# Adolescent Girls' Vulnerability to HIV and AIDS: The Case of Murehwa District, Zimbabwe

**By**

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**ABSTRACT**

The study was undertaken among 538 girls aged 15-19 in 2004 in Murehwa District, Zimbabwe, to determine girls perceptions on their risk to HIV and AIDS, and why they are vulnerable, using both quantitative and qualitative methods of data collection. The results revealed that a small percentage of girls admitted to sexual activity. A significant proportion of the sexually experienced girls reported that they were forced, raped, coerced or tricked into initiation of sexual activity. Although most girls perceived themselves not at risk of HIV infection, misconceptions of the pandemic prevail among some of the girls. Self-efficacy in condom use was low and more barriers to condom use were reported. Economic and socio-cultural factors such as poverty, "sugar-daddies", wife inheritance, the unhygienic practices during healing sessions by traditional and faith healers, traditional beliefs, some religious values and practices, and peer pressure were also cited as contributing to the high risk.

## Introduction

### *Background*

The Joint United Nations Programme on HIV/AIDS (UNAIDS, 2000) estimates the number of people living with HIV and AIDS globally at 40 million people. Sub-Saharan Africa is the worst affected with an estimated 28.5 million people living with HIV and AIDS i.e. 70% of the global total. Zimbabwe is one of the Southern African countries with a high prevalence of HIV and AIDS. Current estimates from the Ministry of Health and Child Welfare (2005) estimates that 1.6 million Zimbabweans are living with HIV and AIDS; of whom 1.39 million are adults aged 15-49. The 2005-06 Zimbabwe Demographic and Health Survey estimates that the prevalence rate in Zimbabwe is 18.1%. Although Zimbabwe is the first Southern African country to record a significant drop in the HIV prevalence rate in the adult age group (15-49), from 24.6% in 2003 and 20.1% in 2005, the rate is still unacceptably high". Government, through the National AIDS Council, with the support of local and international organizations, has managed to sustain efforts to fight and mitigate the impact of HIV and AIDS. The decline is attributed to, among other possible reasons, change in sexual behaviour. However, it should be reiterated that although the rate has declined, HIV prevalence is still unacceptably very high, and efforts are being made to reduce it further to single digits by the turn of the decade.

The HIV and AIDS epidemic is wiping out the gains Zimbabwe has achieved since attaining independence in 1980. It is estimated that there were 135,000 AIDS-related deaths among adults and 36,000 among children in 2003 (MOHCW, 2003). Life expectancy has declined from 60 years in 1990 to 43 years in 2004 (National AIDS Council, 2004), while the 1999 and the 2005/6 Zimbabwe Demographic and Health Surveys (ZDHS) recorded increase in infant mortality from 51 deaths per 1,000 births in 1994 to 65 and 60 respectively, a trend largely attributed to HIV and AIDS.

Fifty five percent of those known to be infected by the virus are women. Of the estimated 135,000 new adult (15-49 years) HIV infections during 2005, 58% (78,000), were in women (MOHCW, 2005). An estimated 166,000 new infections occurred among adults aged 15-49. Unfortunately, almost half of these new infections are among adolescents aged 15-24, with girls often risking infection very early. Young women aged 15-29 years are the most vulnerable to HIV infection. It is estimated, for instance, that the ratio of young women (15-24 years) living with HIV to young men (15-24 years) living with

HIV is three times higher. The Young Adult Survey (YAS) 2001-2002 found that overall 18% of youth (15-24) were HIV positive. Women and girls are more vulnerable to HIV and AIDS than their male counterparts because of a variety of reasons that include their risky sexual behaviour, biological vulnerability, poverty and socio-cultural norms and values, as well as insufficient knowledge and misunderstanding about the HIV and AIDS i.e. their vulnerability to it, how to prevent it.

Existing documentation about adolescent girls' vulnerability to HIV and AIDS has been generally presented as the views of the elders. The voice of the adolescents has not often been audible. Information coming from the "voices" of the young girls is very important in determining how they perceive themselves as being vulnerable. Therefore, an understanding of the complex socio-economic, cultural and psychological factors on girls' vulnerability is important for the design of prevention programmes for this particular age group.

***Rationale of the Study***

The 2005-06 Zimbabwe Demographic and Health Survey (ZDHS) reports that more women than men are infected with the HIV virus. The HIV prevalence rate is higher among women aged 15-49 years (21%) compared to their male counterparts (14.5%). The 2005-06 ZDHS further suggests that women are infected earlier than their male counterparts. The gender gap is even wider amongst young people aged 15-29, for example, HIV prevalence rate among ages of 15-19 years is higher among females (6.2%) than their male counterparts (3.1%). Examination of other data sources (PSI VCT Service records, 2006; Gomo et al. 2005[1]; 2001-02 Young Adult Survey[2], MOHCW, 2000) shows the same pattern and suggests that women are infected earlier than their male counterparts. According to the PSI VCT records (2006), at younger ages 19 years and below, women are six times more infected than their male counterparts, which is even higher than the ZDHS. Ministry of Health and Child Welfare (2000) also reported closer estimates to the PSI where HIV infection in females was said to be almost five times that found in males in the age group 15-19 years.

[1] Among the 19-24 year olds, prevalence is three times higher among females compared to males (Gomo et al., 2005).
[2] The 2001-2002 Young Adult Survey found that young women aged 15-24 years are three to six times more likely to be infected than young men.

Young women and girls are particularly more vulnerable to HIV than their male counterparts due to a number of reasons. Adolescence is often characterised by patterns of thinking in which immediate needs tend to take priority over long-term implications, and by the initiation of behaviours that may be perpetuated over a lifetime (WHO, 1996). Young women and girls are most vulnerable because they often practise high-risk sexual behaviours, such as having short-term sexual relationships, as well as sexual engagement with older men, who are in most cases more sexually experienced. Women may be compromised in their ability to ward off unwanted sexual attention or negotiate safe sex. They are also reluctant to use contraceptives, including condoms. Increasing levels of poverty lead some women into casual or commercial sex work, while male norms allow for multiple and concurrent sexual partnerships, including casual and commercial sex (NAC, 2006). They also tend to have insufficient knowledge and understanding of HIV and AIDS, i.e. their vulnerability to it, how to prevent it. This misunderstanding is also deeply rooted in misconceptions. Myths, e.g. the belief that sex with a virgin girl could cure men of HIV and AIDS, make girls more vulnerable.

Young women may face obstacles such as adult related factors (e.g. the negative health workers' attitudes to access contraceptives), and socio-economic and cultural issues, which influence their decision-making with respect to sexual behaviour. Girls' vulnerability to sexual violence or abuse and exploitation, which is reportedly on the increase in the country, puts young women at risk. Young women are also at greater risk to HIV infection due to biological reasons as their reproductive tract is more susceptible to HIV infection and other sexually transmitted infections (STIs). Since the main mode of HIV transmission in Zimbabwe is heterosexual contact (92%), the emphasis must therefore be on prevention of sexual transmission. Thus, HIV prevention efforts targeting adolescents before they become sexually active may hold the greatest hope of changing the course of the epidemic (Mataure et al., 2002; UNAIDS, 2002).

***Objectives***

The overall objective of this study was to generate information on girls' perceptions of their own vulnerability to HIV and AIDS. To achieve this general objective, the following specific objectives were set:

- To investigate adolescent girls' sexual behaviour and their attitudes towards teenage sexual behaviour.
- To collect information on adolescent girls' health beliefs and misconceptions about HIV and AIDS.
- To assess girls' self-efficacy to effectively perform the required behaviour.
- To determine barriers to condom use sex.
- To determine the external factors (socio-economic and cultural) that influence girls' vulnerability to HIV and AIDS.
- To investigate girls' perception of their risk to HIV and AIDS.

### *Study Significance and Scope*

Several studies (e.g. Kim et al., 2001; Mataure et al., 2002) on adolescent health have been conducted but none has explored girls' vulnerability to HIV and AIDS. Girls are more vulnerable to HIV and AIDS and such documentation has been presented from the views of the elders and not the voice of the adolescents. Such information coming from the voices of the young girls is very important in determining how they perceive themselves as vulnerable. Are they abstaining or engaging in sexual behaviour? If they are engaging in sex, is it risky or safe? Do they perceive themselves at risk of HIV and AIDS? If so, what are factors and what measures are they taking? These questions were explored in this study. An exercise like this is aimed at contributing to an understanding of the complex socio-economic, cultural and psychological contexts in which adolescent girls expose themselves to the risks of HIV and AIDS. Such information is useful to Ministry of Education, Sports and Culture, Ministry of Health and Child Welfare, and organisations and stakeholders dealing with adolescents' health. Research that focuses on young girls' perceptions of their vulnerability contributes to the existing knowledge.

## Conceptual Framework

The study's conceptual framework was drawn from several theories that included the Health Belief Model (Becker, 1974), Theory of Reasoned Action (Fishbein and Ajzen, 1975), the concept of self-efficacy from Bandura's Learning Theory (Bandura, 1977) and Lay Health Beliefs. The Health Belief

Model (HBM) postulates that one's behaviour in relation to health is related to their perceptions of the severity of the illness, their susceptibility to it and the costs and benefits incurred in performing a particular behaviour (Bowling, 1997). The self-efficacy concept, i.e. one's perceived ability to perform a particular behaviour, was included to account for an individual's control over her behaviour. The HBM assumes that people make rational decisions before taking an action but this is not true in many occasions, as some adolescent girls have little control over their lives. Young people's behaviour is not always voluntary or rational, and neither do they always plan what they want to do nor have control over their sexuality (UNICEF, 2001; Kim et al., 2001), hence, the inclusion of the self-efficacy concept. The Theory of Reasoned Action takes into consideration the individual's attitude toward a particular behaviour and the subjective norms (i.e. social influence). The significant others play a significant role in the African context. The Lay Health Beliefs are important in explaining girls' vulnerability to HIV and AIDS.

As can be seen from the theoretical perspectives discussed above, there is no one theoretical model that is adequate to explain adolescent sexual behaviour. Each model adds important factors that can affect behaviour, but none is able to capture the whole experience of sexual risk and behaviour. Thus, the study's conceptual framework was constructed by using the reviewed theoretical perspectives and other factors from empirical research.

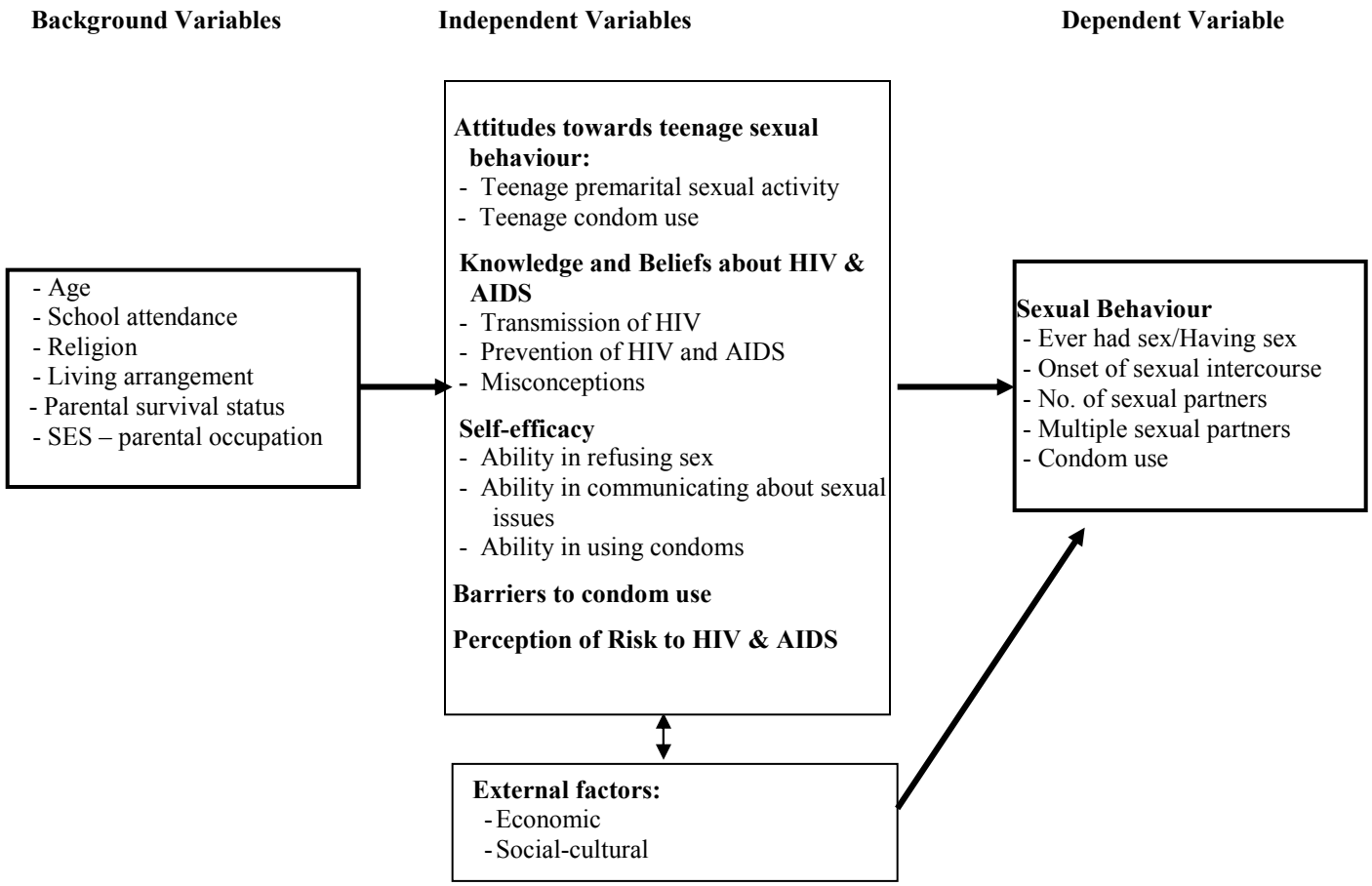
Figure 1 presents the study's conceptual framework. The dependent variable consists of sexual behaviour, which is measured by the initiation of sexual intercourse, number of sexual partners, and use of condoms to avoid sexually transmitted infections including HIV and AIDS. The independent variables consist of:

1. Attitudes towards teenage sexual behaviour – these include the perceived consequences of risky sexual behaviour weighted by the value an individual places on the positive and negative consequences.
2. Individual's knowledge and beliefs about HIV and AIDS. Indicators of misconceptions, beliefs and knowledge are an important prerequisite for prevention programmes to focus on increasing adolescents' knowledge about sexual transmission, and to overcome the misconceptions that act as a disincentive to behaviour change.

3. Self-efficacy, encompassing girls' perceptions of self-control. Three variables were used to measure self-efficacy: self-efficacy in refusing sex, self-efficacy in communication, and self-efficacy in using a condom. These measures were taken from Basen-Engquist et al. (1999) and adjusted to suit the Zimbabwean situation.
4. Perceived barriers to condom use – a set of six items on condom use measured barriers to condom use.
5. External Factors – Economic factors, and social influence (norms i.e. attitudes of the significant others, cultural practices, and religious beliefs and values).
6. Perception of Risk to HIV and AIDS, which is self-risk assessment by each respondent.

Background Variables – Factors included are respondent's age, ethnicity, religion, education, living arrangement, whether parents are alive and parental employment status.

**Figure 1**



## Methods

### *Study Design and Sample*

A cross-sectional study was carried out among 538 in- and out-of-school girls aged 15-19 in Murehwa, a rural district north east of Zimbabwe. The participants were all rural day schools. Murehwa was selected because it lies along the Mutoko Highway, en-route to Mozambique and Malawi. There is a lot of interaction between long distance truck drivers and commercial sex workers on centres situated along this corridor. HIV prevalence rates are higher in roadside trading centres along major highways in Zimbabwe (Gregson et al., 2002). Higher HIV prevalence rates are also found at rural growth points (central business centres). Also, a rural site was chosen because most studies have tended to be urban-biased.

### *Data Collection Methods*

The study collected both quantitative and qualitative data, which included a desk review of relevant documents, 5 focus group discussions with in and out-of-school girls, and the main survey carried among adolescent girls, using semi-structured questions. Focus group discussions, using a FGD guide, were conducted in order to develop survey research instruments as well as obtain qualitative information to enrich the quantitative data. Four research assistants were recruited and trained in carrying out a group discussion. Translations of the FGD guide were agreed upon during this one-day training. Five FGDs were conducted in the sampled survey areas with adolescent girls in and out of school. Schoolgirls were from 3 secondary schools, while out-of-school girls were from the areas surrounding the selected. Each group consisted of 10 to 15 participants and each discussion lasted between 60 and 90 minutes. The discussions among schoolgirls were held in the school grounds while discussions among out-of-school girls were held outside the school. The proceedings were held in Shona (respondents' mother tongue) to ensure maximum participation. The proceedings of the FGDs were tape-recorded, in addition to note taking. A trained moderator led the discussions while another assistant took notes. Verbal consent was also sought before discussions. The data was transcribed in Shona and later translated into English.

The survey was also conducted using an interviewer-administered questionnaire. The FGD helped in improving the draft questionnaire. A pilot study was conducted to test the

questionnaire to ensure that questions were easily understood. This pre-test improved the data collection tool; the sequencing of questions; phrasing of some questions; and improved the general flow of the interview schedule, the final tool used for the survey.

***Sampling Procedure***

A multi-stage sampling procedure was used to select the respondents. In schools, girls were randomly selected from 7 out of the 27 secondary schools in the district. Schoolgirls were selected from each Form, alternating the Form 3s and 4s, as well as the classes to avoid bias on academic performance. Out-of-school girls were from the surrounding communities served by the sampled schools in both the FGDs and survey. Door-to-door visits were conducted to recruit the participants. This was a difficult task as out-of-school girls were difficult to find. However, through snowballing, some of the girls identified their fellow counterparts. Village headmen also assisted the research assistants in locating out-of-school girls.

***Data Processing and Analysis***

Quantitative data was analysed using the statistical package for social scientists (SPSS). Cross tabulations were run to test the relationships of the variables. The Pearson's Chi-square was used to test whether there was an association between variables, p value to test the strength of the relationship and the Cronbach's alpha to assess the internal reliability of scales on attitudes, knowledge about HIV and AIDS, self-efficacy, norms, and barriers to condom use. Data from the FGDs was analysed using DT Search, a programme for qualitative analysis.

***Project Management***

The research project was funded by the Organisation for Social Science Research in Eastern and Southern Africa (OSSREA) under the "HIV/AIDS Challenge in Africa" programme. The researcher wishes to extend her appreciation to OSSREA for providing the funds. Preparations made before the survey included project clearance and training of research assistants. Permission to carry out the study in schools was sought from the Ministry of Education, Sport and Culture and from the school headmasters. Headmasters were treated as the guardians since the schoolgirls were in the custody of the school. For girls not in school, clearance was sought from the Ministry of Local Government through the office of the District

Administrator and local headmen. Also, permission was sought from the parents or guardians for those girls out of school aged below 18 years. The research assistants, who were University students, were trained on how to administer the questionnaires and to conduct focus group discussions.

### *Ethical Considerations*

The study participants were informed as to the nature and purpose of the study. They were informed that participation in the survey was voluntary, and were assured of anonymity and confidentiality. Informed consent was obtained from the participants. Consent from minors was sought from parents and guardians. In the case of FGDs, participants were informed that the discussions were to be tape-recorded, and if anyone objected to tape-recording of the proceedings, was allowed to leave the group. However, no one objected to the use of the tape recorder.

## Findings

### *Characteristics of the Adolescent Girls*

Respondents consisted of girls in and out of school, aged between 15 and 19 years. Sixty-five percent of the respondents were schoolgirls and 35% were out-of-school. Schoolgirls were relatively younger, with a mean age of 16 years compared to 17 years among out-of-school girls. Of the 348 schoolgirls, the majority (89%) were in Forms 3 and 4 while the remainder were in Forms 1 and 2. Most of the out-of-school girls attained O' Levels (48%), while 23% had completed primary education and 13% had completed Form 2. None of the girls had never been to school. The majority of the out-of-school girls (44%) were not in school because they had completed their O' Levels, while 41% could not afford the school fees. Other reasons given for leaving school included failed examinations, left school to care for younger siblings or ill parents, and lack of interest in school.

The majority of the respondents (88%) were Zezuru, while the remainder consisted of Manyika (4%), Karanga (3%), Ndebele (1%) and others. This was expected as the Zezurus are situated in Mashonaland. Most of the respondents were Christians, with the majority belonging to the

protestant churches (36%), and 30% were Catholics and 13% Pentecostal. A significant proportion (19%) belonged to the Vapostori, a religious sect found mainly in East and Southern Africa. Two percent were either traditional or not affiliated to any religion.

On living arrangements, 34% of the girls lived with their mothers, while 22% lived with both parents, 19% with grandparents, and the remainder lived with their aunt/uncle, brother/sister or employer (each 6%) and 1% with their fathers. In terms of orphanhood, 23% lost their mothers and 41% lost their fathers. In both cases, out-of-school girls were more affected than schoolgirls.

Among the 190 girls who were out of school, 43% reported no economic activity while 18% were working as housemaids and 12% were involved in farming. Although most of the girls reported no economic activity, it is suspected that most of these were engaged in farming, which they may not have considered as an economic engagement.

***Sexual Behaviour***

The results revealed that about 15% of the girls had had sex, with out-of-school girls more likely to be sexually experienced than schoolgirls. However, under-reporting of sexual activity by the girls is suspected. This finding is consistent with other studies carried out in Zimbabwe on this particular age group (Wekwete, 2002; Phiri and Erulkar, 2000; Meekers and Wekwete, 1998). The rates of unplanned pregnancies, school drop out and infection rates support the view that significant numbers of girls are sexually active.

In contrast to the HBM and TRA, which stipulate that girls make rational decisions before they engage in sexual activity, the findings seem to suggest that sexual activity "just happened" as reported by 30% of the sexually experienced girls. Other reasons for engaging in sexual activity cited include showing love to a partner (25%), forced sex or rape (16.3%), coercion or tricked (13.8%), to experiment (8.8%), and peer pressure (2.5%). When such unintended or unplanned sexual behaviour occurs, girls are in most cases not likely to use methods to prevent HIV transmission thereby putting themselves at risk of HIV infection. In most cases, these men are older than them and are more likely to have had multiple sexual partners.

Nearly half of the sexually experienced girls had one lifetime sexual partner, which meant that the other half had more than one partner. About 40% of the sexually experienced girls never used condoms to prevent contracting STIs and HIV. These girls subject themselves to higher chances of HIV infection. Premarital sex, compounded by having multiple sexual partners, is considered as a risk factor in HIV and AIDS infection.

***Attitudes towards Teenage Sexual Activity and Condom Use***

Nearly two-thirds of the respondents had negative attitudes towards teenage sexual activity. Schoolgirls were more likely to have negative attitudes towards teenage sexual activity than out-of-school girls.

However, most of the respondents were liberal in terms of condom use by the sexually active adolescents. Just over half (51%) of the girls were more positive towards condom use by the sexually active adolescents, with younger girls and schoolgirls more likely to be acceptable to condom use than older girls and those out of school. The relatively high acceptance of condom use in comparison to attitudes towards sexual activity is largely attributed to the AIDS awareness in the media and several AIDS service organisations, such as Population Services International (PSI), that promote condom use to prevent HIV infection.

***Beliefs and Misconceptions about HIV and AIDS***

HIV and AIDS awareness was almost universal among the respondents as 99.6% reported that they had heard about HIV and AIDS. Level of knowledge about HIV and AIDS among the girls was also generally high (69.2%). This can be attributed to Government's initiative to disseminate HIV and AIDS information nationwide. Schoolgirls were more likely to have high levels of knowledge of HIV and AIDS compared to out-of-school girls. The high level of knowledge among schoolgirls is mainly due to the introduction of a course on "HIV, AIDS and Life Skills Education" in secondary schools by the Ministry of Education, Sports and Culture. This is evidenced by the relatively high percentage of girls (80%) who reported that they had heard about HIV and AIDS from school when compared to the second mentioned source, the media (38.7%). Other sources included clinics (15.3%), family members (15.3%)

and peers (10.7%). Also, schoolgirls are more exposed to other sources of information such as drama, theatre and the media (i.e. newspapers, magazines and radio).

Despite girls having high levels of awareness and knowledge of HIV and AIDS, misconceptions about the disease still prevail among some of the girls. Some of these beliefs are factually incorrect and since perception of risk is related to knowledge, girls may subject themselves to infection thinking that they are safe. For example, 8.1% believe that a man can be cured of HIV and AIDS if he slept with a virgin while more than a quarter of the girls still believe that HIV can be transmitted through mosquito bites.

***Self-Efficacy***

Only 6.7% of the girls had low self-efficacy in refusing sex, while 47.9% and 45.3% had moderate and high levels of self-efficacy, respectively. However, girls who never had sex were more likely to have high self-efficacy in refusing sex compared to the sexually experienced. Thirteen per cent of the girls had low self-efficacy in communicating about condom use, 42.5% had moderate and 44% high levels. Younger girls were more likely to have high self-efficacy in communication than older girls. Self-efficacy among adolescent girls was lowest in condom use. More than half (50.6%) of the girls had low self-efficacy in condom use, while 29.6% and 19.9% had moderate and high levels, respectively. Also, self-efficacy in condom use is lower among out-of-school girls than schoolgirls.

***Barriers to Condom Use***

A significant proportion of the girls (44.3%) reported more barriers to condom use. About two-thirds (62.6%) of the girls agreed that it would be an embarrassment to buy condoms from the store, 64.4% found it uncomfortable to carrying condoms with them, and 72.3% believed that if they carried a condom with them they would be labelled as sexually active. Higher percentages of "not sure" responses were recorded on items like "being a hassle to putting on a condom", "embarrassed in using a condom", and "displeasure in sex when using a condom". Younger girls and the sexually inexperienced were more likely to report more barriers than the older and the sexually experienced.

*Poverty*

The issue of poverty as the underlying factor that puts young women at risk came out vividly from girls in and out of school. In trying to break the vicious cycle of poverty, some parents marry off their girl children to 'perceived' well-to-do men. However, most of these men are married and more sexually experienced and are known for indulging in extra marital relationships, which then put young girls at a high risk of contracting HIV. The quote below emphasizes this point:

> *Some parents are to blame because they send out their girl children to businessmen to end the poverty in their homes.*

Orphans are more vulnerable as they have lost parents who are breadwinners in their households. The loss of parents may mean that no one is there for them for protection and provision of all basic requirements for the children.

> *As orphans they will have been accustomed to getting everything they want, so when they fail to get those things they will then start being promiscuous and in the process get infected.*

*Sugar Daddies*

The problem of sugar daddies, found elsewhere in the rest of the continent, emerged in the discussions as contributing to the risk of HIV and AIDS among female adolescents. Young girls are said to put themselves at risk of HIV and AIDS infection through having relationships with economically established older men who pamper them with money in exchange for sexual favours.

> *We are at risk because we will be in relationships with people who are older than us.*

> *Young girls love money and they will tend to associate with men who are not of their age.*

Since the girls would have accepted gifts form these men and also because they are much younger than the men, they may not be able to refuse or to negotiate for safer sex. As one schoolgirl puts it:

> *You will have spent someone's money so he will then refuse to use a condom.*

*Socio-Economic and Cultural Factors*

The socio-economic factors, identified in the group discussions as drivers of girls' vulnerability to HIV and AIDS, included poverty, "*sugar daddies*" who tend to be older and more sexually experienced than the girls, dressing by girls which was seductive to men, peer pressure and sexual abuse. In many societies, there are cultural practices and beliefs that put young girls at high risk of HIV and AIDS. Their negotiation to safe sex may encounter barriers such as cultural practices and values. These practices embrace the use of young girls for spirit appeasement, the practice of levirate, polygamous unions, and 'kuzvarirwa' (marrying off a girl child to an older man). The man could be infected with the virus, thereby putting the girl at risk. This concern was expressed in the discussions:

> *You may be given away to an HIV infected older man as a sacrifice to appease an avenging spirit.*
>
> *Your paternal aunt may be childless and you may be made to live with her husband so that you can bear children on her behalf*'
>
> *You may have your aunt. Your aunt may die and you are made to marry her husband. You will not know what will have killed your aunt.*

In some areas there is a practise where it is acceptable for a husband to fondle his wife's young sister (chiramu). However, this practice has been exploited by men who are now sexually abusing the young girls. This also emerged from the focus group discussions;

> *Other sisters' husbands want to play with you by fondling your breasts. You will fondle one another such that you end up sleeping together.*
>
> *Some brothers-in-law become too playful with their wives younger sisters and they end up sleeping with them.*
>
> *After having fun with your brother-in-law, a relationship may develop.*

Despite the availability of modern medicine in Zimbabwe many people still rely on traditional and faith healers for advice and healing. Traditional and faith healers were also not spared as they were reported to be using unsterilised instruments such as needles ad razors, during healing sessions. Nevertheless, in the healing process traditional healers use unhygienic and unsterilised instruments, which may spread infection among patients.

> *What about traditional healers and the incisions they make as a way of treating? One may get infected with the virus because only one razor blade is used.*

Some religious sects, such as the "vapostori", who promote early marriage of young girls to older men from the same apostolic church were also blamed. In this era of HIV and AIDS some churches, such as the "vapostori", still encourage polygamous unions and marriage of young girls to older men.

> *…Churches. The faith healers take on many wives and you may become one of the wives and may end up contracting the disease*.
>
> *When you reach 12 years they will say that you are old enough to be married so you marry an older man who may have the virus"*
>
> *Churches such as Johane Marange can tell you that they have dreamt about you being in love with a certain older church member, therefore you have to get married to that man who already has other wives.*

Traditional healers may also give advice to clients to sleep with young girls in order to cleanse themselves of HIV and AIDS or as a means for a business to thrive.

> *Traditional healers are encouraging men who have the virus to sleep with virgins for them to be cured.*
>
> *Other traditional healers tell you that if you want your business to prosper you have to sleep with your child and you can get the virus from that*.

Similar sentiments were echoed pertaining to faith healers.

> *Faith healers may tell you that they want to go up the mountain to heal you and they then lie that what is bothering you is in your private parts, therefore he has to sleep with you in order to heal you. You can then get the disease from that*.
>
> *If we go looking for help from faith healers, for instance when not performing well in school, you are then told that you have to sleep with the faith healer for you to pass. And also some faith healers tell you that you are the wife he was shown while he was possessed by the spirit*."

*Peer Pressure*

Some young girls engage in sexual activity due to influence by friends. In most cases, they do not use any methods to protect themselves against HIV and AIDS. These views emerged from the discussions;

> *Peer pressure. Friends may be misleading you into having many lovers*.

*In our culture, there is a time of dances during bringing home ceremonies, which are held at night. At these dances there is a lot of peer pressure and you may be made to believe that having sex is the norm.*

*Child Abuse*

According to media reports, cases of incest are generally on the increase in Zimbabwe. Instances where the father has sex with his daughter were also reported in the focus group discussions.

*A mother may leave behind her young daughter because her husband will be harassing her. The husband will stay behind with the daughter and rape her.*

*Norms*

The majority of the respondents (82.5%) agreed with the statement that, "most of my friends believe girls of my age should wait until they are older before they have sex", and only 6% disagreed. This shows the perceived strong negative attitudes of the peers on teenage sexual activity. This is consistent with the second statement although not so restrictive as the first, where a lower proportion of the girls (28.7%) agreed with the statement that, "most of my friends believe its okay for girls of my age to have sex with a steady boyfriend", 55.5% disagreed. Some girls tend to trust their boyfriends as the relationship gets older or becomes steady and may end up having sex with them. However, when it comes to norms about multiple partners, are very restrictive as an even lower proportion of girls (8.9%) agreed to the statement that, "most of my friends believe its okay for girls of my age to have sex with more than one man in the same month", and 74.3% disagreed.

In summary, more than half (52.8%) of the girls reported conservative norms about teenage sexual activity. Younger girls and schoolgirls were more likely to report conservative norms than the sexually experienced and older girls. With regards to norms about teenage condom use, a relatively lower proportion of girls (30.3%) reported conservative norms about teenage condom use, with younger girls and schoolgirls more like to report the norms as conservative than older and out-of-school girls. The sexually inexperienced girls were more likely to report conservative norms about teenage condom use than the sexually experienced.

***Perception of Risk to HIV and AIDS***

The majority (87.9%) of the girls perceived themselves not at risk of HIV and AIDS, with the sexually experienced girls more likely to perceive themselves at risk than the sexually inexperienced. The major reason given for not being at risk was that they were not sexually experienced (79.2%). Other reasons given included not having had any blood transfusions or injections. The reasons given by the sexually experienced girls for perceiving themselves not at risk were that they used condoms and had been faithful to one sexual partner. On the other hand, the sexually experienced girls perceived themselves at risk because they had not used condoms and they have had multiple sexual partners.

## Discussion

Girls are vulnerable to HIV infection because of various reasons. First and foremost, girls' reluctance to discuss sexual issues put them at risk. This is seen in the proportion of girls who reported sexual experiencing. Underreporting of sexual activity was suspected as reported by other studies. The reluctance to admit to sexual activity among adolescent girls emanates from the prevailing restrictive social norms and values that are strongly against premarital sexual activity, especially among schoolgirls. This is shown by the high percentage of girls who were conservative about teenage sexual activity. Similar sentiments were also noted by the subjective norms. Given that pre-marital sexual activity is not accepted by the society at large and in schools, girls, especially schoolgirls, tend to report on what is acceptable to the community and not what is actually taking place. Inaccurate reporting of sexual activity not only undermines efforts to document and to explain sexual behaviour among adolescent girls, but also compromises program implementation and evaluation. Girls' unwillingness to reveal information about their sexual activity could partly be the reason for the high infection rates in this age group.

Girls mentioned that sex "just happened" and this is a concern that needs to be addressed. The social norms do not accept sexual engagement outside of marriage and yet a significant number do so. A possible explanation could be that these girls are not able to refuse sex even though they are aware of the social norms that discourage pre-marital sexual activity. However, it could also be argued that these girls may be making rational decisions in their

purposeful quest for sex for a variety of benefits and reasons and thus taking the socially prudent stance of disclaiming any responsibility for their sexual behaviour.

Of major concern is the significant number of girls who reported sexual abuse of rape and forced sex. Such incidences are also reported by the media to be on the increase in the country. The study did not probe to find out who these perpetrators were. However, the media reports of cases of fathers sexually abusing their daughters, prophets and pastors abusing young female church members, and older men molesting young girls. These men are older than them and more likely to have had multiple sexual partners, thereby risking the young adolescent girls. However, further questions about the girls who reported sexual abuse were not sought.

Faithfulness and sticking to one partner was one of the factors mentioned by a minority of girls as putting them at risk of infection because of the unsafe practices by their partners. This issue of fidelity is very critical because faithfulness is not only to be observed by the female partner alone but by both parties. This emanates from the double standards in the society where different sets of sexual rules for women and men prevail. Society usually promotes fidelity on the one hand, and at the same time transmitting the message that women should not question male unfaithfulness and/or men are expected to show their manhood by having multiple sexual partners. Thus, pressure may make it difficult for boys to resist experimenting with multiple partners, while girls are expected to remain virgins until marriage or to at least remain faithful to one partner. This puts girls at higher risk of HIV infection because of infidelity on the part of the man.

Despite the high levels of knowledge about HIV and AIDS, misconceptions and beliefs are still found among adolescent girls. Such beliefs are not only found among girls but in other sections of the community and thus the society is to blame on some of the misconceptions among young girls. Some of the misconceptions are also related to such beliefs that ‘a man could be cured of AIDS if he has sex with a virgin girl’. The community takes its share of blame on girls’ vulnerability to HIV and AIDS as they also have such beliefs.

Although self-efficacy was low in refusing sex and communicating about condom use, it was lowest in condom use. It has been shown that sexual activity increases with age and is higher among girls out of school. This has implications in that girls are less able to negotiate safe sex and protect themselves from infection as they become more sexually active, older and/or leave school. The ability to negotiate safe sex is vital to protection of young women against STIs and HIV, especially those in stable relationships or those entering marriage who continue to face risks to SITs and HIV infections. Girls may have been reluctant to talk about condoms and more responses of '*not sure*' were registered under this measure. Consequently, the embarrassment to discuss sexual issues might be a barrier to HIV and AIDS programmes addressing infection risk among girls and young women.

## Conclusion

Despite girls having high levels of awareness and knowledge of HIV and AIDS, misconceptions about HIV transmission and prevention still exist among the girls. It is recommended that the Ministry of Education, Sports and Culture should prioritise HIV and AIDS education by making the course on HIV and AIDS examinable. The Ministry must also take the responsibility of training teachers to equip them with the skills in HIV and AIDS education. This may result in increased internalisation and commitment of students and teachers towards the course.

Some of the beliefs, such as "a man cured of HIV by sleeping with a virgin", emanate from the elders in the community, including traditional healers. Young girls will not be spared of such misconceptions. Therefore, there is need for involvement of family, traditional leaders and community at large in addressing cultural beliefs and practices in order to attain effective HIV and AIDS programmes.

Girls were reluctant to talk about sexual issues. Under reporting of sexual experience was suspected. Girls were also not comfortable talking about sex and condom use. Inaccurate reporting of sexual activity not only undermines social science analyses that attempt to document and explain sexual behaviour, but also compromises programme implementations and evaluations. Programmes that encourage girls to talk about sexual matters should be

introduced, such as the talk show programmes that were aired on the national television in the past years, such as "Let's talk about it", so that girls can freely talk about such issues. Also, an expansion or provision of youth friendly centres to dispel the misconceptions and obtain information on reproductive health is also recommended. However, the success of these programmes to freely discuss sexual issues will depend on the broader changes in attitudes in the community.

A significant proportion of girls dropped out of school because they could not afford school fees. It has also been shown that out-of-school girls were more likely to be sexually experienced than schoolgirls. As soon as one drops out of school, the chances of getting exposed to the risks of HIV infection increase and these need to be reduced. By keeping girls in school longer or providing alternatives to keep them busy, this may keep more girls away from engaging in risky sexual behaviour. Thus, Government should scale up self-help projects for the youth to keep them busy.

Girls of school-going age should be kept in school and those that cannot afford school fees should be assisted. Government is assisting under-privileged children through its Basic Education Assistance Module (BEAM) scheme, but is overburdened by the increasing number of orphans due to HIV and AIDS. It is not the responsibility of the Government alone, but non-Governmental organisations, the private sector and the rest of the community sector should also be involved in looking after the young girls.

An increase in sexual abuse among girls was reported both in the study and from the media. Therefore, there is need to decentralise Police posts to village level to increase reporting of sexual abuse in the community and also setting up HIV and AIDS or Gender Desks to encourage reporting and confidentiality.

The reported negative cultural practices and beliefs that fuel HIV and AIDS should be addressed by enforcing legal instruments. Young women and girls need to be protected against such practices. Further, protection of young girls is needed against HIV infected men who believe that they can be cured of the diseases if they had sex with virgins. There is need

to educate the community and introduce policies that protect the rights of young girls and women against sexual abuse. All this will not be successful without Government's enforcement of the laws. Thus, what is needed is the political will by Government through the enforcement of policies that protect the rights of young girls and women against sexual abuse, such as the Sexual Offences Act (2001).

## BIBLIOGRAPHY


Abraham S.C.S., Rubaale T.K. and Kipp W. (1995) "HIV Preventive Cognitions amongst Secondary School Students in Uganda:. *Health Education Research*, 10 (2): 155-162.

Aggleton P and Homans H. (1988) *Social Aspects of AIDS.* Palmer Press, London.

Ajzen I. (1988) *Attitudes, Personality and Behaviour*. Open University Press, Milton Keynes.

Bandura A. (1977) "Self-Efficacy: Towards a Unifying Theory of Behavioural Change". *Psychological Review,* 84 (2): 191-125.

Barker G.K. & Rich S. (1992) "Influences on Adolescent Sexuality in Nigeria and Kenya: Findings from Focus-Group Discussions". *Studies in Family Planning*, 23 (3): 199-210.

Bassett M. and Sherman J. (1994) "Female Sexual Behaviour and the Risk of HIV Infection: An Ethnographic Study in Harare, Zimbabwe". *Women and AIDS Program Research Report Series*. Washington DC: International Center for Research on Women.

Basen-Engquist K., Masse L.C., Coyle K., Kirby D., Parcel G.S., Banspach S. and Nodora J. (1999) "Validity of Scales Measuring the Psychosocial Determinants of HIV/STD-Related Risk Behaviour in Adolescents". *Health Education Research*, 14 (1): 25-38.

Becker H.M. (1974) "The Health Belief Model and Personal Health Behaviour". *Health Education Monographs*, 2: 236-473.

Becker H.M. and Rosenstock I.M. (1987) "Comparing Social Learning Theory and the Health Belief Model". *Advances in Education and Promotion*, 2: 245-249.

Central Statistical Office (CSO) [Zimbabwe] and Macro International Inc. (2007) *Zimbabwe Demographic and Health Survey 2005-2006,* Calverton, Maryland: CSO and Macro International Inc.

Cusick L. (1998) "Non-use of Condoms by Prostitute Women". *AIDS CARE*, 10 (2).

De Bruyn M. (1992) "Women and AIDS in Developing Countries". *Social Science and Medicine*, 34 (3): 249-262.

Djamba Y.K. (1997) "Theoretical Perspectives on Female Sexual Behaviour in Africa: A Review and Conceptual Model". *African Journal of Reproductive Health*, 1 (2): 67-78.

Fishbein M. and Ajzen I. (1975) *Belief, Attitude, Intention and Behaviour: An Introduction to Theory and Research*. Adison-Wesley, Reading M.A.

Gage A.J. (1998) "Sexual Activity and Contraceptive Use: The Components of the Decision-making Process". *Studies in Family Planning*, 29 (2): 154-166.

Gorgen R., Maier B., & Diesfield H.J. (1993) "Problems Related to Schoolgirl Pregnancies in Burkina Faso". *Studies in Family Planning*, 24 (5): 283-294.

Janz N. and Becker M. (1984) "The Health Belief Model: A Decade Later". *Health Education Quarterly*, 11 (7): 1-47.

Kim Y.M., Kols A., Nyakauru R., Marangwanda C and Chibatamoto P. (2001) "Promoting Sexual Responsibility among Young People in Zimbabwe". *International Family Planning Perspectives*, 27 (1): 11-19.

KIT (Royal Tropical Institute), SAfAIDS and WHO (1995) *Facing the Challenges of HIV, AIDS and STDs: A gender-based response*. KIT, Amsterdam, The Netherlands; SAfAIDS, Harare, Zimbabwe; and WHO, Geneva, Switzerland.

Klepp K.I., Ndeki S.S., Thuen F., Leshabari M. and Seha A.M. (1996) "Predictors of Intention to be Sexually Active among Tanzanian School Children". *East African Medical Journal*, 73 (4): 218-224.

Machipisa L (2001) "HIV/AIDS: Women and Girls Bear the Burden in Zimbabwe", *CHOICES* Dec. 2001

Mataure P., McFarland W., Fritz K., Kim A., Woelk G., Ray S. and Rutherford G. (2002) "Alcohol Use and High Risk Sexual Behaviour among Adolescents and Young Adults in Harare, Zimbabwe". *SAFAIDS News*, 10 (2): 18-21.

Ministry of Health and Child Welfare (2000) *HIV/AIDS, STI and TB Fact Sheet*. National AIDS Co-ordination Programme (NACP), Planning Monitoring, Evaluation, Research Unit, Ministry of Health, Harare.

Nzioka C. (1996) "Lay Perceptions of Risk of HIV Infection and the Social Construction of Safer Sex: Some Experiences from Kenya". *AIDS CARE*, 8 (5): 565-579.

Parsons J.T., Halkitis P.N., Bimbi D. and Borkowski T. (2000) "Perceptions of the Benefits and Costs Associated with Condom Use and Unprotected Sex among Late Adolescent College Students". *Journal of Adolescence*, 23 (4): 377-391.

Peltzer K. (2000) "Factors Affecting Condom Use among South African University Students". *East African Medical Journal*, 77 (1): 46-52.

Phiri A. and Erulkar A.S. (2000) *Experiences of Youth in Rural Zimbabwe*. Zimbabwe National Family Planning Council, Harare; Population Council, Kenya.

Pitts M, McMaster J., Hartmann T. and Mausezahl D. (1996) "Lay Beliefs About Diarrhoeal Diseases: Their Role in Health Education in a Developing Country". *Social Sciences and Medicine*, 43 (8): 1223-1228.

Rosenstock I.M., Strecher V.J. and Becker M.H. (1994) "The Health Belief Model and HIV Risk Behaviour Change", in DiClemente R.J. and Peterson J.L. (1994) *Preventing AIDS: Theories and Methods of Behavioural Intention*. Plenum Press, New York, pp 5-21.

Schwarzer R. (1994) "Optimism, Vulnerability and Self-Beliefs as Health-Related Cognitions: A Systematic Overview". *Psychology and Health*, 9: 161-180.

UNAIDS (2002) *Report on the Global HIV/AIDS Epidemic*. Geneva: UNAIDS.

United Nations Children's Fund (UNICEF) (2001) *A Situation Analysis of Orphans and Vulnerable Children and Adolescents in Zimbabwe: Summary Report*. New York: UNICEF.

United Nations Children's Fund (UNICEF) (2002) *The State of the World's Children 2002. Geneva: UNICEF.*

United Nations Children's Fund (UNICEF) (2002) *Knowledge, Attitudes, Beliefs and Practices: A Baseline Survey for the Government of Zimbabwe/UNICEF Country Programme of Cooperation 2000-2004*. Harare: UNICEF.

Walker L. and Gilbert L. (2002) "HIV/AIDS: South African Women at Risk". *African Journal of AIDS Research*, 1: 75-85.

Warwick I., Aggleton P. and Homans H. (1988) "Young People's Health Beliefs and AIDS", in Aggleton P and Homans H. (eds.) *Social Aspect of AIDS*. Falmer Press, London.

Webb W. (1994) "Teen Sexuality: Empowering Teens to Decide". *Population Studies Review*, 13 (1/2): 127-140.

Weiss E., Whelan D. and Gupta G.R. (1996) *Vulnerability and Opportunity: Adolescents and HIV/AIDS in the Developing World - Findings from the Women and AIDS Research Program*. International Centre for Research on Women (ICRW) Washington DC, USA.

Wekwete N.N. (2002) *Adolescent Pregnancy and Marriage in Rural Zimbabwe: Risking the Future*? Submitted to University of Exeter, Devon, England as a thesis for the degree of Doctor of Philosophy in Applied Population Research.

Wellings K. (1988) "Perceptions of Risk – Media Treatment of AIDS", in Aggleton P and Homans H. (eds.) *Social Aspect of AIDS*. Falmer Press, London.

Wilson D. and Lavelle S. (1992) "Psychological Predictors of Intended Condom Use among Zimbabwean Adolescents". *Health Education Research*, 7 (1): 55-68.

Zvinavashe M. and Rusakaniko S. (2000) "The Reported Quality of Condom Use by Young Adult Zimbabwean Males at Higher Learning Centres in Harare". *Central African Journal of Medicine*, 46 (6): 158-161.