education, these distinctions often position men and boys in negative discourses in need of change and young women as victims, responsible for safe sex and in need of protection. Therefore, school health and HIV programmes, such as CSE should deeply interrogate the gender norms and practices, if they are to succeed in empowering girls, boys and others.

In addition, Skelton *et al.* (2006:383) indicate that children often do not hold complex knowledge about sexuality, but they vary from, and sometimes overlap adult understandings. Secondly, children and young people do not simply learn about sexuality passively, but they mould and reproduce such knowledge, articulating it in diverse ways within their friendship cultures while forming their own social realities. To summarise, although schools do teach about sexuality, adolescents and young people also have their own forms and sources of learning about sexuality, and these should be acknowledged as school health and sexuality education unfold within the school setting. In the same manner, the gender differences between these learning mechanisms should also be noted and taken into consideration.

5.7 CONCLUSION

Although there have been investments in the Education sectors' responses to health, HIV and other social challenges, the results do not necessarily match the investments. The sector is still marred by serious challenges, including high and increasing HIV incidence and prevalence among adolescents and young people, high levels of sexual

and gender-based violence, increasing numbers of inter alia orphans and vulnerable children (OVC), child-headed households (CHH) and high levels of early and unintended pregnancy. This explains the need for countries, development partners and other stakeholders to act and do business differently, to increase the quantity and improve the efficiency and effectiveness of school health and HIV programmes, especially in the education sector.

I am of the view that for school health and HIV programmes to be effective and respond to the health needs of adolescents and young people, particular attention should be focused on the current modalities of offering group-based and / or class-focused interventions and health promotion. Both sociodemographic factors, as well as the individual and peculiar issues facing adolescents and young people may not necessarily require group-based interventions. Communities should work together to meet the needs that young people themselves identify, and should focus on the strengths and assets of young people rather than the 'problem' behaviours they may demonstrate.

On the contrary, Kasule (2014:1-2) presents some cautionary views that although the approaches for preventing risky sexual behaviour are sexual and reproductive health education at school and other social outlets, such education can be a double-edged sword. This is because such education can help adolescents learn to control themselves but can also act as a stimulant to sexual experience among those who know nothing. My view differs from this as I believe that approaches stressing prevention and health promotion require an interdisciplinary approach, comprising strong collaboration between the teaching staff and the health team of a school, while also respecting sectoral roles, responsibilities, and professional cultures. As earlier indicated, Panchaud, Keogh, Stillman, Awusabo-Asare, Motta, Sidze and Monzón (2019:278) opine that much of the available school health and CSE research and programmes have focused on characteristics, quality and inadequacies at the programme level, yet several studies show that a key prerequisite for successful school health and CSE programmes is the existence of a sound policy framework, as is the case in South Africa.

Finally, it is important for people to find local solutions to their problems; thus, it is crucial to work with local actors and communities to identify how local challenges such as those facing adolescents and young people today can be addressed with relevant and effective tools and strategies. Carm (2018:13) notes that when dealing with any individual or societal problem, the local culture, traditions, and gender dynamics cannot be dismissed or ignored, as culture in all forms guides and controls the behaviour of populations. This underscores the need for in-depth contextual understanding in order to apply culturally relevant and appropriate approaches to development work, school health and HIV programmes. My advocacy for efficient and effective school health and HIV programmes is also substantiated by Louw, Shisana, Peltzer and Zungu (2009:217) as they call for multi-sectoral and integrated services, as the quality of education will improve only if educators can focus on teaching, rather than providing social assistance to learners.

In conclusion, although there are commendable efforts to implement school health and HIV programmes, a lot more still needs to be done to ensure that the policy and other commitments translate into evident and sustainable results in practice. These will not be feasible if the larger communities and stakeholders are not part of the discourse; a notion affirmed by Wong and Candolin (2015:667), that behaviour changes results from the interaction of individuals and their environment. This therefore means that the entire community – families, peers, schools, faith communities, businesses, government, and community organisations should participate in fostering the capabilities of the adolescents and young people to prevent HIV and other diseases and challenges. It is only if HIV and school health programmes consider the realities and developmental needs of the community's adolescents and young people that they will succeed - in line with their values, attitudes, and beliefs which vary significantly across cultural, socioeconomic, and ethnic groups.

The next chapter will present the results from the focus group discussions, highlight the key sociodemographic factors influencing school health and HIV programmes, present the Gender and Culture Transformative Implementation (GCTI) framework, and recommend some of the critical conditions that are conducive for school health and sexuality education programmes.

CHAPTER 6: RESEARCH RESULTS - ANALYSIS AND INTERPRETATION OF DATA

6.1 INTRODUCTION

The study aimed to critically analyse the influence of sociodemographic factors, especially gender and culture, on school health and HIV programmes, with a specific focus on comprehensive sexuality education in schools. This chapter therefore describes and discusses how data was analysed towards the comprehension of the sociodemographic factors that have a strong influence on school health and HIV programmes in Lesotho. The comprehension and analysis will then be used to formulate the framework highlighting key sociodemographic factors required for effective school health programmes, with a specific focus on HIV and sexuality education programmes.

At the analysis and interpretation level, social constructivism was used as observations were made on how the various study participants collaborated and engaged with the key issues, and how they failed or managed to reach consensus on some contentious issues during the focus group discussions. Data were collected through focus group discussions and categorised in terms of the objectives of the study. The focus group discussions were held within the social contexts of the participants, in the Motse-Mocha village in Mafeteng and the Ha Abia village in Maseru.

The data are then presented in the form of the voices of the participants as co-researchers of their own situations and contexts. As indicated in chapter 1, after constituting a research team, which included note takers and transcribers, the seven focus group discussions were held in various places in Maseru and Mafeteng, during which the participants dealt with a set of open, non-directive questions. Three types of questions were used, and these were engagement questions in order to introduce respondents to school health and HIV programmes. To make them feel comfortable, open-ended exploration questions were employed which encouraged participants to freely express their views, thoughts, and beliefs on the issues. The discussions concluded with two exit questions to ensure that all views were covered.

As indicated in chapter 3, the research participants comprised teachers, parents, adolescents and young people, government officials, development partners, and faith and community leaders from the Mafeteng and Maseru districts in Lesotho, and they participated in the seven focus group discussions. The participants were aged between 18 and 59. In terms of geographic location, the majority of participants were domiciled in Maseru (69), with the majority of the government officials and development partners from Maseru, while the rest of the participants (45) were from Mafeteng, and mainly comprised the combined group of community and faith leaders, parents, and teachers, as well as the students.

These seven focus groups were used to the advantage of the study to acquire data saturation and get as many diverse views as possible. This was aligned with the selection of the interpretivist paradigm, as the discussions gave me the opportunity to deeply comprehend the different views on school health, especially on HIV and sexuality education programmes within the various social contexts.

Following the transcription and translation of the data from Sesotho to English, content analysis was done, which is defined by Krippendorff (2004) in Bengtsson (2016:3) as "a research technique for making replicable and valid inferences from texts (or other meaningful matter) to the contexts of their use". This analysis includes human speech, observations of behaviour, and various other forms of nonverbal communication, including particular phrases and nonverbal communication generally prevalent in Lesotho and specifically in the two districts of Mafeteng and Maseru.

This chapter reports on the responses of the participants in this research and concludes by highlighting the key findings that will be used to develop the envisaged framework to enhance effective and sustainable school health and HIV programmes that incorporate key sociodemographic factors, specifically gender and culture. I will present the data from the focus group discussions, which will be categorised by theme, in order to highlight the sociodemographic issues and attributes that either facilitate or hinder the implementation and success of school health, HIV and comprehensive sexuality education programmes in Lesotho.

6.2 KEY SOCIODEMOGRAPHIC FACTORS INFLUENCING SCHOOL HEALTH AND HIV PROGRAMMES

This section discusses data with respect to the key sociodemographic factors that influence school health programmes, with a specific focus on HIV and comprehensive sexuality education programmes. These highlight the need for a framework that integrates key sociodemographic factors, specifically gender and culture for effective health and HIV programmes in schools.

In alignment to the study aim and to respond to the study objectives, specifically the intention to highlight the relationship and connections between the specific sociodemographic factors and education, and to critically analyse the influence of gender and culture on school health and HIV programmes, with a specific focus on comprehensive sexuality education (CSE), some key themes were extrapolated from the focus group discussions. These are limited comprehension of school health and sexuality education, from personal and collective perspectives; the perceived benefits of school health and HIV programmes; the social and cultural relevance and alignment of school health and HIV programmes; adolescents' and young people's perspectives on school health and HIV programmes, specifically comprehensive sexuality education; and the critical sociodemographic factors for school health and HIV programmes, as well as threats to school health and HIV programmes. These themes are directly linked to the study objectives and will inform the proposed Gender and Culture Transformative Implementation (GCTI) framework.

6.2.1 Limited comprehension of school health and sexuality education

The importance of parents' and community leaders' clear comprehension of school health and HIV programmes, especially comprehensive sexuality education cannot be overemphasised. This is because health and especially sexual and reproductive health (SRH) issues can be efficiently dealt with and improved through education and prevention activities undertaken by two key actors, the family and the school, as clearly outlined in the socioecological model in chapter 2.

As indicated in Chapter 2, adolescent and youth reproductive health (AYRH) outcomes and behaviours are influenced by various sociodemographic factors and social norms which are beyond the individual's control (Nguyen, Costenbader, Plourde, Kerner & Igras 2019; Bundy, de Silva, Horton, Jamison & Patton 2018). This necessitates clear and strong advocacy for, and implementation of interventions that go beyond individual behavioural change, but those which seek to shift the negative normative environments that affect adolescents' and young people's health and well-being, as these will enhance adolescents and young people's health.

Similarly, in Chapter 4, research (Faludi and Rada 2019; Toska, Cluver, Orkin, Bains, Sherr, Berezin and Gulaid 2019; Paruk & Karim 2016; Koon, Goudge Norris 2014; Kasule 2014; Sagatun 2009) did highlight that although their friends' behaviour plays an important role in adolescents' decision to begin a sexual life, parents remain an important source of information about sexuality, as teenagers are influenced by parents' attitudes and behaviours. This was evident in the focus group discussions with both the adolescents and the parents. The majority of the parents were of the view that the way they were raised was very beneficial to their academic and psychological development as they did not go against their parents' wishes and teachings, especially with regards to sex and sexuality related issues.

> *Unfortunately, today our children seem to know better than us, maybe it is because of this new school syllabus, I don't know….but I will not let my child decide when and how to do things in my house. If she is my child, then I should 'see' my younger self when I look at her. That is how it should be! We really hope this new curriculum (life skills-based sexuality education) is not another way to take us there again where they know more than us* [Parent, 57, Mafeteng].

The understanding and consensus from the all the discussions was that school health and HIV programmes should be anchored in and aligned to the sociodemographic factors peculiar to specific country, district, and community. The emphasis was made as some parents and community leaders were of the view that most policies in Lesotho, not just for education, have been imported from other countries and do not necessarily respect and honour the views, beliefs and culture of Basotho.

> *You will remember, not long ago, the government wanted to introduce a law to allow and enable our women and girls to freely have abortions if, and when they wanted to? Do you think that is how we were raised? No! We are Christians and we believe that children are a gift from God* [Community leader, 41, Maseru]

During the focus group discussions, the general understanding of school health and HIV programmes being offered in schools was quite mixed, though the majority of the participants did not clearly understand school health versus the hygiene curriculum that was taught in Lesotho schools during the 70s and early 80s. "*All I want is for my child to be taught how to brush their teeth and take good care of their bodies and be clean*" [Community leader, Male,66 years old, Maseru]. This was endorsed by several other nods and agreements as not one of the older participants (aged 40 and above) even wanted to mention sex, sexuality or sexually transmitted diseases in discussing health issues facing adolescents and young people.

However, among the younger participants, there was a general understanding that school health programmes need to cover "*everything concerning the health of adolescents and young people*" [Student, 18, Mafeteng], although there was still some hesitation about delving into sexuality education or HIV programmes in school. What is also interesting is that most of the women strongly emphasised the need for school health programmes to cover issues of menstruation among girls, and sexually transmitted infections in the case of boys, as well as the need "*for the teachers to reprimand these young people who have sex so early as we are tired of these endless pregnancies among our high school girls*" [Community Health Worker, 45, Mafeteng].

From the discussions, there was some collective understanding that sexuality education and school health programmes were mainly limited to issues of hygiene, vaccinations and school feeding, and for improved nutrition, as they linked good nutrition with sound academic performance. "*We used to be very involved in these programmes when we were told how and when things would be done. I can't even remember when last children were given vaccinations in school – no wonder we are troubled by these many diseases lately"* [Faith leader, 39, Maseru].

My understanding and views from the focus groups was that the participants' hesitation to delve into sexuality issues was due to their inclination towards either the abstinence only programmes or the old health and hygiene programmes that most of them had been exposed to during their school days. This is because their views and discussions lacked the overall promotion of positive ideas towards sexuality, attention to diversity, and a clearly defined gender sensitive approach which includes discussions of power, which are all attributes of Comprehensive Sexuality Education (CSE).

Regarding the policy environment and the participants' awareness on the Lesotho school health and nutrition policy and the new curriculum on sexuality education (LBSE) that is being implemented in schools around the country, mainly the young participants and those still in school were aware of the sexuality education curriculum but not of the school health and nutrition policy.

> *The government makes all these decisions about our children without involving us. I recently heard that our girl children are now being vaccinated against sexually transmitted diseases or some cancer, and I repeat, we shall all regret these practices from the West* [Community leader, 42, Mafeteng].

These community leaders' views were complemented with some agreement, as there were follow-up concerns on the non-involvement of parents in school and education decisions. These views therefore highlight the need for parental involvement in the design, implementation and monitoring of school health and HIV programmes.

6.2.2 Benefits of school health and HIV programmes

Lesotho has had some components of school health and hygiene for a long time, although in recent years, the subject 'Hygiene' has not been sustained in the curriculum as a 'stand-alone' subject, as was the case in the eighties. It is however, interesting to note that the participants still made many references to hygiene when asked about school health. The other components of school health, such as skills-based health and nutrition education, health and nutrition services, and a safe physical and psychosocial environment for learners, as outlined in the Lesotho School Health and Nutrition Policy of 2018, were not necessarily mentioned. According to one of the participants, they solely focused on hygiene as they were not aware that nutrition and

a safe school environment are part of school health. "*All we know is that sometimes the children get food at school, though the food programme has been inconsistent lately*" [Community leader, 54, Mafeteng].

Regarding HIV programmes, the majority of the participants were of the view that it is important to teach learners about HIV, with a general consensus that HIV education should not be about condoms and family planning, as "*those are for people with families*" [Community leader, 56, Maseru]. According to some of the participants, HIV is a big challenge in Lesotho, although with the provision of free anti-retroviral therapy (ART) by the government, there have been improvements in the overall health and wellbeing of most people.

In responding to whether the HIV and health programmes are essential for young people, there was general agreement that the programmes are necessary, but with some conditions, such as the need to ensure that these programmes are taught by female teachers.

> *Some of these male teachers "ba ja mohlapeng" (meaning that they have sexual relations with the learners) - and we know some of these teachers in our schools, as we now have to compete with them* [Male Student, 19, Mafeteng].

The above assertion was seconded by several young and old participants, and it was an issue in both the Mafeteng and Maseru discussions. The ability of the male teachers to be objective, assertive and to be seen to be serious about emphasising delayed sexual activities among young people and to promote HIV prevention was questioned, with follow-up discussions about male superiority in sexual relations. Some of the younger participants strongly advocated for peer education and peer-led programmes as they asserted that those work better than if the programmes are delivered by the teachers. Among some of their issues were the lack of trust in teachers due to instances of broken confidentiality when some sex and sexuality issues were discussed.

> *Can someone tell us where the good old peer education programmes have gone? Who, in their right mind would stop such programmes? We were free to discuss all our issues and concerns, as young people, without teachers in our*

> *midst, and we really held each other accountable* [Community health worker, 38, Maseru]

In addition, the younger participants shared how the peer education programmes used to be fun and very educational as they were free to discuss issues and challenges facing them as young people, without feeling intimidated by the teacher and the whole classroom setting. They emphasised that the manner in which the current life skills-based sexuality education is delivered within the classroom "*does not make it exciting at all!"* [Female student, 18, Mafeteng]. The participants did however acknowledge that the HIV and health programmes are very important, even though some of them had issues with the "*non cultural, unusual and insensitive content Basotho would not be free to openly discuss with their children"* [Community leader, 42, Mafeteng; Community Health Worker, 54, Mafeteng; Community member, 29, Maseru].

Relating what they particularly like about HIV and health programmes, particular emphasis was placed on the content of the curriculum, even though most participants could not really point out which of the content they did not approve. Sex and sexual behaviours were repeatedly mentioned when discussing sexuality education, indicating the lack of awareness and understanding of what school health and sexuality education are about.

> *Even though we have heard over the radio that issues of sex are now taught in schools, we honestly have no idea of what actually is being taught as the schools have not engaged us. Even when we go for parents' meetings, we only get reports of bad behaviour and how many girls are becoming pregnant. We are therefore very worried about what is actually being taught, because now these children "ba bonahala ba le bohlale ho re feta" (they now seem to know much more than us) when it comes to issues of sex* [Parent, 44, Maseru].

The conclusion from the discussions was that these programmes can be beneficial in curbing the high levels of premarital sex, multiple and concurrent sexual relations, as well as inter-generational sex as most of the examples mentioned were around inter-generational sex. These included how the rich, older men usually fetch young girls from school, and have sex with them in exchange for money, clothes and other extravagant things, such as mobile phones. In both focus groups in Mafeteng, the

participants called for legislation to curb and eliminate inter-generational sex as they asserted that if the older men were arrested, then the adolescent girls and young women would not be in danger of the "predators" as one community health worker referred to the older men. They emphasised that teenage pregnancies, as well as new HIV infections would be reduced if there was proper legislation. Furthermore, they strongly recommended that parents and leaders should also be involved in the development of laws, policies and programmes for schools and the education sector.

On the other hand, the discussion with the development partners and civil society organisations working with the government of Lesotho on the School Health and HIV programme were very optimistic and positive in relating some of the benefits and successes of the programme.

> *We have seen how the perceptions of some of the community leaders have changed during our consultations with them. We are proud to say we have some real champions among the traditional and faith leaders, and they continue to give us updates on the positive behavioural changes that they see in their communities* [Development partner, 38, Maseru].

In addition, the Ministry of Education and Training also provided some of the reports showing some benefits as relayed by mainly teachers from the pilot schools. Some of the benefits of these programmes mentioned include the catalytic effects such as the realisation to review the school re-entry policy for pregnancies among learners.

> *Through our monitoring and support visits to the schools, we were shocked to hear some of the strategies used by schools even though the Ministry has clearly indicated the school re-entry policies in the case of pregnant girls* [Ministry of Education and Training official, 42, Maseru].

Some of these practices that were shared include the decision by some schools to instruct the mother or guardian of a pregnant learner to come to school with the girl throughout her pregnancy, to 'take care of the pregnant girl' as the teachers affirm that they are not trained in health or midwifery issues, just to mention one example. This was discussed as one of the schools' practices to continue to indirectly expel pregnant learners from schools, contrary to the national policy.

Furthermore, some of the benefits of the school health and HIV programmes discussed include the need to strengthen collaboration between the education, health, social development and youth ministries, as well as between the sectors and the faith leaders. The increased interest in sexuality education and school health among the teachers and schools was also noted as one of the benefits by the multisectoral working group.

> *We are glad to report that we are now receiving some good feedback from our health centres and youth peer educators from the districts that parents and community leaders are more active in current outreach events. Even at one pitso (community gathering) called by Ministry of Water, the Chief started talking about the need for sexual and reproductive health services in the community. For us that is a good sign that we are making a difference* [Ministry of Health Official, 53, Maseru].

This is complemented by increasing levels of knowledge as captured through national processes such as the Demographic and Health Survey as the knowledge of HIV prevention was seen to increase with education, with 93% of women and 92% of men with more than secondary education knowing more than one prevention methods, compared to only 69% of women and 61% of men with no education (Ministry of Health Lesotho and ICF International 2016:192).

In conclusion, the benefits of the school health and HIV programmes, especially the life skills-based sexuality education were unanimously highlighted as positive through all the discussions. The key issues were around the implementation, coordination and information sharing between the various stakeholders. The younger participants also emphasised the need for these programmes to be rolled out to all schools as they found them very useful, with recommendations around teacher selections for these programmes, consistency on the delivery of the lessons, as well as the frequency of the lessons which is not consistent like other subjects. These conclusions are directly linked to the Sociocultural Theory as it emphasises the importance and critical links between social interactions and language, and how these are embedded within culture, and therefore influencing how they cognitively develop and understand issues. The discussions clearly highlighted the need to ensure that learning and educational strategies, specifically school health and sexuality education programmes in this

instance, are implemented in line with the socially and culturally acceptable means and standards.

6.2.3 Social and cultural relevance and alignment of school health and HIV programmes

Owing to the high HIV incidence and prevalence in sub-Saharan African countries, including Lesotho, it is critical to comprehend how young people receive information regarding sexuality, HIV and AIDS; hence the incorporation of HIV and health education into the school curriculum through comprehensive sexuality education (Khau 2016:99). Because of these and other challenges facing young people and adults, the implementation of school health and sexuality education programmes have become a necessity more than an option, if we are to overcome these hurdles, and have positive health and education outcomes. In terms of their social and cultural relevance, the majority of the participants felt that most of the sexuality education and school health programmes are not socially and culturally acceptable and relevant.

> *We know that culturally, young people are supposed to abstain from sex until they are married, but if these programmes are teaching them how to have sex in a safe way – which is a way for them not to get pregnant, but while enjoying adult stuff, then we have a serious problem* [Community leader, 56, Maseru].

On the other hand, some of the teachers emphasised the cultural sensitivities that they have to regularly deal with during sexuality education sessions. Even though they acknowledged that sexuality education helps learners make informed decisions about sexual behaviours and the choices that they have to protect themselves, they indicated that culturally and socially, they are not even "allowed" to have sexuality discussions with young people, and these were mostly the older teachers.

> *Can you just imagine me standing in front of those kids and talking to them about sex and how nice it is? Honestly, this curriculum is difficult, and I agree that it might promote promiscuity. Which adult talks to their child about sex? Yes, I went for training, but I told them that this is against my culture and my Christian beliefs* [Male teacher, 54, Mafeteng].

This therefore highlights some real or perceived bias among the teachers with regard to school health and sexuality education programmes, leading to questions on the quality of these programmes within schools. This also emphasises the need to carefully and systematically select teachers who can and are willing to teach subjects related to school health and sexuality education in schools. The above views are in a way aligned with the findings of Robinson, Smith and Davies (2017:334), in that the social anxieties encountered by many parents continue to exist despite the demonstrated value of comprehensive sexuality education for young people's health and well-being. This was also realised by Chirawu, Hanass-Hancock, Aderemi, de Reus and Henken (2014:265) as they discovered that although HIV and sexuality education have been incorporated into the school health policy in South Africa, and that teachers seemed to have an overall positive attitude towards comprehensive sexuality education, in the classroom they were more likely to discuss 'soft topics', such as relationships and personal skills, with issues concerning sexual behaviours and risks being usually ignored. Their findings suggested that restrictive attitudes and beliefs towards certain topics of sexuality education may also produce weak teaching practice in the classrooms, emphasising the importance of addressing beliefs and values, in order to enable teachers to provide comprehensive health and sexuality education programmes in schools.

As the Biopsychosocial framework interprets human health as a product of social environments, these assertions by both adults and adolescents clearly elucidate the notion that even though school health and sexuality education programmes are designed to safeguard the health of adolescents and young people, the shared influences of the psychological, interpersonal, and macrosystem contextual dynamics have an effect on the success of the programmes. The benefits might be evident but the sociodemographic factors tend to become the determining factor of whether communities, including parents, teachers and learners will accept these programmes; hence the need for early involvement and orientation for buy-in and collaborative partnerships. Among some of the recommendations they made for these programmes to be aligned with their social and cultural dynamics and beliefs, the teachers submitted that parents should discuss sexuality issues with young people, including their own children. This, they believed would urge parents to find more culturally and socially acceptable means of teaching their children about sexuality and health issues

in general. The issue of parenting programmes was also raised by the parents as they alluded to many instances which indicate that the generation gap makes it problematic for them to engage with their children on sexuality issues or any other issues beyond the usual health and hygiene topics.

My view is that these challenges are further worsened by that in Lesotho schools, teacher training on life skills-based sexuality education and school health focus only on the sexuality education and / or school health "focal person" in the selected schools. Little or no attention and interaction with the other teachers within the school seems to occur, leading to sexuality education and school health programmes being seen to be the responsibility of only the 'focal-person' rather than a school initiative. This is another way that can facilitate the institutionalisation of CSE and school health programmes.

6.2.4 Adolescents and young people's perspectives on school health and HIV programmes

The perspectives and views of adolescents and young people on school health and HIV programmes were closely aligned to the overall benefits and value of implementing these programmes as communicated by school health and sexuality education advocates, governments, partners and leaders at various levels who advocate for their implementation.

It is also worth noting that some of the younger participants also felt that some of the sessions make them 'uncomfortable', and during the discussion, the 'discomfort' seemed to be mainly around the particular teachers who deliver the content, their relations with the learners, and most importantly, the sexuality education teachers' relations with parents and within the community.

> *Even if they are not saying much now, we all know that during some of those lessons, the boys in our class usually start giggling when the reproductive system is discussed, even in our science class , as our science teacher is very serious and never smiles* [Female student, 19, Maseru]

The levels of comfort and freedom were deemed to increase in instances where the content or sessions were facilitated and taught by younger teachers, and mainly teachers not from within the same community or village as the learners. Even though the adolescents and young people were very supportive of the current HIV and school health programmes, they had many views on how these programmes could be improved to become useful and beneficial to them.

> *Indeed, I like the sexuality education sessions at school, and I know most of my friends also like them, especially when they are taught by Teacher X (female teacher). She is very free, exciting, and open and allows us to ask questions. As for Mr X, we can't even ask questions because he is very strict…and boring* [Male student, 18, Mafeteng]

The younger participants had some thoughtful suggestions about the design and delivery of school health and sexuality programmes in schools, and Figure 6.1 presents a summary of some of the views from the adolescents and young people who participated in the focus group discussions in both Mafeteng and Maseru.

Figure 6.1 Adolescents' perspectives on school health and sexuality education in Lesotho

Even though some parents and teachers were of the view that some of the adolescents' perspectives and suggestions were not realistic, with some murmuring that they were disrespectful, the other parents and community leaders were in agreement with some of these suggestions, especially regarding the teachers who should be assigned to teach sexuality education.

> *We all know that the teachers' roles and responsibilities now are very different from what our teachers were responsible for, now that even some of our practices like* ***lebollo*** *(traditional initiation) and* ***Thakaneng*** *(a place where young people used to go for culture and sexuality lessons) are no longer as legitimate and beneficial as they used to be. They have now been turned into business ventures and have lost their meaning. So, the teachers' roles and*

tasks are becoming more and more demanding, as they are expected to teach and educate in the place of the parent [Parent, 46, Mafeteng].

This therefore affirms the notion that given its socially and culturally sensitive nature, sexuality education may need to be executed by an educator with special attributes, and not just any educator or teacher. One can therefore conclude that some of the current methods of teaching and learning in Lesotho public schools may not be conducive to the delivery of school health and sexuality education programmes. The current system is strongly anchored in theories of empiricism and logical positivism. Allais and McKay (1995:82) define empiricism as relating to the acquisition of facts, proposing a *tabula rasa* (blank slate) approach to teaching, which assumes that the child comes into the education system without any knowledge or ideas and eventually emerges as an educated person. Logical positivism on the other hand, places the teacher's performance on 'logical operations', such as defining, classifying, and explaining as an integral aspect of instilling facts in the learners, with the teacher's main role being that of instruction.

I therefore propose that in order for school health and sexuality education programmes to be effectively delivered and implemented, there should be a paradigm shift from the current method of instruction, to a more democratic and learner-centred methodology of teaching. The learner-centred approach is more participatory and open, leaving an opportunity for both learners and teachers to participate in the teaching and learning process, as requested by the adolescents. This will add the 'excitement' that was mentioned by the adolescents and young people, and will allow them to freely share their thoughts, concerns, feelings, and suggestions of what works for them.

6.2.5 Critical sociodemographic factors for school health and HIV programmes

Lesotho is a homogenous nation, both in terms of the ethnic makeup of its population, as well as its religion and culture. Stoddard (2000) in Letsie and Hlalele (2012:73) argues that Lesotho's strong cultural identity does not translate into a strong national identity, since its location deep in the heart of South Africa has historically forced the small country into dependence on its much larger neighbour. He goes on to assert that traditional authority is the basis of village governance. The system of chieftaincy

follows the progression of the king, principal chiefs, area chiefs, headmen and sub-headmen. The domestic family unit consists of any number of the extended family. Often second or third cousins become 'brothers' or 'sisters'. Grandmothers become official mothers, though some other challenging gender dynamics indicate that by tribal custom, widows become the wife of the brother or other male member of her deceased husband's family. These are some of the issues that affect the implementation and acceptance of school health and sexuality education programmes by societies, as some of the community members and leaders are not involved in the conceptualisation and implementation of these programmes to make them socially and culturally sensitive and relevant. This is despite the community leaders / chiefs being represented on the school boards, as dictated by the Education Act.

The discussions also highlighted the gender dynamics within and between the groups. The sitting arrangements were automatically delineated as the men and women did not necessarily sit together, without any initial or spoken instructions. Some of the discussions also emphasised the issues and dynamics as some of the recommendations and assertions focused on the gender roles. Some heated debates emanated as some community leaders strongly emphasised that the new curriculum (school health and sexuality education) should not attempt to change the way things have been done '*ka Sesotho'* – meaning the Sesotho way.

> *This new curriculum should not attempt to tell us how to treat our husbands or for girls to disrespect their men like we have seen and heard some city women (mainly women from Maseru) talking about this disrespectful gender thing. We know our place as Basotho women and we do not want to change, as that is the reason we still have our families, and our parents did not go through these high levels of divorce that we see today* [Female community leader, 56, Maseru].

One can therefore conclude that some of the social and cultural customs and practices may either contribute to the spread of HIV within a family and community setting or be used to overcome some of the challenges posed by HIV, health and other social challenges facing young people. For instance, in a Basotho (people of Lesotho) family with very close family ties, the phenomenon of single parenthood may not be as obvious and challenging as in the case of modern day family structures where a single

parent is single-handedly charged with the responsibility of raising children and supporting them through the various development stages to enable them to avoid HIV, other health risks and social challenges.

The Sesotho saying "*It takes a village to raise a child"* is a well-known and accurate description of African and Basotho practices as it means that every adult is eligible to correct an erring child, to rescue one in difficulty, and to provide encouragement to all. This therefore highlights that community involvement among the Basotho is entrenched in their culture and considered normal; hence the importance of involving communities in all school health, HIV programmes including sexuality education programmes, as well as in other development programmes. This will enhance the acceptability and implementation of these programmes, as UNESCO (2015:3) also indicates that although there are core components of effective sexuality education programmes, there are still several challenges in various countries in the East and Southern African region, including Lesotho. This was also emphasised by the participants in both districts.

> *Even though it is no longer the same as we are now a bit scared to reprimand children other than your own, our Sesotho culture and ways of living do not allow me to walk past a child doing something wrong, even if I do not know them. As long as they are in this village, I cannot keep quiet* [Community leader, 53, Maseru]

The participants indicated that the school boards and their functions seem to be not very clear to all involved, including the school board members themselves. They noted that the role of the school boards would be to facilitate the involvement of parents and communities in the development and implementation of new programmes and initiatives, but that does not happen. They cited most of the evident functions of the school boards being the recruitment of teachers and in certain instances where there are strikes or criminal activities within a school. Some participants felt strongly that the school board members are merely ceremonial during parents' meetings as they are usually as "*clueless and shocked as we are when we are told some issues by the school principal*", noted one of the parents. This therefore highlights a missed opportunity, to utilise the school board members to facilitate parental interaction and involvement in school and education issues and developments.

6.2.6 Threats to school health and HIV programmes

Sociodemographic factors, specifically gender and culture have a great contribution and impact on the implementation of school health and sexuality education programmes, especially in the context of HIV and gender-based violence in Africa, and in Lesotho specifically. This has been affirmed by the research and evidence in the previous chapters, but most importantly by the findings from the focus group discussions as highlighted earlier. These influences, which are both positive and negative pose some risks and threats to the implementation, success, and sustainability of these programmes.

> *We do appreciate the presence of any programme or intervention that will benefit us and our children. We don't really care if this comes from the school or the church, as long as it preserves our culture, heritage and ensures that our children behave accordingly* [Community Health Worker, 49, Mafeteng].

This assertion, as well as others from the parents and development partners' focus groups corroborate the selection of social constructivism in Chapter 1. The agreement and collaboration of the participants on the need for deeper and more focused parental and community consultations regarding school health and sexuality education programmes does emphasise how the participants managed to reach consensus in this case. Furthermore, they collectively agreed on shared meanings about their social concerns and environments influencing HIV and school health programmes in Lesotho, and the need for more intentional involvement in these programmes, if they are to succeed and be sustained.

The need for a comprehensive framework for health and HIV programming in the context of gender and culture was evident, as it will guide school health and sexuality education programmes for them to be based on the active and direct involvement of communities. It is only when these programmes are informed by, and based on collective action in terms of community involvement that they will be effective and attain the desired outcomes.

As the study is anchored on the biopsychosocial integrative framework, the findings are aligned to the framework as they highlighted the perspective that people are inherently biopsychosocial organisms. This means that people's biological,

psychological, and social dimensions are inextricably intertwined hence the strong emphasis from the participants that the ongoing and prospective school health and HIV programmes, especially comprehensive sexuality education programmes should address comprehensive health and psychological issues, while at the same time taking into considerations and being implemented in line with the social, cultural and gender dynamics guiding the communities and families of the learners.

The participants, especially the parents, community leaders and teachers, were able to interpret human health as a product of social environments as they constantly referred to how health and hygiene programmes were implemented in the past and therefore highlighting the macrosystem contextual dynamics that unfolded, over their personal and social historical timelines.

It is therefore worth noting that to conclude the theoretical positioning of the study, the Sociocultural Theory emphasises the relationships between an individual's psychological aspects and the social and culturally produced contexts that transform the individual's cognitive or mental functions, as noted by (Turuk 2008:244) in Chapter 2. In its recognition of the social and cultural aspects of humanity, the "theory of mind" recognises the central role played by culture and social relationships in people's ways of thinking. This is critical for this study as it clarifies the importance of culture and social capital in the way learners, parents, teachers, and leaders think and comprehend health and HIV programmes within the school and community settings.

The above findings and discussions also highlight some views or thoughts that the implementation of school health and sexuality education programmes have, for many years, not managed to clearly and deliberately integrate the socio-cultural and gender related protective factors to health, HIV information, education and communication (IEC), and sexuality education programmes. I am therefore of the opinion that since the introduction of what was then, Population Family Life Education, to Life Skills Education (LSE), to Life Skills Based Sexuality Education (LBSE) in Lesotho, the programme has been driven by strategies and programmes targeting learners in terms of their sexuality education needs (real or perceived), and not necessarily focusing on the key issues that affect learners in relation to their age, the communities they reside

in, as well as the socio-economic situation of the various learners, and the involvement of communities in the implementation of these programmes.

It is evident that if communities are not involved in school health and sexuality education programmes, their success and future will be compromised. This is already manifesting itself in countries, such as South Africa where some parents and religious groups are strongly against the implementation of the revised sexuality education curriculum. Freedom of Religion South Africa (2018: online) announced that,

> *CSE may seem fairly innocuous and even a good idea. In countries where CSE has already been implemented (including the USA, the UK, Australia, Sweden, etc) however, it has become clear that CSE has a different and more sinister agenda, namely the radical sexualisation of our children. In this regard, the following statement by the American College of Pediatricians is insightful: "Comprehensive Sexuality Education (CSE) goes far beyond sex ed and is a dangerous assault on the health and innocence of children"*.

In the same manner, if some of these concerns by families and communities are not taken into consideration, the implementation of school health and sexuality education programmes in some parts of Lesotho will continue to be marred by similar challenges.

6.3 GENDER AND CULTURE TRANSFORMATIVE IMPLEMENTATION (GCTI) FRAMEWORK

In an effort to position school health and HIV programmes within the sociocultural sphere and environment, this section presents and discusses the components of a framework that is being proposed to facilitate and enhance the processes geared towards addressing the challenges outlined in section 6.2 above.

6.3.1 Sexuality Education

The learning outcomes of Lesotho Life-Skills Based Sexuality Education (LBSE) curriculum address the transmission of knowledge and critical thinking; development of Life Skills; and the development of values, attitudes and behaviour change. Its content is organised around six interrelated themes:

1. Knowing oneself and caring for others
2. Human rights and child protection

3. Gender norms and gender equality
4. Sexual and reproductive health
5. HIV and AIDS and STIs
6. Drug, alcohol, and substance abuse

Although the curriculum has these six thematic areas, there are glaring gaps as noted by the study findings. Building on the IPPF Framework for Comprehensive Sexuality Education (CSE), and its seven essential components of CSE, I therefore propose the below culture sensitive, gender transformative framework entrenched in the basic principles of Human Rights. Even though it specifies sexuality education programmes, the same principles can be applied for school health programmes.

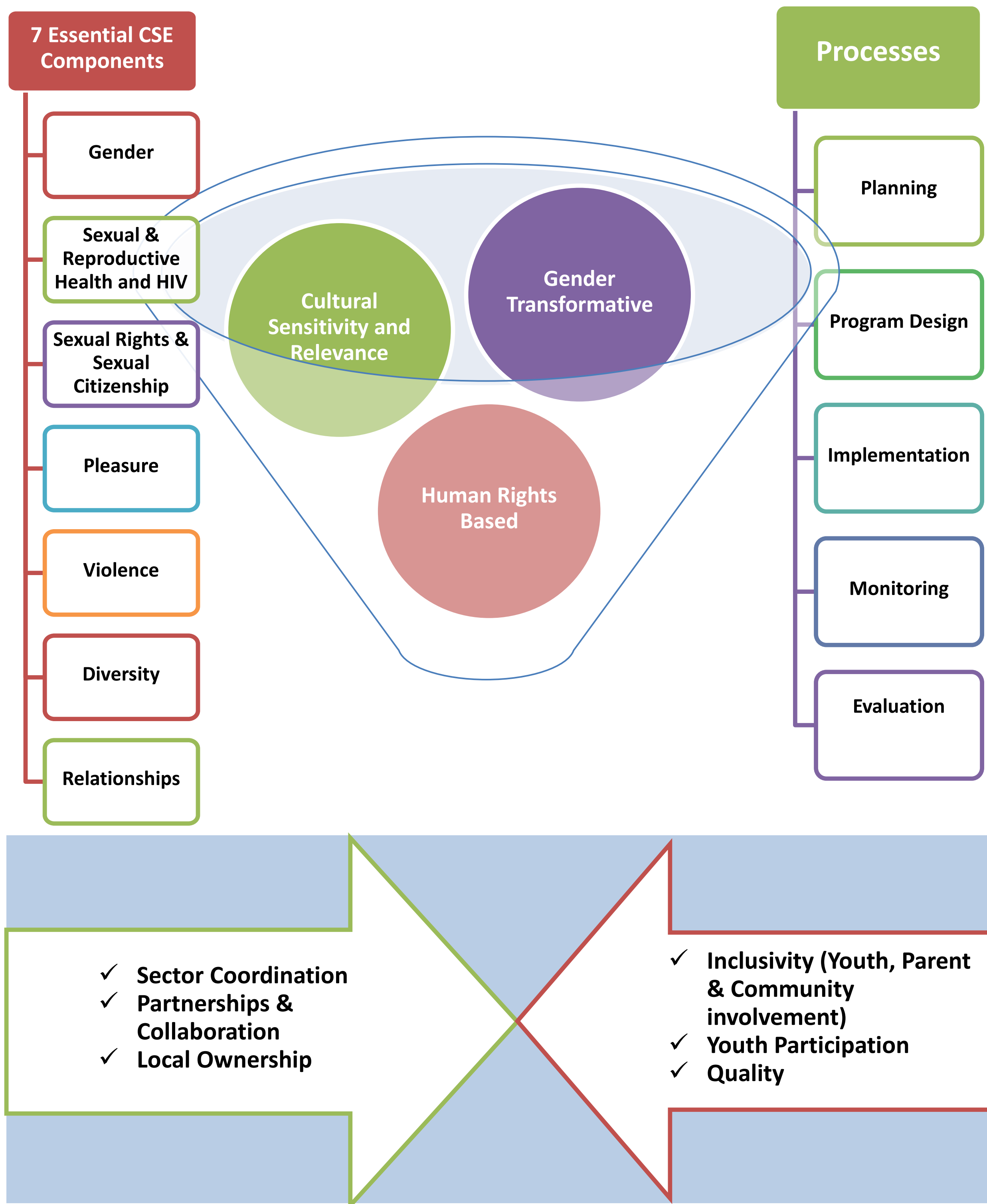


Figure 6.2 Gender and Culture Transformative Implementation (GCTI) Framework

6.4 CONDITIONS CONDUCIVE FOR SCHOOL HEALTH AND SEXUALITY EDUCATION PROGRAMMES

The inclusion of the seven essential components of school health and sexuality education is critical as they are comprehensive and all-encompassing, because they cover some of the much-dreaded issues, such as pleasure and diversity and explain them in more depth than other frameworks and curricula. This framework, however, indicates that in order for these components to be effectively implemented, the three key issues of Cultural Sensitivity and Relevance, Gender Responsiveness, and Human Rights should be integrated at all stages, from the curriculum and programme planning, design, implementation, and monitoring to the evaluation stages. This is because even if the curriculum or programmes are designed well, if they do not include or integrate issues of culture, gender and human rights, they do not become useful and effective, as their relevance is also compromised due to the influence of sociodemographic factors on the education sector and related programmes.

6.4.1. Cultural sensitivity and relevance

All curricula and programmes should be aligned with the culture of the particular country, region, district, community and school, in order for them to be relevant and effective. This does not mean that the content should be diluted to avoid some sensitive issues, but it should be culturally relevant within a particular setting. Similarly, and more importantly, the mode of delivery, teaching aids and methodologies should not be culturally offensive. For instance, aids, examples and processes should resonate with the learners, teachers and parents, and not be deemed to be too foreign within a particular setting in order for them to be effective.

6.4.2. Gender transformative

The curricula and programmes should not be gender blind or gender neutral. They should respond to the gender needs of all groups within the particular country, region, district, community and school, as these entities are not homogenous. It is essential to implement context specific, age appropriate, gender transformative and culturally relevant content for each specific group. They should aim to change harmful gender norms and practices, and facilitate gender equality and equity.

6.4.3. Human Rights Based

It is proposed that the programme should go beyond just integrating or mainstreaming human rights in the delivery thereof. In essence, it means that human rights principles should be mainstreamed throughout all processes. Most importantly, decision making in the planning, design, implementation, monitoring and evaluation of school health and sexuality education curricula and programmes should be anchored in human rights principles. For instance, the decision to omit some of the critical gender and diversity components within some sexuality education programmes can be classified as a violation of the right to information, as learners need to understand all the key issues around the seven CSE components.

I have therefore strengthened the original framework developed by IPPF with the abovementioned framework (Figure 6.2), which has been improved and strengthened by my affirmation to emphasise that all the above conditions should be underpinned by six (6) key principles: Sector Coordination; Partnerships & Collaboration; Local Ownership; Inclusivity (Youth, Parent & Community involvement); and Youth Participation, as well as Quality.

6.4.4. Key Principles

The key principles reinforcing the key components and processes are:

6.4.4.1. Sector Coordination

The Ministries of Education and Training should strengthen their efforts to coordinate the Education sector, and other sectors working with young people, as it is their mandate. The kind of content, mode of delivery and means of implementation of all school health, especially HIV and sexuality education programmes should be coordinated by the Ministry. The reason for this is to avoid the current scenarios of different ministries, non-governmental organisations and developmental partners, each implementing their own school health and sexuality education programme without the knowledge, oversight and quality assurance of the responsible ministry or department. This also relates to the content, as it should be cleared and approved by the Ministry of Education and Training is externally developed.

6.4.4.2. Partnerships and Collaboration

These are essential as the Ministry of Education cannot do everything without the inputs and contributions of the relevant stakeholders, including other sectors, civil society organisations, the private sectors, and communities; hence the need for multi-sectoral collaboration and partnerships in order to strengthen the implementation of school health and sexuality education policies and programmes.

6.4.4.3. Local Ownership

School health and sexuality education programmes should be owned by the communities within the setting in which they are being delivered. This will be helpful in avoiding resistance by some communities and constituencies if they are fully involved in the design and planning processes, and not simply brought in during implementation. Some communities and partners resist such programmes because they are not aware of their content, but they become cooperative and supportive once they get to understand the programme and its contents.

6.4.4.4. Inclusivity

It is acknowledged that initiatives and programmes which are not inclusive usually encounter challenges and problems as people and beneficiaries often do not relate to such initiatives and programmes. This means that if youth, parents and communities are not meaningfully involved and engaged in all processes and stages, the success of such initiatives and in this case of such CSE programmes, is usually compromised.

6.4.4.5. Youth Participation

Meaningful participation of youth in decisions that affect them is of utmost importance. In designing, developing and implementing school health and sexuality education programmes, the voices of youth should be heard and incorporated throughout all processes and stages in a manner that is youth friendly. Platforms that are relevant, and which afford youth the space and atmosphere that will encourage them to participate, should be used.

6.4.4.6. Quality

If there is no quality assurance throughout all the processes, the programme will not yield the desired results, even if the content is good. For instance, if the school inspectors and principals are not aware of the school health and sexuality education curriculum and programme and their contents, their oversight roles will not be useful for this particular programme as they can be counter-productive to the processes, from design to evaluation.

6.5 CONCLUSION

It is evident that the school and its environment are highly influenced by society, societal norms and cultures, as well as practices. This places more emphasis on the need to take into account societies' and communities' needs, cultures and practices in the development and implementation of school health and sexuality education programmes across the board. All issues that affect the development and implementation of these programmes are largely focused on and around communities' or societies' limited involvement in the processes and related programmes; leading to the myriad issues affecting the implementation of school health and sexuality education programmes within and outside schools. These factors include parental involvement in school-based health and HIV programmes; community involvement in the review of curricula; and stakeholder perceptions about the key issues around sexuality and related challenges.

The next and final chapter will therefore present the conclusions about the research problem, and implications for both theory and practice, within the key sectors of Education and Health for the implementation of school health and sexuality programmes. It will conclude by highlighting the study limitations and recommendations for further research.

CHAPTER 7: CONCLUSIONS AND IMPLICATIONS FOR PRACTICE

7.1 INTRODUCTION

This study intended to explore and interrogate the influence of sociodemographic factors on school-related HIV and health programmes, with a specific focus on gender and culture. The first chapter provided the orientation, research overview and structure of the research, while chapter 2 presented the selected paradigms and theories in psychology and social research. Chapter 3 highlighted the research design and methodology, while chapter 4 presented an overview of HIV and health among adolescents and youth. Chapter 5 linked HIV, school health and sociodemographic factors in the education sector. Chapter 6 then reported on the responses of participants in this research and concluded by highlighting the key findings that were used to design the framework that can be used to enhance effective and sustainable school health and HIV programmes. Special focus was on school health and comprehensive sexuality education programmes that incorporate key sociodemographic factors, specifically gender and culture. The chapter ends by presenting the data from the focus group discussions and highlights the views of the participants; and concludes with the presentation of the *Gender and Culture Transformative Implementation (GCTI) Framework for Sexuality Education and School Health* programmes.

This chapter therefore reflects on the study aim and objectives through a synopsis of the literature review, assumptions and assertions highlighted in the preceding chapters, with the aim of presenting the findings. The recommendations of the study will also be presented in order to highlight the critical sociodemographic factors influencing and affecting school health and HIV programmes, specifically comprehensive sexuality education. In addition, the study limitations will be discussed, with the intention to acknowledge and emphasise some research gaps for future study interventions. The chapter will culminate with the conclusions about the research problem, and the implications for policy in both theory and practice, within the key sectors of Education and Health, for the effective and successful implementation of school health and sexuality education programmes.

7.2 STUDY AIM AND OBJECTIVES

The aim of the study was to critically analyse the influence of gender and culture as the selected sociodemographic factors, on school health and HIV programmes, specifically comprehensive sexuality education programmes in Lesotho. To achieve this, several research questions were asked to ascertain the key health and social challenges facing adolescents; the nature and scope of school-based health and HIV prevention programmes in the Southern African region and in Lesotho specifically; the relationship between sociodemographic factors and the education sector; and the specific sociodemographic factors that affect school health and HIV programmes with a specific focus on comprehensive sexuality education (CSE); as well as what is required for effective health and HIV programmes in schools.

Using focus group discussions, some critical questioning methodologies and techniques were used to clarify and contextualise the responses from the participants and broaden the comprehension of the key issues and challenges. The participants' views helped to respond to the study objectives, which were to explore the key health and social challenges facing adolescents; to investigate the nature and scope of school health and HIV programmes; to highlight and emphasise the relationship and connections between the specific sociodemographic factors and education; to critically analyse the influence of gender and culture on school health and HIV programmes, with a specific focus on comprehensive sexuality education (CSE); and to provide a framework highlighting key sociodemographic factors and issues required for effective school health and HIV programmes, specifically sexuality education programmes.

In order to achieve the study objectives, literature from national, regional, continental and international sources was reviewed. This sought to comprehend and document issues facing adolescents and young people, as well as the historical, current and planned school health, HIV and sexuality education programmes from other social, cultural and geographical settings with a view to learn from them and to take into consideration some of their challenges and how they have been overcome. These literature constructs were then compared and aligned with the data obtained from the participants from the two communities and national stakeholders, with the intention to develop a *Gender and Culture Transformative Implementation Framework for*

Sexuality Education and School Health programmes as outlined in Chapter 6, that is entrenched in the basic principles of Human Rights, for effective and sustainable school health and sexuality education programmes.

7.3 CONCLUSIONS ABOUT THE RESEARCH PROBLEM

School health and sexuality education programmes are designed to ensure the rights of young people to access health education and promotion, and health services, as well as to be informed about their sexuality, so as to make responsible decisions about their sexual and reproductive health (SRH). Although these programmes have demonstrated some successes in delaying sexual debut, reducing the frequency and number of sexual partners, and increasing condom and contraceptive use (where allowed), they continue to face implementation and acceptability challenges within schools, communities, national, regional and other global institutions and contexts.

International Planned Parenthood Federation (2010:5) indicates that there is a need to move away from an 'instrumentalist' approach that frames comprehensive sexuality education (CSE) as a means to an end. Instead, sexuality education programmes are worth the investment and thoughtful implementation, because they empower and build the self-esteem, competence and confidence and lead to better health and well-being for the individual young people that they reach. It is, however, worth noting that not all partners and stakeholders realise and acknowledge these benefits, especially parents and community groups including some faith groups. These resistance groups need to be acknowledged, as in order to be successful, school health and sexuality education programmes need to consider the sociodemographic factors, including related social norms. These norms are important because they influence and uphold behaviour, and reinforce social inequities, including gender inequities and inequality.

The Institute for Reproductive Health (2019:7) further asserts that programmes that seek to improve adolescent and youth sexual and reproductive health (AYSRH) need to comprehend that unequal power means different risks and opportunities among girls and boys, men and women. Thus, programmes that are not responsive to underlying sociodemographic factors, such as gender norms and power relations can be ineffective, or even backfire and exacerbate harmful norms and practices. This

bolsters the recommendations from this study for school health and HIV programmes to integrate the gender and cultural factors into school health and sexuality education, and other health and HIV programmes.

In 2008 the Lesotho Ministry of Education and Training embarked on an exercise to review the entire primary and secondary education curricula with the purpose of making education at these levels accessible, relevant, efficient and of the best quality. The exercise led to the development of the Curriculum and Assessment Policy Framework, and among its objectives were to address the emerging issues pertaining to new demands, practices and life challenges of the modern global world, and to propose a fully localised secondary education curriculum and assessment (Ministry of Education and Training 2008:3).

It should however be noted that the localisation aspect has not been well applied to school health and HIV programmes in Lesotho, especially comprehensive sexuality education. This was affirmed by UNESCO (2018:14), as they noted that even though there were efforts to convene traditional and faith leaders to adopt the curriculum, the majority of primary (73.3%), and secondary (88.2%) schools did not conduct orientation sessions for parents and guardians, leading to 71.8% of schools in Lesotho having not engaged the parents or guardians in the Life skills-based HIV curriculum. This oversight then creates challenges and clashes with the sociodemographic factors within most communities and schools as the parents, guardians and community leaders were not fully aware of what the curriculum entails, leading to very limited implementation and uptake of school health and sexuality education programmes. This realisation, complemented by the study findings emphasises the critical need to align school health and sexuality education programmes to the socio-ecological model, among others. This is because the model emphasises the role and influence of community, their beliefs and social networks in policy and programming, and it is useful in facilitating the comprehension of human and social dynamics.

7.4 IMPLICATIONS FOR THEORY

The role, attributes, behaviours and level of comfort of parents / guardians and teachers significantly affect the success of school health and sexuality education

programmes. Regarding teachers, they are also influenced by their social and cultural values and norms, yet they are central to the delivery of these programmes; thus the need to invest in their training and orientation on a long-term basis, including pre-service training becomes urgent. Within the school setting, it is recommended that school health and sexuality education programmes and teaching should be assigned to selected and assessed teachers, and not based on whether they teach Biology or not, but on their attributes in terms of openness, flexibility, adaptability and rapport with the learners and other teachers. This should be complemented with the key gender and cultural factors that affect teaching and learning, both within the school setting and outside.

Teachers and parents should interact with leaners in an open, friendly manner that is age-appropriate, culturally sensitive and gender responsive, in order to dispel the current myths and overcome barriers in the implementation of school health and sexuality education programmes. Finally, the school health and sexuality education curriculum content should be informed by prevalent and positive gender transformative and culturally sensitive materials and issues, with learners and communities also contributing to the development of the curriculum and strategies to roll it out.

However, in terms of the content, the study highlights the need for deeper and more meaningful content within the curriculum, as the majority of the participants felt that CSE should include some details on HIV prevention, especially condom use from as early an age as 12. Another key issue was the inclusion of issues related to sexual orientation and gender identity and expressions (SOGIE) in the curriculum, which are currently non-existent, with sexual diversity just being mentioned, without necessarily including the details of sexual diversity and sexual orientation versus gender identity for the comprehension of both learners and teachers. One final glaring gap, which was also acknowledged by a senior official in the Ministry of Education and Training is content and even basic discussions on menstrual health management (MHM) within the revised curricula. These lacunae call for the need to interrogate and review the current content of the school health and sexuality education curricula in order to strengthen them.

Findings from this study therefore clearly highlight the need to acknowledge and incorporate gender and culture in the implementation of programmes, specifically school health and sexuality education programmes. The importance of the involvement of young people in the design, implementation, monitoring and evaluation of these programmes cannot be overemphasised. This is also confirmed in chapter 4, as it highlights that although schools do teach about sexuality, we need to note that young people also have their own forms of learning about sexuality, and these should be acknowledged as school health and sexuality education unfold within the school setting. In the same manner, the gender and cultural differences between these learning mechanisms should also be noted and taken into consideration.

7.5 IMPLICATIONS FOR POLICY AND PRACTICE

There is a strong and urgent need to develop and adapt school health and sexuality education programmes to specific social and cultural contexts, and for educators, curriculum developers and policy makers to know about the cultural traditions and religious beliefs that may form obstacles to the effective implementation of these programmes in Lesotho and in the region. The regular and continuous use of community-based participatory approaches (CBPA) is strongly recommended to ensure that communities and community systems are fully involved in the delivery of school health and sexuality education programmes.

It becomes apparent that even with the advances of school health and sexuality education in Lesotho, the critical and contextual culture, gender issues and dynamics are not necessarily factored into the curriculum. It is recommended that these issues be included as these programmes are being rolled out; a process that may call for regular curriculum reviews in order to ensure that the education sector stays relevant in the delivery of its mandate. Governments, especially local governments, should take responsibility in supporting gender equality in education through their leaders, technical support, budgets, and their policy.

This study has provided a critical opportunity to interact with some of the learners, community leaders, parents and teachers entrusted to deliver school health and sexuality education programmes in Lesotho. Their views and suggestions highlighted

in chapter 6 strongly indicated the need for the standardisation of the school health and sexuality education curriculum and tools (teachers' and learners' guides, for instance) across the country, so that the curriculum is implemented in all government, church and private schools, with the inputs of all stakeholders. These programmes should, as anticipated, be allocated time on the school programme and timetable. The current way of not allocating time does not yield the anticipated results as they are treated as optional subjects – contrary to policy guidance.

Although the majority of the study participants understand the importance of school health and sexuality education programmes and are of the opinion that they should be taught in schools, not all schools in Lesotho offer school health and comprehensive sexuality education (CSE) as subjects, including some of the CSE pilot schools. I therefore recommend the need for a standard template or profile for selecting teachers who can teach school health and sexuality education programmes, as they need to be approachable, trustworthy, empathetic, and dependable. There are currently no set or standard selection criteria; thus, some teachers are not interested in being involved in these programmes. This selection is key as with the levels of school-related gender-based violence, schools cannot afford to trust perceived or real perpetrators of gender-based violence and some other practices, such as engaging in inter-generational relationships with learners, to deliver school health and sexuality education programmes.

In terms of capacity development, my observation is that the Lesotho Teaching Service Department (TSD) has a Training and Development Unit, which should ideally lead all capacity development initiatives for teachers and schools. However, some partners and service providers directly liaise with the schools, without the involvement of the Department, therefore creating a challenge for the Department to standardise, monitor and report on initiatives aimed at teacher development and training. Some of the capacity development initiatives require computers and the internet, which the schools do not have, leading to the compromised quality of such initiatives. All these lead to the duplication of efforts and conflicting messages in some instances; thus, the need for the Ministry of Education and Training to enhance its coordination for effective implementation of school health and sexuality education programmes, and tangible results for better education outcomes.

As UNESCO (2018:28) indicated, even though the initiative of the education sector to mitigate HIV by including Life skills-based HIV and sexuality education for primary and secondary students in the curriculum, the implementation challenges result in distorted content delivery to learners. This defeats the whole purpose of school health and sexuality education programmes as they do not yield the intended results and benefits. The need for school health and sexuality education programmes to be designed, implemented, and monitored in a comprehensive, inclusive, gender transformative and culturally sensitive manner in all schools cannot be overemphasised.

Finally, for school health and sexuality education programmes to be effective, meaningful, and efficient, they should be implemented alongside youth-friendly health services. These can be through arrangements and collaboration with the Health sector, though ideally the institutionalisation and implementation of effective school health programmes will lead to the optimisation of sexuality education programmes in the region.

However, all the above-mentioned suggestions and recommendations will not be of much benefit if the voices and meaningful participation and engagement of the adolescents and young people are not entrenched in the development of these programmes, in order for them to be contextually relevant. This is summed up by Browes (2015:3) as she notes that it is increasingly being acknowledged that for school health and sexuality education to have considerable impact, programmes must look beyond the individual to the society, addressing not only safer sexual practices, but underlying contextual issues, such as gender inequality and culture, that may obstruct these programmes.

7.6. LIMITATIONS

This was an interpretive study based on several theories, consisting of qualitative research methodologies, aimed at critically analysing the influence of gender and culture as specific sociodemographic factors on school health and HIV programmes, with a specific focus on sexuality education programmes in Lesotho. While it is hoped that the findings will contribute to broader theorising and a general direction concerning school health and sexuality education programmes and their

implementation, the findings may not necessarily be representative of other countries or school health and comprehensive sexuality education (CSE) programmes, where the implementation has been guided by key inclusion principles and implemented in line with the contextual gender and cultural dynamics. Furthermore, policy makers and curriculum developers' voices are largely missing from the study, including the voices of political and national government leaders who are the custodians of government policies.

7.7 RECOMMENDATIONS FOR FURTHER RESEARCH

More research is still needed to monitor and recommend how the integration of key sociodemographic factors in the design and implementation of school health and sexuality education programmes, coupled with parental and community involvement, can be institutionalised across schools, districts, regions and countries. The need to identify some replicable gender transformative and culturally sensitive strategies in the delivery of these programmes is still a noticeable gap. It will also be worthwhile to understand the views, issues and challenges facing national and regional leaders, policy makers and curriculum developers in designing and developing school health and HIV programmes, especially sexuality education programmes. The development of relevant frameworks and tools to gather data, monitor and evaluate the effectiveness and efficiency of integrated school health and sexuality education programmes in curbing new HIV infections, teenage pregnancy, as well as sexual and gender-based violence (SGBV) within schools, will be a critical undertaking and contribution to the education sector and the overall responses to HIV and sexual and gender based violence, as well as the attainment of good health and development outcomes.

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