Voluntary medical male circumcision and condoms for HIV prevention among school youth: Marginal voices for a coherent sexual and reproductive school health policy in Zimbabwe

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DECLARATION

I, _____ state that this thesis titled: *Voluntary medical male circumcision and condoms for HIV prevention among school youth: Marginal voices for a coherent sexual and reproductive school health policy in Zimbabwe* has not been submitted either to this university or elsewhere, for any degree qualification, or other purposes. The current submission is the first at the University of KwaZulu-Natal in fulfilment of the requirements for a Doctor of Philosophy qualification.

I further declare that this thesis is a culmination of my own unaided effort and acknowledged supervision received from duly appointed supervisors (both main and co-supervisor) indicated on the cover page of this thesis. Any assistance received towards the success of this study has been appropriately acknowledged.

Lastly, I certify that effort was made to ensure that all information sources and relevant literature used in this thesis are cited according to the requirements of the American Psychological Association (APA), Sixth Edition (2010) reference style.

Kemist Shumba (Student ID Number: 213565322)

14th of February 2018.

DEDICATION

To all the learners in Zimbabwe, and those elsewhere in similar contexts, whose sexual and reproductive health is compromised by factors beyond their control, muted and erased from the dominant discursive platforms.

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ABSTRACT

Background: Voluntary medical male circumcision (VMMC) is a component of HIV prevention. It is important to the HIV prevention agenda in priority settings; characterised by hyper endemic and generalised epidemics coupled with low percentages of circumcised males. Literature relating to school youth vis-à-vis VMMC and condoms is sorely missing. The study sought to fill this gap.

Method: The study adopted a qualitative research design and an interpretivist paradigm. It used focus group discussions (FGDs) with learner participants, and key informant interviews (KIIs) with adults drawn from four schools (two per district: Mberengwa and Zvishavane). Seven sex-segregated FGDs were conducted. In terms of KIIs, a total of nine adults participated in one-on-one in-depth interviews. Adult participants were either Guidance and Counselling educators or health workers. Seven educators and two health workers participated in the KIIs. Data were thematically analysed.

Findings: Both FGDs and KIIs produced rich and thick data indicating that school learners have limited knowledge and comprehension of basic facts related to HIV and AIDS. Many of the learner participants were ignorant of facts around VMMC for HIV prevention. Findings suggest that the acceptability of VMMC is high, but there is need for improving access to VMMC services. Furthermore, the need to make VMMC more comprehensive through increasing access to condoms and robust sex education, were some of the prominent findings. The study revealed that HIV prevention options, particularly for female learners were too limited, and those for boys were largely fragmented. Participants also identified several challenges that confront educators, the education system, and other stakeholders in their attempt to mitigate HIV among school adolescents, and adolescent sexual and reproductive health. These include a discriminatory, judgmental and narrow focused legal and policy framework.

Conclusion: The study's findings suggest that learners tend to prefer risk reduction methods to risk avoiding strategies such as abstinence. As such, most of the learner participants framed abstinence as being Utopian. Both data sets advance a discourse of a rights-based approach to adolescent sexual and reproductive health that is not dismissive of the agency of young people in enhancing sexual health and well-being.

ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ASRH	Adolescent Sexual and Reproductive Health
AGYW	Adolescent girls and young women
CCA	Culture-Centred Approach
CEDAW	United Nations Convention on the Elimination of All Forms of Discrimination against Women
HIV	Human Immune Virus
FGM	Female genital mutilation
MDGs	Millennium Development Goals
MC	Male Circumcision
MoHCC	Ministry of Health and Child Care
MoPSE	Ministry of Primary and Secondary Education
NAC	National AIDS Council
NGO	Non-Governmental Organisation
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNGASS	United Nations General Assembly Special Session
UN	United Nations
USAID	United States Agency for International Development
PEPFAR	President's Emergency Plan for AIDS Relief
STIs	Sexually Transmitted Infections
VMMC	Voluntary Medical Male Circumcision
WHO	World Health Organization
UZCHS-CTRC	University of Zimbabwe College of Health Sciences-Clinical Trial Research Centre
ZACH	Zimbabwe Association of Church Hospitals
ZiCHiRe	Zimbabwe Community Health Research Project

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CHAPTER 1
INTRODUCTION

1.1 Background

The AIDS epidemic is a public health threat (Baxter & Abdool Karim, 2016; UNAIDS, 2014b). Owing to its unparalleled devastating effect, the AIDS epidemic has courted a myriad of responses from multiple sectors in most governments across the global spectrum, and such organisations as the group of eight nations (G8) and the United Nations–UN (Mane & Aggleton, 2001). Since its emergence, responses to the epidemic were largely disjointed and poorly coordinated (Mutevedzi & Newell, 2014). This persisted until the historic UN General Assembly Special Session on HIV/AIDS (UNGASS) Declaration of Commitment, 2001 was held (Poku, 2005; WHO/UNAIDS, 2001). This political declaration by the world's governments marked a watershed juncture in the global response to the AIDS epidemic. Some key goals set include quantifiable and time-bound targets to reduce HIV infection among infants and adolescents, and improvement in HIV and AIDS education (Chevo & Bhatasara, 2012; UNAIDS, 2001). Subsequently, HIV prevention went on the overdrive, and combating the epidemic was designated as a Millennium Development Goal (MDG) with a target of reducing 50% of both sexual and parenteral HIV transmission by 2015 (Mutevedzi & Newell, 2014; UNAIDS, 2001). Of course, this ambitious target was missed by a huge margin. The hope to end this stubborn epidemic has since been extended to 2030 (Isbell et al., 2016; Poku, 2016; UNAIDS, 2014). Optimism lies in the HIV prevention mantra. However, the devil is in the details.

Africa in general and the sub-Saharan region in particular, constitute the epicentre of the global HIV and AIDS epidemic (NAC, 2015). Despite a reported decline in HIV prevalence from 18.1% (2005/2006) to 15.2% (2010/2011), Zimbabwe remains one of those countries

worst affected by the epidemic (NAC, 2015). Although this downward trend is significant, the current prevalence rate is still high and therefore threatens the target to achieve zero new HIV infections (Govender & Poku, 2016; UNAIDS, 2014). A combination prevention strategy consisting of biomedical, behavioural, and structural interventions (Bekker, Johnson, Wallace, & Hosek, 2015; Dehne et al., 2016) is probably the best approach. This is so because HIV prevention remains the primary method of controlling the AIDS epidemic (Barnett & Whiteside, 2002; Smith et al., 2016). Both voluntary medical male circumcision (VMMC) and condom promotion fall within the biomedical approach to reducing HIV transmission (Baxter & Abdool Karim, 2016).

According to randomised control trials (RCTs) conducted in Kenya, South Africa and Uganda, there is substantial evidence that VMMC decreases the risk of HIV transmission in heterosexual men by an estimated 60% (Bailey et al., 2007; Gray et al., 2007). VMMC thus provides partial protection and therefore does not replace either barrier methods such as condoms or other known forms of mitigating HIV incidence including those located within the behaviour change approach for example; shunning age-disparate sexual liaisons, reducing the number of sex partners, and adherence to correct and consistent condom use (Matovu et al., 2007; UNAIDS, 2007). As a sequel to this breakthrough, the WHO and UNAIDS recommended VMMC as a prevention strategy for mitigating the heterosexual transmission of HIV (Bailey et al., 2007; WHO/UNAIDS, 2007). This is a first in the history of modern medicine for a surgical procedure (VMMC) to be recommended as an intervention strategy in response to a major public health challenge (Buve et al., 2007). Furthermore, VMMC is the only biomedical approach capable of preventing (though partial), the sexual transmission of HIV through a female-to-male mode, and only through vaginal penetration (Berer, 2007).

Before getting into the depth of the discussion, there is need to draw a distinction between VMMC for HIV prevention and male circumcision in general, a procedure that may

be conducted for either socio-cultural or religious purposes (Aggleton, 2007; Gollaher, 2000; Mavundla, Netswera, Bottoman, & Toth, 2009). VMMC is the complete surgical removal of the foreskin, usually conducted by trained personnel under clinical conditions and is specifically done for health reasons – preventing sexually transmitted infections (STIs), including HIV (WHO/UNAIDS, 2007). With regards to semantic clarity, the term voluntary which almost always accompanies this type of circumcision is of significance because it seeks to highlight that those who undergo this procedure do so out of their own volition and are not coerced. Mutilation of genitalia can be a sensitive human rights issue, as exemplified by the case of female genital mutilation (FGM) which has been abolished and criminalised (Ako & Akweongo, 2009). On the other hand, male circumcision may be defined as cutting of the entire or a part of the foreskin for cultural, social or religious reasons (Gwandure, 2011; WHO/UNAIDS, 2007).

Despite that both procedures include the cutting of the prepuce, though at varying degrees, the protective efficacy of the latter against HIV prevention is subject to scientific debate. This distinction is important because available literature suggests that partial circumcision might not be effective in terms of preventing HIV infection (Gwandure, 2011; WHO, 2007). However, again this is debatable as it is believed that cultural or religious male circumcision could be the reason why HIV prevalence is relatively lower in West Africa where percentages of circumcised men are higher when compared to other countries in East and Southern Africa (Auvert et al., 2005). Others do not attribute this low prevalence to circumcision per se but cite other factors such as the controls exerted by the Muslim religion in matters of sexuality, usually enforced through the administration of sharia law (Jackson, 2002).

Zimbabwe adopted a National Male Circumcision Policy in 2009 in compliance with the WHO/UNAIDS' recommendation for countries worst hit by the AIDS epidemic

(technically referred to as priority locations) to add VMMC to the armoury against HIV infection (WHO/UNAIDS, 2007). This national male circumcision policy seeks to promote the provision of VMMC for HIV prevention across the broader male population (NAC, 2011). VMMC and consistent condom use are therefore integral components of what Tatoud (2011) termed the 'HIV prevention buffet'. Offered as a comprehensive package (VMMC and correct, consistent condom use), coupled with abstinence, and sexual partner reduction, this biomedical approach makes an effective combination of prevention methods against HIV transmission (Bailey et al., 2010; WHO, 2012).

The urgency to scale-up HIV/AIDS prevention efforts in developing countries such as Zimbabwe is both a moral and humanitarian imperative (DeJong, 2003). According to DeJong (2003), "epidemiologically, the rapid transmission of HIV/AIDS can only be countered when prevention efforts are organised at sufficient scale to affect the dynamics of the epidemic" (p.11). In line with this otherwise plausible argument, circumcising at least 80% of males between 15 and 29 years by 2015 was projected to have a population level impact of reducing HIV incidence by between 25% and 35% (Government of Zimbabwe – GoZ, 2011). Through the nationwide program, *'Pinda MuSmart, Ngena KuSmart, Get Circumcised Today!',* VMMC for HIV prevention is not only extended to adolescents currently in school through inter-ministerial collaborative work, but is also offered at no cost to any willing male (Ashengo et al., 2014; Shumba, 2014).

Because it provides partial protection, VMMC has proved to be far from being a "silver bullet" per se (Scalway, 2010, p.9) or "a standalone panacea" for HIV prevention (Mathew, 2012, p.2). As such, condoms play a critical role in complimenting the efficacy of VMMC. Condoms are the first choice for preventing the sexual transmission of HIV (Bailey et al., 2010; Baxter & Abdool Karim, 2016). Heterosexual transmission of HIV is a key route, contributing about 80% and 90% of all transmissions in Zimbabwe and southern Africa, respectively (Bailey

et al., 2001; NAC, 2015). This makes scaling-up VMMC and condom promotion (including distribution) very critical. Both male and female condoms constitute the lifeblood of many HIV prevention interventions (Baxter & Abdool Karim, 2001; Hearst & Chen, 2004).

Studies on VMMC mainly focus on three broad areas. Firstly, there is a body of knowledge on VMMC's efficacy as an HIV 'prevention technology' (Aggleton, 2007; Auvert et al., 2005). Numerous epidemiological studies have reported a significant association between absence of male circumcision and HIV infection, leading to recommendations for VMMC to be added to the armamentarium of effective HIV prevention strategies (Bailey et al., 2007; UNAIDS, 2016). For example, a study in Pune, India, showed that VMMC was strongly protective against HIV-1 with uncircumcised men being 6.7 times more likely to contract infection than their circumcised counterparts (Carael & Glynn, 2007). Secondly, a significant number of studies deal with risk compensation. Risk compensation or behaviour disinhibition refers to increases in risky behaviour triggered by reductions in perceived risk because of having undergone VMMC for HIV prevention (Cassell et al., 2006; Grund & Hennink, 2012). A study among newly circumcised Swazi men confirmed that men do engage in a sex "romp" following VMMC (Grund & Hennink, 2012).

Furthermore, there are also studies which focus on the acceptability of this novel strategy, both among circumcising and non-circumcising communities (Daimon, 2013; Rennie, Perry, Corneli, Chilungo, & Umar, 2015). For example, some empirical studies conducted among communities that practise traditional circumcision suggest that VMMC can be acceptable. A study by Scott, Weiss, and Viljoen (2005) looked at a traditional Zulu community in KwaZulu-Natal regarding VMMC that most participants would accept VMMC for their sons. Similarly, Mshana and colleagues (2011) conducted a study among a traditionally circumcising community in northern Tanzania that produced similar findings to those of prior research, indicating high acceptance of this population health strategy. In Zimbabwe,

Mhangara (2011), focused on the acceptability of VMMC among workers at Border Limited in eastern Zimbabwe. Later, Hatzold and colleagues (2014) focused on understanding barriers and motivations to the uptake of VMMC among both circumcising and non-circumcising Zimbabwean communities. Moyo, Mhloyi, Chevo, and Rusinga (2015) explored barriers to uptake of VMMC in Zimbabwe's Mhondoro-Ngezi rural area. Generally, literature on VMMC for HIV prevention targeting school going youth is sorely missing. Most studies on VMMC conducted in southern Africa did not focus on adolescents. Therefore, it is against this background that this study strives to fill this gap in the body of knowledge.

1.2 Rational for the study

Sub-Saharan Africa continues to bear an inordinate share of the HIV and AIDS global epidemic, hosting 19.4 million cases (UNAIDS, 2017a). Prior to that, about 24.7 of people were living with HIV (PLWHIV) by end of 2013 (UNAIDS, 2014b; Bekker et al., 2015). During the same period, 3.2 million were children and a significant proportion of them was residing in the sub-Saharan region, and an estimated 145 000 were in Zimbabwe (New Zimbabwe, 2015). HIV prevalence is high among Zimbabwean school going adolescents, and some schools have an estimated 16% of their pupils infected by HIV (Nleya & Langa, 2014). This scenario is unsustainable as it contradicts UNGASS' 2001 "Declaration of Commitment" to reduce HIV infection rates in young people aged between 15 and 24 years by 25% globally by 2010 (WHO/UNAIDS, 2001). It is against this background that a combination prevention approach which includes VMMC and condoms for HIV prevention finds its relevance. VMMC is critical to resuscitating the hope to realise the zero new infections dream (UNAIDS, 2010), not only among this specific population but also across the entire human race.

Adolescents in sub-Saharan Africa's high schools are designated as a key population for HIV prevention interventions (Karim et al., 2014; NAC, 2015). The term adolescent is normally contested (Curtis, 2015). For this reason, the term is operationalised in this study to

refer to young people between 10 and 18 years of age (Curtis, 2015). However, the age demarcations may not be as rigid as this definition by Curtis (2015) suggests since anyone who was in high school may been included in this study. The researcher acknowledges the fluidity of the concept *adolescence* but wishes not to take it as a priority since the term is hereby used to merely refer to young people who are still in school.

Despite that adolescent sexuality is constantly under the surveillance of adults to ensure that it aligns with religio-cultural expectations and obligations, research has shown that in-school adolescents in both Western society and even globally, actively indulge in sexual activity (Casas & Ahumada, 2009; Dowsett & Aggleton, 1999; Muparamoto & Chigwenya, 2009). Indicators of high-risk sexual behaviour among adolescents include unplanned pregnancies, a dramatic rise in STIs, and a high HIV prevalence (Guttmacher Institute, 2014). Consistent with fellow sub-Saharan countries identified as priority locations for the scale-up of HIV prevention efforts (WHO/UNAIDS, 2007; 2009), Zimbabwe's HIV response also includes an accelerated VMMC Programme. In-school adolescents (10-19 years) represent 61% of Zimbabwe's VMMC client base (NAC, 2011). This makes it critical for the voices of this population segment to be included in the dominant discursive spaces that shape sexual and reproductive health policy in Zimbabwe. However, literature is replete with accusations against mainstream society for neglecting or erasing the voices of young people particularly with regards to issues of sexuality.

> *Young people are a group whose behaviour, particularly sexual behaviour, is often regarded as premature if not immature, immoral or at least unfortunate, and whose own ideas, experiences and concerns about sexuality are mostly neglected by society at large…. We must rethink notions of sexuality…. Sexual expression can be seen as a set of meaningful acts, not just as a biological urge* (Dowsett & Aggleton, 1999, p.11).

A typical sexual and reproductive health policy issue is that of VMMC, condoms and a robust sex education. The integration of condom promotion with VMMC provision in schools remains critical for effectively mitigating HIV risk among adolescents. However, the Ministry

of Primary and Secondary Education (MoPSE) went on record as being opposed to condom promotion and distribution in schools (Langa, 2015). This is despite previous calls by the then Ministry of Health and Child Welfare (MoHCW), and health activists, among other stakeholders that condoms be distributed in schools (Newsday, 2012). The inconsistency displayed through rejecting condom promotion in schools while promoting VMMC, whose efficacy in preventing HIV is dependent on correct and consistent condom use, makes the study critical to Health Promotion. Furthermore, schools' punitive responses to pupils found in possession of condoms militate against adolescents' sexual and reproductive health practices (New Zimbabwe, 2015). Health experts express concern that Africa's opportunity to stem the tide of HIV/AIDS in line with the United Nations' Millennium Development Goals (MDGs) may be wasted (Moyo, 2015) through failure to implement relevant structural "configurations" such as aligning VMMC for HIV prevention with increased condom access.

The launch of the *Life Skills, Sexuality, HIV and AIDS Strategy* in 2013 was hailed by most stakeholders in the health and human rights fraternity as a milestone achievement since the Constitution of Zimbabwe had silenced voices on youth sexuality for decades (Washaya, 2013). Despite this bold step, incoherent policies regarding the provision of VMMC, promotion and distribution of condoms among in-school youth impact negatively on accessibility of condoms to this vulnerable group. On the one hand, the MoPSE poses as a moral entrepreneur and argues that condom provision in schools is immoral and would heighten sexual activity among learners, thereby leading to the decay of society's moral fibre (Langa, 2015). On the other hand, the Ministry of Health and Child Care (MoHCC) view the issue differently.

Ironically, the crafting of the *Life Skills, Sexuality, HIV and AIDS Strategy* is allegedly premised on the experiential evidence that adolescents who get exposed to age-appropriate sex education imparted by qualified educators are less likely to become sexually active and delay sexual debut. Furthermore, if the adolescents have initiated sexual activity, chances are such

that they tend to reduce the frequency of sexual liaisons, the number of sexual partners and would use contraception (UNICEF, 2013 cited in Washaya, 2013). The same school of thought is articulated by previous research (Johnson, 2002). This disconnect is worth exploring particularly from the learners' perspectives not least because in the education sector, the voices of the youth are marginalised, yet they are the ones worst affected by policy and programmes designed with little or no input from them (Ajodhia-Andrews & Berman, 2009). It is against this backdrop that this study assumes a social justice perspective and seeks to solicit the views of the adolescents and selected adults.

The MoHCC regards condom inaccessibility among in-school youth as a threat to the progress achieved to date in as far as the fight against the AIDS epidemic is concerned (Newsday, 2012). Being the overall watchdog over the health of Zimbabwe as a nation-state, the MoHCC together with most health activists view the stance of the MoPSE as problematic since contradictory discourses between anti- and pro-condom promotions have the potential to negatively impact on the youth's sexual practices, thereby increasing risk sexual behaviour including unprotected sex. This would inadvertently accelerate both HIV incidence and prevalence (Moyo, 2015). This thesis argues that contradictory discourses on condoms pose a threat to the protective efficacy of VMMC.

Furthermore, the harsh punitive measures such as suspension from school for long periods meted out to learners caught in possession of the protective sheath (New Zimbabwe, 2015) can be viewed as gross violation of youth's rights to access tools for protection that can enhance their sexual and reproductive health. Among other international human rights instruments, the Cairo Declaration empowered the young persons to take full control of their sexual and reproductive health. Furthermore, Section 76 (1) of the Constitution of Zimbabwe (2013), stipulates that access to basic healthcare services is a right to be enjoyed by all, without regard to age. Therefore, concern is raised that limiting school adolescents' access to sexual

and reproductive health (SRH) services and preventative accessories such as condoms is a violation of their right to live healthy lives, and to make choices that suit them. Lessons learnt since the fight against HIV incidence begun favour ensuring that at risk populations are empowered through provision of prevention choices that suit individuals' needs (Golub, 2006). However, youth sexuality is often frowned at (Dowsett & Aggleton, 1999), and such a stance is arguably unstainable since the benefits of suppressing youth sexuality are obviously outweighed by those offered by a more tolerant approach.

The MoHCC wishes to increase youth's access to condoms since clinics and other places where condoms can be accessed by adolescents are for all practical reasons, inaccessible. This is so because not all clinics are youth friendly and so are bars and other public drinking places where condoms are freely distributed. These places are obviously not appropriate for school youth to visit. Furthermore, the judgemental attitudes of health professionals at health centres often pose as a deterrent to youth's access to condoms (Muparamoto & Chigwenya, 2009). While condom use is reiterated in VMMC messages, particularly in the mass media, the contraceptive sheath remains taboo in VMMC school campaigns, and within school premises. The inherent contradiction in offering VMMC within the school context but denying learners condom access in the same context raises questions about the arguments offered for the embargo on condoms within the school. Great concern is raised that the anticipated lower risk of HIV infection linked to VMMC may promote higher levels of unprotected risky sexual behaviours among youth.

Overall, there is a dearth of research focusing on HIV prevention among in-school youth using VMMC and condoms, not least when compared with the countless studies conducted to date with adult populations since the inception of VMMC as an HIV prevention strategy in 2007 (Ashengo et al., 2014; Grund & Hennink, 2012). This is perhaps understandable given that VMMC remains the "newest weapon in the arsenal" in terms of HIV

prevention technologies particularly those targeting female-to- male transmission (Dowsett & Couch, 2007, p.33). As researchers have focused predominantly on adult populations and other aspects of their sexual and reproductive health services, there is thus the need to pay attention to adolescent populations and their perspectives on HIV prevention efforts that use VMMC and condoms.

1.3 Philosophical underpinnings of the study

As a point of departure, it is critical to highlight the philosophical underpinnings of the current study. The study directly falls under the ambit of Health Promotion. As such, it is cognisant of the fact that AIDS is an epidemic, and epidemic diseases are essentially social processes (Schoepf, 2004). The spread of HIV is thus intricately tied to various social determinants (WHO, 2008). From a Health Promotion perspective, the study therefore sustains a keen commitment to addressing the AIDS epidemic in its appropriate context, recognising that several factors (socio-religious, economic and political), either distal or causal, effectively interact to influence the spread of HIV. Most importantly, the study places human rights at the centre of HIV prevention efforts (Hunt, 2010), recognising that in-school adolescents are mostly relegated to the margins, a scenario which further exacerbates their susceptibility to infection. Therefore, the data collection process was informed by a social justice approach, which aimed at giving a voice to the marginalised. Similarly, the data analysis is done through a public health approach as well as a right-to-health lens.

1.4 Aim (s) and objectives of the study

1.4.1 Study aim

The main aim of the current study is to explore use of voluntary medical male circumcision for HIV prevention among in-school youths to gain an in-depth understanding that can help to

improve the sexual and reproductive health, and welfare of in-school youth using a qualitative research design.

1.4.2 Study objectives

The study seeks to:

1. Explore learners' perceptions of HIV prevention in schools through use of voluntary medical male circumcision (VMMC) for HIV prevention.

2. Examine stakeholders' perceptions of VMMC among school youths.

3. Explore the challenges that educators, the education system, and other stakeholders encounter in mitigating HIV incidence among learners.

1.5 Research questions

The key research questions are as follows:

1. What are the learners' perceptions of using VMMC as a strategy to mitigate HIV incidence among school learners?

2. How do stakeholders perceive the roll-out and scale up of VMMC in schools?

3. What are the challenges that educators, the education system, and other stakeholders encounter in mitigating HIV incidence among learners?

To address the above questions, a multi-method qualitative approach is used in this study. The approach entails focus group discussions (FGDs) and key informant interviews (KIIs) with purposively selected learners and adults, respectively. Essentially, no one primary method of data gathering influenced the use of the other. Using the two modes of qualitative data collection culminated into a form of method and data triangulation. Importantly, the use of triangulation promoted the exploration of multiple viewpoints, a benefit that is synonymous with interpretivism as a paradigm which this study adopts. The concept of data triangulation

is critical in research because it increases researchers' confidence in their findings, and, among other things, triangulation diversely contributes to producing a clear illumination of the phenomenon under study (De Vos, 2005).

1.6 Outline of the thesis

The outline of the thesis is presented below. This presentation includes the various aspects that are dealt with in each individual chapter.

Chapter 1: *Introduction*

As illustrated above, Chapter One, an introductory chapter, provided a background to the study, outlined its objectives, and need for the study as well as the research questions the study sought to answer.

Chapter 2: *Literature Review*

Chapter Two is an overview of the literature review pertaining to the HIV/AIDS epidemic and school youth. It focuses on the global and regional responses to the epidemic. Apart from the origins of the AIDS epidemic, an overview of the dominant transmission routes is given. As part of the responses to the HIV/AIDS epidemic, the chapter details the dominant discourse on the topic, particularly the orthodox view vis-à-vis AIDS denialism. Sequentially, these are followed by prevention strategies, specifically condom use and promotion. Since the study's main thrust is prevention of HIV among adolescents, a focus on youth sexuality and HIV/AIDS was a necessary inclusion. Furthermore, equally important was a focus on gendered constructions of adolescent sexuality since these seem to impact differently on the respective sexes in terms of HIV transmission. The chapter concludes by generally examining sexual and reproductive health in Zimbabwe.

Chapter 3: *Zimbabwe's response to the HIV/AIDS epidemic*

This chapter contextualises Zimbabwe's response to the HIV/AIDS epidemic. To do so, it provides an account of the socio-economic and political environment in question. This is important as research has shown that the epidemic is exacerbated by the socio-economic and political milieu. In terms of the socio-economic aspect, the impact of the economic structural adjustment programme (ESAP) is given prominence as it impacted on social service delivery which inevitably affected the country's health delivery system leading to its total collapse. Politically, Zimbabwe's "year 2000 and beyond" crisis and its impact on the health sector and other social determinants of health is discussed. Since the study specifically focuses on HIV/AIDS, the policy environment is presented to locate the position of VMMC for HIV prevention. This chapter is concluded by presenting the theoretical framework that informs the study.

Chapter 4: *Research methodology*

In Chapter Four, a description of the research process that unfolded in conducting this study is provided[1]. This includes the identification and justification of both the research design and the paradigm within which the study is located. The study adopted a qualitative design, informed by an interpretivist paradigm. The chapter describes the research setting, data collection instruments, the pilot phase of the study, data collection, and data analysis. It also describes in detail; how issues of rigour and ethical considerations were addressed.

Chapter 5: *Knowledge and comprehension of HIV/AIDS*

This is the first of three chapters that present the findings and discussion of the key themes identified in the study. This chapter focuses on adolescents' understanding of the various routes

[1] The methodology chapter is comprehensive and therefore the need to repeat the methods sections in each of the findings chapters is unnecessary.

through which HIV can be transmitted. Furthermore, it focuses on the possible ways of mitigating HIV incidence. A central concept the chapter examines is that of a combination prevention approach to HIV prevention. Since the condom (both male and female) featured as a critical preventative technology, this chapter pays attention to condom literacy which is a phrase coined and operationalised in this study. Condom literacy focuses on issues regarding both knowledge and the practical skills to effectively use condoms to mitigate HIV incidence.

Chapter 6: *Accessibility and acceptability of Voluntary Medical Male Circumcision among school going youth in Zimbabwe: A Qualitative inquiry*

Chapter six is a paper under review. The paper was accepted by the *African Journal of AIDS Research* on 21 November 2017, on condition that certain issues raised by reviewers are attended to, satisfactorily. The paper focuses on the acceptability of VMMC for HIV prevention among in-school adolescents. It also examines possible barriers to the adoption of VMMC among this population segment. Accessibility and acceptability are critical elements of any population health service. Focusing on VMMC for HIV prevention, this article presents the perceptions of both adults and school youth regarding the above two independent yet interconnected critical dimensions of access. The study adopted a qualitative design and used Penchansky and Thomas' theory of access as the analytical framework. Participants were purposively selected. Data were collected using in-depth interviews with adults and focus group discussions with school youth. Views elicited were thematically analysed using the Nvivo (QSR International, Melbourne, Australia) software programme. Findings indicated that both the accessibility and acceptability of VMMC are quite high. Participants indicated that VMMC is largely acceptable based on its protective efficacy. It also emerged that there is need to establish more VMMC centres to ensure that services are found within considerable proximity. However, there is no guarantee for the increased uptake of this biomedical approach because several areas still need considerable attention, particularly from a policy perspective.

The authors recommend that the legal and policy framework must be aligned to ensure that VMMC is offered in a comprehensive manner—accompanied by adequate accessories such as sexual and reproductive health education and condoms to enhance combination HIV prevention.

Chapter 7: *HIV prevention options among school going youth in Zimbabwe*[2]

The HIV 'prevention revolution' has culminated into several combination prevention approaches e.g. behavioural, biomedical, and structural interventions, being implemented to change the trajectory of the AIDS epidemic. This paper focused on purposely selected adults and school youth's perceptions of prevention options available to the latter. Qualitative interviews with nine (9) adults and seven (7) sex-segregated focus groups with learners were used to collect data. Data were thematically analysed using the Nvivo (QSR International, Melbourne, Australia) software programme and manual thematic analysis as described by Braun and Clarke (2006). Findings indicated that although girls are more vulnerable and susceptible to HIV infection compared to their male counterparts, they are expected to solely rely on abstinence. However, it emerged that vows of abstinence are often broken, and this proved to be a matter of concern. On the other hand, boys are circumcised but important preventative tools such as condoms remain inaccessible, yet VMMC provides partial protection against HIV incidence. The paper recommends that the legal and policy framework must be aligned to promote the sexual and reproductive health needs of school youth and support current interventions such as VMMC.

Chapter 8: *Reflections on public policy: Mitigating HIV incidence among school-youth using voluntary male circumcision and condoms among high school learners in Zimbabwe*

[2] Chapter 7 and 8 consist of manuscripts under preparation to be submitted for publication

Cognisant of the critical role played by VMMC in the current HIV prevention revolution, the paper focused on the legal and policy framework informing school health in Zimbabwe. Structural interventions are critical elements of the HIV combination prevention approach, not least because structural factors can either promote or constrain preventative efforts to stem the AIDS epidemic. With the aim to optimise the preventative efficacy of VMMC for HIV prevention among school youths, this paper focused on purposefully selected adults' perceptions of the current school health policy in Zimbabwe. This qualitative study used key informant interviews to collect data. Findings indicated that the current policies are narrow focused, characterised by a discriminatory legislative and policy framework, and an overall lack of stakeholders' participation in policy formulation. The paper recommends that the legal and policy framework must be aligned to best practices such as adopting human rights-based approaches and the promotion of non-judgmental policies that are youth relevant to ensure school youths' sexual safety.

Chapter 9: *Integrative discussion and conclusion*

This chapter provides an integrated discussion of the study's key findings. Overall, it summarises the findings reported on, in relation to the relevant and current literature. It provides proposals for policy and health promotion interventions for not only a coherent sexual and reproductive school health policy in Zimbabwe but also relevant interventions. This is important because it is envisaged that the findings of this study will inform policy and achieve improved adolescent sexual reproductive health, and overall well-being. The chapter is concluded by highlighting the doctoral study's contribution to scholarship and providing suggestions for future research paths. Limitations of the study are also highlighted in this section.

CHAPTER 2
CONTEXTUALISING HIV/AIDS IN ZIMBABWE

2.1 Introduction

This chapter focuses on HIV/AIDS, and the responses that the epidemic has prompted since 1985 when the first AIDS case was reported in Zimbabwe (Duri, Stray-Pedersen, & Muller, 2013). The chapter provides the national context for this study on mitigating HIV/AIDS among in-school adolescents through VMMC for HIV prevention alongside condoms. The study aims to tackle the AIDS epidemic from a preventative front, through reducing the heterosexual transmission of HIV. This is not only important because Zimbabwe has a heterosexual epidemic, but also because in southern Africa, school going adolescents are a key population (Abdool Karim et al., 2014; National AIDS Council– NAC, 2011).

2.2 Background

According to Kalichman, "nothing can account for AIDS in Africa other than a heterosexual HIV epidemic" (2009, p.83). Heterosexual transmission is prevalent in sub-Saharan Africa, hence the phrase 'heterosexual epidemic' (Bailey et al., 2001; NAC, 2011). A high prevalence of intergenerational sex has been found to be a key driver in this epidemic (Chikovore, Nystrom, Lindmark, & Ahlberg, 2009; Jackson, 2002). Research has demonstrated that age-disparate sexual liaisons increase young female adolescents' vulnerability to HIV incidence (Abdool Karim, 2016), and importantly these young females continue to have relationships with boys of their age, thereby expanding the sex networks. Zimbabwe has been characterised by a harsh socio-economic and political atmosphere since 2000, resulting in an increase in transactional sex (Duri et al., 2013). As such, an increase in transaction and largely intergenerational sex was a pragmatic response to the unfavourable material conditions precipitated by the deteriorating economic atmosphere (Chikovore et al., 2009).

The chapter provides a contextual overview of the country's diverse responses to the HIV epidemic by reflecting on the general socio-economic and political context within which the epidemic evolved. It illuminates on key policies and programmes that guided the Government of Zimbabwe (GoZ hereafter) and other stakeholders such as local and foreign non-governmental organisations (LoNGOs and FoNGOs) in their concerted efforts to stem the epidemic. Furthermore, the conceptual framework informing the study is presented at the end of the chapter.

Certain specific factors make some population segments more vulnerable than others (Dutta, 2008). On a global scale, youth carry a huge burden of HIV infection annually and this is estimated at around 39% (Pettifor et al., 2015). According to Idele and colleagues (2014), owing to their age, social and economic status, adolescents (particularly those in developing countries) experience limited access to information and other important health resources. This obviously increases their susceptibility and vulnerability to HIV incidence. Research suggests that globally, adolescence is the sole age group that is experiencing a double burden of increasing HIV incidence and HIV related mortality (Bekker et al., 2015). As such, in-school adolescents in sub-Saharan Africa are designated as a key population for HIV prevention interventions (Abdool Karim et al., 2014). Without exception, Zimbabwean adolescents are equally vulnerable to HIV/AIDS (Nleya & Langa, 2014).

Research has shown that results for adolescent HIV prevention interventions targeting individual behaviour change have little or no impact on HIV incidence (Johnson, 2002). This has led to investing hope in those interventions seeking to address structural drivers of the epidemic (Bekker et al., 2015). Therefore, since this study focuses on preventing behaviourally transmitted HIV that is acquired through high-risk behaviours including unprotected sex (Lall et al., 2015), it may be argued that scaling up VMMC for HIV prevention and increasing condom access is one such strategy Zimbabwe's youth urgently need.

Bhana (2007) has argued that among the diversity of strategies to combat HIV, preventing new infections among those with increased vulnerability is critical. As indicated earlier that in-school adolescents are among young key populations (YKP), such an approach may pay significant dividends. Zimbabwe's policy environment is squarely focused on abstinence as the sole answer to adolescence sexual and reproductive health (ASRH hereafter) challenges (Muparamoto & Chigwenya, 2009). This is unsustainable because sexual release does not occur only through will power (Johnson, 2002). Furthermore, research has shown that "the vows of abstinence break far more easily than latex condoms" (Elders, 1999, p.14; Johnson, 2002).

Risky sexual behaviour is widespread among the youth (Bekker et al., 2015; Tanser et al., 2013). This often culminates into STIs including HIV, unplanned teenage pregnancy, and adolescent maternal mortality (Guttmacher Institute, 2014). Often, young adults are ill-prepared for open communication with their sexual partners, hence early sexual encounters are mostly unplanned and unprotected (Lear, 1997). In Zimbabwe, efforts to stop an upsurge of maternal mortality among adolescents have recently prompted the government to consider providing pupils with hormonal contraceptives (The Herald, 2015). It is envisaged that contraceptive pills will mitigate the challenge of unplanned teenage pregnancies and the attendant negative health outcomes such as maternal mortality. However, this trajectory is severely criticised for failing to consider the need for prevention technologies that serve the dual purpose of preventing pregnancy and decreasing HIV incidence (Shumba, 2015).

The provision of contraceptives to in-school youth is important to reducing unplanned pregnancies thus key to sustainable human development (SHD). However, the strategy blatantly flies in the face of logic. It is critical to highlight that condoms are the sole contraceptive method with the potential to protect against both unintended pregnancy and HIV, among other STIs (Guttmacher Institute, 2014). Therefore, there is merit in arguing that barrier

contraceptives such as the condom (both male and female), and other contraceptive methods controlled by women, that have proven to offer protection against STIs should be used (Baxter & Abdool, 2016).

Research has shown that contraceptive use is often higher among sexually active young people with a background of sex education. However, sex education in Zimbabwe is in crisis, with little consensus on quality and content of the curricular (Jackson, 2002; Chikovore et al., 2009). In most cases, ASRH matters are woefully relegated to the margins of the curricular or they are non-existent at all. In Zimbabwe, school-based sex education is nothing more than mere rhetoric, not closer to being responsive to the pertinent and practical questions pertaining to adolescence, and despite glaring evidence of utter failure, abstinence remains a refrain, a dull normative chorus that does not appeal to most of the young people (Shumba, 2015). Against this backdrop, the current VMMC programme for HIV prevention among in-school adolescents may have little impact on mitigating HIV incidence among this group of young key populations. Best practice recommends that VMMC should be accompanied by clear and consistent messages to avoid offsetting the benefits of partial protection conferred on those who are circumcised medically (Hankins, 2007).

2.3 HIV/AIDS, the socio-economic and political environment in Zimbabwe

Southern Rhodesia (1890s-1965) and Rhodesia (1965-1979), got its political independence from white minority rule in 1980 and adopted its current name Zimbabwe (Bond & Manyanya, 2002; Duri et al., 2013). Diplomatic isolation, economic sanctions and a protracted guerrilla war, among a constellation of various factors all gave birth to Zimbabwe (Terry, 2006). Importantly, this section does not seek to rehearse content on the history of Zimbabwe as a country per se but attempts to reconstruct the ‘dramaturgical architecture’ (Lubombo, 2014) of the Zimbabwean HIV and AIDS epidemic. The epidemic, like that of fellow neighbours in southern Africa, was a culmination of several factors, which are social, economic and political

in nature. Furthermore, the policy environment apparently had its own share in contributing to both HIV prevalence and incidence in Zimbabwe.

Davies (2004) draws a timeline representing the history of Zimbabwe (1980-1990, 1990-1997 and 1997-). The three phases drawn by Davies represent socialism, neo-liberalism, and authoritarianism respectively. Each of these phases impacted on the health of the general population differently. During the first decade of majority rule, positive health indicators were witnessed. Duri and colleagues (2013) affirm that the standard of living in Zimbabwe significantly improved and as such, key health indicators which included life expectancy, maternal and infant mortalities bore testimony. Sadly, this phase was short-lived and ended with a total collapse of the health system (Terry, 2006). Perhaps, this paved way for the HIV and AIDS epidemic to spread unrestrained.

The dawn of a new political dispensation in 1980 was embraced with joy. The new democratic government advanced a discourse of national reconciliation, geared towards ameliorating racial relations between blacks and whites after the brutal war, and ultimately to inspire nation building (Chuma, 2005; Raftopoulos & Phimister, 2004). Despite potentially devastating challenges such as the 'Ndebele insurgency' and economic inequality between blacks and whites, Zimbabwe was largely framed as a symbol of post-colonial hope. Both its economic and social policies were designed in such a manner that equity would be attainable (Sachikonye, 2003).

Ideologically, the new leadership had a slant towards socialism, which manifested in a considerable degree of state interventionism in social welfare sectors such as health and education (Bond & Manyanya, 2002; Raftopoulos & Phimister, 2004). An increase in social expenditure, particularly around education, housing and health delivery was witnessed. According to Davies (2004, p.22-23), "the rapid expansion of the education system and

improved access to both preventative and curative health services were the most notable successes…[such that] no rewriting of history can negate these achievements and their significant outcomes". Both primary health and education were offered for free and this culminated into a substantial improvement in literacy rates and health standards (Murisa, 2010).

Half a decade into the post-colonial period, AIDS was officially reported in 1985 (Duri et al., 2013; Muparamoto & Chigwenya, 2009). During the early days of Zimbabwe's independence, no issue seemed insurmountable (Terry, 2006). Zimbabwe was the first less economically developed country (LEDC) to implement a policy that made it mandatory for all blood to be screened prior to transfusion as mitigation for HIV transmission (Iliffe, 2006). The National Blood Service Zimbabwe (NBSZ) started screening blood and blood products for HIV-1 (Duri et al., 2013). Blood transfusion was a major transmission route in the early days of the epidemic (Iliffe, 2006). One would argue that such an expeditious response was a pointer to the government's commitment to tackling the epidemic. However, research has shown that, "there was so much denial by the government until 1990 when HIV/AIDS issues were debated in the public domain" (Duri et al., 2013, p.17). The first decade of independence was therefore a lost opportunity to arrest the AIDS epidemic.

The history of Zimbabwe's AIDS denial is well documented. Henry Muradzikwa, then an editor of the weekly *Sunday Mail* newspaper was sacked following a publication exposing the prevalence of AIDS among a cohort of Zimbabwean students to Cuba. Students on a government teacher training scholarship programme were deported from Cuba for 'unspecified health reasons' which many understood to mean being HIV-seropositive (Austin, 2011; Chuma, 2005). Cuba was the first government in the world to implement a strict quarantine for HIV-infected and AIDS persons in 1987 (Iliffe, 2006; Johnston, 1992).

The Zimbabwean deportees were secretly and arbitrarily detained on arrival back in Zimbabwe as the authorities made frantic efforts to suppress evidence of AIDS prevalence, especially among their own, as the scholarship beneficiaries were former Zimbabwe National Liberation Army cadres (ZANLA, the military wing of the ruling ZANU- PF) (Austin, 2011). Detention of these students was essentially a violation of human rights in every sense (Johnston, 1992). In his memoirs, John Austin (2011) laments that HIV/AIDS in east and southern Africa started during Zimbabwe's youthful democracy during the mid-1980s. Austin insinuated that the deliberate cover-up and deception were political gimmicks meshing into the ruling ZANU party's interests in maintaining its hegemony and that of other revolutionary parties such as the African National Congress (ANC) and the Pan-African Congress (PAC) hosted in Harare at that time.

It can be argued that the initial stance to suppress AIDS cases in Zimbabwe paved the way for denial, discrimination, stigma, and an inadvertently slow response to designing preventative interventions. Zimbabwe's 'unofficial' policy of HIV/AIDS silence can be viewed as an opposite of Uganda's policy of openness which significantly assisted this Great Lakes country to put the epidemic under control, thereby standing out as a symbol of hope in HIV/AIDS prevention (Iliffe, 2006). Research has shown that political commitment and structural changes within the health delivery system are significant variables in the management and prevention of new HIV infections (Chevo & Bhatasara, 2012).

To a large extent, Zimbabwe's response to the epidemic in the first two decades, framed in the words of an official at the helm of the National AIDS Coordinating Program under the Ministry of Health and Child Welfare (MoHCW) was one characterised by a keenness to maintain a "misguided conspiracy of silence" (Terry, 2006, p.31). It was only in 2004 that Zimbabwe hosted its first national conference on AIDS (Terry, 2006). Against this backdrop, one may argue that this moralising had, and continue to have far reaching negative implications

on strategies to mitigate HIV incidence in Zimbabwe, including VMMC particularly among the YKPs. Adolescent sexuality is stigmatised (Chikovore et al., 2009; Marindo, Pearson, & Casterline, 2003).

2.4 Economic Structural Adjustment Programme, HIV/AIDS and social service delivery in Zimbabwe

Zimbabwe's 'economic bliss' was short-lived. Before the end of the first decade of democratic rule, the economy begun to perform poorly, with inflation rising to unprecedented levels, coupled with serious shortages of foreign currency and depreciation of the Zimbabwean dollar (Chuma, 2005). This necessitated the introduction of the Framework for Economic Reform – popularly known as Economic Structural Adjustment Programme (ESAP), recommended by the International Monetary Fund (IMF) and the World Bank (WB) to salvage the plummeting economy (Bond & Manyanya, 2002; Pappas, 2012).

The hope to stem the tide of HIV begun to fade as ESAP was accompanied by massive job losses and a significant slash is government expenditure on social services, thereby reversing the gains of the short-lived welfarist dispensation. Furthermore, an increase in both poverty and unemployment levels emanating from ESAP exacerbated the spread of HIV and AIDS among the Zimbabwean population (Pappas, 2012). The effect of poverty on increasing susceptibility to HIV infection is almost a cliché in AIDS discourses (Dellar, Dlamini, & Abdool Karim, 2015). Due to soaring unemployment and grinding poverty, women were constrained to earn a living through various means, resulting in an increase in transactional sex, and the attendant risk of HIV infection (Jackson, 2002; Pappas, 2012).

ESAP failed to stimulate economic growth as was previously envisaged (Sachikonye, 2004). Both Finance Minister Bernard Chidzero, the chief architect of ESAP and the World Bank had projected a significant economic growth (Bond & Manyanya, 2002). To a large

extent, it can be argued that ESAP reversed the gains of an exemplary social policy driven by a 'quasi-socialist' commitment maintained by the Mugabe regime during the first ten years of independence. This decade had seen, a significant reduction in infant mortality from 86 to 49 per 1000 live births, increasing the rate of immunisation from 25% to 80% while life expectancy rose from 56 to 62 years, yet at the peak of Zimbabwe's HIV/AIDS epidemic which coincided with ESAP, per capita spending on healthcare drastically fell (Bond & Manyanya, 2002).

The US Centers for Disease Control (CDC) is on record indicting the Bretton Woods institutions – World Bank and IMF's prescribed structural adjustment programmes for fuelling the spread of AIDS in Africa (Bond & Manyanya, 2002). The immediate negative effects of ESAP on social outcomes include a drop in social service delivery because of the introduction of user fees at health and education in the context of increasing unemployment (Murisa, 2010). The introduction of user fees at health facilities, and an end to free education in the backdrop of declining employment militated against social service delivery as these critical services got out of the reach of many. This had tremendous implications on the country's response to the challenge of containing an AIDS epidemic that was silently spreading into the population while the government was preoccupied with attending to the ailing economy and increasing social unrest (Chuma, 2005).

2.5 HIV/AIDS and authoritarian statism: 2000 and beyond

The period from 2000 to 2008, represent what became known as the 'Zimbabwe crisis' (Chuma, 2005; Murisa, 2010). 'Zimbabwe crisis' is an important historical epoch as it shaped the socio-economic and political terrain, which inadvertently helped fuel the HIV and AIDS epidemic (Pappas, 2012). The emergency of a vibrant opposition political movement, a large scale and chaotic land reform programme, hyperinflation, unemployment, mass displacement of urbanites, and a constellation of other debilitating challenges all contributed to 'Zimbabwe

crisis' (Bond & Manyanya, 2002; Sachikonye, 2004). 'Zimbabwe crisis', like any economic or political crisis, had far reaching implications on the *AIDSscape*.

The government's loss of legitimacy was glaringly evident and use of coercion became the mode of governance, as expounded by Gramsci's concept on use of coercive power when rule by consent fails (Strinati, 2004; Murisa, 2010). The crisis of legitimacy led to disillusionment, grinding poverty, staff attrition in social service sectors, and social unrest among other factors and that militated against efforts to stem the HIV and AIDS epidemic in Zimbabwe.

Communications ideological state apparatus–ISA (Althusser, 1971; Strinati, 2004) became the government's 'elixir of life' as political dissent increased, and the government became desperate to legitimise its hegemonic political relevance. By so doing "[t]he Ministry of Education, Sports, and Culture works [worked] in conjunction with the Ministry of Information to provide limited television and radio programs concerning HIV/AIDS and sexual health" (Marindo et al., 2003, p.10). One may argue that as political messages, largely those romanticising the land reform programme, *The Third Chimurenga* or Third liberation struggle and a discourse of 'No to recolonisation' pervaded the airwaves, health communication messages were marginalised as they were seen not to be a priority during a desperate struggle for survival, and reaffirmation of legitimacy.

At the peak of the historic economic doldrums and political turbulence, Zimbabwe had "the world's most virulent AIDS pandemic", benchmarked against a context of widespread socio-economic vulnerability (Terry, 2006, p.16). At that time, the AIDS crisis was much a political crisis as it was a public health challenge (Terry, 2006). Most of the population was trapped in grinding poverty, hyperinflation, human rights violations and general pessimism further exacerbated a raging food crisis, partly a product of drought but largely intensified by

a brutal and chaotic land reform policy (Sachikonye, 2003; Terry, 2006). Between 1990 and 2006, average life expectancy dropped from 60 to 40 years, with malnutrition and AIDS held accountable for exacerbating this downward trend (Duri et al., 2013). The once vibrant health system got to its knees during the 'crisis decade' (Murisa, 2010). A total collapse of the health delivery system saw HIV and AIDS statistics experiencing an astronomical rise. Pappas (2012, p.30) asserts that "HIV/AIDS prevalence was at 34% among adults [in 2003], which was the second highest in the world at the time—behind only Botswana." The spread of HIV is not only based on individual behaviour per se but can be impacted on by structural elements as well. These structural elements include laws and policies which can either constrain or enable health and well-being (Dutta, 2008).

Professionals in different sectors, including the health fraternity had, but to look for the proverbial 'greener pastures', resulting in severe brain drain, which crippled the health delivery system (Duri et al., 2013; Pappas, 2012). Challenges related to high staff turn-over in the health sector had an adverse impact on the quality and implementation of HIV and AIDS health programs (Duri et al., 2013). One can plausibly argue that loss of health workers affected programs meant to suppress HIV infectivity such as the provision of anti-retroviral therapy (ART), thereby increasing the susceptibility and vulnerability of the broader population, particularly adolescents. Adolescents are at risk of HIV infection, especially adolescent girls and young women (AGYW). In the sub–Saharan context, adolescent girls and young women acquire HIV at an earlier age by comparison to their male counterparts (Karim et al., 2017). AGYW are approximately up to eight times more likely to be infected by HIV than males their age (Dellar et al., 2015).

In a manner consistent with the adage 'necessity is the mother of invention,' the tumbling economy paved way to an escalation in unprecedented levels of informalisation or underground economic activities, as the impoverished masses endeavoured to devise survival

strategies (Zimbabwe Human Development Report–ZHDR, 2003). It is of paramount significance to note that, "the informal sector income is largely unsustainable and entails behaviours that are generally risky under the HIV and AIDS epidemic mode" (ZHDR, 2003, p.2). Therefore, there is considerable merit in arguing that Zimbabwe's economic and political crisis between 2000 and 2008 created a fertile ground for the spread of the AIDS epidemic. Duri and colleagues (2013) attest that in a bid to mitigate the harsh economic atmosphere prevailing at the time, most Zimbabwean citizens, including women had to resort to cross border trading which inadvertently increased their exposure to various forms of abuse and vulnerability to HIV incidence.

It is against this backdrop that the discourse of AIDS as a structural disease, caused by poverty earns relevance as people are often exposed to infection not because of their promiscuous behaviour per se, but rather because of being constrained by the circumstances of their existence. Zimbabwe's unfavourable economic atmosphere arguably led to the feminisation of both poverty and AIDS as women bore the brunt of an ailing economy. Similarly, Dellar and colleagues (2015), argue that young women (15-24 years) contribute approximately 30% of new infections in Southern Africa.

There is merit in arguing that the 'Zimbabwe crisis' phase provided a fertile ground for the AIDS epidemic to spread. The volatility of the political atmosphere legitimised violation of the female body as 'institutionalised rape' was used as a weapon against those opposed to ZANU-PF rule. Women, both old and young bore the brunt of politically motivated violence during this period of 'madness' as sexual violence became a cliché. A case in point is that of a "60-year-old woman [who] said she was raped by 18 militia members who told her they wanted her to have a ZANU-PF baby" (Country of Origin Information Report, 2009, p.144). Empirical studies indicated that women were sexually violated because either their political activities or those of their spouses. According to the Research and Advocacy Unit (RAU hereafter), rape

was rampant in Zimbabwe, and victims suffered genital trauma and psychological damage (RAU, 2011). High levels of genital inflammation are synonymous with risk of HIV infection (Jackson, 2002; Dellar et al., 2015).

Research has shown that politically motivated rape is a psychological weapon whose *modus operandi* is to undermine the morale of the victim (RAU, 2011). Although Zimbabwe's politically motivated sexual violence assumed various forms such as extreme violence, insertion of objects in the female genitalia, and gang rape among others; the latter had a direct causal effect as it increased the victims' vulnerability to HIV infection. Jackson (2002, p.96) argues that, "because of trauma to the delicate lining of the vagina (or anus), rape carries a high risk of transmitting infection, if the man has HIV or an STI". The practice of safe sex during gang rape episodes is almost impossible, as indicated above, where rape is appropriated as a corrective device.

Another contested event which transpired within the context of the 'crisis decade' and is believed to have cultivated a fertile ground for HIV, is that of *Operation Restore Order/Murambatsvina*. *Operation Restore Order*, popularly known as *Tsunami* around informal social spheres and in journalistic terms, owing to its disastrous and seismic nationwide impact, was engineered by the Zimbabwe government in June 2005. The campaign was characterised by the demolition of illegal structures and mass displacement of the country's urban population (Pappas, 2012).

Zimbabwe, like any other developing countries has recently witnessed an upsurge in urban population, due to rapid urbanisation. By year 2000, 4.8 million of the country's estimated 13 million people resided in urban areas (Murisa, 2010). This burgeoning urban population apparently stiffened competition for not only urban spaces, but social services as well, notably education and health. Woefully, all this occurred in the context of soaring

unemployment and rapid informalisation of the economy, whose roots are linked to the failure of ESAP discussed above (Bond & Manyanya, 2002; Pappas, 2012). Therefore, the implementation of *Operation Restore Order* worsened the conditions of existence for most of the country's population.

Operation Restore Order attracted various criticisms as some viewed is an extension of the onslaught against opposition supporters as the urban centres constituted the stronghold and focal point for the opposition Movement for Democratic Change (MDC). The inception of the MDC in 1999 as a formidable political force to challenge ZANU-PF hegemony (Chuma, 2005), transformed Zimbabwe's political terrain into a 'war zone'. Therefore, many argue that *Tsunami* was largely a political gimmick rather than a sanitisation drive as the government claimed (Pappas, 2012). Like the controversial land reform programme of 2000-2003, *Operation Restore Order* was ill-planned and haphazardly implemented. It's hastily implementation had far reaching implications such as the disruption of health delivery services such as anti-retroviral therapy (ART) for PLWHA (Murisa, 2010).

Urban dwellers' sources of livelihood were destroyed, and the level of desperation increased, compelling some people, especially women to resort to sex work while males had to migrate in search of work, leaving behind their spouses (Pappas, 2012). The relationship between migration and HIV transmission has been empirically established. Research reports a high prevalence of HIV among communities of the mobile, and these often include the socio-economically and politically marginalized populations (Eshete & Sahlul, 2017). Zimbabwe's economic and political migrants sought refuge in neighbouring countries, but maintained sexual ties with their spouse back home, thereby increasing susceptibility to HIV infection as the sex networks became more complicated.

A detailed report by the UN Secretary General's Special Envoy, Anna Tibaijuka (2005) drew the conclusion that *Operation Restore Order* exacerbated vulnerability as well as risky sexual practices, and significantly tempered with the provision of HIV and AIDS services. It is against this backdrop that *Operation Restore Order* is criticised for having caused more harm than good. Ironically, the consequences of a campaign which was supposedly a drive to sanitise Zimbabwe's urban spaces were so cataclysmic that justifying its original objective became highly contestable.

2.6 Sexuality and HIV/AIDS in Zimbabwe

AIDS, in Zimbabwe, like anywhere else was, and continues to be closely linked to sexuality. The epidemic closely knits into the moral fibre of society. Unfortunately, some people are not cognisant of the fact that "moralising and public health do not mix well" (De Waal, 2003, p. 248). As De Waal has argued; "The language of sin and morality is perhaps the most pervasive of all in public discourse on AIDS" (2003, p.248). People infected by HIV/AIDS are generally considered immoral (Duffy, 2005). Lynne Duffy conducted an ethnographic study in rural Zimbabwe which did not only confirm a deep rooted and enduring prevalence of stigmatisation, but also explored the complex relationship that stigmatisation has with silence, secrecy and denial which all have serious implications for the management and prevention of HIV and AIDS. Goffman (1963) defines stigma as referring to "bodily signs designed to expose something unusual and bad about the moral status of the signifier" (p.1). This definition of stigma is a pointer to why people are judgemental towards sufferers of specific diseases. No one wants to be indicted for being morally deficient. This thesis argues that prevalence of stigma did not only promote the spread of HIV in Zimbabwe but continue to negatively affect preventative responses through both policy and legislation.

Stigmatisation and discrimination of HIV infected people is self-defeating and inadvertently threatens public health as those who should benefit from contact with health and

social services may shun these as they attempt to escape the brunt of the public's moral gaze (Iliffe, 2006). Zimbabwe's early response to the AIDS epidemic was and continues to be largely problematic. Iliffe (2006, p.81) clearly articulate that early HIV/AIDS awareness messages were based on fear appeals, and largely propagated prejudice. Popular among these were; 'AIDS kills' was understood to mean imminent death, 'AIDS cannot be cured', [which] encouraged hopelessness, and 'AIDS is spread in promiscuous sex' [which] signified that all HIV-positive people were promiscuous". To a large extent, these messages bear evidence of intolerance.

The intolerance is also manifest in the government's continued refusal to provide prisoners with condoms despite that there is overwhelming evidence that homosexuality is rampant in the country's penitentiaries. Current statistics indicate that a considerably significant number (28%) of prisoners are infected with HIV (NewsdzeZimbabwe, 2015). Former President Robert Mugabe was openly homophobic and spiteful towards 'deviant' sexualities. He is on record insulting gays and lesbians, comparing them to pigs and dogs, and importantly, declaring that they absolutely do not have any rights to talk about. This clearly shows that sexual minorities have no recognition in Zimbabwe, and this has serious repercussions on public health. The need to protect sexual minorities from HIV incidence is not only a human rights issue but is also important to the greater population which is rendered at risk. This is so because microbes know no boundaries, hence there is no guarantee that the virus will remain among the marginalised population who are judged as deviant. In the current matrix, the risk is worse for school adolescents who may belong to this marginalised population segment because they suffer a double tragedy of being ostracised and offered no prevention options.

As such, the government is reluctant to promote condoms in prisons since homosexuality is codified as a crime in the country's criminal law (Constitution of Zimbabwe,

2013). From a health promotion perspective, this is problematic because microbes do not have boundaries. Therefore, it can be argued that the unsafe sexual practices among men having sex with men (MSM) have strong implications on the mainstream heterosexual population (Newsday, 2015). Therefore, one may argue that Zimbabwe's discriminatory HIV policies negatively impact on health promotion interventions. For example, a moralistic approach regarding the sexuality of key populations such as prisoners and in-school adolescents impact on matters of access to preventative accessories such as condoms. Condoms are critical to most prevention strategies and must be made available in all contexts to all populations (Baxter & Abdool Karim, 2016; UNAIDS, 2002).

Despite calls from both human rights organisations and public health experts encouraging the Government of Zimbabwe to tolerate homosexuality, at least in the name of promoting HIV/AIDS prevention and management, the country remains in a state of denial. Tolerance towards lesbian, gay, bisexual, transgender, and intersex people (LGBTIs) promotes the public health enterprise in that, these may get access to interventions which are meant to stem the tide of HIV/AIDS. At the 2015 International Conference on AIDS and STIs in Africa (ICASA) which Zimbabwe hosted, the government displayed its entrenched abhorrence and perpetual denial of the reality of homosexuality by disrupting LGBTI presentations. Therefore, there is merit in arguing that discrimination of some key populations in Zimbabwe fuelled, and continue to promote the spread of the AIDS epidemic. As one activist argued, "sex between men is criminalised in Zimbabwe, thus driving them underground and making them difficult to reach with HIV interventions" (Newsday, 2015).

Similarly, denying prisoners protection from HIV infection does not only defeat public health efforts as these people are later released into the same society, but also infringes into the rights of other people they are linked to in various ways. The implications of denying this key population protection from HIV are far and wide (Jackson, 2002). For example, there are

negative ripple effects in that both the families and broader communities to which prisoners are released such that they face increased risk of infection. Family members and the broader community also suffer the economic consequences of providing care and support during ill-health and in worst cases bear the psychological trauma of AIDS related deaths. In-school youth are not exempted from this deliberate structural marginalisation (Dutta, 2008). While they are recruited in schools to undergo VMMC, condoms remain a taboo, and so are partial protection messages relating to this biomedical approach to mitigating HIV incidence.

However, the likely success of reducing HIV transmission in prisons through use of condoms may be a mere gamble since sexual encounters particularly among inmates take place in complex circumstances. A case in point is that sex among prisoners often takes a coercive form where it is motivated by the will to assert power and control, mostly over weaker inmates. Under such conditions, practice of safe sex is greatly compromised. As such, micro-abrasions during anal sex provide portals for HIV entry (Johnson, 2002). Despite this, condom access remains critical among this population segment and other key populations such as in-school youth.

2.7 HIV/AIDS and the policy environment in Zimbabwe

Although it has been argued that the Government of Zimbabwe has lacked the political will to tackle the AIDS epidemic with the necessary urgency it deserved (Terry, 2006), this is not to say that no progress was made since AIDS was discovered in 1985 (Duri, et al., 2013; ZHDR, 2003). Zimbabwe is a signatory to several declarations. Despite that declarations are not drafted in binding language, they provide a blueprint to guide organisations and countries in their conduct (Johnston, 1992). In 2001, Zimbabwe demonstrated its commitment to combat the epidemic by adopting the United Nations General Assembly Special Session (UNGASS) Declaration of Commitment on HIV and AIDS (Chevo & Bhatasara, 2012; WHO 2001). As such, specific AIDS responses were largely shaped in line with international declarations, and

treaties adopted by the United Nations (UN) and other population services related organisations.

This section focuses on the broad efforts made through different AIDS policies implemented in Zimbabwe, particularly those serving a preventative agenda. While many of the policies were directly shaped by international declarations and treaties, some were purely home grown. An example of an indigenous initiative is the AIDS levy where 3% is deducted from individuals and corporates' incomes to fund HIV/AIDS programmes (Duri et al., 2003). However, this section does not seek to rehearse all the policies implemented in Zimbabwe since doing so is beyond the scope of the study.

According to the Zimbabwe Human Development Report – ZHDR (2003), Zimbabwe like other countries went through the denial, panic and acceptance continuum. There is merit in arguing that the absence of an expeditious response gave the pandemic the impetus to spread far and wide within the largely ignorant population (Chamuka, 2014). The responses were largely fragmented until 1999 when the government got out of the denial mode and formed the National AIDS Council–NAC (Chevo & Bhatasara, 2012; NAC, 1999). The same year NAC was formed, the National HIV/AIDS Policy which aims to coordinate all AIDS prevention and sexual reproductive health activities was put in place (GoZ, 1999; Muparamoto & Chigwenya, 2009).

In Zimbabwe, various ministries craft their HIV and AIDS related policies in line with the National AIDS Policy (NAP). For example, the Ministry of Education, Sports and Culture (MoESC, now MoPSE) relies on the NAP (Muparamoto & Chigwenya, 2009). It is important to highlight that in some cases; there are contradictions and conflicts between the country's statutes and policy standing at ministry level (Chikovore et al., 2009; Marindo et al., 2003). As

such, inconsistences may be held responsible for the lack of coherence in policies that the MoPSE must implement in ASRH.

In their criticism of the NAP, Muparamoto and Chigwenya (2009, p.38) argue that "the policy emphasizes abstinence among young people as the sole strategy for HIV prevention. The policy is moralistic in tone and advocates long-term abstinence among young people." Similarly, the AIDS Action Plan in Schools (MoESC, 1997; UNICEF, 1997), the Reproductive Health Guidelines and Policy (MoHCW, 1998), and the National Youth Policy (1999) all view abstinence as the panacea. This is despite the fact that research has produced compelling evidence demonstrating that abstinence is difficult to sustain because vows to abstain are often broken (Johnson, 2002). Marindo and colleagues (2003, p.7) bemoan that:

> *What is striking is not the advocacy for abstinence per se, but rather the absence of any promotion of condom use as an alternative and complementary strategy for HIV prevention. As in other government policy documents, the unwillingness to accept that sex occurs among young unmarried people and that they need effective protection is clear.*

Of all the known HIV prevention methods, abstinence is the most effective, providing 100% protection (Johnson, 2002; Baxter & Abdool Karim, 2016). However, its dependability is not guaranteed as those who have taken vows have often, relapsed into risky sexual behaviour. Furthermore, failure to accept that young people are sexually active is nothing more than sheer naivety. Both public discourse and key policies are replete with unrealistic expectations and perceptions insinuating that teenagers are celibate or asexual beings (Casas & Amahuda, 2009; Chikovore et al., 2009).

There is ongoing tension in Zimbabwe between the government and religious groups who have attempted to promote adolescent well-being through abstinence vis-à-vis human rights movements and UN related NGOs who advocate for condoms, VMMC and robust

sexuality education initiatives targeting the youth. It is important to state that condom use, or its discussion is prohibited largely as a social norm while being supported by legislation that is vague. In Zimbabwe, "[p]olicymakers and traditional and Christian leaders promote abstinence as the exclusive strategy for all young people, whereas nongovernmental organizations and the private sector promote condom use" (Marindo et al., 2003, p.1). Similarly, the Nigerian society bombards its youth with mixed messages of abstinence and protected sex to the point of creating confusion in terms of decisions regarding the path to take to remain healthy (Titiloye, Agunbiade, & Kehinde, 2009). It is important to highlight that although it is not legally stipulated, Zimbabwe is generally a Christian nation (Duri et al., 2013). As such, the church offers a critical voice that shapes policy, both the written and unwritten policy.

2.8 Conclusion

The chapter briefly focused on Zimbabwe's national HIV and AIDS response. It provided the socio-economic and political environment within which the HIV/AIDS epidemic evolved. To do so, focus was all the three timelines a demarcated by Davies (2004), and their specific characteristics that influenced the course of the epidemic in several ways. Furthermore, the chapter explored issues to do with sexuality in the context of the AIDS epidemic as well as the policy environment that informed Zimbabwe's response. The next chapter focuses on the mitigation of HIV incidence among in-school adolescents through a combination prevention strategy entailing VMMC and condoms. It also focuses on the study's conceptual framework.

CHAPTER 3
VOLUNTARY MEDICAL MALE CIRCUMCISION (VMMC) AND CONDOM USE AMONG ADOLESCENTS

3.1 Introduction

The focus of this thesis is on a holistic approach to voluntary medical male circumcision (VMMC) for HIV prevention. Unlike condoms which have a high protective efficacy, VMMC provides partial protection of about 60% against the heterosexual transmission of HIV (Bailey et al., 2007). Therefore, the strategy does not replace other known methods of HIV prevention, such as condoms. It is useful to briefly focus on the condom; its history and use, both in preventing sexually transmitted infections (STIs) and unplanned pregnancy. Recently, through complementing the efficacy of VMMC, the important role condoms play in mitigating HIV and other STIs has been further reaffirmed. The chapter also focuses on male circumcision particularly and VMMC in particular. Other areas of concern include gender, adolescence, sex and sexuality in the context of HIV, as well as an overview of adolescent sexual and reproductive health (ASRH) policy in Zimbabwe. The chapter also include the theoretical frameworks informing the study, which are the culture-centered approach by Dutta Mohan (2008) and the sociology of adulthood by James and Prout (1990).

3.2 VMMC for HIV prevention in Zimbabwe

Recent scientific studies have demonstrated that medically circumcised males have a significant degree of protection from HIV incidence (Baxter & Abdool Karim, 2016; Hatzold et al., 2014). According to randomised control trials (RCTs) conducted in Kenya, South Africa and Uganda, there is substantial evidence that VMMC decreases the risk of HIV transmission in heterosexual men practising vaginal penetrative sex by an estimated 60% (Bailey et al., 2007; Gruskin, 2007). This section examines the various studies conducted in Zimbabwe that

focused on VMMC for HIV prevention since the strategy was added to the HIV prevention tool box (Hatzold et al., 2014; Montague et al., 2014).

To date, no study, to the knowledge of the researcher has focused on the perspectives of youth in-school regarding the prevention of HIV incidence through a combination strategy of VMMC and condom use. The voices of in-school adolescents are sorely missing, and this area remains under researched. In-school youths continue to be marginalised from what Dutta (2008) describes as, 'dominant discursive spaces'. VMMC was incepted in 2007 following WHO and UNAID's formal incorporation of medicalised circumcision into the broad HIV prevention armoury (Gruskin, 2007; WHO/UNAIDS, 2007). Several studies have been conducted since then, but none known to the researcher has focused on this topic.

The following are examples of studies relevant to the topic of VMMC conducted in Zimbabwe. A note of caution must be raised that these studies are not the only ones done because some may be unknown to the researcher. Furthermore, it is vital to indicate that a review of all the literature on the topic, VMMC and condoms for HIV prevention among in-school youth in relation to the Zimbabwean context is beyond the scope of this literature review.

VMMC was incorporated in the comprehensive approach to HIV prevention, which Tatoud (2011) refers to as the 'HIV prevention buffet', in 2007 (Bailey et al., 2007; WHO/UNAIDS, 2007). Several studies have focused on exploring knowledge and acceptability of this prevention intervention (Chamuka, 2014; Mhangara, 2011). Furthermore, various factors were expected to militate against the acceptability and uptake of VMMC (Gwandure, 2011). However, it must be clarified that such studies did not take a linear approach and assume that knowledge leads to acceptance, since knowing is one thing and accepting a preventative strategy is another thing. As such, others have argued that the

acceptability of a public health intervention may not solely rely on its efficacy (Berer, 2007). However, knowledge and acceptability of VMMC as an HIV prevention strategy was and continues to be critical because this is a first in the history of public health that a surgical procedure has been included as a population health measure (Buve et al., 2007).

Zimbabwe introduced VMMC for HIV prevention through the *National Male Circumcision Policy* of 2009. This policy sought to promote the provision of VMMC for HIV prevention across the broader male population (NAC, 2011). A study by Mhangara (2011) focused on establishing the level of knowledge among workers at Border Timbers Limited in Manicaland province on the benefits offered by VMMC in preventing HIV incidence. The aim was to gather baseline information on VMMC as a prevention intervention to inform future health promotion programming. The study was in the form of a cross-sectional survey and it focused on both male and female adults.

An ethnographic study by Daimon (2013) explored the practice of male circumcision among the Yao community of Malawian ancestry staying in the commercial farming and mining areas of the Mashonaland West province with the view to creating synergy with the biomedical approach of medicalised circumcisions. Basing on data from pregnant women attending antenatal clinics (ANC), HIV prevalence among mining and commercial farming areas was excessively high (Daimon, 2013; MoHCW, 2007). As such, this high prevalence of HIV provided the impetus for implementing VMMC to mitigate the epidemic in this typical AIDS 'hot spot'. By design, VMMC targets priority locations, which areas characterised by high HIV prevalence and low percentages of circumcised males (WHO/UNAIDS, 2007).

Furthermore, the Yao, along with the Lemba, Tonga, Shangani and Xhosa/Fengu constitute minority groups practising male circumcision as a rite of passage in Zimbabwe (Chamuka, 2014; Mandova, 2013; Shumba & Lubombo, 2017). Zimbabwe's *National Male*

Circumcision Policy of 2009 foregrounds the need to offer VMMC in a culturally congruent "manner that fosters respect and collaboration with traditionally circumcising communities and their practices" (Newsday, 2014). Daimon's study revealed that despite initial resistance, the Yao have since embraced medicalised circumcisions among their initiates.

In another study, Shumba (2014) conducted a qualitative exploration of Lemba perspectives on VMMC for HIV prevention in the Midlands province's Mberengwa district. Like the Yao and the Shangani of south-eastern Zimbabwe, the Lemba culturally circumcise their young males in a highly secretive manner (Shoko, 2009; Shumba, 2014). It emerged that the Lemba cultural circumcisers appreciate the benefits of medicalised circumcisions. As such, they expressed willingness to create synergies with those who offer VMMC on condition that Lemba values such as secrecy and male dominance are not compromised in the process (Shumba, 2014).

The Lemba, regard their culture as both dynamic and progressive, thereby creating opportunities for collaborative work with biomedical circumcisers since health and well-being are critical pillars of this Semitic culture (Davis, 2004; Doyle, 2005). The flexibility and dynamism of the Lemba complements Gausset's (2001) argument that culture has the potential to adapt to new conditions, particularly in the context of health challenges confronting its members. Related literature is often replete with allegations that cultural circumcisions are responsible for transmitting HIV (Gausset, 2001; Gwandure, 2011). In this study, apart from Lemba circumcisions being adequately sanitised, it also emerged that their teachings reiterate that initiates must demonstrate, and exercise sexual restraint, delay sexual debut, and remain faithful in monogamous relationships. This is contrary to anecdotal reports that cultural circumcisers encourage promiscuity to test virility (Mavundla et al., 2009).

Chamuka (2014) conducted a study in Harare, Zimbabwe's capital, among sexually active adult men who had undergone VMMC for HIV prevention. The study sought to understand and explore post circumcision behaviour among men in concurrent sexual partnerships (CSP). Literature on VMMC often highlights the ambivalence that circumcision status may trigger risk compensation. Risk compensation refers to an increase is potentially risky behaviour caused by a decrease in either real or perceived risk (Grund & Hennink, 2012).

The concept of risk compensation is linked to the work of Richens, Imrie, and Copas (2000) postulating that the introduction of car seat belts resulted in some motorists experiencing a false and increased sense of safety to the extent of disregarding road safety rules. In the context of VMMC, it is feared that the partial protection conferred on the circumcised male may lead to increased risky behaviour such as unprotected sex, CSPs and early sexual debut for adolescents. The Zimbabwe 2010-2011 Demographic Health Survey (DHS) indicated that risk compensation was particularly prevalent among VMMC graduates (Shoko, 2012; ZIMSTAT, 2012). Similarly, a study by Grund and Hennink (2012) documents the prevalence of risk compensation or behaviour disinhibition among Swazi men during the post circumcision phase.

While Chamuka (2014) reports evidence of risky sexual practices following circumcision, evidence of risk compensation at population level is generally scarce. The prevalence of unsafe sex reported by participants in this study (Chamuka, 2014) was not motivated by risk compensation. Participants cited several factors that lead to the practice of unsafe sex, such as condom unavailability, drunkenness and the embarrassment associated with purchasing condoms (Chamuka, 2014). Elsewhere in the eastern and southern African region (ESA), a study conducted in both Siaya and Bondo districts of Kenya did not show any significant levels of risk compensation (Agot et al., 2007).

3.3 Condom use and promotion

The condom has several synonyms which include among others; safety-rubbers, protective sheaths, skins, and prophylactics. They are an old invention for preventing STIs and pregnancy (Titiloye et al., 2009; Holmes, Levine, & Weaver, 2004). Gabriello Fallopio, the legendary 16th century Italian anatomist made early descriptions of the condom as a medicated linen tubular sheath, made to fit the glans (Youssef, 1993). The condom was invented in Europe to stem a syphilis epidemic (Mindel & Sawleshwarkar, 2008).

Early Egyptian men were among the first to use condoms, which by then were 'devices' made of animal intestines and used as a protective sheath during coital sex (Youssef, 1993;). As far back as the 18th century, the condom was described in military imagery as either 'protective machine' or 'armour', owing to its efficacy driven popularity (Youssef, 1993). The condom has been traditionally used not only as a standalone strategy, but also as the sole and most efficient technology to decrease HIV transmission among other STIs (Peters, Jansen, & van Driel, 2010). It is evident that use of the condom to prevent STIs and pregnancy is a longstanding practice, and three decades into the epidemic, it remains the lifeline of almost all HIV prevention strategies (Baxter & Abdool Karim, 2016; UNAIDS, 2002).

Condoms exist in two distinct types, which are the male condom (MC) and the female condom (FM). The latter is a recent invention, by Lasse Hessels in 1984 (Peters et al., 2010). It was approved by America's Food and Drug Administration (FDA) in 1993 (Gollub, 2000). While the first coloured condom was introduced by a Japanese firm in the middle of the 20th century, rapid technological developments have seen condoms being flavoured, studded and current research is pointing towards introducing a smart condom, the *S.T. EYE*, designed to detect STIs and indicate through colour change (Shoemaker, 2015).

Compelling evidence indicates that condoms decrease the risk of STIs, including HIV on both the insertive and receptive partner (Pinkerton & Abramson, 1997). Recently, it was shown that the condom plays a critical role in complementing the 60% protective efficacy VMMC for HIV prevention (Matovu et al., 2007). VMMC only offers partial protection to the insertive partner and no research has confirmed its direct benefits to the receptive partner in terms of HIV transmission, except that females benefit from reduced HIV prevalence among males (Berer, 2007; Gruskin, 2007). This makes the condom an essential accessory to ensure maximum protection against HIV incidence in medically circumcised heterosexual males who practice vaginal penetrative sex.

Cohen and Farley (2004) hypothesize that if condoms were consistently used, HIV would not have reached epidemic and alarming proportions. Because condoms are highly effective if correctly and consistently used, there is need to ensure that they are included in all HIV prevention packages across populations (Baxter & Abdool Karim, 2016). While the decision to use a condom remains with the individual, it is a fact that structural factors also affect an individual's risk and vulnerability to HIV (Gupta et al., 2008; Lubombo, 2015). UNAIDS (2014) indicates that in sub-Saharan Africa, approximately eight condoms are available to each sexually active individually per year. Obviously, this structural constrain needs to be addressed if strategies such as VMMC are to be successful in reducing HIV incidence.

At population level, evidence pointing to the effectiveness of condoms is often derived from success stories such as that of the government of Thailand during the early days of the AIDS epidemic (UNAIDS, 2002). Through a 100% condom policy, the Thai government constitutionally mandated commercial sex workers (CSWs) and their clients to condomise during every sexual encounter, resulting in a remarkable increase in condom use coupled with plummeting bacterial STI cases among CSWs and their clients (Mukandavire & Garira, 2007;

UNAIDS, 2002). Both the Sonagachi project in India and Uganda's pioneering of the ABC approach, characterised by aggressive social marketing of condoms are pointers to the effectiveness of condoms in mitigating HIV incidence (Dutta, 2008; Nkwi & Bernard, 2012).

3.4 The female condom

The female condom, alternatively referred to as the femidom, is a barrier method used during coitus serving the same functions as that of its male counterpart, the male condom (Gollub, 2000). It was introduced to offer better protection than the traditional male condom, and to give women more control over their sexual health (Chacham, Diniz, Maia, Galati, & Mirim, 2007; Gollub, 2000). The femidom is worn by the female partner for a longer period before the actual act of intercourse (Meekers & Richter, 2005). However, Baxter and Abdool Karim (2016) argue that due to gender dynamics which often dictate how sex is performed, the ultimate decision to use protection is largely male dominated meaning that the condom remains a preventative tool that is controlled by the woman's partner.

Acceptability studies conducted in several countries including Britain, South Africa, Thailand, Zambia and Zimbabwe among others demonstrated high levels of client satisfaction with the femidom (Ray et al., 1995). Both men and women in Zimbabwe demonstrated preference for the femidom to the male condom. The femidom appeal to men because it does not disrupt sexual spontaneity and decreases men's responsibility for protection (Meekers & Richter, 2005; Ray et al., 1995). Reluctance to use a condom is something of a cliché, as some men view the contraceptive sheath as a burden and further claim that it reduces sexual pleasure (MacPhail et al., 2012; Mnyika, Kvale, & Klepp, 1995). Young men in the Summertown project study in South Africa indicated that ensuring the practice of safe through condom use was the women's obligation (Campbell, 1997).

The first femidom was manufactured from an expensive material called polyurethane (Peters et al., 2010). Apart from its guaranteed product efficacy, uptake of the FC1 condom was low due to cost related constraints (Marseille, Kahn, Billinghurst, & Saba, 2001). Cohen and Farley (2004) argue that like many commodities, high costs make very few people access and use expensive consumer products. Therefore, the FC1 was not much of an option to many, despite the benefits it offered. However, the cost barrier was later remedied in 2009 when the second generation FC2 version made of synthetic nitrile or latex, a comparatively less expensive material got US FDA endorsement (Peters et al., 2010). The FC2 appealed to users as it made no noise during use, unlike the FC1.

In Zimbabwe, the femidom was launched in 1997, earlier than most countries in the region (Center for Health and Gender Equity, 2011). According to the Center for Health and Gender Equity (CHANGE hereafter), women's rights and reproductive health activism played a pivotal role through lobbying for government intervention in bringing the femidom to Zimbabwe. For example, Women and AIDS Support Network (WASN) was instrumental in engaging an overdrive nationwide campaign to promote the femidom (CHANGE, 2011; Peters et al., 2010). Obviously, the initiative increased access to women-controlled prevention methods.

Through AIDS activism, policy shifts are often catalysed. The Treatment Action Campaign (TAC) in South Africa achieved remarkable results through government-civil society commitment to treatment provision for people living with HIV/AIDS (PLWHA) (Msimang & Ekambaram, 2005). Similarly, the Aids Coalition To Unleash Power (ACT-UP), one of the trailblazing AIDS activist organisations in the US played a critical role in compelling the federal government to commit to tackling the epidemic with the urgency it warranted (Heywood, 2005). Today, the USA and South Africa offer models of remarkable activism (Msimang & Ekambaram, 2005).

By comparison to other prevention approaches, the procurement and scale-up of the femidom in Zimbabwe has been generally negligible. Zimbabwe is often cited as a female condom success story, with one of the highest distribution and sales rates for the femidom globally (CHANGE, 2011; UNFPA, 2007). One of the merits of the femidom is that by comparison to the male condom; it can be more acceptable with specific partners particularly where the male partner shuns condom use, or has challenges using them, something which is common among older people (Chacham et al., 2007).

3.5 Condom availability

The availability of condoms, just like that of any other commodity is critical as it determines whether that commodity is used. It is often argued that limited access to condoms can be a serious structural barrier to people who might have the inclination to practise safe sex through consistent condom use (Gupta et al., 2008; Lubombo, 2015). Youth in the Summertown study in South Africa indicated that limited access to condoms has often resulted in unsafe sex, with females bearing the brunt of 'not so-youth friendly' nursing staff at local clinics (Campbell, 2003). The need to ensure that health services are youth friendly is critical to a serious HIV prevention strategy (Poku, 2005). In Zimbabwe, despite that the country has the highest levels of condom use in the world, certain populations such as young people still face challenges in assessing condoms, and other contraceptives (NAC, 2015; NewsdzeZimbabwe, 2015).

A substantial number of studies have demonstrated that condoms, if correctly and consistently used are efficient in preventing the heterosexual transmission of STIs/HIV (Cohen & Farley, 2004; Guttmacher Institute, 2014). Focusing on the youth in Zimbabwe, increasing condom use is a challenge as most adults do not believe that 12–14-year-olds should be taught about how condoms can prevent HIV infection (Chikovore et al., 2009; Guttmacher Institute, 2014). A study conducted by Muparamoto and Chigwenya (2009), among youth in school indicated that condom users are often accused of being immoral. De Waal (2003) criticises the

use of sin and morality in matters of public health. Policymakers, traditional and socio-religious leaders in Zimbabwe prescribe abstinence as the sole strategy to stop HIV transmission while non-governmental organisations (NGOs) and the private sector see hope in condom use (Chikovore et al., 2009). Clearly, this creates a puzzle for the youth. With the inception of VMMC, solving this conundrum is quite pertinent.

To mitigate increasing cases of unplanned teenage pregnancy and HIV incidence, some health activists in Zimbabwe are calling for the distribution of condoms among in-school adolescents (News Day, 2015). Research shows that if correctly and consistently used, condoms are efficient in preventing both HIV transmission and unplanned pregnancy (Holmes et al., 2004; Titiloye et al., 2009). A significant decrease in HIV incidence in South Africa between 2002 and 2008 is attributed to increased condom use (Mutevedzi & Newell, 2014). Despite such compelling evidence, there the idea of increasing adolescents' access to condoms is heavily contested in Zimbabwe. There is clearly lack of tolerance for adolescent sexuality.

In Zimbabwe, and other African countries, evidence that sexual debut occurs much earlier than ever before is overwhelming (Guttmacher Institute, 2014; Mbotho et al., 2011). Hunter (2003) argues that, denying young people the means to enhance their practice of safe sex in this context of high HIV prevalence is almost equal to condemning them to death. As such, denying adolescents access to condoms is more than a human rights issues. In the context of VMMC for HIV prevention, a strategy that only offers partial protection (Berer, 2007), restricting youth access to condoms renders the strategy inadequate and severely compromised because best practice requires that it be provided as a comprehensive package (Hankins, 2007).

3.6 Male circumcision

The history of circumcision is contested terrain. Gollaher concisely described circumcision as "the oldest enigma in the history of surgery" (2000, p. x). The surgical alteration of both male

and female genitalia has always stirred debate particularly around the concept of "genital integrity" or completeness (Berer, 2007, p.47). In the African context, male circumcision is a complex and multi-dimensional concept and is often done for a variety of reasons ranging from aesthetic, biomedical, cultural, religious, and spiritual (Peltzer et al., 2009). There is merit in arguing that the multi-dimensional nature of circumcision renders it subject to controversy.

The focus of this thesis is on the efficacy of VMMC for HIV prevention and condom use among in-school adolescents. However, that doesn't provide adequate rationale for relegating the religio-cultural significance of male circumcision because this has implications on the uptake of VMMC. Religio-cultural circumcisions remain pivotal to the success of a VMMC strategy. For example, the collaboration between Zimbabwe's Yao cultural circumcisers and their medical counterparts typifies best practice in creating synergy between cultural and biomedical perspectives to increase the efficacy of male circumcision in preventing HIV incidence (Daimon, 2013). Furthermore, focusing on male circumcision in general helps to understand the topic through drawing a distinction between medicalised and non-medicalised male circumcision.

In Zimbabwe, like other neighbouring countries with a colonial past such as Botswana and Malawi, it is believed that the practice of circumcision was abolished by European missionaries and colonial administrators (Kang'ethe & Gutsa, 2015; Peltzer et al., 2007). Despite being previously viewed as a primitive and dangerous practice responsible for promoting the spread of HIV (Gausset, 2001), the practice of circumcision now occupies an integral part of HIV prevention efforts (Daimon, 2013). However, there is no guarantee for men who are not medically circumcised to benefit from the partial protection in terms of heterosexual transmission of HIV incidence largely associated with the total removal of the prepuce (Gruskin, 2007; Gwandure, 2011).

A high prevalence of circumcision is often attributed to the low HIV prevalence in West Africa (Auvert et al., 2005). Perhaps, other important variables such as fewer sexual partners, faithfulness in mutual monogamy (Ramjee & Daniels, 2013) and strict religious dictates (such as sharia law) help reduce HIV in this region (Kalu, 2003). Proponents of sharia law argue that sharia might be the solution to the HIV and AIDS epidemic (Kalu, 2003). However, all these suggestions do not serve to undermine the efficacy of VMMC as demonstrated by scientific research (Auvert et al., 2005; Bailey et al., 2007). Importantly, it remains difficult to quantify the protective efficacy of non-medicalised circumcision against HIV incidence, if there is any at all since the procedure is hardly standardised. Various groups of non-medicalised circumciser groups cut varying amounts of the foreskin (Gruskin, 2007; Peltzer et al., 2007).

Considering the above, it is vital that a distinction be drawn between the different forms of circumcision. It is predicted that doing so would not only help to highlight the variance between male circumcision and VMMC, but also to indicate that circumcision for HIV prevention is markedly different from female genital mutilation (FGM) in its diverse and invasive forms (Hankins, 2007). FGM is largely considered a violation of the female body without any medical benefits and has since been outlawed by several stakeholders following recommendations by the United Nations Convention on the Elimination of All Forms of Discrimination against Women– CEDAW (Ako & Akweongo, 2009; Mavundla et al., 2009).

VMMC is a surgical procedure that includes the complete removal of the penis' foreskin for medical reasons (Daimon, 2013; WHO/UNAIDS, 2007). The prefix 'voluntary' is important in that it helps to highlight the fact that the clients of this kind of male circumcision undergo the procedure out of their own volition. They are not coerced, and this aspect is important and must be emphasized lest medicalised circumcision might be viewed in a negative way as being invasive. Those who cannot give independent consent seek informed consent from a parent or legal guardian. On the other hand, male circumcision (MC), mostly for social,

cultural or religious reasons, is often carried out by a non-medical practitioner, and involves the surgical removal of some part or the rest of the prepuce (Gruskin, 2007; Gwandure, 2011).

3.7 Adolescence, sexuality and HIV/AIDS

Understanding youth sexuality is critical to the formulation of appropriate and adequately inclusive programs in response to the twin challenges of HIV and AIDS (Muparamoto & Chigwenya, 2009). One of the ultimate objectives of this study is to illuminate the path leading to a relevant and coherent ASRH policy for in-school youth in Zimbabwe. Doing so requires a clear understanding of the various notions of adolescence sexuality and the dynamics of the AIDS epidemic.

The expression of sexuality (through desires and practices) does not occur in a vacuum, but in social contexts within which power is embedded (Holland, Ramazanoglu, Scott, Sharpe, & Thomson, 1990). As such, power differentials tend to play an important role in the negotiation of safer sex in heterosexual encounters where men almost always dominate women. This increases women's vulnerability to HIV infection (Baxter & Abdool Karim, 2016). Perhaps combination prevention approaches, as suggested by Tatoud (2011) in his 'HIV prevention buffet' or Montague and colleagues' (2014) 'HIV prevention toolbox' are currently the best strategy to reduce HIV incidence. As such, the need for safe sex practice must be a shared responsibility where females also control prevention technologies such as condoms.

It is important to understand the three-pronged relationship between adolescence, sexuality, and HIV/AIDS because the virus is predominantly transmitted through heterosexual penetrative sex (Bailey et al., 2001; NAC, 2011). A more pragmatic argument for the need to scale up prevention efforts among the youth is premised on the logic that due to their limited access to accurate information on the potential consequences of unsafe sexual behaviour, they are at risk of contracting STIs including HIV (DeJong, 2003). STIs are a co-factor in the

transmission of HIV and they must be treated early, and more importantly, they must be prevented at all costs (Jackson, 2002).

Acknowledging adolescent sexuality is a formidable challenge. A proliferation in research confirms that youths are active sexual beings, whose majority experience sexual debut prior to formal marriage (DeJong, 2003; Guttmacher Institute, 2014). Research in Zimbabwe indicates that school pupils are continuously framed as asexual, 'innocent', and highly dependent on adults for guidance and protection (McLaughlin et al., 2012). Such attitudinal barriers are detrimental to the delivery of comprehensive ASRH services and have far reaching effects since adults' construction of adolescent sexuality forms the basis of their resultant efforts to regulate it (Chikovore et al., 2009; Lesko, 1996). As such, the effects are not only limited to negative sexual health outcomes such as high STI incidence (including HIV) and unintended teenage pregnancy but can also include the limiting of legitimate endeavours aimed at promoting human development and well-being such as social research with adolescents (Chikovore et al., 2009; UNICEF, 1996).

It is on record that Zimbabwe's then Ministry of Education, Sports and Culture (MESC hereafter) once denied researchers working on a UNICEF sponsored project gatekeeper permission to conduct interviews with learners below the age of 16 years on issues about sexuality on the pretext that such exposure would make them sexual (Hunter, 2003; Pattman, 2007). Evidently, such an excuse carries 'protectionist' connotations, and is engrained in a discourse of denial and suppression of youth sexuality (Sloth-Nielsen, 2012, p.15). Hunter (2003) contends that, research shows that being knowledgeable helps reduce both impulsiveness and compulsiveness. Importantly, teenagers who have facts about sex and sexuality tend to make informed decisions. Furthermore, attempts at restricting adolescents from accessing preventive information when pornographic materials are scattered everywhere is mere hypocrisy (Hunter, 2003). This is particularly true given that the emergence of social

media platforms such as Facebook and Whatsapp has increased adolescents' access to traditionally 'adult content'.

At the turn of the millennium, the MESC collaborated with the Ministry of Information and Publicity to provide limited television and radio programs on both HIV/AIDS, and sexual and reproductive health (Marindo et al., 2003; Muparamoto & Chigwenya, 2009). These were unimportant since the government was facing a legitimacy crisis, thereby opting to use the state media to propagate ideas of nationhood (Chuma, 2005).

Hoffman and Futterman (1996) posit that a majority of the adult population find difficulty in conceiving adolescents as sexual beings. Owing to that, adolescent sexuality is; retrogressively conceptualised and regarded as something which must be restrained. A discourse continually negating youth sexuality is incessant, despite resonating calls from adolescent sexuality experts not only reiterating that sexuality be acknowledged as a positive and healthy aspect of life (Dowsett & Aggleton, 1999), but also highlighting the need to help young people "determine not only when to say 'no,' but when to say 'yes' as well" (Bay-Cheng, 2003, p.65).

Negative perceptions of youth sexuality have regrettable implications on the formulation of ASRH policies and the crafting of appropriate interventions. For example, a majority of the government's policy documents display reluctance to acknowledge that unmarried youth indulge in sexual activities and therefore need preventative tools to mitigate STIs, including HIV (Marindo et al., 2003; Chikovore et al., 2009). Recently, a 14-year-old Grade 7 pupil from a school in Mberengwa gave birth during a national examination session and claimed that the father of the new born baby was a Form 3 learner at a neighbouring school (The Herald, 2016). The story went viral and became of interest to several stakeholders.

Importantly, the story added to the already glaring evidence that adolescents are neither asexual nor celibate.

Aggleton and Warwick (1997) observed that young people's access to information, sexual health services, and protective resources (such as condoms) is openly constrained due to the stereotypical and often contradictory ways in which adults view them. Youth sexuality is, often, viewed as problematic (Frizelle et al., 2013). Such prejudice, probably emanate from a burgeoning body of literature in health psychology and adolescent medicine which tend to vilify and pathologise young people (Aggleton & Campbell, 2000). Such presumptions of youth sexuality are detrimental, particularly when viewed from a health promotion perspective where the need to think outside the confines of the mainstream constitutes best practice.

Early social research on young people and HIV/AIDS in the global north, largely informed by prejudice-riddled ideas regarding this 'homogenous group' subsequently produced a discourse that framed the youth as "high-risk" (Frizelle et al., 2013, p.1). Such ideas about young people find resonance in adult conceptions of adolescence as a problem stage and are linked to the seminal works of American psychologist, G. Stanley Hall (1904, cited in Cote & Allahar, 2006). Adolescence is a stage of psychosocial development during which teenagers undergo several changes in both the physical and psychological realm. Hall (1904) characterised adolescents as a period of 'storm and stress' (Cote & Allahar, 2006). These are often manifested through mood-swings and physical changes associated with puberty (Cote & Allahar, 2006). Confidence and self-esteem are very fragile at this early stage in social development (Aggleton & Campbell, 2000).

Despite a proliferation of psychological literature that normalises conflict during the transition stage, debunking this discourse which depicts adolescence as a period of turmoil proves a mammoth task (Frizelle et al., 2013). Youth in the global south were not an exception.

HIV/AIDS paraphernalia meant for adolescents in South Africa, mainly informed by the above 'transition discourse' framed adolescents as irrational beings (Frizelle et al., 2013; Macleod, 2006). Due to their sporadic behaviour, young people are therefore regarded as lacking autonomy, are vulnerable, and irresponsible; and subsequently in dire need of adult guidance, protection and constant surveillance (Frizelle et al., 2013). It is against this backdrop that some adults oppose granting young people autonomy that would see them accessing preventative health resources such as condoms.

3.8 Gendered constructions of adolescent sexuality

It is important to draw parallels between sex and gender, "two distinct aspects of human identity" which are often either conflated, or used interchangeably (Franke, 1995, p.1). While sex is a biological endowment and a product of nature, gender can be construed as a function of culture or socialisation (Franke, 1995). From this basic definition, one can realise that while sex is anatomical; gender is a social construct, something that society arbitrarily agrees on. It is based on gender construction in that boys and girls are treated differently, and this inadvertently increases individual risk and vulnerability to infection. Girls normally bear the brunt of prejudiced gender stereotypes.

Historically, sexuality has been, and continues to be intricately interwoven with gender (Bay-Cheng, 2003). Courtesy of a gendered discourse, youth sexuality is, oftentimes constructed as exclusively heterosexual (Frizelle et al., 2013). Although this study primarily revolves around the prevention of heterosexual transmission of HIV through VMMC, coupled with correct and consistent condom use, two main reasons spurred the inclusion of this section on gendered constructions of sexuality.

According to Walker (1997), a non-sexist strategy, one that views boys and girls as equals tends to pay little or no attention to the differences in power and social meaning within

relationships. To avoid this pitfall, a gender-aware approach is, probably best practice for successful adolescent health promotion interventions and prevention programs, as it is cognisant of the possible impacts of gender on the milieu within which sex is negotiated and done (Baxter & Abdool Karim, 2016; Walker, 1997). Substantial evidence suggests that women [particularly those young and inexperienced] tend to be viewed, and to view themselves, as passive receptacles of men's sexual desires (Holland et al., 1990). Such prejudices require health promotion interventions to be gender-aware. This thesis argues that if school-based sex education can be delivered in a relevant manner, such gendered perspectives and biases can be mitigated, leading to meaningful communication that can include such health promoting behaviours as condom use negotiation. Hunter (2003) laments that if priority was given to gender relations in HIV and AIDS prevention programs and all other human development initiatives, women would gain control of their sexuality and exert more control over HIV incidence. Research has demonstrated that socio-cultural beliefs regarding the normative sexual conduct expected of young women have made them to be sexually available to partners and permit male partners to have total control of sexual decision making (Casale et al., 2011).

This study is firmly anchored on a bed-rock of Health Promotion; thus, it is inspired by the spirit of the historic Alma-Ata Declaration of 1978. At this international conference on Primary Health Care (PHC), the world's public health agenda was steered along a 'preventative trajectory'. As promulgated by the WHO, PHC is a guiding philosophy central to which is the notion of health as a human right. Furthermore, health was [re]defined as a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity (WHO, 1978). The PHC philosophy is, at least in this study, applicable through the researcher's commitment to the design and implementation of interventions such as VMMC for HIV

prevention in a manner that inclusively addresses the interests and needs of both male and female adolescents.

Secondly, both adolescent males and females play equally important roles in the fight against the heterosexual transmission of HIV. Since VMMC directly involves the cutting of the prepuce of a male's penis, no reference to females poses the danger of rendering the whole strategy a concern for males only. The success of VMMC in HIV prevention requires consented effort from both parties. The ability of females to negotiate condom use, as well as their understanding that VMMC is partially protective against heterosexual female-to-male transmission of HIV is critical (Berer, 2007). Therefore, if female adolescents are not able to insist on condom use, either the male or female condom, or other alternatives to safe sex, partner circumcision status does not protect them from getting infected with HIV. All hope is not lost as some researchers argue that not all women are submissive to male authority (Bernstein & Osman, 2016; Shefer, 2016).

Mainstream psychological literature on adolescent gender and sexuality is laden with images of adolescent male 'superiority' juxtaposed against adolescent female 'inferiority'. While the sexual relationship is essentially a site where the exercise of power and resistance unfolds (Hillier, Harrison, & Warr, 1998), the terrain is far from being level. For example, it is normative that boys are privileged as active sexual subjects while girls are passive and desired sexual objects (Bay-Cheng, 2003; Poku, 2016). Such skewed representations tend to limit the adolescent female's expression of sexual agency, which if she dares assert, can earn her labels such as deviant, pervert, weird, and many other undesirable tags (Bay-Cheng, 2003).

Adolescent women occupy a subordinated status that significantly disempowers them by limiting their bargaining power in negotiating safe sex (Baxter & Abdool Karim, 2016). Furthermore, adolescent females are, often, expected to display a degree of naivety in sexual

matters (Hillier et al., 1998). It is my estimation that if a robust school-based sex education is offered, females will benefit by gaining confidence in themselves and their decisions. Similarly, adolescent males would also appreciate and respect the decisions of their female counterparts.

3.9 Adolescent sexual and reproductive health in Zimbabwe

For the past decades, Zimbabwe's ASRH policies did not occupy a place of prominence on the country's public health agenda (Guttmacher Institute, 2014). In line with cultural norms and values, adolescent sexuality is severely stigmatised in Zimbabwe (Chikovore et al., 2009; Marindo et al., 2003). Zimbabwe is largely a Christian country, characterised by a high literacy rate (Duri et al., 2013). Niehaus (2000) argues that one of the effects of a colonial past is that colonial education took an ambitious and repressive puritan stance towards adolescent sexuality. This resulted in an unwarranted obsession with abstinence. As such, the Education Ministry continues to promote abstinence as the sole approach to the challenges of adolescent sexuality, despite compelling evidence that in-school adolescents are indulging in illicit sexual activities (The Herald, 2016).

According to the Guttmacher Institute (2014), a substantial number of female and male adolescents (15-19 years) in Zimbabwe have had sexual intercourse. Indicators of youth high-risk sexual behaviour include unplanned teenage pregnancy, an increase in STIs, and a high HIV prevalence. In a bid to reverse such negative sexual outcomes, the inception of the *Life Skills, Sexuality and HIV and AIDS Education Strategic Plan 2012-2015* by the MoPSE was embraced with optimism (UNICEF, 2013). Key areas that this educational plan cover HIV testing and counselling (HTC), increasing condom knowledge and self-efficacy, shunning cross-generation sexual relationships and VMMC for HIV prevention (Guttmacher Institute, 2014). It can be argued that the gist of such an education plan is not prevention of negative outcomes per se, but also the promotion of positive sexual health among adolescents (Bay-

Cheng, 2003). Such an approach is basically contrary to the dominant paradigm where school-based sexuality programs are largely informed by a moralist agenda determined to advance abstinence as the sole prescription to maintaining an HIV free status (Bay-Cheng, 2003; Marindo et al., 2003). Others argue that, insisting on chastity in a global space where sexualities are very diverse and significantly diverge from the prohibitions of elite fundamentalists is largely responsible for the spread of the epidemic among adolescents (Hunter, 2003; Poku, 2016).

While abstinence is possible and totally effective if adhered to consistently; pragmatically, the strategy is susceptible to failure (Dailard, 2003). Some critics attribute Uganda's success in markedly decreasing HIV prevalence to the promotion of sexual abstinence, an argument that refutes the popular claim that reduced HIV prevalence in this east African country was a result of the three-pronged Abstain Be faithful, and Condomise (ABC) approach (Mulwo, 2008). Zimbabwe's ASRH policy gives prominence to abstinence. Other strategies such as VMMC for HIV are new tools in the "HIV prevention toolbox" and are not promoted in a comprehensive manner as best practice requires (Hankins, 2007; Montague et al., 2014). This selective implementation of a strategy that should be offered as a comprehensive package is obviously problematic.

However, if the *Life Skills, Sexuality and HIV and AIDS Education Strategic Plan* is implemented holistically, it offers a plethora of opportunities for achieving positive sexual health outcomes such as; decreased HIV incidence, reduced STIs among adolescents and fewer cases of teenage pregnancy. Buzwell and Rosenthal's (1996) theory of adolescent sexual self-concept conceptualises sexual self-efficacy as three-pronged; and entails the ability to resist unwanted sexual advances, assertiveness with regards to individual desires and wishes, and the ability to exercise control in sexual encounters (Bay-Cheng, 2003). This is critical because sexual health, particularly among the youth ought to be preoccupied with the fulfilment and

expression of sexual pleasure, and not to either deny or suppress sexual energies and desires (Aggleton & Campbell, 2000).

3.10 School based sexual and reproductive health education

Defining 'sexual health' is a contested enterprise. Aggleton and Campbell (2000) link the regular use of this phrase to the advent of the AIDS epidemic, particularly in Britain. For Aggleton and Campbell (2000), current use of the phrase 'sexual health' perhaps, marks a paradigm shift in the way society currently view sex, sexuality and sexual relationships. Evidence that youth are increasingly recognised as a marginalised social group regarding their access to health care as well as relative neglect by policy makers is overwhelming (Mashamba & Robson, 2002; Matthews & Tucker, 2000).

This thesis is anchored on the premise that reproductive health is a basic human right (UNFPA 2000; WHO 2000). Because of early sexual debut among the youths (Guttmacher Institute, 2014), opinions have varied on which strategy to emphasize. Young people are now in a dilemma with choices to either adopt abstinence or be protected. Apostles of protected sex have adjudged the use of contraceptives as a potential strategy to curbing the spread of STIs and the negative consequences of unprotected sexual intercourse (Baxter & Abdool Karim, 2016). Uganda and Thailand are typical examples of condom success in reducing HIV incidence (Mulwo, 2008; Shafii, Stovel, Davies, & Holmes, 2004). However, it is important to understand that increasing condom access in a typical hypodermic syringe style may not be effective in reducing HIV transmission.

The society preaches both abstinence and protected sex. Today's young people are thus saturated with mixed messages without completely identifying with any (Alubo, 2000). Religious teachings clearly support abstinence from premarital sex and their followers are

expected to comply. However, there is difficulty in convincing all youths to privately comply with religious teachings on abstinence. Hence, the fallibility of religious and non-religious youths to sexual sins demands an urgent consideration in the social marketing of contraceptives, particularly condoms.

3.11 Conceptual framework

This study applies the concept of theory triangulation. Theory triangulation entails the use of more than one theory or several perspectives to make sense of a single data set (Neuman, 2014). Mohan Dutta's (2008) culture centred approach (CCA), and James and Prout's (1990) 'new' sociology of childhood is used as the conceptual frameworks for this study. The most compelling reason for using this approach in the current study is dual; it is both methodological and philosophical. A combination of both theories informed the methodological approach (qualitative design) adopted in the execution of the study and offered the relevant philosophical perspective (interpretivism). This was necessary, because, triangulation sought to encompass the youth in their complexity, and ultimately guide the execution of the study starting from literature review to data collection and analysis. According to Delport and Fouché (2005), theory assists in directing inquiry into those areas with the potential to reveal useful patterns and explanations.

This section describes both the origins of the culture centred approach (CCA), and its place in theorising health communication, as well the 'new' sociology of childhood and its relevance to critical youth studies. These two theories form the bedrock upon which this study is firmly grounded. The CCA has its roots in several disciplines such as critical theory, cultural studies, post-colonial theory and subaltern studies (Dutta, 2008). As such, its theoretical, methodological and application-based focus is to a large extent, influenced by these disciplinary roots. While the CCA is not a theory per se, it is an important approach to health communication. The CCA is an approach that is in the process of becoming a theory (Dutta,

2008). This section seeks to briefly motivate for the choice of the conceptual frameworks, present the main concepts, and lastly apply these to the study.

The decision to use the CCA as the overarching conceptual underpinning for this study was consciously arrived at. Two important factors informed the decision to use this conceptual framework. Firstly, the researcher's background and training in both education and cultural studies respectively, played an important role. The researcher subscribes to renowned Brazilian educationist, Paulo Freire's (1970) critical pedagogy, and is inspired by his work with peasants in Brazil. Loyalty to Freire's seminal and germane work inspired the researcher to appreciate the empowering character of research. As such, learner participants who are the primary source of data for this study were, contrary to mainstream pedagogy, viewed not as empty vessels in need of the all-knowing educator/researcher's expert knowledge. Instead, the researcher opted for doing research *with*, and not *on* the learners through the provisions of both the CCA and the 'new' sociology of childhood. The intention was to enhance dialogic engagement between the two parties (researcher and participants) as they converged at what Kvale (1996) described as, a site of knowledge construction.

Secondly, as implied by the title of this thesis, school youth are mostly a marginalised group. They are particularly communicatively marginalised, hence the absence or erasure of their voices from mainstream discursive spaces is often presumed to be normative. By default, the CCA has roots in subaltern studies where the marginalised are given a voice to articulate their concerns. Therefore, due to his understanding of the importance of empowering the marginalised, the researcher saw it appropriate to use the culture centred approach (CCA) to inform, implement and analyse the data generated from in-depth qualitative interviews and focus group discussions. Importantly, it must be acknowledged though, that empowerment means different things to different people. In the theory and practice of health promotion, empowerment is viewed as a process of assisting people to take control of the factors that affect

their health (Gibson, 1991). Similarly, identifying school youth as study participants and key producers of knowledge related to ASRH and well-being is quite empowering.

The CCA is made up of three different but intertwined concepts which are culture, structure and agency. According to Glanz, Rimer and Lewis (2002, p.27), concepts are "the building blocks or primary elements of a theory." Further, these concepts function as the window through which to view the social world. The following paragraphs explain each of the three concepts of the CCA in detail.

3.11.1 Culture

Within the ambit of the CCA, the concept of culture relates to the local contexts within which health meanings are not only constituted but negotiated and interpreted. Importantly, culture is both constitutive and dynamic in nature (Dutta, 2008). Culture is embedded in the day-to-day practices of groups or communities as they negotiate their health, among other important social facets of their lives.

3.11.2 Structure

Structure refers to the various aspects of a social system, which simultaneously constrain and enable the capacity of social members to either access certain health care resources or engage in some health-related behaviour (Dutta, 2008). Structure refers to "the institutional frameworks, ways of organizing, rules and roles in mainstream society that constrain and enable access to resources" (Dutta, 2011, p.9). It is through structure that certain population segments have their access to health care services either limited or promoted. As a function of structure, certain population groups are relegated to the margins of the health care system, and vice-versa (Dutta, 2008). Consequently, marginalised individuals and communities are structurally sidelined and cannot access certain health care resources. Furthermore, their voices do not feature on the various important health communication platforms. It is at such discursive

spaces that health care policies are discussed, and health information disseminated (Dutta, 2008).

3.11.3 Agency

Agency, in this context, relates to the ability of cultural members to make decisions relating to their health as well as to participate actively in negotiating the existing structures that impact their health. The concept, agency entails the conscious process through persons, groups or communities are involved in actions that directly interrogate the structures constraining their lives, and, concurrently, seek to engage with the structures in identifying or supporting initiatives that enhance their health and well-being. Importantly, where culture, structure and agency meet, openings for listening to traditionally marginalised voices are created, and discursive spaces for negotiating the erasure of those on the margins enacted, and opportunities for co-constructing the voices of the subaltern are made available (Dutta, 2008). Similarly, Bandura's (2006) agentic theory attests that human beings have the potential to influence their circumstances hence they are not merely products of the systems within which they exist.

3.12 Application of the CCA to the study

While it is logical to assume that an approach such as the CCA is applicable to different cultures and social research with several marginalised population segments, it is also important to realise that no theory is all inclusive. Some of the constructs may need to be adapted to make them more relevant to this study focusing on preventing HIV incidence through use of voluntary medical male circumcision (VMMC) and condoms. As such, there are also some key characteristics of the culture centred approach which directly relate to this thesis. These are voice and dialogue, structure, context and space, as well as criticism (Dutta, 2008).

The CCA privileges dialogue and regards it as a moral commitment. As an approach, the CCA strives to ensure that there is dialogic engagement between members of a subaltern

community who are largely voiceless, and the structures which impact on their health. In the words of Paulo Freire (1970), "being dialogic is not invading, not manipulating, [and] not imposing orders (p.46). Being dialogic is pledging oneself to constant transformation of reality." One of the critical commitments of the CCA is foregrounding the voice of the subaltern participant (Dutta, 2008). In the context of this study, in-school adolescents are a marginalised population. Because of their marginalisation, these adolescents continue to exist and negotiate their sexual and reproductive health in contexts characterised by information vacuums and constrained access to health communication resources.

Furthermore, in terms of the role of the researcher, the CCA proposes a shift in perspective. In the context of the CCA, the researcher's role changes from that of an all-knowing interventionist who designs and implements health interventions on behalf of passive recipients to that of a listener, and participant who foregoes his privileged position and actively engages subaltern members in dialogue (Dutta, 2008). Subalternity can be understood as the position of being muted by the dominant paradigm, and being located on the margins (Dutta, 2008). Therefore, the CCA has a significant implication on the methodological approach used in this study since adolescents are given an opportunity to articulate their specific realities. For example, the study seeks to demonstrate the significance of understanding the meanings of combination HIV prevention as voiced by the youth. Essentially, the CCA became the tool for exploring the experiences of in-school adolescents in the context of HIV prevention with reference to VMMC and condoms in mitigating HIV incidence.

Considering the above, it is the communicative marginalisation played out in the lack of access to communicative spaces that this study seeks to interrogate. By implication, communicative marginalisation refers to the condition of being erased, unseen or silenced from articulating health concerns through the dominant discursive spaces (Dutta, 2008). It is on these discursive spaces that policy issues are discussed and evaluated. Dutta (2008) laments that

health policies are often crafted on behalf of the marginalised without the policy elites seeking to ensure participation by the subaltern. By making in-school adolescents subjects, rather than objects of social research, this study seeks to challenge the dominant approach to health communication whose argument is that decisions regarding adolescents must be arrived at by adults who act in the interest of youths.

3.13 Contextualising the 'new' sociology of childhood

This study foregrounded the young population; in-school adolescents as its key research participants. Conducting research *with* the youth is in keeping with the paradigm, 'new' sociology of childhood (James & Prout, 1990). James and Prout's (1990) germinal concept of the 'new' sociology of childhood has broader implications for contemporary critical youth studies, a paradigm to which this current study largely subscribes. Consistent with this paradigm, the current study is located within the contours of the philosophy of distributive justice. In social research, distributive justice is pre-occupied with the goal of redressing previous societal injustices (Marshall & Rossman, 2011). The logic of employing this approach finds relevance in the fact that an ethical researcher conducting research with humans has the prerogative to seek social justice.

As highlighted above, social justice entails a due consideration for previously marginalised populations such as the youth in general, and youth in-school in particular. Several scholars offer a spirited defence in favour of conducting research *with* the 'marginals' in pursuit of remedying previous injustices (Conrad et al., 2015; Goldberg, 2013). There is no debate that the youth are 'othered' in social research (Conrad et al., 2015). Furthermore, these authors contend that consistent with contemporary ethical guidelines for social research, excluding "individuals from the opportunity to participate in research based on attributes such as age" does not constitute best practice (p.110). Similarly, Singh et al. (2006) assert that because adolescents bear the brunt of the HIV and AIDS epidemic, particularly within the

context of sub-Saharan Africa, studies in this group are not only critical but also pertinent, and they constitute best practice.

In pursuit of a social justice agenda, which the researcher surmised that it would enhance engagement with the youth (conceived as marginals) in a critical sense, as the title of this thesis intimated; the researcher was keen to conduct research *with*, rather than *on* in-school youth. The researcher is conscious that some readers might interpret *"with"* as implying a participatory action research (PAR) approach, which was not the case in this study, hence the need to raise a note of caution. Foregrounding the preposition *"with"* simply serves to locate the research within the contours of Health Promotion, a field synonymous with commitment to a social justice approach to public health matters.

Apart from such apparent dividends synonymous with conducting research *with* young participants as the opportunity for meaningful engagement to co-create knowledge that is relevant to young key populations (YKPs), doing so can be immensely rewarding to the researcher. Precisely, it provides a window through which the researcher can explore young people's ways of knowing and meaning making (Conrad et al., 2015). The adult researcher gains a glimpse into the life worlds of adolescents. On the other hand, the youth participants get an invaluable opportunity to define their material realities, and importantly share their own constructions of reality.

Selecting in-school youths as the primary focus in this study did not only serve an ethical mandate, that of affording the previously marginalised and muted voice an opportunity to be heard, but also assisted in (re)asserting the youth's social agency. Both the notions of voice and social agency proved to be critical. The study therefore, created a space for asserting the social agency of marginalised youth participants. More so, the strategy to foreground youth participants did not only succeed in granting the in-school adolescents a sense of self, but

further demonstrated deep respect for their worldview which is clearly critical to health promotion interventions such as mitigating HIV incidence through a combination prevention approach.

In conducting research, it is possible to marginalise some population segments (Greenwood & Levin, 2000). Research can perpetuate hegemony through traditional stereotypes where 'othered' populations such as the youth are relegated to the margins while researchers pre-occupy themselves with the 'centre' (Goldberg, 2013). In research, adults epitomise the centre, and they are often privileged to speak on behalf of children and the youth, a scenario this thesis accuses of being unsustainable, conformist and importantly in conflict with the ideals of the United Nations' (1989) *Convention on the Rights of the Child*. This watershed convention stipulated that, "children [and/or the youth population in general] be informed, involved and consulted about matters that affect their lives" (Conrad et al., 2015, p.115). Working with the youth population in the field of health promotion, Flicker et al. (2008) proposed that the youth should be regarded as community assets, privileged with the potential to forge viable partnerships in making a diagnosis of community health challenges and developing possible solutions.

3.14 Conclusion

This chapter contextualised Zimbabwe's response to the HIV/AIDS epidemic. It provided an account of the socio-economic and political environment. In terms of the socio-economic aspects, the impact of the economic structural adjustment programme (ESAP) was given prominence as it impacted on social service delivery which in turn affected the country's health system leading to its total collapse. Politically, discussion focused on the "crisis decade", starting from year 2000, and its impact on the health sector and other social determinants of health. Discussion also focused on HIV/AIDS and the policy environment. Doing so helped to locate the position of voluntary medical male circumcision (VMMC) for HIV prevention in the

country's response to the AIDS epidemic. The chapter also focused on the theoretical frameworks for the study, which are Dutta's (2008) culture centred approach (CCA), and James and Prout's (1990) "new" sociology of childhood. Using theory triangulation in this study is critical to foregrounding the voices of the marginalised youth who experience their sexual and reproductive health from the margins.

CHAPTER 4
METHODOLOGY

4.1 Introduction

According to Terre Blanche and Durrheim (2006, p.6), "methodology specifies how researchers may go about practically studying whatever they believe can be known." It is critical to acknowledge that the terms method and methodology are used in conflicting and often confusing ways in research literature (Carter & Little, 2007). However, defining methodology is beyond the mandate and scope of the current chapter. Suffice it to say that the methods and techniques used in executing the study are described comprehensively, to paint a clear picture of how the data was collected and analysed. Effort is made to meticulously, logically and succinctly describe the research setting as well as to provide a rationale and justification for the research design considered ideal for this study.

The chapter describes the research paradigm and design, methods and techniques used in identifying participants, the collection, presentation and analysis of data (Marshall & Rossman, 2011; Mouton & Muller, 1998). The logical descriptions of the various steps taken, and the justifications provided for each of the steps and decisions, resonate with Mouton and Muller's (1998) conceptualisation of methodology as, "a systematic approach to research which involves a clear preference for certain methods and techniques within the framework of specific epistemological and ontological assumptions" (p.2). Providing this definition does not invalidate an earlier claim regarding the reluctance to be pre-occupied with the definition of methodology, and risk being bogged down in technical jargon, but rather seeks to emphasize that social inquiry ought not to be haphazardly conducted. Importantly, the definition in question merely foregrounds the centrality of logic in social inquiry, and the role played by both epistemology and ontology.

4.2 The study context– Zimbabwe

Zimbabwe is a landlocked southern African country with a population of approximately 13 million people (Government of Zimbabwe, 2015). It covers an approximated area of 390,784 km² (Duri et al., 2013). The country is divided into ten administrative provinces which are sub-divided into 62 districts (Government of Zimbabwe, 2015). This study was conducted in two of the fourteen districts found in the Midlands province, Mberengwa and Zvishavane Urban. The two districts are geographically located at the bottom of the mineral rich Great Dyke region which stretches south-northerly across the country. While Mberengwa boasts of both agriculture and small scale-indigenous mining activities, Zvishavane Urban is a purely mining town sustained by the extraction of four different minerals; asbestos, diamond, gold and platinum, making the small but inversely populous town the hub of Midlands' mining industry. Furthermore, Zvishavane is a road transport nodal linking Harare to the north, Masvingo-Mutare to the east, Beitbridge to the south, and Bulawayo to the west.

Like border towns, mining establishments and transport route nodes are HIV hotspots (Helman, 2007). The case of Zvishavane and Zimbabwe in general is further exacerbated by a labyrinth of other factors in as far as both HIV incidence and prevalence are concerned. For example, due to the economic doldrums experienced over the last two decades, coupled with a political quandary precipitated by the cataclysmic, and allegedly despotic rule of former President Robert Mugabe, migration trends in Zimbabwe demonstrate dominance in urban to rural migration (Government of Zimbabwe, 2015) and cross-border movement as living standards fall (Duri et al., 2013).

Economic stagnation, migration and poverty are among the key drivers of the HIV/AIDS epidemic (Helman, 2007). Mining operations at Sabi gold and Shabane asbestos mines recently succumbed to the current economic woes and operations hopelessly halted, leaving Mimosa Platinum and Murowa Diamond as the only operational large-scale miners.

This precipitated an unprecedented wave of unemployment and abject poverty in Zvishavane and its hinterland. The consequences of unemployment are far reaching, and impact negatively on susceptibility and vulnerability to HIV incidence.

The chain reaction culminated into both formal and largely informal gold mining activities christened *Chikorokoza* in the dominant, vernacular Shona-Karanga dialect. A booming commercial sex industry 'survival sex' sprung up as illegal miners converge in Zvishavane from the vast hinterland of Mberengwa, Chivi, Filabusi, Shurugwi and Zvishavane rural districts as the hunt for the 'king of metals' – gold, stiffens. While Mberengwa is also littered with small scale gold mines including C-Mine and Vanguard, it is in Zvishavane where the gold sales are transacted, and the proceeds spent. In pursuit of logic, the cascading effects of unemployment, poverty and informalisation of the economy on HIV incidence and prevalence cannot be overemphasized. It is these and other factors that made the two districts fertile ground for this study. These two districts were purposefully selected due to, among other things, the fact that they are culturally diverse, with Lemba and Yao cultural circumcisers adding to the diversity largely comprising the *zindji* (non-traditionally circumcising tribes).

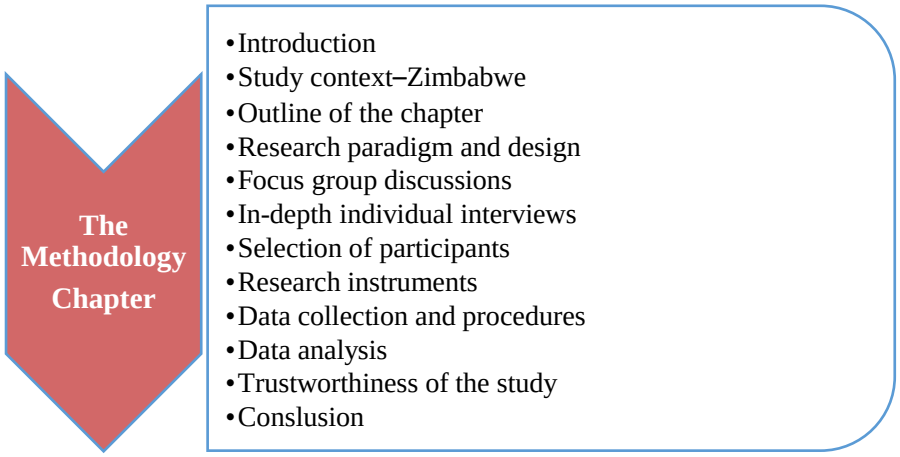
On the other hand, Zimbabwe being one of the priority locations for the roll-out of voluntary medical male circumcision (VMMC) for HIV prevention (NAC, 2015), there are several hospitals in both Mberengwa and Zvishavane Urban districts offering free VMMC to the public (Shumba, 2014). Zimbabwe is among countries classified as priority locations for VMMC roll-out because of its generalised and hyper-endemic HIV epidemic, coupled by low prevalence of male circumcisions (Duri et al., 2013; Matovu et al., 2007). In Zvishavane Urban, VMMC is only offered at Zvishavane District Hospital (White Hospital), while Mberengwa has several healthcare centres offering this important health service. These are Masase, Mnene and Msume mission hospitals, and an exceptional case of Jeka Rural Hospital which is a government healthcare centre.

Population Services International (PSI) is the key implementer of the *Pinda MuSmart, Ngena ku Smart, Get Circumcised Today* programme, and uses a social marketing strategy to popularise the circumcision drive. In collaboration with partner organisations such as The President's Emergency Plan for AIDS Relief (PEPFAR), United States Agency for International Development (USAID), ZAZIC, a local health consortium comprising the Zimbabwe Association of Church Hospitals (ZACH), Zimbabwe Community Health Research Project (ZiCHIRe), and University of Zimbabwe College of Health Sciences-Clinical Trials Research Centre (UZCHS-CTRC) and the Ministry of Health and Child Care (MoHCC), PSI embarks on back to school campaigns targeting in-school youth, as well as using schools as their recruiting grounds for circumcision clientele. Young boys above thirteen years of age are recruited from secondary schools, ferried, and circumcised at the various centres identified above.

4.3 Outline of the chapter

Overall, this methodology chapter is presented under the main headings summarised below.

Figure 4.1 Outline of the methodology chapter



Source: Author

4.4 Research paradigm and design

A common characteristic of paramount significance is that all scientific research is carried out within the confines of a given paradigm (De Vos, 2005). Therefore, it is incumbent upon researchers to clearly indicate to their reading public, the specific paradigm within which the study in question is located, and of course adequately motivate such a choice. Put simply, a paradigm refers to ways in which researchers view their material, and this is influenced by fundamental beliefs namely; ontology, epistemology and axiology. These beliefs ultimately influence the research methodology (Wahyuni, 2012). The current study uses a qualitative approach and is located within an interpretivist paradigm. Interpretivism subscribes to the existence of multiple realities, and subjective meanings which are ontological and epistemological orientations, respectively (Hennink, Hutter, & Bailey, 2011; Wahyuni, 2012).

The salient tenets of the interpretivist paradigm are of relevance to the current study. Because interpretivism adopts the emic or insider perspective to research, which implies approaching social reality from the perspective of the participants or people concerned, the

adopted research paradigm meshes with the study's topic and research questions. The philosophical underpinnings of interpretivism are thus used as the lens through which to view reality as it is experienced, constructed and interpreted by the participants themselves. It is the participants who experience the world and produce subjective meanings. To answer the research questions, the views and opinions of the participants are of paramount importance. O'Connor (2015) asserts that, any researchable problem is better understood as a constitutive element of the social world largely explained from the vantage point of participants as social actors.

The current study employed a qualitative research design using a multi-method approach. The approach entailed focus group discussions (FGDs) comprising male and female learner participants (in sex segregated groups) with the aim to elicit multiple perspectives to illuminate the research issue. On the other hand, were in-depth interviews with adult participants to enhance data triangulation. These key informants were a diverse set, with different backgrounds, and purposively selected to provide a wide range of perspectives. These were teachers-cum counsellors, and health service administrators.

By its nature, a research design is more of a road map that describes the path linking the research questions to the actual implementation of the study. Others see it as an architectural blueprint (Durrheim, 2006). This conceptualisation of a research design has several connotations, including that this framework is put in place prior to the execution of the study and that compiling it requires some technical expertise. Importantly, the phrase 'architectural blueprint' emphasises that coming up with a robust research design requires a rigorous and well thought out process. However, viewing the research design as a blueprint implies a positivist orientation which apparently follows a linear path, and uses deductive logic (Neuman, 2014). From a qualitative interpretivist approach, research is an iterative process which is neither rigid nor sequential (Durrheim, 2006). Qualitative research assumes a non-

linear path, and uses inductive reasoning (Neuman, 2014). As such, pragmatic considerations were made in accordance with what the situation required.

The choice of a qualitative research design was primarily determined by the type of questions the study sought to address, that is, to gain a deep understanding of in-school youth's perspectives on the use of a combination prevention approach (VMMC and condoms) to stem the tide of HIV among this selected group. According to Carter and Little (2007), "Methodology shapes and is shaped by research objectives, questions, and study design" (p.1316). Furthermore, these authors argue that epistemological and ontological assumptions to which the researcher subscribes play an important role in the choice of the research design. Specifically, I subscribe to the interpretivist paradigm, and therefore an inclination towards naturalism gave impetus to the adoption of a qualitative design. Naturalism is pre-occupied with studying people in the naturally occurring social milieu (Spicer, 2012). This was further buttressed by the limitless benefits of a qualitative approach which include enabling the researcher to explore the broad contours of diversity among social actors. Furthermore, the fact that depth takes precedence over breadth in qualitative research (Ulin, Robinson, & Tolley, 2005), strongly influenced the decision to select this research design.

In support of a qualitative approach, Poovey (1995) noted, "there are limits to what the rationalizing knowledge epitomized by statistics can do. No matter how precise, quantification cannot inspire action, especially in a society whose bonds are forged by sympathy, not mere calculation" (p.84). This quotation may read like some kind of 'methodological fundamentalism', rigidly insisting on a given research design as 'the design' (Carter & Little, 2007). Logically, Poovey (1995) can be interpreted as simply emphasizing that some research questions can be best explored and understood using a qualitative approach since it seeks meaning and not generalisation. Generalisation is normative in, and synonymous with quantitative inquiry (Neuman, 2014). In this instance, the researcher wanted the opportunity

to pose questions that would elicit responses in participants' own words and this was important to fostering deeper understanding of the topic.

The nature of the topic of enquiry also called for a qualitative enquiry. Buve, Delvaux, and Criel (2007) noted that, use of VMMC, a surgical procedure as a recommended intervention to mitigate a public health problem of epidemic proportions such as HIV/AIDS is a novel idea in the long history of modern medicine. A qualitative design therefore, offered participants the opportunity to bring forth diverse and relevant dimensions the researcher might never have envisaged, something which is not possible in a quantitative study. To this end, focus group discussions (FGDs) and key informant interviews (KIIs) were used. The two constitute the most popular methods of qualitative data collection (Harding, 2013). Precisely, the decision to use these two methods was on the one hand influenced by the research questions the study sought to answer, while on the other hand it was an epistemic decision. Because both unstructured interviews and focus groups often assume an informal style, thereby precipitating a "naturally occurring conversation" (Spicer, 2012, p.482), the researcher saw this characteristic as being consistent with the qualitative approach. Below are further explanations of the research design in depth.

4.4.1 Focus group discussions

Focus group discussion (FGD) is a method of collecting qualitative data which often involves engaging a relatively small group of people in an informal discussion centred on a specific topic (Wilkinson, 2011). The use of FDGs as a data collection tool in social research is a firmly established tradition within the ambit of the qualitative paradigm hence it resonates with the current study design. While Wilkinson (2011) regards the FGD an informal discussion, this interaction is not necessarily a haphazard platform for exchanging views and sharing lived or daily experiences. Instead, it is the normal practice in qualitative research to have a moderator steering the discussion in a particular direction to solicit salient views or capture experiences

relevant to fulfilling the research objectives (Polkinghorne, 2005). In the current study, focus group discussions were guided by an interview guide and a moderator, hence the researcher argues that it cannot be "an informal discussion" as suggested by Wilkinson (2011).

Moderating an FGD requires skill since the quality of data collected is largely dependent on researcher competence (Harding, 2013; Polkinghorne, 2005). The researcher as a key instrument in qualitative research (Kvale, 1996; Patton, 1990) had to familiarise himself with the intricacies of social research, and ultimately master the requisite skills to conduct FGDs. The goal was to yield rich and thick data that could adequately answer the study's research questions. Fusch and Ness (2015) describe richness and thickness of data through a binary of quality and quantity, respectively. The current study sought to elicit both rich and thick data through exploiting the group dynamics characteristic of FGDs.

The group context enriches the data because participants directly question one another, seek further clarification and react to what they would have heard such that they unwittingly reveal more in terms of their individual perspectives. According to Krueger and Casey (2000), the FGD, by comparison to the individual interview presents a more natural environment because of group dynamics which operate in a manner reminiscent of the interactions in real life. Owing to this, focus groups are therefore synergistic (Stewart & Shamdasi, 1990) and the interaction of group members serves to generate the required data. This study sought to harness group dynamics to enrich the data and adequately answer the key research questions. Morgan and Krueger (1993) dismiss the myth that people are reluctant to discuss sensitive issues in group environments. Instead, they attest that FGDs have often enhanced frank and fulsome discussions.

FGDs were ideal for this study in several ways. They are an effective qualitative technique, often praised for enabling participants to exercise a considerable degree of control

over their own interactions (Morgan, 1996). Therefore, FGDs do not only enhance the Freirean process of raising consciousness (conscientisation), but also facilitate dialogue and member interaction which culminates into active co-construction of knowledge and meanings. If properly moderated, group interactions lead to deeper insight into why particular opinions are held (Krueger, 1988).

The researcher also chose FGDs not only because the group environment provides support to individuals within the group which promotes greater openness in participants' responses (Green & Hogan, 2005; Vaughn, Schumm, & Sinagub, 1996), but also due to the nature of the topic under scrutiny. The study aimed at soliciting learners' views regarding a combination approach including VMMC and condoms to mitigate HIV incidence among in-school adolescents, hence a diversity of views was being sought. Thus, FGDs were selected out of necessity since the researcher wanted to afford participants an opportunity to question each other's convictions in a naturalistic milieu. Because FGDs are group in-depth interviews, they were an appropriate tool since they enable participants to question each other's frames of reference on the subject of interest (Finch & Lewis, 2003), which often results in the extraction of rich and thick data that illuminates the research problem.

There is no consensus regarding the ideal number of participants in each FGD. Practical factors such as the moderator's level of competence and the complexity of the discussion often determine the size of an FGD (Harding, 2013). Although FGDs typically consist of seven to ten participants, anything within the range of four to twelve is acceptable (Krueger, 1988). In principle, FGD participants should be homogenous, and preferably strangers (Krueger, 1988; Morgan, 1988). For Krueger, "the rule for selecting focus group participants is commonality, not diversity" (1988, p.26). Furthermore, Barbour (2007) recommends that a guiding principle in the selection of participants is that homogeneity of interest must prevail among group members, meaning that participants ought to have something in common, but obviously not in

terms of their views. Disagreement is acceptable and may be a significant demonstration of the strength characterising participants' convictions (Harding, 2013).

In terms of group composition, boys and girls had separate focus groups. The rationale behind single-sex groups was to mitigate the broader dynamics of gender power (Tonkiss, 2012). By comparison, students placed in sex-segregated groups are more comfortable and openly discuss sensitive topics than those in mixed groups (Neuman, 2014; Peek & Fothergill, 2009). A total of seven FGDs were conducted in this study, with the aim to reach theme saturation. Theme saturation was achieved at the third school. Four FGDs were conducted with boys while three FGDs had girls, and each group had six to eight purposively selected participants. Among the boys, FGDs comprised both the medically circumcised the uncircumcised, or yet to be circumcised and culturally circumcised. The rationale behind including girls in the study was to explore their understanding of the role played by VMMC in HIV prevention, and to elicit their views regarding the broad topic of HIV combination prevention.

Participants were adolescents between the ages of 16 and 18 years, and while they were schoolmates, effort was made to avoid selecting friends, and or relatives to participate in one focus group. Ideally, total strangers make the best of FGD participants (Finch & Lewis, 2003; Krueger, 1988). FGDs conducted with strangers facilitate both open questioning and disclosure (Finch & Lewis, 2003), which ultimately culminates into realising rich and thick data.

Several authors caution that an FGD must not be too small as this may render the desire to generate meaning such a difficult task (Harding, 2013). Group size must not be too big either, since the moderator must afford all the participants an opportunity to adequately contribute to the salient issues (Krueger, 1988). In this study, the researcher aimed at ensuring that FGD participants felt a sense of being valued. Doing so was part of the broad aim of creating a

permissive environment to foster both openness and tolerance for diversity of perceptions. While conducting several FGDs can be quite strenuous, the fact that doing so adds rigour to the findings can be rewarding. Furthermore, it is unlikely that patterns established in the findings may be due to unrepresentative views of the individual participants or the researcher's misinterpretations of contributions by participants (Barbour, 2007).

4.4.2 In-depth individual interviews

Interviews have long been viewed as the "gold standard" for qualitative research (Barbour, 2008, p.113). Owing to that, some argue that it is not necessary to motivate for using interviews as a form of qualitative data collection (Harding, 2013). However, it remains critical that researchers should strive to lay bare the reasons for their preference for interviews to other qualitative forms of data collection. Often, qualitative in-depth interviews are primarily used when the researcher seeks to capture people's lived experiences considering a given topic (Hennink, Hutter, & Bailey, 2011). In this study, the main reason for selecting unstructured face-to-face in-depth interviews was to enable exploring adult stakeholders' perceptions of mitigating HIV incidence among in-school adolescents through a combination prevention approach. Unstructured interviews contain open-ended questions hence they are so permissive that the interviewer has the greater leeway to (re)formulate questions as the interaction may require (Sarantakos, 2005). Furthermore, the face-to-face interview mode of data collection was appropriate because it offers a full range of communication enabling both parties to respond to the non-verbal cues displayed by the other (Harding, 2013).

In his attempt to explain the implications of different theoretical underpinnings of interview research, Kvale (1996) articulates two dissimilar positions regarding interviewing namely the 'miner' and the 'traveller' metaphors. The 'miner metaphor' is classified under the ambit of the modern social science research model which assumes that knowledge is 'given', and "is understood as buried metal and the interviewer is the miner who unearths the valuable

metal" (Kvale, 1996, p.3). This metaphor is consistent with an objectivist, positivist paradigm (Elton-Chalcraft, 2011). On the other hand, the 'traveller metaphor' belongs to the interpretivist paradigm, to which the researcher belongs; and importantly this study is firmly anchored on the interpretivist paradigm.

Of the two theoretical positions presented by Kvale (1996), the traveller metaphor appealed more to the researcher, despite that both epistemic positions view the interviewer as a key research instrument (Kvale, 1996; Rubin & Rubin, 1995). Therefore, the researcher used the qualitative interview to engage the adult participants in deep, animated conversations. According to Webb and Webb (1930, p.130 cited in Ritchie & Lewis, 2003), the interview is a "conversation with a purpose". Unlike an ordinary conversation, the in-depth interview is guided. Precisely, the interview schedule serves as a memory aid, thereby ensuring that the relevant questions are reflected on, and adequately explored (Hennink et al., 2011). To do this, an interview schedule was used. The interview guide contained all the broad areas the researcher intended to explore in-depth. To extract rich and *thick* data, amplification probes and follow-up questions were used. An amplification probe is one used to encourage a participant to provide more detail that is relevant to the topic (Hennink et al., 2011). Legard et al. (2003) argue that a single probe may not be adequate, hence the need to supplement with follow-up questions.

The qualitative interview grants the researcher the opportunity not only to listen to the participants' views that are relevant to a given subject of study, but to also seek further clarification through probing (Harding, 2013; Rubin & Rubin, 1995). As their name suggests, in-depth qualitative interviews were also conducted in line with Kvale's (1996) concept of deep-drilling to access the deep buried nuggets of "languaged data" (Polkinghorne, 2005, p.138). It is noteworthy to raise caution that use of a mining related imagery should not be interpreted as the researcher's inclination towards the miner metaphor discussed above, but

rather the terminology is used because it laudably emphasizes the notion of in-depth interviewing particularly that qualitative interviews give prominence to depth and not breadth. Since qualitative research involves fewer participants than those used in quantitative studies, the qualitative researcher should spiritedly strive to obtain rich and thick data from those few participants.

Because depth takes precedence over breadth in qualitative research mentioned above (Ulin, Robinson, & Tolley, 2005), the researcher saw it ideal to have multiple interview sessions with each of the nine adult participants. The aim was to get fully nuanced accounts of individuals' daily experiences viewed as being of relevance to the study. Others have critiqued the common one-shot sessions covering a duration of about 60 minutes as being insufficient to produce adequate, rich and worthwhile languaged data (Seidman, 1991, 1998; Polkinghorne, 2005). Similarly, the researcher used repeated sessions to develop good rapport, and importantly to elicit rich and thick data from the participants.

Overall, a research design should provide a clear strategy which encompasses the practical techniques to be used in the implementation of the study (Durrheim, 2006). These refer to strategies used to select participants, implement data collection procedures, and to conduct data analysis. A detailed description of these three categories is presented below.

4.5 Selection of participants

Participants in this study, who were male and female in-school adolescents (circumcised and uncircumcised males) for the focus groups and selected adult participants (teachers and health service administrators) for key informant interviews, were purposively selected. Carter and Little (2007) posit that qualitative research samples purposively, emphasizing that participants are selected not to be statistically representative of a bigger population, but rather to fulfil an investigative purpose. Honigmann (1982) and Burgess (1984) refer to this type of qualitative

participant selection as judgemental sampling. However, LeCompte and Priessle (1993) argue that the term criterion based is a better alternative to purposive sampling. This argument is validated by the fact that all sampling (whether quantitative, qualitative or mixed -methods) is essentially purposive (Ritchie, Lewis, & Elam, 2003). However, purposive sampling features the most in the relevant and vast literature on social research.

Perhaps some clarification regarding the term sampling is necessary as this term was borrowed from the quantitative paradigm, and therefore its use in qualitative studies should be explained. The term is loosely used in both qualitative and quantitative approaches to refer to the selection of research participants (Durrheim, 2006; Polkinghorne, 2005). However, others argue that its use in qualitative research often create confusion (Neuman, 2014) because the implication is such that participants are representative. Similarly, Durrheim (2006), although not disapproving the use of the term sampling in qualitative research per se, asserts that its central concept is representativeness and hence, it is largely acceptable in quantitative designs. Representativeness is considered irrelevant in qualitative studies because the sample is not supposed to be statistically representative (Ritchie et al., 2003; Sarantakos, 2005). Instead, Flick (1998) argues that it is the people's relevance to the topic of interest rather than representativeness which determines the way suitable participants are selected. However, other researchers such as Miles and Huberman (1994) consider representativeness an indispensable element even in qualitative research. Importantly, participants in the current study were selected based on their relevance to the topic.

Purposive selection of participants is in tandem with the qualitative approach adopted as ideal for this study and its objectives. According to Polkinghorne:

> *Because the goal of qualitative research is enriching the understanding of an experience, [therefore] it needs to select fertile exemplars of the experience for study.*

> *Such selections are purposeful and sought out; the selection should not be random or left to chance* (2005, p.140).

Therefore, study participants were not only selected because they were conveniently available at the time the researcher wanted to conduct the study, but rather they were chosen because they met certain stipulated characteristics. To be precise, convenient sampling is the most criticised method of selecting participants in qualitative research (Polkinghorne, 2005). Owing to that, the researcher avoided the temptation to use convenience sampling since the intention was to produce quality data that would adequately illuminate the research issue.

To select information-rich cases (Patton, 1990), a priori sampling was used to select participants. This technique involves the stipulation of specific characteristics and structure of selection criteria ahead of the interview (Ulin et al., 2005). To gather rich data, with several layers (multi-layered), detailed and highly nuanced, overall, homogeneous samples were drawn, as suggested by Krueger (1988). Participants for focus group discussions (FGDs) were those circumcised either the medical and cultural way, as well is those who were not (or yet to be) circumcised. The rationale behind the circumcision-based segregation of focus groups was to enhance the process of data elicitation in conducive focus group environments. Because the researcher sought to achieve a diverse mix of participants to elicit multiple perspectives, the uncircumcised, drawn from both traditionally circumcising and non-circumcising cultural backgrounds were also selected. Religious affiliation was also considered, to cater for the main religious groupings, which are Christianity and African Traditional Religion (ATR). Nevertheless, belonging to a specific focus group was solely based on circumcision status.

Although the individual groups were homogeneous as indicated above, overall the study used heterogeneous samples in the sense that different FGDs with different participant compositions were used. Ritchie, Lewis and Elam (2003) assert that heterogeneous samples are appropriate when the research aims to identify and explore central themes dominant across

the diversity of cases or people. To align the research with ethical requirements, participants were supposed to be older than 16 years of age. Above all, willingness to participate was a critical criterion; Polkinghorne (2005) emphasizes this requirement. Participants were selected through a snowballing strategy. Snowball sampling or the chain referral technique, as it is alternatively known entails requesting already identified participants to suggest others with special understanding of the topic in question, while at the same time "meet [ing] some important predetermined criterion" (Polkinghorne, 2005, p.141). This strategy was ideal since the topic had personal aspects such as circumcision status. Circumcision status is a personal affair, thus circumcised participants may be regarded as 'hard-to-reach' or 'a hidden population', making it difficult for a researcher to locate them. Researchers need use skill to arrive at hidden populations (Miller, 2003; Peek & Fothergill, 2009).

In this study, the researcher approached those learners whom teachers knew were culturally circumcised, especially those who use the *Zhou* or elephant as their totemic symbol. The researcher then discussed about his study with those learners and requested them to identify and recommend fellow colleagues who were medically circumcised. He would then approach and invite those learners to participant in the study. Once initial prospective participants were identified, the process of recruitment became easy. Learners would identify fellow learners with the stipulated characteristics whom the researcher would approach and invite to participate. Although teachers had some knowledge of those learners who attended health education sessions on VMMC for HIV prevention as part of the recruitment drive, they had limited knowledge of those who finally got circumcised. Despite their limited knowledge, suggestions by teachers also enhanced the initial scouting process.

Therefore, teachers were key informants in this study. An informant in field research is a reliable person that is knowledgeable about the field. The researcher develops a relationship with the key informant (Neuman, 2014). Key informants are an important resource in social

research because they make the process of recruiting participants relatively easy. Most importantly, they help the researchers to locate hidden or hard-to-reach participants (Peek & Fothergill, 2009). In the same vein, teachers were very invaluable persons in the process of participant selection.

A total of nine adult participants (five males and four females) were selected to participate in key informant interviews (KII). These were either educators in charge of guidance and counselling or health administrators for a VMMC relevant organisation. The majority (seven) were teachers while two were health administrators at VMMC relevant organisations. Youth participants were learners aged 16 to 19 years[3]. Circumcision status was considered because the study sought to explore the views of circumcised and non-circumcised adolescent males. Willingness to participate in the study was an important inclusion criterion.

4.6 Research instruments

This section focuses on the study's research instruments, namely the researcher(s) and the interview guide. Questions on the interview guide were generated after a thorough review of relevant literature and a scrutiny of the research problem, research questions and study objectives.

4.6.1 Researcher as key instrument

In qualitative research, the researcher is the key instrument (Patton, 1990). This characterisation makes the researcher inseparable from the research (Jackson, 1990), and has broader implications. For example; the credibility of the researcher is of significance in qualitative research, and it is so because he/she is the main instrument of both data collection and analysis (Fusch & Ness, 2015; Patton, 1990; Shenton, 2004). The principal researcher was

[3] Detail relating to the actual number of participants and other demographic details are presented in the first Findings chapter (Chapter Five).

at the forefront of data collection and collected most of the data except for three FGDs with school girls where female educators were brought on board as co-researchers. The minimum qualification for the co-researchers was a diploma in education, and importantly, these were subjected to thorough training to improve their interview skills, for example; probing, iterative questioning and rigorous ethical considerations in the conduct of social research. The principal researcher was exquisitely aware that among other factors, the quality of data is dependent on researcher competence, hence adequate time and resources were dedicated to researcher training and preparation for quality data collection.

4.6.2 Interview guide

Interviewing is consistent with an interpretive approach which "aims to explain the subjective reasons and meanings that lie behind social action" (Terre Blanche & Durrheim, 2006, p.7). The data collection tool used in this study was an interview guide. It was used to gather data that was relevant to answering the key research questions. The structure and order of the questions contained in the interview guide was not concrete but rather fluid as they could always be adjusted depending on how the conversation would unfold. The key areas of exploration included: VMMC promotion among in-school youth, condom accessibility among adolescents in schools, knowledge of combination prevention, and the acceptability of VMMC as a comprehensive HIV prevention strategy. Krueger (1998), identifies a typology of opening, introductory, key, and ending questions. Similar issues were explored in both key informant interviews and focus group discussions.

4.6.3 Piloting the interview guide

To produce the richest data possible, and evade the risk of collecting flawed data, the interview guide was pilot tested with a similar sample (and these participants did not participate in the main study). As recommended by Hennink and colleagues (2011), a small number of participants were used during the pilot phase. Twelve adolescents and six adult participants

who were similar to the study participants participated in the pilot study. Pilot testing the research instrument proved to be very important in a diversity of ways. For example, to establish; if questions were understood, if research questions could be answered using data generated through the interview guide, and if the questions were logically arranged. Overall, the process of piloting helped to solicit feedback from the participants which significantly improved the interview guide. Through the pilot phase, the principal researcher got an opportunity to rekindle his research skills. This was important, particularly given that he had to train co-researchers (female educators) who would conduct FGDs with female learner participants.

4.7 Data collection and procedures

Any research that involves learner participants or public schools in Zimbabwe is sanctioned by the Ministry of Primary and Secondary Education's (MoPSE) Department of Policy Planning, Research and Development situated at head office in Harare. It is procedural that initial gatekeeper permission is sought from the head office which generates a letter that the researcher must present to the provincial education director (PED) in charge of the research sites. The PED then formally advises the districts in question to allow the researcher access to the study sample. As such, the researcher approached the MoPSE head office seeking gatekeeper permission to conduct this study among selected schools in the Midlands province and was advised to submit a full study proposal with clear objectives and the relevant data collection tool(s), (an interview guide). A detailed study proposal accompanied by an interview guide was submitted.

Gatekeeper permission was granted through a formal letter on the following day and the researcher was mandated to judiciously follow all the protocols which were stipulated therein. The researcher presented the written permission to the provincial education director (PED) who actioned the approval and generated another letter of permission directed to the

district education officers (DEOs). All this was done within a week's time. The letters generated at each of the three hierarchical stages were used to apply for ethical clearance from the University of KwaZulu-Natal's Humanities and Social Sciences Research Ethics Committee. Ethical clearance was granted (HSS/1515/015D) (see Appendix 1).

Equipped with the clearance certificate and gatekeeper letters, the researcher entered the field on an introduction and familiarisation tour, and to present the research plan to the local gatekeepers at the research sites (head teachers at selected schools) and to establish initial contacts. Key informants (KIs) (teachers) were identified at each school and relevant organisation during both the initial and subsequent visits. Communication with KIs was initiated and sustained telephonically.

4.7.1 Entry into the research site

Entering the research site requires the researcher to employ common-sense judgment and relevant skills for social interaction (Neuman, 2014). Therefore, the researcher accepted the schools' proposal to use female teachers nominated by school authorities and trained them in interviewing skills for them not to only facilitate focus group interviews with the girls, but also to better address the study's key questions. The use of Guidance and Counselling educators was acceptable on the understanding that there already existed a relationship of openness and mutual trust between these educators and the learners. This assumption is consistent with the ethics of teaching Guidance and Counselling in schools, compelling educators to uphold the twin principles of privacy and confidentiality.

The good rapport, openness and trust between Guidance and Counselling teachers and their learners was viewed as strength to foster the quality of data and mitigate the risk of participants answering to questions in a socially desirable way. While the researcher harbours great respect for Morgan and Krueger (1993) and their work in focus group research, he is

somewhat uncomfortable with their dismissal of conformity as not being a problem arguing that, "focus groups never push groups to make decisions" (p.7). The researcher views conformity as a problem that a good researcher must strive to mitigate. Consequently, the researcher reiterated that moderators should, in their opening instructions, emphasize that there were no right or wrong answers since the study sought to explore as much as possible, participants' views regarding the use of a combination approach comprising condoms and VMMC to mitigate HIV incidence among in-school adolescents.

4.7.2 Navigating the initial, ethical and methodological hurdle

Initially, the strategy was to recruit independent female research assistants to help interview female learners as a way of enhancing openness in discussions. However, authorities (at the school level) did not approve of the use of external female research assistants neither would they allow the researcher to interview learners of the opposite sex. Therefore, the researcher grappled with an ethical dilemma and a methodological challenge that had both ethical implications and huge potential to negatively impact on data quality. However, in hindsight, upon reflection on the nature of this initial hurdle, the researcher realised the other aspects he had overlooked during the study proposal stage. The researcher realised that establishing a relationship of trust and openness between female learners and an adult male stranger would have perhaps taken an eternity.

Gatekeeper letters did not stipulate that a non-staff member could not work as an interviewer in FGDs with girls. As such, school authorities viewed this as a major omission by the MoPSE's department of Policy Planning, Research and Development. They felt that the study was of a sensitive nature so much that they needed to be certain that no irregularities would occur. They preferred that female teachers conduct FGDs with girls to ensure that the discussions remain focused on the relevant topic and to guard against any eventuality. They indicated that the policy framework within which they were operating was too restrictive,

particularly with regards to the girl child. Their fear of the unknown prompted them to suggest that their own teachers should be tasked with conducting the interviews, as a contingency measure. From both a theoretical and methodological perspective, the decision to use female teachers aligned with feminist approaches which privilege women to interview participants of the female sex (Oakley, 1981).

Tacitly, the researcher used what can be termed 'social intelligence' to navigate the above hurdle, while at the same time striving to protect the integrity of the study and the quality of data. Female Guidance and Counselling teachers were suggested as a workable alternative by the local school management in the first school, and then the researcher used the same strategy with subsequent schools. Considering the rapport these teachers had with female learners, the researcher looked at what initially appeared as a hurdle as essentially a strategic opportunity to solicit rich and thick data.

Selected female teachers were then trained for a period of three days (1-hour session daily) by the researcher to enhance their data collection skills, and to uphold acceptable standards and efficiently navigate around ethical issues, and to mitigate the negative impact of power dynamics between teachers as authority figures, and the learners. This was based on the understanding that a skewed relationship had the potential to prejudice what the learners would choose to share with the interviewer (Elton-Chalcraft, 2011). In their study on understanding socio-cultural milieus and sexually transmitted infections in South Africa, Meyer-Weitz, Reddy, Weijts, Van den Borne, and Kok (1998) trained interviewers to enhance collection of rich and thick data. Rich and thick data is multi-layered, nuanced, detailed, expanse etc. (Dibley, 2011). The researcher was influenced by Meyer-Weitz and colleagues (1998) to train research assistants prior to data collection. Pilot focus groups conducted as part of researcher training were audio-recorded, discussed and evaluated by the researcher who then gave feedback to the teachers (research assistants).

To mitigate the possibility of learners not opening enough perhaps for fear of being negatively labelled, researcher training sessions emphasized such ethical demands as privacy, anonymity and confidentiality. During their training sessions with the researcher on conducting effective FGDs in such circumstances where power differentials exist, teachers as moderators of the FDGs were encouraged to reiterate the need to assure participants of total protection. A good moderator should feel obliged to ensure that an open and permissive atmosphere prevails during FGDs as a way of empowering participants to freely share their diverse points of view (Morgan & Krueger, 1993).

4.7.3 Data collection

As indicated above that a multi-method approach comprising key informant interviews and focus group discussions was used, data collection is thus discussed separately. The rationale behind this decision is the understanding that one group had young people and the other group, adults – obviously different issues and procedures were involved. Data collection through focus groups with learner participants is presented first, followed by key informant interviews with adults. This order is not in any way suggestive of the sequence in which data were collected since; data collection happened simultaneously depending on availability of either participants in each case.

4.7.3.1 Focus group discussions

Selected learner participants were invited to participate in the study. Using the language that they understood and felt comfortable to communicate in (*Shona-Karanga*), the study's aims and objectives were explained. Young people must be provided with clear and unambiguous information concerning the research study using a language they are best conversant with (Acton, 2003). Participants were informed that participation was purely voluntary, that they reserved the right to withdraw from the study at will without penalties, and that both anonymity and confidentiality were guaranteed as outlined by Wassenaar (2006). However, in the case of

FGDs, Liamputtong (2011) argues that promising confidentiality in focus group research is difficult as the researcher can only request participants to regard views shared by fellow participants as confidential information but cannot guarantee their compliance. Questions raised by participants concerning the study were clearly and adequately answered. The researcher(s) asked for permission from participants to audio-record the interviews and permission was granted.

Participants were then issued with informed consent forms (appendix 2), encouraged to read the information on the form and to ask the questions that they might have had. They were given the consent forms to take home for parents and guardians to grant permission to them to participate in the study. As observed by Acton (2003), obtaining informed consent from young people below the legal age of majority to participate in research is dependent on the amount of access adult gatekeepers are willing to grant researchers. The implication is that despite learners' willingness to participate, they may not do so without adults' consent.

Furthermore, research with young people is both ethically and legally complex (Wassenaar, 2006). As such, the researcher(s) remained vigilant, cognisant that having secured informed consent from parents or legal guardians, and permission from the school authorities to conduct the study did not take away the learner participants' autonomy and right to assent. Learner participants were enthusiastic to participate, and they assented to both participation and being audio recorded. Researcher(s) explained the benefits of recording, for example; easy capturing of participants' contributions, ensuring truthfulness of the data (that the data is captured in participant's actual words), and ultimately to enhance easiness of transcribing and data management. The ethical aspects of recording were explained satisfactorily, with emphasis placed on fact that the recordings would be solely for the study purpose and would be kept secure by the principal researcher.

All the FGDs were conducted after informed consent forms were signed by the parents or legal guardians of the learner participants in question. The interview venues were always on the schools' premises to ensure the learners' protection. Furthermore, a neutral location characterised by a supportive infrastructure to ensure that learners were relaxed was necessary. The interviews were slotted in during school hours and at times convenient to the school programme as the gatekeepers' conditions cautioned against any disruption of the learning, and or teaching programmes at the schools. The FGDs were conducted in the dominant *Shona-Karanga* dialect. The decision to use a vernacular language was arrived at in pursuit of learners' maximum freedom to express themselves since the schools were not strictly English medium. Both the principal researcher and the co-researchers (teacher assistant interviewers) were fluent speakers of the *Shona-Karanga* dialect.

Focus group discussions (FGDs) to elicit the views of in-school youth regarding use of voluntary medical male circumcision and condoms in HIV prevention among school learners were conducted. A total of seven FGDs were conducted with learners, four with boys and three with girls. Each FGD comprised six to eight participants. The researcher made a conscious decision to have groups with fewer participants. Preference for smaller groups to large groups was based on the estimation that having fewer participants makes it easier for the interviewer to direct the discussion towards answering the study's key research questions. Furthermore, all participants are afforded adequate opportunity to actively participate and explain issues if the group is reasonably small. Influenced by Freire's (1970) work among Brazilian peasants of subaltern status, the researcher subscribes to the school of thought that research has an empowering character. As such, he was keen to ensure that no single participant dominated the discussions and that all participants actively contributed.

Each focus group lasted for approximately 60 minutes. To supplement audio recordings, field notes were also taken during the interviews. Data collection spread over a

period of six (6) weeks. As a token of appreciation for participation in the study, the learner participants were each given a 'goodie bag' containing bath soap, body lotion, and toothpaste. Sanitary pads were added for the girl participants. The 'goodie bags' were given to learners at the end of the interviews.

4.7.3.2 Key informant interviews

All the ethical procedures explained above were followed as they applied to the adult participants. As proposed by Seidman (1991; 1998), the researcher conducted three sequential and strategically staggered sessions with each of the nine adult participants. The first one was meant to familiarise the participant with the topic and develop rapport. Establishing rapport with the participant is critical to the quality of data generated because there will be a desirable level of trust which ultimately leads to openness (Hennink et al., 2011; Steinke, 2004). It was assumed that the period between the first contact with the participant and the second interview would allow the participant to deeply engage with the topic leading to the interview yielding rich and thick descriptive data. The researcher had to listen to audio recorded interviews before conducting the final follow-up interviews where vague issues would be clarified.

4.8 Data analysis

Like the data collection methods and techniques described above, the analytic framework considered ideal for this study was influenced by both ontological and epistemological assumptions (Mouton & Muller, 1998; Marshall & Rossman, 2011). The recorded interviews and FGDs translated and were transcribed verbatim into written form by the principal researcher. Verbatim transcripts are considered both loyal and authentic, because they can be true to the intentions of the participant (Kvale, 1996). With the help of two independent moderators, the principal researcher painstakingly made all efforts possible to reduce the effects of distortions and bias. Because most interviews were conducted in the local *Shona-Karanga* dialect, the audio clips were initially translated to English.

Qualitative research tends to produce huge volumes of data, which some scholars suggest could be a result of unfocused interviewing (Kvale, 1996). It is arguable that the production of huge quantities of data is inevitable hence the inception of computer programming made data analysis more efficient. However, computer-based programmes are meant to assist with data analysis. Nvivo (QSR International, Melbourne, Australia) software programme was used to organise and manage the data through identifying categories (codes), themes and domains. However, such computer based qualitative data soft wares are only tools in the qualitative data analysis toolbox, and obviously they cannot human input to meditate on the data to arrive at a conclusion (Atherton & Elsmore, 2007; Morison & Moir, 1998).

Data was further analysed using thematic analysis. Thematic analysis using a six-phase method as explained by Braun and Clarke (2006) to, "provide a rich and detailed, yet complex, account of data" (p.78) was considered ideal for this study. The initial stage of data analysis was characterised by the researcher's perusal of the transcripts generated. However, Ulin et al. (2005) argue that in qualitative research, analysis is not a specific event but rather an on-going process that informally unfolds well before the formal stage of data analysis. In this study, each recorded audio interview clip was listened to prior to the next interview being conducted. This approach is supported by Lindlof (1995) who posits that transcription should be conducted immediately after the focus group interview to help shape the next discussion since it could highlight issues that required being followed-up, dropped or introduced. The researcher endeavoured to use Lindlof's (1995) suggestion to generate the richest data. Overall, Lindlof's (1995) approach helped to enrich the quality of the data collected.

Thorough reading resulted in the researcher becoming "immersed" in the data which precipitated an increased familiarity with the depth and breadth of the data sets. Immersing oneself in the data is analogously described by Fourie (2007) as 'deep-drilling,' a phrase that emphasises the essence of gaining a deep understanding of underlying issues in a study. In the

second phase, interesting features of the data were systematically coded. Relevant data was coalesced to each code.

Thirdly, codes were collated into tentative themes. At this stage, all data related to each theme were grouped accordingly. As such, some codes would form either main themes, sub-themes or they could even be discarded. Essentially candidate themes were combined, refined, separated or discarded. The fourth phase was that of reviewing the themes, verifying if they corresponded with coded extracts thereby creating a thematic map of the analysis. At stage four, there were two levels of theme reviewing and refinement and these were: reading each collated extract within individual themes and reading through the whole data set. This was followed by defining and naming of the themes and finally relating the analysis to both the research and literature.

Constant perusal of the data set for the researcher to be closely acquainted with the findings, a process described as 'immersion' culminated into the identification of four broad themes. A theme is defined as the main, recurrent idea. In simple terms, a theme captures some level of patterned experiences and views relevant to the research question (Braun & Clarke, 2006). To avoid the 'smash and grab' approach to research which scholars such as Holdaway (2000) warn against, the findings were discussed with study participants. Doing so served a duality of purposes, firstly to enhance data validation, and secondly, that step was an ethical consideration where the researcher sought to demonstrate responsibility for whatever undesired consequences that could have emanated from their participation in the study.

4. 9 Trustworthiness in the study

In line with the qualitative paradigm, quantitative terminology is deliberately avoided, not only to steer clear from the long-standing debates and proclaimed rivalry between the two major traditions, but also to demonstrate consistence with the research approach adopted in the

current study. Often, novice researchers, use the terms validity and reliability indiscriminately, even when referring to qualitative inquiry; doing so is a problem of nomenclature that should be avoided, not least to show the autonomy of the qualitative paradigm. The equivalence of validity and reliability is trustworthiness (Guba, 1981; Silverman, 2001; Shenton, 2004). Positivists often critique and question the trustworthiness of qualitative research, perhaps because it is assessed differently when compared to quantitative methods (Shenton, 2004). At the core of trustworthiness in qualitative research is capacity to sustain the argument that findings emanating from the inquiry are worthwhile (Lincoln & Guba, 1985). In assessing trustworthiness, researchers should strive to convince themselves and others that study findings are meaningful (Babbie & Mouton, 2003). The various strategies used to enhance trustworthiness in the current study are described below.

Guba (1981) identifies four important criteria to enhance trustworthiness in a qualitative inquiry. These are; credibility (internal validity), transferability (external validity generalisability), dependability (reliability), and confirmability (objectivity). Like validity and reliability, these critical aspects are interdependent (Babbie & Mouton, 2003). For example, one cannot talk of transferability in the absence of credibility, or credibility where there is no dependability. To ensure the credibility of findings, member checks were conducted where participants got the opportunity to check the data as well as the interpretation. This was an important exercise because it helped assess accuracy of the findings. Secondly, member checks yielded extra volunteer information that ultimately contributed to the richness and thickness of the data. The other strategy used in pursuit of credibility was peer debriefing. The researcher and the supervisors would meet regularly, and different epistemological and methodological aspects were discussed, and the interview guide was refined. Shenton (2004) argues that frequent debriefing sessions help widen the researcher's vision and may expose researcher bias and preferences which can then be mitigated. Because interviews were conducted in a local

dialect (*Shona-Karanga*) such that transcription was done concurrently with translation, transcripts were availed to two independent moderators to compare recordings with the written data.

Furthermore, triangulation of sources through use of FGDs and key informant interviews (KIIs) enhanced credibility. Triangulation is a process that involves looking at a topic from different viewpoints (Neuman, 2014). Denzin (2012) suggests that the concept of triangulation should be renamed 'crystal refraction' to emphasize the aspect of viewing the research issue from multiple vantage points. Most people understand triangulation of methods as involving a mixed method approach, combining qualitative with quantitative methods in one study (Creswell & Plano Clark, 2011; Tashakkori & Teddlie, 1998). However, using FGDs and KIIs in a single study is basically a form of triangulation. Furthermore, soliciting views from both adolescents and adult participants constituted triangulation. Neuman (2014) refers to this as triangulation of observers. FGDs and KIIs were combined in this study because it was a lot easy since the two are both qualitative techniques and therefore they complement each other very well. This kind of triangulation enhances credibility in qualitative research through a net gain: the strengths of each method more than cancel the weaknesses of their counterpart (Brewer, 2003).

In the current study, transferability was enhanced through providing thick descriptions of the data. Doing so was a way of placing the data in its proper context to allow the reader to understand participants' views in relation to a given topic. It was assumed that providing the nuances of the contexts in which discussions were held would help the reader understand the interview excerpts better. Furthermore, use of a purposive sampling strategy also contributed to transferability. Participants comprising the study sample were relevant to the topic. In line with arguments by prominent scholars such as Babbie and Mouton (2003), Lincoln and Guba (1985) and Shenton (2004), a plausible description of credibility suffices to demonstrate the

dependability of the current study findings. This argument precludes regurgitation of the same strategies described above to demonstrate how dependability was enhanced in the current study.

The last criterion is confirmability. To sustain confirmability, which often seeks to mitigate researcher bias, the data collection tool was pilot-tested, and the researcher acknowledges that use of two qualitative forms of data collection (FGDs and KIIs) could have impacted on the quality of the data. Furthermore, the research interview is far from a conversation between equal partners because the researcher "defines and controls the situation" (Kvale, 1996, p.6). In this study, the researchers were conscious of their 'privileged position' and its implications on what the youth, through this skewed relationship could or couldn't say which ultimately enhanced the trustworthiness of the data generated.

According to Marshall and Rossman (2011), trustworthiness is essentially intertwined with ethical considerations observed during the execution of the study. As such, these authors advance an argument that judging trustworthiness using 'traditional' canons for judging the soundness of a study such as credibility, dependability, confirmability, and transferability, should not be separated from ethical concerns. As such, the researchers in this study scrupulously upheld the injunction *primum non nocere* – first, do no harm. There was an exquisite sensitivity to the power dynamics involved between the researchers (as figures of authority) and the young learner participants, and the other study participants in general. Similarly, Davies and Dodd (2002) argue that, "ethics are an essential part of rigorous research…not to be treated as a separate part of our research – a form filled in for the ethics committee and forgotten" (p.281). Essentially, the researchers constantly sustained a keen commitment to sensitive 'ethics in practice' issues. For example; emphasizing that participants were free to withdraw from the study is an ethical concern, but it also impacts on data quality

in that those who take part are less likely to lie because they voluntarily participate (Shenton, 2004).

4.10 Conclusion

This chapter of the thesis described the study's methodology. It demarcated the research context; describing its outstanding features important to the study such as geographic, demographic and socio-economic profiles. The research design, epistemologies (epistemic positions), methods and techniques used in the selection of participants, data collection and processing as well as analysis were detailed in the current chapter. The chapter was concluded with a reflection on how trustworthiness of the study was ensured. The next chapters present the findings in chapters 5–8.

CHAPTER 5
DOUBLE-UP: IN-SCHOOL ADOLESCENTS' KNOWLEDGE OF COMBINATION HIV PREVENTION

5.1 Introduction

Several themes were derived from the data set generated through the FGDs and KIIs, and the findings are presented below. Effort is made to capture the nuances and subtleties of the context within which the discussions were conducted. This is so because understanding the excerpts in isolation is difficult, if not impossible. As such, the themes are adequately nuanced using relevant direct quotes from the study participants.

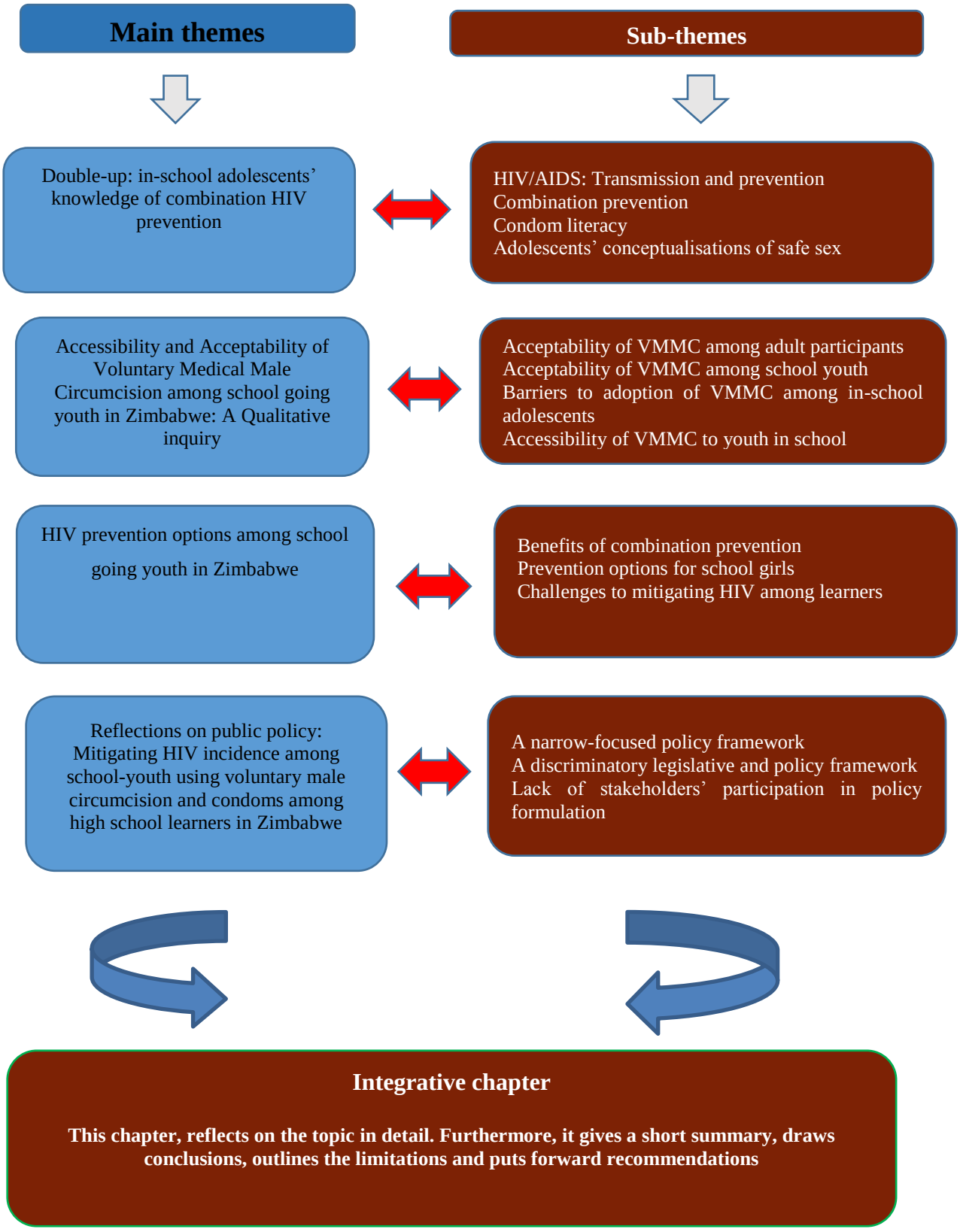
Constant perusal of the data set for the researcher to be closely acquainted with the findings, a process described as 'immersion' culminated into the identification of four broad themes. A theme is defined as the main, recurrent idea. In simple terms, a theme captures, "something important about the data in relation to the research question and represents some level of patterned response or meaning within the data set" (Braun & Clarke 2006, p.82).

The following themes are presented as independent chapters (5–8) in the same sequential order they assume in the illustrative diagram.

5.2 Emergent themes from the findings

The following themes are presented as independent chapters (5-8) in the same sequential order they assume in this introductory section. Chapter 9 is an integrative chapter.

Figure 5.1: A map of the findings chapters in their sequence



Source: By Author

These themes, which centre on the most salient issues in this study, are not mutually exclusive. The researcher does not seek to suggest that these four themes represent an exhaustive list of the most salient topics regarding VMMC and condoms for HIV prevention among in-school adolescents. The themes are merely a culmination of this study.

In each results chapter, the findings and discussion sections are separately presented. The findings are a synopsis of the data analysis process while the discussion and interpretation are a rational attempt to neatly link the findings with relevant literature. To tie the loose ends, the final chapter (9) comprehensively summarises all the four chapters, illuminating on all the outstanding findings collectively.

5.3 Socio-demographic data for study sample

Learner study participants were within the age range of 16 to 19 years, and 17 was the average age. Participants were drawn from Form four and Upper sixth classes (fourth and sixth [final year] in secondary school, respectively). There were no Form five (lower sixth formers or first year learners in the two-year Advance Level course) learners because enrolment for this class was underway during the period when data for this study was collected (January to March 2016). The total learner participant sample was N=44, 24 boys and 20 girls. Most male participants were circumcised, either medically or otherwise: 13 were medically circumcised while six were circumcised culturally, and five were not circumcised. No participant was circumcised for religious or aesthetic reasons. Girls' circumcision status was not sought not only on the assumption that genital mutilation is outlawed, but also because it had no relevance to the study. In terms of religion, Christianity was the most dominant with 38 participants while four subscribed to African Traditional Religion (ATR), and only two participants did not disclose their religious affiliation. A summary of the learner participants' socio-demographic characteristics is tabulated below (Table 5.1).

Table 5.1: Learner participants' socio-demographic characteristics

Characteristics	**Number**	**%**
Sex		
Male	24	54.5
Female	20	45.5
Age groups (Mean age =17)		
16-17	19	43.0
18-19	25	57.0
Level of education		
Form 4	18	40.9
Form 6	26	59.1
Religious affiliation		
African Traditional Religion	4	9.1
Christianity	38	86.4
Not indicated	2	4.5
Circumcision status		
Culturally circumcised	6	25.0
Medically Circumcised	13	54.0
Not circumcised	5	21.0

The sample of adult participants comprised nine adults (4 females and 5 males) who participated in key informant interviews. Most of them (seven) were educators teaching Guidance and Counselling and were drawn from the four schools that participated in the study. The remaining two participants were health workers. Below is a table indicating the adult participants who took part in the key informant interviews.

Table 5.2 Key informant interview participants

Pseudonym	**Sex**	**Profession**	**District**
De Beauvoir	Female	Teacher	Zvishavane
Ma Moyo	Female	Teacher	Mberengwa
Molly	Female	Teacher	Zvishavane
Rosemary	Female	Teacher	Zvishavane
Hoto	Male	Teacher	Mberengwa
Muromwe	Male	Teacher	Zvishavane
WeGanda	Male	Teacher	Mberengwa
Dhadza	Male	Health worker	Mberengwa
Philip	Male	Health worker	Zvishavane

Through Thematic Analysis (TA), as described by Braun and Clarke (2006), four main themes were overall identified, as indicated earlier. It is noteworthy to reiterate that these themes are closely related hence some sub-themes may tend to overlap. This is so because the key questions were crafted in such a way that they would contribute to the goal of gaining insight into adolescents' understanding of safe sex practices in general, and particularly the reduction

of HIV incidence through use of VMMC and condoms. The themes are presented according to the chronological order presented above. The sequencing of the themes was a deliberate process in pursuit of coherence since the themes are closely related. In terms of focus group discussion (FGD) responses, these are presented in the following pattern; FGD: 1B and FGD: 1G, indicating the sequence of the schools and composition of interviews; boys (B) and girls (G), while categories FGD 1–2 and FGD 3–4 represent Zvishavane and Mberengwa, respectively.

5.4 Knowledge and comprehension of HIV/AIDS: A focus on prevention

According to Babalola, Awasum and Quenum-Renaud (2002), awareness and knowledge of HIV and AIDS has the potential to influence decisions on HIV risk reduction behaviours such as condom use. Condom use makes risky sexual behaviour safer (Jackson, 2002). Under this overarching theme, several sub-themes which constituted the building blocks in the construction of this main theme were identified. The sub-themes are as follows; HIV and AIDS: Transmission and prevention, combination prevention, condom literacy, and lastly, adolescents' conceptualisations of safer sex.

5.4.1 HIV/AIDS: Transmission and prevention

Establishing participants' knowledge about HIV was a common point of departure across all interviews, using a probe question: What do you know about HIV? Some of the responses illuminating this question are indicated below:

> *HIV stands for Human Immune-deficiency Virus. It is passed by unprotected sexual intercourse with an infected partner, sharing sharp objects like razor blades, needles (etc.) with an infected person. Another way of passing it on is through mother to child transmission as well as having contact with an infected partner when both of you are having open wounds/cuts* (FGD: 1G, Zvishavane).

> *It is a viral infection that is usually transmitted through sexual intercourse with an infected partner. However, HIV can also be transmitted through contact with fluids from the human body such as blood, say in the event of an accident. Sharing of sharp objects can also expose a person to the risk of contracting HIV even if they have abstained from sexual activity* (FGD: 3B, Mberengwa).

A general observation is that most participants were well informed about what HIV is, both as a microbe and as a disease. Although it is not clearly stated in the interview, participants referred to HIV and AIDS as one and the same thing. Their conception of the two (HIV and AIDS) was clearly convoluted. However, more significantly, participants had a satisfactory grasp of the several modes of HIV transmission. In this regard, sex (heterosexual) was identified as the dominant mode of HIV transmission, and this is clearly encapsulated in the above excerpts.

However, fewer participants demonstrated lack of understanding in their conceptualisation of risk. HIV risk is intricately linked to transmission. The following is a demonstration of limited awareness:

> *HIV is a sexually transmitted disease. It is caused by engaging in unprotected sex and failure to wash off the dirt from the act… I am not very sure, but I believe you won't get HIV if you wash because it is transmitted through dirt such as sperms and these are usually harboured in the foreskin, leading to HIV infection (FGD: 4B, Mberengwa).*

In the above quote, the participant establishes a naïve causal relationship between the post-coital process of washing the genitalia and HIV transmission. Although the former part is correct, the latter is erroneous, displaying a clear lack of concrete understanding which could be interpreted as clear testimony of ignorance. Participants with superficial knowledge or who lack in-depth understanding of HIV/AIDS were generally few.

Furthermore, in line with the sub-theme of an HIV/AIDS knowledge deficit, another participant responding to a question on whether medical male circumcision should be promoted as an HIV preventative strategy in secondary schools or not, had the following to say:

> *Circumcision should be promoted in schools. It is important because at times young people engage in sexual activities so if they are circumcised, it will be an advantage for them. If he is circumcised, he does not have HIV (FGD: 4G, Mberengwa).*

The above line of thinking is understandable, given that the *modus operandi* for providing VMMC for HIV prevention in Zimbabwe is characterised by HIV testing and counselling (HTC). HCT is also a prerequisite for access to routine health services such as anti-retroviral therapy (ART), pre-ART care and support, and for most of the biomedical interventions including prevention of mother to child transmission (PMTCT) and VMMC (GoZ, 2015). Given that a negative sero-status is the licence to get medically circumcised, some adolescents run the risk of assuming that being circumcised automatically translates to being HIV- free, which is not always the case as sero-status can change post-circumcision.

The other aspect central to the discussion was prevention of HIV transmission. As a matter of principle, successful prevention is premised on ensuring that exposure to disease is minimised, and when there are chances for infection, susceptibility is significantly reduced. According to Barnett and Whiteside (2002) "the principle of successful prevention is in ensuring that people are not exposed to the disease or, if they are, that they are not susceptible to infection" (p.40). This study is firmly anchored on the first part of Barnett and Whiteside's (2002) definition of prevention. When asked whether there is need for medically circumcised males to use condoms, one participant said:

> *He must wear a condom; may be either partner would be HIV positive, so it helps to prevent its transmission from one infected partner to the other. This also helps to prevent the woman from falling pregnant. The condom can also prevent sexually*

transmitted infections (STIs). If one partner is infected and no condom is used, then the other partner will be infected too (FGD: 4G, Mberengwa).

This participant is very clear about the transmission and prevention of HIV. Despite the significant reduction in susceptibility due to a circumcision status, it can be observed that participants were clear that in as much as VMMC reduces chances of contracting HIV by an estimated 60%, the strategy does not benefit the female partner, hence the need for condom use. The following was said;

Fine, he might be circumcised, but might be already HIV positive, and then he tells you that he is circumcised; that doesn't protect you as a woman and ultimately you get infected….It is also possible that some are circumcised while they are already positive [HIV sero-positive], so it is not safe not to use a condom (FG1: 3G, Mberengwa).

Circumcised or not, a condom remains necessary. However, the problem is that for us as girls it's difficult to insist on a condom, it's difficult because you will be judged as a prostitute…yeah, it's tricky (FGD: 4G, Mberengwa).

Secondly it is clear that participants didn't view HIV as an STI. This is perhaps a result of mother tongue intervention as STIs are referred to as *siki* and HIV/AIDS is different from these since it takes longer to manifest, unlike syphilis and gonorrhoea, and mostly importantly that infection with HIV doesn't leave signs on the genitals.

In another focus group discussion (FGD), one participant collectively blamed both oral contraceptives and condoms for promoting a culture of promiscuity among adolescent girls based on the pretext of an increased protection against falling pregnant. Such behaviour is technically referred to as risk compensation. Risk compensation refers to an increase in risk behaviour resulting from an individual's perceptions of reduced risk (culminating from the adoption of a protective measure such as medically circumcising for HIV prevention) (Grund & Hennink, 2012). The following response was offered as a counter argument in favour of condoms, when contraceptive methods were collectively castigated:

> *No, it's different. Condoms are better in that they prevent both diseases and pregnancy; a condom is a paper that you use and dispose of, but some of these birth control measures include injectable contraceptives such as Depo which can last long, and while on them you tend to relax and do whatever you feel like doing, knowing that you won't fall pregnant and at the end you may contract HIV* (FGD: 3G, Mberengwa).

The above can be interpreted as a duly informed position regarding HIV transmission. This finding does not only demonstrate knowledge per se, but an in- depth understanding of the context within which HIV is transmitted, and possibly prevented.

In a bid to elaborate on how total protection against HIV infection can be achieved by a circumcised male, since VMMC provides partial protection, FGD participants had the following to say:

> *We must complement circumcision with other methods of HIV prevention such as abstinence, use of condoms and reducing the number of sexual partners. If pupils are [medically] circumcised, they must be taught that this method is not 100% effective, and that they must use other ways of preventing infection when they decide to be sexually active. Before marriage, they must have a blood test, and [additionally] being faithful to one [uninfected] partner is another way of preventing HIV* (FGD: 3B, Mberengwa).

> *You must condomise. His being circumcised doesn't help prevent transmission and acquisition of HIV by the female. However, demanding that he use a condom is not easy since it's difficult for a girl to show a boy that she wants sex* (FGD: 1G, Zvishavane).

Medical male circumcision and condom use are biomedical approaches to HIV prevention. In this finding, the participant provided an array of prevention strategies to tackle the epidemic from the preventative side, thereby epitomising Tatoud's (2011) 'HIV prevention buffet'. This finding encompasses different, but compatible approaches, foregrounding behaviour change as a rich ingredient to HIV prevention. Importantly, the primacy of combination preventions illustrated in this study resonates with relevant literature within the trajectory of HIV prevention (Baxter & Abdool Karim, 2016). Prevention of new infections

occupies the centre-stage of the current global response and to the HIV/AIDS epidemic (UNAIDS, 2014b). Precisely, it is envisaged that this ambitious target can be achieved through the deployment of tailor-made combination HIV prevention strategies (Baxter & Abdool Karim, 2016).

5.4.2 Combination prevention

HIV epidemics are quite complex, and research has demonstrated that use of single preventative methods is unlikely to reverse the epidemic's trajectory (Baxter & Abdool Karim, 2016). Responding to a question whether a medically circumcised male should put on a condom during sex, since this form of circumcision is for HIV prevention, a participant (female) said:

> *He must wear a condom. Maybe one partner would be HIV positive, so it helps to prevent transmission from one infected partner to the other. This also helps to prevent pregnancy in the woman. The condom can also prevent sexually transmitted infections (STIs). If one partner is infected and no condom is used, then the other partner will be infected too* (FGD: 4G, Mberengwa).

It can be interpreted that the participant is aware that although circumcision status reduces chances of infection, the method is not an independent or stand-alone preventative method. Furthermore, when not accompanied by correct and consistent condom use, the method does not benefit the female partner.

Premised on the understanding that in public health related issues, nothing must be taken for granted, the researcher asked about the percentage of protection a condom provides, all things being fair and equal. The following was said:

> *I am not sure of the percentage, is it 40% or 60% protection against AIDS? What I understand is that the condom must be used, whether you are circumcised or not because AIDS can still get in through the urethra, even when one is [medically] circumcised* (FGD: 4B, Mberengwa).

It was previously highlighted that participants used HIV and AIDS interchangeably, as evident in the above quote. This is understandable since the distinction between the two is vague in the dominant Shona-Karanga narratives, emanating from the fact that the vernacular language (Shona) has no word for HIV (Garrett, 2000). More significantly, the participant demonstrated understanding that the two methods (VMMC and condom use), must be used simultaneously. However, lack of accurate knowledge regarding the theoretical efficacy of condoms was disturbing, particularly considering that these participants are in-school adolescents who should be expected to be privileged to know better when compared to their illiterate counterparts.

A general observation across all the interviews is that participants understood the importance of dual protection. Most participants were clear that being circumcised is not adequate since the method is not 100% efficient in preventing both sexually transmitted infections, including HIV infection and unplanned pregnancies. The role played by condoms in combination HIV prevention is unquestionable. The following quote were captured during focus group discussion (FGD):

> *You know what, circumcision is an independent method and therefore there is need to promote condom use since we are saying that circumcision is 60% efficient. They are therefore supposed to go further and explain that although you embraced Smart*[4]*, you have these other methods to cater for the remaining 40%* (FGD: 3G, Mberengwa).

The concept of combination prevention is perhaps best practice in HIV prevention (Coates et al., 2008; Horton & Das, 2008). It is predicated on the principle of complementarity, that a weakness in one approach be supplemented by the strength in another approach. With medical male circumcision providing an approximated 50-60% protective efficacy against HIV (WHO/UNAIDS, 2007), and condoms not being 100% efficient, it was but legitimate for the

[4] Smart is a term used to refer to VMMC, emanating from the catch phrase *Pinda MuSmart/Ngena ku Smart/Get circumcised today* campaign.

study to establish adolescents' knowledge and understanding of dual protection/combination prevention.

5.4.3 Condom literacy

Condoms are the first choice for preventing the sexual transmission of HIV (Bailey et al., 2010). Given that southern-Africa's epidemic is heterosexual (Bailey et al., 2001; GoZ, 2015), it is therefore imperative that if HIV prevention interventions that include condom promotion are to be successful, condom users must be "literate". The phrase *condom literacy* refers to a state of being accomplished with regards to knowledge and skill required to ensure that the efficacy of condoms in HIV prevention is not compromised.

In the preliminary stages of the data collection process, one key informant interview (KII) participant made an important eye-opening contribution. She viewed important developments such as Zimbabwe's unveiling of the teen condom in 2015 against a backdrop of reverberating calls to increase condom access, especially among in-school adolescents as positive steps towards reversing the impact of the epidemic. She said:

> *How? Ummmm... The how aspect is yet another critical issue! I once volunteered at one of the NGOs where we were targeting school leavers. Iii, it's not that people don't want to use condoms; they want. But using it, how to use it, aaah, thus the problem- thus the major issue. Even for adults, some of them don't know how to use it* (KII participant: De Beauvoir – a female teacher, Zvishavane).

The above testimony triggered the researcher's quest to further explore this issue in-depth. The researcher expressed his conviction that knowledge or information on its own is not adequate if one doesn't have the requisite practical skills to use a condom, not least because if condoms are to be used in HIV prevention, users must have knowledge, beliefs and required skills. In response, the same participant said:

> *You are right. Apparently, our kids do not know how to use a condom. If you want to check, even if you leave these schools today, go to the adults. At church for example, I am a counsellor, I talk to people. They don't know how to use a condom. Some of them will have the condoms in their pockets but when it comes to action, they just feel uncomfortable; what if I fail in front of this lady, what will happen? What if, what if? And they won't use it [she laughs]. They end up not using it* (KII participant: De Beauvoir – a female teacher, Zvishavane).

In one focus group discussion (FGD), participants were exploring condom use with consideration of the twin challenges of high STI prevalence and incidence (including HIV/AIDS), and teenage unplanned pregnancies. One participant made the following contribution:

> *The youth should be informed that condoms are not completely perfect for preventing HIV and pregnancy. However, despite that they are not perfect; they should be provided for free in school toilets and other health corners to help prevent unplanned pregnancies. We shouldn't however forget that demanding that he use a condom is not easy. Contrary to the previous proposal that pupils be given oral contraceptives, they should not be given these because they will be reluctant to prevent STIs/HIV, and the pills have side-effects* (FGD: 1G, Zvishavane).

Having such an in-depth understanding among adolescents that condoms are not 100% efficient is quite promising to the fight against HIV incidence. Although condoms significantly reduce the risk of HIV infection if constantly and correctly used, the stark reality that they are not a 'magic-bullet' against infection is critical. Jackson (2002) refers to this clarity of understanding as being 'sex and AIDS competent'.

> *What I discovered is that, there is no product which is 100% efficient. That's why they even say that no machine is 100% efficient and similarly, no product is completely safe…condoms are 98 point something percent efficient, they can either break or slide. That being the case, perhaps abstinence is the only way to go* (FGD: 2B, Zvishavane).

In another different, but related focus group interview, the following was uttered by one of the participants;

> *I think it is important that such skills be imparted. There are some of our friends whom we are not with here because they made mistakes in using condoms and they are parents as we speak. They became parents before completing school. Therefore, it is my opinion that such knowledge should be shared with young people. Someone may have a condom but fail to put it on due to fear that they may fail to use it, which leads to humiliation in front of a girl* (FGD: 3B, Mberengwa).

It became clearer that condom literacy might be a real challenge to HIV prevention efforts among the youth in general and in-school adolescents. This prompted the researcher to probe further. It emerged that the bulk of knowledge on sex and sexuality school adolescents have is socially generated as they discuss as friends. The following responses were given in separate FGDs:

> *The arguments would centre on issues such as the use of one versus two [condoms]. Using two simultaneously means that you are double protected. However, others claim that despite being totally protected, it defeats the purpose as it reduces the amount of pleasure; sex won't be pleasurable. It's like you are not doing anything. But I feel that using two or three condoms at the same is important since it is not possible for all the three to break at the same time* (FGD: 2B, Zvishavane).

> *As friends, we always discuss issues of dating and of course sex and stuff. There are debates we always engage in, e.g. condoms and their efficiency in preventing STIs. Apparently, condoms easily break, especially the free ones, many friends have shared this* (FGD: 4B, Mberengwa).

This was further probed to encourage participants to provide more detail. Amplification probes were used (Harding, 2013). Responses to the probe were related to a common myth that most participants had alluded to, that condom use reduces sexual pleasure. The participant shared that:

> *Condoms have issues. Like circumcision, they make sex dull. Sex with a condom is different from sex without a condom; without a condom, sex is nice. Friends share that when circumcised, it feels as if the penis is not yours* (FGD: 2A, Zvishavane).

> *The issue of 'super pleasure' will come later, when the opportune time comes. Now, what is more critical is experience, so by putting on two condoms at the same time; it's being less pleasurable is not a concern. Pleasurable sex awaits us in marriage, and for now it's the experience that matters* (FGD: 4B, Mberengwa).

It did not only become apparent that condom education is important to ensuring that the opportunities offered by increased condom access are not wasted, but also that young people understand the unwritten sex education scripts which they socially co-author with their peers. Although not stated directly in the excerpt, the undercurrents of the desire for experimentation are discernible, something which is commonly associated with adolescence (Mbotho et al., 2011; Sumter, Bokhorst, Steinberg, & Westenberg, 2009). The implication is that experimentation should occur while the adolescent is empowered with both knowledge about HIV transmission and skill to negotiate and practise safer sex.

5.4.4 Adolescents' conceptualisations of safe sex

It is argued that the concept of safe sex was invented by gay men (Watney, 1994; Hillier et al., 1998). However, as efforts to stem the tide of the AIDS epidemic stiffened, the concept 'safe sex' was appropriated and deployed for interventions among heterosexual populations (Hillier et al., 1998). In this study, it emerged that learner participants narrowly conceived *safe sex* as sex using a condom. Their conceptualisation of safe sex was tantamount to 'protected sex', implying that a barrier method must be used. As such, approved non-penetrative methods including abstinence and masturbation were mostly castigated or grudgingly accepted during discussions. A participant in a focus group discussion (FGD) expressed concern that:

> *If we tie our hope on abstinence, we will be lying to each other. There are very few people who can abstain. Those who can abstain are the ones who haven't had their*

> *sexual debut because once you have tasted it, it's difficult to stop* (FGD: 3B, Mberengwa).

It can be interpreted that this participant is making a distinction between primary and secondary sexual abstinence. In his analysis, primary sexual abstinence is practical while its counterpart is clearly difficult. It is on record that the age at sexual debut is on the decline in Zimbabwe (GoZ, 2015). As such, anyone relying on abstinence as a citadel against HIV transmission among adolescents is deluding themselves.

During the same FGD, another participant also had the following to say:

> *The problem is that abstinence is classified as a method of HIV prevention, yet young people view a method as something that can be implemented. What kind of a method is abstinence? How can "not doing" be regarded as a method? A method should be something that allows you to do what you like doing but protects you from risk. To many people, a method should include use of some sort of device or material. Ironically abstinence is classified as a method equivalent to say use of a condom* (FGD: 3B, Mberengwa).

Although it is not stated in the interview excerpt, this finding is implying that in the absence of the recently adopted VMMC, in-school adolescents (particularly males) were without any method of mitigating HIV transmission. In this regard, I argue that there is a strong case in arguing that girls are more vulnerable to HIV incidence, not only because of their socio-economic or biological 'configuration' per se but also because VMMC does not help reduce male to female transmission of the virus.

It was highlighted earlier that the themes derived from the data set generated during this study are interwoven. The former part of the following quote is ideal for illuminating the debate on condom promotion and distribution in schools, which is a different theme handled later in this thesis. Be that as it may, the latter part of the same excerpt directly speaks to the current theme:

> *The issue of distributing condoms in schools is encouraged because school youths are in three categories. These are; (1) not yet sexually active, (2) sexually active wishing to stop, (3) addicted to sex. Therefore, to the last two categories, condoms will be useful to prevent spread of HIV as well as unplanned pregnancies. Furthermore, since many of the youth are indulging, it's much better that they are taught how to use condoms. At least we reduce the risk of spreading HIV by condomising because abstinence is like a joke to us youths* (FGD: 1B, Zvishavane).

The above quote is laden with meaning, cutting across several sub-themes. While the excerpt is used here to illuminate the sub-theme (Adolescent conceptualisations of safe sex) by demonstrating the deficiencies of abstinence as a recommended method of HIV prevention, it knits well with the previous sub-theme; condom-literacy. Under condom literacy, it insinuates that adolescents need to synchronise knowledge with practical skills on correct condom use.

Some participants also made critical remarks concerning masturbation, another method of HIV prevention, although it (masturbation) is often placed on the margins of Tatoud's (2011) 'HIV prevention buffet'. Although literature is clear that masturbation is a recommended form of safe sex practice, most participants either displayed lack of knowledge about, or clear understanding of this method. The following views were expressed when abstinence was being discussed, where one participant suggested that implementing abstinence as a stand-alone method is a challenge, which may be overcome by buttressing it with masturbation:

> *You can't implement it [abstinence], maybe if it is combined with masturbation* (FGD: 2B, Zvishavane).
>
> *But is masturbation recommended? I understand that it is harmful, and obviously it can't replace real sex* (FGD: 2B, Zvishavane).
>
> *I have a question though; can masturbation bring sexual satisfaction?* (FGD: 3A, Mberengwa).

An observation was made that participants who had in-depth knowledge were particularly those learners doing science subjects at Advanced Level such as Biology. For example, the initiator

of this proposal to adopt a dual prevention approach using abstinence and masturbation had this to say:

> *Our Biology teacher told us that masturbation is not a problem to boys, but to girls. The boys maintain their state, but a girl can, due to inserting foreign and harmful objects, break her virginity through masturbation*. *Besides, masturbation can't replace the actual thing…chunks can't replace actual meat* (FGD: 3B, Mberengwa).

An overall interpretation was that a lot of knowledge gaps exist among in-school adolescents regarding available alternatives to the practice of safer sex. Be that as it may, this ultimately increases their susceptibility to HIV infection, which is an area that health promotion interventions may explore.

5.5 Discussion

This chapter focused on knowledge and comprehension of HIV and AIDS, with a specific focus on prevention of HIV incidence. The following themes emerged from the data analysis; HIV/AIDS transmission and prevention, combination prevention, condom literacy and adolescents' conceptualisation of safe sex.

It emerged that abstinence constitutes the bedrock on which the Ministry of Primary and Secondary Education's (MoPSE) response to mitigating the HIV epidemic among learners is anchored. This is not surprising since many responses to the epidemic have been both moralising and stigmatising (Jackson, 2002; Schoepf, 2004). Verkuhl (1998) asserts that there are basically two ways of assisting the youth to stay safe, which are repression and exercise of control vis-à-vis information and empowerment. When using these two approaches suggested by Verkuhl (1998), abstinence belongs to the former. However, it emerged that the emphasis on abstinence can be counter-productive since learners indicated that they cannot abstain. As such, this thesis calls into question the rationale of clinging on to an approach which has proven beyond doubt that it is futile. Solely relying on abstinence leaves learners highly susceptible to

HIV infection since adherence is particularly a major challenge to this method of prevention (Jackson, 2002; Mavedzenge et al., 2014). It has been argued that empowering approaches are the best to keep adolescents safe (Jackson, 2002). Similarly, learner participants intimated that once they are offered a supportive environment, they can positively contribute towards perpetuating health behaviours.

Most learner participants indicated that despite the perceived susceptibility to HIV infection, abstinence proved to be a very difficult method of averting HIV incidence, particularly among adolescents whose age at sexual debut has significantly dropped (Mbotho et al., 2011; GoZ, 2015). This finding is consistent with those of related studies conducted with learner participants (Jackson, 2002; Mavedzenge et al., 2014). In a study among Zimbabwean secondary school learners, abstinence was described as merely a 'textbook solution' (Muparamoto & Chigwenya 2009, p.41). It is therefore clear that learners view abstinence as a less practical method of mitigating HIV transmission.

Knowledge levels about how HIV is transmitted, and how it can be prevented were high among most learner participants. However, it is argued that while knowledge is a prerequisite, it is not certain if the recommended behaviour change will ensue (Barnett & Whiteside, 2002). The researcher observed that those in the urban settings, both boys and girls were more knowledgeable compared to their counterparts in the rural areas. The lack of in-depth knowledge of the transmission of HIV among the rural folk that this study found is not surprising, considering that access to information, education and communication is limited there and not comprehensive in terms of geographical coverage and content. Clearly, a major and disturbing finding is that most learner participants lacked critical knowledge about possible modes of HIV transmission, leading to low perceptions of susceptibility to infection. This finding meshes with previous studies in similar contexts such as one by Muparamoto and Chigwenya (2009). In terms of policy implications, there is a strong case for those working in

the HIV and AIDS field to explore the question of increasing learners' access to expert knowledge. This may therefore compel the current restrictive sexuality education policy (Chikovore et al., 2009; Guttmacher, 2014) to embrace a more liberal approach to allow adolescent sexual health practitioners to directly interact with learners.

From the findings of this study, comprehensive knowledge of HIV is irreplaceable. For example, linking the transmission of HIV to failure to wash after having unprotected sex may perpetuate risky behaviours hoping that merely washing with soap and water can be prophylactic. With regards to sexually transmitted diseases, a broad category constitutive of HIV, literature is replete with discourses and notions of clean versus dirty. For example, Doyal (2013) argues that sexually transmitted diseases are associated with dirt, allegedly emanating from defying rules regarding contact with bodily fluids. This explains why strong stigma is attached not only to disease but even preventative tools such as condoms.

Women in general and young girls in particular bear the brunt of the HIV epidemic as their susceptibility is exacerbated by a constellation of factors ranging from their socio-economic to biological make up. As such, chances for the female-male transmission are quite slim (Poku, 2005). Clearly, the need to empower adolescents particularly female adolescents is a matter of urgent concern, since most adult males tend to seek sexual relations with younger women assuming that these are clean, and uninfected (DeJong, 2003; Muzenda, 2016).

Although most participants claimed that they regarded the condom as the sole effective method of mitigating both unplanned pregnancy and STIs including HIV, it emerged that most of them were not adequately empowered to negotiate condom use. Apart from issues to do with access to quality condoms, successfully negotiating condom use is critical to preventing HIV incidence (Baxter & Abdool Karim, 2016). It was also clear that learners lack the relevant skills for proper use of condoms which can certainly impact condom efficacy. Condom failure

such as breakage and slippage, which may diminish the efficacy of latex condoms, is largely attributed to poor user skills among other factors (Hensel, Selby, Tanner, & Fortenberry, 2016).

It has been argued that there is high condom breakage among and incorrect use of condoms by adolescents (Hensel et al., 2016). Some study participants indicated that they feel safer when they use two condoms during a single coital act. Clearly this is a result of misinformation and misconceptions propagated through peer interaction. Similarly, sex workers in a study by Chacham and colleagues (2007) reported this practice, despite that there is no scientific evidence to support it. Instead, some studies have found the practice of using more than one condom in a single episode of intercourse, also called 'double bagging' to increase risk, for example, it can lead to condom breakage due to friction (Munoz, Davtyan, & Brown, 2014). This knowledge deficiency can be directly linked to adults' silence in dealing with issues of youth sexuality and safer sex practice (Muparamoto & Chigwenya, 2009). School based sexual and reproductive health education should therefore strive to fill in this niche.

Since the discovery of HIV, the condom (both male and female) has been in use (Krishnaratne et al., 2016; Myer, 2005). Condoms constitute an integral component of effective HIV prevention and as such, their promotion must be scaled-up (Ochieng, Kakai, & Abok, 2011). Evidence from the current study indicates that this HIV prevention technology is popular among learners as both a prophylactic and a contraceptive. Both boys and girls expressed admiration for the condom for its dual role of preventing HIV infection and avoiding unplanned pregnancy. Furthermore, an important finding is that most participants suggested that condom promotion and distribution among in-school adolescents has the potential to inculcate a culture of consistent condom use. Evidence from a systematic review of reviews by Krishnaratne and colleagues (2016) indicated that supply-side interventions, such as mass

condom distribution and needle and syringe exchange initiatives have previously demonstrated a positive impact on use of these HIV preventative methods.

Whereas much has been done to improve access to condoms among the adult population, the inaccessibility of this preventative technology among in-school adolescents is a matter of both public health and human rights concern. Zimbabwe's 'condom gap' may be generally decreasing (NAC, 2015), the inaccessibility of this preventative technology among in-school youth raises the red flag to signify the urgency and need for a comprehensive and sustainable approach to heterosexual prevention of HIV transmission. The fact that the ability to access condoms is a barrier to their use is given (Myer, 2005). Be that as it may, an additional concern is that this scarcity of condoms may have a detrimental ripple effect on the efficacy of medical male circumcision for HIV prevention. As such, this thesis calls into question the laxity exercised in the implementation of VMMC guidelines, particularly that it must be delivered as a comprehensive package including condoms and clear messages of partial protection against STIs including HIV (Hankins, 2007; UNAIDS/WHO, 2007).

Learner participants in this study identified the condom as their first preference preventative technology, and they also indicated a keen willingness to practice safe sex through condom use. Most of them were confident and comfortable to use condoms either as the sole method or through a combination approach to prevent both unplanned pregnancy and HIV infection. This finding is contrary to that by Hillier et al. (1998). As if VMMC was an independent method of HIV prevention, most participants had a strong preference for condoms. Although cognisant of both the need for dual protection and the efficacy of VMMC (Coates et al., 2008; Gruskin, 2007), many participants were ambivalent about VMMC. Reasons given related to problems of VMMC's failure to provide protection against unwanted pregnancy, not preventing male to female transmission of STIs including HIV and reducing sexual pleasure.

This was a rare finding because VMMC only provides partial protection, and therefore is not a stand-alone method (Aggleton 2007; Berer, 2007).

It emerged that there is need for schools to promote sexual health education in a more vibrant way to adequately address the critical issues of adolescent sexuality. This is important since lack of adequate knowledge regarding alternative forms of enhancing sexual release was observed. Sexual urges do not simply disappear through resolve alone (Jackson, 2002). As such, there is a strong case for the promotion of a vibrant sexual health education which would help to expose learners to non-penetrative safer sex alternatives such as masturbation, and thigh sex. The fact that non-penetrative sexual acts constitute safer sex practice is beyond question. However, masturbation is discouraged and often condemned as immoral in several religio-cultural contexts, despite that research has shown that this method of sexual release works well especially in enhancing abstinence (Jackson, 2002). Seemingly unrelated, religion and public health are that's intricately intertwined (Ogolla, 2015; Schoepf, 2004). Empowering learners with the relevant knowledge and skills to enable them to make informed decisions remains pivotal to an effective and sustainable HIV response (Jackson, 2002; Muzenda, 2016). No matter how out-dated it may sound, the saying 'knowledge is power' remains relevant in several social spheres including the domain of public health (Dodds, Bourne, & Weait, 2009).

Considering the above, this thesis argues that the success of VMMC and condom promotion is largely dependent on the input of religio-cultural leaders who should support such population health interventions based on a *means to an end* approach (Dowsett & Couch, 2009). In other words, this is a call to being pragmatic in the sense that if the means justify the ends, then let it be. According to the culture centred approach, culture is dynamic and as such cultural members are flexible especially in response to public health matters (Dutta, 2008; Gausset, 2001). Through a robust sex education curriculum, learners may have their

understanding of sex broadened to include non-penetrative methods of sexual release which in turn prevent both pregnancy and HIV infection (Jackson, 2002).

Limiting in-school youth access to condoms can be viewed by conservatives who include religious groups and other moral entrepreneurs as safeguarding the interests of the learners (The Herald, 2015). On the other hand, those who are motivated by a deep desire to stem the epidemic may view this not only as a blow to public health efforts but also a gross human rights violation (Casas & Ahumada, 2009; Muzenda, 2016). The UNGASS Declaration of Commitment clearly spells out the importance of respect for human rights in fighting HIV (UNAIDS, 2001). Most importantly, research has shown that adopting a human rights-based approach to tackling the HIV/AIDS epidemic is not only critical, but rather constitutes best practice necessary for an effective and sustainable response (Hunt, 2010; Jürgens et al., 2009). As encapsulated in international human rights discourse, all people (inclusive of in-school youth) are duly entitled to full and accurate information as well as the tools and technologies for effective and comprehensive HIV prevention (Jürgens et al., 2009). This study identified dissonance between international human rights and public health standards on the one side and prohibitive laws and policies on the other side. From a health promotion point of view, such a scenario is not sustainable as it not only denies but also discriminates against adolescents based on age, something which in turn constrains their health and well-being.

Considering the above, this thesis argues that by denying in-school adolescents access to condoms, which are the first choice for preventing the sexual transmission of HIV (Bailey et al., 2010; Jayawardena, 2007), Zimbabwe's legal and policy framework is at odds with the mainstream international human rights discourse. Therefore, it can be argued that such stark contrasts have the potential to undermine the gains made to date, with regards to the promotion of safe sex and its attendant effects on the HIV epidemic. At the recent 21st International AIDS Conference, Durban 2016, South Africa's Health Minister Dr. Aaron Motsoaledi got a 'rude

awakening' from learners demanding that condoms be distributed in schools to mitigate the increasing rate of both unplanned pregnancy and HIV incidence among in-school adolescents (Draga, 2016). Draga (2016) argues that denying learners access to condoms is a violation of leaners' right to health.

Similarly, with Zimbabwe having ratified several key UN Human Rights Conventions including CEDAW and CRC, this thesis argues that the current policy standing is not only restrictive, but also discriminatory based on age, despite that both research and adolescents' health outcomes have demonstrated that learners are sexually active (Chikovore et al., 2009; Guttmacher Institute, 2014). Furthermore, the fact that the government has allowed school learners to be recruited for VMMC for HIV prevention should have provided an opportunity to allow for increased adolescents' access to condoms since medical male circumcision only provides partial protection (Aggleton, 2007; Berer, 2007). VMMC must be implemented in a comprehensive manner, with adequate information and the necessary preventative technologies such as condoms to enhance combination prevention (Coates et al., 2007; Hankins, 2007).

Furthermore, by failing to increase both condom access and condom competence among in-school youth, authorities are inadvertently defeating the gains made in the past three decades in fighting the HIV/AIDS epidemic. Overall, there is no alignment between what happens on the practical field and what the country strives to portray to the international community as they crave for relevance in HIV prevention efforts. Similarly, a study conducted by Casas and Ahumada (2009) in Chile also revealed that the health of in-school adolescents is severely constrained by an unfriendly and restrictive youth sexuality policy framework.

5. 6 Conclusion

While adolescents are capable of exercising control over their health and well-being, the fact that their willpower is negatively impacted on by both the adults' moralising gaze, working as some moral campus, aided by a restrictive policy environment is beyond question. An over-emphasis on abstinence proved not only counter-productive in terms of mitigating HIV incidence but it is also a marker of adults' ambivalence when it comes to adolescent sexuality. In terms of policy implications, this study's findings demonstrated that a sex-positive approach that promotes the nurturing of safe sex practices through enhancing negotiation skills constitutes best practice in keeping adolescents safe.

CHAPTER 6

ACCESSIBILITY AND ACCEPTABILITY OF VOLUNTARY MEDICAL MALE CIRCUMCISION AMONG SCHOOL GOING YOUTH IN ZIMBABWE: A QUALITATIVE INQUIRY[5]

6.1 Background

Male circumcision is one of the oldest, and most controversial of surgeries in the history of human kind (Aggleton, 2007; Gollaher, 2000). This surgical procedure is conducted for a variety of reasons including religious, cultural, social and lately medical (Aggleton, 2007; Gollaher, 2000; Le Roux, 1999; Mavundla et al., 2009). Despite its long existence, it was only a decade ago that a specific type of male circumcision (voluntary medical male circumcision—VMMC) became an approved component of the biomedical prevention of HIV infection (Ferraz & Paiva, 2015; UNAIDS, 2007). Precisely, the inception of VMMC as a prevention technology constituted a paradigm shift. It was a first in the history of modern medicine that a surgical procedure was endorsed as a population health intervention (Buvé, Delvaux, & Criel, 2007). Both the World Health Organization (WHO, 2007) and the Joint United Nations Programme on HIV/AIDS (UNAIDS, 2007) recommended VMMC for adoption as an HIV prevention technology following the release of compelling scientific evidence from three randomised control trials (RCTs) conducted in Kenya, Uganda and South Africa (Auvert et al., 2005; Bailey et al., 2007). The RCTs confirmed that VMMC offers partial protection against the heterosexual, female to male transmission of HIV by approximately 60% (Bailey et al., 2007; UNAIDS, 2007). Furthermore, women were also found to benefit from VMMC through

[5] The manuscript titled *Accessibility and acceptability of voluntary medical male circumcision among school going youth in Zimbabwe: A qualitative inquiry* was submitted to the African Journal of AIDS Research. Author details are as follows; Shumba, K., Meyer-Weitz, A., & Oppong Asante, K. The manuscript was accepted on condition that recommended suggestions were effected. It is currently under review at the same peer reviewed journal mentioned above.

a decrease in HIV and STI prevalence among their male partners (Mutevedzi & Newell, 2014; Ridzon et al., 2016).

Africa in general, and eastern and southern Africa (ESA) carries a disproportionate share of the global burden of the HIV and AIDS epidemic (NAC, 2015; UNAIDS, 2016). Sub-Saharan Africa remains the epicentre of the global HIV epidemic (National AIDS Council–NAC, 2015; UNAIDS, 2017). Among young people (15–24 years) with an HIV + sero-status, approximately 80% (4 million) are reported to live in sub-Saharan Africa (UNAIDS, 2017). As such, VMMC intervention for the adolescent age group (10–19 years) and youth (20–24 years) should be a strategy for all ESA priority countries (Ashengo et al., 2014; UNAIDS, 2012). Importantly, VMMC is one of the five prevention pillars of the 90–90–90 approach, which targets to intensify efforts to avert new infections to 500 000 by 2020 (UNAIDS, 2016).

Zimbabwe, with an estimated HIV prevalence rate of about 15% is among the now 15 priority countries (including South Sudan) identified by the WHO and UNAIDS for the adoption of VMMC as a prevention strategy against the heterosexual transmission of HIV (Chiringa, Ramathuba, & Mashau, 2016; NAC, 2015; Tshimanga et al., 2016; UNAIDS, 2016). The pre-condition for the designation 'priority country' was an epidemiological profile indicating a hyper-endemic and generalised epidemic characterised by low prevalence of male circumcision (Chiringa et al., 2016; Mutevedzi & Newell, 2014). Heterosexual transmission of HIV is a predominant route, contributing about 80% and 90% of all transmissions in Zimbabwe and southern Africa, respectively (Bailey et al., 2001; Chiringa et al., 2016; NAC, 2015). This presents a strong case for the scale-up of VMMC as a component of a comprehensive HIV preventive approach.

Projections informed by robust modelling indicated that circumcising 80% of sexually active males (15-49 years) by the year 2025, would culminate into several positive cascading

effects such as saving lives, averting suffering, massive savings in HIV and AIDS related health care costs, and a decrease in other sexually transmitted infections such as herpes simplex virus and human papillomavirus and other genital cancers (Ashengo et al., 2014; Mavhu et al., 2017; Ridzon et al., 2016). Clearly, VMMC is a highly cost-effective prevention strategy, particularly for countries characterised by generalised and hyper-endemic HIV epidemics (Sgaier et al., 2014). Zimbabwe is not exempted from this classification. Furthermore, VMMC is among the 19 global health priorities identified by the Copenhagen Consensus Centre as a 'best-buy' in efforts to achieve sustainable development goals (Ridzon et al., 2016). The procedure offers a unique protective mechanism in that it merely requires a one-time action to provide continual dividends (Sgaier et al., 2014). However, what must not be forgotten is that VMMC only provides partial protection, hence it is not a stand-alone panacea to the problem of HIV and AIDS and therefore must be emphasized that this biomedical approach must not replace other known HIV prevention methods such as abstinence, condom use, and fidelity (Matovu et al., 2007; WHO/UNAIDS, 2007). In response to the recommendations of the WHO and UNAIDS to implement and scale-up VMMC in priority countries, Zimbabwe adopted VMMC as an HIV prevention strategy in 2009, to complement the existing Abstain, Be faithful, and Condomise (ABC) behaviour change model (Chiringa et al., 2016; NAC, 2015).

Zimbabwe's VMMC roll-out initiative was informed by an enabling legal and policy framework. The National HIV and AIDS Policy for Zimbabwe (1999) (NAC, 2006) constitutes the bedrock on which the country's current HIV and AIDS response is anchored. Through this policy, a multi-sectoral approach to the prevention and management of the AIDS epidemic was adopted, and the National AIDS Council (NAC) was formed (Ashengo et al., 2014; NAC, 2006). This hallmark policy also promoted establishment of the National AIDS Trust Fund (AIDS Levy), an innovative 3% tax on all taxable incomes to fund HIV/AIDS programmes, managed by the NAC (Duri, Stray-Pedersen, & Muller, 2013; Mavhu, 2014). Amid these

developments, HIV and AIDS was declared a national emergency in 2003 (Duri et al., 2013). Later, the Zimbabwe National HIV and AIDS Strategic Plan (ZNASP) 2006 – 2010 was adopted and implemented (NAC, 2006) to guide the country's AIDS response. In 2007, VMMC for both adult and infant males was adopted as a priority HIV prevention strategy (Ashengo et al., 2014; Mavhu et al., 2017). A stakeholder meeting was convened in 2009, to obtain consensus on the goal and objectives of a national male circumcision (MC) strategy, and to conduct a strengths, weaknesses, opportunities and threats (SWOT analysis) considering the implementation of a full-scale MC programme (Mavhu, 2014). This was in keeping with the recommendations of the WHO and UNAIDS (WHO/UNAIDS, 2007). Finally, the Ministry of Health and Child Welfare (MoHCW) launched the National Male Circumcision Policy for HIV Prevention later in 2009. This policy had an ambitious target namely to circumcise 1.3 million males between the ages of 13 and 29 years by the year 2015 (Ashengo et al., 2014).

Despite several initiatives to scale-up and increase VMMC uptake in Zimbabwe, like in other priority settings, the progress has been modest (Kang'ethe & Takudzwa, 2015; Sgaier et al., 2014). To increase VMMC uptake, and to strive towards meeting the target for 2017/18, innovative strategies remain necessary (Mavhu et al., 2017). These strategies include creating a demand for VMMC accompanied by promotional VMMC campaigns, and the establishment of supplementary health service delivery sites i.e. health centres at workplaces e.g. in mining and commercial farming establishments, and educational institutions such as schools and universities (Ashengo et al., 2014). Furthermore, all these authors aver that a combination of mass media and interpersonal communications were used as a vehicle for propelling this health intervention at a population level. Inter-ministerial collaboration between the ministries of Health, and Education allow for VMMC mobilisation in schools and tertiary institutions, involving head teachers, teachers, youth VMMC cadres, and parents.

While in-school adolescents (10-19 years) represent 61% of Zimbabwe's VMMC client base (NAC, 2011), a dearth in literature exists regarding the acceptability of, and accessibility to VMMC services among this population segment. Research has established a strong correlation between both acceptability, and accessibility vis-à-vis health service utilisation (Buve, Delvaux, & Criel, 2007). Several empirical acceptability and accessibility studies have been conducted, focusing on population segments which are not inclusive of school youth, and most of them did not focus on HIV mitigation strategies such as a combination prevention approach entailing VMMC and condoms. For example, Mhangara (2011) focused on Border Timber workers' knowledge and perceptions of VMMC; Shumba (2014) focused on the Lemba cultural circumcisers' perceptions of VMMC; Kang'ethe and Takudzwa (2015) explored the challenges to a successful VMMC campaign in Zimbabwe; Moyo and colleagues (2015) explored men's attitudes towards VMMC, while Chiringa and colleagues (2016) examined factors contributing to low uptake of VMMC among adults.

More recently, Tshimanga and colleagues (2016) explored the safety profile of the Prepex device among adolescents while, Mavhu and colleagues (2017) focused on early infant male circumcision (EIMC). Having articulated the importance of increasing VMMC uptake among adolescents who constitute a majority of the client base for this biomedical approach (Ashengo et al., 2014; NAC, 2011), the need for an in-depth understanding of the current views regarding the acceptability and accessibility of VMMC services for youth by adults and the youth themselves cannot be over-emphasised.

6.2 Analytical framework

To understand both school youth and adults' perceptions of accessibility and acceptability of VMMC by the former group, this article adapted Penchansky and Thomas' (1981) theory of access as its overarching analytical framework. Accessibility in health care generally relates to a service being available within considerable proximity to the client in terms of the time and

distance involved. This article focuses on specific dimensions of access namely; geographic accessibility, availability and financial accessibility as well as acceptability. On the other hand, acceptability centres on consumers' perception of a health service (Saurman, 2016). It relates to the compatibility of a health service vis-à-vis the socio-cultural expectations of the users (Peters et al., 2008). Although acceptability is reiterated in the Alma Ata Declaration (WHO, 1978), there is generally a dearth on research pursuing this trajectory (Peters et al., 2008).

An increase in acceptability literature on VMMC particularly in sub-Saharan was experienced prior to WHO and UNAIDS' (2007) release of "Conclusions and Recommendations", marking VMMC as an officially recognised component of combination HIV prevention. This article argues that given the strategic position occupied by in-school adolescents in the effective implementation of VMMC, coupled with limited studies focusing on in-school adolescents and VMMC in Zimbabwe, it was therefore critical that a study of this nature was conducted, especially foregrounding issues of accessibility and acceptability of VMMC.

Access, in its various dimensions plays an important role in people's utilisation of health services, and this is pertinent in low-and middle-income countries— LMICs (Peters et al., 2008). Zimbabwe is a less economically developed country and falls within the ranks of countries worst affected by the AIDS epidemic (Chiringa et al., 2016; Duri et al., 2013). In terms of acceptability of service, it is argued that when it comes to circumcision, social and religio-cultural considerations far out-weigh medical ones, hence social desirability complexities tend to take priority over medical advice (Brown & Brown, 1987; Hankins, 2007). Therefore, this paper argues that little is known about school youths' perceptions regarding accessibility and acceptability of VMMC in Zimbabwe, hence the suitability of a framework that foregrounds these two critical aspects. This paper argues that given the strategic position occupied by in-school adolescents in the implementation of VMMC, coupled with limited

studies focusing on this group especially in Zimbabwe, a study of this nature is of paramount significance.

6.3 Findings

Data elicited through FGDs and KIs revealed several themes. In total, 44 learners (n=24 male; 20 females) participated in the study. The emergent themes revolving around both accessibility and acceptability of VMMC among adults and youth in the Mberengwa and Zvishavane districts are presented in the subsequent sections.

6.3.1 Acceptability of VMMC among adult participants

The gradual acceptance of the VMMC was noted as a consequence of community engagement and effective health education efforts. This view was commonly expressed, for example, in an interview with Philip [pseudonym] who has worked for the National AIDS Council (NAC) for more than a decade and is currently involved in the implementation of the nationwide voluntary male circumcision programme. He opined that uptake of VMMC has been so low that the targets for 2015 were missed by a wide margin. However, Philip shared the following regarding the increasing acceptability of VMMC among in-school adolescents:

> *With a lot of health education and community mobilisation, and emphasising the advantages of the voluntary medical male circumcision programme, we are seeing a gradual acceptance of the program to the point that there is an over demand for the service particularly among school learners* (KII participant: Philip – a male health administrator, Zvishavane).

The health benefits that VMMC offers, particularly in relation to its protective efficacy against the heterosexual transmission of HIV from an HIV-positive female to a medically circumcised male of a negative HIV sero-status, seemed to have played a role in the positive attitudes shared by most adults. The following was shared:

VMMC is good in several ways. Learners are adventurous, and circumcision can significantly help them. A figure like 60% is a huge degree of protection which can't be ignored. Youth circumcision also helps in adult life because once formally sexually active, the waiting period before commencement of sex post-circumcision may be a deterrent. Because this is a once-off procedure, one will be covered for life (KII participant: WeGanda – a male teacher, Mberengwa).

Circumcision is hygienic and medically beneficial. The strategy is good, and it must be promoted. If I had a son, I wouldn't hesitate to have him circumcised. However, the pre-circumcision HIV test is problematic; it is the most fearful moment. If they just remove that; maybe more learners would go for circumcision. Nevertheless, VMMC is gradually becoming youth culture (KII participant: Hoto – a male teacher, Mberengwa).

While most participants felt that VMMC has received significant buy-in from most of the stakeholders, there exists some scepticism among some parents. The reasons below seem to be linked to concerns about increased promiscuity rather than the practice of abstinence among adolescents and about the perceived invasive and culturally foreign nature of circumcision raised by some.

Personally, I see circumcision as a good and promising strategy. However, I don't think that there are adequate acceptability levels because many people are still sceptical about circumcision. People still have a lot of fears. They need to be adequately educated about VMMC. Parents should be conscientised that pupils don't comply with abstain messages. Educating parents may result in learners making informed decisions and embracing VMMC (KII participant: Rosemary – a female teacher, Zvishavane).

Similarly, in some focus group discussions, some participants indicated that some parents are ambivalent regarding circumcisions for HIV prevention and had the following to share:

Our parents look at VMMC differently. A majority, particularly those with little or no formal education discourage children from circumcising because it's foreign to their culture. They claim that they grew up intact, and so should their children. However, the teachers embrace it well since they teach subjects such as the Sciences; they generally have a good understanding of the benefits of circumcision. I was once barred from

getting circumcised. My father told me that I could not do a procedure he hasn't done as a parent (FGD: 2B, Zvishavane).

When I was in Form 4, my father refused to sign my consent form raising concern that the requirement for an adult to put his/her signature is linked to potential risk or harm. I finally got circumcised only last year (FGD: 3B, Mberengwa).

6.3.2 Acceptability of VMMC among school youth

Discussions with learner participants largely indicated that VMMC is an acceptable strategy for reducing HIV incidence. Like adult perceptions, the preventative efficacy of VMMC seems to have an important role in increasing the level of its acceptability.

Scientifically, circumcision is known to have disadvantages. It is known to reduce pleasure because it kills sensitive cells. However, the catch here is the 60%. I personally got circumcised because I considered the degree of protection conferred though medical circumcision as being considerably significant (FGD: 1B, Zvishavane).

Circumcision should be promoted in schools. It is important because at times young people do engage in sexual activities so if they are circumcised, it will be an advantage for them. If he is circumcised, he does not have HIV (FGD: 4G, Mberengwa).

In two other different focus group discussions, the participants mentioned that circumcision for HIV prevention is a critical strategy for HIV prevention. They expressed their satisfaction in having taken the decision to get circumcised and indicated that many of their schoolmates are seemingly considering getting circumcised:

As youth, we strongly feel that circumcision and condoms must be promoted. Circumcision removes cells most attractive to HIV. The dryness reduces bacteria since when the penis is circumcised, the head is dry (FGD: 2B, Zvishavane).

Most learners are realising that Smart [VMMC for HIV prevention] is a good programme and many of them recently did it during the holidays. When we did it during the term, some were laughing at us particularly that we were enduring the pain, but indications that they were also planning to do it during the holidays were discernible.

Most of them were looking at us, to monitor what would happen to us so they could also do it (FGD: 3B, Mberengwa).

Youth's insight into the macro level impact of HIV preventative strategies and VMMC as a governmental initiative was emphasized. The benefits of VMMC were viewed at both macro level and micro levels, for the individual. A participant in an FGD stated that the roll-out of VMMC is agreeable, giving credence to the fact that this intervention is an initiative of the government's pursuit of increased health for all its citizens.

Circumcision must be promoted because it's is a government initiative. It will be an expense for the government to manage HIV/AIDS because drugs are imported and it's expensive. Therefore, promoting VMMC is a sustainable way to reduce costs… If this age is protected from HIV, it means that life expectancy will increase which is good for the country as skilled manpower will live longer, thus production in the various sectors will be increased (FGD: 3B, Mberengwa).

While the study did not seek to compare VMMC with other known forms of HIV prevention, most discussions instinctively culminated into comparison. While the acceptability of VMMC was quite significant, condoms were viewed to be the preferred prevention method as it was generally accepted by most youths. The following were shared:

Male is circumcision is good, but condoms must be distributed to prevent pregnancy and STIs (FGD: 1G, Zvishavane).

There are some boys who take advantage of gender and dominate a girl as if they are a married couple, where a boy insists on his demands being met. Therefore, while circumcision must be promoted, condoms too must be promoted so that we (girls) are also protected. It's also possible that some are circumcised while they are already HIV positive, so it's not safe not to use a condom (FGD: 3G, Mberengwa).

6.3.3 Accessibility of VMMC to youth in school

This section entails views from two groups– youth's perceptions about accessibility (exploring transport and culture) and then the perceptions of programme implementers who view transport

as a major barrier for them to deliver the programme in recruiting youth and transporting them to health facilities. While there is a degree of perceived accessibility exists, there are also barriers when it comes to accessibility.

Most learners said that VMMC is made accessible to youth through the school-based campaigns. They also indicated that VMMC is offered free of charge. The following was shared:

> *Circumcision is offered for free at all provincial, district and mission hospitals countrywide. As such, access is not limited by financial constraints, particularly given that almost everything is currently expensive in Zimbabwe. One must simply gather the courage and go to the circumcision facility. They even reward you with items such as labelled wrist bands, a T-shirt, or hat. These items may be small, but they have sentimental value. They are medals marking both the victory and shift to HIV prevention mode* (FGD: 2B, Zvishavane).

However, most of the participants indicated that despite circumcision being a free service in either existing or programme designed health centres, distance from their place of residence to the nearest facility offering VMMC is a critical factor affecting access, especially for those residing in rural settings. The following was said in one FGD:

> *The hospital is too far for most learners. You can't walk for 15km to be circumcised, and return home, limping. Sometimes you won't have money for transport. Remember you don't get circumcised and stay there; you must go back home yet the wound will be still fresh. Organised transport doesn't do door to door service, its drop of point is the school, hence the need to walk home. Therefore, due to such factors as distance, we can't say circumcision is easily accessible especially here in the rural areas. That distance is too long, it's such a long march* (FGD: 3B, Mberengwa).

However, transport challenges faced by most school youths in their quest to access circumcision services were being resolved through the provision of free transport to the health

facilities. The arranged transport ferries learners from the school to the health centre, and back to school. A participant shared:

> *What they do is that they come here and put their posters or announce through the announcements system here at school or stick posters at the shops and obviously at the clinic itself. They stipulate that on this or that day, there will be circumcision for HIV prevention at the hospital [name supplied]. They provide transport for both the initial trip to circumcise, and during post-circumcision reviews. Providing transport makes it easy for learners because you can't be expected to walk, especially after the procedure* (FGD: 4B, Mberengwa).

Although some learners acknowledged the critical role played by free transport to VMMC centres, some concerns pertaining to confidentiality were highlighted:

> *But I don't like the idea of being transported. Everyone gets to know that you're going to, or you got circumcised. It's wrong because circumcision is a private affair. Once you're seen riding in that car, even if you decide not to get circumcised when you get to the hospital, people will simply conclude that you got circumcised. I would prefer going to the hospital on my own, through my own means* (FGD: 4B, Mberengwa).

The problem of transport was not only identified as a challenge confronting the youth, but it also emerged that the providers of VMMC are also faced by transport constraints. Subsequently, such challenges limit clients' access to health services including VMMC. The following was shared in one in-depth interview:

> *There are several factors crippling service delivery in terms of VMMC provision and scale-up. We have serious transport challenges. We're sharing one vehicle with other two districts. Sometimes you mobilise clients for VMMC and you are told that the vehicle is not available* (KI: Philip – a male health worker, Zvishavane).

Despite that VMMC is a free service provided to those who voluntarily opt to adopt this health intervention, some participants indicated that for some youth, culture poses as an insurmountable barrier to access VMMC. This was common in both rural and urban settings. The following was said:

Although they taught us here at school that VMMC prevents the acquisition HIV, I can't go to hospital for that kind of circumcision. That is totally against my culture. We, the Lemba are known as a circumcising tribe. As such, someone who circumcise in any other way apart from the prescribed Lemba cultural circumcision is either ostracised or severely dealt with (FGD: 3B, Mberengwa).

Medical circumcision is not the way for us. As the Chewa, our circumcision is done in the bush, by our elders, who are the custodians of our culture. If you're medically circumcised, it is as good as being uncircumcised because the elders won't allow you to get any closer to tribal business (FGD: 2B, Zvishavane).

Study participants identified several challenges militating against the desired accessibility of VMMC by the youth population, which inadvertently lead to low uptake of this health service. The following was said:

There are also challenges to do with our community mobilisers in terms of motivation and incentives. Community mobilisers are very important cadres for VMMC, but their incentives have not been coming timely, to a point that it has created discontent among these people… It is not that people [particularly the youth] do not want to be circumcised, but it's a challenge on the part of the implementer, just like I was telling you that there is one vehicle, they're paying incentives for community mobilisers in retrospect, very late. Late payment of those incentives affects the programme (KI: Philip – a male health worker, Zvishavane).

It emerged that matters of consent by parents and/or legal guardians limit school youth from accessing VMMC. The constitution of Zimbabwe regards anyone below the age of 18 years as a minor (Constitution of Zimbabwe, 2013). As such, most of the school youth thus require an adult's consent for them to be circumcised, a requirement which is not without its own complications. The following were shared:

We turned away some of the clients particularly these school going boys. Some of them went to the point of crying saying, "I want to be circumcised; all my friends are circumcised". Some of them even came without consent letters from parents and we could not allow them to access the service, but we could see that there was an

overwhelming response from the community, particularly from these young boys (KI: Philip – a male health worker, Zvishavane).

About two years ago when VMMC engaged the overdrive, learners were advised to have their forms filled by parents so that they could go to hospital for the procedure. Some of them never got to their parents, they just signed on their own. Then they underwent the procedure only to be discovered because they didn't have the salt to use. Apparently, circumcision is a personal issue; just like starting to menstruate for girls, it's something that is too personal; some students don't even feel free to disclose to their parents that they have undergone the procedure (KI: De Beauvoir – a female teacher, Zvishavane).

6.4 Discussion

Findings bear testimony to the increasing acceptability of VMMC for HIV prevention among school youth by adults and youth themselves. Generally, acceptability of VMMC is high, but the researcher decided to consider this aspect of the analytical framework used to analyse the findings. Furthermore, formative research on VMMC is necessary (Ashengo et al., 2014). The acceptability of VMMC largely hinges on the evidence base and prophylactic effectiveness of medicalised circumcision. This finding corresponds with previous studies, e.g. several acceptability studies in priority settings indicated that most participants viewed VMMC as acceptable largely due to its protective efficacy against STIs including HIV (Bailey et al., 2007; Hankins, 2007). Dowsett and Couch (2007) assert that for some people, scientific evidence (usually medical or experimental) is required for a prevention intervention to be acceptable. This is exemplified by the findings in this study that frame the degree of preventative ability as playing a significant role in VMMC acceptability.

Majority of the participants highlighted that the preventative effect of VMMC is key to making the decision to be circumcised. However, the requirement for HIV counselling and testing (HCT) proved to be a deterrent, yet this is a critical entry point into HIV management which one cannot wish away. UNAIDS' 90–90–90 testing and treatment programme targets

that by 2020, 90% of HIV sero-positive people should know their status (UNAIDS, 2014). Therefore, this finding highlights potential for HIV self-testing currently being piloted in SSA.

Despite the acceptability of VMMC, some participants especially girls viewed condoms as being more important due to the protection they offer against pregnancy and STIs. Furthermore, these participants demonstrated an urge to resist being domineered by males and felt that having access to condoms will empower them to negotiate for safer sex. This is an important finding suggesting the agency of some female adolescents, which is quite promising. However, research has demonstrated that due to gender power imbalances, females often face challenges in negotiating condom use, hence condoms remain a protective tool largely controlled by the male partner (Baxter & Abdool Karim, 2016).

It is clear from both youth and programme implementers' perspectives that logistical constraints play a role in the uptake of VMMC. However, the fact that demand for VMMC among school youths is more than what are currently being supplied, creates hope that with proper monitoring and evaluation, the maximal benefits offered by VMMC could be harnessed. If more people take up VMMC, HIV incidence and prevalence will be ultimately reduced. The rate of medicalised circumcisions must be increased to the range of 50-80% for risk reduction to be felt at a population level (Gruskin, 2007). The findings suggest that VMMC is acceptable since the individual can conduct some cost-benefit analysis to determine whether it is worthwhile to get medically circumcised. The fact that the procedure provides more than 50% protective efficacy emerged as an important factor influencing the acceptability of VMMC among school youth. Similar findings were reported elsewhere (Hankins, 2007).

To cater for challenges relating to transport constraints, the programmatic arrangement for free transport proved quite useful. This is particularly pertinent, given that the public transport system is currently dominated by private operators who are not government

controlled and mostly operate illegally. Subsequently, customers bear the brunt of such illegal collusions. This finding reiterates the need for VMMC implementers to pay attention to unique context-specific constraints that can negatively impact on uptake.

An important finding is that although VMMC is acceptable among school youth, condoms have a better appeal largely due to their contraceptive function and potential to prevent a host of STIs. Condoms were particularly favoured by adolescent girls based on their concerns about pregnancy and STIs and their desire to destabilise and interrupt the common belief that safe sex is a male's responsibility. This is a demonstration of agency (Bandura, 2006). This finding is important in that it creates hope for combination HIV prevention. Given the complexity of the way HIV is transmitted, Baxter and Abdool Karim (2016) suggest that combination HIV prevention is perhaps the panacea to the problem of increasing HIV incidences. Condoms must be available and accessible, and this is critical to enhancing the efficacy of VMMC. It is generally accepted that for condom use to mitigate HIV incidence and prevalence at a population level, they must be widely accessible (Baxter & Abdool Karim, 2016) as well as acceptable.

Although the acceptability level of VMMC was found to be quite high among the study participants, implementers' capacity to deliver this population health service clearly impacts scale-up and uptake of this intervention negatively. Prior research has indicated that a high uptake of VMMC hinges on a high demand for male circumcision and services that are able to meet the demand (Buve et al., 2007). Therefore, implementers must not only generate adequate demand for this health service, but should also seek to ensure that VMMC services are found within walkable distances. This finding is particularly relevant to the rural settings where participants indicated that distances travelled to health centres offering VMMC impact access to service negatively. The World Health Organization, WHO (2010) recommends that distance travelled between place of residence and health facility, is 5-10km. However, participants in

this study indicated they travel long distances to the nearest facility offering VMMC. This finding is consistent with previous studies such as those by Kiwanuka and colleagues (2008), and Feikin and colleagues (2009). According to these authors, there are many African communities living more than 12km from the nearest heath facility. Clearly, accessibility is a significant hurdle to the uptake of VMMC as a method of mitigating HIV infection among school youth. Implementation of mobile services and resuscitation of school holiday campaigns may also increase access to VMMC. The rapid results initiative (RRI), a mechanism to expedite service delivery is yet another option.

While it may not be denied that the uptake of VMMC is generally affected by structural barriers, the policy framework within which this service is provided in Zimbabwe (e.g. parental or legal guardian consent to minors- those younger than 18 years) seemed to limit access to VMMC. Consent by parents or legal guardians is required for all clients below 18 years of age and this requirement affects youths' access to VMMC in many other countries e.g. Tanzania (Mbeba et al., 2012) and Uganda (Birungi, Obare, Mugisha, Evelia, & Nyombi, 2009). According to UNAIDS (2016), 72 out of 90 countries with available data enforce this requirement to under 18s seeking access to sexual reproductive health services. Therefore, this requirement complicates the consent process resulting in some youth not being able to undergo VMMC irrespective of their desire to be circumcised. There is need for further research on how to navigate through such structural barriers.

Responses from both FGDs and KI interviews highlight that parents seem to feel that if they support VMMC rather than abstinence, adolescents will become more sexually active. Similarly, Langhaug, Cowan, Nyamurera and Power (2003) established that even health professionals such as nurses discourage youths' access to contraceptives fearing that doing so would give the impression that adults are implicitly sanctioning adolescent sexuality. In Zimbabwe, there is an enduring stigma towards youth's sexuality.

Findings from adolescents demonstrated that a sense of cultural belonging has a significant role when it comes to the acceptability of VMMC. Similarly, cultural tradition was a prominent constraining factor among the traditionally circumcising VaRemba tribe of southern Zimbabwe; the need to preserve the socio-cultural significance of traditional circumcision was a commonly heard refrain during in-depth interviews (Shumba & Lubombo, 2017). However, Yao cultural circumcisers commonly found in Zimbabwe's mining and farming towns embraced VMMC as part of their initiation ceremony (Daimon, 2013). Such synergy between traditional and biomedical approaches has been reported in other countries such as Kenya and South Africa (Peltzer, Nqeketo, & Kanta, 2009). Unfortunately, most initiates in South Africa harboured fears of stigmatisation following medical circumcision (Peltzer et al., 2009; Wambura et al., 2011).

While collaboration between clinical providers and cultural leaders has been previously suggested (Wambura et al., 2011), perhaps this collaboration should be taken to a higher level where the elders themselves are trained to perform circumcision in a manner that complies with clinical standards (Shumba & Lubombo, 2017). Doing so would perhaps not only retain the symbolic meanings of traditional circumcision, but also allay fears that VMMC aims to supplant cultural circumcision (Gwandure, 2011). In a study among Lemba cultural circumcisers by Shumba (2014), it emerged that cultural circumcisers do acknowledge the significance of complying with clinical standards to enjoy the protective efficacy against HIV incidence conferred through medical male circumcision.

6.5 Conclusion

Data highlights that VMMC is largely acceptable. However, the need to reflect on the restrictive consent requirements is pertinent to enhancing school youth's access to VMMC. Secondly, condom access must be increased to ensure that VMMC is offered in a comprehensive manner, and obviously robust health education must be provided to mitigate

risk compensation. Thirdly, there is need to increase the geographical accessibility of VMMC. Offering VMMC on a free basic caters for the financial accessibility and must continue. The need to offer VMMC in a culturally sensitive way is clear; this may entail creating synergy between VMMC implementers and cultural circumcisers. It is envisaged that doing so can ensure that those youths from culturally circumcising ethnic groups do not miss out on the protective effect conferred on medically circumcised males.

CHAPTER 7

HIV PREVENTION OPTIONS AMONG SCHOOL GOING YOUTH IN ZIMBABWE[6]

7.1 Introduction

The twin burden of HIV and AIDS necessitated the implementation of numerous prevention interventions aimed at reducing HIV incidence and prevalence, particularly among key and vulnerable populations. Tatoud (2011) refers to this as the 'HIV prevention buffet', metaphorically encapsulating both the 'combination prevention' mantra, and the plurality of prevention options (Baxter & Abdool Karim, 2016; Coates, Richter, & Caceres, 2008). Combination HIV prevention comprises behavioural, biomedical, and structural interventions (Bekker et al., 2015). Importantly, combination prevention constitutes best practice in the current HIV 'prevention revolution' because weaknesses in one method are complemented by strengths in the other (Bekker et al., 2015; Coates et al., 2008).

The combination HIV prevention approach is largely premised on the argument that mitigating HIV incidence remains the primary method of controlling the AIDS epidemic (Kurth, Celum, Baeten, Vermund, & Wasserheit, 2011; Smith et al., 2016). The prominence of this approach emanates from empirical evidence indicating that single prevention strategies are far from being the panacea (Hankins & de Zalduondo, 2010; Piot et al., 2015). Single prevention strategies often fail to bring about the desired outcome of reducing both HIV incidence and prevalence (Baxter & Abdool Karim, 2016). In settings characterised by

[6] This manuscript was completed and is yet to be submitted to a peer reviewed journal. The title of the manuscript is; *HIV prevention options among school going youth in Zimbabwe.* The authors are, Shumba, K., Oppong Asante, K., & Meyer-Weitz, A.

generalised HIV epidemics, the role of combination prevention is thus invaluable (Baxter & Abdool Karim, 2016; Dehne et al., 2016).

Among a diversity of prevention strategies is voluntary medical male circumcision (VMMC) (NAC, 2015; UNAIDS, 2007). Circumcision is a form of surgery with a long history of existence, performed for a variety of reasons including religious, cultural, social and recently medical (Aggleton, 2007; Gollaher, 2000; Le Roux, 1999; Mavundla et al., 2009). VMMC constitutes a paradigm shift, and falls within the biomedical trajectory (Bailey et al., 2007; Niang & Boiro, 2007). Most HIV epidemics are heterosexual and male driven (Jewkes & Morrell, 2010). Therefore, VMMC constitutes an integral part in most prevention efforts. However, its efficacy is heavily dependent on both behavioural and structural interventions such as comprehensive sex education and broader policies that particularly favour condom (both male and female) promotion. This is reasonable because VMMC offers partial protection against the heterosexual transmission of HIV and is therefore complementary to other known methods of mitigating HIV incidence (Matovu et al., 2007). The strategy occupies a central position in Zimbabwe's response to the HIV epidemic (Ashengo et al., 2014; NAC, 2015), since the country is among the initially 14, and now 15 priority countries recommended by the WHO and UNAIDS to adopt VMMC as a preventative strategy against the spread of the AIDS epidemic (Tshimanga et al., 2016; UNAIDS, 2016).

Overall, Joint United Nations Programme on HIV/AIDS (UNAIDS) statistics indicate a global decrease in HIV incidence (UNAIDS, 2015a). Ironically, estimates indicate that HIV-related morbidity is on the increase among the adolescent age group (Bekker et al., 2015). This unsustainable trend has culminated into AIDS becoming the leading cause of death among African adolescents and the second leading cause for adolescents on a global scale (Bekker et al., 2015). Both sub-Saharan Africa and South Asia bear an inordinate share of the global HIV epidemic (Bekker et al., 2015; Mutevedzi & Newell, 2014). Research has demonstrated that an

important step in advancing the HIV prevention agenda is the recognition of people at risk. In that regard, school youth are young key populations (YKPs) (Abdool Karim, 2015).

To maximise prevention benefits, the need to scale-up available interventions such as VMMC must not be an end per se; but such interventions must be provided in a comprehensive manner (Baxter & Abdool Karim, 2016; Matovu et al., 2007). Reaching out to at risk populations such as adolescents should be regarded as both pertinent and urgent. The rationale behind considering adolescents as a prime target for HIV prevention interventions is twofold. They are not only a priority group for prevention efforts because of their vulnerability to infection, but also because of their high potential to transmit the virus to others. The latter is often ignored; hence a gap exists in HIV preventative literature (Bekker et al., 2015). Most of the studies on HIV combination prevention have been based on adults, and not youth populations (Baxter & Abdool Karim, 2016; Coates et al., 2008; Grund & Hennink, 2012; Kurth et al., 2011; Njeuhmeli et al., 2011).

In Zimbabwe, VMMC took a school-based approach largely targeting the 15-19 years age group (Ashengo et al., 2014). However, adolescents' utilisation of HIV combination prevention strategies including preventative health products (e.g. male and female condoms) has not been fully explored even though adolescents below the age of 18 years constitute the largest number of VMMC clients in Zimbabwe (NAC, 2015; Tshimanga et al., 2016). Thus, there is a paucity of studies particularly focusing on combination HIV prevention among school youth. This study therefore sought to explore the perceptions, perspectives and understanding of combination HIV prevention among selected adults and school youths, particularly in the context of VMMC roll-out and scale-up.

7.2 Findings

Following a data analysis process, three themes were identified. These are; benefits of HIV combination prevention, HIV prevention options for school girls, and challenges to mitigating HIV among learners. These themes are presented in detail below, and appropriate quotations are mobilised for illustrative purposes. Responses from FGDs are referenced according to the sequence in which the FGDs were conducted, and the sex of the participants. E.g. FGD: 1A and FGD: 1B indicate that these focus group were conducted at the first school, with boys and girls respectively.

7.2 1 Benefits of HIV combination prevention

The adolescents' accounts suggest that most young people understand the importance of combination HIV prevention especially in relation to VMMC and condoms. The following were said in separate focus groups:

> *Combination prevention is practice of safe penetrative sex through condoms despite being circumcised. Circumcision provides 60% protection…*40% *depends on you as an individual. Therefore, condom use compliments circumcision, or rather the two complement each other to achieve maximum protection against HIV infection* (FGD: 1B, Zvishavane).
>
> *Maybe one partner would be HIV positive, so condom use helps to prevent transmission from one infected partner to the other. It also helps to prevent pregnancy sexually transmitted infections (STIs), so if one partner is infected and no condom is used, then the other partner will be infected too. Benefits of condom use are thus; prevention of unwanted pregnancy and STIs* (FGD: 4G, Mberengwa).
>
> *Despite being circumcised, you may never know perhaps he will be infected already, so condom use helps protect you from HIV because being circumcised is not a guaranteed HIV negative status. Some are circumcised while they are already positive*

or contract HIV post circumcision, so condom use prevents HIV infection (FGD: 3G, Mberengwa).

The circumcised penis is like a natural condom. Since they say one must condomise then literally its two condoms, one is a natural one while the other is man-made. Two are better than one. However, circumcision is good, but condom use in addition to circumcision is even much better (FGD: 2B, Zvishavane).

Adolescent male participants largely focused on the benefits of HIV combination prevention comprising medical circumcision and condoms with a keenness on preventing HIV infection and general cleanliness. Their female participants were mostly concerned about preventing pregnancy. Therefore, female participants demonstrated an overt inclination towards condoms than medical circumcision because of their dual role.

I believe you won't get HIV if you wash after sex because HIV is transmitted through dirt such as semen and other vaginal fluids and these are usually harboured in the foreskin. A circumcised penis is dry and hard, so abrasions are rare, so it's not easy to get HIV. If you add a condom, then you are more than 100% protected. If circumcised, you can also stay long without having taken a bath and still feel fresh (FGD: 3B, Mberengwa).

Although it is important for a man to be circumcised, because they say that it reduces his chances of getting HIV, I think condoms are better than circumcision because they also prevent pregnancy. Therefore, use of condoms even when he is circumcised helps both of us because as girls, one won't fall pregnant (FGD: 3G, Mberengwa).

Being circumcised is a good thing. However, some boys end up having a lot of girls because they know that they are less vulnerable to HIV. In that case using a condom will help to avoid pregnancy. Hence, condoms are a much better option because both parties benefit. Using both methods is a fair deal (FGD: 1G, Zvishavane).

The importance of HIV combination prevention was extensively discussed in the study. While participants hailed the condom for its dual prevention (against STIs and unplanned pregnancy), issues related to condom failure and user error surfaced. Being circumcised for HIV prevention was therefore regarded as a fall-back plan.

A condom is not 100% efficient. It can break in the process, hence if you are circumcised; you stand a better chance in terms of exposure to HIV. That is why it is important to be circumcised. However, some think that when they are circumcised, they don't need condoms (FGD: 3B, Mberengwa).

Because sex normally happens with the girl offering some degree of resistance, you may fail to appropriately wear the condom. This can lead to the condom breaking during sex. I feel using two or three at the same is a better approach since it isn't possible for all the three to break at the same time (FGD: 2B, Zvishavane).

7 .2 .2 HIV prevention options for school girls

Most participants, particularly adolescent males appeared to be content with HIV combination prevention using VMMC and condoms to promote HIV prevention among school youth, despite that they raised concern over other issues, e.g. condom inaccessibility. It emerged that female participants felt that as members of the female sex, HIV prevention options available to them were too limited. The issue of limited prevention options for girls was quite compelling.

Reproductive health services are of crucial importance when adolescents become sexually active, especially girls. Girls tend to suffer greater reproductive ill health by comparison to boys. Therefore, hoping that girls will rely on abstinence alone is like condemning them to swim in a flooded river without the relevant regalia (KII participant: MaMoyo – a female teacher, Mberengwa).

Access to both male and female condoms must be increased because both parties don't want the negative consequences of sex. Besides, as females we're more susceptible to infection and generally we're at the receiving end because you may realise that he impregnates you and infects you with HIV at the same time. He doesn't feel the pinch as he can do the same to a chain of girls, just like that (FGD: 3G, Mberengwa).

Most participants indicated that in line with both national legislation and relevant policy, school girls are protected from HIV through school-based sex education. Within the ambit of school-based sex education, abstinence emerged as the only fortress protecting girls against HIV incidence.

The ministry recommends abstinence for the learners. We instil abstinence. However, we know that some are engaging. We tell them; don't use your organs for sex, but for urinating only, you're still young [she laughs]! As for girls; use them for menstruation and urinating (KII participant: De Beauvoir– female teacher, Zvishavane).

Abstinence is the best and only option, and as long you focus on your school work and forget about relationships, you're certain that you are safe. Of course, there are those who have started indulging in sexual activities, perhaps it is those who need condoms and stuff. But as a girl, condoms are almost useless because it's difficult to ask a boy to use a condom since agreeing to have sex is not an openly discussed and mutually agreed process (FGD: 4G, Mberengwa).

Learner participants indicated that as school adolescents, there is no specific prevention option that they can talk about; they dispelled abstinence as being a method for mitigating HIV transmission. Female learner participants felt that, unlike their male participants who benefit from VMMC, they were unfairly left susceptible to infection because no national programme targets them.

I don't think they consider our need for protection from HIV as something urgent. Boys have VMMC, which shows that at least something is being done for them. Perhaps as girls, we were going to benefit if condoms were to be distributed in schools. Now condoms are beyond our reach; physically, socially and economically. They are found in pubs, which are out of bounds for us, and we also can't buy them; besides how will you be viewed if a condom is discovered on you? (FGD: 3G, Mberengwa)

Condoms should be provided for us youths as they reduce the chances of getting HIV and falling pregnant. They are important because some of our partners are unfaithful. However, some men or boys still refuse to use condoms because they are often used by prostitutes (FGD: 1G, Zvishavane).

Discussions revealed that learners do embark on risky adventures which increase their susceptibility to both HIV infection and unplanned teenage pregnancy. Narratives centred on juvenile sexual escapades highlighted the need for prevention options for school adolescents. The following was shared in a focus group:

> *Use of public toilets as condom distribution centres is inadequate. Take e.g. the scenario at boarding schools. Learners usually sneak at night to see their partners. Safe sex without condoms is thus compromised because condoms are found at drinking places which are out of bounds for learners. At least if condoms are made available in schools, learners may be safer from both HIV and unwanted pregnancies. That will also increase girls' access to condoms* (FGD: 3B, Mberengwa).

It also emerged that the lack of prevention options is negatively impacting on adolescent girls who end up carrying the double burden of STIs including HIV and unplanned teenage pregnancy. The dire situation is further exacerbated by fact that these female adolescents resort to illegal and unsafe abortions which further puts their health and lives at risk:

> *I think the proposal to distribute condoms in schools is OK because that will also reduce unplanned pregnancies. Some boys are also addicted to sex, so increasing condom access will be a good thing, girls will indirectly benefit* (FGD: 4G, Mberengwa).

> *I believe it's critical for condoms to be given to learners because they are having sex with or without them. This also contributes to teen pregnancies, child marriages and abortions. Some girls drink washing powder to terminate pregnancy* (FGD:1G, Zvishavane).

7. 2. 3 Challenges to mitigating HIV among learners

One prominent challenge to the implementation of VMMC for in-school youth was that of dissonance between laws, policies, and VMMC guidelines. Several participants in this study raised concern that the current policy atmosphere does not favour implementation of the VMMC program among in-school youths, hence it poses several challenges.

> *Considering that our sexual debut is quite low, I would encourage condom distribution within schools. Once we do that, then we come with more health education. It's not like we're just encouraging them to give condoms to pupils then we leave it like that; no, condom promotion must be accompanied by vigorous health education so that learners can make informed choices* (KII participant: Dhadza – a male health worker, Mberengwa).

In several FGDs, a very poignant analysis of the inconsistences in government policy was highlighted. It was also noted that the government is largely indifferent to in-school adolescents' sexual and reproductive needs. The following are illustrations of this:

> *They can't provide us with condoms because the understanding is that as school pupils, we don't engage in sexual activities. However, truth is that we do engage; sheer experience is important, she will replace you if you don't take the initiative. Girls don't like shepherds (a male who practices sexual chastity)* (FGD: 2B, Zvishavane).

> *They brought circumcision to us meaning that they acknowledge we do have sex, and that is why they want us protected from HIV infection through circumcision. If they thought as per your argument, then we were only expected to be circumcised after completing school. Therefore, they must give us condoms* (FGD: 4B, Mberengwa).

Furthermore, participants highlighted policy gaps in the health framework, citing the implementation of prevention of mother to child transmission (PMTCT) which discriminates against some sectors of the population such as the apostolic sect. The researcher's use of an amplification probe led to the following being said:

> *The policy that condoms should not be introduced to pupils, yet they are circumcised and circumcision must be accompanied by condoms; those are some of the policy contradictions. VMMC must incorporate clear partial protection messages, and condoms, but learners are denied condom access. Possessing a condom is a punishable offence* (KII participant: Philip – a male health worker, Zvishavane).

Participants indicated that HIV/AIDS experts are not, according to policy, allowed to have direct interface with learners to promote sex education and provide expert knowledge to prevent the unintended outcomes of adolescent sexual activeness. Unfortunately, teachers are only providing superficial ASRH detail. Clearly, there is a problem bigger than imagined. This is understandable because educators largely feel constrained to provide in-depth knowledge in an environment that is not only highly censored, but also one in which they are not trained.

> *We improvise, e.g. you can tell them that if a person of the opposite sex comes to you, and triggers something in your body, it doesn't mean that you must act upon it; you must use your brain. But if you fail to control yourself, please use a condom* (KII participant: De Beauvoir – a female teacher, Zvishavane).

Another participant, Rosemary was asked to give an overall comment regarding Zimbabwe's response to the epidemic particularly focusing on the plight of in-school adolescents. She had this to share:

> *Government commitment is both lacking and desperately inadequate. The MoPSE must be totally committed to HIV prevention. E.g. recently, the so-called teen condom was unveiled. By implication, the condom is for teenagers who are largely young people in schools, but ironically there is no circular to that effect. We work with circulars and when there is no circular, there is no authorisation. Therefore, there is a disconnection between government and the education ministry. This compromises efforts to mitigate HIV among learners* (KII participant: Rosemary – a female teacher, Zvishavane).

Other participants shared similar sentiments. The government was criticised for failing to demonstrate political will in the implementation of the VMMC strategy to ensure that it is promoted extensively. The policy environment was also blamed for failing to ensure that VMMC is delivered in both a comprehensive manner, and through innovative ways that appeal to adolescents.

> *Government involvement in the fight against HIV/AIDS should be strengthened, e.g. the Ministry of Health should take AIDS and prevention interventions such as VMMC as critical issues, like they do with polio, cholera and other "urgent diseases"* (KII participant: MaMoyo – a female teacher, Mberengwa).

> *For most learners, health messages are easy to understand and implement if they come from teachers, they grasp concepts better if they're coming from their teachers. Therefore, if the messages about VMMC can be incorporated into the curriculum, they will be understood better* (FGD: 2B, Zvishavane).

> *If you look at HIV, little or no depth is currently dealt with in those sex education classes. What's so taboo about health? These are the things which must be adequately*

discussed without being afraid or shy.... It's also surprising that we're punished for possessing condoms, yet the media is abuzz with condom adverts (FGD: 3B, Mberengwa).

7.3 Discussion

The main purpose of this study was to explore perceptions of HIV combination prevention among school adolescents and their significant others (teachers and health service providers). The findings revealed that the benefits of HIV combination prevention were widely acknowledged and understood. Furthermore, the findings show that youths in school are confronted by a serious challenge of limited HIV prevention options which inadvertently increases their vulnerability to both HIV incidence and other negative outcomes of adolescent sexual activity (e.g. unplanned pregnancy)

Generally, the findings as reported in this study showed that combination prevention plays a pivotal role in mitigating the AIDS epidemic (Baxter & Abdool Karim, 2016). Global health research has indicated that decreases in HIV transmissions will only be possible if combination prevention interventions that are biomedical, behavioural, and structural oriented are implemented (Pettifor et al., 2015). Similarly, it emerged that while VMMC is a strategy of paramount significance to prevention efforts, its efficacy is maximised by a combination prevention approach. Controversial as they may be (Hearst & Chen, 2004), condoms proved to be inevitable accessories for safe sex practice. The major implication of this finding is that of the need for both the legal and policy framework to re-align with VMMC guidelines to improve condom access to all sexually active persons without regard to either age or sex. Accolades

Among various HIV prevention options, condoms were reported to be prominent for the study participants. This finding highlighted the decisive role played by cultural norms in people's access to, and the acceptability of certain health products, and the challenges pose to health promotion interventions. Condoms use is central to the success of combination

prevention (UNAIDS, 2016). However, this health accessory of such paramount significance is overall stigmatised. Due to the seemingly indelible, negative label attached to condoms at risk populations such as school girls may only benefit from improved access to condoms indirectly; through male partner's willingness to use them. This finding doesn't only highlight the urgency for promoting female controlled HIV prevention options (Baxter & Abdool Karim, 2016), but also the need for condom negotiation skills particularly among girls. Previous research has revealed that in sub-Saharan Africa, sexual scripts are largely written and shaped by males because cultural and gender norms favour those (Bhana & Anderson, 2013).

The results further showed that the state has a mandate to guard the boundaries of normative adolescent sexuality through laws and policies advancing discourses of abstinence. Similarly, findings by other researchers indicate that governments seek to guard the normative boundaries of sex and sexuality through legal and policy frameworks that emphasize adolescence sexual intolerance (Muparamoto & Chigwenya, 2009; Chikovore et al., 2009). For example, in South Africa, Glover and McLeod (2016) lamented that the school curriculum frames adolescent sexuality in a negative way, an approach largely characterised by negative sexual outcomes. Adolescent sexuality is largely disapproved and frowned upon, despite that, global trends in public health vehemently challenge that moralistic and admonitory approach in favour of a health promotion preference that views access to safe-sex supplies including condoms as a human right (Shumba, 2016; UNAIDS, 2016).

Findings from this study bear testimony that school adolescents have unmet reproductive health needs. Yet, the ‘‘prevention revolution,’’ has emphasized the urgency for comprehensive, tailored combination HIV prevention interventions for adolescents, comprising structural, biomedical and behavioural interventions within a rights and privacy framework (Bekker et al., 2015; Isbell, Kilonzo, Mugurungi, & Bekker, 2016). Despite that adolescent girls are by comparison to their male counterparts more vulnerable and susceptible

to HIV infection, the study revealed that this group has an unmet reproductive need; they are limited from accessing accessories and relevant information to mitigate the unintended consequences of adolescent sexual activity.

Condom prohibition among school adolescents is quite worrying as reported in this study. Increasing both autonomy and choice for young people is consistent with the rights-based approach to HIV prevention (Sundby, 2006). Apparently, aligning laws and policies to public health interventions helps to ensure that the call to scale-up VMMC in a comprehensive way does not technically exclude school adolescents based on age while they are the ones to optimise the benefits offered by this strategy not least because they are the prime target by virtue of being the sexually active group (Ashengo et al., 2014; UNAIDS, 2016). For example, possession of HIV preventative paraphernalia such as condoms mustn't result in punitive measures being instituted against school adolescents (e.g. corporal punishment, detention or suspension from attending classes). We argue that such restrictive policies compromise the protective efficacy of VMMC. In terms of female adolescents, this study realised that this group doesn't have any prevention option which falls under the risk reduction (Thomas, Bassi, Continoho, & Goyal, 2017) trajectory, which obviously exacerbates vulnerability and susceptibility to HIV infection. Latest developments in HIV prevention seek to widen the range of efficacious approaches as well as promoting individual's autonomy and choice (Godfrey-Faussett, 2016).

Findings indicating that male adolescents are compelled to engage in sexual activities to fulfil gender expectations are very critical to health promotion practice. Boys expressed fears of being deserted if they abstain from sex. Unfortunately, sexual violence, which they resort to, is often associated with negative health outcomes (De Vries et al., 2014). Discourses of negative gender norms blended with notions of masculinity appeared in male adolescents' accounts, raising concern that relevant health education should be offered to the (15-19 years)

age group to optimise the benefits of VMMC. Health education should seek to "destabilise and interrupt the dominant myth" (Manyozo, 2016, p.5) that boys should dominate in sexual relationships e.g. through using force. Such gender stereotypes tend to promote HIV transmission as they may result in the girl's vaginal tract sustaining abrasions which act as entry points for HIV, no use of condoms or condom failure (Jackson, 2002). This finding concurs with previous research, e.g. a study by Bhana and Anderson (2013) indicated that boys view sexual scripts as being characterised by a certain degree of violence linked to masculinity.

Adolescent participants' accounts suggest that in-depth knowledge of VMMC is largely low among this population group. In previous research, participants demonstrated ignorance basic facts about VMMC (Kang'ethe & Takudzwa, 2015; Mavhu et al., 2011). This gap may be attributed to the fact that school-based health education, as some participants have highlighted is too superficial and fails to delve into topical health issues such as VMMC for HIV prevention. This despite evidence that school-based interventions bear considerable promise to change the trajectory of the epidemic (Krishnaratne, Hensen, Cordes, Enstone, & Hargreaves, 2016; Mavedzenge, Luecke, & Ross, 2014). UNAIDS (2016 citing UNESCO, 2013) suggests policy modifications where education ministries in ESA countries designated as priority settings should include VMMC upscale as an additional objection in sex education and adolescent sexual and reproductive health (ASRH) services. While school-based sex education is often, from a lay perspective accused of promoting adolescent sexual activity, scientific research has produced findings to the contrary (Ashengo et al., 2014). Therefore, given the pivotal role school-based sex education it plays in increasing knowledge, we suggest that it be revived in schools, with a keen focus on youth relevant topics such as VMMC for HIV prevention.

7.4 Limitations of the study

The study was solely qualitative; hence it is not possible to generalise the findings to other contexts. It is hoped that perhaps either a quantitative study or mixed method approach to the topic may further illuminate the challenge of limited prevention options for school youth. Further research particularly on how VMMC delivery can be made more comprehensive particularly among school youth is necessary to optimising the benefits of this biomedical approach in mitigating HIV incidence.

7.5 Conclusions

The purpose of this study was to explore participant's perceptions of HIV prevention among school youth. Findings show that approaches to HIV prevention among school youth are characterised by a rigid commitment to the risk avoidance at the expense of risk reduction, hence abstinence is the sole approach promoted. There is need for policy shifts to ensure that VMMC among school youth is comprehensively offered to further maximise its protective efficacy.

CHAPTER 8

REFLECTIONS ON PUBLIC POLICY: MITIGATING HIV INCIDENCE AMONG SCHOOL-YOUTH USING VOLUNTARY MALE CIRCUMCISION AND CONDOMS AMONG HIGH SCHOOL LEARNERS IN ZIMBABWE[7]

8.1 Background

The AIDS epidemic remains a major public health threat (Baxter & Abdool Karim, 2016). To halt the spread of HIV, and change the trajectory of the AIDS epidemic, the prevention of new infections remains first prize (Poku, 2016). The hope to end this stubborn epidemic has been extended to 2030 (Isbell, Kilonzo, Mugurungi, & Bekker, 2016). Optimism lies in the HIV prevention mantra. However, the devil is in the detail.

To optimise prevention outcomes, best practice entails the use of a combination approach comprising biomedical, behavioural, and structural interventions (Isbell et al., 2016). Biomedical approaches include voluntary medical male circumcision (VMMC), sexual health education and condom use (Department of Health, 2016). VMMC is one of the five prevention pillars anticipated to avert new infections to a record low 500 000 by 2020 (Buthelezi, Davidson, & Kharsany, 2016). While its efficacy can be optimised by behaviour change (e.g. shunning age-disparate sexual liaisons, reducing the number of sex partners, and adherence to correct and consistent condom use), the crafting of supportive policies is a structural response to the AIDS epidemic (Rhodes, Singer, Bourgois, Friedman, & Strathdee, 2005). Toska et al. (2016) indicate that structural constraints constitute the key drivers of HIV infection among adolescents in Eastern and Southern Africa (ESA). The epidemic has its firmest grip in sub-

[7] This manuscript was completed and is yet to be submitted to a peer reviewed journal. The title of the manuscript is; *Reflections on public policy: mitigating HIV incidence among school-youth using voluntary male circumcision and condoms among high school learners in Zimbabwe*. The authors are; Shumba, K., Meyer-Weitz, A., & Oppong Asante, K.

Saharan Africa (Baxter & Abdool Karim, 2016), and adolescents in the ESA region bear the brunt (Toska et al., 2016).

HIV acquisition does not solely rely on either individual behaviour or use of biomedical approaches (e.g. VMMC) but is also impacted by other causally distal factors beyond the individual's control (Abdool Karim, Meyer-Weitz, & Harrison, 2009). Thus, structural factors can either hamper or facilitate preventative efforts (Gupta, Parkhurst, Ogden, Aggleton, & Mahal, 2008). Logically, structural interventions hold promise for reducing sexually transmitted infections (STIs) inclusive of HIV (Abdool Karim et al., 2009). Structural interventions include efforts at improving the socio-economic and political environments to positively impact health outcomes (Sumartojo, 2000). Ensuring that legal systems and public health policies are compatible and do not impinge on the health outcomes of a particular "at risk" population is critical to effective HIV prevention efforts. As such, structural approaches emphasize the importance of addressing underlying drivers of HIV risk and vulnerability (Gupta et al., 2008). In this logic, the critical role played by a coherent legal framework and adolescent sexual and reproductive health (ASRH) policies, cannot be overemphasized.

This paper forms part of a doctoral study focusing on HIV prevention among in-school adolescents in Zimbabwe through a combination prevention approach (VMMC and condoms). Young people provide a window of hope, making this age group the most critical for HIV prevention interventions (Klepp, Flisher, & Kaaya, 2008). Adolescent sexual and reproductive health has emerged as a critical area since young people are confronted by a diversity of sexual reproductive health problems including STIs, unintended pregnancies, unsafe abortions and maternal child mortality (Klepp et al., 2008). Consequently, ASRH has since emerged as a focal point for research pursuing a health preventative agenda. Adolescents in southern African high schools are categorised as a key population for HIV prevention interventions (Abdool Karim et al., 2014). Apparently, a plethora of issues affecting at risk populations such as young

key populations (YKPs) need to be resolved, particularly in the realm of ASRH and HIV prevention. We question the logic of concerted commitment to upscale VMMC among school youth without paying attention to the current disjuncture in the legislative and policy framework.

Considering the above, provision of ASRH services requires a supportive national policy environment (Klepp et al., 2008). Tailor-made early ASRH education, coupled with demand creation for VMMC and other relevant health services among adolescents create opportunities for healthy lifestyles (UNAIDS, 2016). To maximise HIV prevention benefits, current programmes should target to scale-up available interventions (Smith et al., 2016). If VMMC is offered as a comprehensive health (inclusive of ASRH) package that foregrounds HIV, HCT and VMMC relevant messages, there is potential for increased uptake and efficacy of VMMC among high school boys (George et al., 2014). Apparently, the need for policy level synergies to strengthen the implementation of a comprehensive ASRH school health policy is crucial.

VMMC is central to the current HIV prevention matrix. It is among the five prevention pillars supporting the 90–90–90 approach, aimed at decreasing new HIV infections to 500 000 by 2020 (Buthelezi et al., 2016; UNAIDS, 2016). VMMC is an efficacious prevention strategy and is mostly recommended for males in settings characterised by generalised, hyper-endemic epidemics and low prevalence of male circumcision (Godfrey-Faussett, 2016). Zimbabwe is among the 15 priority locations responding to the HIV epidemic through VMMC (Mavhu et al., 2017). To attain a population level impact using VMMC, a time-bound target to circumcise 80% of sexually active males (15-49 years) by 2025 was set (Ridzon et al., 2016).

In 2007, VMMC was adopted as an important HIV prevention strategy (Mavhu et al., 2017). The Ministry of Health and Child Welfare launched the National Male Circumcision

Policy for HIV Prevention later in 2009 (Ashengo et al., 2014). The policy had an ambitious target to circumcise 1.3 million males between the ages of 13 and 29 years by 2015 (Ashengo et al., 2014). This target was missed. The male circumcision policy doesn't portray VMMC as a substitute for other known preventative methods; it rather compliments them (NAC, 2015). To optimise the efficacy of VMMC, this biomedical method should be accompanied by a minimum package of HIV prevention and reproductive health services, comprising; HTC, treatment for STIs where necessary, promotion and provision of condoms (male and female), and counselling on risk reduction and safer sex (NAC, 2015). These provisions alert us to the fact that support services for VMMC are selectively implemented, and this may compromise the health of medically circumcised school adolescents who may choose to be sexually active since they are not allowed access to condoms.

However, in Zimbabwe, 61% of VMMC clients, like in most priority countries are adolescents (10-19) years old (National AIDS Council–NAC, 2011). We argue that without aligning the legislative, policy framework and VMMC programme guidelines with best practices, as recommended by WHO and UNAIDS (2007), the dividends earned in prevention efforts over the years may be eroded. Zimbabwe is one country characterised by stark contrasts, particularly with regards to the legislative and policy framework informing interventions targeting school youth (Chikovore et al., 2009). A typical example of such a disjuncture exists in the implementation of VMMC among school youth. While the strategy should be provided as a comprehensive package (UNAIDS, 2007), elements of this 'prevention combo' are selectively applied. For example, despite the critical role that condoms play in complementing the partial protective efficacy of VMMC, they remain a taboo.

8.2 Adolescents, HIV/AIDS, the legal and policy framework in Zimbabwe

Limitations of space precluded presenting all the legislative sections relating to adolescents, HIV and AIDS, and ASRH policies implemented in Zimbabwe since the beginning of the AIDS

epidemic. Therefore, the legal sections and selected health policies presented in this section are merely illustrative since the use of a systematic data collection procedure was beyond the scope of this study.

Zimbabwe is a signatory to several international obligations that articulate ASRH as a basic human right. This paper assumes a right based approach and is anchored on the discourse reiterated by the World Health Organisation (2000) and UNFPA (2000b) regarding reproductive health as a basic human right. We therefore argue that the current legal framework presents an aporia especially that Zimbabwe ratified several international instruments such as the Maseru Declaration on HIV and AIDS; UN Convention of the Rights of the Child (CRC), African Charter on the Rights of Children, and the International Conference on Population and Development (ICPD) (NAC, 2015). It is mandated not only to protect, but also promote adolescents' right to SRH information and services (UN, 1994; UN, 1995). The word 'services' can encompass the accessories for safer sex practice such as condoms and prophylactics. Furthermore, Section 76 (1) of the Constitution of Zimbabwe (2013) stipulates that access to basic healthcare services is a right to be enjoyed by all, without regard to age.

The National AIDS Policy (NAP) of 1999 forms the bedrock on which Zimbabwe's current response to the HIV and AIDS epidemic rests (Government of Zimbabwe, 1999). It aims to coordinate all HIV and AIDS related activities including ASRH using a multi-sectoral approach (Muparamoto & Chigwenya, 2009). This policy forms the cornerstone of the Ministry of Primary and Secondary Education's (MoPSE) sectoral response to the AIDS epidemic (Government of Zimbabwe, 1999). The MoPSE is constitutive of the policy elite, and plays a critical role in crafting policies that inform responses to the AIDS epidemic.

The NAP is aligned to the AIDS Action Plan in schools (Government of Zimbabwe 1997). The AAP, which is not a policy per se, provides guidelines for all HIV prevention

activities in schools (Chikovore et al., 2009). Abstinence is at the core of this plan of action. This repressive–restrictive policy environment is buttressed by a mix of legal discourses regarding the age of majority, religious and socio-cultural mores reproachful of adolescent sexuality (Sambisa, Curtis, & Stokes, 2010). In Zimbabwe, anyone under the age of 18 years is considered as a minor (Constitution of Zimbabwe, 2013). Therefore, this constitutional stipulation automatically limits school youths from accessing SRH services inclusive of preventive methods since sex is framed as belonging to the domain of adults (Sambisa et al., 2010). Furthermore, the legal age of majority severely affects adolescents' access to SRH services (Chikovore et al., 2009; Langhaug, Cowan, Nyamurera, & Power, 2003).

Therefore, we raise concern that limiting school adolescents' access to SRH services and preventative methods such as condoms is a violation of their rights, especially in the context of VMMC because it offers partial protection against HIV incidence.

8.3 Findings

Data analysis resulted in three themes being identified. These are; a narrow-focused policy framework, a discriminatory legislative and policy framework, and lack of stakeholders' participation in policy formulation. These are explored in detail below, with quotations mobilised for further illustration.

8.3.1 A narrow focused policy framework

Participants highlighted that policies that guide the Ministry of Primary and Secondary Education (MoPSE) in relation to broader issues of ASRH, HIV/AIDS and adolescents' sexuality, are narrow focused and restrictive. These issues were explored to locate the position of VMMC and condoms within the prevention matrix and the larger implications of the current policy framework. The MoPSE was criticised for promoting a single approach; abstinence:

> *Policies seek to regulate learners' behaviour within a normative framework. The normative legal, cultural and religious framework prescribes that youth sexuality must be suppressed. Suppressing sexuality paves way for sexual abstinence, which must be promoted as the sole and viable option. However, some youths choose to be sexually active, thus abstinence messages may not be helpful to them. Helping such youths is difficult because policy prescribes a universal solution* (KII participant: WeGanda – a male teacher, Mberengwa).

> *The current policy framework is problematic. Learners have the right to relevant knowledge and means to make informed decisions about their sexuality, but policies limit us; they're largely moralistic and judgmental. E.g., you can't advise a learner to use a condom even if you know he/she engages in risky sexual behaviour. Condom discussion is prohibited; one must avoid being misconstrued as a condom promoter (condoms are regarded as immoral objects), hence the normative discourse is abstinence* (KII participant: Rosemary – a female teacher, Zvishavane).

In other interviews, it emerged that public policy's emphasis on abstinence wastes the golden opportunities that could be provided by biomedical approaches such as school-based sex education for mitigating HIV incidence among adolescents. E.g., prohibiting condoms may compromise the protective efficacy of VMMC. Participants argued that condom discussion can improve knowledge, attitudes, and safe sexual behaviours in general but also particularly on the importance of correct and consistent condom use:

> *VMMC offers approximately 60% protection and the other 40% comes from condom use; interpreting this can be a complex task, yet, school-based sex education could be a feasible option, but the problem is our ministry. Condoms are merely mentioned as an HIV preventative measure and pupils aren't explicitly instructed to use them, although need may arise. We don't recommend condoms because we must emphasize abstinence, although we know they're sexually active. Factual and normative knowledge could assist them because adolescent sexual encounters have become lethal in this era of HIV/AIDS, given that most infections occur among adolescents (particularly females)* (KII participant: Hoto – a male teacher, Mberengwa).

> *Learners may not know how to use a condom, but as educators, we aren't allowed to go practical, i.e. to demonstrate correct condom use. They think that if you equip learners with such knowledge, they'll in turn indulge in sex, yet they're already indulging. Policy makers are ignorant of facts on the ground that learners aren't sexually chaste. I don't think they know, or they think it's just a small number, but now I think it's increasing* (KII participant: De Beauvoir – a female teacher, Zvishavane).

Discussions with most educator participants indicated that theoretically, school-based sex education plays a critical role in mitigating HIV incidence among adolescents. However, it emerged that the subject is a conflict arena and poses a moral dilemma to policymakers, parents and other stakeholders. They suggested that perhaps it is this moral dilemma that makes the policy to be so parochial that it does not consider alternative ways of dealing with the reality of HIV among school adolescents. A case in point was the way ASRH education was provided:

> *ASRH education must be innovative and relevant, but as teachers, we're constrained; we walk a tight rope. We're torn between limiting ourselves to the confines of the normative framework and deliver irrelevant messages or become "deviant" and provide relevant skills and knowledge, and importantly challenge adolescents to explore alternative norms. Critical discussions on norms, gender roles and communication skills needed to negotiate condom use (perhaps more important to girls as recipients of penetrative sex) can't be fully explored; we're liable to being charged for being too explicit and deviating from the normative discourse of abstinence* (KII participant: Muromwe – a male teacher, Zvishavane).

According to health worker participants, school-based ASRH can be a vehicle for delievering age specific health messages e.g., expanding the VMMC knowledge base, there are also challenges with this approach, e.g., the complexity of handing mixed classes in discussing sensitive issues. The challenges are further exacerbated by policy restrictions. They expressed concern that while regular teachers may be the best transmitters of health messages due to established rapport with learners, some teachers in charge of sex education are either not

knowledgeable enough about the content they teach or shy to teach it. One health worker had the following to say:

> *It is common to discover that some teachers are ignorant about the issues that form the core of their duty. If knowledgeable, they may be shy to effectively deliver the content. In that case, several feasible options could remedy the situation e.g., offering in-service training to improve teachers' grasp of the content and stimulate innovative ways to impart ASRH knowledge. Unfortunately, the MoPSE doesn't have a provision for such in any of its policy documents. Doing so would increase the effectiveness of current health interventions including VMMC* (KII participant: Philip – a male health worker, Zvishavane).

In another interview, the same challenge of shortage of competent sex education teachers and the absence of relevant policy provisions featured prominently. This scenario was blamed for limiting the diffusion of important expert knowledge that could catapult such interventions as VMMC to fruition. The following was said:

> *Teaching ASRH isn't limited to basic biology facts; it must be reflective of the real social contexts through which microbes such as HIV are transmitted. Lay information must be displaced and replaced by scientific facts. E.g.; in VMMC, expert knowledge is required to clarify critical concerns such as why circumcision, condemned yesterday for promoting the spread of HIV suddenly becomes a solution. However, some teachers may not adequately explain such, and this may negatively affect VMMC uptake. Forming alliances with competent health workers (e.g. health educators) may be a viable strategy. Unfortunately, there is no policy provision for such inter-ministerial collaboration. There's potential for VMMC to be isolated as a ministry of health initiative that has nothing to do with the MoPSE* (KII participant: Dhadza – a male health worker, Mberengwa).

The above challenge was also reiterated by teachers themselves who attributed the problem to current policy, as largely a result of omission rather than commission. They stated that their teacher training curricula does not feature ASRH as a module. As a result, when they are

assigned to offer sex education, they often struggle because the content is outside their subject speciality.

> *Sexual health education is a diverse area. It can be explored from a wide range of perspectives such that with my own examinable subject content to master, it's difficult to divert attention to a subject like sex education. The ministry doesn't demonstrate its commitment to the teaching of this subject* (KII participant: MaMoyo – a female teacher, Mberengwa).

> *Ministry position on sex education is vague. There is no syllabus or specific teachers to offer this subject. As a G & C teacher, I recognise the critical role of sex education but lack of clear guidelines threatens its future. It's a policy issue; the ministry must formulate proper guidelines and invest in manpower development starting from tertiary level, and perhaps make it a compulsory and examinable subject. Collaboration with the ministry of health will be inevitable, and this will positively impact on current HIV prevention interventions e.g., VMMC and those girl child empowerment initiatives* (KII participant: De Beauvoir – a female teacher, Zvishavane).

Participants demonstrated that school-based sex education has the potential to contribute to averting several negative health outcomes associated with adolescent sexuality, including HIV and AIDS. Further deliberations indicated that the current policy framework is too narrow focused and not accommodative of alternative norms. This may negatively impact HIV preventative interventions such as the use of condoms and VMMC, especially among school adolescents.

8.3.2 A discriminatory legislative and policy framework

The legal and policy framework was largely described as discriminatory. Participants highlighted that in its narrow focus, public policy on ASRH promotes heteronormativity; it totally delves on issues of normative heterosexual relationships. Both educators and health worker participants indicated that Zimbabwean legislation and health policies are intensely

restrictive, and therefore discriminate against those belonging to alternative sexualities such as lesbian, gay, bisexual, transgender and intersex (LGBTIs). The following were said;

> *The law is prohibitive of either homosexuality or any other sexual orientations that deviate from heterosexuality. Homosexuality is both criminalised, and pathologised. The President is anti-gay rights enemy number one! He condemned LGBTIs, characterised them as being worse than dogs and pigs. Apparently, any health services rendered to citizens are provided from a normative heterosexual perspective and this compels LGBTIs to go underground for fear of persecution. The consequences on mitigating HIV among LGBTI adolescents are dire* (KII participant: Philip – a male health worker, Zvishavane).

> *In health promotion practice, there is need to destabilise and interrupt discourses that present heteronormativity as the only sexual orientation. Doing so will allow space to cater for all youths. Law enforcers in Zimbabwe descend heavily on those who demonstrate any inclination towards vulnerable sexualities. Consequently, the policies are mute regarding diversity in sexuality. Therefore, strategies such as VMMC are irrelevant to learners belonging to the LGBTI community and may increase their risk due to ignorance* (KII participant: Dhadza – a male health worker, Mberengwa).

> *Zimbabwean law, policy and society at large define sexuality from a narrow perspective of being heterosexual. This makes it difficult for either sex education classes or health promotion interventions such as VMMC to effectively tackle issues of divergent sexualities to provide relevant messages, knowledge and skills e.g., to help LGBTIs practise safer sex. Furthermore, alternative methods of achieving sexual relief such as masturbation remain unexplored because they're viewed as being anti-social, yet they are important in supporting abstinence which is the normative preventative method prescribed to adolescents* (KII participant: Molly – a female teacher, Zvishavane).

However, some teachers did not indicate having any problems with both the law and policy favouring heteronormativity. They felt that the issue of divergent sexual orientations was against both the dominant Shona-Karanga cultural norms and Christian beliefs, and that it is largely Western and alien to Zimbabwe. One teacher had the following to say:

> *Remember MoPSE was previously Ministry of Education, Sports and Culture. As such, our background which includes an unadulterated culture, and a black elite educated that went through mission education can't tolerate any relationship that isn't heterosexual. I don't think it's moral to tolerate homosexuality; it's a Western practice getting unnecessary attention courtesy of globalisation* (KII participant: Hoto –a male teacher, Mberengwa).

However, the law was indicted for discriminating against school adolescents based on age. The Constitution of Zimbabwe (2013) defines a young person under the age of 18 years as a minor. While the law was generally hailed for protecting school adolescents from serious sexual offences such as statutory rape (known as defilement elsewhere) and aggravated indecent assault, how policy makers interpret such age demarcations in the context of ASRH and HIV prevention was raised as a cause for concern:

> *The law defines almost every learner as a minor, assumption then is children don't do, or rather aren't supposed to have sex. Implication is, VMMC among learners serves the same purpose as early infant medical circumcision (EIMC); its gains are not immediate, but rather distant and anticipated. Circumcised babies aren't sexually active and aren't in need of condoms. With early sexual debut common among adolescents, conceiving school adolescents as angels is problematic, especially when they're circumcised; they may feel that they aren't at risk of infection* (KII participant: WeGanda – a male teacher, Mberengwa).

> *Having 18 years as the legal age of majority act (LAMA) is strategic, it helps protect children against sex predators and paedophiles. However, its broader implications on ASRH services can't be debated. The "children" know, and do a lot, which increases their risk and susceptibility to HIV infection, e.g. experimentation with drugs and alcohol can't be ruled out among learners* (KII participant: Philip – a health worker, Zvishavane).

The issue of confidentiality in adolescents accessing health care such as VMMC or other ASRH services, including condoms was also topical, especially from a legal lens. Some felt that school adolescents deserve the right to give consent when it comes to issues of their health. By

implication, a school adolescent would therefore be able to make independent decisions such as being circumcised without seeking parental (or guardian's consent). However, not all participants agreed on this issue. The following were said:

> *Gazetting that adolescents must seek adult consent when they intend to access health care services such as VMMC is unfair on young persons, and by insisting on such, the law is being dismissive of the agency of young people. E.g., the age at which an adolescent can give independent consent for the purposes of accessing health services should be reviewed and lowered to 14 or 15 years* (KII participant: Philip – a male health worker, Zvishavane).

> *If adult consent is done away with, things will be chaotic. The mental maturation of some adolescents may need to be confirmed by an adult. They may assent to health decisions they will regret of; so, I think the 18 years and above age limit is reasonable* (KII participant: De Beauvoir – a female teacher, Zvishavane).

8.3.3 Lack of stakeholders' participation in policy formulation

Participants indicated that they felt the policy making process is rigidly top-down in approach and as a result, does not reflect the views and opinions of certain critical sectors of the population.

> *Policy makers are divorced from learners and the reality around them; they seem not to see how urgent ASRH is. E.g., both cultural and religious figures emphasize the importance of virginity and sex after marriage, something which today's young people no longer treat as a priority…As a parent, I don't see any problem with giving condoms to learners, especially to complement VMMC, and of course for the girl child as primary defence against STIs and pregnancy; it will do more good than harm. However, policy is the stumbling block. Policy makers are blind. They also turn a deaf ear to the reverberating calls that learners are sexually active and need condoms, like anyone else* (KII participant: WeGanda – a male teacher, Mberengwa).

> *People who make policies don't know what's happening on the ground. There wasn't any consultation done; we just implement, we feed the learners with information from above, and encourage them to abstain…Policy makers are ignorant that these learners*

are already indulging in sex. I don't think they know that, and if they know, they think it's just a small number, but now I think it's increasing (KII participant: De Beauvoir – a female teacher, Zvishavane).

The policy making process is not representative of all the stakeholders. It's those with expert knowledge who solely contribute to policy formulation. It's disturbing that people such as the teacher who spends most of his/her time with learners is left out yet his/her understanding of the dynamics of sexual relations among the learners is even better than that of the bosses at head office. Learners are also left out yet they're the ones who experience the challenges of biological pubertal development. ASRH must be 'youth relevant', and youth relevance is determined by none other than the youth themselves; they best know what appeals to them (KII participant: Dhadza – a male health worker, Mberengwa).

8.4 Discussion

The provision of bio-medically related adolescent sexual and reproductive health (ASRH) services featured prominently. Prominence of ASRH is testimony to the critical role played by combination prevention in changing the trajectory of the AIDS epidemic (Baxter & Abdool Karim, 2016). The context within which either biomedical or behavioural interventions are delivered is to a considerable extent affected by legislation, policies and programme guidelines. These can either promote or constrain the efficacy of a intervention (Gupta et al., 2008). Discussions also demonstrated that tailor-made adolescent health intervention such as VMMC scale-up may only have a minimal impact on the trajectory of the epidemic if structural drivers such as a restrictive policy are not destabilised and disrupted. For example, liberal laws would help remove bureaucracies that limit school adolescents' access to VMMC due to consent requirements. Analysis also highlights that the need to reinvigorate school based ASRH education is important and may also support current interventions e.g. VMMC that seem to suggest the most significant possible impact.

The notoriety of the National AIDS Policy (Government of Zimbabwe, 1999) and associated policies emanates from the emphasis on abstinence as the sole HIV prevention strategy to be implemented among school youth. Its tone is blatantly puritanical (Marindo et al., 2003). Clearly, the sexuality of school adolescents is not acknowledged by policymakers in Zimbabwe, and some sections of society, despite glaring evidence of their being sexually active (Mashamba & Robson, 2002; Guttmacher Institute, 2014). Its major shortcoming is the assumption that school youth are celibate or asexual, and do not deserve any alternatives to mitigate HIV incidence e.g., condoms to fall back on when abstinence fails (Muparamoto & Chigwenya, 2009).

There is also an urgent need to adopt non-judgmental adolescent health policies (Sundby, 2006). From a health promotion perspective, a discriminatory and judgemental legal and policy framework has far reaching negative implications, including STIs and unplanned pregnancy (Sundby, 2006). Obviously, such a framework is at loggerheads with a rights based approach to mitigating HIV among marginalised population segments such as school adolescents. We argue that use of legal censure in issues of sexuality e.g., suppressing LGBTIs is self-defeating and derails HIV prevention efforts. Ordinarily, people have diverse sexual preferences hence ASRH policies mustn't be narrow focused. Adolescents attracted to members of the same sex require special attention (Sundby, 2006).

Abstinence is unrealistic especially in contexts were boys are subtly compelled to allow their masculinity to manifest through being sexually aggressive while girls are cocooned from understanding their sexuality (Poku, 2016). Several studies on HIV prevention has indicated that abstinence only programmes have failed to yield the required positive health outcomes (Baxter & Abdool Karim, 2016). There is need to adopt a health promotion stance that destabilises and interrupts the largely unrealistic ideal of virginity. Most African cultures, inclusive of the dominant Shona-Karanga culture of Zimbabwe disregard pre-marital sex

(Chigwedere, 2000; Marindo et al., 2003). As such, aspects such as virginity are articles of faith, a normative prerequisite for marriage, and securing family honour. Perhaps this explains why the different policies relevant to ASRH are mute in terms of the provision of preventative health resources such as condoms. However, given that some adolescents will deviate from the normative expectation, prevention options should be increased (Sundby, 2006). Offering VMMC to school adolescents in the absence of condoms and adequate messaging that emphasises the partial nature of VMMC's protective efficacy is unethical and tantamount to deception. It also undermines the significance of dual protection (Baxter & Abdool Karim, 2016). This status-quo raises concern since issues of condom access by males who undergo VMMC has always been a major concern, with fears of promoting a false sense of protection based on circumcision status. We argue that reluctance on the part of implementers to ensure condom availability may negatively affect circumcised adolescents' condom use behaviour.

Health policies have the tendency of being acceptable to adolescents if they, as the target consumers of those policies are consulted in both policy formulation and implementation processes (Pillay & Flisher, 2008). Adopting a participatory approach in matters of adolescents' health is not only a lucrative endeavour in soliciting relevant data reflective of their thought frames regarding a given topic (e.g. their health), but also affirms their agency. According to Bandura's (2006) agentic theory, human beings have the potential to self-regulate and positively influence own behaviours. As such, school adolescents are also agentic beings who can identify and pursue "purposeful and foresightful behaviour" (Bandura, 2006, p.164). Similarly, Sundby (2006) identifies enablers such as high self-esteem, good self-concept and future ambitions as ingredients to adopting protective behaviours. We argue that progressive ASRH policies must strive to destabilise and interrupt mainstream psychology discourses that frame adolescence as a phase of 'turmoil and stress', hence legitimising the need for adults, through relevant structures e.g. health policies, to patronise young people.

Non-judgmental policies constitute best practice in HIV prevention. Increasing individuals' autonomy and choices is a critical approach to prevention interventions (Godfrey-Faussett, 2016). As such, health interventions that are not truly reflective of the youths' needs are irrelevant.

CHAPTER 9
INTEGRATIVE DISCUSSION AND CONCLUSION

9.1 Introduction

This chapter is the last of a total of eight sequentially presented chapters. It begins by reflecting below on the title of the thesis to refresh the reader's mind. The chapter briefly focuses on the study participants, before delving into an integrative discussion, reflecting on the key findings from each of the four findings chapters. It describes the limitations of the study and explores the contribution that the study makes to the body of knowledge. Finally, it presents the recommendations and conclusion. Suggestions are also made for future research.

9.2 Title of the thesis

As a form of recap, the title of the thesis reads: *Voluntary medical male circumcision and condoms for HIV prevention among school youth: Marginal voices for a coherent sexual and reproductive school health policy in Zimbabwe.* The title is largely informed by, and squarely falls under the ambit of Health Promotion. The roots of Health Promotion as a field are firmly planted in the Ottawa Charter of 1986, a document which largely constitutes the *Magna Carta* for Health Promotion as a discipline. This landmark international agreement merges into the WHO's (1948) conceptualisation of health as a fundamental human right (Nutbeam, 1998). The Ottawa Charter identifies three different, but related strategies for Health Promotion. These are; (1) advocacy, (2) enabling all persons to attain their full health potential, and (3) mediating between society's diverse interests in the pursuit of health (Nutbeam, 1998). Importantly, all the elements of the three-pronged approach to Health Promotion were intricately knitted in this thesis to present health from a rights-based approach.

In pursuit of the above, the title of the thesis took a social justice flair by foregrounding learners as its key participants, a population segment which is traditionally marginalised both in policy formulation processes and most of social research endeavours. Often, in-school youth are often alienated in the research process and they are mostly presented as objects of research. The greater involvement of youths, a marginalised social group is consistent with the tripartite strategies informing Health Promotion presented above. The second part of the title sought to expose the *aporia* or logical disjunction in Zimbabwe's current school health policy framework. This thesis argued that rolling-out VMMC in a context where condom access is not only limited but forbidden and 'criminalised' is actually self-defeating. Furthermore, the thesis argued that through punitive responses espoused by the Ministry of Primary and Secondary Education (MoPSE) in the context of in-school adolescents found in possession of barrier contraceptives such as condoms, the government of Zimbabwe has inadvertently made itself a formidable enemy of adolescent sexual and reproductive health (ASRH). All these are subtly encapsulated in the title of the thesis.

9.3 Integrative discussion

Findings from the current study exposed the limits of sole dependence on abstinence, particularly when dealing with adolescence in general and youth in school. Clearly, an over emphasis on abstinence is contradictory to the HIV combination prevention approach that seeks to provide prevention choices that can be selected and used in combination to mitigate the risk of getting HIV infection (Kelvin et al., 2016). The study highlighted the need for multiple options, especially given that a one size-fits all approach is not adequate (Gollub, 2006). For example, research has shown that despite stern warnings against early sexual debut, some young people elect to be sexually active with their peers (Sundby, 2006). It is a fact that there is differential exposure and risk to HIV infection between boys and girls, with girls being more vulnerable and susceptible by comparison to their male counterparts; hence gender is a

significant social determinant of health. Research has shown that adolescent girls (between 15 and 19 years) are four times more likely to be infected with HIV than boys their age (Bekker et al., 2015; Abdool Karim et al., 2017). Therefore, there is need to ensure that even those sexual liaisons among peers are safe. If anything, there is no guarantee that sexual activity involving school youth is limited to their peers.

Considering HIV prevention options, there is need for policy makers to rethink prevention options for adolescent girls since "something is better than nothing" (Gollub, 2006, p.211). Abdool Karim et al. (2017) lament that most known methods of HIV prevention such as abstinence, condom use mutual faithfulness have had little effect on reducing HIV incidence, hence those who are confined to messages emphasizing abstinence only are at increased risk of infection. This thesis argues that for schools to maintain their traditional function as centres for the dissemination of important SRH messages that can assist the girl child to maintain an HIV sero-negative status, avoid unintended pregnancy, and STIs which may culminate into excelling in academic performance, there is need for a shift to youth relevant ASRH education and increased access to HIV prevention options.

Although it is known that a whole constellation of factors militates against young adolescents' quest for protection against the unintended consequences of sexual activity for example power differentials emanating from both socio-cultural gender norms, and economic vulnerability, the need to empower this population segment through making some choices available remains pertinent. Providing adolescents with prevention option is a strategy of paramount importance. This is so because abstinence, since its inception for example in the ABC approach, has been known as a prevention strategy that despite being highly effective against HIV infection if adhered to, but offered little or no impact at all in terms of HIV prevention.

While it cannot be denied that the socio-cultural, and religio-cultural milieu within which school youth are raised in Zimbabwe, and obviously in most ESA countries, is rather restrictive in terms of youth sexuality, other factors should be considered, and questioned. For example, most aid programmes and interventions require adherence to abstinence and faithfulness (Doyal, 2013). These are ideals which are rather Utopian in nature. The President's Emergency Plan for AIDS Relief (PEPFAR), is an example of an NGO known for advancing these ideals. Such could be responsible for the fragmented way VMMC is implemented among school youth. Given that the current study indicated that abstinence was viewed as some form of 'textbook solution', it is important that options to mitigating HIV be explored as a matter of urgency.

The current study explored in-school adolescents and selected adults' perspectives on the mitigation of HIV incidence through a combination approach using voluntary medical male circumcision (VMMC) and condoms. The study is timely given the recent roll-out of VMMC in the so-called 'priority locations', which are countries characterised by a low prevalence of circumcision and a generalised heterosexual HIV epidemic. Zimbabwe is one of the priority locations and is urgently in need of such a health intervention as VMMC. There is a dearth on research foregrounding youth participants, who ironically constitute above 60% of the VMMC client base in this Southern African country (Ashengo et al., 2014; WHO, 2013).

Most of the adult participants were teachers. Teachers act in 'loco parentis', meaning that they assume the role of parents to the learners. As such, their views are critical to the harmonisation of adolescent sexual and reproductive health policy, and legislative provisions of other international agreements such as the United Nations' (1989) *Convention on the Rights of the Child*. While most of the teacher participants interviewed were supportive of a right-based approach, some opposed it, and accused it of being too liberal, alleging that such permissive approaches pose the danger of compromising chastity and promoting promiscuity.

This largely religio-cultural perspective contradicts with the human rights mantra espoused by the guiding philosophy of Health Promotion. Similarly, social worker participants in a study by Essack, Toohey and Strode (2016) bemoaned that liberal laws in South Africa promote sexual irresponsibility among adolescents. However, majority of adult participants in this study expressed concern over discourses framing adolescent sexuality in negative terms and that these must be questioned to pave way for alternative discourses that promote (re) examination of youth narratives on sexuality.

It emerged that school youth's meaning making regarding combination prevention of HIV/AIDS is too parochial, and hence a cause for serious concern. Precisely, they framed a sustainable HIV prevention method as one that includes use of prevention products such as condoms. As such, these youths in question failed to appreciate that protective behaviour, which include reducing the number of sexual partners, avoiding inter-generational (age-disparate) sex, and importantly abstinence are methods of mitigating HIV incidence recognised by the HIV/AIDS discourse community. These protective behaviours are entailed in the 'ABC' approaches (Baxter & Abdool Karim, 2016). The first two components (A and B) of the 'ABC' approach are based on avoiding risk, while the last one (C) aims at reducing risk (Thomas, Bassi, Continoho, & Goyal, 2017). Apparently, narratives originating from most of youth participants indicated that their constructions of the reality of preventing HIV incidence are largely a dichotomy of risk reduction versus risk avoidance.

The broader implications for this new and critical finding are such that the promotion of a multiplicity of combination prevention approaches must be accelerated. It was evident that school youths' understanding of combination prevention is limited to medicalised circumcision for HIV prevention and condoms only. In keeping with Tatoud's (2011) 'HIV prevention buffet', the HIV/AIDS knowledge economy needs to be boosted to fully equip young key populations (YKPs) with the knowledge of multiple prevention methods. While methods such

as masturbation (a form of non-penetrative sex) which are critical in terms of enhancing sexual release are even encouraged by experts, learner participants demonstrated lack of knowledge, and a negative attitude towards non-penetrative options of sexual gratification. Perhaps such responses emanate from the fact that adolescent sexual behaviours are largely influenced by peer pressure, particularly in early adolescence (Selikow, Ahmed, Flisher, Mathews, & Mukoma, 2009).

It also emerged that despite the failure of abstinence only programmes (Baxter & Abdool Karim, 2016), the government of Zimbabwe through the Ministry of Primary and Secondary Education remains adamant, and no policy shift towards recognising alternative methods of HIV prevention among in-school adolescents is foreseeable soon. It is this adamancy to shift from abstinence as *the* method, which has inadvertently led to the current *aporia* or logical disjunction in the provision of VMMC for HIV prevention among in-school adolescents where a biomedical method whose efficacy is clearly known to be dependent on correct and consistent condom use is provided in a manner that portrays it as if it is a standalone method. Best practice or the public health model requires that emphasis must be made to clarify that VMMC provides partial protection against the heterosexual transmission of HIV (Matovu et al., 2007; UNAIDS, 2007).

This thesis advanced a spirited argument that offering of VMMC in a fragmented fashion, that is, without a robust health education and critical preventative accessories such as a supply of condoms has the potential to undermine the benefits of medicalised circumcisions. Evidence indicates that the most effective strategy to decrease HIV incidence is a combination of biomedical, behavioural, and structural interventions, which simultaneously reduces susceptibility to new HIV infections and promotes the uptake of key prevention methods (Isbell et al., 2016).

Despite the finding that in-school adolescents' knowledge of combination prevention was rather parochial, and limited to condoms and VMMC, which is apparently a matter of concern, all is not lost. Adolescent female participants demonstrated their understanding that a male partner's status of having been medically circumcised does not directly reduces the woman's susceptibility to infection. This is important because there is limited and insignificant evidence from epidemiological studies indicating that a woman directly benefits from the man's medicalised circumcision status (Weiss, Hankins, & Dickson, 2009). The knowledge position demonstrated by study participants, triggers concern, although it is known that knowledge per se is not adequate. As such, it will be reductionist to postulate that knowledge would directly translate to healthy behaviours among adolescent girls.

Adolescent girls are young key populations (YKPs), accounting for over 62% of new infections in east and southern Africa (ESA) (UNICEF-ESARO, 2015). Therefore, young female participants' understanding of the protective efficacy of VMMC as being limited to the male must be reinforced and reiterated in VMMC interventions. It is critical that in terms of VMMC information, education and communication (IEC), no one should be left behind. Therefore, public health messaging should strive to be adequately nuanced and sufficiently clear, not only in highlighting the partial protective efficacy of VMMC against the transmission of HIV through heterosexual, penetrative vaginal sex, but also in bringing to the fore the message that women do not directly benefit from partner's circumcision status. Having many men circumcised reduces HIV prevalence hence women indirectly benefit because chances for meeting an HIV sero-positive partner are reduced.

The argument of this thesis has been that the efficacy of VMMC as a population level health strategy can only be realised if it is offered as a comprehensive approach. As such, VMMC messaging must not be sex-segregated, but inclusive so that females are not deceived by men's circumcision status. There is potential that women in general and young adolescents

might be complacent and take it for granted that the partial protection from HIV infection conferred through medicalised circumcision is also about them. Gruskin (2007), raised a similar caution that messaging promoting risk awareness and prevention should equally target women who have sex with circumcised men, since the partial protection messages can create false hope.

Young women are more vulnerable to HIV incidence than their male counterparts, due to a mosaic of factors ranging from physical to socio-economic (Poku, 2005; Harrison, Colvin, Kuo, Swartz, & Lurie, 2015). Therefore, their acknowledgement of susceptibility to HIV is risk important. The fact that some female adolescent participants thought that a male counterpart's circumcision status is confirmation for a sero-negative HIV status is a matter of concern.

From the findings, one thing seems certain ─ youth in-school will not stop either having sex or wanting to have sex. This is in keeping with the notion that, "human beings are sexual by nature" (Berer, 2004, p.7). Adolescents have sexual urges to fulfil, and these cannot be quenched by the mere wish to abstain. Perhaps, this explains the reason why they dismissed and excluded abstinence from the list of methods for preventing HIV incidence. According to Jackson (2002), perhaps the only way abstinence can work is through combination approach where it is buttressed by non-penetrative methods of attaining sexual gratification (e.g. masturbation). Findings indicate that masturbation is no option, condemned by both the society and the individual.

However, a conundrum exists in that despite in-school youth being sexually active, the social legitimisation of contraceptives such as condoms has a long way to go, and a bumpy road ahead presents itself. The accessibility of condoms to in-school youths is socially frowned upon to the extent that adolescents' attainment of full sexual rights may remain an inconceivable dream. Findings from this study demonstrated that the political economy of

adolescent sexuality remains highly contested to the extent that even safest forms of sex such a sex with oneself remain highly abhorred and stigmatised behaviour. Furthermore, taking a gendered approach, young male participants indicated that heterosexual sex also plays a critical role, that of asserting maleness and gaining the experience which is needed later in life. Similarly, some argue that such acts as caressing, kissing and even sex are developmentally normative (Essack, Toohey, & Strode, 2016).

The finding that fear of starving the girlfriend during the healing period might constitute a barrier to the uptake of VMMC corroborated with previous evidence emanating from girl participants in the current study that grouped boys in the three categories as follows; *(1). Not yet sexually active, (2). Sexually active and willing to stop (3). Addicted to sex* (FGD: 1A). It is against this background that the conservatism towards adolescents' access to SRH services is raised in this thesis as a matter of concern. Through anti-adolescent sexuality policies, the government sanctions the accessibility of condoms to in-school youth without apparent concern for the consequences of such sanctions on the ultimate health of youth in-school. Attempts at understanding how policymakers view the contradiction in promoting VMMC for HIV prevention while ignoring the issues of access to condoms can be a thought provoking process.

This thesis also argues that there is need to critically think about the broader health implications of a discourse of "best interests of the young person" particularly in matters of adolescent sexual and reproductive health (ASRH). The very *best interests* may turn to be retrogressive especially when we look at the potential repercussions of a prohibitive stance towards mitigating HIV incidences among the young key population. Young adolescents find themselves becoming a key population through no fault of theirs. For example, there is a bulge of misconceptions and misinformation including that having sex with a virgin treats or reverses an HIV sero-positive status and that young people are HIV free (Dowsett & Couch, 2007). As

such, a robust sex education and increased access to contraceptives particularly barrier ones such as condoms should be promoted based on the principle; the end justifies the means. Caution should be raised that listening to moral entrepreneurs who mix cultural rigidity and religious dogma with public health can be detrimental to ASRH. Young adolescents need to be enabled to attain healthy lifestyles.

9.4 Implications for interventions and practice

The study has several implications for interventions and practice. The need for public health programme implementers to be mindful of a considerable proportion of adolescents who choose to be sexually active, despite the normative framework that prohibits them to initiate sexual activity. Although early onset of sexual activity by adolescents is often frowned upon as a moral shortcoming, it is important to reiterate that such young people still have the right to escape the undesirable consequences of unsafe sexual activity (Sundby, 2006). It is therefore incumbent upon adults to avoid being judgmental, particularly through restrictive policies and legislation. It has emerged that VMMC among school youths is a neglected area, perhaps because learners are expected to be sexually chaste, but if so, one would wonder why they are circumcised now.

While policies and legislation are by design meant to advance the interests of the young people, and protect them from sexual exploitation, they tend to discriminate based on age. As such, there is need to (re)examine the concept of 'reproductive rights' and its broader implications. Reproductive rights are often misconstrued as adult privilege, which is not correct. Adolescents have the right to self-protection as well as the right to be protected against STIs; hence they must be allowed access to preventative tools such as condoms. If adolescents go through voluntary medical male circumcision (VMMC) for HIV prevention, it only defeats

logic that they are not entitled to a comprehensive package that comes with this biomedical approach to ensure total protection. Some participants indicated that they are keen to practice safe sex to the extent of using two condoms per sexual episode. This thesis argues that such positive tendencies need to be strengthened, and misconceptions that practices such as 'double bagging' (using two condoms at once) enhances safety must be cleared.

To increase the efficacy of strategies such as VMMC particularly among school youths, there is need to adequately address the various aspects that may conspire to constrain the efficacy of medicalised circumcision. Messages of the partial protective efficacy of VMMC must be clear, and accessories such as condoms must be made available particularly for those who may not abstain. However, the harmful effects of adolescent sexual activity must be explicitly articulated to enable adolescents to make informed choices. Furthermore, while prevention of HIV among boys has received attention through VMMC, the sexual and reproductive health of girls in school has received much less or no attention at all since school-based sex education is now defunct. This is so despite that girls are more susceptible to HIV infection than their male counterparts (Abdool Karim et al., 2017). Therefore, best practice should ensure that both sexes have programmes adequately tailor-made for their needs.

An important finding in this study is agency. In line with Bandura's (2006) agentic theory, adolescents have demonstrated that they are not without norms. Adolescents have shown that despite that their mental maturation is often questioned; they have the capacity to act responsibly. This inherent agency manifests in their initiative to evade structural barriers such as consent requirements to get circumcised without adult involvement or knowledge. The broader implication is that VMMC is acceptable among adolescents, but there is need to increase access to the service. The various dimensions which encompass availability, accessibility, affordability, adequacy, acceptability, and ability must be fulfilled (Obrist et al.,

2007). This is particularly pertinent in resource constrained settings such as less economically developed (LEDCs) countries, including Zimbabwe.

9.5 The study's contribution to academic knowledge

The study foregrounded young people (in-school adolescents) as its key research participants. Conducting research *with* the youth is in keeping with the paradigm, 'new' sociology of childhood (James & Prout, 1990). James and Prout's (1990) germinal concept of the *'new' sociology of childhood* has broader implications for contemporary critical youth studies, a paradigm to which this current study largely subscribes. Consistent with this paradigm, the current study is located within the contours of the philosophy of distributive justice. In social research, distributive justice is pre-occupied with the goal of redressing previous societal injustices (Marshall & Rossman, 2011). The logic of using this approach finds relevance in the need for ethical researchers conducting research with humans to honour their prerogative to seek social justice. It cannot be denied that most social research tends to illuminate issues relating to adolescents through the adult's lens, something which obviously undermines the agency of young people. Findings from this study have revealed that youths are agentic and taking cognisance of that may positively impact health promotion interventions such as VMMC for HIV prevention.

As highlighted above, social justice entails a due consideration for previously marginalised populations such as the youth in general, and youth in-school. Conrad et al. (2015) offer a spirited defence for conducting research *with* what Goldberg (2013) terms the 'marginals', in pursuit of remedying previous injustices. Furthermore, Conrad et al. (2015, p.110) contend that consistent with contemporary ethical guidelines for social research, excluding "individuals from the opportunity to participate in research based on attributes such

as age" does not constitute best practice. Similarly, Singh et al. (2006) assert that because adolescents bear the brunt of the HIV and AIDS epidemic, particularly within the context of sub-Saharan Africa, studies in this group are not only critical, but also constitute best practice.

Driven by a social justice agenda, the researcher surmised that it will enable him to engage with the youth (conceived as marginals) in a critical sense, as the title of this thesis suggested; the researcher deliberately committed to 'conducting research *with'*, and not 'conducting research *on'* school youths. The researcher is conscious that other readers might interpret *"with"* as implying a participatory action research (PAR) approach, which was not the case in this study, hence the need to raise a note of caution here. Foregrounding the preposition *"with"* simply serves to locate the study within the contours of Health Promotion, a discipline synonymous with commitment to a social justice approach to public health matters.

Apart from the apparent dividends synonymous with conducting research *with* young participants such as the opportunity for meaningful engagement to co-create knowledge that is relevant to young key populations (YKPs), doing so can also be immensely rewarding to the researcher. Precisely, it provides a window through which the researcher can explore young people's ways of knowing and meaning making (Conrad et al., 2015). Conducting research with adolescents offers the adult researcher an opportunity to throw a glimpse into the life worlds of adolescents. On the other hand, the youth participants got an invaluable opportunity to define their material realities, and importantly shared their own constructions of reality regarding how they experience their sexual and reproductive health and well-being. A vivid example of such age specific constructions is the youth participants' rejection of abstinence as a prevention method against HIV infection. To them, a method is one that allows an individual to indulge in sex in a context of perceivably limited opportunity for negative consequences; an example of such is condom use and the reduced risk (real or perceived), of STIs or unplanned pregnancy.

Selecting in-school youths as the primary focus in the current study did not only serve an ethical mandate; that of affording the previously marginalised and muted voice an opportunity to be heard, but also assisted in (re)asserting the youth's social agency. Both the notions of voice and social agency proved to be critical. In his agentic theory, Bandura (2006, p.164) affirms that "people are self-organising, proactive, self-regulating, and self-reflecting…they are not simply onlookers of their behavior". The youth did not only appreciate participating in the study, but they also valued the opportunity to conduct a diagnosis of community problems through their own privileged lens as subjects of the public's moralising gaze. In that sense, youths should be conceived as community assets (Flicker et al., 2008), because they have an agentic characteristic (Bandura, 2006). Essentially, acknowledging the agency of adolescents challenges the hegemonic 'storm and stress' discourse that inadvertently undermines the agency of young people.

The study therefore, created a space for asserting the social agency of marginalised youth participants. More so, the strategy to foreground youth participants did not only succeed in granting the in-school adolescents a sense of self, but further demonstrated deep respect for their worldview which is clearly critical to health promotion interventions such as mitigating HIV incidence through a combination prevention approach. Doing research with such 'othered' members arguably contributes to challenging the erasure of their voices from dominant discursive spaces and (re)asserts their agency. Voices of the marginal are critical to policy formulation not least because they challenge us to appreciate knowledge from alternative perspectives. Furthermore, policies are likely to be acceptable to adolescents if they are crafted in a consultative manner that demonstrates respect for the views of young people as the primary beneficiaries of specific health policies.

Research is a potentially marginalising process (Greenwood & Levin, 2000). It can perpetuate hegemony through traditional stereotypes where 'othered' populations such as the

youth are relegated to the margins while researchers pre-occupy themselves with the 'centre' (Goldberg, 2013). In research, adults epitomise the centre, and they are often privileged to speak on behalf of children and the youth, a scenario this thesis accuses of being unsustainable, conformist and importantly in conflict with the ideals of the United Nations' (1989) *Convention on the Rights of the Child*. This watershed convention stipulated that, "children [and/or the youth population in general] be informed, involved and consulted about matters that affect their lives" (Conrad et al., 2015, p.115).

Working with the youth population in the field of health promotion, Flicker et al. (2008) propose that the youth should be regarded as community assets, privileged with the potential to forge viable partnerships in making a diagnosis of community health challenges and developing possible solutions. Similarly, this study makes a clarion call for greater inclusion of young people in the design and implementation of health interventions targeting the youth. In the current study, the narratives of school youth obviously illuminate the research problem of mitigating HIV incidence among youth in schools. Participants demonstrated a plausible degree of understanding the challenges posed by HIV at both the micro and macro levels. Their resilience and agency challenged the taken-for granted assumptions.

9.6 Limitations of the study

The study adopted a qualitative research design, using key informant interviews (KIIs) and focus group discussions (FGDs) to elicit adequately nuanced views, feelings, opinions and thoughts regarding mitigating HIV incidence among in-school adolescents through a combination prevention approach. In qualitative research, the researcher is the key instrument for data collection (Kvale, 1996; Neuman, 2014). Therefore, limitations I would bring to the fore relate to methodological considerations and their broader implications on the findings reported in this doctoral thesis.

As mentioned above, that the researcher plays an integral part in qualitative research; I made effort to defocus, prior to entering the research site. Defocusing is a process of getting rid of one's own biases to enhance entering the field with a clean mind-set, one devoid of previous misconceptions and inclinations (Neuman, 2014). In keeping with the concept of the researcher as key instrument, I must declare that my presence in the study cannot be ignored. According to Davies and Dodd (2002, p. 281), "An implicit part of ethical practice thus involves the acknowledgment and location of the researcher within the research process". In pursuit of the goal to produce insightful findings, I maintained a reflexive attitude throughout the study, conscious of my own short-comings. However, this again is subjective and cannot be ignored because its effect on the quality of results may be difficult to estimate.

The second limitation is that of positionality. In social research, positionality is pre-occupied with the power relationship between the researcher and study participants (Harding, 2013). The researchers (principal researcher and research assistants) made meticulous efforts to develop rapport as a means to an end, which was to enhance the authenticity, confirmability and trustworthiness of the study findings. Good rapport enables participants to feel comfortable to share nuanced snippets of their experiences, feelings, opinions and thoughts related to the topic being explored. The researchers did what they could reasonably do to ensure rigour. Throughout the data collection phase, the researchers were constantly aware of the existing power dynamics and the potential impact on the data. However, in a study where data were partly collected by others, it is difficult to guarantee that what the research yielded is the best of what could have been elicited, had it been that the principal researcher was the sole moderator of focus group discussions.

Despite the cogent descriptions of researcher-participant interactions detailed in the Methodology chapter, taking into cognisance the sensitivity of the topic, largely emanating from its focus on health and sexuality vis-à-vis learner status (in-school youth) coupled with a

diversity of what I can describe as ‘puritanical expectations’; it remains difficult to guarantee the reader that social desirability bias was completely eliminated. This is further exacerbated not only by the fact that the researchers were adults, but also the double privilege of being educated adults in positions of authority and interviewing learner participants on a topic culturally regarded as taboo. Against this background, it may be possible that learner participants may have exercised a considerable degree of caution in sharing their views with adults because of the fear of being judged.

Thirdly, although the principal researcher scrupulously reminded co-researchers (female educators who assisted in the study by interviewing female learner participants) to provide particularly thorough assurances of privacy, anonymity and confidentiality, the overall impact of such on mitigating social desirability bias remains an estimation. This is particularly so, given that focus group discussions (FGDs) were the mode of data collection among in-school youths. According to Liamputtong (2011), it is impossible for a focus group moderator to promise confidentiality in an FGD set up because he/she can only request members to treat the views shared by fellow participants as confidential but does not have control over what happens after the interview. Precisely, the moderator’s privileged position is short-lived, and I surmise that participants understood that, hence the limits to confidentiality in FGDs.

Lastly, given the small sample of adult participants in this study, it is possible that their perspectives on the combination prevention approach to mitigating HIV among school-goers may not be reflective of all teachers and health workers in the Midlands province or Zimbabwe more broadly. However, it is possible that perspectives emanating from this study may be espoused in the general context of adolescent sexual and reproductive health in Zimbabwe.

9.7 Recommendations

Actionable recommendations for both an effective and sustainable roll-out of VMMC ought to adopt a social justice approach. It is so because a one-size fits all approach to ASRH is not best practice as adolescents, like adult beings have varying cognitive capacities (Essack, Toohey, & Strode, 2016). This thesis surmises that a rights-based approach to ASRH, coupled with robust implementation of research studies would present better opportunities to implement youth relevant interventions.

This study has established that educators are structurally constrained and cannot explicitly impart sexual and reproductive health knowledge and the practical skills required by the youth particularly in the school setting. Similarly, educators in Chile and South Africa are not free to dissect the subject of youth sexuality (Casas & Ahumada, 2009; Muzenda, 2016). Therefore, there is need for policy reviews that seek to align policies and guidelines with findings from formative research.

9.8 Conclusion

The need to protect adolescents requires to be cautiously balanced with the need to establish solutions that are consistent with the social realities of this young population. This thesis argued that a patronising stance towards the autonomy of adolescents can be counterproductive. As such, the adult driven decisions which supposedly advance a discourse of 'best interests of the youths' needs to be interrogated more critically, particularly from a social justice perspective. This thesis challenged stereotypical assumptions about the capacity of in-school adolescents regarding HIV prevention.

While increasing condom access among school youths in the name of firstly, enhancing the efficacy of VMM, and secondly to increase prevention options for school girls may be judged as a radical idea, the call is legitimate. This is so because it exposes the empirical failure of such normative approaches as the "existence of a 100% method" (Gollub, 2006, p.211).

Dependence on abstinence while energetically endorsing VMMC which is known to provide partial protection against HIV incidence HIV incidence is confusing, especially to young people who may still be grappling with the dynamics of adolescence.

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APPENDIX 1: ETHICAL CLEARANCE CERTIFICATE

UNIVERSITY OF KWAZULU-NATAL
INYUVESI YAKWAZULU-NATALI

6 November 2017

Mr K Shumba 213565322
School of Applied Human Sciences
Howard College Campus

Dear Mr Shumba

Protocol Reference Nnumber : HSS/1515/015D
New Project title: Voluntary medical male circumcision and condoms for HIV prevention among school youth. Marginal voices for a coherent sexual and reproductive school health policy in Zimbabwe.

Approval notification – Amendment Application

This letter serves to notify you that your application for an amendment dated 1 November 2017 has now been granted **Full Approval**.

- **Change in Title**

Any alterations to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study must be reviewed and approved through an amendment /modification prior to its implementation. In case you have further queries, please quote the above reference number. PLEASE NOTE: Research data should be securely stored in the discipline/department for a period of 5 years

The ethical clearance certificate is only valid for a period of 3 years from the date of issue. Thereafter Recertification must be applied for on an annual basis.

Best wishes for the successful completion of your research protocol.

Yours faithfully

Dr Shenuka Singh (Chair)
Humanities & Social Sciences Research Ethics Committee

/pm

cc Supervisor: Prof A Meyer-Weitz and Dr KO Asante
cc Academic Leader Research: Dr Jean Steyn
cc School Administrators: Ms Ayanda Ntuli

Humanities & Social Sciences Research Ethics Committee
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APPENDIX 2: CONSENT FORM FOR INDIVIDUAL PARTICIPANTS

School of Applied Human Sciences

College of Humanities,

University of KwaZulu-Natal,

Howard College Campus,

Dear Participant

Informed Consent Letter

My name is **KEMIST SHUMBA**. I am doing a degree of Doctor of Philosophy in Health Promotion at the Department of Psychology, University of KwaZulu-Natal (Howard College Campus) Durban, South Africa.

The study topic is: *Voluntary medical male circumcision and condoms for HIV prevention among school youth: Marginal voices for a coherent sexual and reproductive school health policy in Zimbabwe.* To gather the information, I am interested in asking you some questions.

Please note that:

Your confidentiality is guaranteed as your inputs will not be attributed to you in person but reported only as a population member opinion.

The interview may last for about 1 hour and may be split depending on your preference.

Any information given by you cannot be used against you, and the collected data will be used for purposes of this research and/relevant scholarly publication only.

Data will be stored in secure storage and destroyed after 5 years.

You have a choice to participate, not participate or stop participating in the research. You will not be penalised for taking such an action.

The research aims at knowing the participants' perceptions of mitigating HIV incidence among school youth through use of condoms and voluntary medical male circumcision.

Your involvement is purely for academic purposes only, and there are no financial benefits involved.

If you are willing to be interviewed, please indicate (by ticking as applicable) whether or not you are willing to allow the interview to be recorded by the following equipment:

Recording equipment	Willing	Not willing
Audio		
Video		

I can be contacted at:

Email: 213565322@stu.ukzn.ac.za /kemishumba@gmail.com : Mobile Number 0774 715 258

My supervisors are Professor Anna Meyer-Weitz (PhD) (main supervisor) and Dr. Kwaku Oppong Asante (co-supervisor) of the Discipline of Psychology (Howard College Campus) University of KwaZulu-Natal.

Contact details:

Tel: + 27 (0) 31 260 7618 (South Africa)

E-mail: meyerweitza@ukzn.ac.za

You may also contact the Research Office through: Mr P. Mohun

Humanities and Social Sciences Research Ethics Committee

University of KwaZulu-Natal Research Office,

Tel: + 27 (0) 31 260 4557 (South Africa)

E-mail: mohunp@ukzn.ac.za

Thank you for your contribution to this study.

DECLARATION BY INDIVIDUAL PARTICIPANT

I…… **(**Full names of participant) hereby confirm that I understand the contents of this document and the nature of the research project, and I consent to participating in the research project.

I understand that I am at liberty to withdraw from the project at any time, should I so desire.

SIGNATURE OF PARTICIPANT DATE

…… ……

APPENDIX 3: CONSENT FORM FOR PARENT/GUARDIAN OF LEARNER PARTICIPANTS

My name is **KEMIST SHUMBA**. I am doing a degree of Doctor of Philosophy in Health Promotion at the Department of Psychology, University of KwaZulu-Natal (Howard College Campus) Durban, South Africa.

The study topic is: *Voluntary medical male circumcision and condoms for HIV prevention among school youth: Marginal voices for a coherent sexual and reproductive school health policy in Zimbabwe.* To gather the information, I am interested in asking your (son/daughter) to participant in a focus group discussion with fellow learners.

Please note that:

The anonymity of your (son/daughter) is guaranteed as his/her inputs will be reported only as a population member opinion.

The interview may last for about 1 hour and may be split depending on preference.

Any information given by your (son/daughter) cannot be used against him/her, and the collected data will be used for purposes of this research and/relevant scholarly publication only.

Data will be stored in secure storage and destroyed after 5 years.

Your (son/daughter) has a choice to participate, not participate or stop participating in the research. He/she will not be penalised for taking such an action.

The research aims at knowing the participants' perceptions of mitigating HIV incidence among school youth using condoms and voluntary medical male circumcision.

The involvement of your (son/daughter) is purely for academic purposes only, and there are no financial benefits involved.

If you are willing to allow your (son/daughter) to participate, please indicate (by ticking as applicable) if you are willing to allow the interview to be recorded by the following equipment:

Recording equipment	Willing	Not willing
Audio		
Video		

I can be contacted at:

Email: 213565322@stu.ukzn.ac.za /kemishumba@gmail.com : Mobile Number +263 774 715 258

My supervisors are Professor Anna Meyer-Weitz (Ph.D) (main supervisor) and Dr. Kwaku Oppong Asante (co-supervisor), Discipline of Psychology (Howard College Campus) University of KwaZulu-Natal.

Contact details: Tel: + 27 (0) 31 260 7618 (South Africa)

E-mail: meyerweitza@ukzn.ac.za

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Tel: + 27 (0) 31 260 4557 (South Africa); E-mail: mohunp@ukzn.ac.za

DECLARATION BY PARENT/GUARDIAN OF LEARNER PARTICIPANTS

I…… **(**Full names of parent or legal guardian) hereby confirm that I understand the contents of this document and the nature of the research project, and I consent to my (son/daughter) participating in the research project.

I understand that my (son/daughter) is at liberty to withdraw from the project at any time, should (he/she) so desire.

SIGNATURE OF PARENT/LEGAL GUARDIAN DATE

…… ……

APPENDIX 4: FOCUS GROUP GUIDE FOR LEARNERS

This form contains confidential (demographic) information. Complete in in privacy and return to the researcher folded.

Personal Information

(a) Age: ……

(b) Sex: ……

(c) Religion: …….

(d) **NB:** For male learners ONLY;

Circumcision status (*circumcised/uncircumcised*) Circumcision type, i.e. medical, cultural or religious (*medical, cultural, or religious*).

Main topic for discussion: Knowledge and understanding HIV and AIDS

Probe: knowledge about transmission and prevention of HIV

Knowledge and understanding of HIV combination prevention.

Understanding of voluntary medical male circumcision (VMMC) and its role in HIV prevention

Perceptions of roll-out and scale-up of voluntary medical male circumcision among learners.

Perceptions of prevention options available to learners.

Main topic for discussion: Access and acceptability of voluntary medical male circumcision for HIV prevention among youths.

Discuss learners' access to voluntary medical male circumcision for HIV prevention.

Discuss learners' utilisation of voluntary medical male circumcision for HIV prevention.

Explore significant others' (adults) perceptions of VMMC and condoms as a methods of preventing HIV transmission among learners.

Understand adolescent sexuality (including adolescent sexual and reproductive health).

APPENDIX 5: INTERVIEW SCHEDULE FOR KEY INFROMANTS

Main topic for discussion: *Knowledge and understanding HIV and AIDS*

Probe: knowledge about transmission and prevention of HIV

Knowledge and understanding of HIV combination prevention.

Understanding of voluntary medical male circumcision and its role in HIV prevention

Perceptions of roll-out and scale-up of voluntary medical male circumcision among learners.

Perceptions of prevention options available to learners.

Main topic for discussion: *Access and acceptability of voluntary medical male circumcision for HIV prevention among youths.*

Discuss learners' access to voluntary medical male circumcision for HIV prevention.

Discuss learners' utilisation of voluntary medical male circumcision for HIV prevention.

Explore adults' perceptions of condoms as a method of preventing HIV transmission among learners.

Main topic for discussion: *Challenges and opportunities for mitigating HIV incidence among school youths.*

What challenges do educators, the education system, and other stakeholders encounter in mitigating HIV incidence among learners?

Identify opportunities for promoting adolescent sexual and reproductive health (mitigating STIs, including HIV; and increasing knowledge of, and communication about adolescent sexuality).