# Speaking their minds: Adolescents' understanding of their vulnerability to HIV/AIDS in the context of existing intervention programmes in Malawi

**Dominic Mapopa Ndengu**

Submitted in fulfilment of the requirements for the degree of

Philosophiae Doctor

of the University of KwaZulu-Natal

Faculty of Education

Durban, South Africa

Supervisor: Prof. Naydene de Lange

December 2009

# Dedication

This work is dedicated to the youth of Malawi who have succumbed to HIV/AIDS and to those who are silently but painfully struggling with the virus.

# Declaration

I, Dominic Mapopa Ndengu, declare that the work contained in this study is my own and that it has not been, nor is it being, concurrently submitted for any other degree than the degree of Doctor of Philosophy of the University of KwaZulu-Natal. All reference material contained in here has been duly acknowledged. The views expressed in this dissertation are my own and do not in any way reflect those of the University or my supervisor. I take full responsibility for any error of fact or judgement herein.

Signed_____ Signed_____

(Dominic Mapopa Ndengu) Prof. N. De Lange)

(Student) (Supervisor)

# Abstract

This study is undertaken against the background of a seemingly worldwide outcry against the lack of behavioural change among adolescents, in spite of their knowledge about how one can contract or avoid contracting HIV/AIDS, and the availability of intervention programmes. The study is set in four secondary schools in Nkhata Bay District in Malawi and involves forty four learners ranging in age from 15 to 19. It seeks to understand how secondary school adolescents view their own vulnerability to HIV/AIDS by exploring their understanding and experiences with regards to the pandemic.

The study is informed by a qualitative, interpretivist paradigm and follows a phenomenological design, allowing participants to create meaning around the phenomenon of their vulnerability to HIV/AIDS. In addition, the study is guided by the conceptual and theoretical frameworks derived from key concepts and theories in the fields of Educational Psychology, health and HIV/AIDS, with an eco-systemic frame as the over-arching framework. I utilised individual interviews, photovoice and focus group discussions as the main methods of data generation. I incorporated elements of participatory approaches, allowing participants to reflect on their understanding of their vulnerability to HIV/AIDS. The data generated was subjected to an inductive process of analysis known as open coding, which provided me with insight into the contextual factors that lead to adolescents' vulnerability to HIV/AIDS.

The findings indicate that the mediating factors of adolescents' vulnerability to HIV/AIDS are more complex than has been thought, and that no single model can meaningfully explain adolescents' motives for engaging in risky sexual behaviour. The findings, however, tend to point to the fact that adolescents understand their vulnerability to HIV/AIDS as arising firstly, from an individual level where knowledge, attitudes and beliefs are major

determinants of behaviour, and secondly from the interpersonal level comprising family, peers, school, community and society at large as additional crucial determinants of behaviour. The findings also seem to indicate that adolescents who participate in intervention programmes in school experience some positive behavioural change, but that the delivery inhibits their full potential. I therefore theorise a new perspective of looking at the phenomenon to be called *"Revolving adolescents' vulnerability to HIV/AIDS"*. I propose that adolescents' vulnerability to HIV/AIDS can best be viewed from the perspective of multiple theoretical lenses in which the adolescent interacts with protective and risk factors, both from within himself and from the social environment in relation to intervention programmes.

This study has further lent support to the growing body of knowledge about photovoice as a method of research. I further theorise that photovoice has the potential to facilitate the understanding of complex social issues such as HIV/AIDS which words or numbers cannot adequately explain, and which I call **"** a *hidden reality"*.

# Acknowledgements

This was a long and arduous journey especially at 60. Fortunately, I never walked alone. Many people have been pulling me all the way. I am particularly indebted to the following individuals, groups and institutions:

To my government (the Malawi Government) and Mzuzu University for according me this rare opportunity to pursue my PhD studies at the University of KwaZulu-Natal. Thank you for the moral and financial support you gave me.

To my supervisor, Prof. Naydene de Lange for your patience, warmth, understanding and untiring advice. You embraced me at a critical stage of my journey, the proposal writing. You gave all that you could. Thank you. I thank you also for the NRF grant which has greatly contributed to the success of this work.

To my first supervisors, Prof. N. Bojuwoye and Prof. A. Shumba without whose foundation I would not have started on this journey. Indeed without a start there is no ending.

To Dr. Shakila Reddy for generously lending me your draft thesis which I have kept for three years and which provided me with valuable insights into researching HIV/AIDS.

To my fellow PhD cohort students and supervisors whose constructive criticism and encouragement kept my fire of hope burning. Without you I would have tumbled.

To my participants, research assistants, link teachers and school management at all study schools. I was thrilled by your enthusiasm. To my

learner participants I say, you directed the course of this study and have improved my ideas of your understanding of the HIV/AIDS pandemic.

To my father, mother, brothers and sisters for your encouragement and love even in the face of adversities. You have been the fountain of my inspiration. I thank you!

To my son, my daughter-in-law and lovely grand children- Mapopa (jnr), Yamikani and Lindiwe for the deprivation my absence caused at the time when you needed me most. May this piece of work give you inspiration to tackle similar and bigger life challenges.

To my colleagues at Mzuzu University, and in particular Ellen Mulaga, P.B. Kayira, C.E Sangoma, Allan Kanyundo, Catherine Chibambo, Hamida Chiwaya for your moral and technical support. To Mr Sangoma I say, your initial contacts with schools opened doors for this study. I thank you.

To Rose, Tereza, Fayi, my dearest, words cannot express my deepest gratitude to you for having allowed me spaces to pursue my dreams and for enduring my absence so long. During this journey you provided me with unfathomable love, encouragement and support. I thank you!

# Table of Contents

# Table of Figures

# List of Tables

# List of Appendixes

# List of Abbreviations

| | |
|---|---|
| AAUW: | American Association of University Women |
| AIDS: | Acquired Immuno-Deficiency Syndrome |
| CDSS: | Community Day Secondary School |
| FGD: | Focus Group Discussion |
| FHI: | Family Health International |
| FIFA: | Federation of International Football Associations |
| GNDP: | Gross National Domestic Product |
| GRS: | Grassroots Soccer |
| HBM: | Health Belief Model |
| HIV: | Human Immuno-deficiency Virus |
| LO: | Life Orientation |
| MANEB: | Malawi National Examination Board |
| MBC: | Malawi Broadcasting Corporation |
| MOEHRD: | Ministry of Education and Human Resources Development |
| MPRS: | Malawi Poverty Reduction Strategy |
| MSCE: | Malawi School Certificate Examinations |
| NAC: | National AIDS Commission |
| NGO: | Non-governmental Organization |
| NSO: | National Statistical Office |
| PLSCE: | Primary School Leaving Certificate Examinations |
| PLWA: | People Living with AIDS |
| PTA: | Parent-Teacher Association |
| PYD: | Positive Youth Development |
| SABC: | South African Broadcasting Corporation |
| SADC: | Southern African Development Community |
| SAHRC: | South Africa Human Rights Commission |
| SCOM | Student Christian Organization of Malawi |
| SRGBV: | School-Related Gender-Based Violence |
| SSP: | Safe Schools Project |
| STI: | Sexually Transmitted Infection |
| T.A: | Traditional Authority |
| TRA: | Theory of Reasoned Action |
| TVM: | Television Malawi |
| UNAIDS: | United Nations AIDS |
| UNDP: | United Nations Development Programme |
| UNESCO: | United Nations, Scientific and Cultural Organization |

| | |
|---|---|
| UNFPA: | United Nations Population Fund |
| UNICEF: | United Nations Children's fund |
| USAID: | United States Agency for International Agency |
| VCT: | Voluntary Counselling and Testing |
| WHO: | World Health Organization |

# Chapter One:
# Introducing the Study

> *"Ah! this disease (sic) (is) very dangerous because as we can see nowadays most of the youth are the ones which (sic)(who) are dying because of this disease; mostly you can see that they are doing bad things but some people inherit from their parents."* (Khoza[1], age 17)

## 1.1 Introduction

In this chapter I provide an overview of the study which is visually presented in Figure 1. I begin the chapter by presenting the problem statement and then discuss the background to the HIV/AIDS problem in the world, Sub-Saharan Africa and Malawi. A brief description of the Malawian context, showing the socio-economic environment in which the HIV/AIDS pandemic is unfolding and being managed, is then presented. I also foreground my personal position and experiences with regard to the problem under study. This is meant to "bracket" my biases during the research process (Moustakas, 1994 cited in Creswell, 2007, p. 235). I then present the rationale for the study, its focus, aims, and research questions which guide the study. Furthermore, the conceptual and theoretical frameworks that inform the study are briefly highlighted and the concepts used in the study clarified. Finally, I describe the research design and methodology, and conclude the chapter with an outline of the remaining chapters.

[1] Pseudonym of participant

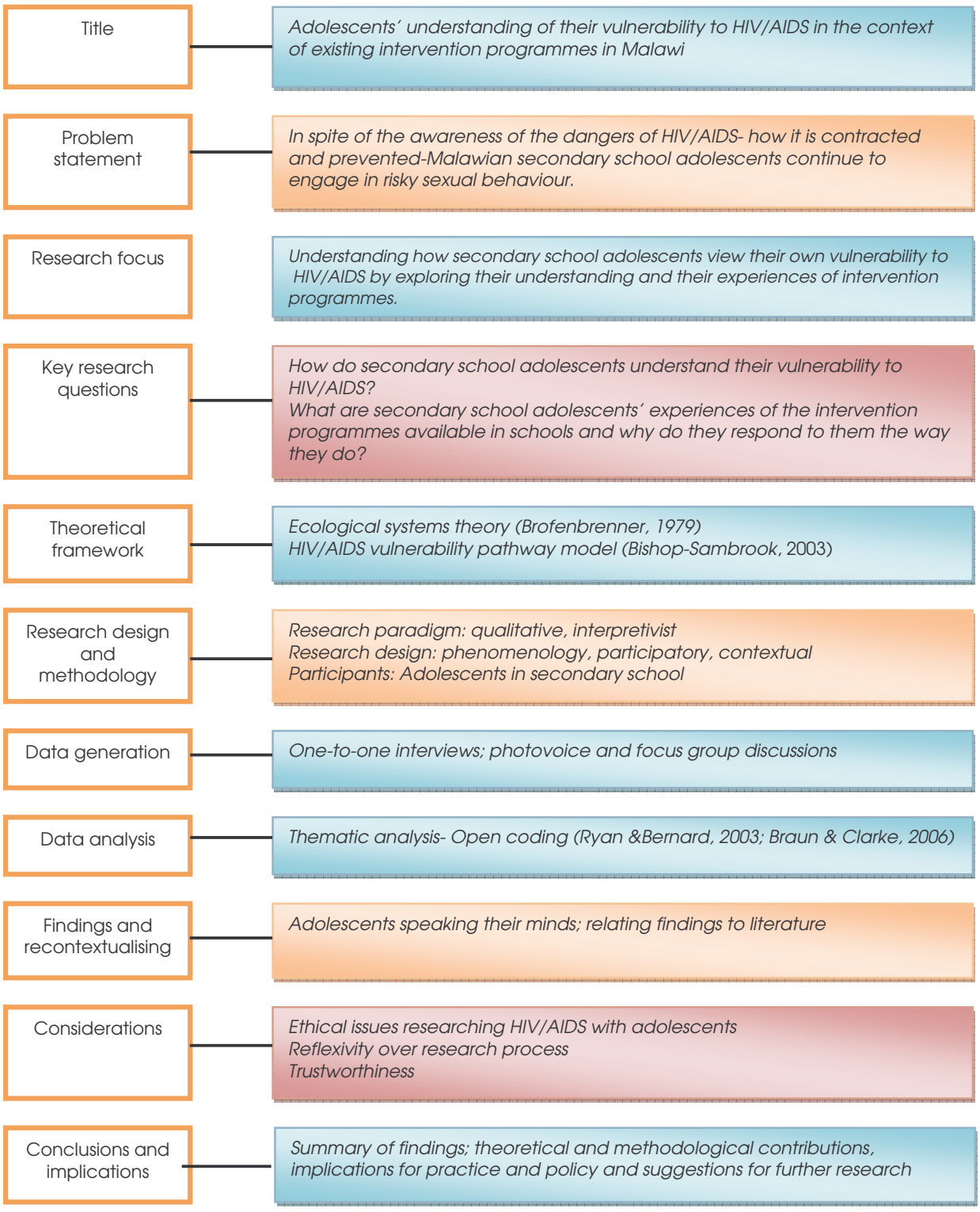



**Figure 1: An overview of the study**

## 1.2 Problem Statement

As alluded to in the quotation at the beginning of the chapter, in spite of the awareness of the dangers of HIV/AIDS, how it is contracted and prevented, Malawian adolescents continue to engage in high-risk sexual behaviours (McAuliffe & Ntata, 1994; UNAIDS, 2006). Several studies, both in Malawi and other countries, have pointed to youths having abundant knowledge about the pandemic, but the corresponding levels of positive behavioural change have been insignificant (Hartell, 2005; Izugbara, Undie, Mudege & Ezeh, 2009; Kadzamira, Maluwa-Banda, Kamlongera, & Swainson, 2001; NAC, 2004; Reddy, 2002; UNDP, 2002). Many Malawian adolescents are increasingly being infected with HIV as a result of being subjected to social, economic and cultural forces that predispose them to the dangers of HIV/AIDS. For example, UNAIDS (2006) reported that the majority of HIV infections occur among young people, particularly those between 13 and 24, accounting for one quarter of new AIDS cases. This is the age bracket which includes most secondary school adolescents who have been exposed to various behavioural change interventions. Risky sexual behaviour among adolescents is compounded by their sexuality development and other pressures that compel them to experiment with sex resulting consequences such as contracting sexually transmitted diseases including HIV/AIDS, and teenage pregnancies.

In the 1990s the Malawian Ministry of Education introduced a number of intervention initiatives in schools, such as the Population and Sexuality Project, the Life Skills Programme, the Why Wait Programme and the AIDS "Toto" Clubs. (I present a detailed discussion of these initiatives in 2.3). Evaluation of some of these programmes has been done and has revealed varying degrees of success and failure. For example, in an evaluation of the Life Skills Programme and AIDS "Toto" Clubs, Reijer and Chalimba (2000) revealed that some learners have adopted safer sexual practices. However, it also indicated that most teachers in the Life Skills Programme lacked sufficient in-

depth knowledge of the content of the programme and its methodology for effective delivery. A school-based survey by Kadzamira et al. (2001) revealed marked variations in terms of staffing, commitment and levels of activity from one AIDS "Toto" Club to another, possibly contributing to the limited impact they have. The impact of the other two programmes is unknown as there are no records of their evaluation.

With the proliferation of information, communication and education about the disease, and all the intervention efforts, one wonders why adolescents continue to engage in risky sexual behaviour, making themselves vulnerable to HIV/AIDS. What is the understanding of the youth regarding their vulnerability to HIV/AIDS? What should be done to make the available interventions work and what alternative interventions would be appropriate?

## 1.3 The HIV/AIDS Situation in the World and Sub-Saharan Africa

### 1.3.1 Global AIDS situation

Globally HIV/AIDS has reached devastating proportions. The last UNAIDS (2008) report (cited in AVERT.ORG, 2009) indicates that since the outbreak of the epidemic an estimated 60 million people have been infected with HIV/AIDS worldwide and 25 million of these have died of the disease. The report states that by the end of 2007, 33 million people were living with HIV/AIDS of which about 95% lived in developing countries; 2.7 million new infections and 2 million deaths were reported. The report further states that at the end of 2007, women accounted for 50% of all adults living with HIV worldwide, 59% of them in Sub- Saharan Africa. A worrisome trend according to an UNICEF (2006) report is that the disease is "increasingly becoming the disease of the young and vulnerable, especially girls, with more than a third of all people living with HIV/AIDS today being under the age of 25 and of the 5 million new infections in 2002 half were among the young people" (UNICEF,

2006, p. 1). The sub-Saharan African situation, which includes Malawi, calls for a special analysis and this is presented below.

### 1.3.2 HIV/AIDS situation in sub-Saharan Africa including Malawi

According to UNAIDS/WHO (2008) as cited in AVERT.ORG (2009), sub-Saharan Africa bears the brunt of the HIV/AIDS pandemic, where 22 million people were living with HIV/AIDS at the end of 2007; 1.5 million were reported to have died of AIDS leaving 11.6 million orphans behind. The countries of the Southern Africa Development Community (SADC) region have been the hardest hit with the top nine rankings of prevalence in the world coming from this region, as the following table shows:

**Table 1. HIV/AIDS prevalence rates in the SADC in rank order UNAIDS, (2008)**

(cited in CIA, 2009)
(http://www.cia.gov/library/publications/theworldfactbook/rankorder/2155rank.html)

| World Rank | Country | People living with HIV/AIDS | Adult (15-49) | Women with HIV/AIDS | Children with HIV/AIDS | AIDS deaths | Orphans due to AIDS |
|---|---|---|---|---|---|---|---|
| 1 | Swaziland | 190,000 | 26.1 | 100,000 | 15,000 | 10,000 | 56,000 |
| 2 | Botswana | 300,000 | 23.9 | 170,000 | 15,000 | 11,000 | 95,000 |
| 3 | Lesotho | 270,000 | 23.2 | 150,000 | 12,000 | 18,000 | 110,000 |
| 4 | South Africa | 5,700,000 | 18.1 | 3,200,000 | 280,000 | 350,000 | 1,400,000 |
| 5 | Namibia | 200,000 | 15.3 | 110,000 | 14,000 | 5,100 | 66,000 |
| 6 | Zimbabwe | 1,300,000 | 15.3 | 680,000 | 120,000 | 140,000 | 1,000,000 |
| 7 | Zambia | 1,100,000 | 15.2 | 560,000 | 95,000 | 56,000 | 600,000 |
| 8 | Mozambique | 1,500,000 | 12.5 | 810,000 | 100,000 | 81,000 | 400,000 |
| **9** | **Malawi** | **930,000** | **11.9** | **490,000** | **91,000** | **68,000** | **560,000** |
| 10 | Angola | 190,000 | 2.1 | 110,000 | 17,000 | 11,000 | 50,000 |

When the first HIV/AIDS case was diagnosed in Malawi in 1985, no one thought the disease would have a devastating effect, but it has spread fast with catastrophic consequences, touching the lives of almost everyone across the country (UNDP, 2002). By the end of 2007, 930,000 people were said to be living with HIV, 91,000 of whom were children under the age of 15; about 68,000 people had died of AIDS; 560,000 children were orphaned and the prevalence rate among the 15-49 years old was at 11.9%. The good news, however, is that infection rates seemed to be slowing down compared with the earlier figures, which put the prevalence rate at 16 % in 1999 (NAC, 2003). How far this trend in the fight against HIV/AIDS would continue depends on the efforts of all parties. Like in the rest of the world, the worrisome trend is that more youth are contracting the disease, the major concern of this study.

As indicated in Table 1, by comparison with her neighbours in the SADC region, Malawi is still among the highest HIV infected countries in the world with an infection rate of 11. 9% of the adult population, ranking number 9 in sub-Sahara Africa and the world UNAIDS/WHO (2008) (as cited in CIA, 2009). Fortunately, there is some political will on the part of the government which has established the National AIDS Commission (NAC), an AIDS coordinating body and a Ministry of HIV/AIDS which, together with co-operating partners both nationally and internationally (UNICEF, UNAIDS and OXFAM) are working hard to address the pandemic. A comprehensive strategic framework has also been put in place to guide the efforts, but unless they are supported by appropriate information emanating from research findings, policy documents, interventions, and institutions become ineffective.

The statistics described earlier are alarming and call for urgent attention to be paid to the youth and to finding effective interventions to assist them. There are suggestions that solutions to these problems might lie in establishing effective evidence-based intervention programmes, if behavioural change is to be expected. Within NAC's (2003) Behavioural Change Intervention

Strategy document, research takes central stage to inform the development of interventions. Unfortunately, as Muthukrishna and Mitchell (2006, p. 1) have observed, "the research literature on HIV/AIDS in education to date has generally focused at macro-level of national education using quantitative research approaches (with) little attention given to the micro level analysis of the effects of HIV/AIDS on schools and communities and the concrete experiences and responses of educators, beginning teachers, learners and parents." They further observe that "micro-level research, using more qualitative and participatory methods can elicit very different information that offers valuable insight for policy makers as well as participants themselves." (Muthukrishna & Mitchell, 2006, p.1). This scenario represents the situation in many countries, including Malawi. Researching adolescent sexual behaviour in Malawi appears to have yielded valuable results, which have guided policy and practice in HIV/AIDS, but all at national macro-level (Kadzamira, Chibwana, Chatsika, & Khozi, 1999; Kadzamira et al., 2001; Maluwa-Banda, 1999; McAuliffe & Ntata, 1994). For example, drawing on research findings, NAC has developed a number of policy documents on HIV/AIDS such as the National Behaviour Change Intervention Strategy for HIV/AIDS and Sexual Reproductive Health (2003), the National Plan of Action for Scaling up Sexual and Reproductive Health HIV Prevention for Young People 2008-2012, Condom Strategy (2006), Abstinence Strategy (2008) and the National HIV Prevention Strategy 2009 to 2013.

This study, therefore, is designed to explore the issue of HIV/AIDS in schools in particular, through a different theoretical lens than used in previous studies, focusing on a small sample at school level and using a qualitative approach. A micro-qualitative study is ideal in gaining access to the lives of adolescents, as well as exploring their understanding of their own vulnerability to HIV/AIDS, usually not explored by macro-level studies.

## 1.4 The Malawian Context

In order to appreciate the socio-economic environment in which HIV/AIDS is unfolding and managed, I shall present brief background information on Malawi. Malawi is a small country located in South Central Africa and is almost surrounded by Mozambique. To the east, south and south west it is bordered by Mozambique, to the north by Tanzania and to the west by Zambia. Malawi is thus a landlocked country.

The country covers 118,484 sq km one fifth of which is taken up by Lake Malawi. This fresh water lake runs almost the entire length of the eastern border of the country and has a number of holiday resorts with beautiful sandy beaches. The latest national census by the National Statistical Office (NSO (2008) has revealed that the population of Malawi is 13.6 million. The census also shows the population distribution as 51% females and 49% males. The census further shows that children below the age of 15 accounts for 45% and that those between 15 and 64 for 3% (NSO, 2008). This indicates that Malawi's population is a youthful one and this is where the HIV/AIDS takes its greatest toll.

Like other African countries, Malawi experienced colonial domination for over a century. The British came to Malawi in the middle of the nineteenth century bringing with them their culture; Christianity and western civilisation have been the main legacies of British influence. Today, Malawi is predominantly Christian except for small pockets of Islamic influence and other religions. Religion plays a crucial role, both positively and negatively, in the fight against HIV/AIDS. For example, some religions vehemently object to the use of condoms while others are liberal about condom use; some condone polygamy, others do not. Some religious institutions, however, have been at the centre of HIV prevention and treatment. Western influence, too, has been both good and bad. The breakdown of the traditional extended family system is one of the negative consequences of western influence, meaning that children orphaned by HIV/AIDS cannot be accommodated in the

modern nuclear family system, where each family takes care only of its immediate family members.

Malawi gained its independence in 1964 but for a period of 30 years was under a one-party dictatorship until 1994, when a new political dispensation replaced it. The dawning of a multiparty democracy in 1994 brought with it new freedoms such as the observance of human rights, liberalisation of cross border trade and the opening up of territorial boundaries. This process of democratisation took place when the HIV/AIDS pandemic was already on the rampage. Liberalisation of trade and the opening up of territorial boundaries led to an increase in cross border trade and an influx of people to and from Malawi. The result has been the importation and exportation of diseases, including HIV/AIDS. Some people, however, believe that the change of regime also provided new opportunities as the new political dispensation created a more liberal climate in which HIV/AIDS issues could be discussed more freely than during the one-party rule, when publicly talking about HIV/AIDS and sexuality issues was banned or censured (http://www.avert.org./aids-malawi.htm.).

Administratively, the country is currently divided into three geographical regions, the north, centre, and south, with 26 administrative districts. Nkhata Bay, the setting for this study, is one of the 26 districts located in the northern region. In each district there are a number of traditional leaders, known as traditional authorities (TAs) who are the custodians of culture. Malawi has scores of ethnic groups with diverse languages, cultures and practices, some of which have impacted negatively on the spread of HIV/AIDS. I discuss this in detail under cultural practices (see 2.2.7), as situations that possibly contribute to the spread of HIV. Linguistically, however, the nation is unified by one national language, Chichewa, which today is spoken by nearly everyone. In schools it is both the medium of instruction and a subject of study, making communication around issues of HIV/AIDS relatively easy.

Malawi's educational system, basically a British prototype, is a three tier system: basic or primary, secondary and tertiary education levels. Primary school caters for children from 6 to 14 years; secondary school for students from 13 to 18, while tertiary education absorbs those above 18 (these age ranges are only approximate as they greatly overlap). Many children rarely go beyond primary education either because of poverty or the impact of HIV/AIDS. According to the UNDP (2002), only about 18% of school going age children reach secondary education. This group is the focus of this study. In 1994 the Government of Malawi introduced free, though not compulsory, primary education. The introduction of free primary education has made significant strides towards literacy, which, according to a UNDP (2002) report, went up from 38% in 1987 to 42% in 1999. An understanding of literacy levels is important because knowledge levels about HIV/AIDS are often contingent on the levels of education in a society.

Like education, the health service is the product of British missionary influence. In the process of evangelisation, the missionaries also provided medical treatment for a wide range of ailments. Wayne (2006, p. 166) reports that in 2006, there were 510 health care facilities throughout the country, each serving an average of 15,000 persons. He observed that the greatest challenge to the health delivery system is accessibility to the health centres because of the large distances to be travelled. Wayne (2006) further says that malaria, tuberculosis and HIV/AIDS are ranked high as killer diseases, and that mortality rates, especially among children, were very high, about 120 to 1000 live births. This high mortality rate can be attributed to a number of factors such as poverty, malnutrition, and HIV/AIDS, which themselves form a vicious cycle. The combined effect of all these systemic factors has been a drastic reduction in life expectancy from 48 years to 38 years (UNDP, 2002). In view of the HIV/AIDS pandemic, the government of Malawi has started providing free antiretroviral drugs to those who have been infected by the virus. Consequently, a number of HIV testing centres, where people are encouraged to have voluntarily test for their HIV status, have been

established. As in many other countries, HIV/AIDS has put a great strain on health service delivery; it has become not only a health but a social issue as well, requiring more than just medical attention.

Economically, Malawi is one of the poorest countries in the world, ranking 151 out of 162 countries, according to the Human Development Index (UNDP, 2002). The country is basically a subsistence farming country, though there are a few isolated commercial enterprises which farm tobacco, tea, coffee and sugar. It has a few minerals of economic value that have been exploited to date, but has greater potential in tourism and agro-forestry processing industries. Its landlocked nature makes imports and exports expensive. According to a UNDP (2002) report, Malawi's Gross National Domestic Product (GNDP) per capita was estimated at US$165. The local currency stands at about MK150 (Malawi Kwacha) to US$1. Fifty four percent (54%) of the population of Malawi is living below the national poverty line causing many Malawians to migrate to neighbouring countries such as South Africa, Botswana, Namibia and Zambia for employment. Unfortunately, the majority of such people are seasonal migrant labourers who leave their families behind. This trend has been another major factor in the spread of HIV/AIDS as both men and their spouses are put at risk. So when talking about vulnerability to HIV/AIDS and planning interventions, it is in the context of poverty-stricken communities, making it worse for youth, especially girls, whose desire for modernity can drive them to sell sex.

I am a Malawian who grew up, and now works in Malawi. Therefore, in the next section, I present my personal position researching HIV/AIDS in Malawi.

## 1.5 Positioning Myself as Researcher

I have a personal interest in issues concerning adolescents and HIV/AIDS arising from my experience as headmaster of secondary schools, both single sex (boys only and girls only) and co-education schools in Malawi; as

coordinator of HIV/AIDS programmes and also as one of the student counsellors at the university where I work. Due to personal experiences around HIV/AIDS, it is possible that I might bring my own inclinations into the study, but borrowing from Husserl's concept of "bracketing," I have set aside my experiences and inclinations as much as possible and have adopted a fresh perspective towards the phenomenon of adolescents' vulnerability to HIV/AIDS which I am investigating (in Creswell, 2007, p. 59). Bracketing is utilised in a phenomenological study, when it is possible that our preconceived notions and prejudices will get in the way of the study, so one needs to `bracket" or temporarily forget them so that the phenomenon is allowed to show itself by "intimate communion" (Terre Blanche, 2006, p. 322). Bracketing implies constant reflexive engagement because qualitative researchers are bound to be influenced by their own assumptions and values. Consequently, I found it necessary to openly acknowledge my biases and decide how to deal with them (Leedy & Ormrod, 2005).

Also as an adult male researcher and lecturer in a university, researching the sensitive issue of adolescent sexuality and HIV/AIDS, I was, from the outset, confronted with the challenge of gaining access to the lived experiences of the youth. I viewed it as likely to create power imbalances between my participants and me. My experience as headmaster, coupled with my counselling skills, enabled me to create an optimal environment for open discussions with my participants. I also found that using their own teachers, especially AIDS teacher patrons with whom they discuss HIV/AIDS issues regularly, some of whom are males like me, also contributed towards an evening up of power relations. They embraced me as part of the team in the fight against HIV/AIDS. Additionally, the involvement of research assistants from my university, themselves adolescents and almost the same age as the participants, further assisted in accessing the adolescents' lived experiences. This is discussed further in Chapter 4. Despite all these efforts at easing up the power relations between my participants and me, I am not sure to what

extent my position influenced the data collection. Having fore-grounded my position, I discuss my motivation for undertaking this study below.

## 1.6 Rationale for the Study

Although much research has been done on HIV/AIDS and the youth in Malawi, for example the research of Kadzamira et al. (1999); Kadzamira et al. (2001); Maluwa-Banda (1999) and McAuliffe and Ntata (1994), the few studies that I found specifically on adolescents did not explore adolescents' own understanding of their vulnerability to HIV/AIDS at a micro-level, nor why the interventions do not bring about the necessary behavioural change or effectively contribute to the design of intervention programmes. The previous studies cited above have researched adolescents and HIV/AIDS on a national scale, mostly using survey methods and eliciting representative data in terms of adolescents' knowledge, attitudes and practices. These studies tended to focus on the adolescents' frequency of engaging in particular risk behaviours. Moreover, where studies looked at vulnerability of adolescents to HIV/AIDS and risks, they did so from an adult point of view, establishing what was risky and what was not. Wekwete and Madzingira (2005) concur with this view and argue that most documentation about adolescents' vulnerability to HIV/AIDS has been presented from the view of adults and not as the voice of the adolescents. Such an approach does not seem to be helpful in understanding risk perception among adolescents. Rodham, Brewer, Mistral and Stallard (2006) assert that trying to understand adolescent risk perception based on assumptions driven by adult beliefs may not be appropriate. They argue that adult-centred approaches to research into adolescent risk perception may limit understanding of adolescent behaviour. It is therefore necessary to give adolescents the opportunity to speak for themselves, to have their voices heard. It is in this light that this study aims to get a better understanding of adolescents' own understanding of their vulnerability to HIV/AIDS using participatory approaches.

Why study secondary school adolescents? My experience as headmaster has indicated that senior learners in secondary school in forms 3 and 4 (grades 11 and 12) display the riskiest sexual behaviour and that first year students at university also tend to display risky behaviour. Most are reluctant to seek counselling services. For example, when I was headmaster of a secondary school, in 2000, eight form four girls who were writing their Malawi School Certificate Examinations, sneaked out of the school campus in the evening to attend an all night party organised by people in town; a "Welcome to the World" party for school leavers, not sanctioned by the school. When interviewed upon their return , the girls admitted to having drunk alcohol and danced with men the whole night. Some even confessed to having had unprotected sex. In 2004, when I was a counsellor working at the University, one male student who was persistently sick refused to go for VCT even when his closest friends advised him to do so. He eventually committed suicide by throwing himself into Lake Malawi. In their study, Izugbara et al. (2009) reported that although many Malawian youth were aware of the availability of VCT services, only a few expressed a willingness to undergo VCT.

The adolescents chosen for the study are typical secondary school adolescents from Malawi. Through information about the adolescents' personal worlds and their lived experience, which have not been taken into consideration in previous studies, the intention of this study, therefore, is to use the findings to theorise adolescent understanding of their own vulnerability, as well as establish policy and practice regarding intervention programmes appropriate for adolescents. Furthermore, based on the findings, this study aims to suggest how existing programmes can be strengthened to address the needs of adolescents. Moreover, the use of participatory approaches might help secondary school learners to explore their own behaviour and lifestyle choices, enabling them to identify the patterns that make them vulnerable to HIV/AIDS. Thus this study seeks to understand how secondary school adolescents view their own vulnerability to HIV/AIDS by exploring their understanding and experiences with regards to the pandemic.

## 1.7 Aims of the Study

In line with its focus, the aims of the study are to:

- Explore secondary school adolescents' understanding of their vulnerability to HIV/AIDS
- Explore secondary school adolescents' experiences of the HIV/AIDS intervention programmes available in schools and why they respond to them the way they do.

## 1.8 Key Research Questions

Drawing on the aims of the study, the key research questions are formulated as follows:

- How do secondary school adolescents understand their vulnerability to HIV/AIDS?
- What are adolescents' experiences of the HIV/AIDS intervention programmes available in schools and why do they respond to them the way they do?

## 1.9 Conceptual Framework

A number of concepts have been used in this research which may have varying meanings in their everyday usage. I present an overview of these concepts and define them as they are used in this study. I present a detailed discussion of the conceptual framework in chapter 3.

### 1.9.1 Vulnerability to HIV/AIDS

Vulnerability, as used in this study, refers to "social vulnerability" of secondary school adolescents as a social group (De Guzman, 2001, p. 665). It recognises an individual adolescent as well as his/her social position which affects sexual behaviour that could result in risk of contracting HIV/AIDS. Both individual and environmental factors are explored to ascertain how they contribute to vulnerability.

### 1.9.2 Adolescence and adolescent

Adolescence is a developmental period which marks the transition period between childhood and adulthood. The emergence of pubertal changes in girls and boys signals the onset of adolescence. In Malawi, this period is characterised by initiation rites in various forms which usher the youth into adulthood. In this study *adolescents* refer to secondary school learners between the ages of 15 and 19, who might or might not have experienced initiation rites in their communities. The terms *adolescent* and *youth* are used interchangeably in line with Franzkowiak and Wenzel's (1994) classification of *youth* as young people between the ages of 15 and 24 ; and to refer to the sample of this study.

### 1.9.3 Adolescent sexuality

Sexuality involves physical aspects, such as body growth and associated physiological changes, that influence decisions about engaging in sexual intercourse (Esere, 2006). Since adolescence is described as a period of intense sexual drive and experimentation, sexuality is explored in this study in order to better understand its impact on adolescents' vulnerability to HIV/AIDS (Sathiparsad & Taylor, 2006). In this study sexuality is defined in terms of heterosexual orientation among secondary school adolescents.

### 1.9.4 Sexual behaviour

Adolescent sexual behaviour is closely related to sexuality. Karim (2005, p. 268) defines sexual behaviour as "a set of behaviours and practices that define sexual risk from HIV/AIDS typically including partnership characteristics, sexual networking and the timing and experience of sexual initiation." She argues that there is a close relationship between health, disease and sexual behaviour. Sexual behaviour is examined in this study to understand how adolescents' sexual risk-taking behaviour is influenced by multiple social behaviours and situational factors making adolescents especially vulnerable (Karim, 2005).

### 1.9.5 HIV/AIDS

These are two acronyms which stand for Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS) respectively, which up to now, have no known cure. It is HIV that causes the disease AIDS. This study is more interested in how the sexual behaviour and lifestyle choices of adolescents put them at risk of contracting the disease than the etiological agent associated with the disease AIDS (Reddy, 2002).

### 1.9.6 Interventions

The saying goes "prevention is better than cure". For a disease with no known cure, there cannot be any better caution than intervention or preventive measures. Intervention means "any approach or strategy used to support an individual's ability to adopt or maintain new behaviour" (NAC, 2003, p. 23). Gibson and Mitchell (2003, p. 367) define prevention as "an effort that seeks to avoid the occurrence of something undesirable; the prevention of that which threatens life or healthy living". Intervention and prevention are related concepts. In this study, intervention and prevention are used as synonymous, and the study explores the interventions provided to secondary school

adolescents, whether as part of the school curriculum or as extracurricular activities. (A detailed discussion of these interventions is provided in 2.3).

## 1.10 Theoretical Framework

In order to better understand how adolescents view their vulnerability to HIV/AIDS, I decided to situate this study within an eco-systemic framework (Bronfenbrenner, 1979) and complement it with the HIV/AIDS susceptibility and vulnerability pathway model of Bishop-Sambrook (2003). The eco-systemic framework of human development, which was first put forward by Bronfenbrenner (1979) is based on the understanding of interdependence and interrelationship between the developing person and the environment (Huitt, 1995). I chose this approach for my study because, as Fraser and Galinsky (1997) cited in Normand (2007) suggest, factors that predispose an individual to risk are best understood from an ecological perspective. This perspective also allows for a holistic approach to the study of vulnerability of adolescents to HIV/AIDS within the context of their environment. I have presented a detailed discussion of these frameworks and other related theories in chapter three.

## 1.11 Research Design and Methodology

### 1.11.1 Research paradigm

In this study I adopted a qualitative participatory approach and an interpretivist paradigm guided my research. Merriam (2002) as cited in Normand (2007) states that researchers conducting interpretive studies would be interested in how people interpret their experiences, how they construct their worlds and what meaning they attribute to their experiences. Qualitative methods have the advantage of allowing patterns, themes and categories of analysis to emerge from the data and are thus well suited to

explore complex social phenomena, like vulnerability to HIV/AIDS (Piercy, Fontes, Choice, & Bourdeau, 1998). In this study, for example, I am exploring adolescents' own understanding of their vulnerability to HIV/AIDS. This approach provided me with an opportunity to gain a contextual understanding of adolescents' vulnerability in secondary schools through their own constructions. I present a detailed discussion of my paradigm in chapter four (See 4.2).

### 1.11.2 The research design

I decided on a phenomenological design with participatory principles to explore adolescents' understanding of their vulnerability to HIV/AIDS. An important aspect of interpretive research is to try to make meaning of the phenomenon from the perspective of the person being studied. Somekh and Lewin (2005, p. 121) define phenomenology as "the study of lived human phenomena within the everyday social context in which the phenomena occur, from the perspective of those who experience them." This design provided me with an opportunity to understand the phenomenon of vulnerability to HIV/AIDS from the perspective of the actors (adolescents) themselves, "the emic" perspective (Babbie & Mouton, 2001, p. 273). A detailed discussion of the research design is presented in chapter four (See 4.3).

### 1.11.3 Participants and research context

Adolescent secondary school learners in the age range of 15 to 19 years were chosen. They were drawn from four secondary schools within Nkhata Bay Lakeshore area: one single sex boys' school, one single sex girls' school and two co-education schools. This arrangement ensured a fair distribution of the participants by gender for more balanced data. Each school provided 10 participants, purposively sampled from senior classes of forms 3 and 4 and spread equally by gender, especially where drawn from the co-education

schools. In my choice of learners from senior classes I was guided by Sprady's criteria for the choice of participants in terms of their "enculturation" and "involvement" with the phenomenon (Babbie & Mouton, 2001, p. 288). *Enculturation* means that these learners have stayed at the institution long enough to have experienced the phenomenon of vulnerability to HIV/AIDS, and *involvement* implies that they are currently involved with this phenomenon through the interventions in place. Babbie and Mouton (2001) argue that it is futile to involve first year learners who have little knowledge about the campus life, in a study. Similarly there is little point in asking someone who completed school some time back to provide information on the phenomenon as it is experienced in the present.

The actual selection of participants was entrusted to the head teachers and class teachers, to choose participants who were willing to participate in the study voluntarily, able to express ideas and thoughts clearly, and had knowledge of or participated in the existing intervention programmes at the school. Creswell (2007) states that in a phenomenological study, participants must be individuals who have all experienced the phenomenon being explored and can articulate their lived experiences. Nkhata-Bay Lakeshore Area was chosen for its diverse socio-economic and cultural features which I believed would yield rich data. The socio-economic features, which include tourist resorts, fishing activities, and plantation farming, coupled with a harbour in the vicinity, attract a lot of migrants who go there for leisure, business or job opportunities. Also, statistics from NAC show that Nkhata Bay District has one of the highest HIV/AIDS prevalence rates, with 24% of the population affected (Simwaka, 2008).

Flick (2006) states that for qualitative researchers it is the relevance to the research topic rather than representativeness which determines the way in which people to be studied are selected. Consequently this study which aimed not so much to generate findings for generalisability as to seek an understanding of a particular phenomenon, allowed me to select a small

sample of forty four information-rich participants. The study site and schools were also purposively selected. Leedy and Ormrod (2005) describe purposive sampling as a selection of those individuals who will yield the most information about the topic under study. In chapter four I discuss the research context and how I gained access to my participants.

### 1.11.4 Data generation

In qualitative interpretivist research, Mason (2002) recommends the use of the term data 'generation' rather than data 'collection' to reflect the emphasis on engagement between the researcher and participants during the process in which both are active generators rather than passive providers of data. Data generation for the study took place over five months during the school terms, over week-ends, and sometimes after classes. As alluded to earlier on, in this study, I used a combination of methods: a process known as *triangulation* of methods (Babbie & Mouton, 2001, p. 275). I briefly describe these methods below, but a detailed description of how I actually used these methods for data generation is presented in Chapter 4.

I used one-to-one semi-structured interviews and questions which I constructed to answer research question number one: "How do secondary school adolescents understand their vulnerability to HIV/AIDS?" To complement the data, I also used photovoice - a participatory method developed by Caroline Wang (1992) that allows participants to give voice to their experiences through visual images, allowing for an understanding of how people make meaning or construct what matters (as cited in Royce, Parra-Medina, & Messias, 2006). Focus group discussions (FGDs) were used to address the second research question: "What are adolescents' experiences of the intervention programmes available in schools and why do they respond to them the way they do?" Between eight to ten participants from each school were selected for the focus group discussions.

### 1.11.5 Data analysis

The verbal and visual data that were collected required analysis. Creswell (2002) states that analysis in phenomenological research involves identification of significant statements, the generation of units of meaning, and the development of a thick description. Marshall and Rossman (2006) state that qualitative data analysis is a search for general statements about relationships and underlying themes. So borrowing from both Creswell (2002) and Marshall and Rossman (2006) this study used a six step strategy to analyse the data from the individual interviews and focus group discussions as follows: transcription; reading through the data to get a general sense of the information; coding; categorisation; creation of themes and, finally, interpretation.

The photographs were first critically and reflectively analysed in the field by the participants themselves. This first layer of analysis was linked to the first research question and was guided by the following questions: "What does the photograph mean to me?" (Mitchell, de Lange, Moletsane, Stuart, & Buthelezi, 2005, p. 265) and "With your photograph, what information can you convey to others about adolescents' vulnerability to HIV/AIDS infection? (Royce et al., 2006, p. 83). With these questions the participants then produced a photo essay on a selected photo, a process known as *photo elicitation*. The second level analysis was done by me by analysing, summarising and collating themes covered in the photo essays and relating them to responses from interviews and research question one.

A detailed description of how the data was analysed, including findings, is presented in chapter five showing how it reflected the design of this study.

## 1.12 Synopsis and Outline of the Chapters

In this chapter I have discussed the problem statement, the background to the problem, positioning myself as a researcher, the rationale for the study,

the purpose and aims of the study, the research questions, conceptual and theoretical frameworks and the research strategy, which includes the research paradigm, its design, the sampling of participants, the context, data generation techniques and the process of data analysis. To understand the context within which HIV/AIDS operates and is managed, I have presented a brief account of Malawi's geographical, historical and socio-economic context. The rest of the chapters of this study run as follows:

In chapter two I review related literature on HIV/AIDS and adolescent sexuality. This review follows a thematic approach in which I discuss the literature in themes and their sub-themes, both locally, in Malawi, and internationally. The review begins with the situation in Malawi and then moves on to discussing the situation in other countries. The literature review looks at contextual factors which predispose adolescents to HIV/AIDS such as early exposure to sex, adolescent perceived vulnerability, peer pressure as a motive for engaging in risky behaviour, political, economic and social contexts, development of sexuality and lack of control, the influence of the media, unreliable sources of information, the influence of alcohol, cultural practices, gender disparities and gender-based violence. Finally, I present a discussion of the various intervention programmes available to secondary school adolescents in Malawi.

Chapter three looks at conceptual and theoretical frameworks that have guided this study. The following concepts are discussed and clarified: vulnerability to HIV/AIDS, adolescence, adolescent sexuality, HIV/AIDS and intervention. In this chapter I have contextualised the vulnerability of adolescents to HIV/AIDS within an analysis of the eco-systemic framework of adolescent development as the overarching theory, supported by an HIV/AIDS susceptibility and vulnerability pathway model. Other theories discussed include self determination theory, hope theory, social cognition theory, the health belief model, and the theory of reasoned action.

In chapter four I provide a description of the research paradigm and design which is followed by a detailed description of the process of data generation and analysis and how this reflects the design of the study. This chapter is titled 'Walking the research journey together with adolescents as young researchers,' which reflects the participatory route that was used in generating data for the research. The chapter discusses gaining access to schools and to participants, and the role of research assistants and link teachers. A detailed account of how the research instruments, i.e. the interview schedule, the FGD schedule and photovoice were used to generate data, as well as a reflection on their usage, is further presented. I then discuss the analytical framework that guided my data analysis resulting in themes which formed my units of analysis. Finally, reflection on the ethical dilemmas I encountered in researching HIV/AIDS with adolescents and how these were solved, is discussed along with a justification for the trustworthiness of this study.

In chapter five I present a discussion of the findings of this study. These have been arranged according to the themes that emerged during the data analysis process. The discussions are enriched by data extracts and photographs from participants.

In chapter six I re-contextualise the findings of the research in the literature, theorising how they answer the research questions and adhere to the aims of the study.

Finally, in chapter seven, I present a summary of the findings, implications and conclusions arising from this study and make suggestions for further research.

# Chapter Two:
# Literature review of Adolescent Vulnerability in the Context of HIV/AIDS

> *"Kukuoneka kuti achinyamata'fe, pa nkahani ya hiv/aids pamene tafika pa msinkhu momwe tiliri timatengeka ndi zinthu zambiri; ndiye tikafika pa nthawi yoti kudzigwira, aah! kumatibvutirako, koma poganiza kuti ndife atsogoleri amawa nkofunika kuti tizipewe kutenga matenda'wa. (It looks like we adolescents, on the issue of hiv/aids, at the stage at which we are, we are carried away by so many things, so when it comes to self control, aah! we are failing, but considering that we are the leaders of tomorrow, it is necessary that we avoid contracting this disease)."*(Kamashu[2], Age 19

## 2.1 Introduction

Since its outbreak more than twenty five years ago**,** HIV/AIDS has attracted a lot of attention world-wide, resulting in a proliferation of literature. It is, however, only recently that HIV/AIDS in relation to youth has received more attention. Presumably this is because nations have realised that their futures lie in the youth, and that the disease is having a greater impact on the youth than was realised before. This chapter focuses on adolescents' vulnerability, the impact of HIV/AIDS on adolescents, as well as the nature of some interventions aimed at them.

In this chapter I thematically present surveyed literature which reflects some of the research done, particularly in Malawi, but also internationally - mostly in

[2] Pseudonym of participant

Africa - on HIV/AIDS and the youth, specifically adolescents. The survey does not claim to be exhaustive but assesses what others have researched. This enabled me to refine my problem and also to engage with other ideas, perspectives and approaches where necessary (Leedy & Ormrod, 2005). The review focuses on the contextual factors that predispose secondary school adolescents in Malawi to HIV/AIDS, as well as the intervention programmes available to them by drawing parallel examples from other countries, especially Africa.

## 2.2 Contextual Factors and Adolescent Vulnerability

The literature indicates several factors that predispose adolescents to HIV/AIDS, i.e. adolescent perceived invulnerability to HIV/AIDS, early initiation into sexual activities, peer pressure, political, economic and social contextual factors, cultural practices, gender disparities, gender-based violence, the influence of alcohol and drug use, the influence of the media and unreliable sources of information. These are discussed drawing on literature from both Malawi and other countries.

### 2.2.1 Emerging sexuality and lack of control

Central to exploring vulnerability is the adolescent as an individual. For adolescents whose sexuality is still developing, self-control often becomes a problem, causing them to indulge in unplanned sexual activity, perhaps due to being excited. For example, in Malawi Kadzamira et al. (2001) found that lack of restraint was one of the factors causing adolescent learners to engage in high risk sexual activities. In Zimbabwe, Wekwete and Madzingira (2005) found that most girls engaged in unintended or unplanned sex and cited reasons such as that it just happened, or that it was forced or that it was to show love to a partner. The study further found that girls who had never had sex before were more likely to have high self-efficacy in refusing sex compared with the sexually experienced. However, this spontaneous sexual

activity is not a universal phenomenon. In a qualitative study (See 2.2.2) Rodham et al. (2006) reported that adolescents had control over their decisions whether or not to take part in behaviours which put their health at risk, but that sometimes situations in which they found themselves made them choose risky behaviour because of their lifestyle choices. Lack of control can also sometimes be due to the perceptions adolescents hold of HIV/AIDS.

### 2.2.2 Adolescents' perceived invulnerability

In terms of adolescents' perception of their vulnerability to HIV/AIDS, most studies seem to indicate that adolescents' perception of low risk, especially their confidence in invulnerability, are important drivers of adolescent risky sexual behaviour, but that this belief could be counteracted if adolescents acquired sufficient knowledge of the dangers of risk-taking behaviour (Rivers & Aggleton, 1999). The AIDS Risk Reduction Model by Catana, asserts that knowledge of AIDS is a prerequisite to recognising risky behaviour and then taking action (Prata, Morris, Mazive, Vahidnia, & Stehr, 2006). In Malawi low risk perception about HIV/AIDS has been reported in research by Tiessen (2005), indicating that young males between the ages of 10 and 24 do not often see themselves at great risk from HIV/AIDS; this, despite relatively sound knowledge about the disease. In their study Kadzamira et al. (2001) also found that learners did not perceive themselves as being at risk of contracting HIV/AIDS and consequently engaged in unprotected sex, often with multiple partners. They expressed this indifference as follows: "*Only bad and immoral people get AIDS", "Imfa inabwerera anthu" (Death came for people, we will all die one day)* (Kadzamira et al., 2001, p.21).

Franzkowiak and Wenzel (1994, p.2) also state that adolescents do not perceive themselves as being threatened by HIV transmission but feel that others are, "blaming the victim" in order to conceal their own lifestyle, as the above quotation shows.

However, literature in Malawi and other countries has shown mixed results on the association between risk perception and sexual behaviour. For example, in Zambia, HIV/AIDS knowledge was found to be associated with reduced probability of sexual experiences and an increased probability of condom use among boys. Also, in a cross sectional study that used Demographic and Health Surveys (DHS) cited in Prata et al. (2006) data from Uganda, Kenya and Zambia showed that knowing somebody with AIDS was predictive of protective sexual behaviour. However, they also report on a survey of young women and men in Rwanda that showed that, while the majority had correct knowledge of HIV transmission, only a small percentage had adopted any protective behaviour (Prata et al., 2006).

Adolescents' risk-taking behaviour could best be described as "self harm", a practice where individuals consciously and intentionally cause injury to themselves, which includes risk-taking behaviour such as unsafe sex (Best, 2006). There seems to be a close connection between perceived invulnerability and a desperation that tends to lead to self harm. For example, Kadzamira et al. (2001) found that a significant percentage of sexually active youths in Malawi were engaging in risky sexual activities, such as having unprotected casual sex with multiple partners, and tended to develop a personal fable, thinking that "it cannot happen to them; that they cannot contract the disease; that it's for immoral people and that even if they contracted it everybody will die; after all death came for people" (Kadzamira et al., 2001, p. 21). This observation is shared in the UNDP (2002) report which also noted that adolescents look at the incubation period of about 8-10 years between HIV infection and HIV-related illness and death as being too long to see the severity or fatality of the disease, so they easily underestimated its impact. In another study of Malawian secondary school learners, McAuliffe and Ntata (1994) observed that sexually active male learners engaged in risky sexual behaviours such as inconsistent use of condoms, presumably because they believed that they could not contract sexually transmitted diseases, including HIV/AIDS.

Low risk perception of HIV/AIDS is not unique to Malawian adolescents. In South Africa Hartell (2005) conducted a comprehensive analytical review of available research concerning sexual behaviour of adolescents. He, among others, concluded that few adolescents perceive themselves to be at risk and, consequently, few take the need for safer sex seriously because they do not see AIDS as a personal threat, even though most adolescents acknowledged the severity of the disease. Another qualitative study in South Africa done by Steyn, Myburgh and Poggenpoel (2005) involving male learners from grades 9 to 11 between the ages of 15 and 17 years who come from a multi-cultural school in South Africa and have been exposed to a life skills programme including HIV/AIDS awareness, found that while these learners were aware of the consequences of unsafe sex they were non-committal about susceptibility to the disease and shifted the blame onto girls.

It is interesting to note that adolescent girls seem to be more concerned about getting pregnant than about contracting the virus. This finding was confirmed in a qualitative study in Malaysia by Kamal and Ng (2006) who found that young female and male learners between 18 and 22 years old were more concerned about pregnancy than sexually transmitted diseases. Reasons for not practising safe sex included trust between partners, low risk perception and negative attitudes towards condom use.

However, some studies, as noted by Rodham (2002) and cited in Lerner (2005) have dispelled the notion of adolescent invulnerability as the cause of risk-taking behaviour. They argue that there is little empirical evidence to support the role played by feeling invulnerable in the relatively high level of adolescent risk-taking. Moreover, it is further argued that a feeling of invulnerability is not unique to adolescents alone, many adults harbour similar feelings (Bishop-Sambrook, 2003). The study by Samuelson (2006) done in Burkina Faso among the youth of Bobo-Dioulasso supports this view. The aim of the study was to provide an understanding of how young people reflect on and manage the knowledge they have about HIV/AIDS in their everyday

lives. Using qualitative interviews, the study established quite interesting results not reported in any other studies that, contrary to the popular fable mostly reported about adolescents, youth have a real fear of acquiring HIV/AIDS, and were therefore quite anxious about their own safety and futures. The study also found that youth are especially frustrated by the fact that risk is produced by the same practice namely the sexual relationship which should produce trust, stability and self identity.

It was thus interesting to learn from adolescents themselves what their understanding is regarding their own vulnerability or invulnerability to HIV/AIDS infection, an aspect that is fully discussed in chapters five and six.

### 2.2.3 Adolescents' early exposure to sex

Early exposure to sex puts adolescents at risk of HIV/AIDS since such adolescents are often psychologically not ready to appreciate the implications of their sexual activities. Jackson (2002) notes that early exposure to sex means more sexual encounters and more risks. A study that was done in Malawi by McAuliffe and Ntata (1994) around barriers to behaviour change in the wake of HIV/AIDS, revealed that 66% of the secondary school learners surveyed were sexually active, and most of them had initiated sexual activity between 10 and 14 years of age. Later studies by Kadzamira et al. (2001) Maluwa-Banda (1999) yielded similar results. Elsewhere in Swaziland, a study by Zwane, Mngandi and Nxumalo (2004) reports that the age of sexual debut in Swaziland is as young as 13 for boys but could be as low as 11 for girls. Such early engagement in sexual activities is often linked to gender-based violence, but also to peer pressure.

### 2.2.4 Peer pressure as a motive for engaging in risky behaviour

The influence of peers during adolescence is so great that youths conform to group norms to become part of a group even if such behaviour is detrimental to their well-being. For example, Vanlandigham, Suprasert,

Grandjean and Stittitrai (1995) argue that peers exercise an important influence on the sexual decisions of adolescents, not only because close friends are often the most important source of information about sex, but also because peer groups are an important source of both physical and psychological support, conformity being an important feature of peer groups. In Malawi, studies by Kadzamira et al. (2001), Maluwa-Banda (1999), and McAuliffe and Ntata (1994), reported peer influence among boys as one of the major reasons why secondary school learners engage in risky sexual activities and cite friends, especially girl friends, as the ones who exert pressure.

Further afield, in countries like South Africa, Swaziland and the United Kingdom, the influential role of peers on adolescents' risky behaviour has also been reported. A study was carried out in a secondary school in the Hlabisa district in KwaZulu-Natal Harrison, Xaba, Kunene and Ntuli (2001), which involved girls of 14-15 years old, and used peer discussion to explore adolescent sexuality in the context of HIV/AIDS, specifically to understand the nature of young women's risks within sexual relationships. The study established various kinds of peer pressure, coming from both boys and girls, that drove young women to become involved in sexual relationships. These included: the desire to have the experience; to find out whether sex is nice; to please a boy-friend; for a couple to prove that they love each other; and the desire for money and other material goods. The study also found that a number of myths dominated their perceptions of relationships, sexual activity, and reasons for sexual initiation, for example, that if they did not have sex close to the age of puberty, evil spirits would haunt them.

Zwane, Mngadi and Nxumalo (2004) did a study in Swaziland to explore adolescents' views regarding risky behaviours. Among other things, their study established that adolescents have low risk perceptions of the disease and engaged in risky sexual behaviours which they also attributed to peer pressure. In relation to condom use, participants believed that condoms are

for prostitutes or those who have casual sex partners or engage in extra-marital sex. The study further found that the participants whose friends had sexual intercourse and never used condoms, were three times more likely than their peers to demonstrate risky behaviour.

In the United Kingdom, Rodham et al. (2006), did a qualitative study in selected schools in the Bath and North East Somerset Local Education Authority to identify what adolescents perceived to be risky behaviour and to explore factors they felt influenced their decisions to engage in or avoid risky health behaviours. Using focus group discussions with single sex groups, the study established that adolescents believed they had control over their decisions whether or not to take part in risky behaviour, but that, sometimes, situations in which they found themselves made them decide to engage in a particular risky behaviour because of lifestyle choices. They mentioned the need to fit in with a group and be accepted by them, hence the risky behaviour even if they did not want to engage in it.

While most qualitative studies have reported peer pressure, the research of Sieving, Eisenberg, Pettingell and Skay (2006) yielded very different findings. They conducted a longitudinal study in the US between 1994 and 1995 involving approximately 90,000 learners of grades 7-12 to examine forms and pathways of friends' influence on adolescents' sexual debuts. The assumption of the study was that individuals are especially motivated to adopt attitudes and behaviours of others with whom they have strong social bonds, such as their immediate circle of friends. A questionnaire was administered to respondents and the data analysed using multivariate models and chi-square tests. The results indicated that there was no significant relationship between friend variables (proportion of friends who were sexually experienced, friends' attitudes about sex, and perceived respect from friends for having sex) and adolescent sexual initiation. The study concluded that peer influence on adolescent sexual debut was insignificant. Ungar (2000) as cited in Steyn et al. (2005) also disagrees with the notion of peer pressure as

the driving force behind adolescents' behaviour, arguing that adolescents conform knowingly to a specific group behaviour in order to raise their personal and societal power and not simply to conform to group demands. The above inconclusive views about peer pressure compel me to consider broader aspects that could influence the vulnerability of youth.

### 2.2.5 Political, economic and social context

Socio-economic transformation and socio-political changes in Malawi, and indeed in other countries too, have had various influences on the behaviour of individuals, including adolescents, and consequently their vulnerability to HIV/AIDS. Although adults are also vulnerable to HIV/AIDS as a result of these contexts, adolescents are rendered more systematically vulnerable. Baxen and Breidlid (2004) argue that adolescents face a great deal of problems in protecting their sexual and reproductive health, partly as a consequence of external pressure (socio-economic and cultural) within the context in which they find themselves and partly as a result of how adolescence is commonly constructed, namely that it is a time of high risk and low responsibility. What follows is an overview of how the different socio-economic and political factors predispose adolescents to the dangers of HIV/AIDS, especially in Malawi but elsewhere as well.

In Malawi, the impact of socio-economic transformation on the spread of HIV/AIDS has been expressed in the UNDP report (2002). This report, while admitting the difficulty of establishing a causal relationship between processes of political, economic and social change and the spread of the HIV/AIDS pandemic, suggests that there is a close link between the two. The UNDP report contends that the emergence of multiparty democracy has led to the liberalisation of the economy, and facilitated increased mobility of people and cross border trade, which are risk factors in the spread of HIV/AIDS.

The emergence of democratic values and human rights that came with the advent of multiparty democracy in Malawi in 1994, has been misinterpreted by adolescents as freedom to do whatever one pleases, including indulging freely in sexual behaviour (Kuthemba-Mwale, Hauya and Tizifa, 1996). The authors also link the marked decline in discipline in schools in Malawi to societal moral decay.

Poverty has driven many Malawians to migrate to neighbouring countries such as South Africa, in search of livelihoods, but in the process they have made themselves, their spouses and families vulnerable to HIV/AIDS. Chirwa's (1997) qualitative study, involving 163 Malawian migrant mine workers returning from South Africa, found that earnings from the mines played an important role in sexual and marital relations, enticing women for sex, winning more women friends and paying for "lobola" or bride price. Chirwa further observed that 52% of the mineworkers indicated that they had had more than five regular sexual partners "m'bulo" during the first 12 months after their return to Malawi. The practice of migrant labour in Malawi is not only confined to cross-border crossing as people also migrate from rural areas to towns and from one part of the country to agricultural farming areas with the same consequences as cross-border migration. This internal migration requires further study to establish its impact on the spread of HIV/AIDS as, in most cases, the young men involved do not move with their spouses.

Poverty and materialism also encourage school girls to engage in commercial sex. In Malawi, girls who engage in transactional sex with teachers do so both for money and other gains, such as private tuition or leakage of examination papers (Kadzamira et al., 2001, p. 35). They further report a practice called "sugar daddies", where older, wealthy men engage in sexual relationships with younger girls in exchange for money. A current trend of calling sugar daddies "Chidyamakanda"[3] seems to be slowing down this practice as men do not want to be seen in the company of young girls

[3] "Chidyamakanda" is a Chichewa term meaning " eaters of babies or infants" with "makanda" meaning babies.

for fear of being embarrassed and labelled as "chidyamakanda".(What does it mean?) But men have ways to get around this and it does not seem to scare the habitual sugar daddies. The real impact of this derogatory term is yet to be ascertained. The practice of transactional sex does not take place between girls and "sugar daddies or mummies" only; it also takes place among adolescents themselves. In a multi-country study that involved Malawi, Burkina Faso, Ghana and Uganda, transactional sex between girls and sugar daddies and among adolescents as well has been noted (Amuyunzu-Nyamongo, Biddlecom and Ouedraogo, 2005). The expectation of transactional sex is that once a girl receives money or gifts from a man or boy, she owes him something in return, normally sex or the promise of having sex in the future. Girls, in turn, expect money or material goods from their male partners for having sex with them. The practice of transactional sex puts all parties involved at risk of contracting HIV/AIDS, because, as was observed in the same study when a girl has received money or gifts from her partner, she finds it difficult to negotiate condom use (Amuyunzu-Nyamongo et al., 2005).

Further afield in Nigeria, Omorodion (2006) did a study aimed at highlighting the activities related to oil exploration in the delta region and how these activities placed female adolescents at greater risk of contracting sexually transmitted diseases, including HIV/AIDS. Using in-depth interviews, focus group discussions, and case studies involving adolescent females, the study established that poverty was the driving force which made girls engage in multiple transactional sex, and that oil workers took advantage of the poor village girls - a case similar to the "sugar daddies" scenario in Malawi.

To some extent the girls themselves contribute to the risk as they tend to develop wrong perceptions of being free and empowered, as this excerpt in Madlala's (2004) South African study (as cited in Wood, 2008, p.55), which represents typical attitudes of school girls today even in Malawi, demonstrates :

> "I am happy to be a girl. God gave me a bank and I can use it to get money. Today you need money; it's not like before because everything is expensive in town. Before it was just men who could enjoy everything and do anything they liked. Now it's our turn."

Turning to tourism and poverty, international tourists have often been blamed for the spread of HIV/AIDS by using their wealth to entice the poor local inhabitants to have sex with them, sometimes unprotected. For example, in Malawi, in August, 2006, the Minister of Tourism closed some tourist holiday resorts in Nkhata Bay because they were suspected of harbouring tourists who were involved in clandestine activities such as drug abuse, pornography and sexual abuse of local school girls. Local tourists from the urban centres also flock to the lakeshore tourist resorts with partners, some of whom are school girls looking for a good time. These activities put school adolescents at risk of contracting HIV/AIDS.

On the international scene, Ragsdale, Difrancesco and Pinkerton (2006) report that the risky sexual behaviour that often accompanies international tourism especially the risky sexual behaviour of western male tourists who travel to developing nations to engage in sexual relationships, often with sex workers who are considerably younger than their clients, has been recognised as contributing to the increase in HIV/AIDS and STIs, The literature cited above reveals the interrelatedness of poverty and materialism, while the broader political, economic and social context places adolescents at risk of contracting sexually transmitted diseases including HIV/AIDS.

### 2.2.6 Influence of alcohol and drugs

The issue of risky sexual behaviour which is linked to drugs and alcohol is contentious, as some research indicate a link and others not. Risky sexual behaviour by adolescents has been associated with the use of alcohol or drugs because excessive consumption of the latter leads to blurring of consciousness and poor judgment in decision making. It can also lead to a lower level of ability to negotiate condom use (Jackson, 2002). For example,

in their study of Malawian adolescents, Kadzamira et al. (2001) observed that alcohol and drug abuse were factors in adolescents' engagement in casual sex. This has been observed in other countries as well. For example, in Sri Lanka, Pereira and Reece (2006) did a study of secondary school learners which aimed to explore the relationship between alcohol and drug use and risk-taking behaviour. Among other findings, the study showed that alcohol and drug use were predictors of sexual activities.

However, the experimental study done by Fortenberry (1998) among American adolescents yielded quite different results. Fortenberry wanted to find out whether a potential causal relationship between alcohol and drug use and risky sexual behaviour exists. He used female participants ranging in age from 14 to 21 who were asked to keep diaries of their sexual activities recording when and when not they had sexual intercourse and when alcohol or drugs were used. Three months later, they reported that most of their sexual encounters were not associated with substance use, thereby dispelling earlier findings.

### 2.2.7 Cultural practices, beliefs and HIV/AIDS

Cultural practices have been seen to render people of all ages vulnerable to HIV/AIDS but as the discussion that follows illustrates, adolescents are specifically vulnerable. Adolescents in Malawi get a great deal of sexual knowledge, including knowledge about sexual practices, through various cultural practices. However, some cultural practices and beliefs have been blamed for the spread of HIV/AIDS. Mugambe (2006, p.73) defines culture as "the totality of socially transmitted behavioural patterns, arts, beliefs, institutions and all other products of human work and thought". In Malawi, initiation rites, polygamy, the use of a surrogate husband, wife inheritance, and funeral cleansing have been blamed for promoting the spread of HIV/AIDS. I describe how each one of these practices predisposes adolescents to contracting HIV/AIDS.

#### *2.2.7.1 Initiation rites*

Initiation rites, which usher boys and girls into adulthood, are practised among almost all ethnic groups in Malawi, but practices differ from one ethnic group to another. The age of the initiates could be as low as 10 years, and the duration of these ceremonies varies from one tribe to another, ranging from a few weeks to a couple of months (Kadzamira et al., 1999). Whatever the period, the ceremonies follow a similar pattern: initiates are taken from their homes to live in the bush under the supervision of chosen renowned instructors called "Nankungwi". They give lessons ranging from societal norms, economic empowerment to how initiates can take care of their families once married. Lessons in sexual activities are also provided. Unfortunately, issues of safe sexual practices do not form part of the curriculum at these rites as they are basically a preparation for married life. Among the Yao tribe of the Southern Region, activities include circumcision of the young initiates, both male and female. Of late, a debate has ensued concerning the effect of circumcision on HIV transmission.

Recent research seems to point to the fact that the circumcision of males reduces their chances of HIV infection. For example, it has been observed that in cultures with high rates of circumcision, HIV infection rates are low (Mugambe, 2006). Furthermore, studies carried out in Uganda and Kenya support this proposition (Mugambe, 2006; Valerian, 2007). However, they caution that there is a need for more studies to be done before this practice can be used universally. There do not seem to be any parallel studies of circumcision in the Malawian context yet, which could be another area of study.

Initiation rites are meant to build character but as Munthali, Chimbiri and Zulu (2004) have observed, they are also known to encourage early sexual debut. For example, among the Chewa of the Central Region, initiates are encouraged to experiment with sexual intercourse through a practice known as "Kutchotsa fumbi" (removing dust). Girls sleep with a man called "fisi"

(hyena) whose role it is to initiate girls into sexual intercourse. The "fisi" can sleep with several girls on the same night without protection, thereby increasing the vulnerability of girls to sexually transmitted infections, including HIV/AIDS.

Graduating from initiation schools poses its own problems as new initiates are seen to be elevated on the social ladder and are expected to be men and women who are ready to marry, yet they are still at school. This, as Kuthemba-Mwale et al. (1996) observed, works in sharp contrast to the schools' expectations, where they are still treated as children. This newly found social status encourages early marriages and premarital sexual practices to reinforce lessons learnt at the ceremonies, all of which put adolescents at high risk of contracting the HIV.

However, if properly handled, initiation rites can be used as a vehicle to introduce behavioural change. Webb (1997) argues that initiation rites offer a useful opportunity for intervention programmes, where not only information about HIV/AIDS can be introduced, but also sexual negotiation skills can be imparted. Groce, Mawar and Macnamara (2006) concur with Webb's view, arguing that it is possible to influence behaviour changes among adolescents by including AIDS messages in initiation ceremonies. They contend that initiation ceremonies provide opportunities for HIV/AIDS messages because:

- Lessons during the ceremonies centre on community attitudes towards marriage, sex and appropriate behaviour towards members of the same and opposite sex.

- During the ceremonies, there is strong adherence to the rules given; the consequences of failure to adhere are clearly spelt out.

- The lessons are conducted with total exclusion of parents or the immediate family, thereby providing an opportunity for open discussion on matters of sex and sexuality which could not be the case in the

presence of parents and immediate members of the family, as it would be considered improper.

#### *2.2.7.2 Polygamous marriages*

In Malawi it is not uncommon to see polygamous marriages. While some religions, like Christianity, advocate monogamous marriages, there are others like Islam and traditional religions which tolerate polygamy or even encourage it. Unfortunately, as observed by the UNDP (2002) report, the religions that allow polygamy do not have institutionalised ways of ensuring that both parties are free from HIV infection. Polygamous marriages, by promoting multiple sexual partners, increase the risk of HIV infection as not all the parties are necessarily faithful. Where a man may not be able to provide the basic necessities for all his wives and their families, the parties involved are at greater risk, as each wife may turn to transactional sex for survival. Although polygamy has no direct influence or impact on adolescents' vulnerability to HIV/AIDS, the fact that adolescence is a transitional period to adulthood, when they are preparing to get married, means they might assume that the customary practice of polygamy is a good and normal one. This belief might eventually put them at risk.

#### *2.2.7.3 Wife inheritance*

When a man dies, a younger brother or some close relative maybe asked to inherit the wife of the deceased person. This is irrespective of the cause of the man's death, which could be HIV. In this respect, a younger brother, who could be a school-going adolescent could be asked to "take care" of his deceased brother's wife, putting the adolescent at risk of contracting HIV/AIDS. Mugambe (2006) reports that this practice is justified by saying it helps to bind the family together as the widow remains in the village. It is further claimed that the system ensures there is someone to take responsibility for the children left behind by the deceased brother. Although it may seem to have some good intentions, the practice not only violates the woman's

rights, but obviously places all parties at risk of HIV infection, assuming that the deceased died of AIDS. This practice, which is commonly known as "Kuhala chokolo", is commonly practiced by the Tumbuka, Ngonde and Ngoni Tribes of the Northern Region of Malawi. In the southern region of Malawi, especially in the districts of Nsanje and Chikwawa, there is a similar practice called "Kulowa Kufa."

#### *2.2.7.4 Use of "fisi" (Surrogate husband)*

When a man cannot father a child, in other words, is unable to reproduce, an arrangement is made between the wife and the man's brother, brokered by elderly women who are close to the man, to have a sexual affair in secrecy until the woman conceives. It is supposed to be a secret, but sometimes to ease tension between the brothers, the consent of the legitimate husband is procured and the affair is carried out with his full knowledge, as long as it does not become the subject of public debate. Once a baby is born, it belongs to the legitimate husband of the woman and not the surrogate husband. The child grows up not knowing his/her biological father. The choice of a relative is meant to mask the true identity of the child as it is most likely that the child will have some features of the clan members, and therefore make it difficult for people to suspect foul play. In some instances, the brother chosen for the task could be a school adolescent, thereby putting him at risk of contracting HIV/AIDS. The choice of an adolescent is also meant to prove whether he can father a child. This practice is common in almost all districts in Malawi and is known by various names, such as "chiphongo" (a he-goat) in the northern parts of Malawi and "fisi" (hyena) in the Chewa-speaking parts of central and southern Malawi (Munthali et al., 2004; UNDP, 2002). The use of "fisi" in this practice is similar to the "fisi" in the initiation ceremony among the Chewa in that the activities take place in secrecy, very much like the man sent to initiate girls into sexual intercourse.

While acknowledging the fact that the practice puts concerned parties at risk of contracting HIV/AIDS, Lwanda (2004) argues that it is possible to accommodate it within the interventions being provided. He suggests, for example, that if a "*fisi*" is to act as a surrogate husband, all parties should be tested for HIV/AIDS before they engage in the practice, in this way minimising the risk.

#### *2.2.7.5 Funeral cleansing rites*

Funeral cleansing, otherwise known as "Kuchotsa fumbi", is common among the Sena Tribe of Nsanje and Chikwawa districts in the southern region of Malawi. It is similar to what is practised by some tribes in East Africa (Ayikwei, 2008; Mugambe, 2006). Funeral cleansing takes place soon after a funeral or burial rites, and is performed on the widow, who is believed to be unclean after the death of her husband. A brother or close relative has sexual intercourse with the widow to make her clean. As with the surrogate husband ritual, adolescents have been targeted to fulfil this practice thereby predisposing them to the dangers of contracting HIV/AIDS. The consequence of this practice is that all parties involved are at risk of HIV infection, should the deceased have died of AIDS.

The UNDP (2002) report speaks of another cultural practice by "Singa'nga", (traditional healers) where tattoos are used for administering medicine. In most cases, the same instrument, the razor blade used for cutting tattoos, maybe used on a couple of patients, thereby predisposing them to the dangers of contracting HIV/AIDS. When taken to a healer for treatment, adolescents just follow the healer's instructions for treatment for fear of being accused of disrespecting their parents and the healer. This might be in spite of the information they have learned at school warning them against the use of unsterilised needles for multiple patients. Because they are voiceless in such circumstances, adolescents are placed at risk of contracting HIV/AIDS.

In all these practices it is the youth who become the victims, directly or indirectly. In most cases, adolescents are targeted for these practices. For example, with wife inheritance, funeral cleansing and surrogate husband practice, one's younger brothers, who might be adolescents, are often requested participate. This puts adolescents into risky situations as customarily they cannot and are not empowered to refuse and consequently contract HIV/AIDS. Lwanda (2004) suggests that to improve the practices of polygamy, wife inheritance, funeral cleansing rites, and the use of a surrogate husband, all parties must undergo HIV testing before engaging in them. In addition, perhaps all should be reviewed in the context of HIV/AIDS.

Since it is acknowledged that cultural practices play an important role in traditional societies, it is possible to effect change in the dangerous aspects of culture by enlisting the help of traditional leaders. Traditional leaders are the custodians of traditions and culture and the more they are involved, the easier it maybe to change some harmful practices. The approach should be to persuade these leaders to reflect on the harmful aspects of some of these practices, changing that which should be changed, while keeping their importance and symbolism. For example, Jackson (2002, p. 137) argues that "(it) is important to note that culture, traditions, beliefs and values are dynamic, changing over time, and that they can be influenced in positive ways". He intimates that "what is required is to promote dialogue with the custodians of culture - the traditional leaders - not to abolish any particular practice or custom, but merely change the damaging elements while retaining the overall custom, its symbolism and meaning" (Jackson, 2002, p. 137).

Currently, efforts are being made to sensitise local leaders to effect change and it looks as if the efforts are paying dividends as most traditional leaders are renouncing harmful practices in their areas as observed by the Bridge Project, (NAC, 2004).

### 2.2.8 Gender disparities in sexual activities

Unequal power relations between men and women render women, especially young women, vulnerable to coerced or unwanted sex and consequently to HIV/AIDS. Such unequal power relations influence the capacity of young women to negotiate when, where and how sexual relations occur (Rivers & Aggleton, 1999). Studies in Malawi have shown that 91% of the sexual relationships are initiated by males, with females feeling powerless to refuse or negotiate safe sex. If a girl initiates sex she is labelled a 'loose' woman (Munthali et al., 2004). However, in a study by Mc Auliffe (1994) and cited by Munthali et al. (2004) when girls were asked how they would feel if their boyfriends did not ask them for sex, the majority (50%) reported that they would feel loved and respected; 22% would think that their boyfriends did not love them; 18% would think that their boyfriends did not trust them and 16% would think that "he was no man" (Munthali et al., 2004).

As in most African societies so too in Malawi, as Jackson (2002) has observed, masculinity is defined in terms of sexual prowess and sexual activity. In fact, several studies conducted in Malawi have revealed marked marginalisation of women when it comes to sex. Extra-marital and multiple sexual partners are considered the norm for men but not for women. Society accepts multiple sex partners as an expression of male sexuality and masculinity (Ntata, 2005 cited in Tiessen (2005). Women who use condoms or request the use of condoms are considered promiscuous and untrustworthy (Panos, 2001 cited in Tiessen 2005). Men refuse to take responsibility for sex or the transmission of AIDS, blaming women for enticing them into sex (Foster, 2001 cited in Tiessen (2005). Similarly, in South Africa it has been reported that having many sexual partners is equated with popularity and importance among young men (Rivers & Aggleton, 1999).

This cultural norm UNDP (2002) encourages male promiscuity as men apparently always want to show their manhood by being sexually aggressive.

Cultural norms in Malawi require that women be inexperienced and naïve in sexual matters and that pleasing men is the primary goal of sex. Consequently, right from youth, girls are treated as sexual beings whose primary objective is to please men, while boys are never taught what it takes to please a woman sexually (Munthali et al., 2004). This norm tends to place women on the receiving end, unable to negotiate sex, let alone safe sex. This gendered notion of what is normal and masculine can harm boys too, as it leads them to engage in sexual activity before they are ready and they also tend to indulge themselves with multiple sexual partners or unprotected sexual acts just to fulfil societal expectations of masculinity (UNAIDS/WHO, 2004).

Similarly, the traditional gender roles of what constitutes an ideal woman also tend to reinforce gender disparities among adolescents. In Malawi, sexual gender disparities are perpetuated by the communities' understanding of what constitutes a cultured and mannered girl. For example, while communities closely monitor and control girls' sexual behaviour, not much is done to control boys' sexual behaviour. Consequently, boys grow up with a distorted sense of fidelity in sexual relationships (Munthali et al., 2004). In South Africa, a qualitative study conducted by Steyn, Myburgh and Poggenpoel (2005) confirm the differences in gender roles in terms of sexual activity, with males viewing their role primarily to satisfy their personal needs and to take the lead in relationships with females, while girls' motives for sexual involvement was linked to material gain.

Looking specifically at how boys and girls construct their gender and sexual identities, Pattman (2006) reports of a multi-country study done in five Southern and Eastern African countries namely Botswana, South Africa, Tanzania, Zimbabwe and Zambia. The aim of the study was to explore how boys and girls construct their gendered and sexual identities in order to develop appropriate and relevant sexuality education resources. The 16-19 year olds indicated, amongst other things, that the attitude of hegemonic

masculinity was high among boys and that boys and girls identified one another as being in opposition. Girls could be rebuked for mixing with boys and for wearing certain kinds of clothes that were considered seductive.

While male college learners in Puerto Rico endorsed many hegemonic masculinity traits, such as being muscular, respected, and courageous and being the provider for the family, they rejected negative traits such as being aggressive, dominant and insensitive. The college boys argue that these cultural constructions of masculinity contradict efforts towards the prevention of risky sexual practices, as they make men more vulnerable to sexually transmitted infections, including HIV/AIDS (Perez-Jimenez, et al., 2007).

In Malawi, some initiation rites tend to encourage sexual activities in adolescents while in South Africa and Swaziland, the stress is in ensuring the virginity of girls in readiness for marriage. This practice has its own drawbacks. The practice of virginity testing of young women, particularly in KwaZulu-Natal (also known as the "reed dance" in Swaziland) which is in part a response to the high rates of teenage pregnancies, STIs and HIV/AIDS, may increase young women's vulnerability to HIV/AIDS, as girls identified to be virgins may fall prey to sexual assault by men and boys who falsely believe that having sex with a virgin can cure AIDS. It is further argued that the practice reinforces gender inequalities, as there is no parallel practice for their male counterparts (Karim, 2005).

Considering male and female views concerning HIV/AIDS, men and boys tend to externalise the HIV/AIDS disease attributing its spread to others, a practice known as "othering" (Squire, 2007, p.117), and not to themselves. For example, a qualitative study was conducted by Sathiparsad and Taylor (2006) in the Ugu district in KwaZulu-Natal with male learners from high schools to explore perspectives of their behaviour in relation to the spread and prevention of HIV/AIDS, plus perceptions of their personal risks. The boys attributed the spread of HIV/AIDS to women's careless behaviour, such as inability to control themselves, being beautiful and attractive, having multiple

sexual partners and deliberately spreading the virus. Boys also indicated that while they were aware that they are at risk of HIV, they did not feel they had any role to play to implement safe sex, and refused to be blamed for the spread of the disease, shifting the blame to girls. Such unequal power relations place girls in a position where they are susceptible to gender-based violence.

### 2.2.9 Gender-based violence

Gender-based violence is a universal problem, manifested in various ways. Gender-based sexual violence remains an additional challenge in the efforts to stop the spread of HIV/AIDS throughout Africa and in Malawi, and accounts for a large proportion of HIV infection (UNAIDS, 2004, as cited in Tiessen 2005). In a number of studies gender disparities, noted in the preceding section, have been associated with gender violence, where a girl child has been the victim of rape or coerced sex. In Malawi, a study by Liwewe and Matinga (2005) and cited in Tiessen (2005) revealed that girls were being coerced by teachers into sex either for money, other favours, or the promise of marriage in the event of the girl becoming pregnant. The belief by some men in the country that having unprotected sex with a virgin cures AIDS makes adolescent girls even more vulnerable to HIV/AIDS.

Turning to schools as potential sites for HIV infection, it has been observed that learners, especially girls, are at special risk of contracting HIV. In Malawi, due to a variety of reasons for the late age of starting school, it is not uncommon to find learners of mixed age in one class. For example, a form one class in a secondary school may have learners whose ages range from 10 years to 17 years or whose sexual knowledge ranges from the naïve and ignorant to knowledgeable. Kelly (2003) argues that this mixing of older boys and younger girls tend to place young girls at risk of contracting the HIV from older boys who have been exposed to several sexual partners and who maybe HIV positive. It has further been observed that long distances

between the home and school, which learners cover every day, is another contributing factor. Learners risk sexual harassment on their way to and from school. Kelly (2003) further argues that boarding schools, which are meant to solve the problem of distances from schools, do not seem to offer a solution either, as learners find opportunities to have sex with residents from the surrounding areas, with fellow students, or even teachers. This has raised debate among policy makers as to whether the government should construct large single sex (girls only) schools to protect them, or build many smaller non-residential secondary schools located close to the communities. In their study in Malawi, Kadzamira et al. (1999) report harassment of girls by boys and male teachers in the form of verbal abuse such as comments about their physical appearances, and ridicule, as teachers look on. In another later study, Kadzamira et al. (2001) reported that sexual harassment of female learners by male teachers is quite pervasive in secondary schools. Female learners were reported as submitting to teachers' sexual demands for fear of being punished or for money and other gains.

Unfortunately schools are not the only place where gender-based violence takes place. The Safe Schools project in Malawi (USAID, 2004) reported that gender-based violence in Malawi takes place within the home context as well as the school context. In the home context the main instances reported included incest committed by parents, forced or arranged marriages for daughters, encouraging daughters to have sex with rich people in exchange for material goods or money, and parents arranging for their daughters to have sex with a male community member soon after initiation ceremonies, a practice called 'fisi' (see 2.2.7.1). In the school context, the following were highlighted: girls having sexual relationships with teachers under coercion; teachers and peers raping school girls; and parents encouraging or forcing their daughters to have sex with teachers in the hope that teachers would marry them once they become pregnant or financially compensate them. It was further noted that girls in boarding schools are especially vulnerable, with some choosing not to study in classrooms after 18:30.

Elsewhere, reports of gender-based violence in schools are not uncommon either. For example, the latest report by the South African Human Rights Commission (SAHRC) (2008) of the rape games played in South African schools demonstrates how endemic sexual violence has become. The report describes games such as "hit me, hit me" and "rape me, rape me," where school children chase each other and pretend to hit or rape each other. The report also uncovered the fact that high levels of prejudice against lesbians in the form of corrective rape, where a male pupil rapes a female lesbian pupil to make her heterosexual, is a growing phenomenon.

Sexual harassment and gender-based violence can create trauma in those affected. For example, further afield in the United States, a study involving grades 7 to 12 in a stratified random sample of Alberta High School found that adolescents who experienced a high rate of sexual harassment or sexual assault, were significantly more likely to have emotional disorders (Bagley, Bolitho and Bertrand, 1997 as cited in Timmermann, 2004). In addition, more adolescent girls who experienced frequent sexual harassment had made suicidal attempts than those with no experience of sexual harassment. In another study by the American Association of University Women (AAUW, 2001) among US learners in public secondary schools, it was found that girls are not only more frequently harassed than boys, but they also experience more severe forms of unwanted sexual behaviours, such as unwanted physical contact (cited in Timmermann, 2004).

### 2.2.10 The influence of the media

> "When you are working to combat a disastrous and growing emergency, you should use every tool at your disposal. HIV/AIDS is the worst epidemic humanity has ever faced. It has spread further, faster and with more catastrophic long term effects than any other disease. Its impact has become a devastating obstacle to development. Broadcast media have tremendous reach and influence, particularly with young people, who represent the future and who are the key to any successful fight against HIV/AIDS. We must seek to engage these powerful organizations as full partners in the fight to halt HIV/AIDS through awareness, prevention and

> education." (Kofi Annan, Former UN Secretary General at the launch of the Global Media Initiative on AIDS, UNAIDS, 2001)

There is growing recognition of the role the media, print or electronic, can play in providing public awareness, opening up debate, and influencing public opinion and attitudes about HIV/AIDS, including the media's ability to point to healthy behaviours for prevention of the latter. Bertrand and Hughes (2005, p. 4 ) define the media as " those technologies which provide a link between many people, that is mass media of radio, television, newspapers, films and the World Web." The recognition of the role of the media in HIV/AIDS is epitomised by the above statement made by the former United Nations Secretary-General Kofi Annan at the launch of the Global Media AIDS Initiative in January, 2004.

A number of initiatives in Malawi have been put forward to spearhead the fight against the HIV/AIDS pandemic. The Sara Initiative is a comic book with an accompanying newsletter "Tisankhenji?" (What should we choose?) which aims to create awareness and inspire confidence in girls aged 10 to 14. Another is the multimedia project called "Nditha!" (I can!) which is aimed at a wider population to reinforce feelings of confidence and self-efficacy among Malawians in their ability to prevent HIV/AIDS. It uses the national radio, Malawi Broadcasting Corporation (MBC), posters, and bill boards (NAC, 2004). Other initiatives that are very popular with adolescents in Malawi include: the television soap opera "Tikuferanji?" (Why are we dying?) and the radio programmes, "Tinkanena!" (We told you!) and "Straight talk." As Reijer (2000) observes, it is not possible to determine the impact of these television and radio initiatives on the youth yet.

In Uganda, experts believe that free discussions about HIV/AIDS in the media have contributed to the country's success in reversing the epidemic (UNAIDS, 2001). In South Africa, the TV soap opera Soul City, which deals with HIV/AIDS and issues of domestic violence, has brought about social policy change. Another initiative is the "Love-life" series, a national HIV/AIDS prevention

programme aimed at youth between 12 and 17 years, which uses television, radio and print. It has reached about 85% of the young people but whether or not the South African initiatives have had any positive impact remains to be seen (Global AIDS Link, 2007, p.8).

The role of the media in addressing HIV/AIDS issues has, however, received mixed reactions from the public. While the literature on the media and adolescent sexual behaviour indicate that the media, especially television, plays a powerful role in influencing teenage sexual attitudes, values and beliefs, its actual impact raises serious doubts. For example, Kuthemba-Mwale, Hauya and Tizifa (1996) attributed violence and deterioration of moral standards in schools in Malawi to the media, especially radio, video, and television which they said were sending various signals to youth which affect their behaviour. These media are often associated with sex, humour and excitement, but the dangers of unprotected sex are rarely illuminated; on television, especially soap operas, sex between unmarried partners is commonly portrayed, but the virtues of abstinence rarely encouraged (Steven & Miriam, 1995). This observation is shared by WHO (1993) which states that adolescents are, enticed by the mass media, under constant social pressure to experiment with sex which is in complete conflict with the traditional religious and societal expectations for chastity (cited in Zwane et al., 2004).

However new research shows that not all adolescents interpret the media in the same way, nor are they equally susceptible to sexual suggestiveness (Steven & Miriam, 1995). WHO (2006) argues that, if properly utilised, the mass media has the potential for reaching adolescents with educational HIV/AIDS messages, since they are attuned to the mass media for information. For example, in Zimbabwe the use of a multimedia approach greatly increased the reach and impact of reproductive health interventions directed at young people, with launch events, leaflets, and dramas being the most influential

campaign components (Kim, Kols, Nyakauru, Marangwanda, & Chibatamoto, 2001).

### 2.2.11 Unreliable sources of information

In Malawi, especially among the rural communities, initiation rites and peers tend to be the main sources of information on matters of sexuality, most of which tends to be unreliable and at times in conflict with the formal school culture (Kadzamira, et al., 1999). This lack of reliable sources of reproductive health and HIV/AIDS information has been identified as another contributing factor to the escalation of the AIDS pandemic among the youth. Where reliable sources are available, communicating issues of sexual activity is beset by a number of taboos and power dynamics. The resultant misinformation predisposes the youth to indulge in reckless and unsafe sexual experimentation which can result in contracting sexually transmitted infections including HIV/AIDS.

The problem of lack of reliable sources of information is sometimes compounded by conflicting messages from various sources. For example, Malawian adolescents who have undergone initiation rites receive conflicting messages when they attend life skills lessons. While life skills lessons emphasise skills in self awareness and self control, initiation rites encouraged experimentation with sex. They also get conflicting messages about condom use as a means of practising safe sexual; some sources say the condom is not 100% perfect, while others say it is better than having unprotected sex (Kadzamira, et al., 2001). In South Africa too, Hartell (2005) found that adolescents received conflicting messages about sex and sexuality and that they lacked the knowledge, confidence and skills to discuss sexual issues, including contraception and prevention of infections. Hartell further argues that most adolescents made decisions about sex in the absence of accurate information.

Taboos about sexuality issues in a society inhibit the free flow of reliable information for adolescents. For example, as in many places in the world, in Malawi it is taboo to talk openly about sex and sexuality issues with your child (Munthali et al., 2004). In Nigeria too, so Esere (2006) states, adolescents have limited access to the information they need on sex and sexuality since questions of sexuality and girl-boy relationships are regarded as taboo, and they have to look for their own sources of information, most of which are questionable and likely to give them misinformation.

Mudaly (2006) reports a study by Fisher and Fisher (1996) in the United States who applied the Information Motivation and Behavioural Skills model to college students to promote HIV/AIDS prevention behaviour. They found that young people expect high risk partners to dress provocatively, be over-anxious for sex and abuse alcohol and drugs. They further found that students who engaged in unprotected sexual intercourse did so with the following beliefs:

- Condoms are associated with mistrust in sexual relationships.
- Negotiating safe sex is problematic because individuals feel uncomfortable discussing the use of condoms.
- Alcohol impairment reduces the ability to verbalise desire for safe sex.

Sometimes the flow of information among adolescents tends to be gendered, with boys and girls having differences in accessing information about sexuality matters. In Malawi, while girls may have an opportunity to get some information from their aunts or even mothers, boys seem to scavenge information on their own, relying heavily on peers (Munthali, Chimbiri & Zulu, 2004). In her study in the UK, Measor (2004) noted similar trends, namely that sources of information were gendered: for example, while both boys and girls indicated friends, peers and magazines as the main sources of information about sexual activity, girls also indicated family members, especially sisters and mothers, as significant sources of information.

The perceptions of adolescence that adults hold, inhibit adolescents' access to information and services on reproductive health. Rivers and Aggleton (1999) contend that the reasons why adolescents are denied adequate access to information and reproductive health services derive from the stereotypical ways in which they are viewed and which are often contradictory. Based on a review of the literature, they outline four images which inhibit adolescents` access to information which I briefly present below.

- All adolescents are risk-taking pleasure seekers who live only for the moment. This tends to homogenise our understanding of adolescents and their needs, but also encourages us to view young people as possessing a series of deficits (in knowledge, attitudes and skills) which need to be remedied by adults and the interventions they make.

- Adolescents are not knowledgeable about sexuality matters and must remain so, consequently their sexuality must be controlled and restrained at all times.

- Adolescents are, by nature, sexually promiscuous so giving them information about sex will make them even more sexually active. Evidence from research, however, indicates that well designed programmes on sexuality education that include messages about safe sex as well as abstinence may delay the on-set of sexual activity, reduce the number of sexual partners, and increase contraceptive use among those who are already sexually active (See 2.2.4)

- Parents across a range of cultures have sought to deny adolescents information about sex and reproductive health in the belief that they are protecting the young from information which they believe may lead to sexual experimentation. Rivers and Aggleton (1999, p.3) contend the evidence suggests however that adolescents who openly discuss sexual matters with their parents are less likely to be

sexually active or (if they are girls) become pregnant before marriage.

These perceptions and the consequent denial of access to information place adolescents at risk of contracting HIV/AIDS, as they resort to unorthodox means to access information, which maybe harmful.

### 2.2.12 Vulnerability arising from the impact of HIV/AIDS on the education system

Although the impact of HIV/AIDS is not at the centre of this study, it is necessary to give an overview of the devastating effects the pandemic has on the lives of both teachers and learners. This is necessary if one is to appreciate the vulnerability of adolescents to HIV/AIDS and interventions being provided to mitigate the effects of the pandemic.

The impact of HIV/AIDS on the education system may have a direct or indirect bearing on adolescents' vulnerability to HIV/AIDS. A UNDP report (2002) observed that HIV/AIDS-related illnesses and deaths are taking a toll in Malawi in many ways: the supply of teachers is being eroded as increasing numbers become infected; this results in large class sizes which affect the quality of education provided; there are very high dropouts, repetition and absenteeism rates among school children affected or infected by the disease, because they are either too sick to attend classes regularly, have to take care of their ailing parents or siblings, or have to take up part time employment to assist their families. Teachers affected or infected by the disease experience frequent absenteeism that impacts negatively on the children's education (Kadzamira et al., 2001). Kelly (2003) earlier estimated that about 30% of teachers in Malawi and Zambia are HIV positive. These factors directly or indirectly place adolescents in school at risk as they increase the vulnerability of learners to HIV/AIDS since they are often unattended and are exposed to risky behaviour, including risky sexual

behaviour. This can be worse for orphans who are heading households, as they may even end up in prostitution to survive.

Since HIV/AIDS also affects other sectors of the economy, the few remaining teachers are absorbed into more lucrative jobs thereby aggravating the shortage of teachers. Teachers are needed to provide learners with education in the critical thinking and communication skills necessary to make appropriate decisions regarding their lifestyle choices. The shortage of teachers means that there are fewer adults to provide social-political and educational guidance to learners, especially orphans, and this renders them more vulnerable to HIV/AIDS (Patterson, 2003). Like learners, teachers also need programmes for behaviour change. The Tiwoloke "Stepping Stone" project pioneered by Action Aid Malawi, UNESCO, (2009) which targets primary teachers for behaviour change, might usher in hope for building teachers' self- awareness about the pandemic. Through the same initiative, a national network of teachers who are living positively with HIV/AIDS has been established in Malawi. In terms of the impact of HIV/AIDS on teachers, in their multi-country study involving Malawi, Botswana and Uganda, Bennell et al. (2006) found that teacher deaths accounted for just less than 20% of teacher attrition in most countries (cited in Wood & Hillman, 2008).

The HIV/AIDS pandemic has created many orphans and, with the decay of extended family values, many of them are now heading households. Some are even reluctant to go to school for fear of being stigmatised. To highlight the magnitude of the problem in Malawi, UNICEF, (2006, p.1) made this report on an orphan:

> "Chisomo Jonasi, who lives in Lirangwe, on the outskirts of Blantyre, lost both his parents to AIDS related illness 18 months ago. He now spends most of his time doing odd jobs in people's gardens to support his three siblings the youngest of which is five."

The issue of HIV/AIDS and schooling is therefore not confined to Malawi alone; other countries in the SADCC are in a similar situation. In Zambia for example a study conducted by Robson and Kanyanta (2007) aimed at

exploring staff and student perceptions of the impact of the HIV/AIDS pandemic on the education of affected children, especially orphans, confirmed earlier findings that learners from child-headed households are likely to drop out of school. The study cites reasons such as the need to devote time to look after their siblings, the need to work in order to earn money for food and clothes, coming to school tired after long hours of household labour and being discriminated against and ridiculed by other children. Adolescent learners are often affected before they are orphaned, for example, when a parent develops HIV related symptoms, the children are forced to drop out of school, either because parents can no longer afford to pay school fees or because they are required to provide care for their sick parents and help with domestic chores (Franzkowwiak & Wenzel, 1994). These adolescents are vulnerable to HIV/AIDS since they may end up engaging in early sexual activities, commercial sex, or prone to sexual abuse.

HIV/AIDS has placed teachers in a very difficult position, having to take upon themselves new pastoral care roles when they too are either infected or affected. Under the circumstances just described, the only place where learners affected or infected with HIV/AIDS can get solace is the school, but teachers and schools are not properly equipped to provide the necessary social support services for such learners.

When it comes to the sharing of national resources, governments are diverting funds from education to health in order to care for the rising number of AIDS patients. For example, it is said that in countries like Malawi, Zimbabwe and Rwanda, over 50% of government health spending goes on AIDS patients (Patterson, 2003). Furthermore, Patterson cites the World Health Organization (WHO) which estimates that the money used to treat one AIDS patient with antiretroviral drugs would keep four hundred children in school for one year (Patterson, 2003). Although the cost of the drugs has decreased, the situation creates a vicious cycle because as the provision of education

services dwindles, adolescents' poor knowledge levels make them more vulnerable to HIV/AIDS.

### 2.2.13 Concluding remarks on contextual factors

Considering the above overview of issues related to adolescents' risky behaviour and the impact the HIV/AIDS pandemic has had on the education of the youth, I became more aware of the complexity of the issue that I was trying to explore. This has implications for the prevention programmes which I next describe.

## 2.3 HIV/AIDS Intervention Programmes in Malawi

### 2.3.1 Introduction

Education is an effective and proven weapon against HIV/AIDS. Studies so far suggest that young people with little or no education maybe twice as likely to contract HIV/AIDS than those who have completed primary education UNAIDS, (2007) (cited in Wood & Hillman, 2008). Kelly (2001) cited in Baxen (2004) argues that education might be the single most powerful weapon against HIV/AIDS transmission since, through it, potential messages that can lead to behaviour change can be transmitted (cited in Baxen, 2004). Family Health International (FHI) (2006) also report that school-going adolescents are less likely to be sexually active and, if they are, such adolescents are twice as likely to use contraceptives than non-school-going adolescents. Kaufuman (2002) cited in Baxen, (2004, p.18) describes his findings in relation to school education and adolescents' sexual behaviour as follows:

> "Our findings suggest that schools have ample latitude to promote the knowledge, understanding and skills to enable young people to make responsible decisions about their sexual behaviour. These findings also suggest that educational effects may persist after school is completed"

The above probably explains why most countries have directed efforts to fight HIV/AIDS on the school front. In Malawi, like in many other countries, a number of initiatives have been introduced in schools since the outbreak of the HIV/AIDS pandemic. The AIDS issue has been addressed in courses or programmes in a variety of contexts and nomenclatures such as AIDS Education, Sexuality Education, Life Skills and Population Education. In this discussion I include any attempt at providing intervention, whether as part of a school curriculum or as an extracurricular activity. Before I discuss these programmes, I would like to present an overview of how these programmes are managed and organised in Malawi, and draw parallel examples from other countries.

At school level two categories of programmes can be identified, namely school-based and non-school-based. Of the school-based programmes, there are those which form part of the formal curriculum and are timetabled. These are either subjects in their own right or integrated into other subjects in which HIV/AIDS forms part of the subject curriculum. They are taught like any other subject but are normally not examinable and have been established to directly address HIV/AIDS issues among learners. Currently these programmes include life skills, population studies and sexuality education. The non-school-based programmes are organised as community youth clubs or mobile clubs by non-governmental organisations. Adolescent learners participate in community clubs in their local communities, while mobile clubs, such as "Youth Alert", make periodic visits to schools with HIV/AIDS activities. I describe these programmes later (see 2.3.7).

### 2.3.2 Sexuality education or AIDS education as an integral part of the school curriculum

Different schools of thought have emerged regarding the position of AIDS education in the school curriculum. There are those who strongly believe that AIDS education should not be presented in isolation as an 'AIDS' period in the

school curriculum, arguing that such an arrangement may lead learners to acquire an irrational fear of the disease. When such fears have been instilled in a leaner, it may interfere with the learner's healthy sexual development because s/he maybecome accustomed to equating sex with disease and death (Van Dyk, 2005). Drawing on the Malawi experience, Schenker and Nyirenda (2006) concur with this view arguing that HIV/AIDS education cannot be taught effectively if fear and uncertainty surrounds the disease, because this may inhibit learners' learning. But in view of adolescents' low risk perception about the disease, it is also argued that it might be helpful to inject a little fear of the disease in adolescents. For example, Parker (2004) argues that preventative programmes that are associated with personally known people who are HIV positive or who have died of AIDS and involving them, or the memory of them, in HIV promotion programmes in the form of wearing of a red ribbon, and providing care to orphans and HIV-positive individuals, may greatly contribute to HIV risk reduction in adolescents. Also a study by Steyn et al. (2005) in South Africa, found that although the participants knew that AIDS is terminal, they had never seen anybody in an advanced stage of AIDS. They therefore agreed that exposure to the harsh realities of AIDS would scare them, which would, in turn, prevent them from becoming involved in high-risk sexual behaviours. Drawing from the Kenyan experience, a delegate at the 2009 Teachers and HIV/AIDS Conference hosted by UNESCO (http://hivaidsclearinghouse.unesco.org) (preferable to give a date rather than the website address) reported that teaching life skills in isolation has proved futile and called for a broader outlook on methodologies to address a range of risk and prevention factors.

The other school of thought advocates a stand alone subject like Life Skills which will be taught like any other subject on the curriculum. Gacguhi (1999) as cited in Griffiths (2005, p. 10) argues that a "stand alone" Life Skills programme or having a weekly lesson entirely separate from other lessons has a better chance of succeeding than those that are infused in the curriculum. This is the practice followed in Malawi with the Life Skills

programme; an arrangement which poses its own pedagogical problems. For example, Griffiths (2005) contends that the failure of most school-based interventions is due to teachers' inability to differentiate between teaching regular subjects like Mathematics and Science and teaching HIV/AIDS and Sexuality Education, because the latter requires an approach which relates more to real life situations than the former. In a multi-country study by UNICEF, participants in Kenya and Zimbabwe complained that Sexuality Education is taught in didactic ways and did not focus on their lives but on sex only, which teachers presented as bad for them (Pattman, 2006).

Teaching of Life Skills or HIV/AIDS as stand alone subjects puts strain on the school curriculum. For example, James-Traore, Finger and Savariaud (2004) assert that teachers fail to deliver the HIV/AIDS curriculum because school curricula are already overloaded. As a result, such programmes are offered as extracurricular activities either during their own free time or after school. Teachers thus spend less time on it compared to subjects which are examined. They suggest special teacher training in the context of HIV/AIDS that will improve teacher's knowledge, attitudes and behaviour regarding reproductive health and HIV.

### 2.3.3 AIDS education and peer educators

Other school-based programmes run on a club basis and participation is voluntary. Such programmes are run outside the school timetable and are facilitated by peers under the supervision of a club patron, a teacher. For example in Malawi, programmes like the AIDS "Toto" Club, and the "Why Wait" programme are normally peer taught. Peer education is becoming an increasingly popular method for promoting behaviour change among adolescents. It involves the training and use of individuals from the target group to educate and support their peers. Peer-based approaches are based on the assumption that behaviour is socially influenced and that behavioural norms are developed through interaction (Visser, 2007).

Visser (2007) argues that peer education can contribute to delayed onset of sexual activity and promotion of condom use through the process of sharing information among equals, but also by providing peer role models. Mirembe (2002) as cited in Baxen and Breidlid (2004, p. 19) holds a similar view arguing that learner involvement in HIV/AIDS education is a useful strategy in combating "information fatigue" among adolescents. An analysis of peer education programmes by FHI (2006) concluded that peer education can be an effective means of connecting youth to services, increasing their knowledge, decreasing the number of sex partners and increasing the use of condoms. To be effective, a peer-based approach requires that the peer facilitators be trained and supervised to cope with the emotional demands of the interactions (Visser, 2007). If not properly handled, this approach may however have unintended long-term negative effects which may run counter to intervention objectives and, in some cases, even constitute "risk training" (Fisher, Fisher, Bryan and Misovich, 2002, p. 178). For example, the main mode of influence, according to the proponents of peer education, is peer modelling. If an adolescent sees a high status member of the group, who could be the peer educator, smoking or taking drugs or having multiple sexual partners, this has the potential to influence behaviour in the same direction. This illustrates the influence of peer education, suggesting "do as I say and not as I do" and, when it comes to HIV/AIDS, positive role models among adolescent peers are very rare, so this influence is counterproductive and amounts to deviance or risk training (Frankham, 1998, p.185). Wight (1999) as cited in Baxen and Breidlid (2004) holds a similar view, saying learner-driven programmes do not work as well as teacher-driven ones because, he argues, there are severe limitations to the efficacy of learner empowerment in sexuality and HIV/AIDS education.

### 2.3.4 Sexuality education, AIDS education and parents

Sexuality education in schools has received mixed reactions from parents. For example, some parents argue that talking about sexuality in schools may

increase sexual activity among youth. Parents in many countries including South Africa, Tanzania, Zimbabwe and indeed Malawi have objected to the inclusion of sex education in the school curriculum on similar assumptions namely that teenagers would engage in sexual activity for they might wish to experiment (Webb, 1997). In Western Nigeria, parents blamed sex education for the irresponsible sexual behaviour that youth were displaying, saying that adolescents' sexual expressions have defied all the culturally accorded respect given to sex in the past (Ojo and Fasubaa, 2005). They were however more compromising about family education if it did not teach about sexual intercourse.

However, in a qualitative study in Ghana (Botchway, 2004), it was found that the belief that children would initiate sexual activity as a result of sex education was only shared by a minority of parents, with the majority favouring open communication with their children about sexuality. Furthermore, in reviews of studies by the World Health Organization and the US National Campaign to Prevent Teen Pregnancies, James-Traore et al. (2004) found that sexuality education did not lead to an increase in sexual activity among young people. On the contrary, the reviews found that effective sexuality programmes could result in delaying first intercourse among youth that are not sexually active and an increase in the use of contraception by those already sexually active.

It remains debatable whether or not parents should be involved in sexuality education. While a lot of literature today calls for parental involvement in sexuality education issues, it has sometimes been argued that parents may not be most appropriate persons for the dissemination of sexuality messages. For example in her study Reddy (2005) noted that the most powerful messages from parents, especially to girls, was about the dangers of sex and the risks of pregnancy. In Ghana Botchway (2004) also noted that parents instilled fear of pregnancy, HIV/AIDS, and God as tactics to pass on information about puberty and HIV/AIDS to their children. But as has been

alluded to earlier, sex should not be associated with fear otherwise it is not healthy for the sexual development of adolescents.

In a multi-country study which involved South Africa, Rwanda, Zimbabwe, Zambia and Rwanda, many participants expressed willingness to discuss issues about sexuality and HIV/AIDS with their parents or guardians, but complained that parents were unwilling to discuss such matters and constructed them as "old fashioned" (Pattman, 2006).

The issue is a challenging one to both teachers and parents. It is therefore noted that both parents and teachers should offer sexuality education, but the diverse cultural values and norms associated with sexuality education should be taken into consideration.

### 2.3.5 Sexuality and AIDS education and Non-Governmental Organizations

Non-school-based programmes are mostly organised by Non-Governmental Organisations which mobilise people at community level around the school. These aim at a wider audience, including out-of-school youth. Sometimes NGOs organise activities based in schools. School management does not have direct control over such programmes. These are either carried out in youth clubs around the school and involve school learners as well, or the NGOs make occasional visits to schools where they stage various HIV/AIDS activities. A notable example of a mobile organisation for the youth in Malawi is "Youth Alert." There are, however, many other initiatives by NGOs targeting both school and out-of-school youth at local level throughout Malawi. The strength of NGOs is their use of local community leaders and local participation, which make them credible in local communities and enhance local participation (Griffiths, 2005).

In Zimbabwe, a Grassroots Soccer (GRS) Programme run by an NGO has had significant impact on student knowledge about HIV/AIDS, their attitudes towards HIV/AIDS prevention and behaviour change (Griffiths, 2005). GRS is a

life skills-based intervention programme that uses national and international soccer stars as role models and involves peers. Because of its success in Zimbabwe, the programme has been extended to other countries in Africa such as Zambia, Botswana, Ethiopia and South Africa and has been embraced by the Federation of International Football Associations (FIFA) as Football for Hope (Griffiths, 2005).

### 2.3.6 The place of schools and teachers in sexuality and AIDS Education

The rationale for situating these programmes in schools has been that schools offer the best opportunities for HIV/AIDS programme implementation because they offer the advantage of a fixed framework within which resources can be invested and monitored (Rochart and Hough, 2007) and because school children are considered a "captive audience", many of whom it is assumed may not be sexually active (Baxen & Breidlid, 2004, p. 10). It is further assumed that providing children with sufficient knowledge may serve to delay their sexual debut and enable them to make informed decisions regarding their sexual practices and behaviours (Baxen & Breidlid, 2004).

Moreover, school-based programmes provide an opportunity to start educating children on issues of sexual and reproductive health at an early age, before they become sexually active and have already acquired attitudes and practices that are often counterproductive to positive sexual behaviour and attitudes (Bennell, Hyde, & Swainson, 2002). Further, it is asserted that school settings are ideal for HIV/AIDS and reproductive health education, because it is in these settings where sexual relationships - both negative and positive - are formed and that they also offer the perfect opportunity to reach adolescents with needed information and services (USAID, 2004). Gallant and Maticka-Tyndale (2004, p. 1338) justify school-based programmes on the grounds that schools provide an established venue for intervention. For example, their location is known, they are

sustained within the community, their hours and mode of operation are known, they have established mechanisms for introduction of new programmes and accessing learners, the size of the population is known, and schools are linked to the communities through families and other community organisations, thereby extending their reach and enhancing local ownership of interventions.

Concerning the role of schools in reducing risk-taking behaviour among adolescents Kirby (2002, p.28) suggests the following:

- That the way schools structure their time, limits the amount of time learners can be left alone to engage in sex;
- That schools increase interaction with and attachment to adults who discourage risk-taking behaviour including sexual risk-taking;
- That schools influence learners' selection of friends who in turn influence their risk-taking behaviour;
- That schools help learners to plan for their future educational and career aspirations which in turn increases their motivation to use contraceptives and delay child bearing; and
- That schools can increase learners' self-esteem, sense of competence and communication and refusal skills.

Unfortunately most school-based intervention programmes are limited to secondary school learners. This is unfortunate because, as Rivers and Aggleton (1999) have alluded to, research shows that interventions are most successful before adolescents' sexual debut and therefore should start in primary schools, which have been noted to be significant sites for the construction of sexual identity among children (cited in Baxen and Breidlid, 2004). Mindful of the need for an early start of interventions at primary school level, this study with its particular focus and rationale, however, limited itself to secondary school learners. (See 1.6) It has been argued that schools, whether

primary or secondary, have failed to provide a healthy supportive environment and have failed to implement strong ethical policies in terms of behaviour of teachers towards learners. With so many cases of girl abuse by teachers, the much needed function of teachers as role models is conspicuously absent. It has further been observed that teachers are still reluctant to discuss issues such as HIV/AIDS and sex education in class, as they are unsure whether it is their responsibility or that of parents. Moreover, in many countries including Malawi, teachers have reportedly complained of being embarrassed to talk about sex with children (Baxen & Breidlid, 2004). Kinsman (1999) as cited in Griffiths, (2005) argues that, in most cases, this is the result of lack of training for this added responsibility.

This assertion has been supported by a three-country study involving Malawi, Botswana, and Uganda, where Bennell et al. (2002) reported that there was little hard evidence to show that school-based HIV/AIDS education programmes or reproductive health and life skills education has had any major impact on sexual behaviour. The study further observed a growing concern about the risk of female learners contracting HIV from teachers and other older men. However, the study established that learners in the survey schools were well informed about the causes and consequences of HIV/AIDS, although translating this knowledge into behaviour change remains the major hurdle. In this regard, Maluwa-Banda (1999) argues that HIV/AIDS education that aims solely to increase knowledge would appear to be limited in its ability to induce and maintain alterations in sexual behaviour. He further suggests that education efforts to control HIV/AIDS must start with an understanding of sexual, educational, cultural and religious values of the society, otherwise such efforts will be ineffective. In his contribution to the question of who should teach HIV/AIDS education, a delegate from Malawi at the UNESCO International Conference which was held from 18 to 29 May, 2009 (http://hivaidsclearinghouse.unesco.org),( recommended that teachers take up this responsibility but only after training, arguing that, at present, there are very few health care experts to take on this role in Malawi.

However, Baxen and Breidlid (2004) warn that training by itself is not enough because, no matter how well a teacher is equipped with knowledge and skills, this will not guarantee that he or she would be willing to deliver HIV/AIDS lessons in the classroom. They argue that the position the teacher holds in and out of school is a key mediating factor in the delivery of HIV/AIDS programmes, because it is this position that will dictate the choice about what knowledge to teach, when and how. Stuart (2006) concurs with this view, arguing that teachers who are dealing with HIV/AIDS education need to recognise their own responses to HIV/AIDS.

### 2.3.7 An Overview of some of the intervention programmes in Malawi

School-based programmes in Malawi have had varying degrees of success. Below, I give a brief description of the operation of these programmes and the results of their evaluation wherever possible. But as Bennell et al. (2002) observed, in their multi-country study that included Malawi, assessing the effectiveness of school-based HIV/AIDS intervention programmes is particularly difficult because there are a number of other institutions such as the family, youth clubs, and church as well as the media that can potentially influence the sexual behaviour of youth.

In 2005 Family Health International (FHI) conducted a comprehensive review of sexuality and HIV education in both developed and developing countries (cited in Parker and Finger, 2005). Eighty three studies reported its significant impact on sexual behaviour, such as reducing the number of sexual partners, condom use initiation and frequency of sex, and on knowledge of the factors that determine risky behaviour, awareness of risk, value and attitudes and self efficacy regarding sexual topics. However, the review reported serious challenges with regards to implementation, which included lack of trained teachers and reluctance of teachers to teach certain topics, such as condom use, because it contradicted their own values (as cited in Parker & Finger, 2005).

#### *2.3.7.1 Population and Sexuality Project*

This is a Malawi Ministry of Education initiative in primary and secondary schools. It was funded by the United Nations Fund for Population (UNFPA) and its objective is to encourage children to control their emotions (Kadzamira et al., 2001). A wide range of teaching and learning materials have been developed and integrated into the primary and secondary school curriculum in social studies, health science education and biology. It is mostly delivered as direct teaching of skills and information, with little observable change in behaviour. This method of teaching tends to yield positive results much later in a student's life, when what has been learned has been internalised (WHO, 1993 cited in Bennell et al., 2002). Unfortunately, there is no traceable record about the evaluation of the Population and Sexuality Project, so its influence on behavioural change has not been established.

#### *2.3.7.2 The Life Skills Programme*

In 1997 the Ministry of Education Science and Technology, in conjunction with the United Nations Children's Fund (UNICEF) developed a "Life Skills" programme (Reijer & Chalimba, 2000). The goal of the programme was to equip learners with key competencies in problem solving, decision making, stress and anxiety management, conflict resolution, interpersonal relationships, planning and entrepreneurship, self esteem and assertiveness, and AIDS prevention. As with the population and sexuality programme, teaching and learning materials were developed for primary and secondary schools, and a Life Skills course introduced as a core subject. According to NAC (2009), teachers of Life Skills have been trained in both primary and secondary schools to implement the curriculum. These teachers are identified by head teachers and they often also teach Social Studies but undergo some orientation in the teaching of Life Skills. The problem however, is that once a Life Skills teacher is transferred to another school, the incoming teacher may not necessarily have had similar training.

As a subject in the school curriculum, Life Skills is offered once a week in every class in the school irrespective of the type of school, whether government or private, boarding or community day school. Each Life Skills lesson lasts for 40 minutes and a total of 39 lessons are offered in an academic year, a period deemed adequate to effect behavioural change, but as discussed in 5.2.2.2 and 5.2.2.3 is not the case.

The Life Skills programme has been evaluated, and there are indications of success, as reported in the UNICEF (2000) evaluation report (as cited in Reijer and Chalimba, 2000). In the evaluation it was reported that most learners had adopted safer sexual practices, either by remaining inactive, abstaining, or by making use of condoms. The evaluation, however, indicated that some teachers of Life Skills education had little knowledge of the content and the participatory teaching methodologies advocated. Also, learners see Life Skills as an additional academic course but one which is not examined and so they tend to put less effort into it. Additionally, apart from the routine school inspection visits, Life Skills and other HIV/AIDS programmes are rarely monitored for their effectiveness. The Life Skills experience in Malawi is very similar to experiences reported by Bhana and Epstein (2007) in the South African context in KwaZulu-Natal regarding Life Orientation (LO), where it was observed that teachers have difficulties in teaching Life Orientation because of a lack of training in the delivery of the Life Orientation programme.

#### *2.3.7.3 The Why Wait Programme*

The "Why Wait" educational programme is a four year programme, offered in both primary and secondary schools in Malawi. Introduced in 1995, its overall aim is to sensitise youth to abstinence from premarital sex. Based on Christian principles, it has been particularly influential in the informal curriculum as an anti-AIDS extracurricular activity, but also in the formal curriculum as a taught programme. About 600 teachers have been trained to deliver this four year programme (Reijer & Chalimba, 2000).

Like the Life Skills Programme, an assessment of the "Why Wait" programme has shown that there has been some success in bringing about behavioural change among the youth. Lack of resources and lack of adequate and appropriate training of teachers has, however, been mentioned as inhibiting factors to a more successful implementation (Munthali, Chimbiri & Zulu, 2004).

I have so far described the school-based programmes that form an integral part of the school curriculum in Malawian Schools. The main problem of school-based curriculum integrated interventions, as reported earlier (See 2.3.7.2) is that teachers are inadequately trained to handle the content, and are too embarrassed to talk about HIV and sexuality issues. For example, in a multi-country study involving Malawi, Uganda, and Botswana, Bennell et al. (2002) observed that there were serious problems with the delivery of HIV/AIDS and sexual reproductive health programmes because teachers lacked both the competence and commitment to teach since they had had little or no training. Also, another regional study cited earlier (Pattman, 2006) reported that in Botswana and Rwanda, teachers expressed discomfort about teaching HIV/AIDS and life skills, and that in Zambia, learners expressed dissatisfaction with the manner in which sex education was taught and complained that they lacked focus in their lives. The study suggested that sex education programmes should focus on the gender dynamics that are forged in class and that programmes should motivate male and female youths to work together.

In some cases learners have themselves complained that they are being lectured to, instead of being listened to or heard. In order to pass examinations in the academic context learners are expected to amass knowledge of subject matter which may have little or no bearing on behavioural change. As has been alluded to earlier on, many adolescents have adequate knowledge about HIV/AIDS but what is lacking is the will towards behavioural change, which should be the target of any intervention. However, one would think that the onus is on each individual learner to bring

about behavioural change because, as Munthali et al. (2004) have observed, unless learners perceive HIV/AIDS as being an important issue, it is unlikely that they will take school-based intervention programmes seriously, no matter how well designed or well delivered the programmes curriculum might be. In the next section I discuss some extra-curricular forms of HIV/AIDS interventions which operate within school premises, but do not form an integral part of the school curricula.

#### *2.3.7.4 The AIDS "TOTO" (Anti- AIDS) Clubs*

AIDS "Toto" (***No! to AIDS***) clubs are the main extra-curricular school-based interventions, established with the help of funding from UNICEF in the late 1980s, and are found in most primary and secondary schools in Malawi. AIDS "TOTO" clubs are composed of learners who join voluntarily. This voluntary membership means that the majority of learners do not participate to take full advantage of the club activities. The clubs, while run by peer learners themselves are directed by patrons who are also members of the teaching staff. Club patrons are identified by head teachers, based on their interests and experience. Some patrons have attended HIV/AIDS workshops or courses. The aim of these clubs is to act as forums for discussion with peers about the dangers of indulging in multiple sexual partners, drugs and alcohol. The programme aims at empowering the youths to make informed decisions with regards to their sexual relationships. An evaluation of this programme indicates that it has had a positive impact on reducing teenage pregnancies (Reijer & Chalimba, 2000). A school-based survey by Kadzamira et al. (2001) revealed marked variations in terms of staffing and commitment, and levels of activity from one club to another. In some cases, learners reported that they were aware of a club's existence but that very few members were active. Club patrons who in most cases have heavy teaching loads, were giving inadequate or no attention to the activities of the clubs, thereby leaving them to be run by peers. A general overview of the AIDS "Toto" Clubs

is that they are inactive and therefore ineffective, and need monitoring and serious attention in order to be revitalised.

#### *2.3.7.5 The Safe Schools Project in Malawi (SSP)*

The safe schools project is the latest initiative by the Ministry of Education and Human Resources Development (MOEHRD) through funding from USAID (USAID, 2004). This project is a response to widely reported school-related, gender-based violence (SRGBV). The aim of the project, which initially covered 40 pilot schools spread across the country, is to create a gender-safe environment for all girls and boys, to promote gender-equitable relationships, and to reduce SRGBV in schools. The SSP uses a social mobilisation approach which involves making use of all relevant segments of society in order to create an enabling environment. At the centre of this model is the individual girl or boy child, and surrounding him /her are layers of his/her life that, in total, make up an enabling environment for behaviour change. These layers of environment include parents and family members, the community, the school, and the societal norms, very much like Bronfenbrenner's (1979) ecological model of human development.

The SSP does not have its own interventions as such but builds on existing ones by developing capacity in learners, teachers, community leaders and Ministry officials. An evaluation of the project by USAID (2004) has revealed that although reproductive health materials for schools had been developed, they were not taught because teachers were not adequately trained to deliver them effectively. Most teachers were not comfortable discussing issues related to sex, condoms and HIV/AIDS. The evaluation also reported serious deficits in institutional capacity to respond to victims of SRGBV and other traumas in the form of school counsellors, school health personnel or social workers.

### 2.3.8 Other potential strategies for addressing HIV/AIDS

#### *2.3.8.1 Condom use promotion by government and civil society organizations*

Promoting the use of condoms has been implemented as one of the risk reduction strategies, but just how effective are condoms when it comes to adolescents? The Malawi Ministry of Education does not have a deliberate policy of promoting accessibility of condoms at schools, but leaves it to learners' discretion to access them through other public avenues available to them. An attempt to distribute condoms and to provide information on family planning in schools in Malawi was rejected by the Parent Teacher Associations (PTAs) (USAID, 2004). In South Africa, the then Minister of Education, Nalede Pandor, said that Government would not allow condoms to be distributed in schools but that it would continue to advocate abstinence among the learners as the strategy to fight the spread of HIV (South Africa Broadcasting Corporation (SABC) SAFM 13.00 hr news of 5th March 2009).

Turning to the use of condoms by learners, in a study conducted by McAuliffe (1994) in Malawi, only 24% of secondary school adolescents reported having used condoms consistently with their girl friends, and only 18.5% reported consistent use of condoms with casual partners. This low usage could be attributed to the negative perception adolescents have of condoms, which in itself is a result of misconceptions about condoms. For example, in the study of Kadzamira et al. (2001) in Malawi, respondents reported use of condoms and availability of condoms as an important factor in encouraging sexual activities among the youth. Participants disliked using condoms because it reduced sexual pleasure; it was like "eating sweets in its wrapper" or "having a shower in a rain coat" (Kadzamira, et al., 2001, p. 18). In their multi-country study that included Malawi, Amuyunzu-Nyamongo et al. (2005) give three reasons for non-use of condoms by learner participants:

- To show love for a partner one has to have sex without a condom.

- Condoms reduce sexual pleasure and were again likened to having sweets in a wrapper.

- Participants were influenced by the physical appearance of their partner. If the partner looked healthy, they never cared to use a condom, but if he looked sick, showing symptoms like weight loss and change of hair, they felt obliged to use a condom. Assessment of physical appearance and deciding to use a condom based on whether or not a partner presents physical symptoms, exposes adolescents to risk of infection from HIV/AIDS. Such assessments may however be deceptive, as a person who looks physically healthy may have the virus.

The whole issue of condom use is compounded by the conflicting messages between advocates of condom use, especially civil societies, and church messages which preach against their use. In their study, Kadzamira et al. (2001) established that secondary school learners were getting conflicting messages, with some people saying condoms are not 100% perfect, and others promoting their use.

On the international scene, Wood (2008, p.49) reports the view held by the Kenyan First Lady who is the chair of the Organisation of African First Ladies against HIV/AIDS on youth and condom use, saying:

> "Those who are in school have no business having access to condoms, and those who are in university and are not married have no business having condoms in their halls of residence. She wondered who gave the authority to the young people to be involved in sex before marriage."

In the United Kingdom, Measor (2006) did an analysis of findings regarding teenage pregnancy. Promotion of condom use, in this regard, was taken as an aspect of sexuality education for the young people. Her analysis uncovered serious negative attitudes by young people towards condom use in sexual intercourse; the problems cited were that they are messy and

reduce the physical and erotic sensation involved in penetrative sex. Narratives by young women reported difficulties their male counterparts faced in using condoms, such as difficulties with erections and experiencing temporary impotence, all of which tended to embarrass males.

The use of condoms has a gender dimension. Ross and Deverrel (2004) argue that the majority of preventative campaigns focus on the use of the male condom and ignore the fact that women are powerless to negotiate for the use of a condom during intercourse. Even the introduction of a female condom has not seemed to make any headway, because many women do not feel sufficiently empowered to assert their rights or desires, and are not permitted this freedom by their partners. In Malawi, women who use condoms or request the use of condoms are considered promiscuous and un-trustworthy (Tiessen, 2005). As indicated earlier (see 2.2.5) where a girl has received a gift from her partner, she finds it difficult to negotiate condom use (Amuyunzu-Nyamongo et al., 2005). Franzkowiak and Wenzel (1994) observe that possession of condoms, either by males or females, is viewed as a concrete request for sex, and this image becomes an inhibiting factor for girls found in possession of condoms in a society that does not allow women to request sex. All these factors place the adolescent girl at risk of contracting HIV/AIDS.

In Zimbabwe, Wekwete and Madzingira (2005) found there was a relatively high acceptance of condom use, which was attributed to the AIDS awareness campaigns. However, when it came to the actual use of condoms for sexual intercourse, a significant number of girls reported barriers which included embarrassment to buy a condom from a store, discomfort at carrying condoms with them, and the belief that if they did, they would be labelled sexually weak.

In her study in South Africa, Reddy (2005) observed that girls linked sexual activity with love and trust, so any demand for condom use during sexual intercourse was perceived to undermine that love and trust. Reddy argues

that when sex is constructed around trust and love it may undermine the need for safe sex.

Condom promotion often fails to recognise the gender power dynamics involved in its use. For example, Ross and Deverell (2004) explain that the majority of intervention campaigns narrowly focus on the use of condoms, and on the male condom without recognising the power dynamics in its use. They argue that women are powerless to negotiate safe sex or the use of condoms. Whether or not the introduction of the female condom might change this power dynamic still remains to be seen.

An alternative strategy to condom use is abstinence. Abstinence is an acclaimed strategy by youth but, in practice, seems not to be feasible. In their multi-country study that included Malawi, Amuyunzu-Nyamongo et al. (2005) found that while participants understood the benefits of abstinence and acknowledged that it is an effective way to prevent HIV/AIDS, they felt that postponing sex until marriage was not a feasible option. Amuyunzu-Nyamongo et al. (2005) posit that, as the age at first marriage continues to increase (due to schooling) in sub-Saharan Africa, the message to abstain until marriage becomes increasingly unfeasible for most adolescent boys and girls.

In a review of studies examining the impact of abstinence only programmes, Kirby (2002) found no published evaluations indicating that such programmes delayed sexual debut among the youth, but cautions that it might be premature to draw conclusions about the impact of such programmes. Kirby's review however, found overwhelming evidence that HIV Education programmes that emphasise abstinence and use of condoms and contraceptives do not increase sexual intercourse among the youth.

In relation to condom availability and condom use among the youth in the Unites States, Kirby (2002) found that making condoms readily available in schools did not significantly increase rates of sexual activity among learners

and that among the reasons the youth gave for non-use of condoms, lack of access was not included. Kirby further reported that an increasing number of states in the US place restrictions on instructions about condoms and contraceptives and a proportion of schools limit instructions to abstinence only (Kirby, 2002).

While adolescents show negative attitudes towards condom use, they rarely put forward alternatives, and continue to engage in behaviour and practices that put them at risk of sexually transmitted infections, including HIV/AIDS (USAID, 2004). These findings and observations, and indeed those I described above in relation to situations that lead adolescents to engage in risky sexual behaviours, however, point to our overestimation of the impact of a condom campaign as a risk-reduction strategy for the youth. While it is a fact that the use of condoms considerably reduces the chances of HIV infection, its effectiveness, especially with adolescents, seems to be the subject of intense debate and an ideal area for further research.

#### *2.3.8.2 Guidance and counselling as potential strategy*

A call for guidance and counselling has been highlighted in the literature in Malawi. The National HIV/AIDS Policy (2003), the National Behavioural Change Intervention Strategies by NAC (2003), the Malawi Poverty Reduction Strategy Paper (MPRS) (2002), Kadzamira et al. (1999), Kadazmira et al. (2001), and USAID, (2004), all urge for scaling up guidance and counselling services in Malawi as interventions for the HIV/AIDS pandemic, especially by providing social support to the majority of affected youths. The expectations of most parents and other stakeholders are that schools should be able to offer some form of pastoral care for their wards in the absence of parents.

Whether or not guidance and counselling services are actually available in secondary schools is an issue worth investigating. In their study, Kadazamira et al. (2001) reported on the guidance and counselling services in some schools in the form of advice given by class teachers, head teachers and

disciplinary committees. Guidance and counselling services have been in existence in Malawi, at least in principle, since 1983 (Kuthemba-Mwale et al., 1996). At that time, emphasis was on career guidance and preparing learners for university career choices. The mode of delivery was through guest speakers, but some volunteer teachers were responsible for advising learners on careers.

At the Ministry of Education Headquarters, a career guidance officer was appointed to co-ordinate the activities of career guidance. The Ministry published a manual that was used as a teacher's handbook and was periodically reviewed. Later on, due to growing psychosocial problems in schools, counselling was added to the concept of guidance. However, teachers were not trained in counselling skills.

Currently, guidance and counselling initiatives are no longer actively pursued in schools; lack of trained personnel presumably inhibits its provision. This is another area worth researching. With the establishment of the Africa Centre for Guidance and Counselling and Youth Development in Lilongwe, it is hoped that these services will be revitalised.

#### *2.3.8.3 Concluding remarks regarding interventions in schools in Malawi*

The overall problem in the intervention programmes in Malawi, as discussed above, appears to be lack of standards arising from lack of coordination among all stakeholders to deliver effective implementation. Reijer and Chalimba (2000) suggest co-operation and collaboration between UNICEF, UNFPA and the Ministry of Education to streamline the programmes.

A number of suggestions have been put forward to try and ensure that HIV/AIDS intervention programmes are effective. Whatever form the programme for adolescents takes, whether school-based or non-school-based, Griffiths (2005) asserts it should include multiple media such as storytelling, role play, and listening, which will give learners an opportunity to be actively involved in the learning process, rather than be subjected to

didactic traditional teaching methods which often focus on information alone. Further, NAC (2003) suggests that any behaviour change intervention strategies for the youth should take into account the needs of specific types of youth, and that they should be involved from the planning stage through to the implementation. Brundy, the World Bank leading specialist for education and HIV/AIDS, contends that education is the social vaccine against HIV/AIDS and that learners, even amid the adversity of the AIDS pandemic, represent our window of hope (Griffiths, 2005). But alas! With the alarming rate of infection among the youth, this window seems to be fast closing !

## 2.4 Synopsis of Chapter Two

From the literature cited above, I have become more aware of the complexities of adolescent vulnerability to HIV/AIDS and this has led me to review my approach. Initially, I thought I could explore adolescent vulnerability and resiliency to HIV/AIDS, but after an examination of the literature, I decided to focus on vulnerability, leaving the issue of resilience to another study worth pursuing. The literature also helped me to reshape my research questions and interview schedules.

In this chapter I discussed a review of the literature related to adolescents and HIV/AIDS. The review, which took a thematic approach, surveyed the literature in terms of the contextual factors, both in Malawi and other countries that predispose adolescents to HIV/AIDS, including the impact of the pandemic on the lives of secondary school adolescents and their education. This was followed by a detailed discussion of the intervention programmes available to secondary school adolescents in Malawi, including an evaluation of their effectiveness where possible, again drawing examples from Malawi and other countries. A discussion about who is best positioned to teach HIV/AIDS and sexuality issues, and the role of parents in such education, was also presented.

In the next chapter I discuss the conceptual and theoretical frameworks that guided this study. A discussion of concepts, models and theories is presented, and so is the justification for their use in this study.

# Chapter Three:
# Conceptual and Theoretical Frameworks for Understanding Adolescent Vulnerability in the Context of HIV/AIDS

> *"Ine ndine wa chinyamata wa zaka 15.HIV/AIDS ndi disease yoti ya chita affect the whole world imene ikusowesa mtendere. anthu akanika kupeza mankwala ake. (I am a youth of 15 years. HIV/AIDS is a disease that has affected the whole world and is disturbing world peace. scientists have failed to find its vaccine"* (Serena, age15).

## 3.1 Introduction

In this section I describe the conceptual and theoretical frameworks that underpin this study. The description of the concepts and theories takes into account the fact that a study aimed at understanding adolescents' vulnerability to HIV/AIDS is a multifaceted one, drawing concepts and theories from a number of disciplines such as psychology, sociology and health. It has been claimed that it is not uncommon for social sciences to draw upon theories from various disciplines. As Anfara and Mertz (2004) argue, the social sciences have many theories that compete with each other. They further argue that the use of multiple theories allows for the phenomenon being studied to be viewed from multiple perspectives or lenses.

In this chapter the following concepts and their constructs are discussed in order to define their usage in the context of the study: vulnerability to HIV/AIDS, adolescence, adolescent sexuality, HIV/AIDS and intervention.

In addition, the theories and models that I discuss in this section include the eco-systemic model of Bronfenbrenner (1979) Bishop–Sambrook's HIV/AIDS vulnerability pathway model (2003), and psychological and behavioural theories such as self determination theory (Field & Hoffman), hope theory (Synder), social learning and social cognition theories (Bandura), the health belief model (Rosenstock, et al., 1974), and the theory of reasoned action (Fishbein, 1975). These theories and models present a good basis for understanding adolescents' understanding of their vulnerability to HIV/AIDS, and why they respond to the various interventions the way they do.

## 3.2 Conceptual Framework

### 3.2.1 Vulnerability to HIV/AIDS

In this study the key phenomenon explored is "vulnerability" to HIV/AIDS of secondary school adolescents in Malawi. Nyambedha (2008) points out that the concept of vulnerability poses some difficulties when it comes to applying it in understanding actual life situations, because it is complex and changes meaning depending on the social context. She argues that a good understanding of vulnerability needs to focus on identifying and describing the social situations in which it emerges and develops. Swartz, de la Rey and Duncan (2004, p. 409) define vulnerability as "susceptibility to negative outcomes under conditions of risk."

The concept of vulnerability, as used in this study, is similar to what De Guzman (2001, p. 665) describes as "social vulnerability". He recognises that individuals are at risk due to their social positions and not simply as a result of sexual behaviour. Furthermore, he posits that social vulnerability recognises that individual behaviour is governed by societal and cultural norms and that, while individual knowledge, attitudes, and beliefs may affect behaviour, these are mediated by relationships with others. Therefore, while individual risk

factors are explored, the emphasis is on how these risk factors make adolescents as a social group vulnerable.

Vulnerability to HIV/AIDS suggests two sets of factors: risk factors and protective factors. Swartz, et al. (2004, p. 409) state that protective factors are those influences that limit or reduce the likelihood of high risk behaviour and play a moderating or buffering role. Dent and Cameron (2007) define protective factors as those factors that modify the effects of risks in a positive direction, while Luther et al. (2000) suggest that the terms, "protective" and "vulnerability" should be used to describe overall effects that are beneficial versus detrimental ones (as cited in Normand, 2007). Normand (2007) notes that risk factors are used to identify individuals with a high probability for problems, although they do not always help or explain how or why problems develop. De Guzman (2001) and Siqueira and Diaz (2004) explain that risk factors relate to individual or environmental hazards that increase an individual's vulnerability to negative developmental outcomes. De Guzman asserts that as the number of risk factors increases, so does the probability of a problem. An understanding of risk factors in adolescence is very useful in understanding their vulnerability to HIV/AIDS. For adolescents, immediate environmental factors such as the family, peers and the school may either increase or decrease their vulnerability to HIV/AIDS, as could cultural aspects. The interplay between risk factors and the child's strengths and weaknesses correlate with the degree of vulnerability or resilience a child experiences. This interpretation further points to the fact that there are adolescents who, through protective factors, can remain resilient to the disease.

Resiliency is defined as "the process of coping with disruptive, stressful or challenging life events in a way that provides the individual with additional protective and coping skills prior to the disruption that results from the event" (Henderson & Milsteon, 1996, p.7). Swartz et al. (2004, p. 409) define resilience as "successful adaptation to the environment despite exposure to risk". Resiliency theory assumes that, against all odds of life, individuals can regain

their lost social comfort, depending on how they manage stress, and the level of social support they receive. Resiliency recognises that although adolescents maybe subject to the same pressures from risk factors, such as those that place them in risky sexual behaviours, there are some who choose to remain sexually inactive, or practise safe sex. Although resilience is not at the centre of this study, it is taken cognisance of in the study.

For the purpose of this study, vulnerability refers not only to the way various contexts at individual, interpersonal, community and societal levels make secondary school adolescents susceptible to HIV infection but also to the way that these contexts act as protective factors from infection, as well as the impact of the disease on their lives

### 3.2.2 Adolescence

Adolescence is conventionally defined as, "a transitional period of human development during which a young person moves from dependence to independence, autonomy and maturity" (Geldard & Geldard, 2004, p. 2). Physiological changes, such as the emergence of pubertal changes in girls and boys, signal the onset of adolescence. According to Franzkowiak and Wenzel (1994) adolescence is the developmental period between 10 and 19 years and youth as being a period between 15 and 24 years. Most Malawian secondary school learners fall within Franzkowiak's adolescent age group. There seems, however, to be an overlap in the usage of the terms *adolescence* and *youth* and these terms have been used interchangeably in this study.

Considering the changes that take place in an individual lifespan, Lerner (2005, p. 3) defines adolescence as "the lifespan period in which most of a person's biological, cognitive, psychological and social characteristics are changing in an interrelated manner from what is considered childlike to what is considered adult-like". This definition seems to suggest that development, for example in the biological dimension, is likely to affect development in

other dimensions such as the cognitive, social and psychological. This view is significant for understanding adolescents who are experiencing rapid changes which tend to influence their behaviour, including risk-taking behaviour. For example, production of sex hormones, a function of biological changes, triggers an increase in sexual arousal, which, unless emotionally well managed, can lead to adolescent sexual experimentation, without full understanding of the consequences of such behaviour.

Geldard and Geldard (2004) borrowing from Elkind (1978) note that during adolescence, adolescent "egocentricity" develops and is manifested in adolescents' belief that they are the focus of everyone's attention (with for example, an imaginary audience). This could have implications for the seeking of medical care for sexually transmitted diseases, including HIV, because they think everyone else is observing them. For example, they might feel shy to go for HIV voluntary testing and counselling. Socially, adolescents are under intense pressure to conform to peer demands just for the sake of approval or acceptance. Excessive conformity to peer pressure leads adolescents to engage in high risk behaviours such as engaging in unprotected sex.

UNICEF/UNFPA/WHO (1989) (http://www.unfpa.org/adolescents/finalKS/defining_adolescence.htm) This should be in your reference list, not the body of the text. argue that adolescence provides a valuable opportunity for instilling preventative behaviours since adolescents are in a stage of rapid learning and more open to change, which means that attitudes and behaviours acquired during adolescence are likely to remain for life.

In Malawi, adolescence is characterised by initiation rites in various forms, which usher young ones into adulthood. The significance of these rites is that they prepare adolescents for marriage; girls in particular are considered ready for marriage after being initiated (Kadzamira, et al., 1999). In traditional Malawian society, sex is very closely related to marriage and any

cohabitation or pregnancy outside marriage is frowned upon. Adolescents, therefore, are anxious to get married quickly and enjoy sexual life. With the western schooling system, which takes a long time, waiting for marriage in order to experience sex becomes unrealistic. Adolescents are then torn between societal expectations of abstinence till marriage, the demands of being at school, and intense sexual drives that are characteristic of this period. This leads them to experiment with sex outside societal norms and, in the process, engage in risky sexual behaviours that predispose them to the dangers of contracting HIV/AIDS. As has been discussed (see 2.2.7.1) initiation rites also put adolescents at risk of contracting HIV/AIDS, for example, by encouraging early marriages and sexual intercourse through such practices as "kuchotsa fumbi."

### 3.2.3 Adolescent sexuality

During adolescence, youth become increasingly aware of their sexuality and develop intimate relationships with members of the opposite sex. According to WHO (2002) in Lerner (2005), sexuality includes sex, pleasure, intimacy and reproduction, and can be expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, roles and relationships. It is influenced by the interaction of psychological, social, economic, biological, political, cultural, ethical, legal, historical, and religious factors. Esere (2006) asserts that sexuality involves physical aspects, including body growth, changes associated with puberty and physiological processes, such as menstruation, ovulation and ejaculation, and that it influences decisions about engaging in sexual intercourse.

Adolescence has been described as a period of intense sexual drive and experimentation, normal for adolescents. As Rivers and Aggleton (1999) have observed, evidence from a variety of countries suggests that the age at which young people become sexually active maybe falling and that young ones are under increasing pressure to be sexually active. In South Africa, a

similar trend has been observed where young children often have early sexual experiences, either by coercion or volition (Bhana & Epstein, 2007). Unfortunately, as both Franzkowiak (1994) and Mwamwenda (2004) have argued, most adolescents engage in sexual intercourse when they are still emotionally too immature to make informed decisions and often do not protect themselves and their partners.

Turning to adolescent developmental tasks, one of them, according to McNeely, Nonnemaker and Blum (2002) is to satisfy their sexual needs in socially acceptable ways. In most cases, as Geldard and Geldard (2004) have argued, adolescents are positioned between exerting their own identities and submitting to societal expectations, peers, parents, family and the church (religion). Dusek (1996) as cited in Geldard and Geldard (2004) states that there are vast differences between cultures with regards to how adolescents are exposed to sexuality issues. He points out that at one end, are cultures where adolescents are expected to refrain from engaging in sex until married, and at the other end of the continuum there are societies where sexual activities maybe allowed or even encouraged among adolescents. Harrison, as cited in Karim (2005) explains that during adolescence sexual risk is influenced by multiple social, behavioural and situational factors, making adolescents especially vulnerable.

A corollary concept explored in this study is sexual behaviour which describes the set of behaviours and practices that define sexual risk for HIV/AIDS. These might include partnership characteristics, sexual networking, and the timing and experience of sexual initiation (Karim, 2005). As has been observed, the advent of the HIV/AIDS pandemic has led to the examination of what sex and sexuality mean in their socio-cultural contexts, the construction and interpretation of sex and sexuality, and the relationship between health, disease and sexual behaviour (Sathiparsad & Taylor, 2006).

In this study sexuality refers to heterosexual orientation as legally acknowledged in Malawi, expressed in sex, pleasure, intimacy and

reproduction by people of opposite gender. Homosexuality is classified as a criminal act in the Malawi legal system (Muula, 2006). However, it is in heterosexual relationships where gender imbalances have been observed, most often with women being the most susceptible to HIV and other sexually transmitted infections because of their feelings of powerlessness and voicelessness when it comes to sexual decisions (Sathiparsad & Taylor, 2006). Sexuality is explored in order to better understand how it impacts on adolescent vulnerability to HIV/AIDS.

### 3.2.4 HIV/AIDS

HIV/AIDS are two acronyms which stand for Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS) respectively. It is the HIV that causes AIDS. As Van Dyk (2001, p. 4) observes, "strictly speaking AIDS is not a disease or an illness but a collection of many different conditions that manifest in the body because the virus has so weakened the body's immune system that it can no longer fight the pathogen that invades the body". Van Dyk (2001) refers to two viruses associated with AIDS which are HIV1 and HIV2. HIV1 is geographically extensive, being associated with infections in Central, Eastern and Southern Africa, North and South America, Europe and the rest of the world. HIV2 is said to only be found in West Africa. Although the two viruses are structurally similar, HIV2 infection has a longer window period, with slower progression to AIDS than HIV1. It follows that Malawi and the SADC countries described in Table 1 are prone to the HIV1 virus which is fast killing many.

Until now, there has been no certainty about how and where HIV/AIDS originated. A number of theories have been put forward but none of them have provided a conclusive explanation. One theory is that the disease might have been with mankind for centuries, but remained undetected because of lack of adequate scientific know-how to detect it. The other theory is that it might have originated from monkeys (chimpanzees) in Central

Africa and been passed on to humans. A third theory, which seems more incriminating, is that it might have originated from the early polio vaccines, in which case it is assumed to be man-made. If found to be correct, someone may have to answer for a crime against humanity. Whatever the explanation, we may never know the origin of AIDS, but an established fact is that the epidemic began to be noticed in humans in the late seventies and eighties. Meanwhile, what we ought to be more concerned with is that we have a killer in our midst, and must find the means to conquer it.

The main mode of HIV infection is through unprotected sexual intercourse with an infected person. Other modes are: receiving contaminated blood through blood transfusion; using needles or syringes that are contaminated; and when one is injured through blood-contaminated needles, razor blades, or other sharp instruments.

One pathological characteristic of AIDS is that there is no known cure for it. It is this threat to life rather than the pathology or etiology of the disease that forms the subject of this study. However, it is important, as Reddy (2002) has noted, to differentiate between the biological roots of the disease and the roots of the epidemic. Reddy argues that while the virus is the etiological agent associated with the disease, the epidemic itself is driven by behaviours and people's lifestyle choices. For the purpose of this research HIV/AIDS is explored in relation to how adolescents' lifestyle choices or behavioural patterns tend to predispose them to the dangers of the disease and how they respond to the interventions available to them in school. What is meant by intervention is discussed below.

### 3.2.5 Intervention

At the root of all preventative programmes is the saying that 'prevention is better than cure'. Prevention is a construct related to intervention. Gibson and Mitchell (2003, p. 367) define prevention as "an effort that seeks to avoid the occurrence of something undesirable - the prevention of that which

threatens life or healthy living". NAC (2003, p. 23) defines interventions as "any approach or strategy used to support an individual's ability to adopt or maintain new behaviour". The Shorter Oxford English Dictionary (1973) defines prevention as "action or occurrence before the expected; keeping from happening or arising" (p.1666) and intervention as "the action of intervening, stepping in; the fact of coming or being situated between in space, time or order" (p.1101). Based on the definition of prevention provided by Gibson and Mitchell (2003) and the dictionary above, HIV/AIDS prevention programmes should be instituted before the onset of a threat, while intervention programmes are normally instituted when the threat is already there. Since the threat of the HIV/AIDS pandemic is already in our midst, prevention and intervention measures are treated synonymously in this study. The study explores the operations of both preventative as well as intervention programmes as health-promoting programmes that empower secondary school adolescents.

WHO (1986) defines empowerment in relation to health promotion as "the process of enabling people to increase control over and to improve their health" (as cited in Rissel et al., 2001, p. 106). It outlines two aspects of empowerment: psychological empowerment which relates to individuals; and community empowerment which relates to what communities can attain. Franzkowiak and Wenzel (1994, p. 4) define empowerment in the context of HIV/AIDS as, "the capacity of the people to share their views on health conditions with their fellow neighbours and to recognise that they may have some of the difficulties in common". Definitions of empowerment tend to suggest that adolescent empowerment is a product of both individual as well as a collective effort, drawing upon the assets of individuals as well as the communities around. De Guzman (2001) suggests that to reduce adolescent vulnerability to HIV/AIDS, it is necessary to both empower the individual and the community as a whole, arguing that failure of most interventions so far has been because they have not taken the societal and

contextual factors that lead to increased vulnerability to HIV/AIDS, into consideration.

For a group experiencing social vulnerability, Parker (1996) as cited in De Guzman (2001) suggests interventions that actually empower a social group. According to De Guzman (2001) empowerment involves access to information, comprehension of information, the ability to make a decision regarding behaviour change and being able to enact that decision. He further posits that a person who cannot obtain the information necessary for informed decision-making or acting on a decision, is less empowered and therefore more vulnerable.

Empowerment uses inherent and external resources. Emphasising the role of assets in empowerment Ebersohn and Eloff (2006) propose the use of an asset-based approach to problem solving. This approach recognises the inherent capacities and assets that an individual possesses which, when combined with societal assets, will enable that individual to cope with a given problem. For example, in the case of secondary school adolescents, the social systems that can provide such assets include the family, the school, the peers and the neighbourhood.

A corollary concept to an asset-based approach is Lerner's (2005) Positive Youth Development (PYD). The PYD perspective sees all adolescents as having strengths and suggests that increases in well-being and thriving are possible for all youth through aligning their strengths with the developmental assets present in their social and physical ecology. The concept of PYD, just like the asset-based approach, is meant to reorient people to focus on adolescent strengths and not deficits, and to promote positive changes across adolescent life.

Using a preventative model, Gibson and Mitchell (2003) suggest that to be successful, preventative programmes must include:

- starting the programme before the onset of the symptoms of the threat;
- interventions aimed at a population rather than individuals;
- interventions that recognise the uniqueness of the individual and their environment;
- strong organisational support.

The preventative model recognises that risky behaviours do not operate in a vacuum, and in order to provide meaningful intervention or preventative programmes, it is necessary to assess the environmental characteristics that place people at risk. For adolescents, this could be the school, the home or the neighbourhood. Franzkowiak and Wenzel (1994) state that today's health promotion programmes use the lifestyle approach which draws on sociological and pathological knowledge concerning patterns of human action and interaction, and their relation to health. Lifestyle refers to "a more or less integrated set of practices which an individual embraces not only because such practices fulfil utilitarian needs but because they give material form to a particular narrative of self identity" (Samuelsen, 2006, p. 213). Franzkowiak and Wenzel (1994) identify two lifestyles: the lifestyle of the social group which is characterised by the totality of patterns of meanings and forms of expression which are produced by the group; and the lifestyle of an individual which is characterised by the totality of normative behavioural structures developed in the course of interaction with his or her environment. The latter aspect, though specific to an individual, remains linked to his/her social group. This approach is very useful in understanding the differences among adolescents in their understanding of vulnerability to HIV/AIDS, even though they belong to the same social group. The concepts of an asset-based approach, positive youth development, and lifestyles are closely linked to the eco-systemic model used in this study, as they all tend to emphasise the role of the environment in shaping people's behaviours.

For the purpose of this study, the terms *preventative* and *interventive* to describe programmes are used synonymously (See 2.3).

## 3.3 Frame of Reference, Theory and Related Theories

In order to better understand how adolescents view themselves as vulnerable to HIV/AIDS, it is necessary to frame this study within an eco-systemic approach, complemented by the HIV/AIDS susceptibility and vulnerability pathway model (Bishop-Sambrook, 2003), and other related theories. I discuss these in detail below:

### 3.3.1 Eco-systemic framework

The ecological system theory of human development, first put forward by Bronfenbrenner (1979), is based on the understanding of interdependence and interrelationship between the developing person and the environment (Huitt, 1995). The assumption of an eco-systemic framework is that an individual's environment consists of several co-occurring systems and subsystems that interact to influence development, according to Becker and Luther (2002) as cited in Normand (2007). According to this model, development should be seen as happening within four nested systems as follows (after Donald, Lazarus and Lolwana, 2002):

- **Microsystems:** These are the systems such as the family, the school and the peer group in which the adolescent is closely involved, through continuous face-to-face interaction with other familiar people.

- **Mesosytems:** Here the peer group, school, and family interact with one another, so that what happens at home or in the peer group affects the adolescent. For example, lack of support at home may make the adolescent insecure at school and cause problem behaviour.

- **Exosystems:** These include other systems in which an adolescent is not directly involved but which may influence people who have close relationships with the adolescents' microsystem, for example a local youth community organisation

- **Macrosysytems:** These involve the dominant social structures, as well as beliefs and values, that influence and maybe influenced by all other levels in the system

**The Chronosysytem:** Is not nested within the above four, but includes all interactions in the four systems across the time frame. For example, an orphaned adolescent will, over time, learn to adjust to her life demands as head of a household who is responsible for her siblings.

For the purpose of this study, a simplified version of Bronfenbrenner's model has been adapted and is illustrated in Figure 2. It is specifically directed at understanding adolescents' vulnerability to HIV/AIDS, including interventions. It must be noted that it is not possible to adequately represent all the levels and interactions in one diagram. The emphasis in the framework, though, is that vulnerability to HIV/AIDS and the design of interventions take place at all levels of the system, from the individual through to the entire social system and vice versa. In the diagram, this interrelationship is shown by the arrows cutting across the system from the adolescent and vice versa, and also by the dotted lines in the circles. The essence of the eco-systemic framework is that human beings do not develop in isolation; they develop in a variety of environments which surround the individual and with which he/she is in constant interaction. These play a major role in development (Huitt, 1995).

Donald, Lazarus and Lolwana (2002), assert that to understand adolescents' understanding of their vulnerability to HIV/AIDS and their unwillingness to change behaviour in the wake of the pandemic, we need to understand the relationships between the various levels of the system and the active engagement of the individual in the system. It is further argued that the

framework is very useful for understanding the diverse contexts in which adolescents live; for identifying factors at each level that are supportive, indifferent or harmful to youth; for suggesting strategies for interventions; and for emphasising connections between levels (FHI, 2006). Swartz, De la Rey and Duncan (2004) posit that according to the eco-systemic framework, vulnerability to HIV/AIDS is determined by a number of risk factors at the biological, psychological and social levels. They argue that an ecological systems framework understands vulnerability to HIV/AIDS as being influenced by multiple contexts which can be broadly categorised into the individual level and the interpersonal level. The interpersonal level is further divided into the family, the peer group, the school, the community level and the societal level. I briefly discuss these levels, illustrating how adolescents become vulnerable to HIV/AIDS and what forms of intervention might be helpful for them (adapted from Donald, Lazarus and Lolwana, 2002).

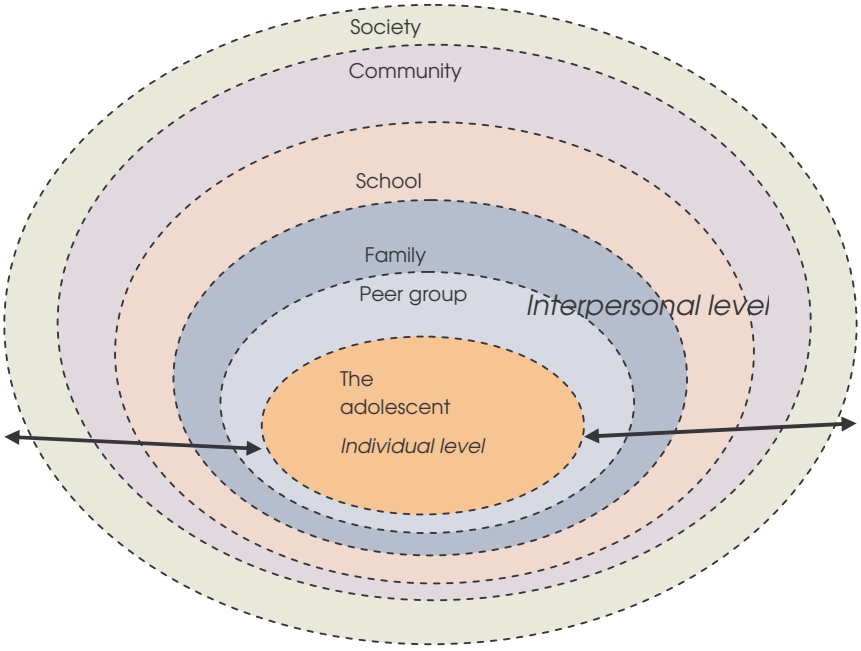



**Figure 2: The Adolescent in context**

#### *3.3.1.1 The individual level*

Donald et al. (2002), state that in the eco-systemic framework, the individual adolescent is not merely passively affected by what happens in the other systems, such as the family, the peer group or the school, but that the adolescent is always an active participant in these groupings. At this individual level understanding vulnerability to HIV/AIDS is concerned with understanding the individual characteristics that influence behaviour, such as knowledge, attitudes and beliefs. Adolescents might be at risk as a result of their lack of knowledge about, their attitudes to and their beliefs about HIV/AIDS. For example, a negative attitude towards condom use could put them at risk of contracting HIV/AIDS. The health belief model and the theory of reasoned action (see 3.3.4.1 and 3.3.4.2) are used to understand why individuals engage in risky behaviour that maybe harmful to their well-being.

At this level it is suggested that interventions address the unique needs and personalities of individuals (FHI, 2006).

#### *3.3.1.2 The interpersonal level*

The interpersonal and individual levels are linked to each other and, in Bronfenbrenner's model, are collectively known as microsystems. This level is concerned with interaction between the individual adolescent and other people in their social world. I divide this level into three parts, namely the family, the peer group, and the school.

##### 3.3.1.2.1 The family

According to Donald et al. (2002), the family is the basic source of security and support, and is the springboard for the physical, cognitive, moral and spiritual development of adolescents. I use the term family in the context of the African extended family, which includes not only father, mother and siblings, but also uncles, aunts, grandparents, and cousins. In Malawi, like the rest of Africa, the traditional family has become disturbed by westernisation

and urbanisation since those who were entrusted with the roles of guiding the youth are no longer capable of doing so. This lack of sense of direction has placed adolescents at risk of many social and interpersonal problems, including HIV/AIDS. Coupled with this is the effect of poverty. Problems arising from dysfunctional families and poverty are actualised by adolescents in a variety of emotional expressions including antisocial behaviour such as drug and alcohol abuse and risky sexual behaviour.

#### 3.3.1.2.2 The peer group

Donald et al. (2002), state that individuals in the group are influenced not only by the values and attitudes of the group but also by the identity and acceptance needs of the individual. They assert that in most cases interpersonal problems at this level arise because adolescents find inadequacies in the other systems such as the family and the school, and so seek alternative sources of identity, status, and acceptance in their peer groups. The peer group exerts great pressure on an individual to engage in risk-taking behaviours, including risky sexual behaviours. In chapter two (see 2.2.4) I have discussed how peer pressure predisposes adolescents to the dangers of HIV/AIDS. In the same vein, because the influence of peers is strong during adolescence, it is argued that interventions should draw on this peer influence to address adolescent social and interpersonal problems, including HIV/AIDS (Donald, et al., 2002).

#### 3.3.1.2.3 The school level:

According to Swartz et al. (2004), schools exert an influence on adolescents through resources and values. Research has shown that poorly resourced schools lead to learners with problem behaviours, as they become frustrated and engage in anti-social behaviour (Cowen, cited in Donald et al. 2002). Donald et al. (2002), argue that values transmitted through good role models by teachers are vital in shaping adolescent learner behaviour. They further posit that life skills education is critical for addressing social and interpersonal problems, including HIV/AIDS, in adolescent learners.

FHI (2006) argue that interventions at interpersonal level, including school and peer programmes, should target friends, families, and teachers.

#### 3.3.1.2.4 The community level

According to Swartz, et al. (2004), this level recognises the presence of social networks as protective factors. They define protective factors as "those influences that limit or reduce the likelihood of high risk behaviour and play a moderating or buffering role" (Swartz, et al., 2004, p. 409). FHI (2006) state that at this level values, beliefs and attitudes held by the community are vital in shaping an individual adolescent. Many adolescents are at risk as a result of values and beliefs held by their community. Consequently it is argued that interventions at this level should be youth-friendly and should connect to the family of adolescent learners as well as other members of the community at large to change community attitudes, beliefs and values.

#### 3.3.1.2.5 Societal level

According to Swartz et al. (2004), societal determinants of risk can be categorised in two categories namely cultural and structural. They argue that our cultural value systems are always brought to bear on the way we judge risk or danger. It is claimed that many times adolescents engage in risky sexual behaviours, not because of the ignorance of the consequences, but because of the way culture perceives it (Swartz, et al., 2004, p411). In chapter two (see 2.2.7), I have discussed how different cultural practices in Malawi predispose adolescents to the dangers of contracting HIV/AIDS. From the structural perspective, adolescents are at risk in terms of power imbalances and material or service inadequacies. For example, adolescent females are more vulnerable because of the power imbalance in negotiating sex with their male counterparts. Also, lack of access to reproductive health services is making adolescents vulnerable to HIV/AIDS. Swartz, et al. (2004, argue that interventions at this level should aim at influencing change in cultural practices and policy, or by empowering youth to challenge structures through conscientisation and social action.

I chose this framework for my study because it allows for a holistic approach to the study of adolescent vulnerability to HIV/AIDS within the context of the adolescent environment. The eco-systemic framework provided me with an opportunity to explore vulnerability in adolescents against the backdrop of the context within which they live, that is the family, school, neighbourhood and community (Normand, 2007). Blum, McNeely and Nonnemaker (2002), as cited in Normand (2007), state that the eco-systemic approach enables us to view vulnerability not as discrete, intrapsychic factors, but as an interlocking set of factors which are heavily influenced by the context within which adolescents live.

Fraser and Galinsky (1997), as cited in Normand (2007), also suggest that factors that predispose an individual to risk are best understood from an ecological perspective. They further state that an eco-systemic model provides a view of adolescents as both influencing and being influenced by their environment. It is for this reason that in this study I took into account the various intra-personal and inter-personal factors that come into play within the adolescent, but also between the adolescent and his/her environment and how s/he is able to shape it in return.

My research activities were centred on the adolescent within the school and its surrounding environment, with the adolescent at the centre of it all. In the diagram below, this interrelatedness is shown by the permeability through the broken lines in the circles and by the arrows.

### 3.3.2 HIV/AIDS Vulnerability Pathway Model

Bishop-Sambrook's (2003) model describes vulnerability to HIV/AIDS as moving in a pathway which has two gates. Gate one involves HIV/AIDS infection and eventual progression to AIDS. Gate two involves AIDS-related death and its consequences. Before each gate there are indicators of susceptibility or vulnerability. Bishop-Sambrook defines susceptibility as the chances of being exposed to the virus, and vulnerability as the likelihood of

significant HIV/AIDS-related impact. I briefly describe how the model works with an illustration in Figure 3 (adapted from Bishop-Sambrook, 2003).

**Figure 3: HIV/AIDS Vulnerability Pathway Model.**

(Adapted from Bishop – Sambrook, 2003)

**Indicators**

***Drivers of susceptibility***

- Income levels
- Mobility
- Knowledge systems/Life skills
- Cultural practices and beliefs
- Power relations

***Sources of resistance***

- Knowledge, attitudes, practice
- Access and use of VCT
- Presence of STIs
- Empowerment

*Key markers for gate 1:*

- Incidence of HIV
- Prevalence of HIV
- Opportunistic diseases
- Morbidity

***Drivers of vulnerability***

- Dependency ratios
- Asset base
- Livelihood strategies

***Sources of resilience***

- Response strategies
- Power relations
- Nutrition
- Networks
- Care practices
- Access to services

***Key markers for gate 2:***

- Mortality due to AIDS

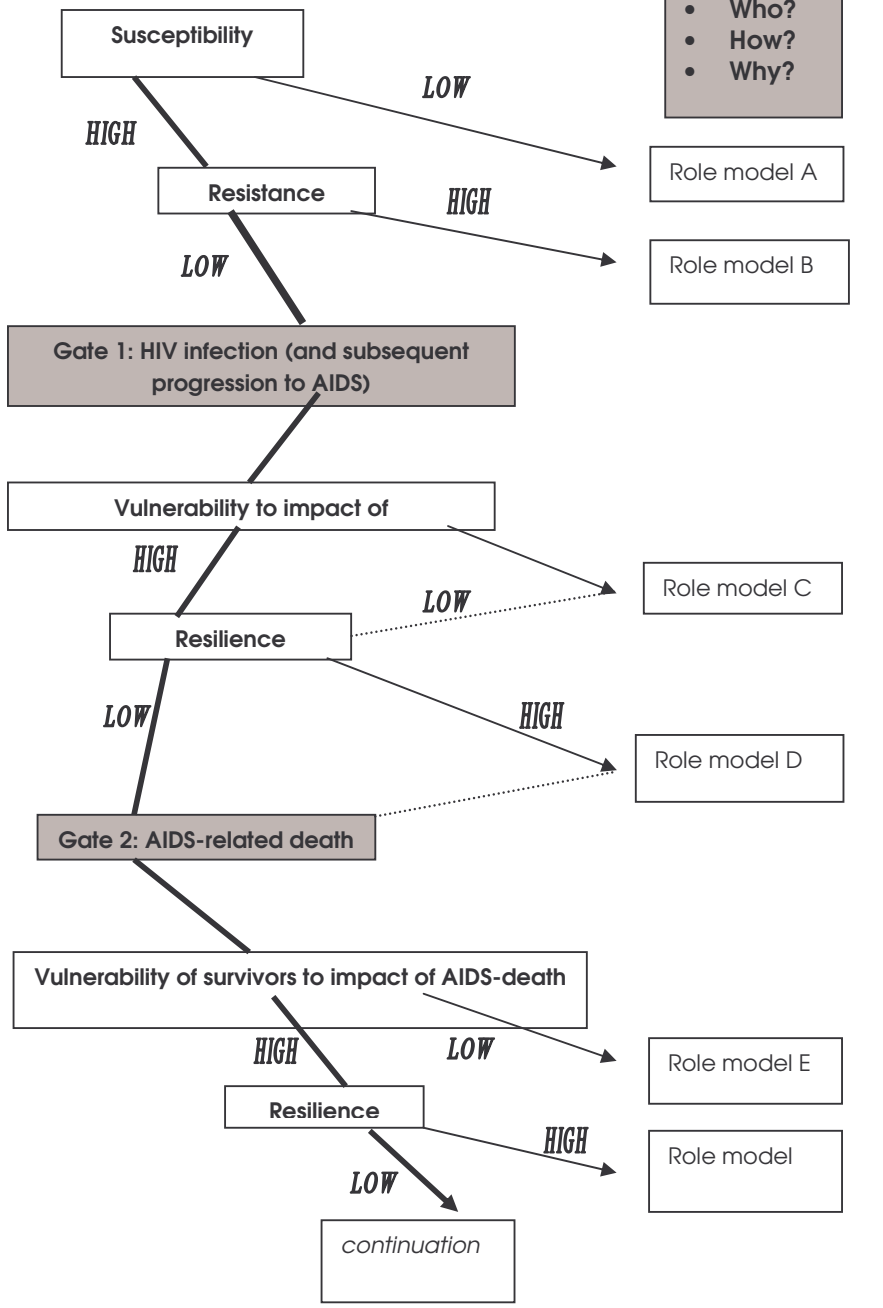
***Vulnerable groups:***

- Orphans and vulnerable children
- Households headed by orphans, single parents, elderly

***Factors influencing vulnerability and resilience:***

- Access to and control over resources
- Life and livelihood skills
- See drivers of vulnerability and sources of resilience above

**Figure 3: HIV/AIDS Vulnerability Pathway Model.**




**Role models/ innovators**

- **Who?**
- **How?**
- **Why?**

Role model A

Role model B

Role model C

Role model D

Role model E

Role model

**Pre-entry to gate 1**: This comprises two aspects: susceptibility and resistance.

Susceptibility to HIV/AIDS refers to:

- the chance of being exposed to the virus, reflecting the risk environment and riskiness of behaviour and
- the chance of being infected with the virus once exposed.

Drivers of susceptibility include: poverty, power relations, cultural practices, knowledge level and mobility.

Resistance to HIV refers to the ability of an individual to avoid HIV infection by escaping exposure or escaping infection.

Sources of resistance include knowledge, attitude and practices (KAP); empowerment and access to VCT.

Susceptibility and resistance maybe high or low, each providing its own role models whom the youth can choose to emulate. Bishop-Sambrook proposes that HIV/AIDS interventions at pre-entry gate 1 should aim at reducing susceptibility and increasing resistance to HIV.

**Gate 1: Involves HIV infection and eventual progression to AIDS**

According to this model, once one has passed through gate 1, there is no turning back. Victims are then vulnerable to the impact of HIV and will either exercise resilience or not, both of which maybe high or low, producing their own role models. Bishop-Sambrook (2003, p.2) defines resilience as "active responses that enable an individual and his household to avoid the worst impact of HIV/AIDS and related death".

Drivers of vulnerability at gate 1 include household livelihood strategies, dependency, and assistance base. Sources of resilience include access to services, care practice, nutrition, power relations, safety nets and response

strategies. Key markers at gate 1 are the incidence of prevalence of HIV and opportunistic infections.

**Gate 2: AIDS-related death**: This involves the vulnerability of survivors close to those who have died of AIDS. This could also be high or low, each producing some resilience that could also be high or low with their own role models. A key marker at gate 2 is mortality due to AIDS. Vulnerable groups include: orphans, households headed by orphans, single parents and the elderly. Factors influencing vulnerability or resilience include access and control over resources, livelihood skills, care practices, nutrition, access to services and safety nets.

The susceptibility and vulnerability model is a useful, complementary model to the eco-systemic one in that, like the eco-systemic model, it acknowledges the role inter-personal and intra-personal factors, both within the adolescent and with the environment, play in making him/her susceptible to HIV/AIDS. Indicators of adolescent susceptibility and vulnerability to HIV/AIDS which are integral parts of this model are an aggregation of the socio-economic factors within the adolescent's environment. For example, indicators of susceptibility and vulnerability such as poverty, loss of social cohesion, unbalanced power relations, cultural practices and beliefs, and care practices are all linked to the environmental factors within which the adolescent lives. A major strength of this model is that it further provides adolescents with an opportunity to identify role models within their communities who have either avoided or deferred the journey towards AIDS. Through the emulation of such role models, adolescents who are not affected will be unlikely to contract AIDS, while those who are affected can learn from role models who are affected, how to cope. In addition, I find its emphasis on the consequences of contracting the disease to be helpful in countering the adolescent illusion that they are invulnerable or that death due to AIDS is a long wait. It can therefore be useful in changing adolescents' low risk perception of the HIV/AIDS pandemic that has been

reported in various sources of literature and in guiding the development of intervention programmes.

### 3.3.3 Psychological perspectives of behaviour and interventions

It is argued that given the fact that HIV/AIDS has no cure and that heterosexual intercourse remains the main mode of transmission, reducing high risk sexual behaviour remains the principal strategy. Psychology therefore plays a vital role in behaviour change at individual and interpersonal levels (Swartz et al., 2004). Swart et al. (2004), further argue that in view of multiple levels of influence that render people vulnerable to HIV infection, it will be necessary to adopt an ecological systemic understanding of risk to ensure that interventions work at all the levels discussed (see 3.3.1). Within the larger social environment in the ecosystem, the adolescent is first and foremost an individual with his/her own likes and dislikes. Individual behaviour is largely a product of choice but how adolescents make those choices, whether rational or irrational in the face of adversaries like HIV/AIDS, still remains debatable. It is for this reason that a number of psychological models have been used to provide an explanation of why adolescents behave the way they do, and have been used to guide the design of HIV/AIDS interventions. Psychological models are largely used because they have been found to be very useful in predicting people's behaviours. They can also facilitate our understanding of intra-personal and inter-personal factors relating to HIV/AIDS (Van Dyk, 2001). It appears that in the absence of a vaccine for HIV, the answer lies in behavioural change.

Parker (2004) however, drawing upon Airhihenbuwa's review of psychological theories, argues that the models do not provide an adequate framework for bringing about behavioural change, especially when applied to the context of Africa, Asia, Latin America and the Caribbean because in these countries cultural and socio-economic contexts are more critical than an individual's volitional control over his/her behaviour. The models that I

discuss in this study include: Self-determination theory (Field & Hoffman, 1994), Hope theory (Harris and Synder, date?), and Social cognition/ learning theory (Bandura, 1997).

Notwithstanding Airhenbuwa's reservation noted above, I include a discussion of these theories with the possibility that they might throw light on the issues of adolescent vulnerability within the context of Malawi. Their inclusion is meant to ensure that prevention efforts are not just directed at the individual level, with respect to empowering adolescents with knowledge and promoting health enhancing attitudes, but that they should also be directed at the interpersonal, community, and socio-cultural levels (Swartz et al., 2004). If we are to understand adolescents' understanding of their vulnerability to HIV/AIDS, we need to understand how, in the process of interaction with their environment, they develop self-determination, hope, and efficacy, and what role modelling plays in the wake of the HIV/AIDS pandemic. An understanding of the interrelatedness of such aspects of human behaviour might also help us to understand why adolescents respond to interventions in the way they do, and provide a framework for the design of appropriate interventions.

#### *3.3.3.1 Self-determination theory*

Self-determination theory was developed by Field and Hoffman (1994) who define self-determination as "the ability to identify and achieve goals based on a foundation of knowing and valuing oneself" (Field & Hoffman, 2002, p. 113). Decci and Ryan define self-determination as "the capacity to choose and to have those choices be the determinants of one's actions" (cited in Field, Hoffman, & Posch, 1997, p. 2).

Self-determination theory asserts that the latter is promoted or discouraged both by variables within the individual's control e.g. values, knowledge and skills, and by variables that are environmental in nature e.g. opportunities for choice making, attitudes and others. According to Field and Hoffman (1997),

individual knowledge, skills, and beliefs that lead to self-determination can be identified in five components: know yourself, value yourself, plan, act and experience outcomes, and learn (cited in Field & Hoffman, 2002). This theory proposes the development of self-determination in adolescents through raising awareness of self-esteem and through development of skills in risk and impulse control (Field et al., 1997). As has been argued, adolescents are good at risk-taking and are prone to sexual impulse. There is a close relationship between risk-taking and self-determination. Field et al. (1997), therefore argue that self-determination skills are critical to the behaviour initiation, informed choice making, relationship building, and increasing independence aspects that are critical to the pursuit of healthy lifestyles.

One aspect the model propagates is the supportive role of the community by peers, teachers, family and other resources, in fostering self-determination in adolescents. This will necessitate the provision of positive role models derived from within the learners' environment from whom learners could learn self-determination to enhance their development of knowledge, skills and beliefs related to self-determination and, consequently, their vulnerability to HIV/AIDS. Sharon and Hoffman (2002), suggest the need for promoting self-determination for all members of the school community, that is, learners, parents and teachers, arguing that such an approach promotes student learning about self-determination. The extent to which adolescents in Malawi feel able to determine the direction of their lives in the context of HIV/AIDS, might throw light on their understanding of their vulnerability.

#### *3.3.3.2 Hope theory*

HIV/AIDS tends to shatter people's hopes. Restoration of hope is at the centre of any intervention for the affected and infected adolescents. Hope theory, conceived by Harris Synder a decade ago, has three components: goals, pathways and agency thinking. Synder, Feldman, Shorey and Rand (2002, p. 2), define a goal as "anything that an individual desires to get, do, be, experience or create" and pathways as "a kind of cognition/thoughts

reflecting a person's perceived capacity to produce cognition routes to desired goals". They define agency cognitions as "thoughts that people have regarding their ability to begin and continue movement on selected pathways towards those goals".

In this theory Synder et al. (2002), propose that emotions are by-products of goal-directed thought, and as such, the more important a goal and the greater the perceived likelihood of success in attaining that goal, the greater will be the positive effect experienced by the person.

This theory has significant implications for adolescent understanding of their vulnerability to HIV/AIDS and for the development of appropriate HIV/AIDS interventions. For example, interventions that address the adolescent's realistic goal setting, and development of pathways and agency cognitions, will improve not only adolescent hope perceptions but also their willingness to participate in such intervention programmes. It has also been claimed that hope can predict many important outcomes. For example, Snyder et al. (2002), argue that high hope adolescents relative to low hope adolescents engage in more health-enhancing activities such as exercise and are most likely to practise safer sex, since such adolescents are likely to possess high levels of self-efficacy. The question of how hopeful orphaned children in Malawi like Chisomo of Lirangwe, Blantyre (see 2.2.12), are, could help in understanding their vulnerability in the context of HIV/AIDS.

#### *3.3.3.3 Social cognition theory*

Bandura's (1977) social cognition theory as cited in Maluwa-Banda (1999), states that human behaviour results from a constant interaction between a person and the environment outside that person. Any HIV/AIDS intervention programme, therefore, must enlist and create social supports which include the larger environment. Central to this theory is the idea that translating health knowledge into self-protective action against HIV infection requires social and self-regulatory skills and a sense of personal power or self-efficacy

to exercise control over sexual situations. Self-efficacy refers to a person's belief that he or she can perform a given task (Kelly, Parker and Lewis, 2001, p.13). According to Bandura (cited in Maluwa-Banda, 1999), for intervention programmes to be effective they must instil in people the belief that they have the capacity to alter their health habits. Studies so far have shown that there is a positive correlation between low self-efficacy and high-risk sexual practices and unwillingness to change behaviour. Bandura argues that the reason adolescents do not change their risky sexual behaviour, even with the full knowledge of the consequences of HIV/AIDS, is because they lack a sense of efficacy to manage situations effectively. Consequently, intervention programmes in schools should increase or reinforce adolescents' self-efficacy by making sure that they possess the required communication, negotiation and problem solving skills.

A related theory also postulated by Bandura is the social learning theory. Ross and Deverell (2004), posit that central to this theory is the notion of modelling, which relates to the imitation of other people's behaviours, positive or negative. It therefore relies on the use of models from the adolescent's environment, who maybe good or bad role models. During adolescence youth are in search of their own identities and modelling becomes very powerful in shaping their behaviours and personalities. Ross and Deverell (2004), therefore suggest the inclusion of positive role models in HIV/AIDS prevention and awareness campaigns for adolescents.

### 3.3.4 Health behaviour models of intervention

Studies on HIV/AIDS, including the design of interventions, have mostly drawn on the following health behaviour models: the Health Belief Model (HBM) (Rosenstock, 1974), and the Theory of Reasoned Action (TRA) (Fishbein & Ajzen, 1975). These models seek to explain how people view the relationship between their behaviour, especially risky behaviour, and health. The main principles governing behavioural change according to these models are that

the individual must realize the need for behaviour change; must know exactly what specific behaviour needs to be changed; must have the intention or commitment to perform the new or required behaviour; must have a positive attitude towards the new or required behaviour; must have the support of friends in changing behaviour; must have high self-efficacy in his/her ability to perform the required behaviour; must know how to perform that behaviour effectively; must perceive that many more benefits and rewards than obstacles will accrue from the new behaviour; and must have the necessary skills to perform and maintain the behaviour (Van Dyk, 2001). I briefly discuss these models below:

#### *3.3.4.1 The Health Belief Model (HBM)*

Developed by Rosenstock in 1974, this model attempts to explain and predict health behaviour by focusing on the attitudes and beliefs of the individual. Below I present the key variables of after Rosenstock, Strecher and Becker's (1994) model and link it to HIV/AIDS intervention efforts.

The first variable is the perceived threat which consists of two parts:

- *Perceived susceptibility* which is the subjective perception of the risk of contracting a health condition. (Can I contract HIV/AIDS?).

- *Perceived severity* which refers to feelings concerning the seriousness of contracting the disease. (What are the consequences for me if I contract HIV/AIDS?).

The second variable is *perceived benefits*, which is the believed effectiveness of proposed strategies to reduce the threat of the disease. (Do I believe that using a condom is an effective strategy to reduce the threat of contracting HIV/AIDS?).

The third variable is *perceived barriers* or *potential negative consequences* that may result from taking a particular proposed strategy, for example,

condom use. (What are the physical, psychological and financial barriers if I use a condom?).

The fourth variable is *cues to action* (symptom development, or the death of a close family member due to AIDS-related diseases). These cues act as motivation to take action and have great influence over adolescents' motivation to engage in healthy behaviour. (Are these symptoms of HIV/AIDS?).

The fifth variable is self-*efficacy,* a concept introduced by Bandura (1977, which refers to the perception that one is or is not, capable of performing a certain type of behaviour (Kelly, Parker and Lewis, 2001, p.13) as discussed. (Do I have the will/capacity to participate in the proposed health behaviour? Am I willing to use a condom?).

This model is very useful in understanding adolescents' low risk perceptions and negative attitudes towards condom use, as reported in literature such as Kadazamira et al. (2001); Hartell (2005) and Fisher and Fisher cited in Mudaly (2006). I find the inclusion of cues the model's greatest strength which, if applied to an intervention, may remove the illusions of invulnerability among adolescents. In this regard it complements the role of consequences of acquiring HIV/AIDS in the HIV/AIDS vulnerability pathway model of Bishop-Sambrook (2003) (See 3.3.2). For example, if adolescents can see and interact with persons living with AIDS, visit home-based care HIV/AIDS patients, visit the "light house" or "rainbow house" clinics where AIDS patients are treated in Malawi, this might prompt them to take caution.

However, the model has its own limitations and has been criticised for having a number of weaknesses. First, human behaviour does not occur in a vacuum and so the model fails to take into consideration other factors such as environmental and economic influences which might affect behaviour. The model also fails to recognise the influence of social norms and peers which tend to be very strongly impact on adolescents' sexual behaviour

(Ross & Deverell, 2004). However, I draw on this model because of its strong inclination towards the role of cues and self-efficacy in interventions aimed at changing adolescents' behaviours, and it also complements the eco-systemic and HIV/AIDS vulnerability pathway models that inform this study.

#### *3.3.4.2 The Theory of Reasoned Action (TRA)*

Developed by Ajzen and Fishbein (1980), the TRA seems to take care of the deficiencies in HBM, especially in addressing the role of peers and reference group norms. This theory asserts that behaviour is determined by two main influencing factors namely individual attitudes towards certain behaviours, and subjective norms. Subjective norms are defined as individuals' perceptions of what others may think of their actions. These two influencing factors together create an intention to act in a certain way. Ajzen and Fishbein (1980), assert that this intention is very closely related to behaviour. Consequently, it is argued that intervention programmes should address individual intentions because, once intentions have been determined, it becomes easy to predict and manipulate behaviour (as cited in Ross & Deverell, 2004). However, the role of intentions in determining behaviour has received mixed reactions in literature.

Vanlandingham et al. (1995), who applied the HBM and TRA models in their study, found a positive association between intentions and consistent condom use among northern Thai males. They attributed this to increased knowledge about the consequences of HIV infection, knowledge about the benefits of condom use for preventing infection, and positive attitudes about condoms which were acquired through peer group facilitation. In another quantitative study among rural Vietnamese adolescents, Kaljee et al. (2005), found that while intentions to use condoms in possible future sexual encounters increased significantly among the youth, changes in actual behaviour could not be accurately measured. The inclusion of TRA in this study is meant to explore the role that subjective norms, arising from peers

and other significant others, have in influencing adolescent behaviour, including risky sexual behaviour.

### 3.3.5 Concluding remarks on psychological and health behaviour models

In conclusion, in the discussion on these models, it is argued that their application is based on the assumption that when making behavioural decisions people consider the information available to them (Reddy, 2002). Unfortunately, the theories assume that individuals are rational in their decision-making, an assumption possibly not accurate as HIV/AIDS-related behaviour is influenced by emotions originating from both the individual and society at large. Moreover, most adolescents, and indeed many adults, do not seem to approach HIV/AIDS issues from such a logical perspective (Ross & Deverell, 2004). Besides, adolescents are under intense influence from peers, which makes individual adolescents susceptible to HIV/AIDS infection because they tend to rely heavily on their friends' knowledge about the dangers of HIV/AIDS (Vanlandingham et al., 1995). I draw on these models to understand how reference peer group norms influence behaviours that put adolescents at risk of contracting HIV/AIDS. Despite these shortfalls in ensuring rapid behaviour change among adolescents, health behaviour models have facilitated the development of interventions that have made an impact on knowledge and awareness of the HIV/AIDS pandemic and have, in some way, contributed to HIV risk reduction (Kelly, Parker, & Lewis, 2001). In this study I draw on the psychological and health behaviour models in an attempt to understand adolescents' understanding of their vulnerability to HIV/AIDS, especially how they affect their lifestyle choices and their perception of risk to HIV/AIDS. Almost all psychological models tend to emphasise common aspects, such as the role of modelling, peers, a supportive environment, self-efficacy and attitudes, and the determining of goals as paramount in adolescent risk taking behaviours. These however have to be understood in the context of a particular eco-system, hence my use of Bronfenbrenner's eco-systemic framework. Since most interventions

have been based on health behaviour models, they might also help me understand and appreciate adolescents' experiences with the various intervention programmes that are available in schools and their responses to them.

## 3.4 Synopsis of Chapter Three

In this chapter I have explained the conceptual and theoretical frameworks that guide this study. I started by discussing the conceptual framework delineating the main concepts used in the study, which included vulnerability to HIV/AIDS, adolescence, adolescent sexuality, HIV/AIDS and intervention. I have also discussed the two models which frame the study, i.e. Bronfenbrenner's ecological theory of development and Bishop-Sambrook's HIV/AIDS vulnerability pathway model, justifying their application in the study. Other related psychological theories (self-determination, hope and social cognition) and health behaviour models (the health belief model and the theory of reasoned action) was (?) also discussed. In the next chapter I discuss the research design and methodology, the process of data generation, the sampling techniques employed and the methods and instruments used to generate data, including experiences I encountered during the process. I also discuss the process of data analysis, showing how the different data were subjected to an analytical framework to produce themes. A discussion of the ethical issues surrounding this study will be presented and the rigour of justifying trustworthiness is argued.

# Chapter Four:
# Research Design and Methodology: Walking the Research Journey Together with Adolescents as Young Researchers

> "This is only one way we young people are talking our minds, because monga kunoko, tilibe chodalira cheni cheni kuti ma youth amayankhula, nkuti (like here we don't have any means that we youth can rely on to speak out so that) the government can get the ideas, so only the bigger people and the rich ones speak about hiv/aids." (Female participant during focus group discussion)

## 4.1 Introduction

The focus of this study is to understand how secondary school adolescents view their own vulnerability to HIV/AIDS by exploring their understanding and experiences with regards to the pandemic. To achieve this objective I decided to use the participatory route in my data generation process. In this chapter I begin by discussing the research paradigm that guided this research and its design. I define what a participatory approach is and justify its use by explaining the phenomenon of adolescent vulnerability in the context of HIV/AIDS. The process of sampling schools and participants is discussed, as is the process of role-sharing among schools, the researcher and the research assistants. I have detailed how research techniques and their related tools were used, including problems and ethical issues that arose in their use. I have included in the chapter the process of data analysis, which begins with a biographical description of my participants, followed by the

analytical framework that informed the process. Finally, other related ethical issues and the trustworthiness of this study are discussed.

## 4.2 The Research Paradigm

Depending on one's ontological and epistemological stances, research could be quantitative or qualitative. Positivists normally use a quantitative approach while interpretivists use a qualitative approach. As alluded to in chapter one (see 1.11.1), I adopted a qualitative approach guided by the interpretivist paradigm in this study. I briefly explain the main characteristics of qualitative research below and, where possible, draw on comparisons with quantitative approaches, relating them to my study.

Labuschagne (2003), explains that quantitative research is mainly concerned with the degree in which a phenomenon possesses certain properties, states, similarities and differences, and the causal relations that exist within and between these, and is based on theoretical or empirical considerations and the quantification of a phenomenon. Qualitative research, on the other hand, is concerned with the properties, state and character of a phenomenon, with the emphasis on processes and meanings that are rigorously examined but not quantified. She observes that, while quantitative research emphasises quantitative statistical description, focusing on counting and quantifying patterns of behaviour, the emphasis in qualitative research is on the production of thick description. It is further argued that while quantitative approaches have the advantage of facilitating comparison and statistical aggregation of the data, leading to generalisability of findings, qualitative approaches on the other hand provide depth through direct quotations and careful description of situations, events, interactions and observed behaviours leading to transferability of the research process to other similar situations (Labuschagne, 2003).

Qualitative research attempts to study human actions from the perspective of the social actors themselves; the primary goal being describing and understanding "verstehen"( rather than explaining behaviour (Babbie & Mouton, 2001, p.270). In qualitative research the researcher takes the "insider view" and is seen as "the main instrument" (Babbie and Mouton, 2001, p.270). They state that unlike in quantitative research, qualitative research rejects the idea of "*a priori*", because, it is argued, qualitative research is exploratory, fluid, flexible, data-driven and context-sensitive. Furthermore, qualitative research is especially appropriate for the study of attitudes and behaviours that are best understood within their natural setting (Babbie & Mouton, 2001). It is further argued that while quantitative researchers usually aim at analysing variables and the relationships between them in isolation from the context or the setting (to increase generalisability), the qualitative researcher aims to describe and understand events within the concrete, natural context in which they occur, to produce a thick description (Babbie and Mouton, 2001). Piercy, Fontes, Choice and Bourdeau (1998), state that qualitative methods have the advantage of allowing patterns, themes and categories of analysis to emerge from the data, and are thus well suited to explore complex social phenomena like vulnerability to HIV/AIDS. They argue that qualitative research is increasingly being used to shed light on the culture of groups who are at high risk to HIV/AIDS, such as adolescents. It is further argued that quantitative data are often not sufficient to understand the motives behind behaviour that puts youth at risk of HIV/AIDS (Piercy et al., 1998).

According to Creswell (2007), qualitative research is fundamentally interpretative, making use of multiple methods that are both interpretative and humanistic, increasingly involving participants where the researcher makes an interpretation of the data including the context and then draws conclusions. He argues that the qualitative researcher systematically reflects on who she/he is in the inquiry and is sensitive to his/her personal biography and how it shapes the study. Creswell (1998), further argues that this

introspection and acknowledgement of biases, values, and interests (reflexivity), typifies qualitative research. I now turn to the interpretivist paradigm for this study.

Sarantakos (2005), defines interpretivism as the process of construction and reconstruction which is laden with personal input. He asserts that interpretivism relates to views, opinions and perceptions of people as they are experienced and expressed in everyday life. From the interpretivist paradigm, the goal of social science is to develop an understanding of social life and discover how people construct meanings in natural settings. So an interpretivist researcher is interested to know what is meaningful or relevant to the people being studied or how individuals experience daily life in their context (Neuman, 2006). Merriam (2002), as cited in Normand (2007), notes that a researcher conducting interpretative studies would be interested in how people interpret their experiences, how they construct their worlds and what meaning they attribute to their experiences. In this regard, the interpretivist researcher believes that people construct meanings of reality by interacting with others in an ongoing process of communication and negotiation and therefore it is fluid (Marshall and Rossman, 2006). According to Neuman (2006), interpretivists see the goal of social science as developing an understanding of social life and discovering how people construct meanings in natural settings. He argues that, unlike the positivists, who see social science reality as "out there" waiting to be discovered, the interpretivist researcher sees reality as intentionally created by various role players. He further argues that for the interpretivist researcher, social life is based on social interactions and socially constructed meanings, so that social reality is being constructed and reconstructed all the time. Consequently, it is fluid and fragile.

Interpretivist researchers see people and their interpretations, perceptions, meanings and understandings as the primary data source (Mason, 2002). The purpose of an interpretivist approach is to produce a "thick description"

during data analysis and to include a thorough description of the characteristics, processes, transactions and contexts that constitute the phenomena being studied (Terre Blanche & Durrheim, 2002, p. 123).

This study aims at exploring adolescents' own understanding of their vulnerability to HIV/AIDS, which is itself influenced by attitudes. Behaviours and attitudes can best be understood within their natural setting as opposed to somewhat the artificial settings of experiments and surveys (Babbie & Mouton, 2001). It is argued that a study involving human actors is significantly influenced by the setting in which they occur. Therefore, the aim of adopting a qualitative interpretivist approach is to gain a contextual understanding of the vulnerability of adolescents in secondary schools through adolescents' own constructions.

## 4.3 The Research Design

This was a phenomenological study aimed at exploring the phenomenon of adolescents' understanding of their vulnerability to HIV/AIDS. Leedy and Ormrod (2005, p. 108), define phenomenology as a "qualitative methodology that attempts to understand participants' perceptions and views of social reality". Somekh and Lewin (2005, p. 121), define phenomenology as "the study of lived human phenomena within the everyday social context in which the phenomena occur, from the perspective of those who experience them." Phenomenological interpretative research attempts to make meaning of the phenomenon from the perspective of the person being studied. Marshall and Rossman (2006), argue that a study that focuses on the lived experiences of participants can only be understood if one can appreciate the meanings that individuals themselves attach to their experiences. This design, therefore, provided me with an opportunity to understand the phenomenon of vulnerability to HIV/AIDS from the perspective of the actors (adolescents) themselves, the "emic" perspective (Babbie & Mouton, 2001, p. 273). In order to understand what this

phenomenon means to my participants, I needed to go into the schools and interact with them in their natural setting, an important feature of phenomenological research. This is important for understanding shared beliefs around a high-risk group like adolescents, because they have shared norms and a sub-culture which shape their sexuality and their understanding of HIV/AIDS (Piercy et al., 1998).

As alluded to earlier (see 4.2), qualitative, interpretative research increasingly uses participatory approaches to better understand the phenomenon from the emic perspective, and below I describe how I involved my participants in this research.

## 4.4 Walking the Participatory Route

Data generation took five months, from May to September, 2008. It was done when schools were in session but after school hours, especially over weekends and during holidays. I have deliberately sub-titled this chapter: "Walking the research journey together with adolescents as young researchers". This is meant to reinforce my philosophy of fully involving participants in the data generation. I decided to use a participatory approach which helped participants to analyse their own social vulnerability to HIV/AIDS and to recognise barriers that hinder the effective implementation of existing intervention programmes (De Guzman, 2001). Participatory approaches were used to help secondary school adolescents explore their own behaviour and lifestyle choices, enabling them to identify what behaviour and lifestyle patterns make them vulnerable to HIV/AIDS.

Notwithstanding the fact that research about or with youth entails special ethical considerations, there is a growing recognition of the role children can play in research on issues that involve them. For example, it is argued that children are the best informed people about their own lives and culture, so they have an expert role to play in that respect (Greene & Hogan, 2005). It is

further argued that children and adults have a similar right to be informed about the nature and purpose of the research; to understand researchers' intentions; to feel confident that the study is worthwhile and to know what will happen to the findings. It is in view of the above that I decided to take a participatory approach which recognises adolescents as young researchers, to create an opportunity for them to speak for themselves, and to make their voices heard about a particular phenomenon, namely their own vulnerability in the context of HIV/AIDS.

Babbie and Mouton (2001), define a participatory approach as that which enables the production of knowledge in an active partnership with participants who are affected by that knowledge. However, Francis, Muthukrishna and Ramsuran (2006), argue that successful use of participatory approaches lies in the process rather than simply the technique used; it involves the ongoing process of information sharing, dialogue, reflections and actions. Participatory methods facilitate the process of knowledge production as opposed to knowledge gathering, which is the case with other methods, such as surveys (Olivier, Wood, & De Lange, 2007). Diaz and Simmons (1999), argue that the common denominator in participatory research methodologies is local participation in decision-making and implementing the study process (cited in Ulin et al., 2002, P.107). Consequently, in this study I involved my participants right from the beginning through to co-operative planning of research activities, from implementation through to data analysis. For example, at the end of each activity I sat together with my participants to plan the next activity and their suggestions were incorporated into the action plan. The processes of photo elicitation and participant validation also contributed to the data analysis. In this study I am not using a participatory approach to imply advocacy that focuses on bringing about change or emancipating people, rather I am using it as a practical and collaborative approach where my study is completed with, rather than on, adolescents (Creswell, 2002,). I engaged adolescents as

active collaborators in the research. I have kept this philosophy in mind throughout the period of data generation and analysis.

## 4.5 Entering the Field and Development of Rapport

### 4.5.1 Gaining access to schools

The journey to data generation and its associated ethical issues starts with the researcher's first contacts with the researched (Somekh & Lewin, 2005). They argue that the first contact is so important that it should not be left to a third party. I nonetheless decided to engage a third party, a colleague from University, who comes from the same district. This was the beginning of the development of rapport for he was a familiar person and acted as my "key actor" (Bailey, 2007, p. 69). Bailey describes a key actor as someone the researcher knows prior to the undertaking of the research, who for "often" unknown reasons, is willing to "adopt" the researcher and become his guide. This colleague volunteered to help but not for unknown reasons; he has been a long time friend dating back to the time we taught together in a secondary school, so he was willing to help.

I enlisted the help of a colleague because I was reading for my PhD at University of KwaZulu-Natal in South Africa which was far from Malawi and also because I did not have the contact addresses or telephone numbers of the schools I wanted to involve. So in November 2007, I decided to mail letters requesting to involve the schools, to this colleague, who delivered them in person to the head teachers. In this letter I introduced myself, the topic of my research, its aims and the accompanying activities. My letter of intent received overwhelming response from the schools, as almost all the schools contacted indicated willingness to participate in the study. One school, however, declined saying that its school board might not be willing to grant permission. Being a private institution I understood their position and the intricacies of getting permission, although one of the schools that granted the

permission was also a private school. Simultaneously, I sent a letter to the Ministry of Education, Science and Vocational Training in Lilongwe, Malawi, requesting permission to involve six secondary schools in Nkhata Bay in the research project (see appendix A1).

Although I needed to work with four schools only, I requested more in order to cast my net wider, in case some schools would not be willing to take part. Unfortunately, while the schools indicated a positive response, the Ministry did not respond to my letter on time. In December 2007, I decided to go in person to follow up my application. This time permission to involve the six schools in Nkhata Bay was granted (see appendix A2). I have since written letters of apologies to the schools that I did not involve and thanked them for their readiness to participate.

### 4.5.2 A brief description of type of schools in Malawi

Basically four type of secondary (high) school exist in Malawi, namely government boarding schools, government day secondary schools, private schools (boarding as well as day schools) and community day secondary schools. Government boarding secondary schools are the country's historic schools which still command very high respect. Normally such schools cater for learners from across the country and are selected on the basis of the best results at the national primary school leaving certificate examinations (PLSCE). They thus get the top candidates. Government day secondary schools are district schools that cater for learners from a particular district. In view of the vast sizes of districts, they are not in essence only day schools but also offer boarding facilities for learners. These schools get the next best candidates from the selection list. Community day secondary schools cater for learners from a specific area within a district that area within walking distance from learners' homes. They cater for the remaining students. Private schools, which are found across the country, are mostly concentrated in towns although a few are found in rural areas. These cater for any student

who has passed the PSLCE, whether or not the student has been selected to go to any of the government institutions. Private schools normally conduct their own entrance examinations to determine selection. The fees in these schools are relatively high and in most cases cater for learners from rich families. Private schools offer the local curriculum as well as an international curriculum, and have the reputation for the best tuition in the country, something which is debatable. While they offer their own curriculum, standards are still monitored by the Ministry of Education. While the curriculum of government schools ends with a school certificate, some private schools do offer advanced level certificates (Matric). The three types of school described in this study are found in almost all the districts and are a fair representative of the schools across the country.

Although the organisation of HIV/AIDS programmes may differ from school to school, equal opportunities are offered to schools by the government. For example, all schools have been requested to appoint an AIDS coordinator to coordinate HIV/AIDS work, while Life Skills and HIV/AIDS materials are distributed free to all types of schools. This means that HIV/AIDS programmes and materials should not differ much from one type of school to another, although commitments to such programmes by both teachers and learners may vary from school to school.

As alluded to in chapter one, Nkhata Bay Lakeshore schools were chosen for the diverse socio-economic factors of the area which I believed would yield the needed data for this study. As Mason (2002) posits, the point of selecting a setting is usually that it provides a useful context or situation for the generation of data. The following was my sample school design: one single sex boys' school, one single sex girls' school and two co-education schools. One of the two co-education schools was used as a pilot study. This arrangement ensured a fair representation of my sample by gender and by type of schools in Malawi, to provide balanced data for the research.

**Table 2: Sample study schools' design by type of schools**

| * Name of school | Type of school | Boys | Girls | Total | No. of Teachers |
|---|---|---|---|---|---|
| Jenjewe | Community Day Secondary School | 70 | 31 | 101 | 11 |
| Chaphuka | Government Boarding School | - | 400 | 400 | 19 |
| Solola | Community Day Secondary School | 65 | 45 | 110 | 12 |
| Ulemu | Private Girls' Boarding School | - | 563 | 563 | 19 |

* Not real names of schools.

### 4.5.3 A description of the school settings

I present a brief description of the school settings which became the laboratory of this study for five months.

#### *4.5.3.1 Jenjewe Community Day Secondary School*

As the name suggests, Jenjewe is a community school with the community having some degree of jurisdiction although the school is resourced by government. It draws its learner population from the surrounding communities and they have to commute to school daily. In many cases these are learners who did not do well enough during their Primary School Leaving Examinations (PSLCE) which are conducted by the Malawi National Examinations Board (MANEB) to secure a place at a government boarding school. Consequently, they are not regarded as top candidates. These learner participants were active and communicated well which is probably a reflection of the quality of education they receive at the school. One could expect learners in the school to be local inhabitants, but this was not the case with Jenjewe because the catchment area includes government employees drawn from

across the country. The participants in the study, therefore, were both from Nkhata Bay District as well as other districts in the country.

In terms of resource provisions, community day secondary schools (CDSS) are generally not adequately resourced, but in spite of this, the school managed to assign one of the female members of staff who was a patron of an HIV/AIDS club at the school to be the link teacher and my key actor for this school.

Jenjewe is only 5 km away from the Nkhata Bay "Boma" – the district administrative centre, with its social amenities and business enterprises: hospital, shops, restaurants, hotels and the ship's dock yard. The centre is the focal point of road and lake steamer transport and is thus a centre of attraction. The school's proximity to the "boma" creates special opportunities and challenges to learners' vulnerability to HIV/AIDS. For example, at the boma there is a district AIDS coordinator who organises a number of AIDS initiatives for in- and out-of-school youth. There is also a social welfare office and a district hospital which offer a range of youth reproductive health services. These are some of the opportunities for the adolescents of Jenjewe. On the other hand, the presence of the social amenities and business enterprises mean that the boma becomes a centre to which boys and girls are attracted, to possibly engage in risky behaviour, including sexual behaviour, also with commercial sex workers. Furthermore, daily commuting between home and school puts learners, especially girls, at risk of being raped and contracting HIV/AIDS.

#### *4.5.3.2 Chaphuka Secondary School*

Chaphuka is one of the Christian missionary schools with its Christian traditions still intact. It is a government-aided school and caters for boys who reside at the school. However a new development at the school which is now common in most secondary schools, has been the establishment of parallel, open day secondary schools which cater for both boys and girls, and share

the same resources as the usual learners. While this arrangement is meant to expand secondary education access to the majority of Malawians, such schools do not form part of the mainstream of the school system and the arrangement is often *ad hoc*. The Ministry of Education does not have direct control of such schools. The result is that open school learners do not receive as much pastoral care as the usual learners in the school. The arrangement is compounded by the fact that such learners reside in privately rented accommodation around the school and their security is not assured. They also pose a threat to boarders as well as themselves, as boarders are tempted to sneak out of the school campus to satisfy their sexual desires with the female open school learners.

As a government boarding school, Chaphuka boasts of drawing the cream of the primary school graduates and being selected to such a school is a special privilege. Learners come from across the country and are selected on the basis of their performance in PSLCE. Although government boarding schools are expected to be well-resourced, they are currently under-resourced. However, they still maintain the historical reputation of being the best public schools. The school made available the HIV/AIDS coordinator as my link teacher and key actor in the study.

Participants from this school were able to express themselves in English although Chichewa became the dominant language of discussion, reflecting the type of learners admitted to the school.

Although Chaphuka is 17km away from Nkhata Bay "Boma", it is located close to the rubber and tea plantations; the rubber plantation almost surrounding the school. The surroundings are thus bushy. While the long distance to the "boma" hinders learners from going there and possibly engaging in risky behaviour, in that they cannot easily reach the boma to socialise, the surrounding bush, the rubber and tea plantations, pose their own challenges. Learners are tempted to sneak into the bush to meet with

local girls or with learners from the open school and engage in sexual activities.

#### *4.5.3.3 Solola Community Day Secondary School*

Like Jenjewe this is a CDSS, managed by the Government but to some extent controlled by the local community. It draws its student population from the communities round about. But like Jenjewe, the community around the school consists of people coming from across the country who are working in various government departments in the area, and so learners are drawn from across the country.

Solola is located close to a thriving trading centre which houses shops, bars and rest houses. The school is also close to tourist lodges which are spread along the lakeshore beaches of Lake Malawi with Lakeshore Highway passing by the school. Its nearness to the highway, trading centre and tourist lodges pose challenges to learners with regards to their engaging in risky behaviour, including risky sexual behaviour, and therefore increasing their vulnerability to HIV/AIDS. The trading centre accommodates many vendors, many of whom are prepared to transact sex with school girls. Also, trading centres tend to have a lot of bars and beer taverns which commercial sex workers, locally known as 'bar girls', frequent. Many of them target young school learners as their customers. Sometimes these commercial sex workers persuade school girls and boys to join them in the trade, promising them a good life. School girls are also exposed to truck drivers who offer them lifts expecting that the girls will pay for the lift with sex. Like any CDSS, daily commuting between home and school puts learners, especially girls, at risk of HIV/AIDS. These tend to be the main risk factors at this school.

Solola also has an HIV/AIDS coordinator who was delegated to be my link teacher and key actor in the study.

#### *4.5.3.4 Ulemu Secondary School*

Ulemu is a private girls' only boarding school located in the rural setting of Nkhata Bay. The lakeshore highway bisects the school, separating the administrative block and classrooms from the student hostels. Although the beaches are only a stone's throw away from the girls' hostels, girls are not allowed to go to the lake unaccompanied. Personal cell phones are not allowed and girls wishing to talk to their parents can only do so on the official school phone. These are signs of the strict discipline enforced at the school. In Malawi, parents associate strict discipline in a school with the safety of their children from unwanted visitors, and possibly HIV/AIDS infections.

The school draws its learners from across the country, especially from urban centres, and has its own entry requirements. As a private school, fees are relatively high and so only well-to-do people send their wards there. Private schools are renowned for their excellence in educational standards, hence its attraction to elite society. It is also the ruralness of the location of the school that attracts parents to send their children there, as they perceive such places to have fewer disturbances for their children's learning.

However, the remote location of the school is both a protective as well as a risk factor for risky behaviours. As a boarding, it creates risk of HIV/AIDS for school learners, both at school as well as on the journey to and from home at holiday times. Because Ulemu is far away from the learners' homes, some learners can play truant by pretending that they are on their way to and from school, when they have actually gone elsewhere with men for sexual activities. The fishing village nearby tends to be frequented by fish traders who have lots of money and who may easily persuade girls to have sex with them. Truck drivers and people driving expensive cars could also stop by the school and pick up girls to have sex with them, unnoticed by the school management. This puts girls at risk of contracting HIV/AIDS.

In terms of the HIV/AIDS at Ulemu Secondary School, as with the other schools, such issues are coordinated by one teacher, who also acted as my key actor in the study.

### 4.5.4 Gaining access to participants: Sampling

HIV/AIDS is a sensitive issue, even more so when children are involved, and so the greatest challenge I faced was to gain access to the adolescents in the schools. My age, my professional background and status as university lecturer, and my gender, were obstacles in gaining access, and also created unequal power relations with my youthful participants. These uneven power relations could have negatively affected my data generation as my participants could have been uncomfortable to discuss issues of sex and sexuality with me. I quickly realised that I needed some structures to help me create rapport and break down the uneven power relations between my participants and me.

In January 2008 I made a follow-up visit to the schools after my colleague's earlier visit. During this visit I reiterated to the school management the aims of the study and the various activities that were to be carried out. I also discussed with them their envisaged role in the project. I arranged with the head teachers to provide a link person (teacher) with whom I could communicate, since head teachers are generally busy. Nearly all the schools appointed a link person, who was also the patron or coordinator of the HIV/AIDS programmes. This arrangement augured very well for my project as it facilitated easy access to participants who also happened to be members of the AIDS club at their school.

The concept of a link person was a continuation of Bailey's "key actor" concept (Bailey, 2007). The key actors had to come from the members of the school staff, and this proved very helpful for me in building further rapport. Bailey (2007), argues that if you can establish rapport by making use of and getting the cooperation of at least one or more members in the research

setting, you have a better chance of proceeding with the type of interaction necessary for a successful project.

My link teachers became my mentors and guides. Each time I wanted to communicate a project activity to my participants I went through the link person. The link person was responsible for organising venues for the meetings and ensured that they were around when needed. They were responsible for identifying my participants on the basis of the criteria required of potential participants, that is: being adolescents from forms 3 and 4 (grades 10 and 11); 15 to 19 years old; willing to participate voluntarily in the study; being able to express themselves clearly; and having participated in, or having knowledge of, intervention programmes available in the school. This purposive sampling follows Sprady's criteria for selecting participants for a phenomenological study, which are "enculturation" and "involvement with a phenomenon under study" (cited in Babbie and Mouton, 2001, p.288). As these learners have been at the schools for a relatively long time, they were in a better position to explain how they saw their vulnerability to HIV/AIDS, and could share with me their experience over time with the interventions offered. Also, as adolescents, this is the age at which they are possibly experimenting with sex and talk about issues of sex and sexuality. One thing that I am not sure of, is the influence my link person might have had on the voluntary participation of my participants.

Based on the above criteria, each link teacher purposively selected 10 to 13 participants for the project at their school. Creswell (2007), suggests that for purposive sampling, researchers select individuals and sites for study because they can purposefully inform an understanding of the research problem and central phenomenon. Creswell (2007), further contends that in a phenomenological study the participants maybe located in a single site, although they need not be, and that they must be individuals who have all experienced the phenomena being explored, and can articulate their lived experiences. Patton (1990), concurs with this view arguing that the key to

purposeful sampling is to select cases that are information-rich (cited in Bailey, 2007). Henning (2004), quoting Warren's metaphor, states that qualitative researchers should choose people who can travel or wander with the researcher on the journey towards knowledge about the topic. Participants purposively selected for this study were therefore secondary school adolescents who have similar developmental characteristics, have been at school long enough to experience the phenomena of vulnerability to HIV/AIDS, and were, therefore, sufficiently information-rich to travel with me in my search for the data required.

In mid January 2008 I made a second follow-up visit to schools; this time to meet my prospective participants whom my link persons had identified. I noted that while I wanted 10 participants per school in two schools more than 10 volunteered. Not to kill their enthusiasm, I decided to take all of them on board. During the visit I discussed the following issues with the participants: that participation was voluntary; that they were free to withdraw from the study at any time if they wished to; that there was a need for written consent to participate from them and from their parents/guardians; and that their confidentiality and anonymity would be guaranteed. I also discussed with them the project activities. Participants completed a biographical form indicating their particulars (see Appendix B7). I then distributed consent letters (see appendix B3) which I was to collect at the next meeting and a folder containing project activities.

Gaining informed consent from all role players, learners and their parents/guardians was essential so that they would be fully aware of the nature of the research content and process, and so that they could make informed decision about participation. Greene and Hogan (2005, p. 66), argue that having the opportunity to give or deny informed consent is not only a right to research which children share with adults but also contributes to their well-being, through showing respect for their sense of control. I am not sure how the process of sampling of participants done through my link

teachers gave adolescent learners the opportunity to choose whether they really wished to participate in the study. However, noting the enthusiasm that participants displayed throughout the study, I have little doubt that they made informed decisions to participate. Consent letters to parents and guardians were delivered by my participants in person (See Appendix B5). For boarders, we agreed that participants should take them home and return them after the holidays as the project was to continue the following school term.

### 4.5.5 Biographical details of participants

Figs 4.1-5.4 illustrates the distribution of the participants by gender, age, class and region. Forty four learners participated in the study, out of which 23 (52.3%) were females and 21 (47.7%) males (see Fig.4.1). This gave fair gender representation and provided me with an opportunity to hear the voices of both boys and girls.

In terms of age, the range was from 15 to 19 years, with 17 being the mean and the median age being 18 (see Fig.4.2). Representation by class ranged from learners in form two to form four, with the highest number of learners from form four (see Fig. 4.3). Three learner participants did not specify their age or class. Representation by age and class reflected the design of the study as I wanted to engage learners who were old enough, have been at the schools long enough to have experienced the phenomenon being studied, and were at the time involved in the intervention programmes being offered by their schools. Sprady calls these characteristics of sampling of participants as "enculturation and involvement" with a phenomenon (Babbie & Mouton, 2001, p.288).

Contrary to my original view that learners might come from Nkhata Bay or the northern region where the study setting was, there was however a distribution of learner participants from all the three regions with 5 (11.4%) coming from the south, 16 (36.4%) from the centre and 23 (52.3%) from the north (see

Fig.4.4). This distribution shows that the voices of the secondary school adolescents across the three regions were represented. Such representation lends further support to the trustworthiness of the study and for its transferability to other districts or regions of the country.

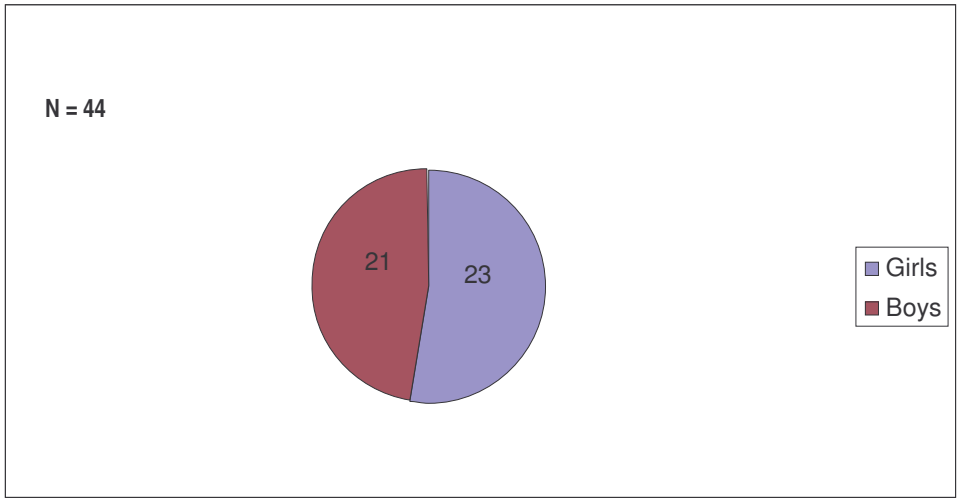



**Figure 4.1: Distribution of participants by gender**

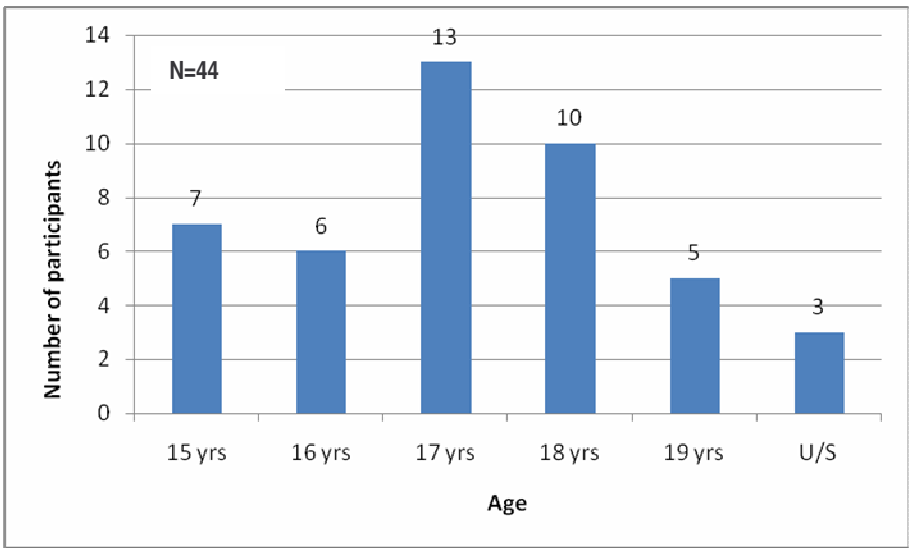



**Figure 4.2: Distribution of participants by age**

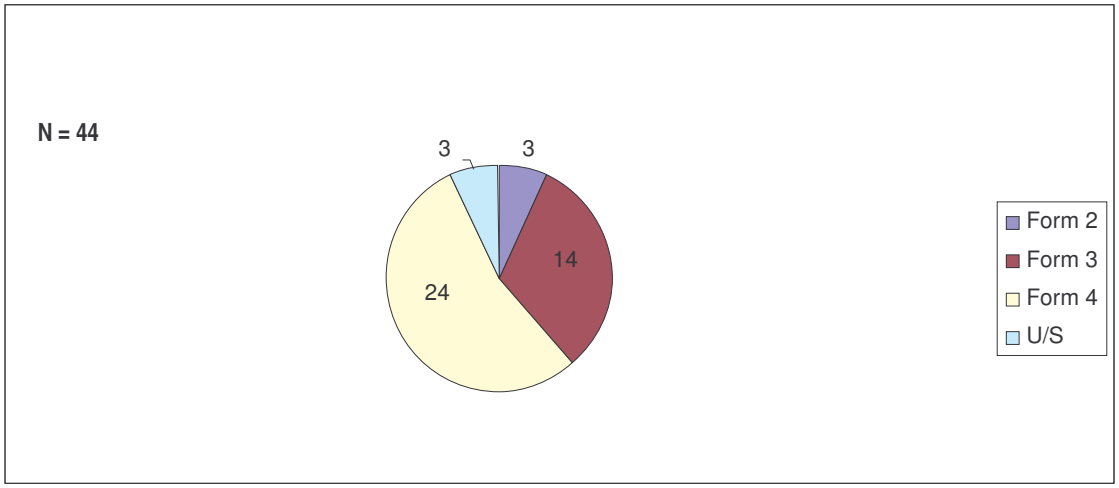



**Figure 4.3: Distribution of participants by class**

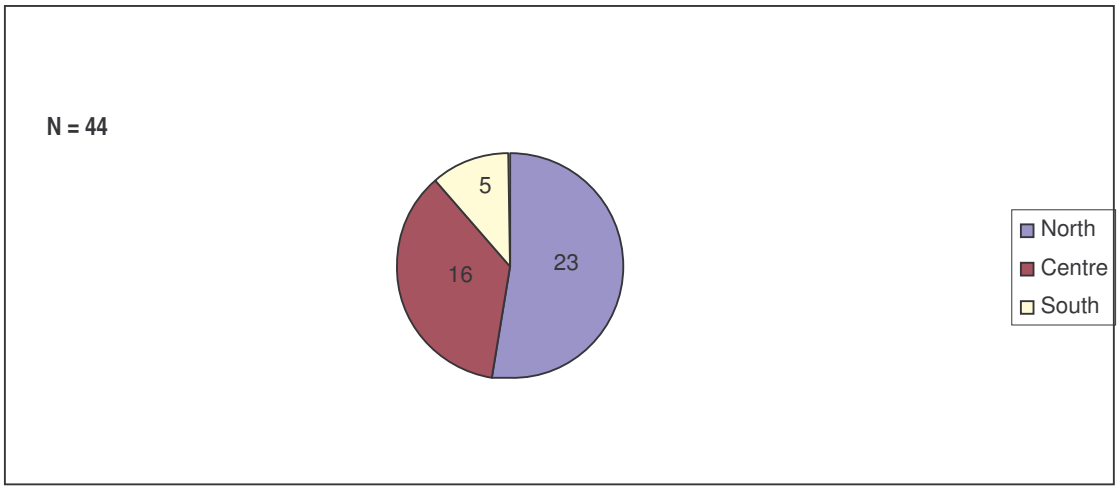



**Figure 4.4: Distribution of participants by region**

### 4.5.6 Research assistants enter the scene

In this study I enlisted the help of 4 research assistants who are young adult students from the university, who come from Nkhata Bay. The idea of breaking down the uneven power relations between my participants and

myself was one of the driving motives for their engagement. The research assistants, being close in age to my participants, of mixed gender and coming from the same cultural background, were meant to ease the uneven power relation. Research assistants were to conduct focus group discussions and help with translations from Chitonga where necessary. They also assisted with the initial analysis of photovoice.

The research assistants were extremely helpful in developing rapport between the participants and myself. Mutual trust was developed so that, apart from research activities, the participants felt free to discuss other issues such as university entry requirements, programmes, and life in the university in general. The research assistants were recruited towards the end of May 2008. Their recruitment had emoluments attached to their services and they were to work with me until the end of the project. As students in the university, they also had their own commitments, so I asked university management for permission to engage them. My research assistants were identified by my colleague, the same one who assisted me with my initial communication with the study schools. The criteria for the selection were that they should be in 1st, 2nd or 3rd year of study in the university pursuing undergraduate studies in different disciplines. This was meant not to disturb the 4th year students with their studies but also provided an interdisciplinary approach to the study. As with my participants, research assistants were engaged outside the university programmes, during weekends and holidays. They were also given letters of consent to sign, as I did with my participants, and assured that they were free to withdraw from the study at any time they wished to do so (See appendix B6).

**Table 3. Details of research assistants from the university**

| * Name of research assistant | Gender | Age | Level/Year | Programme in the university |
|---|---|---|---|---|
| Mr. Wiseman | Male | 24 | 3 | B. Sc. Lib & Information |
| Ms. Brilliant | Female | 23 | 3 | B.Sc. (Education) |
| Mr. Clever | Male | 24 | 3 | BA (Education) |
| Ms Patience | Female | 19 | 2 | BA (Education) |

* Pseudonyms of research assistants

Before I took the research assistants to the field, I conducted six training sessions with them over a period of three days. The training included: working as a team (group), introduction to the research project (aims, research questions, participants, setting and methods of data generation), training in interview skills, how to conduct focus group discussions (FGDs), how to record interviews, and photographic skills, including praxis with photograph shooting, and photograph analysis (See Table 4). Since university students are required to produce a research project at the end of their studies, this training workshop provided them with an opportunity to complement their own research knowledge and skills. Students had the following to say about their experience with the project:

> "It never came to my mind that photos could be such a useful source of research information; I will certainly try to use it in my research project" (Ms Patience, 19)
>
> "Surely, there are many ways of doing research. I am particularly impressed with the idea of a qualitative research. I thought that all research must involve questionnaires "(Mr. Clever, 24)
>
> "This study has given me food for thought especially concerning what constitutes risky situations; we tend to take things for granted" (Ms Brilliant, 23).

**Table 4.Training workshop programme for research assistants**

| Date | Session | Work shop activities |
|---|---|---|
| 30/05/08 (Morning) | 1 | Introductions<br>Working as a team: group dynamics<br>Introduction to broad aspects of research: qualitative vs. quantitative research, the interpretivist approach to research, phenomenology as a research methodology |
| 30/05/08 (Afternoon) | 2 | Introduction to the research project: an overview<br>HIV/AIDS situation in the world and Malawi<br>The research focus, aims and research questions<br>The research design: participants, setting and methods<br>Ethical considerations in research |
| 31/05/08 (Morning) | 3 | Training in how to conduct focus group discussions<br>Training in how to record FGDs |
| 31/05/08 (Afternoon) | 4 | Training in photovoice method: role of photovoice in the research project.<br>Photographic skills<br>Ethical issues involving photovoice |
| 01/06/08 (Morning) | 5 | Praxis with using a camera<br>Praxis with photograph analysis using existing photographs or posters |
| 01/06/08 (Afternoon) | 6 | Planning for the project activities |

### 4.5.7 My relationship with research assistants

We travelled to the research schools in one vehicle and had lunch together. The day before we left we met in my office to plan for the activity. I introduced the nature of the activity and how we intended to go about it, including requirements, time for departure and pick-up points. We shared roles, such as who was going to conduct the FGDs, who was going to tape record, and who was going to take down points during discussions. During the FGDs I attended the introductory part and inspected the venue but left research assistants to conduct the FGDs. I wanted to give my participants some space for discussion with the research assistants but was in the vicinity to attend to problems that might arise. After each research activity we met for a debriefing. We discussed reactions and responses from participants and how, in subsequent discussions, we could improve upon them.

## 4.6 Data Generation

This study had two aims:

- To gain an understanding of adolescents' understanding of their vulnerability to HIV/AIDS.
- To explore adolescents' experiences of the HIV/AIDS intervention programmes available in schools and why they respond to them the way they do.

To address these aims I used a combination of methods of data generation known as method "triangulation" (Babbie & Mouton, 2001, p. 275). Kelly ((2006, p. 287), describes triangulation as collecting material in as many different ways and from as many diverse sources as possible. The authors argue that triangulation can help the researcher "home in" on a better understanding of a phenomenon by approaching it from several angles. Greene and Hogan (2005), concur with this view arguing that triangulation of theoretical orientation, methods and perspectives enhances understanding of a phenomenon. They further argue that triangulation is useful in field research for verification and that it strengthens the case for trustworthiness of the study as various data sets are able to support each other. For me, an area such as HIV/AIDS which deals with human behaviour that can be elusive and is multi-dimensional, can therefore be best understood through the use of multiple methods (Babbie & Mouton, 2001). Leedy and Ormrod (2005), concur with this view, saying qualitative researchers recognise that the issue they are studying has many dimensions or layers, and so try to portray it in its multifaceted form. The use of multiple methods, a common feature of interpretivist research, helped me to gain a deeper and more holistic understanding of the phenomenon of adolescent vulnerability to HIV/AIDS. One important method of generating data in qualitative research is the interview, which provided me with the opportunity to generate data from the participants in their own words. I therefore triangulated methods of data

generation and sources of data, as this process enhanced my understanding of adolescents' vulnerability to HIV/AIDS.

I used three techniques of data generation: one-to-one interviews, photovoice, and focus group discussions, which I discuss in detail (see 4.5.8). According to my original plan, I intended to use these techniques so that the photovoice builds on the interviews, because both involved responses to the same research question, as well as focus group discussions, to reinforce responses from interviews. School programmes did not always allow me to follow my project activities as planned; consequently, I was guided by convenience in my data generation process. However I managed to have focus group discussions after the one-to-one interviews and photovoice which helped me to consolidate responses to each question. Each data generation technique was piloted.

### 4.6.1 The pilot study

According to Brink (1996), as cited in Govender (2007), a pilot study is a small-scale study which is conducted before the main study on a limited number of participants from the same population as the intended project. He asserts that the function of the pilot study is to obtain information for improving the project or for assessing its feasibility (Govender, 2007).

I conducted a pilot study at Jenjewe Community Day Secondary School which is located within Nkhata Bay Lakeshore study area. Participants were purposively selected from forms 2 to 4, and composed of 5 girls and 5 boys. I first conducted one-to-one interviews, then conducted focus group discussions and finally used photovoice. Four participants volunteered to be interviewed: 2 boys and 2 girls. Each interview lasted one hour. The focus group discussion was conducted by a research assistant, with me in attendance. This was meant to test my research assistant's facilitation skills, and lasted for 2 hours. All ten learners participated in the FGD. The photovoice activity was spread over three weeks, allowing time for taking

photographs, developing the film, and the photo elicitation. Participants from the pilot schools formed part of the sample for this study activity.

All pilot study activities took place over three week-ends. I was personally touched by my participants' enthusiasm to attend on week-ends. After the pilot study I came to the following conclusions regarding the data generation tools.

Participants had problems expressing themselves in English but were more comfortable with Chichewa. Discussions in the interviews and focus group discussions had to change to Chichewa, the national language. Contrary to my original fears, the girls were just as expressive on sexual issues, both in interviews and focus group discussions, as were the boys.

Most participants had problems responding to the core questions, both in interviews and focus group discussions, because they appeared too broad and needed rephrasing to enable participants to respond meaningfully. Also, during the interviews, there were some participants who could not elaborate on their answers, no matter how much interviewer tried to probe.

Some participants were not audible on the microphone, so it was necessary to adjust the positioning of the recording machine.

During focus group discussions some participants got carried away and would not stop talking. There was clearly a need to regulate the discussions. I decided to provide some themes for the FGD interview schedules to guide the research assistants. Once one theme was exhausted, the facilitator would move on. This proved helpful in that the discussions were guided and naturally regulated, but at the same time they gave participants some leeway to speak their minds (see appendix C2).

The photovoice generated a lot of enthusiasm in both the participants and the photographic subjects. For most of the participants this was their first experience with a camera. Most photographic subjects were willing to be

photographed and to be "put" in a book (thesis). The only ethical issue encountered was when one participant reported that someone asked to be paid in order to be photographed. Fortunately, the participant did not take the photograph. During the photo elicitation, participants had difficulties with the question: "What does the photograph mean to you?" It required further explanation to convey "What does the photograph mean to me?" Also the question, "What message can your photograph convey to others about adolescents' vulnerability to HIV/AIDS?" needed to be rephrased to accommodate the research prompt. It had to read: "What message can your photograph convey to others about how adolescents can be at risk or not at risk of contracting HIV/AIDS"? (See appendix C 3).

Based on the above, the research instruments and their use were either adjusted or maintained.

### 4.6.2 One-to-one interviews

#### *4.6.2.1 The interview instrument*

The one-to-one interviews were conducted by myself and were meant to answer the first research question: How do secondary school adolescents understand their vulnerability to HIV/AIDS? I used a prepared semi-structured interview schedule that was thematically arranged. It was prepared in English but translated into Chichewa after the pilot study. Bailey (2007) states that, in a semi-structured interview, the interviewer uses an interview guide with specific questions that are organised by topics, but are not necessarily asked in a specific order. The interview schedule was therefore only a guide and the order of discussions with my interviewees was based on their responses. I started every interview with the same opening question for both sexes and thereafter probed according to their responses (See appendix C1). The advantage with this approach is that it provides an informal non-threatening style; "a conversation with a purpose" (Mason, 2002, p.62). The other advantage of a semi-structured interview is that, unlike the unstructured

interview, it represents the amount of control the researcher tries to exercise over participants' responses (Bernard, 2000, as cited in Maharaj, 2006). So, although the method allowed me to probe interviewees' responses, thereby allowing participants to say as much as they wanted to, it nonetheless provided me with some control over the discussions. In addition to igniting discussions, the schedule also provided some direction for the interviews.

#### *4.6.2.2 Organisation and management of the interview*

I conducted the interviews in classrooms, organised by my link persons, which were secluded but non-threatening to participants. Bailey (2007), warns that the location of an interview can affect its quality. So, although the link persons were responsible for organising venues for interviews, I had to be convinced that they were convenient and free from distractions and noise, to provide the "therapeutic frame" needed for the interviews (van der Riet, Hough, & Killian, 2005, p. 83). Occasionally I experienced interferences by curious learners who passed by, presumably to catch wind of what was being discussed. There were however, no serious interruptions.

Between 4 and 8 participants were individually interviewed at each school; the participants for these one-to-one interviews were all volunteers, willing to be interviewed. In the co-educational schools I ensured that a balance was maintained between girls and boys. In total, 22 of these interviews were conducted in the four schools. Table 5 shows details of participants who took part in the one-to-one interviews. With the permission of my interviewees I recorded all the interviews since the preservation of participants' words ensures original data and in the event of a query, researchers can play back and check (Seidman, 1998).

Table 5. Details of participants in the one-to-one interviews

| Name of participant | School | Type of School | Gender | Age |
|---|---|---|---|---|
| Thabie | Jenjewe | Community Day School | Female | 16 |
| Sarisha | Jenjewe | Community Day School | Female | 16 |
| Perani | Jenjewe | Community Day School | Male | 18 |
| Sipho | Jenjewe | Community Day School | Male | 18 |
| Khoza | Chaphuka | Government Boys Boarding School | Male | 17 |
| Shivani | Chaphuka | Government Boys Boarding School | Male | 17 |
| Kamashu | Chaphuka | Government Boys Boarding School | Male | 19 |
| Nikwe | Chaphuka | Government Boys Boarding School | Male | 19 |
| Bongani | Chaphuka | Government Boys Boarding School | Male | 17 |
| Kabela | Chaphuka | Government Boys Boarding School | Male | 15 |
| Sonia | Solola | Community Day School | Female | 16 |
| Bruno | Solola | Community Day School | Male | 18 |
| Thabani | Solola | Community Day School | Male | 19 |

| | | | | |
|---|---|---|---|---|
| Lindie | Sololа | Community Day School | Female | 19 |
| Zondi | Sololа | Community Day School | Male | 17 |
| Duma | Sololа | Community Day School | Male | 17 |
| Ngesi | Ulemu | Private Girls' Boarding School | Female | 17 |
| Nene | Ulemu | Private Girls' Boarding School | Female | 15 |
| Phindile | Ulemu | Private Girls' boarding School | Female | 16 |
| Nellie | Ulemu | Private Girls' Boarding School | Female | 15 |
| Serena | ulemu | Private Girls' Boarding School | Female | 15 |

#### *4.6.2.3 Relevance of the interview for this study*

The interview was the dominant method of data generation in this study. Interviews helped me to explore participants' knowledge, attitudes, opinions and experiences, but most importantly their understanding about their vulnerability to the disease (Mason, 2002). Marshall and Rossman (2006), state that in a phenomenological study the use of interviews is recommended as it focuses on the deep-lived meanings that events have for individuals. It provided me with an opportunity to get to know my participants better and helped me to understand their feelings and experiences better. Furthermore, the method provided me with an opportunity for gathering descriptive data in the participants' own words or language (Terre Blanche et al., 2006). Using open-ended questions during the interviews ensured conversational dialogues; conversations with a purpose between me, the researchers, and my participants (Marshall & Rossman, 2006).

#### *4.6.2.4 Reflections on interviews*

The success of interviews, however, largely depends on the co-operation of participants. Sometimes they may not be willing to say all that one wants to know (Marshall & Rossman, 2006), and indeed as happened in this study some learners were not willing to talk about their own sexual experiences, preferring to talk in general terms like "adolescents" or "they" rather than "I" or "we". This is a reflection of the deep-seated cultural practice where issues of sexuality are still regarded as taboo and not to be discussed openly. Female participants were more general in their responses regarding their sexuality and sexual behaviour; perhaps reflecting the uneasiness they may have had about being interviewed by an adult male researcher. While my interview used open-ended questions that allowed for open discussions, I was confronted with the challenge of exercising a balance between giving more space to my interviewees and exercising control. There were participants who actively participated and could keep on talking and talking, and there were others who simply answered the question posed to them, with no elaboration. This latter group was very difficult to handle since there was no way I could coerce them to supply the relevant information, so I ended up doing most of the talking. For the former group, the themes on the schedule saved me since once I exhausted a theme, I terminated the discussion and moved on to the next. However, in either case I did not lose the ownership of the interview process (Henning, 2004).

### 4.6.3 Photovoice

#### *4.6.3.1 Photovoice as a method of research and its relevance to this study*

Photovoice is a participatory method developed by Wang (1992) that allows participants to give voice to their experiences through visual images which allow us to understand how people themselves make meaning or construct what matters (cited in Royce et al., 2006). According to Wang, as cited in

Pies and Parathasarathy (2004, p.2), photovoice is based on the premise that "(w)hat experts think is important may not match what people at the grassroots think is important". Burke (2008, p. 25), defines photovoice as "a visual methodology in which a camera is placed in the hands of those who are experts in their own lives, in a context that encourages the documenting and sharing of their own reality through photographs, and is also known as talking pictures or visual voice". As a research method, photovoice takes cognisance of the fact that (adolescents) have the ability to represent their thoughts in a manner they choose (Galvaan, 2008). In this study, as a participatory approach, photovoice contributed to the reduction of unequal power relations and promoted adolescents as co-researchers, rather than simply participants (Johnson, 2008). Through the choice of data generation via this participatory visual methodology, ownership and control of the material generated were in the hands of the research participants. In this way, the method engaged my research participants in an active process of knowledge production (Flick, 2006). Furthermore, it is argued that when photographs are produced collaboratively, they combine the intentions of both the researcher and the participants, and represent the outcome of their negotiations (Pink, 2007). The photovoice method was meant to access adolescents' understanding of their construction of what is and is not a risky environment, by taking photographs. Through photo elicitation they explored their vulnerability to HIV/AIDS – using photovoice with no explicit activist agenda. Although the aim of the activity was not to influence policy, the reflexive process of photograph taking and photo elicitation provided my participants with an opportunity to diagnose problems relating to their vulnerability to HIV/AIDS, giving them answers to reconsider their risk-taking behaviour (Mudaly, 2006). In this regard the photovoice was an intervention in itself. Photovoice seems also to have provided my participants with the opportunity to express in visual form what they would otherwise find difficult, thereby revealing their "hidden reality". The following extracts testify to this:

*Poyamba ine sinkadziwa kuti kuzera mukujambula ma pikicha ukhoza kuwona zambiri za momwe tingatengele kapena kupewa matenda a Edzi (At first I didn't know that through taking pictures, there is a lot I could learn about how to contract or avoid HIV/AIDS) (Sarisha, girl, 16).*

*" I have learned something, for example from friends such as on pictures, in particular the picture of truck, that we may develop a lot of thoughts concerning HIV/AIDS on a picture" (Nelie, girl, 15).*

*Project iyi yandithandiza kwambiri kusintha khalidwe langa. Kuyambira tsopano ndizdikhala tcheru kwambiri ku zimene ndi kuziona. (This project has helped me a lot to change my behaviour. From now on I will be more alert to what goes on around me.) (Kabela, boy, 15)*

#### *4.6.3.2 Organisation and management of the photovoice*

The participants were put in groups of 5 with two groups in each school. In total, there were eight photovoice groups in the four schools (See Appendix B8). These groups were provided with simple "point and shoot" cameras. Two cameras were provided and used in turns. Denzin (1986), states that the dilemma in photovoice is how to get information on film and how to get it off the film (cited in Flick, 2006). I provided participants with the following prompt, which guided them in getting information onto the film: "Take photographs of situations where you could consider yourself at risk or not at risk of contracting HIV/AIDS". Before they went out to take photographs, I taught them how to use the camera and about the ethics of photograph taking. In some cases participants who had knowledge and skills in photography came forward to demonstrate to others how to use a camera. Participants then went out taking pictures in and around the school environment, focused by the prompt. They also 'staged' the issue they wanted to present amongst themselves. I expected each group to take between 15 and 20 photographs during a period of one week. The large

number of photographs was meant to give them an adequate pool for choice during analysis. During the time they took photographs, participants recorded details of each photograph in a photovoice journal, and the problems they encountered. After taking the photographs, I processed the films and returned the photographs to participants for elicitation. Seeing their photographs provided much joy and satisfaction because, for most of them, it was a novel experience.

#### *4.6.3.3 Photo elicitation*

The first level of photograph analysis was done in the field by the participants themselves through critical reflection on their photographs. Each participant chose a photograph that best depicted the response to the prompt, a process known as photo elicitation (Wood, 2008) or photo essay (Royce et al., 2006). Wood (2008), describes photo elicitation as the process of allowing each participant to select photographs that speak to him/her and add written text. The photo elicitation was guided by the following questions: "What does the photograph mean to me?" (Mitchell, de Lange, Moletsane, Stuart & Buthelezi 2005, p. 265) and "With your photograph, what information can you convey to others about adolescents' vulnerability to HIV/AIDS infection"? (Royce et al., 2006, p. 83). Photo elicitation was first done on a photo elicitation form, by pasting the photograph on it and writing a brief description of what the photograph was about, and then explaining its message. Participants then assigned a caption to it. They came up with several thought-provoking captions so that even in the absence of a photograph, the message was clear. The following are some examples of imaginative captions by participants: Let's talk about it (group photograph); Hardworking pays (Women working in a plantation); The power of money (photograph of a female adolescent receiving money from a man); In my thoughts (photograph of a lonely boy); Temptation (photograph of a boy and a girl in a secret place); Group as a safe haven? (photograph of adolescents in group).

Before an individual participant finalised photo elicitation, the analysis was shared with the group and members made observations and gave input. I found this round-table sharing of photo elicitation very useful because it helped individuals come up with alternative views which the owner was free to adopt or not. For example, one participant took a picture of women working in a rubber plantation. His initial message was that these women are vulnerable to HIV/AIDS through sexual harassment by men working in the company. His friends thought the same picture depicted that women might be less at risk, since the employment empowers them financially so they would not need to engage in commercial sex to earn a living. During photo elicitation I involved research assistants who clarified the guiding questions for the participants and also assisted with facilitating the process. The research assistants and I went around the groups assisting participants with the exercise. The themes that emerged from the photo elicitation were cross-referenced with those from the one-to-one interviews. (See 4.7.2).

#### *4.6.3.4 Reflection on the photovoice activity*

The photovoice method generated so much enthusiasm that many non-participant learners became attracted to join the project and I had to request the link person not to allow any more participants. Participants asked whether this activity could be extended to other students in the school or even other schools, so that they too could benefit from it. The link teachers at each school agreed to use the photos with the other students in the HIV/AIDS clubs and also in Life Skills lessons. The photovoice method also proved to be an alternative avenue for expressing reality about issues surrounding their behaviours in relation to HIV/AIDS, which in normal circumstances the participants rarely discuss. The following are their remarks about the photovoice activity:

> *Sindinagwilepo kamera ndikale lomwe. Ndaphunzira ku jambula. (I have never used a camera before. I have learned how to take photographs.) (Male participant during FGD) "I think this project is*

*encouraging because at least at the moment I have gained some ideas. Because at first I did not know that if you see various situations they might put you at risk of contracting HIV/AIDS. It would have been better if everyone else in the school took part, not just a few of us!" (Nene, 15).*

*"I have learned something, for example from friends such as on pictures, in particular the picture of truck, that we may develop a lot of thoughts concerning HIV/AIDS on a picture" (Nelie, 15)*

At one school where this activity took place on the last week of the school term some participants asked to be allowed to take pictures using their own cameras at their home environments during the holiday and bring them over to the school for analysis. I found this an interesting suggestion, and allowed them to, but cautioned them about the ethical issues that we had discussed. This enthusiasm carries potential ethical risks in that participants might be carried away to take photographs of places and people without first getting their consent.

Another thing I observed was a lack of critical thinking on the part of participants, for example, they took some very good pictures, apparently full of meaning to me, but could not come up with meaningful analyses. Since this was meant to be their articulation, I did not want to interfere.

#### *4.6.3.5 Challenges of photovoice as a method of research*

The photovoice method has been criticised in terms of ethical issues around the taking of photographs and for its lack of academic integrity and reliability. Karlsson (2008), warns that recognisable identification markers on a photograph carry the risk of harm to participants. However, she concedes that the practice of anonymisation through cropping or erasure of the image is also not without problems. She asserts that such practice is tantamount to betraying the viewer into seeing or not seeing something within the frame, arguing that this is unethical because it reshapes the image according to the

bias of the photographer (researcher) (as cited in Mudally, 2006). In this study, I opted to leave the photographs as is. Since ensuring complete anonymity in photovoice is practically impossible, I constantly emphasised the need to act responsibly. Borrowing from Royce et al. (2006), I advised participants to act responsibly towards the public and obtain permission from the human photographic subject before taking any photograph, and to be sensitive to the local culture. Most of the photographs my participants took were staged among themselves. In addition, they were given the right to remove photographs which they did not feel comfortable with, and the participating schools were given the photographs which were not used in the photo elicitations. These excess photographs would be used to share the photovoice experience with other learners. Above all, I conveyed to all concerned parties that the photographs would be used for the purpose of the thesis only. But to what extent these measures might have affected the ethics of my photovoice activity may not be immediately quantifiable/evident.

Fortunately for me and contrary to my fears, no ethical concerns were reported. In fact, participants reported that most people were willing to be photographed and "placed" into the book, meaning the thesis.

As for the issue of academic integrity and reliability, it can be argued that photovoice, as a research methodology, provides a unique opportunity for adolescents to critically reflect on what images were captured, how they were captured and what could be learned from them regarding the phenomenon of vulnerability to HIV/AIDS (Karlsson, 2008). It is further argued that photographs and words do not express the same thing, nor can they substitute each other (Pink, 2007). So, what words could not express, photographs expressed, which I call the *"hidden reality".* For example, participants took a photograph of a staged scene showing an HIV positive adolescent learner, and what it looks like to be HIV positive. This kind of discourse is rare, considering the stigma attached to the disease and the fear

of stigmatisation in Malawian society. This photograph gave them an opportunity to illustrate the 'reality' in an adolescent's face. In this regard, photographs act like plays to illustrate a phenomenon. As a research method, photovoice also provided significant information as to how adolescents construct their world which other data sources could not possibly have captured as adequately.

### 4.6.4 Focus group discussion (FGD)

#### *4.6.4.1 The focus group instrument*

Focus group discussions were conducted by my research assistants using the interview schedule that I developed. Like the interview schedule, the FGD schedule was prepared in English, but was later translated into Chichewa (see appendix C2). Bryman (2004, p. 346), defines focus group discussion as "a form of interview in which there are several participants, including the facilitator, with an emphasis on fairly defined topics, and the accent is upon interactions within the group and the joint construction of meaning". In this study, the focus was on HIV/AIDS intervention programmes that are available in schools. The schedule was to be used flexibly by the facilitator and started with one broad question. As the discussions progressed, participants themselves raised additional or complementary issues which have been incorporated into the findings. The open-ended questions were arranged in a thematic approach with broad themes. This helped the research assistants who conducted the FGDs. It also proved to be very useful during data analysis, as discussions were relatively controlled and themes emerged naturally.

#### *4.6.4.2 Management of focus group discussions*

Although there is no strict rule as to the composition of a FGD, Marshall and Rossman (2006), recommend 7-10 participants as an ideal composition. Kelly (2006), recommends a smaller group when participants are likely to have a

lot to say, and might be emotionally involved with the topic. I wanted to maintain a small group size as group size is thought to be inversely related to the degree of participation (Rodham, 2006, p.264). Although I originally wanted to use 10 participants from each school, between 10 and 13 participants volunteered to take part in the FGDs and in the co-education schools, a balance was struck between boys and girls and the discussions were conducted in a mixed gender grouping. According to Rodham (2006), previous research has found that mixed gender groups take longer in discussions and that boys tend to dominate. For this reason Greene and Hogan (2005), suggest the use of single sex FGDs for sensitive issues. Contrary to Rodham's (2006) observation, the girls were just as active during the FGDs as their male counterparts and in some cases dominated the discussions. I decided to use both single sex and mixed sex FGDs, and a slightly increased number of participants; an arrangement that enabled me to capture as much diversity as possible (Bryman, 2004). In total, four focus group discussions were conducted, one at each school and in all, 44 learners participated in the FGDs - 23 girls and 21 boys. (Appendix B8 illustrates details of participants in the FGDs for all the four schools).

All FGDs started with participants and research assistants introducing themselves and then the facilitator explained the purpose of the discussion. Rules governing the discussions were framed and agreed upon by all participants. These included respect for each other and maintenance of confidentiality of all that was being said.

FGDs took place in venues organised by the link teachers but which, like the interview venues, were first inspected by me for their usability. This was meant to create a" therapeutic frame" for my participants (Van der Riet, et al., 2005, p.83). All four research assistants shared responsibilities for conducting the FGDs. One was responsible for moderating the interview, one for recording, one for taking down notes and the fourth assisted the moderator. Use of research assistants also greatly decreased the power dynamics between me,

the researcher, and my participants, as it provided them with an opportunity to converse on an equal footing. Discussions were conducted in a round-table manner with research assistants interspersed. The round-table arrangement ensured that everyone was not only given an opportunity to speak, but also that there was easy eye contact. A high sensitivity cassette recorder was placed in the middle and the microphone rotated towards the speaker to capture details of what was spoken. After permission from participants was obtained, all discussions were recorded. Recording ensured that the data was accurately captured and that the recordings could be used for verification of facts later, should the need arise (Bryman, 2004). Each session lasted for about one and a half hours. This period did not require too much commitment from participants and was just enough to ensure concentration. The activity was conducted during the week-ends when schools normally hold sporting activities as I did not want to disturb the schools' programmes. At the end of each session, participants were asked to summarise the contents of the discussions and to give their own views about the project. This enabled the moderator to clarify some issues raised during the discussions, and also enabled participants to insert their voices into the project. One participant had this to say:

> *"This is only one way we young people are talking our minds, because monga kunoko, tilibe chodalira cheni cheni kuti ma youth amayankhula, nkuti (like here we don't have any means that we youth can rely on to speak out so that) the Government can get the ideas, so only the bigger people and the rich ones speak about HIV/AIDS." (Female participant during focus group discussion)*

After each FGD, I organised a debriefing session with my research assistants to evaluate the discussions and plan for the next FGD. Kelly (2006), argues that it is very important to set aside 'debriefing' time immediately after the focus group discussion for the researchers to go through the notes or recording between themselves, and to try and recreate the session while it is

still fresh in their minds. Debriefing sessions took place immediately after the sessions wherever possible, or as soon as we returned to the university. Debriefing sessions also helped me to move at the same pace as my research assistants, as I personally did not take part in the FGDs.

#### *4.6.4.3 Relevance of FGD for this study*

The focus group discussion was meant to address the second research question: "What are adolescents' experiences of the intervention programmes available in schools, and why do they respond to them the way they do?" Ulin, Robinson, Tolley and Mcneill (2002), state that using FGD produces data and insights that would be less accessible without the interaction found in a group. The FGDs provided me with an opportunity to get additional information on their understanding and experiences regarding their vulnerability to HIV/AIDS which may have been missed during one-to-one interviews (Marshall & Rossman, 2006; Mason, 2002). Using the focus group discussion improved responses I collected from the one-to-one interviews since in interviews, participants do not have time to reflect on the topic. FGDs have been chosen as they provide a stimulating environment for participants to express themselves more openly, and so enabled me to get information about their participation, or lack of it, in the existing intervention programmes. Furthermore, the FGDs provided a forum where views that are not correct or not socially shared by the adolescent group, were corrected and validated (Flick, 2006). In line with my participatory approach, FGDs allowed my participants to determine what they wanted to discuss and let their views emerge naturally in the course of the discussion. In this regard, the themes that emerged were not simply a reflection of my agenda, but participants' own (Rodham, 2006). Moreover, it has been argued that results from FGDs have high levels of trustworthiness because the method is readily understood, more people pool their views at the same time and so their findings appear are believable (Flick, 2006). In this study, the use of FGDs also provided a further opportunity to explore unanticipated issues which arose in

the discussions. For example, while the focus was on intervention programmes in schools, issues of school administration that impinge on HIV/AIDS were brought up.

#### *4.6.4.4 Some reflections on the organisation of FGDs*

As in one-to-one interviews, a few organisational problems were encountered. Occasionally, discussions were interrupted by curious learners who walked past the venue, and by occasional noises from outside. FGDs also have the disadvantage that it might be difficult to reach a consensus on an issue, and time maybe lost in the process (Somekh & Lewin, 2005). This was particularly so for these FGDs which were conducted by research assistants who might have exercised less control and unnecessarily lost time. The other challenge posed by FGDs is how to document data in a way that allows for the identification of individual speakers, as in the case of a one-to-one interview. This weakness was addressed through the use of impersonal names such as "girl" or "boy" participant in the analysis of the FGDs and in the report, as it was practically impossible to identify the speakers by name through a tape recorded data source. The other weaknesses, such as lack of confidentiality and control of discussions in the FGDs were handled by holding briefing sessions with all the participants and research assistants on how to conduct themselves during the FGDs. Research assistants were forewarned about participants dragging out the discussions, and were advised to stop "when they have reached theoretical saturation, when all themes have been covered" (Bryman, 2004). Researching sensitive issues like HIV/AIDS can evoke emotions, thereby creating potential harm to participants. I am not sure how such situations were handled and whether they have had any negative impact on my participants, since the FGDs were facilitated by my research assistants, who have limited research experience. But I am of the view that our debriefing session, held at the end of each FGD, took care of this issue.

## 4.7 The Process of Data Analysis

### 4.7.1 Introduction

In this section I start by presenting an overview of my data analysis process. I then discus the data analysis process that was used, that is, open coding, and explain how this process led to the identification of themes which inform the unit of analysis of this study.

Creswell (2002), states that analysis in phenomenological research involves identification of significant statements, the generation of units of meaning, and the development of a thick description. Marshall and Rossman (2006), concur that qualitative data analysis is a search of general statements about relationships and underlying themes. So, borrowing from both Creswell (2002) and Marshall and Rossman (2006), this study used a six step strategy to analyse the data from interviews as follows: transcription, reading the data to get a general sense of the information, coding, categorisation, creation of themes, and, finally, interpretation and re-contextualization of data within the context of literature which is discussed in Chapter 6.

Creswell (2007), further states that analysis is an ongoing process involving making sense of the text and image data. For me, this process started in the field when I was conducting individual interviews, focus group discussions, and using photovoice. During data generation, I wrote memos, held debriefing sessions with the research assistants after each focus group discussion, and allowed participants to explain the meanings of their photographs. These activities formed my first level of analysis. The second level of analysis was done after I had generated all the data which, by then, was in the form of audio tapes of individual interviews and focus group discussions, and photographs with their accompanying photo essays and field memos. I discuss this level of analysis under 4.5. In chapter five I present the findings of the study, showing the themes that emerged from this data analysis process.

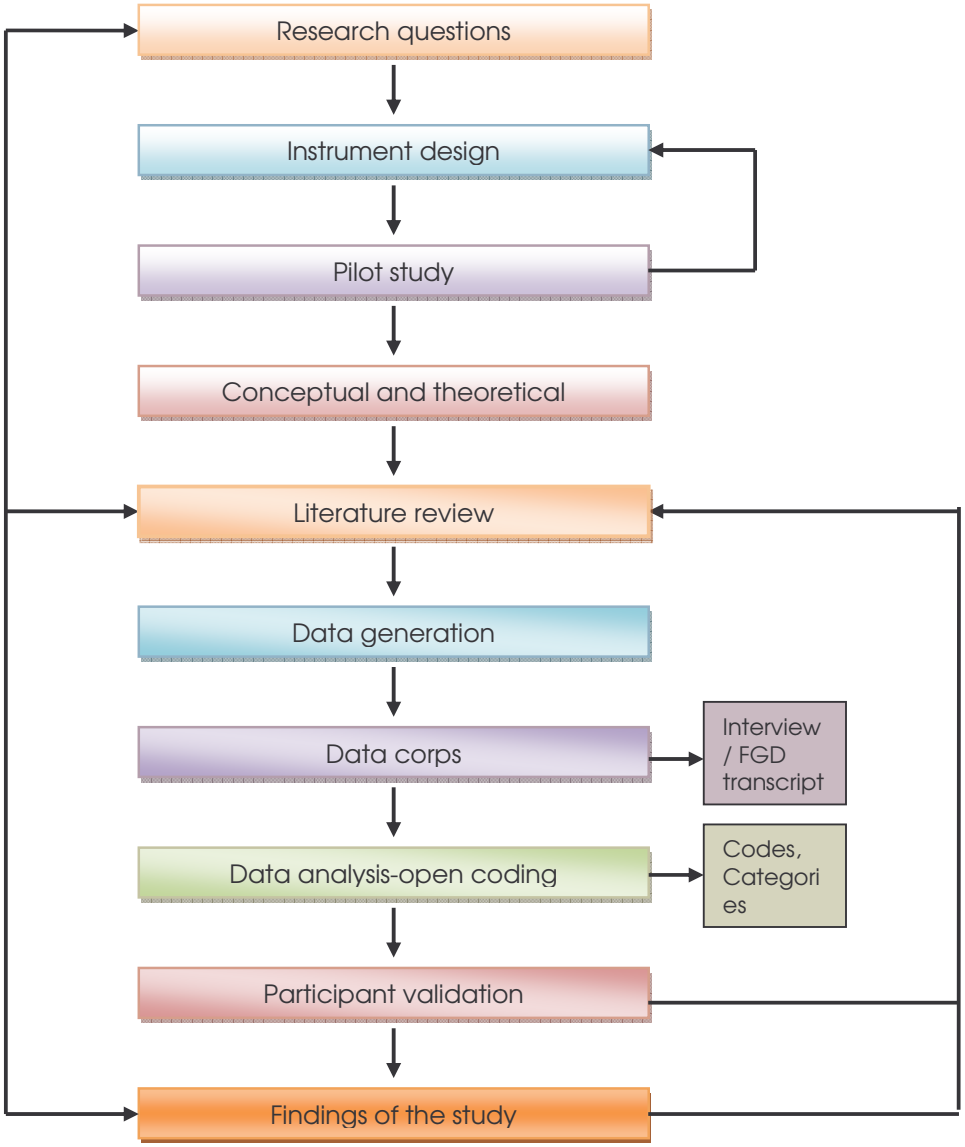



**Figure 5: The process of data analysis**

### 4.7.2 The analytical framework

At the time of my second level of data analysis, I was overwhelmed by the large quantity of data we had collaboratively generated, consisting of 16 (60 minute) audio cassettes of interviews and focus group discussions and 44 photographs, including photo essays. The first challenge was how to organise this huge data set for meaningful analysis. I started by personally transcribing the interviews and focus group discussions from the audio cassettes, while the photo essays which were written by participants in English were typed in their

original form. I had to do this in a manner that retained the information from the verbal data in a way that was true to its original nature (Braun & Clarke, 2006). This personal involvement in transcribing provided me with an opportunity to engage deeper with my data and to see the picture that was emerging. Transcripts of the interviews and focus group discussions were then taken back to my participants for validation, and their inputs fed into my research report. During participant validation fora, I involved at least two research assistants who further engaged with the participants on issues raised during the FGDs, interviews, and photovoice. While one was probing into participants' responses, the other one took down notes and managed the tape recordings of the discussions.

Because the transcripts of the interviews and focus group discussions were in the local languages Chichewa, Chitumbuka and Chitonga, I was confronted with the challenge of having to translate the scripts into English for my supervisor and other readers without losing the original meaning. I had to transcribe interviews and FGD discussions in the language of discussion to maintain its original form and then I translated the text into English. In the study report, all translated versions have been put in brackets.

The corpus of data generated through interviews, focus group discussions and photovoice were subjected to the analytical tool known as open coding (Braun & Clarke, 2006). Braun and Clarke (2006, p.79) refer to *data corpus* as "all data collected for a particular research project", such as the sum total of the individual interviews, FGD discussions, photographs and photo essays. A *data set* refers to all data from the data corpus that is used for a particular analysis, such as a set of one-to-one interviews or a set of focus group discussions or photo essays (Braun & Clarke, 2006). They refer to a *data item* as an "individual piece of data collected from a data set" such as a single individual interview with a participant, or a focus group discussion with a single group. They further refer to a *data extract* as an individually coded chunk of data which has been identified in and extracted from a data set,

such as a participant's quotation or a photograph description. Open coding utilises thematic analysis, which is a method of analysis for identifying, analysing and reporting patterns (themes) within a data corpus (Braun & Clarke, 2006).

First, I read through the transcripts of both the focus group discussions and interviews over and over, to immerse myself in them in order to make sense of the data. I then read through them again, line by line, highlighting key phrases and concepts that could provide an understanding of how my participants experienced the phenomenon of vulnerability to HIV/AIDS and interventions in schools. I entered this analysis process from an inductive approach and had no *a priori* themes, because I wanted to discover the themes from the data. I wanted to play an active role in the process of identifying the latter, selecting which were of interest, and reporting them to the reader. Taylor & Ussher (2001), cited in Braun and Clarke (2006). Ryan and Bernard (2003), argue that entering the coding process with an *a priori* theme tends to inhibit the forming of fresh ideas, and the researcher maybe tempted to find what he or she is looking for. However, they warn researchers not to lose sight of making connections between the data and the research questions.

Each data set, namely the individual interviews, the FGDs and photovoices were coded separately, and the codes and themes that emerged were later cross-referenced. In the process of theme identification, as I was reading the transcripts, I was guided by the question: "What is this an example of?" (Bryan & Bernard, 2003, p.87). Using this question, I was able to assign codes to the various sentences, phrases and concepts that I highlighted in the transcripts. At this level I assigned any descriptor (code) that I thought best explained the concept highlighted. I ended up with hundreds of them. These codes were written in the margins of the transcripts.

Having identified the codes, my next step was to sort out which codes were related to each other as these formed my potential categories. This was the

start of the reduction process. Creswell (2007), describes reduction as the process of taking voluminous amounts of data or information and reducing it to certain patterns, categories, and themes. I took down all the codes and started collating related codes. This was the beginning of my theme-building, as those (what?) which shared common language formed their own "cluster of meanings" (Creswell, 2007, p.61). Codes that were speaking to each other formed categories, and categories that talked to each other formed a theme. Each time I reduced a theme, I moved back and forth in my transcripts in an "iterative" process so see the link between themes and categories, but also not to lose sight of the sources of the data (Maree, 2007, p.109). In the process I created new themes, sub-themes and categories. This process enabled me to engage personally and at a deeper level with my data, and to go back to the data sets to alter, adjust, or modify codes and themes accordingly (Mohangi, 2008). Braun and Clarke (2006), state that analysis involves constant moving back and forth between the entire data set, the coded extracts, and the analysis that one is producing. During the process of data reduction I was guided by my research questions and theoretical framework.

In order to establish a common understanding, themes that emerged from focus group discussions were cross-referenced with those generated from interviews and photovoice. After a series of theme and category reductions, the analysis moved into a more interpretative stage, producing a story-line that would both answer my research questions and present arguments about the phenomenon of adolescent vulnerability to HIV/AIDS, and reflect my theoretical framework. Not all of my codes fitted into the thematic layout that I created. These "orphaned" codes were kept for subsequent review (Maree, 2007, p.109).

During the data analysis process, I worked very closely with my supervisor. Independently of each other, we worked through my list of themes from interviews and focus group data sets and when compared, we arrived at

almost the same themes. This process, known as "inter-coder reliability", further enriched my process of data analysis as well as the findings of this study (Ryan & Bernard, 2003 p.104). Ryan and Bernard (2003, p.104), state that inter-coder reliability "refers to the degree to which coders agree with each other about how themes are to be applied in qualitative data".

In the next chapter I present a discussion of the themes and categories that emerged out of this analysis process under the heading "results of the study", supported by extracts from various data sets. In chapter six, the findings of this study are then recontextualised in the literature.

## 4.8 Reflections Over Ethical Dilemmas of Researching HIV/AIDS with Adolescents

### 4.8.1 Introduction to ethics in this research

Hesse-Biber (2006), states that the term *ethics* comes from the Greek word "ethos" which means "character". She suggests that to engage with the ethical dimension of research the researcher must ask him/herself the following questions: What moral principles guide my research? What responsibility do I have towards my research participants? Aware that researching HIV/AIDS with adolescents has potential ethical risks, I was guided by the four philosophical principles of ethical research, namely autonomy and respect for the dignity of a person, non-malificence, beneficence, and justice (See 4.6.3). These were translated into a number of safeguards, some of which I have discussed in the preceding sections under data generation process and how the use of various data generation instruments might have generated special ethical concerns. In this section I now turn to other issues that might have had an ethical bearing on my study.

Sirber (1993), as cited in Opie, (2004, p. 25), says ethics have to do with the application of moral principles to prevent harming or wronging others, to

promote the good, and to be respectful and fair. Terre Blanche et al. (2006), explain that it is necessary to protect the welfare and rights of research participants.

### 4.8.2 Power relations between the participants and myself

The greatest ethical issue I was confronted with in a research of this nature, as alluded to earlier, is the issue of the unequal power relations between the adolescent participants and myself, the adult researcher. My participants might not have felt free to discuss sexuality issues with me but I believe the key principle in researching sensitive issues like HIV/AIDS is the development of mutual trust through the development of rapport with participants, part of which has been discussed in the preceding sections. Cooke and Kothars (2001), as cited in De Lange, Olivier and Wood (2008, p.110), intimate that being aware of these issues early enough in the study, and being reflexive about the principles of equality, sustainability and empowerment, are key to the success of participatory methodologies. Bailey (2007), cautions, however, that the researcher should continually reflect on this rapport development so that it does not degenerate into manipulation of participants. This is what I discuss below.

### 4.8.3 Reflexivity during data generation process

Throughout this study I adopted a reflexive approach which, Pink (2007) argues, goes beyond the researcher's concern with the question of bias, but also the awareness of the significance of various elements of their identities such as gender, age, ethnicity, class or race. `Reflexivity refers to assessment of the influence of the researcher's own background, perceptions, and interests on the qualitative research process" (Krefting, 1991, p.218). As I interacted with my participants, I continually reflected on my age, the gender difference, and sometimes my own beliefs. My participatory approach helped me to appreciate and value my participants' thoughts

and contributions, and shifted me from viewing participants as objects to seeing them as co-researchers (Galvaan, 2008). I had to tread carefully so as to adopt the "`least adult role" Holmes, (1998) (as cited in Galvaan, 2008, p.3). For example, participants were asked to contribute to the planning of the next research activity after the completion of each activity. This is because the study recognises that adolescents are thinking people with their own values and opinions and that it should be able to make them what Farrell (2005, p. 30), calls "active participants". The study should be able to accommodate their suggestions wherever possible. This further diminished the power dynamics between us.

Additionally, in this study I used my experience as headmaster, and my counselling skills to develop rapport between myself and the participants through sharing information regarding the research activities. I have described how my use of link persons as key actors and the research assistants facilitated this rapport development. Furthermore, I spent five months with my participants generating data, a period long enough to development rapport. Galvaan (2008), argues that spending a long period interacting with participants should even out the power relations to some extent and develop mutual understanding between researcher and participants.

### 4.8.4 The four ethical principles

Terre-Blanche et al. (2006), state that there are four widely accepted philosophical principles that are applied to determine whether research is ethical, namely autonomy and respect, non-maleficence, beneficence, and justice. Although I used these principles to guide my research throughout the study, I discuss them below to highlight some ethical issues that arose during the study and how I resolved them.

#### *4.8.4.1 The principle of autonomy and respect for the dignity of participants*

This principle suggests the researcher should ensure that participants' privacy is guaranteed. In this study the principle was adhered to through informed written consent, and the assurance of confidentiality and anonymity of participants. In my letter of informed consent details of the project were clearly stated so that participants and their parents or guardians could make informed decisions regarding their participation. Participants were told that their involvement was voluntary and that they were free to withdraw from the study at any time if they so wished. Confidentiality and anonymity of participants and sites were guaranteed through the use of pseudonyms. The recording of interviews and FGDs was only done with the permission of participants. Krathwohl (1993), as cited in Normand (2007), states that research data should be kept confidential so that individuals and communities cannot be identified in ways that maybe harmful. Although measures were put in place to ensure confidentiality and anonymity of my participants, I am not sure how the involvement of many parties, like the link teachers, research assistants and parents, might have jeopardised this privacy. Although my research assistants signed a contractual obligation to keep the research information confidential, I am not sure how this might have affected confidentiality outside the research environment. Even amongst the participants themselves, it is impossible for me to guarantee that there was total confidentiality. I am also not sure how genuine the written parental or guardians' consents were. However, as Somekh and Lewin (2005) argue, absolute anonymity cannot be guaranteed since cues such as sites may lead to revelations of people's identities. This is especially so in this study which involved a few schools whose identities could easily be revealed through their descriptions. The authors advise that the best solution is to seek clearance from individuals concerned for the use of data in the research report. Nonetheless, no serious problems regarding the privacy of my participants were encountered or reported.

#### *4.8.4.2 The principle of non-maleficence*

This principle requires that the researcher should ensure that no harm, whether it be physical, mental or legal, befall the participants as a direct or indirect consequence of the research. In this research I ensured that the venues were safe and comfortable and that the research instruments did not subject my participants to any danger or embarrassment. During interviews, when I realised that my participants were not comfortable with a question, I immediately discontinued and moved on to a different one. But I was particularly worried about the photovoice which I thought might place participants in confrontation with photographic subjects. Although nothing averse was reported, I am not sure how the photovoice may have put my participants in danger.

#### *4.8.4.3 The principle of beneficence*

This principle states that the research should have some benefits for the participants or community, which is termed "social capital" (Farell, 2005, p. 140). This study involved an issue at the core of adolescent life which is their sexuality and HIV/AIDS. The participatory approach to data generation was meant to ensure that participants benefited from their participation. The participatory visual methodology enabled participants to reflect on their own lifestyles and this has the potential to bring about positive change in their behaviour. Also, schools and participants embraced the methodology and indicated that they would share this experience with other learners in the school by continuing with the photo elicitation, using the excess photographs that I left with the schools. Farrell (2005), states that with regard to youth increased social capital is seen to be instrumental in improved school retention and general well-being, as well as lower rates of delinquency. Through this study, I get the impression that my participants benefited in various ways as the following extracts demonstrate:

*"These discussions have been very helpful to me because the information I have learned here will not be for me only but I will be able to share with other friends of mine. Me, I will share with a friend; that one too will share with another friend; in so doing it will be like a chain" (Khoza, 17).*

*" I have learned something, for example from friends such as on pictures, in particular the picture of truck, that we may develop a lot of thoughts concerning HIV/AIDS on a picture" (Nelisiwe, 15)*

#### *4.8.4.4 The principle of justice*

Justice requires that the researcher treat participants with fairness. In my study participants volunteered to participate in the research activities during weekends which I thought was a great sacrifice and I had to be considerate. For example, I provided them with refreshments and sometimes with transport to their homes, especially if they were going my way. Participants were also encouraged to suggest the course of our research activities, such as when we could meet next. I am not sure, however, how the offer of refreshments might have affected voluntary participation.

### 4.8.5 Security of research materials

In terms of security, electronic copies of research findings are stored on flash disc or CD, and all research materials are kept securely by me under lock and key in a research briefcase for safety. I intend to keep the research data for 5 years before disposal, to enable those who would want to query something, to do so.

### 4.8.6 Contextual ethical issues

As Somekh and Lewin (2005) caution, I had to take particular care to acknowledge the uniqueness and complexity of Nkhata Bay and the many complex factors that could have a bearing on my study, which they refer to

as "situated ethics". Consequently, some ethical issues were solved as and when they arose during the data generation. For example, some people were not comfortable about being photographed while others felt at ease. These situations required negotiations in accordance with the local culture. Opie (2004), suggests that ethical considerations should apply throughout the research process and this has been at the back of my mind both during data generation and analysis.

## 4.9 Ensuring Trustworthiness of This Study

Creswell (2002), argues that terms like validity, reliability and generalisability do not carry the same connotation in qualitative research as they do in quantitative research. In this study I have used Guba's model of describing the credibility of qualitative research. Guba (1990), prefers to describe the rigour of qualitative research in terms of trustworthiness, and uses criteria like credibility, transferability, dependability, and confirmability as the most applicable. I now turn to how my study achieved these criteria.

### 4.9.1 Credibility

Credibility relates to the truth value of research findings. According to Ulin et al. (2002), credibility in qualitative research focuses on the truth of the findings of a study, including an accurate understanding of the context. Krefting (1991), argues that in qualitative research, truth value is obtained from the discovery of human experiences as they are lived and experienced by participants. Consequently, this study achieved credibility through prolonged engagement with participants during the data generation which took nearly six months. This engagement allowed participants to become accustomed to the research and increased rapport between myself and the participants. As a result they were able to discuss sensitive issues related to sexuality which at the beginning of the research they were not able to articulate. This engagement also allowed me to identify patterns and check my

participants' perceptions regarding their vulnerability to HIV/AIDS. Key (1997), states that this form of corroboration between participants and researcher ensures that the researcher's findings reflect participants' perceptions, and increases readers' understanding that the findings are credible. Furthermore Fetterman (1998), as cited in Creswell (2007), contends that working with people for a long period of time is what gives (qualitative) research its validation and vitality. Moreover, during the data production process I kept an up-to-date and detailed field diary of events. These notes, which have been fed into my thick description, have added to the credibility of the results obtained.

Reflexivity (see 4.7.3) which was followed throughout the data generation period, has also enhanced the credibility of this study, as it helped me to bracket my biases, interests and perceptions so as not to influence the quality of this study.

As has been alluded to earlier, use of triangulation of the methods of data production and analysis has greatly enhanced the credibility of this study, since it allowed the various data sets to talk to and reinforce each other. Creswell (2007), states that triangulation involves corroborating evidence from different sources to shed light on themes or perspectives. In this study, evidence from one-to-one interviews, focus group discussions, photovoice and inter-coder reliability has strengthened the role of triangulation. Bailey (2007, p. 77), states that triangulation is useful in field research for verification, but cautions that using it to try to determine what finding is " the truth" runs counter to some paradigmatic assumptions that underpin qualitative research.

Credibility has also been enhanced by the detailed description of the study settings (see 4.00). Moreover, I have made a thick description of the findings with ample quotations from participants, to show that the findings originate from them. Additionally, I have produced a logical layout of the findings by

theme, followed by a rigorous process of code reduction to categories and then to themes, which has further enhanced the credibility of this study.

After the data generation I transcribed the interviews and focus group discussions. I took the transcripts back to my participants to check whether what was summarised is what they actually said; a process known as "respondent (participant) validation or member checking" (Creswell, 2002; Leedy & Ormrod, 2005). Participant validation is referred to as "a process whereby a researcher provides the people on whom he/she has conducted research with an account of his findings" (Bryman, 2004, p. 274). It involves taking the data, analyses, interpretation and conclusions back to the participants so that they can judge the accuracy and credibility of the account (Creswell, 2007, p.208). This input from participants has added to the credibility of the results because it shows that the report contains their actual voices. Ungar (2003), argues that data are most credible when they reflect the voices of participants (as cited in Normand, 2007). (A transcription of the input of participant validation, also known as member checking, appears as Appendix D).

### 4.9.2 Transferability

Transferability refers to the extent to which it is possible to generalise the data and context of the study to the broader population and settings (Van der Riet & Durrheim, 2006, p.93). Although generalisability of the findings was not relevant to the goal of this study, conclusions from it can be transferrable to other contexts. In this study, transferability has been achieved by producing a detailed and rich description of study contexts which should provide my readers with a detailed account of the contexts in which meaning-making around the phenomenon of adolescents' vulnerability to HIV/AIDS have developed. As Creswell (2007) argues, such description, with its shared characteristics, will allow readers to make their own decisions regarding the transferability of this information to other settings. These understandings can

be transferred to new contexts and could also provide a framework with which to understand the phenomenon in those contexts. Transferability has also been enhanced through sample selection. In this study I used class teachers in the study schools to select participants on the basis of given criteria. This resulted in getting the sample with the characteristics that would provide the needed data, further enhancing transferability to similar samples. Moreover, the data collected through FGDs, one-to-one interviews and photovoice were relevant to my participants and the aims of the study, further enhancing transferability of the findings.

### 4.9.3 Dependability

Guba's (1981) dependability criterion relates to the consistency of findings and refers to the degree to which the reader can be convinced that the findings did indeed occur (cited in Van der Riet & Durrheim, 2006, p.93). This too was achieved through rich and detailed description which shows how my participants' behaviour and actions are rooted and developed out of contextual interactions. This is reflected in their quotations and photo essays. An additional strategy that enhanced dependability of the results of this study was the use of inter-coder reliability during data analysis, where I used my supervisor as an independent coder for my data. After coding we compared the outcome and the results were a close match although we differed in the terms used. According to Ryan and Bernard (2003), the premise of inter-coder reliability is that the more agreement among team members, the more confidence we can have in themes being valid. They argue that strong inter-coder reliability suggests that the themes were not just a figment of the investigator's imagination and leads to the likelihood that the themes are also valid. Patton (1990), refers to such agreement as "triangulation through multiple analysts" as cited in Ryan and Bernard (2003, p.104).

### 4.9.4 Confirmability

According to Ulin et al. (2002), Guba's criterion of confirmability refers to a way of knowing that, even as a co-participant in an inquiry, the researcher maintains the distractions between personal values and those of the study participants which, in this study, were achieved through reflexivity and bracketing throughout the process. Reflexivity refers to "assessment of the influence of the investigator's own background, perceptions and interests on the quality of research" (Krefting, 1991, p.218). These were bracketed in order to obtain an honest and objective view of the study findings. Triangulation of the data generation methods, data analysis and theoretical perspectives added justification for the confirmability of the findings of the study.

In the preceding section on ethical issues, I discussed the various issues that might have affected the findings of the research, and the measures I took to minimise ethical risks and maintain moral integrity. Hesse-Biber (2006), argues that the moral integrity of the researcher is a critically important aspect of ensuring that the findings are trustworthy.

## 4.9 Synopsis of Chapter Four

In this chapter I discussed the process by which the data was generated. I began the chapter with a discussion of the participatory approach that was used in the study by defining what a participatory approach is and justifying its use in the study. This was followed by a discussion about how I gained access to my study schools and learner participants, including how I used this access to develop rapport between the research team (my research assistants and myself) and my participants and the link teachers. I then presented a discussion about the techniques I used to generate data, that is, the interview, the focus group discussions and the photovoice, including the respective instruments and equipment I used and the experiences I encountered. The process of data analysis was presented showing how

various data sets, one-to-one interviews, photovoice and FGDs were subjected to my theoretical framework. This discussion was preceded by a description of the biographical details of my participants. I concluded the chapter with a discussion of reflections on some ethical dilemmas encountered while researching the sensitive issue of HIV/AIDS and adolescents. Finally, I justified the trustworthiness of the findings of the study.

In the next chapter I present a report of the findings of the study, showing how they answer my research questions and how they reflect my conceptual and theoretical frameworks.

# Chapter Five:
# Reporting the Results of the Study: Adolescents Speaking Their Minds

> *"We youth we, should avoid bad company, we should always hang up with people who can help us; osati anthu amene akhoza kutichita lead kwina kwake. komanso ma youth'fe, tikhale oti, we should be managing our own mind, osati tizitengera za munthu wina, zoti poti munthu wina akupanga chakuti, chakuti, inenso ndipangeso chomwecho. tikhale tikuzidalira tokha (We youth we should avoid bad company, we should hang up with people who can help us, not people who can mislead us. but also we youth we should be managing our own mind not just copying whatever other people are doing, and you also do the same. we should be people who can be self reliant)"* (Nelisiwe, age 15, from Ulemu Girls Private Boarding School)

## 5.1 Introduction

The purpose of this phenomenological study was to understand how secondary school adolescents understand their vulnerability to HIV/AIDS by exploring their understanding and experiences with regards to the pandemic. Two questions that the study addressed were: (a) How do secondary school adolescents understand and perceive their vulnerability to HIV/AIDS? and (b) What are secondary school adolescents' experiences of the intervention programmes available in schools, and why do they respond to them the way they do? In the previous chapter I discussed how data from interviews, focus group discussions and photovoice were subjected to my analytical

framework, and how I went about generating the themes and categories. In this chapter I present a detailed discussion of the findings of the study by themes and categories, supporting it with direct quotations and visual representations from my participants. In the presentation I maintain the photo essays as originally constructed by my participants. As alluded to earlier (See 4.5.8.3.2) the scenes in the photographs were staged by participants and permission granted for them to be used in the thesis.

The photo essays contain a number of grammatical errors which I decided to leave verbatim, as trying to correct and insert "sics" would make the flow of ideas awkward. These essays provide the reader with the essence of the messages that participants are conveying. The other extracts from interviews and focus group discussions have been translated and where mistakes occur I have corrected them and inserted "sics". This chapter is focused on what the participants are saying and has deliberately been titled "Adolescents speaking their minds". This is to highlight the participatory approach which recognises that participants' voices remain dominant and what they say is what counts in making sense of the world (De Lange, Olivier and Wood, 2008). Names used in this report are not real names. I deliberately adopted Zulu and Indian names from KwaZulu Natal as this decreased the likelihood of having coincidental names from schools in Malawi.

## 5.2 Presenting the Results of the Study

I have structured the presentation of the results of this study according to the research questions and themes, categories, and sub categories that emerged from my analysis, as the following figures illustrate:

## Figure 6.1: Themes and categories relating to secondary school adolescents' understanding of their vulnerability to HIV/AIDS

**Theme 1: Adolescents' awareness of their vulnerability to HIV/AIDS**

**Categories**

- Awareness that adolescents are a more vulnerable group than others
- Awareness of how one can contract or avoid contracting HIV/AIDS
- Awareness of the dangers/consequences of contracting HIV/AIDS
- Awareness of what constitutes a safe or unsafe/risky environment

**Theme 2: Adolescent perception of HIV/AIDS risky situations**

**Category 2.1: 1nternal factors**

**Sub-category**

- Sexuality development

**Category 2.2: School- related contexts**

**Sub-categories**

- Peer pressure/ influence
- Inter-school meetings
- Sexual harassment/ abuse
- Other related contexts

**Category 2.3: Home and society providing unsafe environment**

**Sub-categories**

- Home environment as unsafe space
- Poverty as risk factor
- Cultural practices and beliefs as risk factors
- Media as risk factor

**Theme 3: Some controversies regarding what constitutes risky situations**

**Categories**

- Co-education and single sex schools
- Relationships in schools
- Seductive dressing and use of language
- Condom promotion and use

**Theme 4: Voices of participants regarding what could and should be done to reduce the risk of adolescents' vulnerability to HIV/AIDS**

**Categories**

- To fellow adolescents
- To parents
- To school management and government
- About ABC strategy

**Figure 6.2: Themes and categories relating to adolescents' experiences with HIV/AIDS intervention programmes in schools**

**Theme 5: Awareness of various programmes offered to learners**

**Categories**

- School-based programmes
- Non-school-based programmes

**Theme 6: Reasons for low levels of participation in the programmes**

**Categories**

- Lack of interest in the programmes and motive for participation
- When and how programmes are delivered

**Theme 7: Learners' experiences of the programmes**

**Categories**

- Positive experiences
- Negative experiences

**Theme 8: Participants' voices of what could and should be done about the programmes**

### 5.2.1 Secondary school adolescents' understanding of their vulnerability to HIV/AIDS

The adolescents' discourse around understanding of their vulnerability to HIV/AIDS is interesting. Although the interview questions were directed at them, so that they would talk about themselves, some participants preferred to talk about adolescents as if they themselves were not part of the category. Statements like "adolescents are…" or "they do this because…." or "many youth…" are signs of "othering" (Squire, 2007 p.117) the disease or the situation and distancing themselves from adolescents who encounter the

problems discussed. This denial of their own vulnerability is also a reflection of deep-rooted cultural norms in Malawi where issues of sex and sexuality, and consequently HIV/AIDS, are still taboo. HIV/AIDS is still shrouded in mystery and stigma and people who are infected believed to be responsible for their fate resulting from carelessness and promiscuity. Sometimes the infection is considered punishment from God or ancestral spirits, or witchcraft at work. The discourse around HIV/AIDS is also derogatory, the disease being called various names like, "nthenda iyi" (this DISEASE!), "nthenda ya Boma" (government's disease), "nthenda ya ku tauni" (town disease), and nthenda ya lero (modern disease). If someone dies, even if it is obvious that he or she might have died of AIDS, it is uncommon for people to accept it, their preferring to look at other causes of death, for example, "he has died of diarrhea", or "has been bewitched" indicating blame and othering. Consequently these adolescents do not want to be associated with the disease of shame. This attitude puts adolescents at increased risk of HIV/AIDS because they are shy to seek services such as voluntary counselling and testing for fear of being associated with the disease and stigmatisation. However, with more advocacy programmes, and also as each family is affected in one way or another, these perceptions are gradually changing.

In my study there were some participants who discussed the issue with reference to themselves, accepting that they are part of the adolescents who are vulnerable and who experience the problem being discussed. This was exemplified by statements like "achinyamata'fe[4] (we youth) are in big problems".

#### *5.2.1.1 Theme 1: Adolescents' awareness of their vulnerability to HIV/AIDS*

##### 5.2.1.1.1 Awareness that adolescents are a more vulnerable group than others

The level of awareness of their vulnerability to HIV/AIDS is relatively high among adolescent learners in secondary schools in Malawi. Adolescent

[4] Achinyamata is a Chichewa term for youth in general irrespective of their sex

participants singled themselves out as more vulnerable to the HIV/AIDS pandemic than any other group in society. This is positive because, as Blake (1990, p. 9) intimates, "by accepting our vulnerability and understanding facts about AIDS we take the first steps towards preventing it". This self-awareness could be attributed to many factors such as the massive campaigns that government has put in place both in school and out of school. Participants clearly articulated an understanding of their vulnerability to HIV/AIDS as demonstrated in the excerpts below.

> *Okay! Ah! being an adolescent in the age of HIV/AIDS,…nditi ah! Achinyamata ambiri ali pa ngozi yayikulu chifukwa choti matenda a Edzi tikatengera ku muwiro wathu titengere kwa akulu kapena ku ana, achinyamata ndi amene ikuwapanga attack kwambiri. (I should say that Ah! many youth are in big danger compared to the older people, because the youth are the ones that AIDS is attacking them quite a lot). (Nikwe, age 19, male participant from Chaphuka Governmen Boys' Boarding School)*
>
> *Inde! ma youth are more in danger than others, chifukwa achinyamata nthawi zambiri amakonda kutengeka ndi azinzawo kusiyana ndi akulu-akulu, those are more minded than us youth. (We the youth are more in danger than others because, in most cases youth are easily taken by what their friends do than older people, those are more minded than us youth). (Shivani, age 17, male participant from Chaphuka Government Boys' Boarding School)*
>
> *"Ah! This disease (sic) (is) very dangerous because as we can see nowadays most of the youth are the ones which (sic) (that) are dying because of this disease; mostly you can see that they are doing bad things but some people inherit from their parents". (Khoza, age 17, male participant from Chaphuka Government Boys' Boarding School)*

*"Kukuoneka kuti achinyamata'fe, pa nkahani ya HIV/AIDS pamene tafika pa msinkhu momwe tiliri timatengeka ndi zinthu zambiri; ndiye tikafika pa nthawi yoti kudzigwira, aah! Kumatibvutirako, koma poganiza kuti ndife atsogoleri amawa nkofunika kuti tizipewe kutenga matenda'wa. (It looks like we adolescents, on the issue of HIV/AIDS, at the stage at which we are, we are carried away by so many things, so when it comes to self control, aah! we are failing, but considering that we are the leaders of tomorrow, it is necessary that we avoid contracting this disease)". (Male participant from Solola Community Day School during focus group discussion)*

#### 5.2.1.1.2 Awareness of how one can contract or avoid contracting HIV/AIDS

Participants were asked if they considered themselves at risk of contracting HIV/AIDS and, if so, how? They were also asked how they could avoid contracting the disease. Learner participants demonstrated considerable knowledge about the modes of HIV transmission and how they can avoid contracting the disease. This knowledge is presumably acquired from the formal programmes in school, such as Life Skills and HIV/AIDS clubs, but also from informal sources such as peers, the media and significant others like relatives and religious leaders. Learner participants showed awareness that having unprotected sex with an infected person is the main mode of HIV transmission. In this regard, having multiple sex partners was particularly regarded as a sure way of contracting AIDS. Girls were concerned that they would contract AIDS from their boyfriends, especially if the latter insisted or forced them to have unprotected sex. Participants also expressed knowledge of other modes of transmission namely blood-contaminated needles, razor blades, tooth brushes and syringes. However, it appeared from responses that most of this knowledge had been regurgitated from class work on HIV/AIDS because in most cases participants seemed to be recalling facts from somewhere else. In terms of knowledge of how one can avoid contracting HIV/AIDS, learner participants felt that abstinence from sex is the

surest way to avoid AIDS. They also felt that if one has an intense sexual drive, the best thing to do is to engage in alternative activities, such as playing ball games and taking or attending drama to suppress the drives. Participants had the following to say regarding how they might contract or avoid contracting HIV/AIDS:

> *(Laughing!). No! I am afraid, I can contract AIDS. If I can have sex with a man and he can also have sex with another woman if she has AIDS she will give him. And if he will come again to me he will give me AIDS. (Sarisha, age 16, female participant from Jenjewe Community Day School)*
>
> *Because, first, we know that it is 99 or 90% through sexual so if I can make myself what? avoid sexual intercourse I can. Also in case of using the same razor blade you just avoid it; I can prevent it. (Khoza, age 17, male participant from Chaphuka Government Boys' Boarding School)*
>
> *Because I have seen the ways people can get HIV/AIDS and the ways people can control to be affected with the disease. As a result, I think that when you sexual stimulus it's better to go somewhere you can resist to feel the stimulus like going to play football, attend drama which means your feeling may end there and when you return back home nothing can happen. (Bruno, age 18, male participant from Solola Community Day School)*
>
> *Yeah! at one time or another yeah! I think there is a risk because for example, I have a boy-friend, right! then sometimes he forces me like to sleep with him which is not good. And maybe over time I maybe in that point of saying, why not try it, which is bad. So somehow in a way I am at risk. (Ngesi, age 16, female participant from Ulemu Private Girls' Boarding School)*
>
> *Yes, also like borrowing some things (coughs!), like razor blades, needles or tooth brushes. If blood comes from the mouth,*

*"chiseyeye" and he gives that tooth brush to his friend, they share the tooth brush; if the first one has AIDS then he can get AIDS. And those they use to make ndolo (pierce ears) Eee….yeah! (Sarisha, age 16, female participant from Jenjewe Community Day School)*

**Figure 7. Bad Practices at Boarding Schools**

*A girl is getting her ears pierced by a friend with a needle. The message conveyed in this picture is that of a girl being pierced with a needle that has been used by several other girls. She runs the risk of contracting HIV and also spreading it. This is common in boarding schools, where girls encourage one another to pirece ears. (Photovoice by Nene, age 15, female participant from Ulemu Girls' Private Boarding School)*

5.2.1.1.3 Awareness of the dangers /consequences of contracting HIV/AIDS

Adolescent learners have a real fear of HIV/AIDS and the consequences of contracting the disease. There is a realisation that contracting HIV/AIDS has serious consequences, not only for their education, but for their lives as a whole. They realise that if they contract HIV/AIDS they will not be able to concentrate on their school work, may be stigmatised and discriminated against and will eventually have to withdraw from school. Participants indicated the danger of suicide attempts associated with adolescents who have contracted the virus and are discriminated against. Participants showed awareness of the consequences of the HIV/AIDS pandemic in their community, which has left a trail of orphans who are destitute and likely to engage in risky behaviours themselves as they grow into adolescence. The fear of the disease is exacerbated by seeing the physical appearance of people living with HIV/AIDS. In addition to their verbal descriptions, participants demonstrated awareness of the consequences of contracting HIV/AIDS through visual representation in the form of photographs and photo essays, for example, photographs of children probably orphaned by HIV/AIDS, an adolescent learner orphan, and an HIV-infected adolescent secondary school learner. The following extracts and photographs illustrate the awareness of the dangers of contracting HIV/AIDS among adolescents.

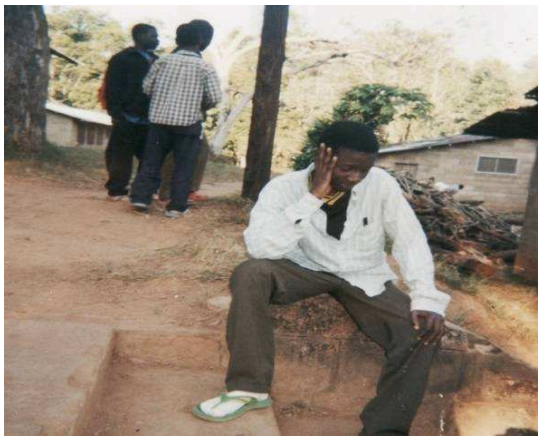
*Ndiye iweyo kuti you get AIDS basi! ndiye kuti your future is doomed. Nthawi iyi kuti upitlize education, ukukhala m'class uzingoganiza kuti I have got AIDS, chani chani. I can't reach far ndiye, ndiye basi mwina nkusiya sukulu; kuli bwino ndingofa. (So if you get AIDS, that's it; it means that your future is doomed. This time to continue with school it means you will always be thinking that I have got AIDS and this and that; I can't reach far, and so decide to drop from school; I should just kill myself). (Nene female, age 15, Ulemu Girls' Private Boarding School)*

**Figure 8. In my thoughts**

*This photo shows a young person who has a lot of thoughts in his heart and there is no friend around him who may assist him to have positive thoughts. Maybe he has AIDS and maybe he is thinking I am going to die. He may think to kill himself. (Photovoice by Thabani, male, age 18, Solola Community Day School)*

*Ah!, the danger is, ngati wa chinyamata wapanga contract HIV/AIDSHIV/AIDS ndiye wasiya sukulu, then has to go to VCT, amupeza kuti ali ndi HIV/AIDSHIV/AIDS, sangathe kupitiriza maphunziro ake, chifukwa aziopa kuti or ngakhale ndipitirize maphunziro anga, chomalizira, maganizo ake ngokhala kuti mapeto ake ine ndimwalira ndiye pali bwino kuti ndingosiya, chifukwa mapeto anga ndikudziwa kale. (Ah! the danger is, if a youth has contracted HIV/AIDS it means the end of school for you; you may have to go for VCT and you will be found positive, then you can hardly continue with your education, because you will be thinking that even if I can continue with school I already know my end, I will die so it's better for me to drop out of school). (Nikwe, male, age 19, Chaphuka Government Boys' Boarding School)*

**Figure 9. Loneliness**



*The photo shows a boy who is alone and has nothing to do. This boy can put his life at risk of contracting HIV/AIDS since he is alone. Maybe he is an orphan. He is thinking what can I do in this life? He may end up into thoughts of doing risky behaviours such as drinking alcohol and smoking hence engage himself in unprotected sexual intercourse with prostitutes. This will make him vulnerable to HAI and AIDS. (Photovoice by Khoza, male, age 17, Chaphuka Government Boys' Boarding School)*

*Okay! Kukhala kuti nthenda yimeneyi yikuononga anthu ambiri, ndiye kuononga anthu ambiri, ifeyo ngati anthu tili ndi mantha kwambiri, chifukwa munthu even kumuona akuyenda pa mseu, siungadziwe uyu ali ndi matenda a HIV ai! koma unless akakatani? akayezesa. Ndiye ambiri timangopanga zinthu mu chimbuli-mbuli. (Okay! it's like this disease is taking on so many people's lives, so we as adolescents are very much afraid, because to see an HIV/AIDS person walking on the road, you cannot recognise him unless he goes for testing and declares his status, so it's really dangerous. So many people just do things in ignorance). (Shivani, male, age 17, Chaphuka Government Boys' Boarding School)*

*Chifukwa ndizomvetsa chisoni kwambiri omwe'wo amene akupanga tsogolo la pa dziko lathu, ndiye ngati tikutaya achinyamata which means patsogolo'pa tikhala opanda atsogoleri a phindu, eh! (Because it's a pity to see the young ones, who are the hope of tomorrow, dying of HIV/AIDS, so if we are losing such people it means that in the near future we shall not have leaders). (Kamashu, male, age 19, Chaphuka Government Boys' Boarding School)*

*Yes, of course! Okay, for example at home I am a chairman of Youth Alert Club, so we do like going to the hospital, so when I see those sick people affected by TB or HIV and AIDS, I feel that ah! it's not good to do those things because I can also be like those people, yeah! (Khoza, male age 17, Chaphuka Government Boys' Boarding School)*

#### 5.2.1.1.4 Awareness of what constitutes a safe or unsafe environment

Adolescent learners are capable of distinguishing a risky environment from a safe one when it comes to vulnerability to HIV/AIDS. They believe that school itself provides a safe environment as schoolwork and extra-curricular activities tend to keep them too busy to contemplate risky behaviours. They also indicated that information obtained from informal sources like school notice boards provides some safety checks. Sports have been particularly singled out as providing a safe space for them at school. Learners also acknowledge that supportive parents, teachers and religious institutions all provide a safe environment for them. Religion, especially reading and sharing the word of God from the Bible, was mentioned as the most inspiring in providing a safe environment. However, learner participants view the physical location of certain schools and the presence of night clubs and bars in the vicinity of the school and their homes as providing risky environments to contract HIV/AIDS. An interesting observation is that adolescents seem to appreciate the role that they themselves can play as peers in providing safe environments for themselves. They believe that talking about HIV/AIDS among themselves and attending HIV/AIDS clubs facilitated can provide a healthy environment for adolescents. Phindile's photovoice (See Fig.11) raises special issues when she says one finds it difficult to express one's feelings about HIV/AIDS among learners, some of whom might be HIV-positive, for fear of losing friends; probably suggesting fear of stigma and discrimination. However, Serena's photovoice (See Fig.15) looks very reassuring and indicates that, when learners of different sero-status mix, it removes stigma and discrimination and promotes cooperation and co-existence. Participants also took several photographs in their neighbourhoods depicting what they consider constitutes safe or unsafe environments. For example, participants took photographs of women working to earn a living, of adolescents engaged in sports, staying together as a group, and sharing HIV/AIDS messages and the word of God as

examples of safe environment, although being in a group or playing games, as well as women working in plantations (See Fig.14) are also perceived as risk factors. Participants also took photographs of adolescents hanging around taverns/bars, rest houses, or with other learners of the opposite sex in a seductive manner, in solitary places showing dangerous and unsafe environments. Their level of awareness of what constitutes risky or safe environments is demonstrated by adolescents' statements and photovoice below.

**Figure 10: A block of classrooms and a notice board**

*This is a classroom which contains about 60 students. But out of all these students you can't just tell who HIV positive or negative is. Sometimes we borrow each other sharp objects and use them carelessly. It's easy in such environment to get HIV/AIDS. With this kind of environment it's hard to express your feelings because your afraid to lose your friends. On the notice board our teacher put things about HIV/ AIDS so we learn many things about HIV/AIDS. (Photovoice, by Phindile, female, age 16, Ulemu Private Girls' Boarding School)*

*Chifukwa choti ngati ndikupanga za sukulu, sindingapangeso zoti zingandiononge moyo wanga, pogonana ndi amuna. Kaya mwamuna akandifuna zili kwa ine kukana. (Because if I do my school work I cannot at the same time engage in things that would spoil my life by having sex with men. If a man wants me for sex, it's up to me to refuse it). (Sonia, female, age 16, Solola Community Day School)*

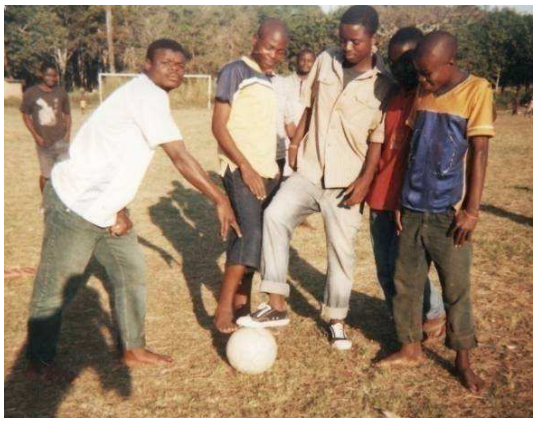
*Eya! kupanga avoid kwambiri makamaka kumapanga nawo za sports, chifukwa ngati munthu ukupanga nawo zama sports, maganizo oti ukhale ndi chibwenzi, and chilakolako chambiri chimathawa. Ukapita, let's say ukapita ku mpira, nthawi yambiri yoti ukanakhala pansi kumaganizira kuti ukhale ndi chibwenzi, onse aja amathawamo. (Yeah! It's important to avoid contracting HIV/AIDS by engaging oneself in sports, because if one does sports thoughts of having a girl friend or sexual desires tend to vanish.) (Nikwe, male, 19, Chaphuka Government Boys' Boarding School)*

**Figure 11. Busy Bodies**

*The photo shows girls being busy doing activities of playing netball hence they lives cannot be at risk of contracting HIV/AIDS. If there was absence of the activity the girls could have been engaged in thinking of sexual intercourse as the result the risk of contracting HIV/AIDS is high. This girls spend much of time in playing netball which means that there is little chance for them to think of doing sex rather than going to the ground to play netball. (Photovoice by Sarisha, female, age 16, Jenjewe Community Day School)*

**Figure 12. Sports Activity**

*These boys are playing football which means that there is little chance for them to think of doing sex rather than think of going to the ground to play football. There is also danger in case of playing in that one maybe is affected and she is injured and it will be possible for someone to get HIV if he had sores and they have become in contact in process of playing.*
*(Photovoice by Shivani, male, age 17, Chaphuka Government Boys' Boarding School)*



*Like my dad, every time he always advise us of not having boyfriends, because boy friends are the ones that lead you to destruction. You don't know the guy kuti ndi munthu otani? Ndiye mwina iyeyo ali ndi Edzi, ndiye iye akuudza kuti let's have sex; you sleep with him, akupatsa Edzi, ndiye kuti basi, ukhala ngati you haven't obeyed ma rules aku ma parents ako. Ndiye ukapanga wekha kumbali ukawona kuti wazionongera wekha tsogolo, ndiye makolo anga amandipanga encourage kuti that do not have boy friends when you are a teenager. (Like my dad, every time he*

*always advise us of not having boy friends, because boy friends are the ones that lead you to destruction. You don't know the guy that what kind of person is he? Maybe he has AIDS so if he asks you let's have sex, you sleep with him, he will give you AIDS. This means for you it will be like you have not obeyed the rules from your parents so if you do things on your own you will find that you have destroyed your own future and so my parents encourage us that do not have boy friends when you are a teenager). (Nene, female, age 15, Ulemu Private Girls' Boarding School)*

*Yeah! Also my parents tell me that you should not have boyfriends, but we should have boyfriends after we finish school and we have our own things; others they steal money from their parents to give to their boyfriends or girl friends. So we shouldn't do that. (Sarisha, female, age 16, Jenjewe Community Day school)*

*Okay, first, I can say where I live, we have groups, like youth clubs. We come to sit down and discuss what we youth we should do to avoid getting this disease. And you sit down and think about that in the group and they are there giving views to youth like don't do that, or that. So if you go outside that environment you just ah!...I should not do other things, and get impressed by that what that person is doing. He doesn't do it, so you say I should also not do it. (Ngesi, female, age 16, Ulemu Private Girls' Boarding School)*

**Figure 13. Working in dangerous places**

*Hard working pays. This photo shows women working on rubber plantation watering seedlings. Maybe these women might have sex with the bosses before employed to win favour. Moreover this environment is no suitable for women because it is bushy and the women can have sex or can be raped. To me, this photo means the women are keeping irrigated seeds rather than thinking in bad ways and they are self reliant since after work they are paid thereby not selling their body with money. (Photovoice by Perani, female, 18, Jenjewe Community Day School, )*

**Figure 14. A group as a self (sic) (safe) haven or risky situation?**

*The photo shows a group of girls enjoying themselves at the lake'. There maybe some HIV/AIDS victims and these people are usually worried. When they interact with friends the burden is eased. There is no discrimination and this makes them feel better. The girls can advise each other on how to prevent the spread of the disease. But this photo can convey another message that these girls are at risk of contracting the virus because while enjoying themselves they can take alcohol and get involved in immoral behaviour there after contracting HIV/AIDS.*
*(Photovoice by Serena, female, age 15, Ulemu Private Girls' Boarding School)*

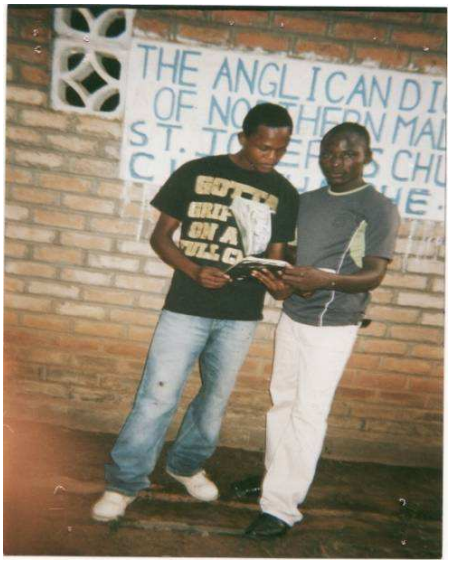
*I think we cannot contract the disease because we teach each other that doing this is bad and most of the teachers are females, nothing can happen. We have, Youth Alert. We discuss HIV/AIDS problems; how we can get it and how we can protect ourselves. (Melisa, female, age 15, Jenjewe Community Day school)*

**Figure 15. Group discussion**

*The photo shows adolescents discussing something an issue important. Maybe they are discussing about HIV and AIDS, about how they can avoid to contract HIV and AIDS. But this is also dangerous because there are equal number of boys and girls, maybe they can think of doing bad things in the end, like doing sex. This will make them vulnerability to HIV and AIDS.*
*(Photovoice by Thabisile, female, age 16, Jenjewe Community Day School)*
*The things that make me safe, ee…eeh! When I go to church we have The photo shows adolescents discussing something an issue important. Maybe they are discussing about HIV/AIDS, about how they can avoid to contract HIV and AIDS. But this is also dangerous because there are equal number of boys and girls, maybe they can think of doing bad things in the end, like doing sex. This will make them vulnerability to HIV/AIDS.*
*(Photovoice by Thabisile, female, age 16, Jenjewe Community Day School)*

*Some teachings which also sometimes encourage me, and I don't like to spend too much time with opposite sex, as I have already said. (Perani, female, age 18, Jenjewe community Day school)*

**Figure 16. Outside the church: Sharing the word of God**




*The photo shows two boys reading the word of God. This situation means that adolescents may not be at risk of HIV/AIDS because the word of the Bible always tells people to have good behaviour, for example, not to do adultery. (Photovoice by Kabela, male, 15, Chaphuka Government Boys' Boarding School)*

*Hmm!... Yeah! I can contract this disease by going to clubs at night. There if you drink too much you say anything, you just say 'yes'. So other boys are too clever, they give you beer and they tell you it is sweet and when you are drank they tell you let us have sex, then you just accept. So when we are at home we should avoid going to the night clubs; we should stay at home; we are still at school. (Sarisha, female, age 16, Jenjewe Community Day School)*

*Maybe I can say ma ujeni, ma bar or tavern aja, ndiye kuti anthu akapita kumenekuja when they drink nzeru zimatha and akhoza kupanga chinthu chilichonse, ndiye ma bar girls amene amakhala muja, nanga si ma bar girls aja amalandira munthu ali yense, maybe they can contract HIV/AIDSHIV/AIDS. (Maybe I can say, what? bars or taverns; so when people go there, when they drink, their reasoning diminishes and can do anything; so bar girls who work there, since they are prostitutes, they entertain anybody who comes there, maybe they can contract HIV/AIDS). (Sipho, male, age 18, Chaphuka Government Boys' Boarding School)*

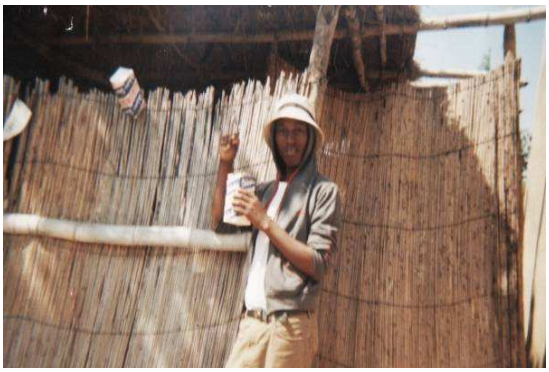


**Figure 17. An adolescent at a chibuku tavern**

*The photo shows an adolescent holding a packet of chibuku beer. The boy looks completely intoxicated that he decides to book a room at a rest house and sleep with prostitute. This means beer or any other alcoholic spirits may put adolescents at risky of sexual behaviours. It tells people that when a person is completely intoxicated either at the bar or somewhere that person might have unprotected sex with prostitutes hence contract HIV/AIDS.*
*(Photovoice by Thabani, male, age 18, Solola Community Day School)*

*Pano'pa sukulu ino inazingirizidwa ndi nkhalango, ndiye mwina popita ku nyumba utha kukumana ndi amuna munkhalango muja,*

*mwina iwe uli wekha ndiye basi akhoza kukufunsira nkuchita za chiwerewere kapena kukukakamiza kuchita za chiwerewere, nanga si uli wekha ndipo nkutchire. (As it is, our school is surrounded by forest and so sometimes when going home alone, you may meet a man in there who can ask you to have sex with him or even force you, but then you are alone and it's in the bush…)*

*(Female participant from Jenjewe Community day School during FGD)*

**Figure 18. Dangerous place /Temptations**

*This photo shows a boy and a girl holding each other tightly in a bush. This is dangerous because they may rise sexual feeling and have sex; but do they have a condom? Maybe no! they might having unprotected sex hence contraction of HIV/AIDS.*
*(Photovoice by Duma, male, age 17, Solola Community Day School)*

*Komanso poti sukulu yathuyi njo yendera, makamaka kwa asungwana, ndiye munjiramu akhoza kukumana ndi ma driver a galimoto, nkuapasa lift. Monga mukudziwira ma driver sangapereke lift mwa ulere ai!! Mapeto ake nkumunyenga musungwana uja kuchita naye za chiwerewere (But also because this is a day school, it's especially risky for girls who might meet truck drivers on the way and offer her a lift. As you know drivers can't offer one a lift for free. In the end the driver forces that girl to have sex with him) (Male participant from Solola Community Day School during FGD)*

**Figure 19. Truck drivers are bad**

*Truck drivers are indeed very bad in the spread of HIV/AIDS. They pass through different temptations on their way. They might sometimes sleep on the road when they have a break down or they are tired. And some respect themselves while others don't even respect themselves that they wish to*

*sleep with anyone mostly girls because they know that girls are easily attracted to the money they surrender to them. But it's not every girl's wish but it's because they want the money to help themselves in their daily living. In this process young girls get contaminated by this disease HIV/AIDS. (Photovoice by Melisa, female age 15 Ulemu Private Girls' Boarding School)*

#### *5.2.1.2 Theme 2: Adolescent perception of HIV/AIDS risky situations*

##### 5.2.1.2.1 Internal factors

*Adolescent sexuality development*

Adolescent learners realise their sexual development exposes them to risk of contracting HIV/AIDS, and at the same time acknowledge that sexual feelings are a natural part of their development. They consider failure to control their sexual feelings and attraction to people of the opposite sex as contributing factors to their risk of contracting HIV/AIDS. Below are some statements about how adolescents regard the development of their sexuality in relation to HIV/AIDS risk.

> *….chifukwa choti zimakhala kuti n'chilengedwe chao. Ndiye anthu amakhala, amalephera kuchita control chilengedwe, keneaka nkuyamba kuchita zinthu zoononga miyoyo yao. (It's like it is their nature; they fail to control themselves, then they start doing things that destroy their lives). (Sonia, female, age 16, Solola Community Day School)*
>
> *Komanso ndi nthawi yomweyo mathupi athu achinyamata amafika poti nkuganiza za atsikana, muthupi mwako zokhudzana ndi chiwerewere zimakhala zambiri. Zimene'zi zimapangisa kuti pamene umamuwona mkazi, ukhale attracted. (But also this is the time when we adolescents our bodies reach a point that we always think of girls and in your mind thoughts related to having sex*

*become tense.) (Kamashu, male, age 19, Chaphuka Government Boys' Boarding School)*

*Komaso tikanena body reaction zoti achinyamata ambiri body lawo limakhala active kumbali oti reaction yina yili yonse, kaya ngati wa chinyamata akucheza ndi – ndinene kuti mwina achinyamata akucheza ndi mkazi, umatha kuganiza zambiri mwinaso ukuyiwala kuti nkhani imene tikucheza pano ndi chani? Chifukwa cha basi! mtima wako umangokhala wa chilakolako choti tizipanga zogonana. (Also when we talk about body reaction that most adolescents their bodies become very active so that when a boy chats with a girl he thinks quite a lot and sometimes even forget the issue you are discussing. Reason? All you think about is to have sex with her.) (Nikwe, male, age 19, Chaphuka Government Boys' Boarding School)*

*Chimawapangisa a chinyamata kuti atenge matenda amenewa a HIV/AIDS ndi chifukwa choti ma sexual feelings amatipeza achinyamataifeyo; chifukwa choti timapeza ma sexual feelings. Ndiye ma sexual feelings aja akatipeza timafuna tikwanilise, kuti mthupi mwanga sindikupeza bwino, koma nditagonana ndi msungwana mwina ndikhoza kukhala bwino bwino. Ndichifukwa choyamba achinyamata amatengera matenda a Edzi (What makes adolescents to contract AIDS it is because of sexual feelings which attack us; because once we are attacked by sexual feelings, we want to accomplish the desires; we don't feel well until we have sex with a girl. This is one of the reasons we youth contract AIDS). (Thabani, male, age 19, Solola Community Day School)*

#### 5.2.1.2.2 School-related contexts

*Peer pressure/influence*

Much been documented about the influence of peers on adolescents' risky sexual behaviours, (See 2.2). Learner participants expressed varying degrees

of peer influence, ranging from mere imitation of what others say and do, to being forced or coerced to conform to the demands of the peer group. Girls were the most susceptible to peer influence, reporting that they are influenced by what their friends tell them to do and hence try to imitate their behaviours. Boys, on the other hand, reported intense pressure from their peers to conform to the latter's behaviour. The pressure takes the form of teasing or ridicule. Girls reported pleasing a friend as a motivating reason for conformity. Volitional imitation seems to be more influential among girls than boys. Girls also spoke of the pressure that girls from poor families have from their counterparts from rich families to engage in sexual relationships in order to obtain material goods. The following excerpts illustrate the impact of peer pressure on adolescent risky sexual behaviours.

**Figure 20. Desk- mates**

*In this photo there are two girls who come from different homes and they are learning at the same school. These two girls are coming from different background, one girl comes from poor family and the other one comes from the rich family, encourages her friend to find a boy friend which can make her friend to get HIV/ADS*
*(Photovoice by Ngesi, female, age 16, Ulemu Private Girls' Boarding School)*

*It's like… momwe panopa (now) we "ma" youth, we have hard times, like mwina anthu ena (maybe other people) we fall for peer pressure, like mwina (maybe) I have a friend who is doing this, inenso (I say me too) let me do that----Mwina (maybe) let me sleep with that guy, chani, chani (this! and that!)! Or some people do just to please someone not to please yourself but you have to please a friend, Yeah..! Peer pressure***! (***Nene, female, age 15, Ulemu Private Girls' Boarding School)*

*I can say it's peer pressure! peer pressure basi! Kumakhala ukuona anzako kuti, my friends are doing that, and why not me? And fashion, people say it's fashion; most people it's fashion, because….matsiku ano sikufuna kutsalira munthu, umafuna upange zinthu zoti inenso ndi dziwike poti ine ndioneke. Matsiku ano anthu amangoti hii! ngati si uli ndi boy friend, siupanga zibwenzi ati ndiotsalira m'mbuyo. Ndiye munthu ukakhala kuti maybe you are in a group of people, eeti!, si ufuna kuti ndikhalire, ufuna kuti udziwike pa level yimene kuli anzako; izi simapangisa ndiye I think those are the things zimapangisa kuti anthu achite behave like that, ndicho chifukwa Edzi ikufala umm!*

*(I can say its peer pressure, peer pressure, that's all. It's just like maybe imitating others, my friends are doing that, why not me? And fashion, people say it's fashion; most people it's because nowadays one doesn't want to remain behind, you want to do things so that you become well known so that I am famous. These days, people say Hii! if you don't have a boy friend then you are remaining behind. So if you are, for example, in a group of people, eeti! you don't want to remain behind; you want to put yourself at the level of your friends. I think those are the things that make adolescents to behave like that and this is the reason why AIDS is spreading fast among the youth uumm!)* **(***Ngesi, female, age 16, Ulemu Private Girls' Boarding School)*

*Uhmm! Sometimes you want… like you want to please your friend, like if all your friends have boyfriends, you want be part of that group, so you start doing this and that, you don't really want to do that but its peer pressure; your friends are pressurizing you to this. Ndiye zimakhala penapake zobvuta kuti wekha ukhale sikufuna. Komanso nthawi zina zimakhala zobvuta chifukwa, anzako onse, they are doing. Umakhala ngati ufuna kupanga zamuchigulugulu. (So at times it becomes difficult that you alone you don't want. So sometimes it becomes very difficult because all your friends they are doing. It is like you are doing blindly through group influence). (Phindile, female, age 16, Ulemu Private Girls' Boarding School)*

*Actually, ah! I must say, these people most of the adolescents it is because of peer pressure, kutengerana kwambiri, and anyamta ambiri timanyadirana, ine ndili ndi chibwenzi nanga iwe bwanji ulibe chibwenzi ahh! Ndiopepera, and as a result, you have an inferior complex that ah! Mzanga'yu ali ndi chibwenzi nanga ine bwanji? (copying from others too much! And most youth we feel proud of each other and boast that I have a girl friend, what about you? You don't have one? It means you are weak and not a man!).*

*(Kabela, male, age 15, Chaphuka Government Boys Boarding School)*

*I think the friends- the group of boys you are hanging with. There are some boys, they are just testing you, they are… they want to see how you can react; they can, maybe just ask you "Do you have a boy friend? and such kind of questions", and you can say more stuff, and they will convince you, tell you like have a boy friend, tell you lies, they always tell you the advantages, likes it's good, it's like that! but they won't tell you the bad things, and they will force you to have one. And because you want to be right, you want to make order with your friends, you want to make them happy and you don't think of yourself. (Ngesi, female, age 16, Ulemu Private Girls' Boarding School)*

### *Inter-school meetings*

Schools organise inter-school meetings for a variety of reasons, such as sports, entertainment and educational visits. Often these are organised during week ends. Learners travel either by hired transport or on foot. While these meetings are initiated with good intentions learner participants reported that at times these events present HIV/AIDS risks. Learner participants for example reported walking back home late from sports gatherings as especially risky since they maybe tempted to engage in sexual activities on the way under cover of darkness. Learners are especially worried that such sexual encounters tend to be unplanned and mostly occur without protection. Learner participants from single sex schools indicated that they are the most vulnerable, especially when they have meetings with learners from the opposite sex. Presumably due to excitement at seeing learners of the opposite sex, they tend to establish relationships purely for sexual purposes. Participants have the following to say:

*Ndikuona kuti njila yimodzi yoti nkufalitsa matenda a AIDS ndi ma trip. Mutha kukwera m'basi yimodzi anyamata ndi atsikana. Mwina*

*mukabwerako usiku. Ndiye m'mawa mutha kumva, "andi ng'ambira pant!" Ndiye funso ndoti Anan'gamba bwanji pant? Ndiye kuti mwina nawe unali ndi chilakolako kuti mwamuna akukhuze! (I see that one way of spreading AIDS is through trips. You may all board a bus when going boys and girls; maybe you will come back late. So the following morning you hear complaints like" He has torn my pants!" Now the question is how did it happen? It means you too had the desire for the man!). ( female participant from Sololа Community Day School during FGD)*

*Mwina mwake ma outings ndiononga. Chifukwa tikakhala pa campus pano, chifukwa ndi sukulu ya anyamata okha-okha, timakhala ngati nkhuku zili mu khola. Tsopano tikangotuluka, yimakhala ngati ndi advantage. (Outings are destructive because when we stay on campus since this is a boys school only we live like chickens in the battery cage. So when we go out it's like we take) advantage to do anything including having sexual intercourse or doing this and that which can put our life at risk. (Male participant from Chaphuka Government Boys' Boarding School during FGD)*

*Komanso tinganene kuti ku mpira, mwina tikamenya mpira ku sukulu yinayo, zimapangika kuti pobwera ku mpira kumakhala usiku ndiye chifukwa cha usiku uja mukati mwayamba kuyenda awiri-awiri, zimapangisa kuti aliyense akhale omasuka, chifukwa si mukuonana pa nkhope, mwina akumugwililira mtsikana, kapena mtsikana atha kumugwililira mwamuna, ngati alibe mphamvu, mapeto ake mupanga zinthu za chiwerewere popanda ku yuza ma kondomu, mapeto ake ukupezeka kuti watenga matenda. (But talking about sports, maybe we go to play football to another school and it happens that we come back late in the evening. You start walking in pairs, a boy and a girl. Since it's in the dark you feel relaxed that people don't see you and you maybe tempted to have sex or even rape the girl without using a condom in the end*

*you get AIDS). (Kamashu, male, age 19, Chaphuka Government Boys' Boarding School)*

*Zina za social zimene ndi kuziona ngati ndi pano, ndi monga kukabwera sukulu yina, let's say kwabwera Ulemu, kwabwera the Angels, ndiye tikacheza cheza, tikalowa mu holo, kumakhalanso ngati ka disco, kukhala ndi ti ma show – variety show, ndiye kumakhala kubvina m'nyamata ndi msungwana. Nazimene zonso ndiye zimakhala zikhoza kupanga kuti munthu atenge HIV/AIDSHIV/AIDS chifukwa sungalola kuti msungwana ungobvina naye nkumusiya azipita, zimapweteka. (Some of the social events are like when we have learners from Ulemu School. So after doing all that they came for at the end we do have a variety show or disco. These too can make us contract HIV/AIDS because a boy cannot accept to just dance with a girl and leave her go; it pains.) (Nikwe, male, age 19, Chaphuka Government Boys' Boarding School)*

### *Sexual harassment/abuse in schools*

Generally, sexual harassment appears to be under-reported. Participants indicated that not much sexual harassment takes place within the school premises but away from school. However, what has been reported tends to point to a deep-rooted problem. Indications are that girls are the main victims of sexual harassment from boys and male teachers. Sexual harassment by boys takes the form of touching body parts of girls and using obscene language, while that of teachers includes sexual acts of some sort. Girls are articulate about sexual harassment by male teachers. Other forms of sexual harassment reported by girls include pressure to have sexual intercourse with boyfriends as proof of love. In most cases it is not a boyfriend from the same school, and such encounters take place during the holidays at their homes. The following is what learners say about their experiences of sexual harassment in schools:

*Kumbali ya anyamata kuti kusukulu kunoko eti! nkumati kumagwira gwira atsikana, nanga si anyamata amakhala ndi ma feelings kwambiri kuposa atsikana ndiye atha kumugwira- gwira mutsikana ndiye pa mapeto pake atha kumugwililira m'tsikana uja. Mtsikana oti sam'dziwa mwina mwakeso osagwiritsa chishango makamaka pano pa sukulu sizimachitika koma m'mbali'mo zimachitika kwambiri. (On the side of boys, here at school eti! the practice of touching girls, since boys tend to have more sexual feelings than girls, it's possible at the end of touching the girl to rape her. This maybe a girl that you don't really know her background and sometimes not even using condom. Here at school this does not happen but away from the school it happens). (Thabie, female, age 16, Solola Community Day School)*

*Maybe I can say, like here at school, there are some of the boys, who come to the girls maybe touching them; this can be dangerous. Maybe this can make someone feel some bad mind. At the end one can think about sex. (Sipho, male, age 18, Chaphuka Government Boys' Boarding School)*

*Ngati kwa ine ndikuona kuti AIDS yikufala kwambili pa sukulu pano chifukwa a phunzitsi a pano ndi mahule. Amakonda kunyenga ana, atsikana. Amawaudza kuti ukandibvomera siusauka kanthu, ndidzakupasa izi ndi izi. Choncho a tsikana otengeka ndi ndalama amalora. Choncho AIDS yikufalikira–falikira chifukwa a phunzitsi ndi mahule. (For me I see that AIDS is spreading fast because teachers here are fond of having sexual relationships with girl learners. They tell them if you accept to sleep with me you will not lack anything; I will give you this and that. Since girls are easily taken up by money, they accept. In so doing AIDS keep on spreading). (Female participant from Solola Community Day School during FGD)*

*Eerr! Ah! ……And also there are teachers, they say we will pass examinations if we sleep with them. (Sarisha, female, age 16, Jenjewe Community Day School)*

*Umm! ndiye chinanso chimene tipanga nkupeza HIV/ADS kwambiri eee! Ndi zinthu zoti ngati umm! when you have ahh! maybe a boy friend, he is forcing you to sleep with him, chani, chani, ndiye munthu sumakhala ndi choice kuti… Komaso ukakana, chitha chibwenzi, ndiye njira yoti tingatengele Edzi zambiri koma yimeyi ngati yogonana ndiyo kwambiri. (The other thing that youth do which spreads AIDS fast are things like umm! when you have ahh! maybe a boy friend, he is forcing you to sleep with him, and this and that, then you seem not to have a choice that… but also if you refuse the relationship will end, so although there are many ways by which we can contract AIDS but this one, through such sexual intercourses.) (Serena female, age 15, Ulemu Private Girls' Boarding School)*

### *Other School-related contexts*

Learner participants reported a number of other school-related contexts that put them at risk to HIV/AIDS. For example, Khoza felt that being at a famous school makes him the centre of attraction for girls during the holidays, which puts him in temptation to have sex with them. Similarly, Kabela felt that achievement at school in class work, sports and drama also puts one in the limelight, exposing one to many girls which can constitute a temptation. Other contexts mentioned by participants include: the sharing of bathrooms at a boarding school; watching pornographic films; the teaching of sexuality issues in subjects like life skills and biology; the seating arrangement that puts a boy in close proximity with a girl; and the practice of hugging especially members of the opposite sex. Participants also reported that learners of the opposite sex staying in lonely places poses a risk as they maybe tempted to have sex which maybe un-protected. All these are perceived as risk factors

to HIV/AIDS. The following represent the other perceived risk factors related to school:

*……..you know this school is well known in Malawi, so it means that when we are going home for holidays, girls, when we are arriving, they do give us support and in turn a lot of girls are looking for us, so sometimes we can fall under what? under temptations! and do that yeah! (Khoza, male, age 17, Chaphuka Government Boys' Boarding School)*

*Ndiye atsikana ambiri even nowadays, kuti mnyamata amene'yo akhale chibwenzi changa, amatengela kutchuka. Monga munyamata uyu akukhoza m'class, munyamatu'yu amamenya mpira, munyamata uja apanga zakuti zakuti, kapena akupanga za ma drama- chili chonse akupanga munthu kuti azitchukirapo, afuna atani, akutsatire cholinga chake, achukire pa iweyo; ndizimene akufuna as a result anyamata amalowa mu relationships. (Kabela, male, age 15, Chaphuka Government Boys' Boarding School)*

*Ma feelings athanso kubwera ngati muli kumalo obisika. Komanso ngati mukuonera ma pictures olaula (pornographic), ma feelings atha kubweranso. Makamaka ngati mtsikana ali pafupi, akukhala ngati akuonjezera moto (laughter!).Koma tikuphunzira kuti ma sexual feelings tikhoza kuchita control. (Sexual feelings may come if you are in a secluded place, but also watching pornographic pictures, especially if there are girls close also watching the film, this adds fire (laughter!) But we are taught that we can control our feelings). (Male participant from Solola Community Day School during FGD.*

*Ahh! I think of bathrooms. Uhh! they are not taken care of, especially during the week-ends. We ourselves, we don't take care of our bathrooms. We girls we do have our periods uhh! So I*

*think…… we are not safe! (Female participant from Ulemu Private Girls' Boarding School during FGD)*

*Chinanso ndi monga ma subjects ena monga Social Skills, momwe muli ma topics okhuzana ndi sex, kapena za momwe mabanja amapangikira. Zime'zo momwe amazifotokozera a phunzitsi zimapangisa kuti ife tichite develop ma sexual feelings (laughter!). Ndiye pamene m'nkatuluka kupezana ndi mtsikana umalakalaka utamfunsira (laughter!). (The other thing is subjects like Social Skills and Biology where there are topics related to sex or the way families start. These subjects, the way topics are explained make us develop sexual feelings (laughter!). So by the time you come out of the class and meeting a girl you develop the desire (laughter!) to try it out! (Male participant from Jenjewe Community Day School during FGD)*

*Ndikufuna kunena za class arrangement. Zikuchitika kuti pa (I want to talk about class arrangement. It happens that on the) desk there is a girl beside you. As you know we male sometimes are full of charge, we can not resist temptation. (Male participant from Solola Community Day School during FGD)*

*Ine ndikufuna kunena khalidwe liri pano la ku hagana (hugging) limene likhoza kutiwika mu mayesero. Mtsikana mukhoza kuhagana kwa nthawi yayitali (laughter!) ndiye mukhoza kuchita develop ma sexual feelings, keneka nkuganiza zokachita chiwerewere. Hagi mpaka 2 hours; izi ukhoza kugwa nazo m'mabvuto (laughter!). (I would like to mention the practice of hugging each other which is very common at this school. This hugging can easily put us into temptation. You may hug a girl for a long time (laughter!) and in the process develop sexual feelings, thereafter thinking of sex. This prolonged hugging can lead us into serious trouble! (laughter!). (Male participant from Solola Community Day School during FGD)*

#### 5.2.1.2.3 Home and society as providing un-safe environment

*Home environment perceived as unsafe space*

While on the issue of awareness of what constitutes a safe environment, participants reported parents as providing a supportive and guiding role in HIV/AIDS prevention, but the location of their homes and lack of good role models around their homes were perceived as risk factors. Lindiwe describes what looks like an everyday scene that she experiences by being close to bars located near her home where men flirt with women. Thabani, Zondi and Nikwe are all concerned with the bad role models they encounter, all of whom display risky sexual behaviours. Participants claim that youth do what they see their significant others do. This is what they say about their experiences in the home environment:

> *Kumene ndimakhalira kulinso ma bala. Ma bala ngapangisaso ifwe achinyamata kuti tito matenda, chifukwa, chake nchakuti vyo: mwamsaniya kuti pe bala, si kubala kukusangika anyamata, asungwansaso mahule aja nunkhu? Ngaja kwenekuwa eeh! Mwamusaniya kuti kuwa amwengi mowa, amwengi mowa anthulume ndi vimabara-girl vija, pakumalira pake mbwenu achitanji? ku chigonana. Agonana kwambuwa kuchiteteza, kugwiritsa ma kondomu cha! Aaha! mbwenu matenda ngachitanji? Awasaniya. (Where I am staying there are bars. These bars also make us youth to contract AIDS because; the reason is that at the bar there are found boys and girls; prostitutes there. You will find that they will keep on drinking beer with those prostitutes in the end what do they do? They do sex. They do it without protection, without using condoms. Aaha! then they have contracted AIDS). (Lindiwe, female, age 19, Solola Community Day School)*
>
> *……..Nyumba yathu ili pafupi ndi bar, ndiye ukuwona zotchitika pa bara'po, ukawona munyamata ndi msungwana ali penapake,*

*akunjoya, ndiye nawe umatengeka, ndiye kuganiza kuti nane ndikayetsere. (Our home is close to a bar and so we see what's happening at the bar. You see a boy and a girl are somewhere there enjoying themselves, and so you too get carried away thinking that you should also go there and try). (Male participant from Jenjewe Community Day School during FGD)*

*Yayi! M'dera m'mene timakhala umu zinthu zomwe zimapangisa kuti ife a chinyamata tichite za chiwerewere ndi zoti ngati kholo likukupasa chithunzi thunzi chabwino iweso umatsatira chimenecho, koma ngati kholo limatsogolera kuchita za chiwerewere naweso umati yayi "like father like son", umatsatira zimenezo. Mowaso ukhoza kuwatanganisa. Kumene ndikukhala ma bara aliko. Achinyamata mowa ukhoza kuwagwetsera m'mabvuto ndi kutenga nthenda yimene'yi ya Edzi. Chifukwa choti muthu ngati wamwa mowa, mowa uja umapangitsa munthu ulezele usadziwe chomwe ukuchita kaya mkazi akhoza kubwera, iwe chifukwa siukudziwa china chili chose, wabalalika ndi mowa, umangogonana naye. Pamene paja watenga kachirombo koyambisa matenda a Edzi. (In my area where I live, things that make us youth to engage in risky sexual behaviours is when we see older people showing good example we tend to follow, but if the older people are the ones engaging in risky sexual activities, you say well "like father like son". You do the same. Again beer can confuse people. Where I live bars are there. Youth, beers can lead them into problems of contracting this disease. The reason is that once one is drunk reasoning goes away and can sleep with any woman that comes by thereby contracting HIV). (Thabani, male, age 19, Solola Community Day School)*

*Kwa ifeyo ngati achinyamata, tikhoza kuonongeka ndi m'tchitidwe umene umachitika ndi amene ali akulu akulu kuposera pamene tili ifeyo. Chifukwa ngati ena am'mabanja'wa amatha kusiya ana*

*awo ali m'nyumba, iwo nkupita ku ma bara ndi kukayenda yenda usiku, kumangopita m'malodge kumangopanga m'chitidwe oipa ngati umene'wu, as a result ana ngati ifeyo timatha kuonera kuti kholo langa ngati likuchitaizi, or mkulu wanga ngati akuchita izi, kuli bwanji kwa ineyo kulephera kupanga zimenezi, inenso ndikhoza kupanga. (For us youth, our lives can easily be destroyed by the behaviour shown by people who are older than us. This is because if those people who are married leave their families and go into bars, moving up and down in the night, visiting lodges and doing all the dirty things like these, what more with us. We will say if those I respect as my elders conduct themselves like this, what more with me, I too, should just do the same). (Zondi, male, age 17, Solola Community Day School)*

*Environment ya kwathu pakali pano'pa ndizoti mwina upeza ka mtsikana kakang'ono chonchi kakuyenda ndi munthu wa mkulu, munthu oti amayenda ndi mahule, mbiri yakeso ndiyoipa. Ndiye ine ndikaona ana ngati amene'wa akugonana ndi anthu akulu-akuklu ndimazifunsa m'mtima kuti aah! Mwana ngati uyu ngati akulolana ndi amenewa, azibambo oti ali ndi ana awo, ndiye kuli bwanji ineyo? Akhoza kukhala ndi matenda, as a result ndimazipanga control kuti ineyo ndisapitako, ndikangozitengerako. (The environment at my home is that sometimes you will find a small girl going about with an old man, a man who goes about with prostitutes and his reputation is very bad. So me, when I see little girls like that sleeping with old people like these, who have children, then what more with me? She may have a disease and so I control saying I shouldn't go there!). (Nikwe, male, age 19, Chaphuka Government Boys' Boarding School)*

### *Poverty as a risk factor*

Like peer pressure, poverty has been widely cited as a risk factor which contributes to contracting HIV/AIDS, especially among girls (See 2.2.5).

Participants reported that girls, especially those who come from poor families, engage in transactional sex with boys or men to get money for their needs at school. It becomes worse when they mix with girls from rich families who have good clothes. The poor girls feel envious of the other girls and would like to be emulate them. This drives them to look for men. Yet even those who come from rich families have their own desires for more and better clothes. They, too, turn to having sex with rich men for money. Participants also mentioned tourists, both local and international, as contributing to the spread of HIV/AIDS because they sleep with local girls and women, especially the tourist guides. Local tourists are known to go with young girls from the town, some of whom are adolescent learners. But for Zondi (See Fig. 26) tourist lodges could be profitably used by adolescents as places of recreation and relaxation. Participants' concern with tourist guides is that the guides' low levels of education make them even more vulnerable to exploitation by tourists. Truck drivers and fishermen, who are quite common in the area, have also been reported as culprits in the spread of HIV/AIDS. Since they always have money, they entice school girls to have sex with them. Also, on the day when the "Ilala" passenger boat docks at the bay, a lot of people converge there and this breeds a conducive environment for interaction between people, including sexual encounters with visitors, businessmen, and the ship's crew. All this happens because of poverty. The following reports and photographs by participants demonstrate their understanding of poverty as a risk factor to HIV/AIDS.

> *In lakeshore here, many girls are coming from poor families, they lack help from their parents, and as a result they think that it's better to go with the boys who can help them to have their needs. As such many girls can be attracted to boys, but those who don't know whether they have HIV/AIDS or not, yeah! like that! (Bruno, male, age, 18, Solola Community Day School)*

**Figure 21. The Power of Money**

*The photo shows a boy giving money to a girl. The boy is giving money so that the girl can buy her basic needs such as clothes. This may also mean that the boy is in a relationship with the girl. By giving her money the boy will need something back in terms of sex. Relationships aiming at receiving gifts like money make adolescents more vulnerable to HIV/AIDS.*
*(Photovoice by Sipho, male, age 18, Jenjewe Community Day School)*

*Okay! actually it is, maybe there are some people who are coming from poor families, more especially girls. If they saw uum! their friends they are in good dressing yeah! they feel that they are inferior yeah! so they want to be like those people. So they may think ah! it's better to go to the bar and make money. (Duma, male, age 17, Solola Community Day School)*

**Figure 22. Young fishermen are vulnerable to HIV /AIDS/ Fishing as a dangerous business**

*Three young fishermen along the lake and one of them is holding fish in his hand. Adolescent fishermen meet several people to buy fish. As a result women are easily attracted to these fishermen to buy fish at cheaper price. They will try to propose these adolescents to have sex with them to get fish at cheap price, therefore are easily vulnerable to HIV/AIDS. Also adolescent girls may not have money to buy the fish, so that fisherman would ask the adolescent girl to have sex with him. An adolescent would have no choice but to have sex with him to have the fish. (Photovoice by Kamashu, male, age 19, Chaphuka Government Boys Boarding School)*

*Maybe like some people come to take girls they give them money to do sex with them. Some girls are very interested with money so they get the money and they go to do sex with them. (Sipho, male, age 18, Jenjewe Community Day School)*

*Ahh! These students they do so because some of them, their parents are poor so.... when,... so when coming here at school be seeing that some of their friends are dressing in good clothes, shoes and good school bag, they have a desire that them too should have these things and you start to do things which are sexual, to find a boy so that you can get some money to buy like those things. (Perani, female, age 18, Jenjewe Community Day school)*

*Komanso ma tourists ndio amenenso ama falitsa matenda a AIDS. Akati akabwera, ma tourist guide amaatenga nkuyenda nawo, kuwasonyeza malo. Pokopeka ndi ndrama zimene azungu alinazo, atha kugonana nawo, ndiye osadziwa kuti munthu uja ali bwanji, nkutola AIDS. Azungu aja akapita, tourist guide yuja nkuyamba kufalitsa AIDS kwa ena. So, ma tourist guide amafunika ma phunziro*

*a HIV/AIDSHIV/AIDS kwambili, chifukwa ambiri mwa iwowo ngosaphunzira kweni-kweni. (But also tourists, they are the ones spreading HIV/AIDS. When they come here they are taken by tour guides showing them places. Attracted by the money they offer, these tour guides sleep with them and they contract AIDS in the process. When these white men have gone, the tourist guides begin to spread the disease to the local girls; these tourists need HIV/AIDS messages a lot, but mostly because most of the tourist guides are not educated). (Male participant from Solola Community Day School during FGD)*

**Figure 23. Adolescents in town**

*Boys and girls in town seem to be very free which can make them to engage in behaviours that may make them contract HIV/AIDS since they maybe copying bad behaviour from their friends (Photovoice by Nikwe, male, age 19, Chaphuka Government Boys' Boarding School)*

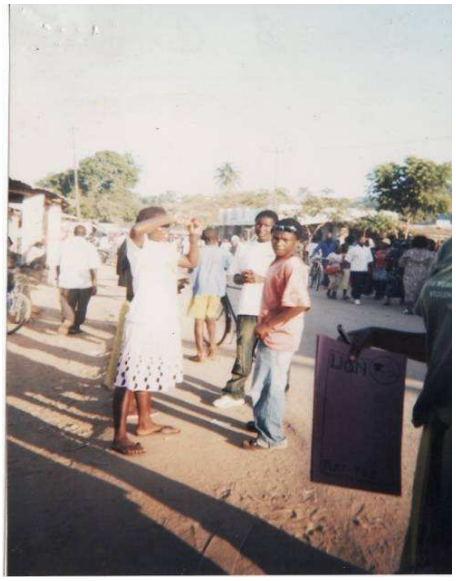


**Figure 24. Attractive place: a lodge**

*This photo shows a beautiful lodge on the lake shore where people come to enjoy with other people.. Many people from different places especially from far away come with young girls (adolescents) to enjoy with them. At the end they can have sex. This can result to contract HIV/AIDS. This place is beautiful, I am sure it's visited by people from outside the country too; and they come with attractive things and money which may attract young girls. As young girls are attracted they can have unprotected sex, as a result they can get HIV/AIDS. (Photovoice by Zondi, male, age 17, Solola Community Day School)*

**Figure 25. Spending time wisely.**

*To others a beautiful lodge like this one it is where adolescents spend their leisure time reading and enjoying themselves not to thinking about sex. So they are prevented from contract AIDS*
*(Photovoice by Zondi, male, age 17, Solola Community Day School )*

*Cultural practices*

Earlier on I discussed the various cultural practices (see 2.2.7) that prevail in Malawi, some of which predispose adolescents to HIV/AIDS. Since my participants came from all three regions of the country, they reported cultural practices from their respective homes which they consider put them at risk. Participants cited traditional dances, such as "chilimika", "adole" and "vimbuza"; initiation rites such as "kuchotsa fumbi" or "fisi"; practices such as

inheritance "chokolo"; use of surrogate husband "fisi"; and widow cleansing "kuchotsa fumbi". Participants acknowledge that these practices are harmful. One female participant was concerned with the lack of HIV/AIDS messages in the villages where these cultural practices, especially the "chilimika" dance, are followed.

What follows are their voices concerning cultural practices:

> *Mwina za chilimika, chioda ndizo zimapangitsa kuti matenda afale. Chifukwa ambiri amene amakonda kuvina ndi ana. Ana ndiwo amachuluka mwinanso akulu-akulu okhala ochepa. Mwina ankavina kutali monga cha uko! Kumeneko amakhala mwina mazuwa angapo. Kugona, amakagona mwina wina atenga m'modzi, wina m'modzi. Komanso kumeneko kumakhalaso anyamata ndi amuna okowonelera kuvina ndiye kudziletsa kumalephera, mapeto ake nkuchita za chiwerewere. Tikawonesetsa ambiri amene akubvina chilimika ndi atsikana ochokera m'midzi, choncho m'midzi simukukhala anthu kuti afalitse mauthenga a AIDS. (Maybe about chilimika and chioda, these are the ones that spread HIV/AIDS, because those who participate in this dance are mostly young girls. It is mostly young girls although older people attend. Sometimes girls go to dance far away from their village. There they may stay maybe a couple of days. Sleeping they sleep with their female partners. But there are boys there too and so self control becomes a problem, in the end they engage in sexual intercourse with the boys or men there. A careful observation shows that those who dance chilimika come from rural villages where AIDS messages do not reach). (Female participant from Solola Community Day School during FGD)*

> *Pa nkhani ya chilimika. Amuna amakhalanso mukatimuja. Choncho akazi akawakhudza ndi ma "breasts" (laughter!) nawonso amuna nkubwezera kuwagwira akazi aja ma bumbu*

*(laughter!). Chonco chilakolako nkubwera, pomwepo nkuganiza za kugonana. (On the issue of chilimika, men also enter the dancing arena. So when girls brush them with their breasts, men retaliate by touching their buttocks (laughter!). In so doing, they arouse sexual feelings and begin to think of doing sexual intercourse). (Male participant from Solola Community Day School during FGD)*

*Pali gule wina timati "Adole". Gule ameneyo amaseweredwa usiku ndipo izi zimapangisa kuti amene ali ndi zibwenzi zawo amapita kuja ngati ankawona gule ndiye mtsikana agwirizana ndi m'nyamata kusiya gule nkukapanga za chiwerewere. Komanso pali gule wina, monga wa "Zimbuza" kumene. Zimatheka kuti zimbuza zija zimabvinidwa usiku. A nyamata amapita ku zimbuza kuja si kuti akupita kuzimbuza kukaimbira odwala uja ai! Koma akupita kuja ndi cholinga choti kuja akatani! akagoneko ndi kupanga za chiwerewere. (There is a dance called "adole.")This dance is practiced in the evening. This encourages those who have boyfriends or girl friends to go there. While there, they leave the dancing venue and go elsewhere to do sexual activities. But also the dance of zimbuza, there it happens that zimbuza too is danced in the evening. Youth go there as if they will assist the vimbuza patient with drumming and singing. But they go there with the aim of meeting their boy or girl friends and sleeping with them. (Kamashu male, age 19, Chaphuka Government Boys' Boarding School)*

*One of the cultural practices I hate most is like initiation ceremony- when a girl has come of age, women go round the villages, like advertising, ululating and telling people that this girl now has become of age. To the youth that message is misinterpreted to mean this is now mature and you can do whatever you want with*

*her. (Bongani, male, age 17, Chaphuka Government Boys' Boarding School)*

*There are practices such as "kuchotsa fumbi". Girls are encouraged once they have done their first monthly period or have reached puberty, to say at this moment you have reached puberty, someone should come in and see if you are really reached the puberty stage. And they may call a man whom they don't know how he is and doing sex with the girl. And if the man has HIV she may also get the HIV, yeah! Also the practice of inheritance "chokolo" "kulowa kufa" here in Nkhata Bay. Sometimes boys are encouraged to inherit their brother's wife and maybe his brother has died with HIV, they say ah! there is no problem you can inherit this one. As such he may also get the HIV. (Bruno, male, age 18, Solola Community Day School)*

### *Media as risk factor*

While the media is renowned for its power to facilitate behavioural change among the youth, it also has the power to institute or reinforce risky habits. Participants reported that watching pornographic films, viewing images on cell phones and the internet and TV soap operas can influence adolescents to engage in risky sexual behaviour. Adolescents like to imitate and practise what their idols are doing. The following demonstrate how adolescents view the negative influence of the media:

*Komanso nthawi zina ma filimu, tikhoza kuonera kunoko, kapena, zi magazine chabe zikhoza kumapangisa influence kuti ndikathe kupenza chibwenzi kuti ndizigonana nacho. (Sometimes films which we do watch here or magazine; these influence us to look for a sexual partner). (Nikwe, male, age 19, Chaphuka Government Boys' Boarding School)*

*Chifukwa kuona ma flm olaula mumakhala ngati mwachotsa za ku chipinda kudzionetsa panja. Chimenechija chimapangisa munthu*

*kuti….kuti wayambe kufuna-funa mtsikana amene ali pafupi ndi sukulu yawo. Mapeto ake mwina amapezeka kuti watuluka kupita kwa mtsikana kuti akamuitane, akagonane naye chifukwa choonela ma film olaula. (Because watching pornographic films it looks like you have exposed the secrecy of the bedroom. This makes a person to look for a girl who is close to the school. In the end he finds himself going out of school bounds to meet the girl so that he can have sex with her). (Kamashu, male, age 19, Chaphuka Government Boys' Boarding School)*

*Ndimaona ngati anthu ambiri amazitengera monga pa TV; amaziona ku ma TV. (Melisa, female, age 15, Ulemu Private Girls' Boarding School)*

*Ine nyimbo. Nthawi zina anthu oyimba'wa amayimba nyimbo za love kapena zolaura (laughter!). Izi zimanditenga mtima. Komanso ma film monga BM, osonyeza zolaura; ukawonera basi ma feelings nkukumenya pomwepo basi maganizo ali ku atsikana. Komanso ma magazine. Ngakhale kuno ku sukulu su angaonere zime'zi, koma tikapita kunyumba ena amakhala nazo. (For me it is music. Sometimes these musicians play love songs or pornographic video music (laughter!). These disturb me quite a lot. But also films like BM which show pornographic pictures; once I watch them I immediately develop intense sexual feelings, and my thoughts are directed at a girl. But also magazines, although here at school we do not watch them, but at home; some do possess them). (Female participant from Ulemu Private Girls' Boarding School during FGD)*

*Komanso ndi ma modern technology, ma internet awa, nkupezeka kuti ena amakhala ndi ma cell phone, chifukwa m'maphone muja amapereka ma images, komanso nyimbo, chani, chani zamatsiku ano'zi. Anyamata ambiri amakhala kumvera nyimbo, zina atani! ajambula zolaula. (But also this modern technology, like internet or cell phones where there are images, songs and others which*

*adolescents can download. Many adolescents do listen to such music and also down-load pornographic videos). (Kabela, male, age 15, Chaphuka Government Boys' Boarding School)*

*Zimenezo zimachitka… maybe I don't know. Kumangokhala kuti they are exposed to too much media. Monga kunjaku zikuchuka kwambiri ndiye anthu amapangira kuti, people are doing it isenso tingopanga, kumakhala ngati kupanga zinthu m'chimbulimbuli. (What is happening is…. maybe I don't know. It's like they are exposed to too much media. For example, because in other countries such things are common, so they say we can also do them here; they copy foreign things blindly). (Phindile, female, age 16, Ulemu Private Girls' Boarding School)*

#### *5.2.1.3 Theme 3: Some controversies regarding what constitutes risky situations*

Sometimes adolescents are not as sure what constitutes risky situations for them and they even contradict themselves. Consequently participants engaged in a debate on a number of issues. I present some of the issues below.

##### *About mixed sex schools and single sex schools*

When asked what kind of school, single sex or co-educational, they considered safe, participants had varied opinions. Some indicated that being at a single sex school provides some security not to engage in risky sexual behaviours. Being at a single sex school, they claim, there is no way one can think of having sexual intercourse because, after all, there are no learners of the opposite sex at school. This view follows their understanding that sexual intercourse takes place in heterosexual relationships only, and does not take homosexuality into consideration. Others thought that being at a mixed sex school reduces tensions and anxieties that arise when meeting learners of the opposite sex since mixing with the opposite sex is commonplace. They claim that in a co-education school, you treat each other as brothers and sisters

and develop resistance to sexual temptations. Learner participants expressed their views as follows:

> *Kuja koti ajenge anthukazi pe, advantage, yake kuwengevye kuti iwe ndikukhumba! Iwe ndikukhumba! palive, nanga si muli anthukazi pe, mukhumbanengenji? Mwampanganji? Palive! Nchimodzi kuti aje anthulume pe, awonana ndi anthu kazi cha palive, Edzi palive! Kweniso kuja koti kuli anthukazi ndi anthulume nkhwamampha chifukwa choti alimbikisana eeh! (A girls' school only its advantage is that there will be nothing like "I love you! I love you!" there is nothing, after all you are only girls so what will you want from each other? What are you going to do? There is nothing! Similarly if the school is a boys' only, they don't see girls around; so there is no AIDS there. But also where boys and girls mix it's also good sometimes in that they may encourage each other on school work). (Lindiwe, female age 19, Solola Community Day School)*
>
> *Ah! Sukuku ino yingokhala single- yisakhale co-education (laughter!). Chifukwa kuti yikhale co-education, ndi anyamata momwe ndikuadziwira pano, momwe ndawa onera kuti pakadutsa atsikana apa momwe amachemelera, ndiye atsikanawo tizikhala nawo pompano, ah! Ndiye zinthu zidzabvuta kwambiri. Sizingatheke, yingokhala single. (Ah! this school should remain a single sex; it should not be a co-education (laughter!) Because if it were to be a co-education, the way I know these boys here; the way they stare and shout at the girls when they are passing by, and then to have them here, ah! things will turn worse; it can't happen; let it remain single sex school). (Nikwe, male, age 19, Chaphuka Government Boys' Boarding School)*
>
> *Okay! as for me, let me say this area, single education it's somewhere, somewhat it's bad, because nkupezeka kuti mwina you don't… chifukwa atsikana tikati tikakhala, we are there talking*

*about anyamata basi! monga kuti zibwenzi, chani, chani! which is not good. Koma kuti mukakhala pa sukulu ya boys and girls you are able to do debate pa zimene'zozo, eti! za ma youth. Mutha kukhalapansi nkukambirana za ma relationships and kusiyanisa kumva ma views a chinyamata akakhala ndi chibwenzi ndi mtsikana komanso maganizo a atsikana akakhala ndi chibwenzi ndi m'nyamata. Ndiye mukaphatikiza ma views, nkuona kuti Okay, kwa achinyamata zimafunika kupanga kuti ukhale kuti uzitsunge upange zakuti zakuti, komaso kwa atsikana upange zakuti zakuti. (Okay! as for me let me say this area, single education it's somewhere, somewhat it's bad, because it happens that maybe you don't…. because we girls when we meet, all we talk about is boys only, like relationships with boys and such other things, which is not good. But if we can be at a school where there are boys and girls you are able to do debate on such things involving the youth. You will be able to sit down and discuss about relationships and comparing views from boys when they have relationship with a girl but also views from girls if they have a relationship with boys. Then when you take all these views together you will see that, okay, for boys what is needed to do is this and this if you are to protect yourself but also for the girls you should do this and this). (Ngesi female, age 16, Ulemu Private Girls' Boarding School)*

*I think I would be safer at a co-education school, because where we are here like we are all girls, atsikana amakonda kukamba za anyamata, chani, chani… ndiye penapake anzako amakupanga influence eti! Koma ukakhala ku co-education eti! Umakhala kuti ..but at a co-education school et! your girls and boys, mumakambirana, you share ideas, ndiye it's better I think it's a lot better if you are at a co-education school. (I think I would be safer at a co-education school, because where we are here like we are all girls, girls like to talk about boys and such things…so somewhere*

*your friends influence you "eti"! But if you are at a co-education school "eti"! You're girls and boys, you discuss and share ideas. And it's better I think, it's a lot better if you are at a co-education school). (Phindile, female, age 16, Ulemu Private Girls' Boarding School)*

### *Relationships in schools*

Participants were asked about their views concerning relationships between learners of the opposite sex in schools, and whether they considered them as a risk factor or not. Again, different points of views emerged, with some saying relationships are healthy, especially if they foster cooperation and assistance with school work, and that not all relationships involve having sex. This is similar to the view expressed by Phindile, above, in connection with being at a co-education school. There were others who felt that any relationship between learners of the opposite sex is a risk factor (see Fig.27) because, they claim, there is no relationship that will not culminate in a sexual relationship, thereby placing each partner at risk of HIV/AIDS. Girls reported that relationships turn into sexual relationships because of the demands by boys for sex. So, in order not to lose their relationship, they give in to the boy's demands. Related to relationships in schools was the issue of single sex and mixed sex schools, with some participants expressing concern that mixed sex schools promote sexual relationships and hence the spread of HIV/AIDS. But others like Sipho (See Fig. 28) think that mixing learners of the opposite sex can be healthy for girls because they will come to know each other well and this could even up gender differences. This is what participants say about relationships in schools:

*Yeah! I believe kuti munthu ukhoza kukhala ndi boy-friend osapanga naye this sex stuff, chifukwa when you are doing that stuff it's like mukupanga zoti nonse mukufuna eti! It's possible. Chifukwa ngati iwe siukufunadi there is no way kuti angakukakamiza chani, chani, unless he's going to rape you. Koma*

*kuti zongofuna wekha ai! Ngati ukufuna you can have boy friend, inde a boy friend like a friend koma ai! You can still have a boy-friend but not do this sex stuff. (Yeah! I believe that one may have a boy-friend without doing this sex stuff, because when you are doing that stuff it's like you are doing things that both of you have agreed upon. Because if you, yourself don't want there is no way that he can force you to do sex or such things unless he's going to rape you. But of your own will, No! If you want you can have a boy friend, just a boy-friend like a friend. You can still have a boy-friend but not do this sex stuff). (Phindile, female, age 16, Ulemu Private Girls' Boarding School)*

*Chifukwa choti timaphunzira pamodzi ndi anyamata, ndiye anyamata aja atha kutipanga ise kuti tizipanga nawo zibwenzi ndiye pa mapeto ake tikhoza kuyamba zogonana, tikhoza kukhala ndi matenda chifukwa sitikudziwa kuti kaya uyu ali ndi matenda kaya alibe. (Because we learn together with boys, and so it's possible that these boys will ask us for relationship and so at the end start having sex and in so doing we may contract AIDS because we don't know the status of the boys whether or not they already have the disease). (Sonia, female, age 16, Solola Community Day school)*

*Yes! It is possible, chifukwa munthu ngati uli ndi mkazi mumatha kuyenda, kumakhala bwino-bwino, penapake ma feelings amakupeza kuti Eee! apa pokha ndiye zandibvuta. Komabe iwe wekha munthu umatha kudziletsa, kukhala ndi mtima oti ndingozisiya basi! kuyamba kuganiza zina. (Yes it is possible, because if you are in the company of a girl, it is possible that you can stay together very well although at times sexual feelings develop ee! And you would say, "Now I am in trouble!" But all the same you can control yourself, thinking that! let me just stop this!*

*and think of other things). (Zondi, male, age 17, Solola Community Day School)*

*Chimachitika nchoti, ngati munthu wa mkazi uja ndi mzako chabe koma nkupezeka kuti muli awiri mukucheza nokha kwa zii! kumangotheka kuti mutha kufunsirana kudzera mu chi friend chokha chija, nanga muti tiziyanganana, takhala nthawi yayitali, mutha nkufunsirana; ndiye zimakhalaso zinthu zolakwika kwambiri. (It happens that if the girl is just your friend but you find yourself in an isolated place, the two of you and for a long time, this mere friendship may develop into a sexual relationship and then engage in sexual intercourse, then this becomes a bad thing, because you would say, should we just be starring at each other? We have stayed long and we cannot ask for sex. And this becomes bad!). (Shivani, male, age 17, Chaphuka Government Boys' Boarding School)*

**Figure 26. Relationships**

*This boy is in a relationship with a girl and they have been photographed in the secret place in a jungle chatting. To me these people are to the disadvantages side with their relationship since in this place they can think of having sex and there is no hindrance since they are in a secrete place but on top of that one of them could be HIV positive which can lead to the spread of this pandemic. To others I pledge them to avoid this behaviour of chatting in the secrete places especially when you are in relationship when you are free of each other to play around with their feelings.*
*(Photovoice by Bongani, male, age 17, Chaphuka Government Boys' Boarding School)*

*What happens is that if the girl is just a friend but you will find that you are chatting it is possible that you might do sexual intercourse through the relationship. I think the main problem is that anthu amene'wa amakhala kuti sana khwime (such people are still immature) they think the only thing they can do in a relationship is sex and they feel like being in a relationship is all about sex; they don't know what to do apart from doing sex. You can have your girl-friend and you may have that decision that you will not have sex but because of the pressure from your peers they may press you to have sex with your partner even if you don't want. (Bongani, male, age 17, Chaphuka Government Boys' Boarding School)*

*Most of the relationships when they come into making those relationships, they think much about sex. Because they know that if I have a girl-friend, that means, they have a girl-friend for sex. Because… nkupeza kuti nthawi zina even I myself, I can have a girl-friend, koma ngati ineyo ndingocheza naye chabe that means I am not at risk of contracting HIVandAIDS Koma anyamta ambiri akamati ali ndi chibwenzi, amaoneka ngati (it happens that sometimes even myself, I can have a girl-friend, but if I myself just chat with her that means I am not at risk of contracting HIV/AIDS. But many boys when they say they have a girl-friend they see it as a sexual relationship). (Kabela, male, age 15, Chaphuka Government Boys' Boarding School)*

*Umm! sometimes it is possible sometimes it is not, Why? You can have a boy- friend …basi, just ngati, just ngati they handle boy-friend in different ways. Pali anthu ena amapanga handle chibwenzi, eeti! munjira zoti basi kupanga zogonana chani, chani; koma pali ena amachita handle chibwenzi basi kuti azingocheza. Koma kwambili when one has a boy-friend they talk about sex, whatsoever!! (Umm! sometimes it is possible, sometimes not, why? You can have a boy-friend just as a mere boy-friend as many do in*

*many different ways. There are some people who handle friendship "eti"! in ways that all they do is sex, sex and so on; but there are others who handle such relationships just for chatting. But in most cases when one has a boy-friend all they talk about is sex and whatsoever!). (Serena, age 15)*

Figure 27. Interaction among adolescents

*This photo shows interaction between a girl and three boys. In my opinion this kind of interaction is useful more especially to the girl. These boys know the tactics used to persuade a girl into sleeping with a girl so they may teach her on how to dodge the persuasions. This will prevent the girl to prevent sexually transmitted diseases, most especially AIDS. (Photovoice by Sipho, male, 18, Chaphuka Government Boys' Boarding School)*

*Not really, ku ngoti people take it that way chifukwa choti ndikophweka kuti munthu ali ndi chibwenzi afunsirane zo gonana. Chifukwa mwina munthu uja umamukonda, akuudza kuti tiye tipange zogonana, siungakane, chifukwa you want to make that person happy, then you do anything for him. Ndiye ukhoza kutenga matenda a Edzi. Koma munthu opanda chibwenzi nkobvuta kuti atenge Edzi kusiyana ndi munthu oti ali ndi chibwenzi chifukwa there are a lot of temptations which you meet in a relationship. (Not really, only that people take it that way because they find it easier to ask for sex from a girl-friend. Because maybe you really love that boy, and he asks you let's do sex, you cannot refuse because you want to make that person happy, then you do anything for him. And so you would contract HIV/AIDS. But for a person without a boy-friend it is more difficult to get AIDS than a person who has a boy-friend because there are lots of temptations which you meet in a relationship). (Nelisiwe, female, age 15, Ulemu Private Girls' Boarding School)*

*Seductive dressing and language*

With the advent of democracy and the observance of human rights in Malawi has also come freedom of dress. During the one-party dictatorship, the wearing of miniskirts and tight pants by girls, and long hair on men was banned, whereas the new political dispensation has liberalised dressing. But participants, both girls and boys, indicated some misgivings about the way learners dressed. Participants felt that some forms of dressing by boys and girls tend to arouse sexual feelings and seduction. Related to dressing is the development of a special youth language which tends to be obscene. Participants say such language also leads to seduction. The following were views of participants about dressing and the use of language in schools.

> *Ah! Yes, dressing! Like we girls, uhh! our dressing nowadays is becoming so risky. Mtima pa zinthu zoti basi showing our private parts of the body monga kuonetsa mwina nchafu, like pa mimba, ma breasts ndiye zija ndizinthu zobvuta, ukumapanga attract anyamata zoti, basi apa ndiye kuti mpaka agone nawo, and get HI etc Ndiponso language yimene yabwera panopa, ndingoti anthu akumayankhula language siyabwino kumayankhula mau tingati mau like seducing words, nkumayankhulira anyamata kapena anyamata nkumayankhulira atsikana. Mau amene aja amapangaso kuti, "eti"! It is easy kuti anthu agonane, chifukwa mau aja amapanga raise sexual feelings ndi oipa kuyankhula. (Ah! dressing! Like we girls, uhh! our dressing nowadays is becoming so risky. Our hearts are at showing our private parts of the body, like thighs, belly, and breasts and so such things are bad. You attract boys so that they think of having sex with you and so get AIDS. Also the language that has developed in schools nowadays. I can say the language that people use; they speak words which are seductive, talking to boys or boys talking to girls. Such words also make that "eti"! It is easy that boys should rape you, because such*

*words raise sexual feelings; it is bad to speak). (Serena, female, age 15, Ulemu Private Girls' Boarding School)*

*Komanso ma bvalidwe. Kaya ndi umbuli kaya ndikosaphunzira amapezeka kuti sexual feelings; it is bad to speak. (Serena, female, age 15, Ulemu Private Girls' Boarding School) mabvalidwe ao azimayi mwina atsikana abvala osakhala bwino, ndiye ukawaona iwe osaugwira mtima, mapeto ake ukuganiza zochita naye chiwerewere. (But also dressing. I don't know if it's ignorance or lack of education, you will find that women or girls put on clothes that are not good. So if you look at them, you can't control yourself, in the end you think of raping her). (Thabani, male, age 19, Solola Community Day School)*

*Okay! For example, the way these girls are dressing, it's not what! it's not good. Like when you are dancing in the hall, they do wear things which sometimes make you, some boys to look at them and propose love and as a result engage in sex. When they wear those clothes they attract people because they wear tight things, yeah! (Khoza, male, age 17, Chaphuka Government Boys' Boarding School)*

*Zinthu zoti nkutiwika m'mayesero zilipo, monga mabvalidwe (dressing); ndikhoza kunena mbali zonse ku anyamata ndi ku atsikana. Anyamata ena amabvala tuma trousers tothina kwambili, ndiye atsikana nawo akhoza kukhala ndi ma sexual feelings. Kwa ine nga m'nyamata, eeh! atsikana pa Kuche-kuche apa sakubvala bwino. Siketi kuchokera Jerusalem mpaka Jerusalemu eeh! (laughter!) ndiye zimapangisa kuti ine ndikhale ndi chilakolako chopanga chiwerewere (laughter). (Things that can put us into temptation are there. For example, dressing. I can say both sides, girls and boys. Some boys put on tight trousers so girls too do develop sexual feelings. To me as a boy, eeh! girls at our Kuche-kuche Trading Centre do not dress well. They put on slit skirts from*

*bottom upwards! Laughter! This makes me to develop sexual feelings and think of having sex with them). (Male participant from Solola Community Day School during FGD)*

Besides the controversial issues participants raised there were a number of misconceptions that arose during participant validation fora which are equally controversial. For example, at Chaphuka Government Boarding School, participants voiced the following: if a person has undergone a vasectomy his chances of contracting HIV is slim; the virus in a drunken person is less likely to be transmitted to a sexual partner; if one has had sex with an albino he/she cannot get AIDS. If not corrected, these misconceptions have the potential to increase the spread of HIV among adolescents. Interventions need to eradicate of such misconceptions. This is how participants expressed their views on these issues:

Jabulani, age 17, male participant: *Monga masiku ano amati ukakhala....., amene apangidwa castrated/ sterlized amati mwai otengera AIDS ndi ochepa. Njira zimenezi zimawapanga encourage, as a result ndizimene zimawapanga anthu kuti atani? Kuti apange plain, osagwiritsa ntchito kondomu, nkutenga matenda'wa. Kukufunika kuti mwina afufuze bwino – bwino zinthu zimenezo* (Nowadays people say that if a man is sterilised/castrated, they say his chance of getting AIDS are slim; these are some of the misconceptions that encourage people to have unprotected sex and so get AIDS. There is need for research on such issues).

Nikwe, age 19, male participant: *Palinso ma rumours oti ngati munthu ali mu blood group 'O', ukatenga ka chilombo sikamapanga multiply mu thupi, si kamafala. Ndiye ngati munthu information yotere anguimva monga mwa mobenthulidwa chabe, maybe akudziwa category yake kuti ndi 'O' azingopanga za chiwerewere kugonana ndi akazi ati kuti blood group yawo ndi ya mphamvu, moti sangatenge kachirombo. Ndiye kumafunika real information kuti ndizoona kapena ai kuti blood group yikhoza kumuteteza munthu akagonana ndi mkazi kapena mwamuna.* (There is also a rumour

circulating that if one's blood is group 'O' even if s/he gets the HIV it cannot multiply in his/her body. So such kind of information, may lead a person who has group 'O' blood to engage in unprotected sex, thinking that the blood group is protecting him/her. There is need for accurate information as to whether this is true or not).

Bongani, age 17, male participant: *Koma pali anthu ena amati ukagonana ndi ma albino si ungatenge matenda. Apaso pofunika kuti pakhale umboni weni-weni, chifukwa ndinzonso zimapangisa kuti atani? Kumagwilira ma albino aja kapena kuwakwatira kumene poganiza kuti Iwo sangatenge matenda.* (And there are some people who spread false beliefs that when you sleep with an albino you cannot get AIDS. This too needs real evidence, because these too are the ones that make people to do what? To rape albinos thinking that they do not have AIDS).

**Figure 28. Bad way of dressing**

*This photo shows two adolescent girls going to the market place using a path which is used by many people and the path is just a bushy. According to my opinion the bad way of dressing to adolescent girls they can seduce boys. And the other boys they cannot control themselves as a result the boys choose an easy way by raping them hence they can spread HIV and AIDS to others.(Photovoice by Lindiwe, female, age 19, Solola Community Day School)*

*5.2.1.4 Theme 4: Voices of participants regarding what could and should be done to reduce the risk of adolescents' vulnerability to HIV/AIDS*

Participants made their voices heard on what they consider should be done to reduce the risk of contracting HIV/AIDS. They addressed their concerns, first to themselves and fellow adolescents, and thereafter to parents, the school management and government. Words of advice to fellow adolescents

centred around abstinence, religiousness, participation in HIV/AIDS clubs and the need to encourage each other in the wake of the HIV/AIDS adversity. The danger of spending time alone with learners of the opposite sex was repeatedly reported as a risk. Female participants were more vocal to parents about their concerns. For example, Phindile called on all parents to talk openly about HIV/AIDS with their children. Ngesi believes that parents should allow their children to interact with others and learn from them, rather than locking them up at home. Nellie pleaded with parents not to encourage their daughters to engage in prostitution or early marriage for money. The voices of participants to the school management and government centred around the provision of more HIV/AIDS clubs, the banning of harmful cultural practices, encouraging learners to remain in school, and protecting female learners from sexual abuse. The ABC (Abstinence, Be faithful, Condomise) strategy is an acclaimed strategy worldwide, that targets both the youth and the old. The idea is that when you cannot abstain, then go for the remaining alternatives. The strategy has been received with mixed reactions from adolescent learners. When asked what they understand about the ABC strategy and to share their views in relation to adolescents' vulnerability to HIV/AIDS, participants mostly tended to condemn strategy C (the use of condoms). In their photovoice, contrary to the discussions in one-to-one interviews or focus group discussions, adolescents seem to acknowledge the positive role condom use plays as a protective device, although they were still sceptical. They also acknowledge that condoms are readily available in shops, thus accessible to adolescents who may not be able to abstain. Participants indicated that they are still shy to ask for condoms in a shop. Below I reproduce the voices of participants on these issues:

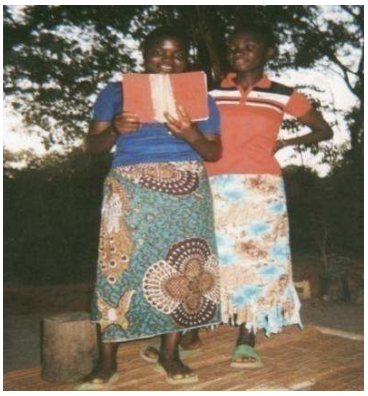
*To fellow adolescents*

> *Komanso kwa ife achinyamata makamaka mu ma community mwathu'mu penapake kumakhalabe ndi chilimbikiso kwa munthu, kumatha kumalimbikisana kuti I say, pomwe zafika apapa, tiyenera*

*kupanga chakuti chakuti. Maganizo amenewa asakhale oipa-zikhale zinthu zoti zikupititseni tsogolo lanu lipite pa tsogolo, Ee Yeah! (To us youth, especially in our communities sometimes it is better to encourage each other, and warning each other saying where things are at the moment it's bad, we need to do this and that. Such advice should not have evil intentions but honest which can make someone to progress in life).*

*I think the best way we can do to avoid the spread of HIV and AIDS among the youth is to encourage these youth to be more religious; they should fear the Lord, because we are told, "The fear of the Lord is the beginning of wisdom". If they fear the Lord, the wisdom will tell them to differentiate between the right things from the wrong things. I think it is the best way of sensitizing our youth in this very dangerous age of HIV /AIDS. (Bongani, male, age 17, Chaphuka Government Boys Boarding School)*

**Figure 29. Bible study**

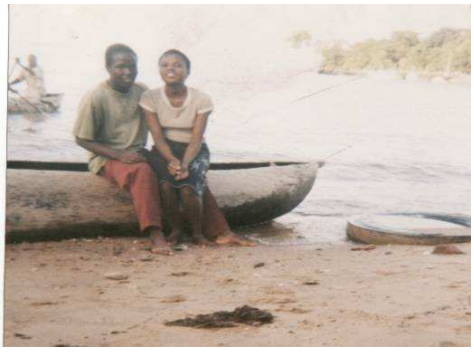


*These two girls are sharing the word of God after their classes at home. These girls are doing the right thing because as they study the Bible they make themselves knowing what is good and bad concerning sexual as the Bible discourages sex when you are not in a family. So these girls will refrain and avoid doing sex because they fear of being sinning against God they can't get HIV/AIDS. (Photovoice by Sonia, female, age 16, Solola Community Day School)*

*To avoid this disease is through abstinence; to abstain. I have to control myself waiting for time, for chili chonse chili ndi nthawi yake. Munthu udzizidikira nthawi. Munthu ukapanda kudikira nthawi ndiye kuti sizikhala bwino ai! (…for everything has its own time. One should wait for time. If you can't wait, then things won't be good, no!). (Serena, female, age 15, Ulemu Private Girls' Boarding School)*

*Kwa ma youth ndikhoza kunena kuti, we should avoid bad company, we should always hang up with people who can help us; osati anthu amene akhoza kutichita lead kwina kwake. Komanso ma youth'fe tikhale oti, we should be making our own mind osati tizitenga za munthu wina, zoti poti munthu wina akupanga chakuti, chakuti, inenso ndipangeso chomwecho. Tikhale tikuzidalira tokha. (To the youth I can say that, we should avoid bad company, we should always hang up with people who can help us and not those who could mislead us. Also we youth we should be able to make up our own minds not copying from others, just because someone is doing this let me also do the same. We should be self reliant). (Nelisiwe, female, age 15, Ulemu Private Girls' Boarding School)*

**Figure 30. Leisure time**



*A boy and a girl are chatting and relaxing at the lake. The way they are seated, they can arouse their sexual feelings. It is not good that members of opposite sex should seat closeness since this can make them have unprotected sex which can make them contract STIs/HIV/AIDS.*
*(Photo and photo essay by Nikwe, male, age 19, Chaphuka Government Boys' Boarding School)*

*Monga ifeyo tizipanga abstain, Ndiposo tisakhale tight kwambiri ndi azinyamata. Nthawi zina kukhala tight kwambili ndi anyamata si zimakhala bwino chifukwa anyamata'ja atha kukuzolowera, kene aka azakuchita zoipa. Komaso monga panopa tili ndi AIDS Toto club tizilimbikisana kupewa AIDS. Nthawi zina titha kuimba nyimbo zopereka uthenga wa HIV/AIDS, mwina kumapanga ma drama ndi zina zotere. (Like us, we should abstain. Also we should not stay too long in the company of boys. Because sometimes staying too close to boys is not good because they will get used to you thereafter make bad things to you. Also like here we have AIDS Toto club, we should encourage each other to avoid AIDS. Sometimes we could sing songs with HIV/AIDS messages or do dramas and such other things). (Thabie, male, age 16, Jenjewe Community Day School).*

*….My advice to my fellow youth is that always, they should not have sex until marriage and they should not spend too much time with opposite sex and always should be encouraging one another on dangers of HIV. Also they should participate in some activities like sport and clubs and societies as our school has some clubs. So you can participate in them so that you spend much time there and not to opposite sex so that we can make our life or our goals to achieve, yeah! (Perani, female, age 18, Jenjewe Community Day School)*

*To parents*

*Uhh! I definitely would advise parents to talk about AIDS with their children more openly not hiding some information. Like some parents say they should not have sex, they should give reasons why they should not have sex, because sometimes eeti! Anthu ena amauzidwa chinthu kuti don't have sex, ndiye iwowo amati why should I not have sex? Amapanga zinthu kuti awone why I should not have sex. Akukaniziranji? Some people just want to break rules just because they are there. I definitely want kuti parents akamalangiza ana they should be more open; they should tell them everything they should do (some people tell their children that don't have sex, so the children say, why should I not have sex? So they do things just to find out why I should not have sex. Why do they refuse? Some people just want to break rules just because they are there. I definitely want that parents when advising their children they should be more open; they should tell them everything they should do). (Phindile, female, age 16, Ulemu Private Girls' Boarding School)*

*Kwa makolo, ndimapemphaso makolo ena ndiwonso amapanga encourage ana zoti kuti hii! Poti tilibe ndrama, pita ukapange chakuti, chakuti. Mwina munthu, mwana akufuna sukulu azamuuza kuti hii! zilibe nchito chani, chani, ungokwatira. Nthawi zinanso mwina anthu amene amati akwatirane nawo amakhala anthu a akulu kuposa iwowo. Ndiye I feel makolo azikhala aujeniso, olimbikisa ana kuti alimbikire sukulu asamapange ma activities otere. (To parents, I would request because some of them are the ones who encourage children that hii! what school! just get married! Sometimes the people they want you to marry are just as old as themselves! So I feel parents should encourage their children to concentrate of their schooling and not doing such activities). (Nelisiwe, female, age 15, Ulemu Private Girls' Boarding School)*

*I think parents should take the responsibility to tell their children about how HIV/AIDS is spread. Kukufunika kuti makolo nawonso azikhala "open to their children". (It requires that parents too should be open to their children). (Male participant from Jenjewe Community Day school during FGD)*

*Komanso makolo nawo atengepo mbali, chifukwa makolo amakonda kuchita manyazi kumutchulira mwana ziwalo zake. Aziwaudza kuti kunja'ku kwaipa. Komanso palinso makolo ena amalimbikisa ana ao kuchita za chiwerewere chifukwa chofuna ndalama. (Also parents should play their part, because some parents are shy to tell their children issues of sexuality. They should be telling them that there is danger out there. But there are also some parents who encourage their daughters to engage in prostitution simply because of money). (Male participant from Solola Community Day School during FGD)*

*Monga kumudzi, makolo ndiwo amapangitsa kuti ana, adolescents atenge matenda a HIV/AIDS, chifukwa chakuti, zimatheka kuti mwana ali pa sukulu. Nkubwera makolo ena nkuti mwana wanga ali ku South Africa ndiye akufuna mkazi kuti amkwatire. Ndiye makolo a mtsikana uja amamuza mwana wawo kuti apite akamange naye banja. Koma sakudziwa kuti munthu'yo ali bwanji? Sono makolo amangotengeka ndi ndrama. (For example in the villages, parents are the ones who lead their adolescent children to get this disease of HIV/AIDS, because of this. It happens that you are at school and some people will come to your parents saying I have my son working in South Africa and would like to marry your daughter. So the parents of the girl will tell her to go and marry that boy. But they don't know the status of that person. So parents are taken up by money). (Female participant from Jenjewe Community Day school during FGD).*

*To school management and government*

*Ndinene kunkhani ya sukulu. Kuli bwino kuti atsikana aziwamangira boarding kuti azikakhala pasukulu, chifukwa mtunda umakhala wa utali ndiye kuti achoke pano kupita ku nyumba kwao amakumana ndi zinthu zambiri mu njira'mu. (Let me speak about school. It is better if government would build more boarding school so that they should live at school, because distance from their homes becomes too far as a result on the way girls meet a lot of problems). (Sonia, female, age 16, Solola Community Day School)*

*And even the Government should introduce the youth clubs and helping them, sometimes they may lack money to do these activities. So the Government should help them. (Bruno, age 18)*

*Okay! Ngati kwa Boma, ndinganene kuti, nkupempha ku Boma kuti lithe kupangisa ma community based organization ambiri. Atati apangisa zimenezizi achinyamata ambiri sitingatenge Edzi, chifukwa tizikhala busy kumapita kuti, kumapita ku ma community kuja, yeah! (Okay! to Government I would say, I request that it should establish more community based youth organizations. If they do this it will help many youth not to get AIDS, because we shall be busy going there at our community youth clubs, yeah!). (Zondi, male, age 17, Solola Community Day School)*

*Government, I think the best way is kulimbikisa m'masukulu or ma areas kuti anthu, ma youth, azikkhala ndi ma club, oti amatha kukambirana ngati zinthu za Edzi ndi how to abstain. For the schools, I would advise the same like, monga kuti atipatse mpata ife ma youth tikhale ndi ma club like Anti AIDS Club momwe tizikambirana about AIDS; moti tizikhala pansi kumakambirana kuti ndi njira zitizo ife angati ana ang'ono titha kupanga, tizisunge kuti tipewe Edzi, motiso tikhale ndi tsogolo la bwino. (Government, I think the best way is encouraging schools or in our community*

*areas, more youth clubs; there should be more youth clubs where we can be discussing about AIDS; how we can abstain. For the schools I would advise the same like, for example, they should give us opportunity to sit down discussing ways of how we youth we can do to protect ourselves from contracting AIDS so that we can have a good future). (Ngesi, female, age 16, Ulemu Private Girls' Boarding School)*

*Kwa Government ndikhoza kupempha zoti apange encourage a chinyamata kuti azilimbikira m'masukulu, chifukwa anthu amene sukulu yawakanika ndiwo anthu amayamba nchito ngati za uhule, zomwe zimabweretsa matenda a Edzi. Ndikupemphaso government yipange discourage ma cultural practices amene timapanga monga "kulowa kufa", "kusasa fumbi" zimeneziso ndikuona ngati zimayambisaso Edzi kwambiri. (To the government I would like to request that it should encourage youth to concentrate on their education, because those who have dropped from school are the ones who resort to going into prostitution. I would also like to ask the government that it should discourage cultural practices that we practice such as "kulowa kufa" "kusasa fumbi" which as I see are the ones that contribute to the spread of HIV). (Nelisiwe, female, age 15, Ulemu Private Girls' Boarding School)*

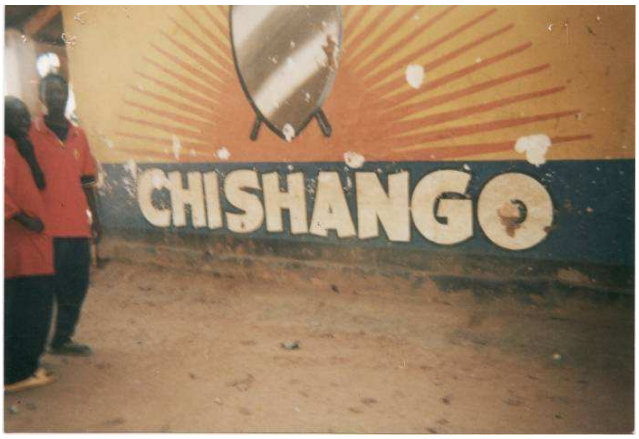
*To the Government, I heard this other time that they were giving condoms to schools. I think penapake akupanga ngati (somewhere they are like they) encourage, chifukwa, (because) it's like telling them kuti (that) have sex but use condom. Me I believe kuti (that) the best way not to have AIDS is to abstain. Because makondomu eti! (condoms, eti!) cannot be properly used, you can still contract the disease. (Phindile, female, age 16, Ulemu Private Girls' Boarding School)*

*I think school should put a tough regulation to dressing and also the government should build hostels for girls. Because girls came from very far, as a result when they knock off late, they travel long distance and sometimes they meet with a man or adolescent boy and sometimes they may rape with her. (Male participant from Solola Community Day School during FGD)*

### *About ABC strategy*

*I believe that the best way is abstain. We should educate people the importance of and the impact of abstaining because be faithful you cannot know that your partner is faithful especially we youth. Condom ah! it is not 100% perfect- people do sex under pressure and it can burst and so you can get AIDS or unwanted pregnancies, and your life is at risk Also people don't know how to use a condom and they don't take those rules which are indicated on the condoms. (Khoza, male, age 17, Chaphuka Government Boys' Boarding School)*

**Figure 31. Protection: Painting of chishango condom on a shop**




*Two adolescents are going to the shop to buy packet of chishango condoms. This is also one way of preventing themselves from HIV/AIDS even though it is not 100% safe. The photo means that adolescents have an access to protect themselves from contracting HIV/AIDS. It means that the condoms are found everywhere in the country and community. It also brings the message of advice that is to say they can make use of condoms to protect themselves if they cannot abstain from sex. (Photovoice by Kabela, male, age 15, Chaphuka Government Boys' Boarding School)*

*Umm! The best is Abstinence, which is A, because it is 100% safe, other than this, other two, B and C. Because if you follow B, Be faithful, you can be faithful to your partner but you don't know what is your partner doing. Your partner may not be faithful to you; she can have a lot of boyfriends. Using condom, a condom can burst during sexual intercourse, it also contains some pores. So it is dangerous to use C in particular. So the most effective, efficient one is A, which is abstinence. (Nikwe, male, age 19, Chaphuka Government Boys' Boarding School)*

*Ineyo malangizo anga ndioti amene amachemelera za kondomu kapena Be faithful asamapange encourage njira zimenezi, koma anthu azi audza kuti apange abstain chifukwa bvuto ndoti akamapanga advertise zoti use a condom, anthu ambiri sadziwa kuti kodi kondomu tingagwiritse bwanji. Komanso amene amachemelera za kondomu sanena side effect ya kondomu, zimene amanena iwowo ndi ma advantages okha-okha, pamene kondomu yili ndi ma disadvantages ambiri, kusiyana ndi ma advantages. Ndiye chimene ndinganene ineyo, ndi choti azichita encourage abstinence rather than condom. (With me, my advice is those who are promoting condoms or Be faithful should not encourage such strategies but they should be telling us to abstain, because the problem is that when they advertise that use condom, many youth do not know how condom is used. Also those who advertise about condoms they do not tell about the side effects of condom, what they say are only advantages, while condoms have more disadvantages than advantages. So what I can say is that they should encourage abstinence rather than condom). (Nikwe, male, age 19, Chaphuka Government Boys' Boarding School)*

*Ah! I can say B and C, yeah! part C is which I hate most. Because by saying use a condom, they encourage even those people who are not ready for sex to have sex, because I will protect myself*

*contracting HIV/AIDS, but the problem with that is that most youth, although many messages are being preached on how to use a condom, they don't know really how to use it and as such they end up catching the disease while they are cheating themselves that they are using the condom, but using it in a very wrong way. Those adverts on the condom, to my thinking, they are the ones that encourage youth to engage more in risky sexual behaviours. Why I say this, the reason is if you look at the pictures themselves, the people they draw there, especially girls, they capture a very beautiful young lady, and they may even capture the thigh or near the whole thing, then from a point of view if you look at those pictures, their main aim is from my point of view, I think it's only to encourage sex. Because what they mean is if you see a very beautiful young lady, what you have to do is propose her, and you go and buy a condom and use it and as such they perpetuate that desire for youth to have sex with partners, feeling they are safe but not. (Bongani, male, age 17, Chaphuka Government Boys' Boarding School)*

### 5.2.2 Adolescents' experiences of the HIV/AIDS intervention programmes available in schools

#### *5.2.2.1 Theme 5: Awareness of various programmes offered in schools*

*School-based programmes*

As with vulnerability to HIV/AIDS, levels of awareness among secondary school learners regarding school intervention programmes are high. Participants are able to state which HIV/AIDS programmes are available to them in their respective schools. Some participants are also able to mention programmes which are available in other schools and not specifically offered in their own school. This high level of awareness of the programmes may partly be attributed to the fact that most participants were members of

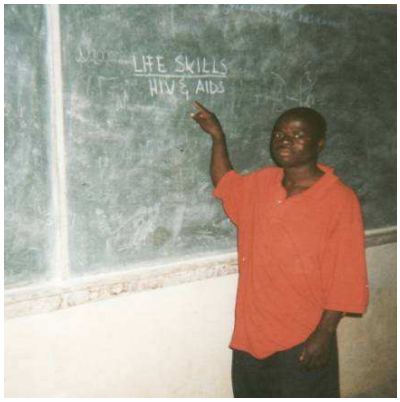
HIV/AIDS clubs in their schools, but also partly due to the fact that government has made a deliberate effort to introduce HIV/AIDS and other reproductive health subjects into the school curriculum. The media, such as TV and radio, put out a lot of HIV/AIDS messages and this has probably further contributed to their awareness.

Participants reported that they have HIV/AIDS clubs, mostly in the name of "Edzi Toto" (Say No to AIDS). Life Skills, as a subject that deals with HIV/AIDS and other reproductive health issues was reported as the most common programme. Every school reported having a Life Skills subject on their timetable. Interestingly, other programmes like the Student Christian Organization of Malawi (SCOM) and Wildlife and Environment, were also reported as significant in schools. The SCOM, which deals with learners' spiritual issues, was reported to include HIV/AIDS in its programme of activities. I was however not able to interrogate how HIV/AIDS issues are integrated into the Wildlife Club programme. One participant reported of an inter-schools press conference, held annually, at which issues of relationships and HIV/AIDS in schools are debated. I find this an interesting development, in view of the fact that, earlier on participants reported that inter-school meetings posed potential risks among adolescent learners. The following reflects adolescents' levels of awareness of programmes available in schools:

> *Tili ndi ma kilabu monga, HIV/AIDS koma tilinso ndi Life Skills momwe timaphunziramonso za HIV/AIDS. (We have clubs such as HIV/AIDS, but we also have Life Skills where we also learn about HIV/AIDS). (Female participant from Solola Community Day School during FGD)*
>
> *Life skills timaphunzira; class ili yonse pamakhala period, ndipo pamene amatiphunzitsa zambiri zokhuzana ndi AIDS. (Life skills we learn; each class has a Life Skills period that's where we are taught more about AIDS"). (Male participant from Jenjewe Community Day School during FGD)*

*We have this other teacher; he has this subject called Life Skills. Amatiphunzitsa momwe thupi lathu limayendera. (He teaches us about how our body works). (Female participant from Solola Community Day School during FGD)*

**Figure 32. Life Skills lesson**




*A teacher is teaching Life Skills where issues concerning HIV/AIDS are taught. To me this means that these youths who attend such meetings are safe from contracting HIV/AIDS because they are made aware of how to contract ways or avoiding to contract HIV/AIDS, contraction are to be eradicated from the adolescent group which is the most vulnerable (Photovoice by Bongani male, age 17, Chaphuka Government Boys' Boarding School)*

*Komanso mbali ya SCOM nkhani za HIV/AIDS ziliko, chifukwa ngati munthu umamva mau a Mulungu si ungapange zoti EDZI yikukhudze. (But also on the side of SCOM- Student Christian Organization of Malawi- issues of HIV/AIDS are touched, because if you listen to the word of God you cannot do things that can lead you to contract AIDS). (Female participant from Jenjewe Community Day School during FGD)*

*We have several clubs; one of them is the wildlife and environment club. Even though we know that the club focuses on the environment, we also have a part in the club that deals with HIV/AIDS. (Male participant from Chaphuka Government Boys' Boarding School during FGD)*

*Monga pa sekondare sukulu yathu'yi, timakhala ndi press conference at the end in the club that deals with HIV/AIDS. (Male participant from Chaphuka Government Boys' Boarding School during FGD) of this term, ndi a ku Tipewe Girls' Secondary School.*

*Pa conference timakambirana za mbiri, monga m'mene ma relationships between a girl and a boy, timakamba ma advantages ndi ma disadvantages ake, ma limitations, zimene zikhoza kuku pangani affect. Ndiye ngati ineyo ndili ndi chibwenzi nitamva uthenga'wo, nditha kuthesa chibwenzi'cho. Iyo msungwana nayenso ali ndi ufulu kuthesa chibwenzi'cho ngati uthenga waumvetsa. (Like at this school we usually have press conference at the end of this term where we invite Tipewe Girls' Secondary School. During the conference we discuss issues such as relationships between a girl and boy, their advantages and disadvantages and limitations, things which can affect one's life. So, for example, if I have a girl friend after getting the message from the conference, I might terminate the relationship. The girl too has the freedom to terminate our relationship if she too got the message from the conference). (Male participant from Chaphuka Government Boys' Boarding School during FGD)*

*I just heard about these while in the primary school. These programmes, "AIDS Toto" and "Why Wait" are not yet being carried out here. Here, we don't have; we don't have a lot of clubs here! (Female participant from Solola Community Day School during FGD)*

### *Non-School based programmes*

Participants indicated their awareness of programmes that operate around the school and, in addition, which involve learners. Participants mentioned "Youth Alert", an organisation that comes to conduct HIV/AIDS activities in schools. Since Youth Alert conducts mobile activities from school to school, it sometimes takes a bit of time before they can return to a school. Other community-based youth organisations have been mentioned which also involve school learners. The following are participants' experiences with non-school-based programmes:

*Eeh! Monga kumbuyoko za Youth Alert, amapanga mwina pachaka kamodzi zokhudzana ndi HIV/AIDS. (Yeah! like in the past Youth Alert used to come at least once in a year to conduct HIV/AIDS discussions). (Female participant from Solola Community Day School during FGD)*

*There are clubs surrounding this school; they usually visit the school and discuss more about HIV/AIDS. Pali certain organization, sometimes amazititenga amatichita involve mu ma activities ao. (There is a certain organization, sometimes they come and collect us and involve us in their activities). (Male participant from Chaphuka Government boys' Boarding School during FGD).*

#### *5.2.2.2. Theme 6: Reasons for low levels of participation in the programmes*

##### *Lack of interest and motive for participation*

Although participants were members of HIV/AIDS clubs, they reported reasons why other learners do not participate in HIV/AIDS activities and why there are low levels of participation by club members as well. Participants reported that learners join AIDS clubs for outings (visits to other schools) and that if these are not organised they tend to give up. Also a preference to study and concentrate on examinable subjects rather than participate in HIV/AIDS activities and life skills lessons was reported by form four learners. Form four learners, who formed part of the study sample, were preparing for the Malawi School Certificate Examinations. So lack of interest and commitment by both teachers and learners were mentioned as major obstacles to the success of such programmes in school. Distances from home was also mentioned by participants from community day secondary schools as inhibiting participation, since HIV/AIDS club activities take place after school hours. One participant reported that although SCOM integrates HIV/AIDS in its activities, issues of God and spirituality do not seem to attract the youth very much. The following reasons were reported by participants for lack of interest in these programmes:

*Amachita participate akaona kuti kuli ma trips (They participate only when they learn that a trip to another school is being organised). (Male participant from Chaphuka Government Boys' Boarding School during FGD)*

*Sometimes it happens that the teacher come every day, but the problem is to us, we students, because we do not attend the class just because the subject does not come in the examinations. And so when the teacher comes we leave, go out to study the subjects which we are going to write during the examinations and this discourage the teachers sometimes. (Male participant from Chaphuka Government Boys' Boarding School during FGD)*

*To my thinking, I think we don't have clubs; clubs are not here because mostly, this discourage the teachers sometimes. (Male participant from Chaphuka Government Boys' Boarding School during FGD) Like form fours, they don't go to the clubs. They say we want to study, they won't go to clubs like AIDS Toto, they say they want to do this and that; we don't have trips we can't have trips we can't go to the clubs and whatever. And that's why we don't encourage each other speaking about HIV and AIDS and we don't know much about HIV because we don't have that time of sitting down discussing about HIV/AIDS, how we can prevent HIV and how we can get HIV. (Female participant from Ulemu Private Girls' Boarding School during FGD)*

*I think even if we had a club, uuh! most schools it is the form fours that encourage clubs, again like we form fours we are so much interested into Music. And also we form fours we like to study subjects that will come during examinations. (Female participant from Ulemu Private Girls' Boarding School during FGD)*

*Ambiri samachita nazo chidwi, komanso ambiri amachokera kutali. (Most students have no interest in these clubs and besides many*

*stay very far from the school). (Female participant from Solola community Day School during FGD)*

*SCOM yinakhazikisidwa kale, koma kuti nkhani za Mulungu anthu ambiri samachita nazo chidwi; koma akati pali ka trip apa, anthu amakhamukila kumeneko. (SCOM was established long time ago, but the problem is that issues related to God do not attract youth very much but when they say there is a trip, everyone rushes there). (Male participant from Jenjewe Community Day School during FGD)*

### *About when and how programmes are delivered*

The times when programmes are delivered and how they are delivered can influence levels of participation. For example, participants reported that HIV/AIDS clubs take place late after classes, so learners return to their homes late. This then becomes a potential risk factor as learners can engage in sexual activities on their way home, thereby making the programme counter-productive. Lack of openness on the part of facilitators or teachers and lack of activities and active learner involvement in the programmes have all been reported as contributing factors to low levels of participation. Participants had the following to say:

*Ngakhale ku ma youth clubs amabwerako m'madzulo, ndiye akamabwera m'madzulo amakhala awiri-awiri, basi! ndiye kumakhala kuti ndiyemweyo! (Even in the case of youth clubs, youth return from activities very late in the evening in pairs, a boy and a girl, and since it's in the evening and it's dark and it's like that is your chance!). (Male participant from Solola Community Day School during FGD)*

*Makilabu amen'ewa amachita after knock off hours- tingoweluka, ndiye amati tikapezane mwakuti-mwakuti, ndiye eeh! 'm'mimba mutalowa galu wa kuda' ndiye amangotseseleka- ndiochepa amapitako. (These programmes take place after school knock off*

*hours, when everybody is really and rushes to get home as a result only a few participate). (Male participant from Jenjewe community Day School during FGD)*

*Ndionjezere pa ma kilabu a HIV/AIDS. Monga mukudziwira, achinyamata'fe timakonda zonjoya-njoya, ndiye mukaona kuti ku ma kilabu ma activities samakonda kuchitika, malinga ndi nthawi, ndizo zimagwesa ulesi- chifukwa "the more we enjoy the more we learn". Pofunika kuti azitipasako nthawi kuti tizipanga ma activities, okhuzana ndi HIV/AIDS. (Let me add on HIV/AIDS clubs. As you know us youth we like to enjoy things so if we see that there are no activities at the clubs, maybe because of time, then we become discouraged).*

*Monga club yathu tilipo anthu ochepa. Monga nanena kale, kuti sitikukhala ndi ma activities oti tizinjoya kumeneko. Samatipasa nthawi kuti tizipanga ma activities ndi kuchita display, ndicho chifukwa anthu samayikonda. (Like in our club we are very few, because as I have already said, we do not have activities so that we can be enjoying there. They don't give us time to do activities; that's why many students don't like it). (Male participant from Solola Community Day School during FGD)*

*Let me add a point on life skills. This has been a problem. It has been a problem in co-education schools. What I mean is that these schools where boys and girls combine in terms of learning. Normally it happens that when the teacher is a man he tells openly about how the body of boys changes but comes to hide some of the messages when he comes to explain more about girls. The same thing happens when the teacher is a lady. She also hides messages about boys. So this has been a problem. But where boys and girls learn separately, they learn more about these things. As a result this can really be a way HIV and AIDS can spread rapidly; just because*

*they are not taught enough. (Male participant from Chaphuka Government Boys' Boarding School during FGD)*

*… the teacher… he just says when doing sexual intercourse you should use condoms but there are some students who don't know how to use these condoms. And they don't tell the girls that when sometimes you walk you should carry some condoms in your pocket, because sometimes the boy may say he don't have a condom and when you are two the sexual feelings may come and you may not had controlled. (Male participant from Chaphuka Government Boys' Boarding School during FGD)*

#### *5.2.2.3. Theme 7: Learners' experiences of the programmes*

##### *Positive experiences*

Learner participants reported that they had had positive experiences with the programmes. These experiences ranged from acquisition of knowledge about HIV/AIDS to personal conviction of some behavioural change. Both the HIV/AIDS clubs and life skills programmes were reported to have had considerable influence on self-awareness, decision-making and behavioural change. One participant reported that the project activities, especially the photovoice, had had quite a positive influence on him and other non-club members. He spoke of non-club members who wanted to join the HIV/AIDS club because of being impressed by the project activities. This view came about because some participants took this research project as part of their HIV/AIDS club activities. For them, these research activities were part of the intervention programmes. The following are what participants had to say about their positive experiences with the programmes:

*Ahhh! Ndaona kuti akutiphindulira kwambiri, chifukwa a chinyamata'fe monga tikakhala ku ma pulogiramu amatilangiza njila zo tsata kuti tipewe nthenda imene'yi. (Ahhh! I have found that the programmes are very helpful, because we youth we are being*

*told how we can avoid contracting this disease). (Male participant from Solola Community Day School during FGD)*

*Ine ndikuona kuti mapulogiramu'wa amathandiza. Mwina nthawi zina timakhala ndi ma drama kusonyeza kuipa kokhala ndi zibwenzi pa nthawi tili pa sukulu, mwina ena owonelera ali ndi zibwenzi. Ena atha kuthesa zibwenzi'zo kamba ka uthenga wa mu ma drama athu pozindikira kuti zibwenzi'zo mathero ake ndimabvuto okha-okha! (Me, I see that these programmes are helpful because sometimes we do have dramas showing the disadvantages of having sexual relationships. After watching the drama some are able to terminate their relationships knowing that the end-result of such relationships is just problems!). (Male participant from Solola Community Day School during FGD)*

*Umm! Zimasintha. Kusintha kwake nkuti, ngati ineyo, poyamba sinkadziwa za HIV/AIDS. Momwe ndanenera, ndikapita kukawonerera ma activities a HIV/AIDS monga ma drama, keneaka ndinaganiza zoti ndiwajoine anzanga. Momwe tayambira zojambula'zi, ndili ndi umboni, oti wina anakanifunsa kuti akufuna ku joina club yathu'yi, ati ankawona kuti ife tikunjoya po yenda ndi ma camera. (Umm! things are changing. The change I see is that like in my case, at first I didn't know about HIV/AIDS. But as I have said, when I go to watch HIV/AIDS activities like drama, I decided to join the club. Also as we have been taking photographs in this project I have evidence of someone who wants to join us. She says she has been touched by the way we seem to enjoy ourselves moving with cameras). (Male participant from Jenjewe Community Day School during FGD)*

*Kwa in akatiphunzitsa Life Skills timatengamo zina ndi zina zokhudzana ndi HIV/AIDS. Amatiphunzitsa monga kuti munthu angayitengele HIV/AIDS kapena kupewa, eya! (To me when he teaches us life skills we are able to get something concerning*

*HIVandAIDS, like how we can contract HIV/AIDS or how we can avoid it yeah!). (Female participant from Solola Community Day School during FGD)*

*But in Life Skills, it helps with awareness. We are told that we should be aware of ourselves so that we should be able to protect ourselves from contracting HIV/AIDS and some other behaviour. We talk also how we can say no to peer pressure so that we don't engage ourselves in contracting HIVandAIDS. (Female participant from Ulemu Private Girls' Boarding School during FGD)*

*Myself I would say yes, because when I was just coming I was just doing anything. Why? Because I could not stand peer pressure. But now I am able to stand on my own, make my own decisions. (Male participant from Chaphuka Government Boys' Boarding School during FGD)*

### *Negative experiences*

Although participants reported positive experiences as individuals they believed that, generally, learners have had negative experiences with the programmes, thus leading to lack of interest. Participants reported that the programmes have not been able to attract most learners, hence there has been little noticeable behavioural change. They also reported negative experiences with facilitators or teachers of the programmes, resulting in low levels of participation. Failure to act as role models and lack of openness and commitment on the part of teachers have been reported as the main negative experiences with the programmes. Participants reported that what facilitators preach and what they do are quite different. The following are comments from participants regarding their negative experiences:

*Ine ndikuona kuti si zikusintha, zikupitilirabe chifukwa panopa anthu sakutenga mbali pa ma kilabu. (To me I see that there is no change in behaviour; bad behaviour among the youth continues because*

*youth do not participate in clubs). (Female participant from Solola Community Day School during FGD)*

*We were not encouraged by teachers; they were not supporting us; and mostly when we went to the club, it was not mostly talking about HIV, we mostly were there joking about trips, we could talk maybe about having a trip to other school. We had a meeting on Wednesday and we mostly talk about making trips, not talking about HIV/AIDS. Encouragement from teachers we never had the support and we never had ideas of ever sitting down to talk about HIV. (Male participant from Solola Community Day school during FGD)*

*Ine mu kalasi langa timaphunzira za HIV ndi AIDS, koma sikweni-kweni. Aphunzitsi athu amalimbikira ku phunzitsa zimene zimabwera pa mayeso. Monga ife a form four sitimaphunzira za AIDS mu class, chifukwa amalimbikira zokha'zo zimabwera pa mayeso. Timakamva za AIDS tikapita ku ma kilabu a AIDS. (In my class we do learn about HIV/AIDS but it's not much; the teacher concentrates on teaching what comes during examination. So we hear about HIV/AIDS when we go to HIV/AIDS clubs). (Female participant from Solola Community Day School during FGD)*

*Kungoti panopa, aphunzitsi ah! sali serious kwambili ai, monga ifeyo tinaphunzirapo Life skills kamodzi basi! (Only that at the moment, teachers ah! they are not very serious; like in our case we learned life skills only once). (Female participant from Solola Community Day School during FGD)*

*Kungoti aphunzitsi amalimbikira kwambiri zomwe zili examinable, pomwe ma Life skills omwewo amakhala ngati amajombapo mu class choncho, nkunena kuti ife ndife akuku akulu, timaziwa kale kuti AIDS tingayitenge mwakuti mwakuti. Ndiye akabwera mu class amangoti akuzidziwa kale, mwina akunenapo patalipatali!"(Only*

*that teachers concentrate a lot on those which are examinable, while on life skills they tend to miss classes a bit so when they come they just say, we already know; they will perhaps just mention a little about AIDS). (Male participant from Chaphuka Government Boys' Boarding School during FGD)*

*Ma kilabu tili nawo ambiri, amabwera, koma chimene chimachitika uthenga amatiudza, koma ife ana a sukulu sitikutembenekuka chifukwa anthu omwe amatiuza ndiwo akupanga zinthu zimenezo. Ndiye mwana wasukulu sakutengapo kanthu, amangoti ah! Nawo'wa akunena zawo. (Clubs, we have many of them; they do come here with HIV/AIDS messages, but what happens is, message indeed they tell us, but we school children we do not get convinced because the very people who come to give us these messages are the ones practising the same irresponsible behaviour they are telling us not to; so we school children we don't get anything and we say, well, they are just talking about themselves). (Female participant from Solola Community Day School during FGD)*

*Ma youth club alipo, monga Malango Youth Club koma kwa ine dandaulo liripo; amene amaphunzitsa samapereka chitsanzo. Ngati munthu amapereka chitsanzo kuti ine simatsegula zipi ndipo umatsonyeza chitsanzo, ndiye kuti amene ukumuudza uja naye satsegula zipi koma ngati iwe umatsegula zipi ndiye kuti uja ukumuudza naye atsegula zipi. (Of course clubs are there, like Malango Youth Club, but I have a complaint against those who present HIV/AIDS messages; for example if someone says he doesn't unzip his trousers and indeed he doesn't then that person he is telling will also follow, but if he unzips his trousers then the person he is telling will also unzip his). (Male participant from Solola Community Day School during FGD)*

### *5.2.2.4 Theme 8: Participants' voices of what could and should be done about the programmes*

A number of issues were raised by participants regarding how the programmes could be improved. In view of a lack of commitment and interest by both teachers and learners, participants suggested making HIV/AIDS and Life Skills compulsory and examinable subjects because, at the moment, teachers concentrate on examinable subjects at the expense of Life Skills or HIV/AIDS. If they are made examinable, both teachers and learners will take them seriously. Other areas of concern included problems of delivery. Participants singled out the need for more activities, involvement of learners and the need to revisit the rules governing HIV/AIDS clubs. They felt that the way the clubs are run promotes risk behaviour among adolescents and reported that some risky sexual behaviour started at the HIV/AIDS clubs as some learners join the clubs for relationships. Participants also expressed the need for more external visitors to schools especially from HIV/AIDS organisations for encouragement, and commended our involvement as encouraging. Participants thought that our coming was part of the regular effort to help with the HIV/AIDS club activities and that we would continue coming to schools. One participant pleaded with us to invite a person living with AIDS (PLWA) next time with whom they could share his experiences because, he said, since we do not have the virus ourselves, we do not provide an example from which they can learn. The following represent some of their voices:

> *Komanso awonetsetse kuti Life Skills yikuphunzitsidwa, chifukwa si tonse timalowa m'makilabu a HIV/AIDS. Moti amene samapitako'wo nawonso amvereko kuti ahh! kasi zinthu zimenezi zimayenda choncho! (But also they should see to it that Life Skills is taught, because it's not all of us that join HIV/AIDS class. In so doing even those who do not go to clubs will learn about HIV/AIDS). (Female participant from Solola Community Day School during FGD)*

*Apa nkhupempha waka Boma kuti chisambizgo cha EDZI nacho wachitole waka nga ni visambizgo vinyake, ivyo vikwiza pa mayeso; panyake chingatovwirako. Kweni kuti vikhale waka ntheura, kuti malinga tasambira, ndivyo wanyane wanena kale kuti asambizi na ise tawana tikuwikapo mtima cha!' (Here I would just like to request the Government that the subject of AIDS also should be taken like other subjects that come on examinations; maybe it would help a bit but if things will be left like this, that provided we have learned, this is what my friends have already said, teachers don't put any effort). (Male participant from Chaphuka Government Boys' Boarding School during FGD)*

*Inde, mapulogiramu a HIV/AIDS alipo, koma aziphunzitsi samakhala serious.' Mwina zikadakhala kuti zili examinable, aliyense azikhala aware kuti za AIDS zikhoza kubwera pa mayeso. (Yes, HIV/AIDS programmes are there but teachers are not serious with them. Maybe if they were examinable and everybody will be aware that AIDS topics may come during examination). (Female participant from Solola Community Day School during FGD)*

*Makamaka ma programme opanda ma activities achinyamata samaakonda ai! Pofunika pazikhala zoyimbayimba, ma drama, mpira, zimenezi zimakoka anthu. (Especially programmes which have no activities youth don't like them. There should be activities like music, drama, ball games, which attract people). (Male participant from Solola Community Day School during FGD)*

*Kuonjezapo, nkhani yayikulu ndi ma activities. Mukapanga ma activities monga kupita ku Community Ground ndi ma activities anthu akhoza kuzibwera. Mwina ena sazatengera attend, koma akhalapo ena atengapo uthenga omwe tabwerera. (To add, the main issue here is activities. When you do activities, like going to Community Ground with activities people will come; maybe some will not get anything but there will be some who will get the*

*message we have brought). (Male participant from Sololа Community Day School during FGD)*

*Pofunika kuti anthu kuchokera kwina ku ma organization akulu akulu nkumabwera kuzakatifotokozela more about HIV/AIDS, mwina mwake zikhoza kuphindula. Komanso, mukabwera choncho, monga ambiri amabwera, Sa ali ndi kachirombo, ndiye anthu mukuaudza aja amangoti ah! awa amangotitayira nthawi chabe. Koma kumafunika munthu iye amene kachirombo alinako ofuna kwabwino Ndiposo wa courage kufika kuno kuzakatifotokozera zimene iye wapanga experience makamaka kuti mpaka azakafike pamenepa, zikukhala bwanji. Komanso kwa ife sitinatenge'fe, kuti nkukhala bwanji! (What is needed is for people coming from big organizations coming to explain more about HIV/AIDS, may it would help. But also when they come as you have done, you do not have the virus and so the people you are telling they just say ah! these people are just wasting our time. What is needed is a person that has the virus that is courageous and good intentions to come and share his/her experiences; like what happened for him to be found in this situation and for us youth that do not have the virus what advice would he like to give us). (Male participant from Chaphuka Government Boys' Boarding School during FGD)*

*Komanso momwe mwabwelera inuyo mwatilimbikisa, choncho chingakhale chinthu chabwino ngati ma bungwe osiyanasiyana atabwera kuzakatigawira uthenga wa HIV/AIDS. Izi zikhoza kutilimbikisa ife a chinyamata. (But also, as you have come, you have encouraged us, and so it would be better if other different groups could be coming to share with us messages of HIV/AIDS. These would really encourage us youth). (Female participant from Sololа Community Day School during FGD)*

*Chinanso aphunzitsi a za HIV/AIDS azikhala omasuka kwa ife. Azitimasukila pa kuyankhula. Monga amachita manyazi kufotokoza za chishango alinacho mu thumba. Ngakhale makolo nawonso azitimasukila pokamba za AIDS. Chifukwa ise tikatenga AIDS adzabvutika ndiwowo makolo, pamene iwo samatifotokozela zinthu, amatibisira, ati, akaziwonera okha, akula, zimene zili zosathandiza. (Another thing, teachers of HIV/AIDS should be people who are free with us; they should be free when talking to us. For example they are shy to explain about chishango (condom) when they themselves have it in their pocket. Even parents too they must be open talking to us about AIDS; because once we get AIDS, it will be them who will suffer while they are hiding information from us, saying we will see the truth for ourselves). (Female participant from Solola Community Day School during FGD)*

*A head achite encourage ma clubs pano pa sukulu. (The head teacher should encourage HIV/AIDS clubs here at school.) I think it should be compulsory pa sukulu, kuti at least aliyense tizikhala mu kilabu moti tizikambirana za AIDS (at the school here that at least everyone should belong to the HIV/AIDS club so that we can be discussing HIV/AIDS issues). (Female participant from Jenjewe Community Day school during FGD)*

*Ine ndimati malamulo mu ma kilabu akhwimise. Chifukwa zinthu zina zimayambira kumakilabu'ko. Mukakhala ambiri, ena cholinga chawo nkupezako zibwenzi, choncho matendawa sangasiye kufala. (Me, I would say rules governing clubs must be tightened because some bad behaviour starts there. When you are many some go there with the aim of just making love relationships, as a result this disease cannot stop spreading). (Female participant from Solola Community Day School during FGD)*

It is clear that the programmes, be it in the school curriculum, such as Life Skills, or extracurricular, such as "Edzi toto" clubs, have an important role to play in making adolescents understand their vulnerability to HIV/AIDS. This is further interpreted in chapter six.

## 5.3 Synopsis of Chapter Five

In this chapter I presented the results of my study, where eight themes emerged out of the data, addressing the two research questions. These themes were further refined to include categories. The results of the study have been enhanced by direct quotations and photovoice from participants. In the next chapter, I interpret the results of my study and contextualise them into the existing literature and my conceptual and theoretical frameworks.

# Chapter Six:
# Re-contextualising Adolescent Vulnerability to HIV/AIDS into Existing Literature

## 6.1 Introduction

In chapter five I presented a description of the results of the study by themes and categories that emerged from my data. These were supported by excerpts from participants' interviews, including their photovoice messages. In this chapter I reflect on the themes that emerged, relating them to the existing literature and the conceptual framework that informed this study. In the process of reflection, I describe similarities and differences between my findings and the existing literature, and make inferences for the differences wherever possible.

## 6.2 Findings of the Study

In chapters two and three I discussed a number of concepts relating to HIV/AIDS. Chapter two was devoted to a review of the literature that centers on the contextual factors that predispose Malawian adolescents to HIV/AIDS and the intervention programmes available to them, drawing parallel examples from other countries especially in Africa. In chapter three I presented key concepts, defining their usage in this study, which included vulnerability to HIV/AIDS, adolescence and adolescent sexuality, HIV/AIDS and intervention. A discussion of the theoretical framework that guided this research was also presented. In this section the themes that emerged from the findings of the study, including how they relate to my theoretical framework, are theorised.

I have structured this section in accordance with the outline of the themes and categories presented in chapter five and in accordance with the research questions as follows:

## 6.2.1 Adolescents' understanding of their own vulnerability to HIV/AIDS

### *6.2.1.1 Adolescents' awareness of their vulnerability to HIV/AIDS*

Vulnerability, the key phenomenon explored in this study is defined as "susceptibility to negative outcomes under conditions of risk" (Swartz et al., 2004). In the context of my study I subscribe to De Guzman's (2001) notion of *social vulnerability* as applied to adolescents as a social group. He asserts that individuals are at risk of HIV/AIDS due to their social position and not simply as a result of their sexual behaviour. Rivers and Aggleton (1999) in this regard, contend that adolescents face increased risks of HIV/AIDS by virtue of their social position such as unequal life chances, rigid and stereotypical gender roles, and limited access to education and health. I further posit that for the purpose of this study, following Bronfenbrenner's ecological model of development, vulnerability takes into account how the various contexts at individual, interpersonal, community and societal levels, make secondary school adolescents vulnerable to HIV infection and how some of them act as protective factors. This is discussed in the following sections.

#### 6.2.1.1.1 Awareness that adolescents are a more vulnerable group than other groups in society

This study has established that adolescents are quite aware that as a social group they are more vulnerable to HIV/AIDS than any other group in society. This is contrary to the findings of other studies such as those of Franzkowiak and Wenzel (1999) and Kadzamira et al. (2001), where it was reported that adolescents did not perceive themselves as being at risk of HIV/AIDS due to their low risk perception and belief in invulnerability. For example, in the Kadzamira et al. study, participants indicated that only bad and immoral

people get AIDS. The findings of this study, however, concur with those of Samuelson (2006) in Burkina Faso, where it was observed that young people have a sense of being more at risk than others; that they have a real fear of the disease. The study also established that participants tended to distance themselves from the disease; "othering" or shying from it. Although they accept that as a group, adolescents are vulnerable, their discourse around HIV/AIDS is that of "they" or "adolescents", rather than saying "us" or "we" are vulnerable. Adolescents would rather speak of their vulnerability in the third person than in the first person. This seems to concur with Winskell and Enger (2009), who found that the youth participants consistently "othered" the pandemic and put the blame for the spread of HIV/AIDS to other people like sex workers, rich people, city dwellers, and those who travelled a lot. As indicated (see 5.2.1.1) the tendency of "othering" the HIV/AIDS reflects the shame associated with the disease which is referred to in derogatory terms. These findings concur with those of Mawadza (2004) in Zimbabwe, and Horne (2004) in South Africa, where various names are associated with HIV/AIDS so that it is not called by its real name. As Horne argues, not saying its name is a way of trying to deny its reality.

Owing to the conflicting arguments regarding the role of low risk perception and invulnerability as advanced by Rodham et al. (2006) that there is little empirical evidence to support the role of invulnerability in adolescents' risk taking behaviour. (Meaning of the last sentence is not clear.) It might be necessary to conduct more studies in this area to further determine adolescents' low risk perception of the pandemic, using more qualitative and participatory methodologies.

#### 6.2.1.1.2 Awareness of how they can contract or avoid contracting HIV/AIDS

The study has also found that adolescents' knowledge about how they can contract or avoid HIV/AIDS is relatively high. For example, they demonstrated knowledge that having unprotected sex with an infected person is the main mode of contracting AIDS and that abstinence is the surest way to protect

oneself from contracting HIV/AIDS. These findings corroborate with those of several other studies, both in Malawi and other countries, which point to the fact that the youth have abundant knowledge about the HIV/AIDS pandemic, but that corresponding levels of behavioural change have been insignificant (Hartell 2005; Kadzamira and Maluwa-Banda, 2002; Reddy, 2000 & UNDP, 2002). As I indicated in chapter five (see 5.2.1) it looks like most of this knowledge is regurgitated from their class work on HIV/AIDS, with very little importance attached to behavioural change. This observation calls for a review of intervention programmes in schools.

#### 6.2.1.1.3 Awareness of the dangers/consequences of contracting HIV/AIDS

Adolescents have demonstrated in this study that they are not just aware of their vulnerability to HIV/AIDS but that they are also aware of the consequences of contracting HIV/AIDS, such as being stigmatised at school and in society, dropping out of school, long illness, and eventually death. Adolescents have a real fear of the consequences of contracting HIV/AIDS and seem to be more scared of the disease when they see the physical appearance of people sick with HIV related diseases. This lends further support to the findings by Samuelson (2005) that youth have a real fear of HIV/AIDS and the consequences of contracting it.

A number of misconceptions arose during participant validation forums, where participants expressed concern over issues circulating about HIV/AIDS. For example, a belief that having sex with an albino can cure one of AIDS, or that when an HIV infected person is drunk, the virus becomes dormant and can therefore not be transmitted to others even during unprotected sex. These findings are similar to those reported by Liwewe and Matinga (2005) and cited by Tiessen (2005) in Malawi where beliefs like having unprotected sex with a virgin cures AIDS were reported. The findings further concur with those by Harrison, Xaba, Kunene and Ntuli (2001) in South Africa, where myths related to sexual activity and reasons for sexual initiation were linked to other myths such as if one does not have sex close to the age of puberty evil spirits

will haunt one. In this study participants also demonstrated misconceptions about VCT thinking that they needed to go for VCT once they fall sick, when in fact they should go before they fall sick. VCT is a process in which an individual undergoes counselling, enabling him/her to make an informed choice about trust (WHO, 2002 as cited in Izugbara, Undie, Mudege, and Ezeh, 2009). The findings of this study regarding VCT concur with those of Izugbara et al. (2009), namely that the youth in Malawi and Uganda are sceptical about going for VCT unless they doubt themselves; meaning that people who know themselves to be healthy need not go for VCT, only those who are suspicious about their health. These sentiments about myths are expressed in Appendix D.

It is clear that such misconceptions have dire consequences for adolescents.

> *Ah!, the danger is, ngati wa chinyamata wapanga contract HIV/AIDS ndiye wasiya sukulu, then has to go to VCT, amupeza kuti ali ndi HIV/AIDS, sangathe kupitiriza maphunziro ake, chifukwa aziopa kuti or ngakhale ndipitirize maphunziro anga, chomalizira, maganizo ake ngokhala kuti mapeto ake ine ndimwalira ndiye pali bwino kuti ndingosiya, chifukwa mapeto anga ndikudziwa kale. (Ah! the danger is, if a youth has contracted HIV/AIDS it means the end of school for you; you may have to go for VCT and you will be found positive, then you can hardly continue with your education, because you will be thinking that even if I can continue with school I already know my end, I will die so it's better for me to drop out of school). (Nikwe, age 19)*

#### 6.2.1.1.4 Awareness of what constitutes a safe or unsafe environment to HIV/AIDS

Vulnerability as alluded to in 6.2.1.1 suggests two sets of factors: risk and protection. According to Swart et al. (2004), protective factors are those influences that limit or reduce the likelihood of high risk behaviour and play a moderating role. Siqueira and Diaz (2004), explain that risk factors relate to individual or environmental hazards that increase an individual's vulnerability

to HIV/AIDS. I assert in this study that an understanding of both risk and protective factors is very useful in understanding secondary school adolescents' vulnerability to HIV/AIDS. In my findings, safe environment refers to protective factors while unsafe environment refers to risk factors.

In relation to adolescents' awareness of what constitutes safe or unsafe environments, this study found it to be equally very high. Participants acknowledge that schools provide a supportive and safe environment through pastoral care and the provision of school activities such as HIV/AIDS programmes and sports. They also acknowledge the supportive role of parents, teachers and religious leaders in general, as providing a safe environment. The role of religion was emphasised by participants as providing a safe environment and seems to support the argument by Steyn et al. (2005), that because of its emphasis on moral standards, religion and religious beliefs are the basis of behaviour. The findings on the influence of religion corroborate with those of Trinitapolis (2006) in Malawi, which found that in addition to care and support for those infected by HIV/AIDS, religious institutions play a vital role in prevention, such as encouraging young people to get tested for HIV before their marriages can be blessed. They further argue that the more people attend religious activities and the more devoted they are to their religion the more conservatively they behave in terms of their attitudes and behaviours relating to sex. It is probable that participants have a strong Christian background and so turn to religion for support. However, Regnerus and Salinas (2007), argue that religious leaders can also be instrumental in promoting HIV stigma and discrimination, especially if such leaders associate HIV/AIDS with sex and immorality.

In terms of an unsafe environment participants lament the location of schools in the bush that are away from homes, and homes located in the vicinity of bars and taverns which constitute risks, especially for girls. Findings on the location of the school as constituting an unsafe environment, supports the argument by Kelly (2003), that girl learners risk sexual harassment from boy

learners on their way to and from school, if schools are located far away from learners' homes. This contributes to their vulnerability to HIV/AIDS.

#### *6.2.1.2 Adolescents' perception of HIV/AIDS risky situations*

As Normand (2007) explains, adolescents' perceptions of their vulnerability are crucial to an understanding of how they engage with their environments because the way they perceive the circumstances in which they find themselves determines their behaviour. These are discussed below in relation to my findings.

##### 6.2.1.2.1 Internal factors

This study has found that the development of sexuality among adolescents, while a normal phenomenon, is considered a contributing factor in the spread of HIV/AIDS. Through internal factors such as the development of sexual feelings and attraction to people of the opposite sex, which characterise this stage of development, adolescents perceive themselves as being at risk of contracting HIV/AIDS since they find it difficult to control their sexual drives. These findings seem to concur with those of Kadzamira et al. (2001), Rodham et al. (2006), and Wekwete and Madzingira (2005), who report that adolescents engage in risky sexual behaviour because they fail to control their sexual feelings and that at times engage in sex unplanned or spontaneously. The observation made by Rivers and Aggleton (1999), that the age at which young people become sexually active maybe falling, might explain why most adolescents engage in sexual intercourse when they are still emotionally immature, thereby leading them to make uninformed decisions and often failing to practice safe sex.

#### 6.2.1.2.2 School related factors

*Peer influence*

Similar to findings by Kadzamira et al. (2001), Maluwa Banda (1999), and Mc Auliffe and Ntata (1994), all in Malawi, my study also found that peer pressure is critical in influencing adolescents to engage in risky sexual behaviour. In this study, peer influence ranged from mere imitation of what others say or do, to being forced to conform to group demands. For example, girls from poor families reported pressure from girls from rich families to engage in sexual activities to obtain material goods like they themselves have. My findings further corroborate with those of Reddy (2005), that girls conform to peer pressure to engage in sex in order to please a boyfriend, or to maintain love or trust. Boys on the other hand try to outdo each other; if one can't have a girlfriend, or cannot have sex with a girl, then one is not considered a man, and so they do things to conform to peer expectations. This masculine hegemonic tendency supports the observation by Jackson (2002), that in African societies, masculinity is defined in terms of sexual prowess and sexual activity. This, as has been observed (see 2.2.8) places boys and girls at risk of HIV/AIDS as boys are inclined to indulge in sex with multiple partners to display their prowess.

*Inter-school meetings*

Unique to my study, and not reported in any literature, is the fact that adolescent learners hold inter-school meetings either for educational purposes or sports which they consider to have the potential to spread HIV/AIDS among learners. For example, participants reported that walking back late from sports increases the potential for contracting HIV/AIDS in that they maybe tempted to engage in sexual activities, including rape, under the cover of darkness. They also reported that at inter-school meetings, learners, especially from single sex schools, hurriedly establish casual relationships with learners from the opposite sex from other schools, purely for sexual purposes, and that they often practise unsafe sex. The findings of my

study, however, reinforce the findings of various studies on the extent of gender based violence in schools as perpetuating the spread of HIV/AIDS throughout Africa including Malawi.

Similar to studies by Liwewe and Matinga (1999), as cited by Tiessen (2005), and Kelly (2003), this study found that sexual harassment by boy learners places girl learners at risk of HIV/AIDS. In this study, sexual harassment by boys took the form of touching body parts, use of obscene language, and pressure or coercion to have sex. However, contrary to the findings by Kadzamira et al. (2001), that sexual harassment of girl learners by teachers is pervasive in schools, this study did not find many cases of sexual harassment by teachers or else it was under-reported. The problem of sexual harassment by teachers was only reported in a single instance where a learner intimated that teachers engaged in sexual activities with girl learners in return for either money or favour with school work or examinations. The under-reporting of this problem could presumably be due to the fact that this study involved teachers from the school as link people and this might have inhibited open discussion of the problem. Also, the limited sample of schools might have curtailed findings on the issue. Nonetheless the findings give some indication of the existence of the problem which requires attention.

### *Other school-related contexts*

This study reports on other school related practices such as hugging between boys and girls; being in the limelight due to achievement in class work, sports, drama or music; seating arrangements where boys and girls sit close to each other; and the teaching of subjects such as biology and life skills, which are viewed by adolescents as tempting them into having sex, and hence putting them at risk of HIV/AIDS. Although not documented in the literature, these issues indicate how easily adolescents are sexually aroused by any stimulus, and therefore require our attention.

Girls, especially in boarding schools, were concerned about the sharing of bathrooms, citing that monthly menstruation in which bleeding takes place

causes a potential risk of HIV/AIDS infection. This is probably more of a belief than a fact because there is no clinical corroboration of HIV spreading through the sharing of bathrooms, unless a person gets into contact with HIV contaminated blood via an open wound. The belief has the potential for stigmatisation of those who are HIV positive.

However, the sentiments corroborate withy those by Hillman, Wood and Webb (2008, that HIV- positive women are highly contagious during menstruation.

#### 6.2.1.2.3 Home and Society as providing unsafe environment

*Home as unsafe environment*

This study found that, as much as homes are meant to provide a secure environment, some home environments put adolescent learners at risk of HIV/AIDS. Some parents are reported to be forcing their daughters into marriage and prostitution. These findings support those by the Safe Schools Project in Malawi which found gender based violence in the home context in the form of forced or arranged marriages, incest committed by parents, encouraging daughters to have sex with rich people in exchange for material goods or money, and parents arranging for their daughters to have sex with a community male member soon after their initiation ceremony "fisi".

*Poverty*

My findings corroborate with many other studies, such as those by Amuyungu-Nyamongo (2003), Kadazamira et al. (2001), and Omorodion (2006), that adolescent girls, especially from poor families, engage in transactional sex with rich men (sugar daddies) to obtain basic needs. In this regard girls are further driven by pressure to possess the things which their counterparts from rich families have. In Nkhata Bay rich people and businessmen from Mzuzu City who come to spend weekends at the lakeshore beaches or ply their fish trade, take advantage of girls and have sex with them.

Transactional sex does not take place with "sugar daddies" only but also amongst adolescents themselves. Adolescent participants indicated awareness of this practice and the consequences of transactional sex. The study established that girls from rich families also practise transactional sex to get things their parents do not buy for them. In this regard my findings support the views expressed by Winskill and Enger (2009), that girls are involved with *sugar daddies* not for their basic needs but mainly to obtain luxury goods such as cell phones and decent clothes. Winskill and Enger (2009), argue that the notion of poverty and transactional sex is overestimated and has the danger of legitimising the practice, putting those involved at even greater risk. They further contend that even prostitution is practiced out of volition, not poverty; a view subject to debate, and an area of further research.

The findings about transactional sex in this study support those by Amuyungu-Amongo et al. (2005), that once a girl receives money or gifts from a man or boy, she owes him something in return, normally in the form of sex, and in such circumstances the girl finds it difficult to negotiate safe sex like condom use.

With regard to tourism in Nkhata Bay, my study supports the view held by the former Minister of Tourism and Information, Patricia Kaliati, that tourist holiday resorts are potential sites for the spread of HIV/AIDS, especially through international tourists who engage in sexual activities with local inhabitants, mostly young girls and boys. Participants singled out relationships between tourists and tourist guides which often culminate in sexual relationships with the potential risk of spreading HIV/AIDS, as young girls are lured by money, and may easily engage in unprotected sex. These findings concur with those of Ragsdale and Pinkerton (2006), who observed that international tourism plays a role in the spread of HIV/AIDS. My findings further corroborate with those of Winskell and Enger (2009) in Senegal, where Senegalese participants reported tourists as also being responsible for the spread of HIV/AIDS. My

study, however, could not establish whether or not tourists engage in sexual activities with adolescent school learners, thereby making them directly vulnerable to HIV/AIDS. In this study, the fishing business has been found to be dangerous for adolescents, in predisposing them to HIV/AIDS, either as fish sellers or buyers. Adolescents fall prey by engaging in transactional sex in exchange for fish, whether they are sellers or buyers. These findings corroborate those by Sabola (2008) in Malawi, which reported that some women ask fishermen for fish in exchange for sex. Sabola also reports of fish traders who go away from home for days in search of fish, and find themselves engaging in sexual relationships with other women or men, putting themselves at risk of contracting HIV/AIDS.

### *Cultural Practices*

On the issue of cultural practices, findings of this study concur with the many cited in the literature, saying that some African traditional practices place people, especially youth, at risk of HIV/AIDS. For example, studies by Kadzamira et al. (2001); Kuthemba-Mwale (1999); Munthali, Chimbiri and Zulu (2004); all done in Malawi, and also by Mugambe (2006), observed that cultural practices, such as initiation rites for adolescents, polygamy, wife inheritance, use of surrogate husbands, and widow cleansing rites, are harmful and predispose those concerned to HIV/AIDS. My study found that cultural practices, such as widow inheritance, "kuchotsa fumbi" for both new girl initiates and widow cleansing, and traditional dances such as *chilimika, vimbuza*, and *adole*, were all blamed by participants for contributing to the spread of HIV/AIDS in NKhata Bay. Participants, however, indicated that some of the practices are not common in Nkhata Bay but in other parts of Malawi where they come from. Unfortunately, most of these practices target the youth, who become the victims of HIV infections.

While I support the view held by Jackson (2002), and Lwanda (2004), suggesting that cultural practices could positively be used in advocacy for behavioural change, this study was not able to establish this, presumably

because it was not part of the question, and so participants were silent on it. Participants, however, strongly requested that the government review some of the practices, and institute legislation that could regulate or abolish them altogether. In this regard, my findings concur with Jackson's (2002) view, that through the engagement of traditional leaders, harmful aspects of some cultural practices could be changed. My participants' plea for legislation on cultural practices as they impact on HIV/AIDS, tends to support the views by former minister of health, Marjorie Ngaunje, who expressed similar sentiments as indicated below, and entrusted the task to the Malawi Law Commission:

> "Government recognizes the role that these two aspects (customs and religion) play in the fight against HIV/AIDS. We have noted the need to regulate these areas in order to align their activities with the broader national agenda for the country to move on in the fight against HIV/AIDS despite the diversities" (Moyo, 2007, p.2).

### *The media*

Contrary to the view that the media can be instrumental in facilitating behavioural change (Bridge Project, 2005; Global Link, 200; WHO, 2006), this study found a negative image of the media since adolescents portrayed it as facilitating the spread of HIV/AIDS. This area may require further study, to ascertain adolescent understanding of the media as a risk and protective factor. In this particular study, adolescent participants concentrated on negative aspects of the media, like watching pornographic films, but were not able to acknowledge the positive contributions of programmes like 'Straight talk', and 'Tikuferanji' on MBC and TVM respectively, which according to Reijer and Chalimba (2000), are quite popular among the youth, but which have not yet been evaluated to ascertain their effectiveness. I would like to support the view held by Mudaly (2006), that the media has tremendous potential as a change agent in raising awareness about issues of HIV/AIDS among the youth, since media plays a significant role in the lives of many youth. In Malawi this is exemplified by the display of big posters on billboards, using eminent political leaders or celebrities and placed in strategic positions, targeting the youth.

*6.2.1.3 Some controversies regarding what constitute risky situations*

#### 6.2.1.3.1 Co-education and single sex schools

Considering that participants were secondary school learners from different types of schools, there were contradictory views regarding what constitute risky situations. For example, participants viewed being in a co-education school as risky since it predisposes them to engaging in sexual activities and consequently contract HIV/AIDS. My findings on co-education institutions as potential sites for risky sexual behaviour seem to concur with the views held by Kelly (2003), that mixing older boys and younger girls tend to place young girls at high risk of contracting HIV/AIDS from the older boys who have been exposed to multiple sexual partners and maybe HIV positive. In most cases, co-educational schools in Malawi enrol learners of mixed ages in all classes with boys being generally older than girls.

#### 6.2.1.3.2 Relationships in schools

Similarly, participants expressed the feeling that boy-girl relationships are not a healthy development in schools, as it puts them at risk of engaging in sexual activities, including risky sexual activities. In this regard, their observations concur with the findings of those by Kadzamira et al. (2001), Maluwa-Banda (1999), McAuliffe and Ntata (1994) in Malawi, and Harrison et al. (2004) in South Africa, who found that boy-girl relationships lead learners to engage in sexual activities, either out of pressure from friends, the desire to experiment with sex, or to please a boy friend. Sexual relationships between learners have the potential for not only unwanted pregnancies, but the risk of contracting STIs including HIV/AIDS if protective measures are not taken. In this regard the findings further corroborate those of Pattman (2006), in a multi-country study of some eastern and southern African countries, where youth opposed relationships as interfering with their class work and often resulting in pregnancies.

#### 6.2.1.3.3 Seductive dressing and language

Silent in the literature, is the role of seductive dressing and language in schools, which this study found to facilitate the spread of HIV/AIDS. It was reported in this study that seductive dressing and use of obscene language arouses sexual feelings and seduces the youth to engage in sex, even rape. These findings support those of Fisher and Fisher (1996), as cited in Mudaly (2006), where it was found that young people expected high risk partners to possess qualities which included dressing provocatively, being over anxious for sex, and abusing alcohol and drugs. They corroborate the findings by Wekwete and Madzingira (2005) in Zimbabwe, where participants, who were all girls, reported that provocative dressing by girls was seductive to men. In my study adolescent participants of both sexes were quite vocal about dressing that exposes parts of the body like thighs, bellies and breasts, which they considered provocative.

Considering that my participants are mere adolescents these views should be taken with caution and considered alongside human rights which guarantee freedom of dress. I posit that any attempt to rape a girl simply because she is seductively dressed, can only be considered a sexual harassment and a criminal act. However a point that is worth considering by school management is the question of what constitutes appropriate dress code in schools.

### *6.2.1.4 Voices of participants regarding what could and should be done to reduce the risk of adolescents' vulnerability to HIV/AIDS.*

#### 6.2.1.4.1 To fellow adolescents and abstinence

The message to fellow adolescents, of practising abstinence and being religious, was very prominent from participants. There is a strong conviction that abstinence and adherence to religious and moral codes are the surest way of avoiding contracting AIDS.

These sentiments corroborate those expressed by some Malawian parliamentarians in a debate on HIV and condom use:

> "People should very much understand the importance of abstinence and agree to the fact that sex should be practiced in the homes by married couples only and not by anyone else. Because married people have a reason for doing this" (Muula, 2006, p.4).

Although adolescents in this study displayed a strong view in favour of abstinence they were not able to elaborate on how practical it is to abstain from sex until marriage. My findings concur with those of Amuyunzu-Nyamongo et al. (2005), that while participants understood the benefits of abstinence and acknowledged that it is an effective way to prevent HIV/AIDS, they also felt that postponing sex until marriage is not feasible. I therefore support the view held by Amuyunzu-Nyamongo et al. (2005), that with the age at first marriage continuing to increase due to schooling in Sub-Saharan Africa, the intention to abstain until marriage becomes increasingly difficult for most adolescent boys and girls to sustain. Furthermore, as alluded to earlier, the age at which young people are becoming sexually active seems to be falling (Rivers and Aggleton, 1999), thereby making abstinence practically more difficult. Also, considering that participants in my study indicated on several occasions that they have problems controlling their sexual desires, abstinence is therefore not a practical option for most of them. It would however be interesting to conduct another qualitative study to learn from these adolescents how they practise abstinence or can become sexually resilient.

#### 6.2.1.4.2 Adolescent voices to parents

Adolescents had a strong message for parents, calling upon them to talk openly with their children about matters of sexuality and HIV/AIDS and to stop pushing their daughters into early marriages and prostitution for money, as this puts them at high risk of vulnerability to HIV/AIDS. On the issue of open talk with parents, my findings corroborate with those by (Pattman, 2006),

where participants expressed willingness to discuss issues about sexuality and HIV/AIDS with their parents or guardians, but complained that parents were unwilling to discuss such matters. These findings further corroborate those of Mafune (2008) in Botswana, where parents were reportedly not discussing issues of sexuality with their children because of embarrassment and because of of a culture where discussing such issues are taboo. In relation to forcing daughters into marriage, the findings corroborate those of the Safe Schools Project in Malawi (see 6.2.1.2.3). They further corroborate those of Chirwa (1997), where Malawian migrant workers in South Africa, on their return, entice parents to offer their daughters in marriage, promising them a good life for their daughters in South Africa and financial support in return.

#### 6.2.1.4.3 To Government

In this study participants voiced their concerns and made appeals to the government in the areas of provision and support for more HIV/AIDS initiatives in schools, to ban or regulate of harmful cultural practices, to encourage learners to remain in school, and to protect learners from sexual harassment and abuse by male learners and male teachers. These findings corroborate the sentiments expressed in a report of the youth national forum for AIDS, presented to the Minister of Sports and Youth Development Sekeleza and Calisto 2008), which highlighted declining levels of education, poor state control of drugs and alcohol, lack of recreational facilities, and lack of counselling services on issues of sexuality, as major concerns for the youth of Malawi.

#### 6.2.1.4.4 About condom promotion and use

The study established that adolescents have a negative attitude towards condom promotion and condom use. Adolescents' concerns are centred around uncertainty about the safety of condoms, their ignorance about its proper use, and the way in which condoms are advertised in Malawi. There is also a feeling among adolescents that promotion of condom use encourages sexual activities, especially in the way they are advertised, which

they consider provocative. Also the promotional language is not that of use of condoms is for protection, but for enjoyment, and this tends to send wrong signals to adolescents. In this regard my findings are supported by the views held by Strasburger, Wilson and Jordan (2009), that advertisements about condom use do not address the risk of pregnancies or STIs or HIV/AIDS but merely the pleasures of sex. They urge manufacturers of condoms to be more responsible, so that their advertisements are not gratuitously provocative.

These findings also find support in the views held by some parliamentarians in contributing to a debate referred to in the previous section, Muula (2006, p.5), as follows:

> "I believe if we could conduct a survey, we will discover with shock that instead of discouraging sexual intercourse, these condoms have promoted the rate of sexual intercourse on our land. People are saying if I have a condom, I can go for these habits. By the end of the day, it is being promoted instead of being discouraged".
>
> "The government should consider very carefully the fight against HIV/AIDS. The fight can never be fought with a condom, which has pornographic pictures on its covers….."

That condom use encourages sexual activity is contrary to the studies reviewed by Kirby (2002) in the US, which showed no significant increase in sexual activities among the youth as a result of access to condoms.

On the issue of negative attitude towards condoms, my findings corroborate those of Kadzamira et al. (2001), and Mc Auliffe and Ntata (1994), who found low usage of condoms and negative attitudes towards condoms by secondary school learners in Malawi. With regard to my study I support the view held by Kadzamira et al. (2001), that negative perceptions about condoms and condom use are based on misconceptions, and arise from conflicting messages from advocates of condoms and religious institutions which preach against their use; stating for example that condom use is not 100% safe or that condoms encourage sexual activities among the youth. Unlike findings by Amuyunzu-Amongo (2005), Kadzamira et al. (2001), and McAuliffe and Ntata (1994), this study was not able to establish whether or not participants had ever used a condom during sexual intercourse or not,

and what the reasons for non-use of condoms are since this was not part of my research questions. The findings however corroborate those by Kirby (2002) in the US, where it was found that youth were not able to explain the reasons for non-use of condoms despite ease of accessibility. In contrast, in their study of some African countries, Winskell and Enger (2009), found that the youth placed emphasis on protection by using condoms, and that abstinence and being faithful were not considered practical options.

I also conclude in concurrence with the view held by USAID (2004), that while adolescents show negative attitudes towards condoms, they rarely put forward alternatives but continue to engage in behaviour and practices that put them at risk of sexually transmitted infections including HIV/AIDS. However, the effectiveness of condom promotion and condom use as measures of protection against teenage pregnancies and HIV infection, might be another area worth exploring from the perspective of adolescents themselves.

### 6.2.2 Adolescents' experiences of HIV/AIDS intervention programmes available in schools

#### *6.2.2.1 Awareness of various programmes offered to learners*

Adolescents displayed high levels of awareness of intervention programmes, both school-based and non-school based. In particular, programmes like Life Skills, AIDS "Toto" Clubs, SCOM, Youth Alert and HIV/AIDS youth clubs were common in schools. This high awareness maybe attributed to the fact that participants were drawn mainly from members of the AIDS clubs in the schools, and so they had been exposed to various programmes and information about programmes. The media too, especially the Malawi Broadcasting Corporation (MBC) and Television Malawi (TVM), may have played a role, as they broadcast many awareness campaigns about HIV/AIDS. Knowledge and participation in intervention programmes may on their own however not mean much unless they are accompanied by

behavioural changes in participants. I subscribe to the view held by Kelly, Parker and Lewis (2001), that intervention programmes as part of HIV/AIDS Education are a potentially powerful weapon against HIV/AIDS, since through such programmes, messages that can lead to behavioural change are transmitted. Furthermore my findings reinforce the views held by UNICEF (2006), that education is an effective and proven weapon against HIV/AIDS.

#### *6.2.2.2 Level of participation in intervention programmes*

While my study found a high level of awareness of the intervention programmes in schools, the overall level of participation by adolescent learners was very low, citing reasons such as lack of interest and commitment by teachers and learners, the desire to concentrate on examinable subjects, and the manner in which the programmes are delivered by teachers, as main deterrents. My findings concur with those by Kadzamira et al. (2001), and Reijer and Chalimba (2000), that while learners' awareness of the existence of programmes in their schools was high, very few learners were active. My findings also corroborate those of James-Traore et al. (2004), Baxen and Breidlid (2004), and Parker and Finger (2005), indicating that lack of commitment on the part of teachers, lack of openness in teaching about sexuality, and learners' attitude to life skills as non-examinable subjects, are some of the reasons for low participation by learners. With regard to my study I support the view held by Griffiths (2005), that programmes fail because of the inability of teachers to differentiate between teaching HIV/AIDS and sexuality education, and teaching regular subjects like mathematics and science. In this regard, the findings concur with Botchway (2004), who argues that by approaching HIV/AIDS from a formal didactic and lecture format, teachers are failing to make a personal association with the message, and are consequently failing to develop preventive skills in adolescent learners. This raises the issue of who should be engaging with this important work? What is the position of teachers around sex, sexuality and HIV/AIDS?

#### *6.2.2.3 Learners' experiences of the programmes*

##### 6.2.2.3.1 Positive experiences of the programmes

Similar to the findings by UNICEF (2000) in Malawi, as cited by Reijer and Chalimba (2000), this study found that learners who participated in the programmes reported positive experiences which ranged from acquisition of knowledge about HIV/AID, to some behavioural changes in individuals. The findings further concur with those in Zimbabwe (Griffiths, 2005), where it was reported that knowledge about HIV/AIDS among school learners was very high, following the introduction of courses in HIV/AIDS and life skills. Unlike the UNICEF (2000), evaluation of the programmes in Malawi cited in Reijer and Chalimba (2000), which reported specific behavioural changes in adolescent learners, such as remaining sexually inactive, or making use of condoms, my study was not able to establish what specific aspects of behavioural changes were effected as a result of these interventions.

##### 6.2.2.3.2 Negative experiences of the programmes

In terms of the experiences with the delivery of programmes, the findings of my study concur with those of UNICEF (2000), Bhana and Epstein (2007), and Baxen and Breidlid (2004), where it was reported that learners experienced dissatisfaction with the manner in which sexuality education was taught in that it lacked focus, that teachers lacked both competence and commitment, and that teachers had difficulties in teaching certain topics because they felt embarrassed to talk about sex and sexuality with children. These findings further support those by Pattman (2006), where participants from Kenya and Zimbabwe reported that HIV/AIDS Education and Life Skills were taught in didactic ways with no focus on their lives. Consequently they could not effect noticeable changes in behaviour. With regard to my study I, however, support the view held by Munthali, Chimbiri and Zulu (2004), that the onus of behavioural change lies with each individual, and so unless learners perceive HIV/AIDS as an important issue, it is unlikely that they will

take intervention programmes seriously no matter how well designed or delivered they maybe.

Considering that most of my participants were from form four, a class that was writing Malawi National Examinations Board (MANEB) examinations that year, I submit that my observation of participants' negative experiences with the intervention programmes might be due to the fact that they were concentrating on preparation for examinations.

#### *6.2.2.4 Participants' voices of what could and should be done about the programmes*

##### 6.2.2.4.1 Making Life Skills and HIV/AIDS compulsory and examinable subjects.

Findings of my study indicate that participants would prefer it if HIV/AIDS and Life Skills were compulsory and examinable subjects so that both teachers and learners would be committed to them, knowing that they will be tested during the examinations. I, however, support the view held by Maluwa-Banda (1999), that HIV/AIDS education, if offered like any academic subject, might increase knowledge but might be limited in effecting behavioural change. Knowledge by itself does not guarantee behavioural change. With regards to the ineffective delivery of programmes, I would like to agree with the observations made by Bhana and Epstein (2007), and Munthali, Chimbiri and Zulu (2004), that lack of resources and appropriate training of teachers are some of the inhibiting factors to successful implementation of these programmes. Based on my findings in this study I further concur with the views held by James-Traore, Finger and Savariaud (2004), that failure of teachers to deliver the HIV/AIDS curriculum might be because school curricula are already overloaded resulting in these programmes being offered as extracurricular activities. Consequently teachers spend less time on them as compared with subjects that are examinable. This observation calls for special teacher training in the context of HIV/AIDS. I posit, in this study, that the views of teachers have not been explored, and so regarding their views on HIV/AIDS education including other interventions, it might be useful to conduct another study to investigate teachers' experiences as well.

#### 6.2.2.4.2 Improving delivery of Life Skills and HIV/AIDS programmes

Similar to Pattman (2006), this study found that the pedagogy of HIV/AIDS or Sexuality Education or Life Skills is not satisfactory. Participants expressed the need for facilitators to focus on their lives, to be actively involved in the programmes, to engage in sporting activities, and to have guest speakers who are themselves HIV positive so that they can learn from them. The suggestion of bringing in a person positively living with AIDS seems to concur with that of Parker (2004), who argues that presenting programmes that are associated with personally knowing people who are HIV positive may greatly contribute to HIV/AIDS risk reduction in adolescents. The suggestion further corroborates the findings by Steyn et al. (2005) in South Africa, where participants requested to see someone in an advanced stage of AIDS, so as to be exposed to the harsh realities of the disease. Similarly Prata et al. (2006), found that knowing somebody with AIDS was predictive of protective sexual behaviour. These sentiments, however, contradict the views by Schenker and Nyirenda (2006), and Van Dyk (2005), who believe that HIV/AIDS education cannot be taught effectively if fear and uncertainty surrounds the disease as this may inhibit learners' sexual development because they maybecome accustomed to equate sex with disease and death. The need to involve adolescents in programmes supports the view by Aggleton, Chase and Rivers (2004, that promoting meaningful participation leads to greater acceptability of the intervention programmes. These findings are further echoed by Family Health International (FHI) (2006), who argue that meaningful participation in the programmes by youth make them more relevant and sustainable. FHI suggests the involvement of youth in the design, implementation and evaluation of programmes. Perhaps lack of adolescent involvement in the design and implementation of the programmes could be one of the reasons why there is low participation by learners in intervention programmes in schools, as noted in this study. The need for more sporting activities in the school and community youth clubs to combat AIDS concurs with the sentiments expressed by the Progressive Primary Health Care Network in

South Africa (Webb, 1997), that the provision of recreation results in surplus energy being used for sport, resulting in adolescents being less inclined to treat sex as recreation. It is further claimed that the status often associated with virility in adolescents can be transferred to the sports pitch (Webb, 1997). These sentiments are further supported by Siqueira and Diaz (2004), who argue that more involvement in extra-curricular activities would help adolescents to develop self-esteem and the ability to resist gangs, drugs and other anti-social behaviour.

Based on my findings, I therefore subscribe to the concept of Grassroots Soccer (GRS), tried in Zimbabwe by an NGO, (Griffiths, 2005), where life skills based interventions that use national and international soccer stars as role models has had tremendous success in behavioural change. Griffiths further contends that, as a result of this success, the concept has already been extended to countries like Zambia, Botswana and South Africa, where FIFA has embraced it under the theme *Football for Hope.* Although a good idea, I must admit that I have not been able to establish its existence in Malawi in any literature. Mwenyemasi and Kapakasa (2008), report of another initiative aimed at delivering HIV/AIDS messages through the use of hip-hop music which seems popular with adolescents. They report of a tour organized by Alliance 2015 under the theme 'Virus Free Generation' which was organised in 2008 and involved Malawi, Tanzania, Namibia and South Africa, as a successful project in spreading HIV/AIDS messages through hip-hop.

One observation by participants in my study, and not documented elsewhere, is the inconsistencies displayed by facilitators of intervention programmes in community youth clubs that sometimes visit schools. Participants lamented that the good message which facilitators bring to the school does not match the actions of the facilitators, claiming that they actually contribute to the spread of HIV by their behaviour. Lack of good role models is what is reflected in this observation. So adolescents need authentic and honest facilitators who live by what they teach. These findings seem to

point to some deficiencies on the part of teachers to adequately handle HIV/AIDS and sexuality education, either out of ignorance, pressure of work, or negative attitude to discussing such issues with adolescents. In some cases attitudinal problems among teachers might be due to "AIDS fatigue" (Squire, 2007, p.117), where both learners and teachers are saturated with AIDS messages and think there is nothing new to discuss. In this regard I would subscribe to the view by FHI as cited in James-Traore et al. (2004), to train teachers and re-orient their attitudes towards HIV/AIDS.

## 6.3 Synopsis of Chapter Six

In this chapter I discussed the findings of my study, and related them to the existing literature. Similarities and discrepancies were presented, as were the reasons for the discrepancies, wherever possible. In the next chapter I present the main contributions of my study to the body of knowledge about our understanding of adolescents' vulnerability to HIV/AIDS, and also methodological contributions. This is preceded by an overview of the purpose of the study, and the ontological and epistemological stance I took during the research process. I conclude the next chapter with a summary of my findings, together with implications, strengths and weaknesses.

# Chapter Seven:
# Summary of Findings, Conclusions and Implications of the Study

## 7.1 Introduction

In chapter six, I re-contextualised the findings of this study in the literature, drawing on research in support of, and contradictory to my findings. As indicated in the previous chapter, the focus of this study was to understand how secondary school adolescents view their own vulnerability to HIV/AIDS, by exploring their understanding and experiences with regards to the pandemic. The two research questions that directed this study were: How do secondary school adolescents understand their vulnerability to HIV/AIDS, and what are adolescents' experiences of the HIV/AIDS intervention programmes available in schools ? In this chapter a summary of the findings is presented, demonstrating how they address the research questions. This is followed by an outline of the implications of this study for policy and practice and the contribution the study has made to knowledge. Limitations of the study as well as suggestions for further study are outlined and then final reflections are provided.

At this juncture I am inclined to briefly revisit my ontological and epistemological stances which I hope will throw light on the sort of conclusion and implications I have arrived at. As I indicated (See 1.11.1 and 4.2), in order to understand how adolescents view their own vulnerability to HIV/AIDS and how they construct meanings of vulnerability to HIV/AIDS, I adopted a qualitative interpretivist paradigm. My ontological and epistemological stances have been that the nature of reality about vulnerability to HIV/AIDS is socially constructed and interpreted by adolescents themselves, and is

subjective, and therefore can best be studied from the perspective of my participants. Sarantakos (2005), defines interpretivism as the process of construction and reconstruction, laden with personal input. He asserts that interpretivism relates to views, opinions, and perceptions of people, as they are experienced and expressed in everyday life. To maximise my understanding of adolescents' vulnerability to HIV/AIDS from the perspective of my participants, I adopted a phenomenological approach. I, however, realised that as I entered this field I would bring with me my own values, beliefs and experiences, having worked with secondary school adolescents before as headmaster, as student counsellor, and HIV/AIDS coordinator in a university. In chapter one I therefore declared my position, and explained how I practised reflexivity and bracketing of my values, beliefs and experiences throughout the research. I also realised that if I were to take an "insider" (Creswell, 1998, p.76), view of the research process I needed to break down the power relations between my youthful adolescent participants and myself, an older researcher from the university, in a process which I have duly explained in chapter four. For example, I achieved this through the use of link teachers from the school, the use of research assistants from the university (who are as young as my participants), through the use of participatory methodologies, and also through the use of reflexivity throughout the research process. I have shown how my long period of stay in the field and the use of photovoice assisted in levelling power relations with my participants. Below I present a synopsis of how the study has addressed my research questions, and its contribution.

## 7.2 Summary of Findings Addressing the Research Questions

### 7.2.1 Research question one: How do secondary school adolescents understand their vulnerability to HIV/AIDS?

The study has established that adolescents understand their vulnerability to HIV/AIDS first as arising from internal factors at the personal level such as their

sexuality development especially their lack of impulse control and decision-making. They also understand that external factors such as peer pressure, poverty and cultural practices at the interpersonal level make them vulnerable to HIV/AIDS.

#### *7.2.1.1 Adolescents' awareness of their vulnerability to HIV/AIDS*

This study has established that secondary school adolescents in Malawi are quite aware of the fact that as adolescents, they are more vulnerable than any other group in society - perhaps a reflection of the general awareness of the pandemic nationwide. These findings have therefore dispelled the notion of low risk perception and invulnerability to HIV/AIDS in adolescents. I also noted that some adolescents tend to externalise or "other" the disease, and that this has a bearing on adolescents' sexual behaviour. Unless adolescents personalise the disease and perceive it as an important issue, it is very unlikely that any behavioural changes will occur. The notion of "othering" (see 5.2.1) is probably a reflection of the societal attitude towards HIV/AIDS, manifested in the negative discourse around the disease, which is crucial in shaping attitudes towards people infected or affected by HIV/AIDS.

While the study found high levels of awareness of how one can contract or avoid contracting HIV/AIDS, misconceptions were highlighted during participant validation, regarding how the virus is transmitted. For example, participants raised incorrect beliefs such as : if a man has had vasectomy his chances of contracting HIV were slim; if a person who belongs to the blood group "O" is infected with the virus it does not multiply in his/her body; the virus in a drunken person is less likely to be transmitted to a sexual partner during sexual intercourse because the virus also becomes drunk and inactive. These misconceptions have serious consequences for adolescents' vulnerability to HIV/AIDS, more especially if these views come from their significant others such as teachers and peers.

The study also established high levels of awareness among secondary school adolescents, of what constitutes a safe and unsafe environment in terms of contracting, or avoiding contracting, HIV/AIDS. This awareness could most probably be attributed to the school and other HIV/AIDS initiatives in their local community.

Adolescents are also quite aware of the consequences of contracting HIV/AIDS which is probably a reflection of knowledge and experiences with the disease in their community. In this study, while acknowledging the consequences of contracting HIV/AIDS, the participants requested interaction with people living with AIDS. With the high prevalence rate of HIV/AIDS in Malawi, it is doubtful if there is any family that has been spared by the pandemic. Presumably because HIV/AIDS is still shrouded in myths and denial by society, my participants are looking for validation or reinforcement of their existing knowledge about HIV/AIDS.

This study has found that adolescents are quite aware of their vulnerability to HIV/AIDS; are aware of how they can contract or avoid contracting HIV/AIDS; are quite aware of the consequences of contracting HIV/AIDS; and are aware of the various environments that can make them vulnerable to HIV/AIDS. The study has also established various misconceptions about their understanding of HIV. Although adolescents are aware of their vulnerability, it does not seem to translate into behaviour change.

#### *7.2.1.2 Adolescents' perception of HIV/AIDS risky situations*

It seems that whether the driving forces are internal or external, sexuality is at the centre of adolescent risky sexual behaviour. It appears that internal factors such as sexuality development, and external factors such as peer pressure, sexual harassment in schools, poverty and cultural practices in the communities, the media, relationships in schools, and seductive dressing and language in schools are perceived to be their greatest threats to HIV/AIDS infection.

In the case of internal factors this study has established that adolescents perceive their own sexuality development as putting them at risk of HIV/AIDS since they perceive themselves as unable to control their sexual urges. For example, the study established that adolescents tend to have sexual feelings aroused as a result of hugging between learners of the opposite sex, attending lessons in biology or life skills, and sitting closer to a learner of the opposite sex in a class. These impulses which may lead them to engage in spontaneous and often unplanned sexual activities, thereby placing them at risk of HIV/AIDS, are probably another reflection of lack of skills in impulse control and decision-making. The problems of adolescents' sexual impulses seem to be compounded by a lack of adequate or correct information about how they can protect themselves from the consequences of their sexual behaviour. Silence in homes around discussing sexual issues makes them bewildered as they seem not to know whom to turn to for advice. The breakdown of traditional structures which used to be help adolescents with their transition into adulthood has left a vacuum in sexuality education for these adolescents. These findings are probably a reflection of low levels of self-efficacy in adolescents which account for their failure to control sexual urges.

The study has also found that peer pressure among learners in schools is very high. While peer pressure on girls take the form of pressure to have sex with a boyfriend to please him, that of the boys seems to reflect the hegemonic tendency where masculinity is defined in terms of sexual prowess and sexual activity as boys try to outdo each other. On the part of adolescent girls pressure to engage in sex to please a boyfriend probably reflects the traditional notion of ideal femininity which views sex in the framework of love, or keeping a male partner by giving him sexual privileges. Peer pressure might also reflect a lack of low self-esteem, self-efficacy and lack of decision-making skills, which are essential in resisting negative peer influence.

The study has established that sexual harassment mostly takes place between learners, especially under the cover of darkness, when they return from sports, or during inter-school meetings in the evening, and takes the form of touching, use of obscene language and at times, forced sex. Sexual harassment during inter-school meetings and sports gatherings might be a reflection of laxity on the part of school management to ensure safety during such encounters. It is probably also a reflection of the excitement and freedom provided by such spaces which under normal situations are not readily available in school. Furthermore, sexual harassment is another reflection of lack of respect for each other's gender and for gender inequalities in society, where females are regarded as sex objects.

Adolescents' perception of the home as an unsafe space point to the location of their homes in relation to the environment, which they consider to have a bad influence on their behaviour. (The meaning of the last sentence is not clear.) It also seems that adolescents' significant others, such as older siblings, parents, and other adults from their homes, do not set good examples. Since imitation is characteristic of the adolescent stage, copying irresponsible behaviour from adults places them at risk as they will want to experiment with what they observe.

This study also established the existence of transactional sex between learners and rich men and between learners themselves, partly arising from poverty. The study found that adolescent girls from poor and rich families practise transactional sex. One wonders why a girl who is provided with all her basic needs might wish to engage in transactional sex. One possible explanation, though, might be the type of lifestyle choices that adolescents follow which often are not understood by parents. Adolescents want so much in life that parents may not provide for. Transactional sex has also been linked to peer pressure (see 5.2.1.2) where a girl might engage in transactional sex under the influence of peers. The practice of transactional sex is compounded by unequal power relations between girls and boys or men, resulting in either

having multiple sexual partners or unprotected sex in response to the demands of the male partners. Forced marriages of daughters and encouragement of daughters to engage in transactional sex by parents, emerged as another serious problem, putting adolescents at risk of HIV/AIDS. This is another issue of concern because one wonders why parents might wish to force their daughters into marriage or encourage them into prostitution in view of the HIV/AIDS pandemic. Is it out of ignorance or purely motivated by poverty? This study has also found that cultural practices in Malawi, such as initiation rites, widow inheritance, widow cleansing, and surrogate husbands, put adolescents at risk of contracting HIV/AIDS. It appears that cultural practices in Malawi are anchored on the notion that sex and sexuality are for procreation. For example, initiation rites are meant to prepare adolescents for married life and child bearing, while practices such as widow inheritance, "fisi" (the use of a surrogate husband), and widow funeral cleansing rites, are meant to ensure the survival of the clan through continued procreation. It also appears from this study that these practices target the youth and have a strong influence on their behaviour. This is so, presumably because society looks at adolescents to continue with the process of procreation. If perpetuation of the clan is the motive, with the AIDS pandemic in their midst, the practices defeat their own purpose because once infected, the process of procreation is most likely derailed.

While the media has the potential for facilitating behavioural change among adolescents, this study has found that the media, especially films and pornographic pictures, facilitate the spread of HIV/AIDS. The negative portrayal of the media is presumably accurate because in this study participants were more concerned with contexts that put them at risk of contracting HIV/AIDS, than those which protect them from the virus. However as I have explained (see 2.2.10), this is an area worth further research as there are known to exist a number of media initiatives, popular with adolescents, which might have some positive influences. For example,

programmes like, "Straight Talk" on MBC and "Tikuferanji" on TVM are quite popular with adolescents.

It seems clear that adolescents perceive their vulnerability to HIV/AIDS as arising firstly from internal factors like their sexuality development and sexual impulse, and they seem to perceive peer pressure and sexual harassment in schools, and poverty and cultural practices in the community and society at large as external factors which put them at risk of HIV/AIDS. These findings also seem to indicate that poverty, peer pressure and sexual harassment are interrelated and gendered, with girls being particularly vulnerable to HIV/AIDS. Lack of good role models in the community is also perceived by adolescents as a risk factor. These perceptions are probably an indication of the knowledge adolescents have regarding risky situations, and one would expect them to use such knowledge as an asset to facilitate behavioural change; unfortunately this is not the case.

#### *7.2.1.3 Some controversies regarding what constitutes risky situations*

The study has identified a number of inconclusive issues that raised debate as to whether they are risk factors or not. Such debates include: what the implications are for being in a co-education or single sex school, boy-girl relationships in schools, and dressing by learners. For example, some participants felt that relationships between learners of the opposite sex have the potential for putting adolescents at risk of HIV/AIDS because, for them, any relationship between people of the opposite sex is deemed to be sexual. However, other participants felt that relationships need not be sexual all the time, but that relationships and mixing with learners of the opposite sex in one school might be useful in breaking the gender inequalities common in schools and society. Dressing is also considered provocative and came under the spotlight by both girls and boys as predisposing them to HIV/AIDS, but caution must be observed not to infringe on people's rights.

*7.2.1.4 Voices of participants regarding what could and should be done to reduce the risk of adolescents' vulnerability to HIV/AIDS*

The study established from the learner participants that promotion of condom use has the potential for encouraging sexual activities in adolescents and that a call for the promotion of abstinence until marriage is preferable. As alluded to (see 2.3.8.1), while adolescents frown on the use of condoms, and while they acknowledge the benefits of abstinence, they do not explain how they could manage to abstain from sex until marriage, and with the age at first marriage continuing to rise due to schooling, abstinence till marriage becomes difficult in practice for most adolescents. This negative attitudes towards condoms is probably due to the wide-spread misconception that condom use makes sex unpleasurable. It probably also explains why there is a high HIV/AIDS prevalence rate among the youth in Malawi. Again, as I have argued, the notion of abstinence until marriage takes the view that sex is only for procreation and neglects the pleasure part of it which adolescents have conceded they crave. However, this could probably be another area of further study to establish how adolescents think they can make themselves sexually resilient.

The study has further established that adolescents are concerned about their vulnerability to HIV/AIDS and they have indicated that collective efforts by adolescents themselves, by parents, teachers, the community, and society at large including government, are required to reduce their vulnerability to HIV/AIDS. This seems to be a reflection of the high level of awareness of the pandemic arising from the influence of various interventions both in and out of school. The findings further reflect adolescents' willingness to participate in the design and implementation of interventions.

*7.2.1.5 Concluding remarks regarding adolescents' vulnerability to HIV/AIDS*

The study has established that adolescents' understanding of their vulnerability to HIV/AIDS and in particular their awareness of how they can

contract or avoid contracting HIV/AIDS, the consequences of contracting HIV/AIDS, and what constitutes risky and safe environments in relation to HIV/AIDS, is very high. Unfortunately this awareness does not seem to translate into behavioural change among adolescent learners. The study has further established that adolescents tend to externalise or 'other' the disease and distancing themselves from it; an attitude that further puts them at risk of contracting HIV/AIDS as they may engage in risky behaviour, believing that they cannot contract the disease. The study has also established that adolescents' view their vulnerability as first arising from internal factors, especially their own sexuality development, and then from external factors such peer pressure, poverty and cultural practices.

### 7.2.2 Research question two: What are adolescents' experiences of the HIV/AIDS intervention programmes available in schools and why do they respond to them the way they do?

The study has established that adolescents have had positive and negative experiences with the intervention programmes available in schools. The ones who are participating in the intervention programmes have experienced some behavioural change. The study has however also established that lack of commitment by both learners and teachers and lack of effective delivery of the programmes limit their potential for behavioural change

#### *7.2.2.1 Awareness of various programmes offered to learners*

This study found high levels of awareness of various intervention programmes both in and out of school, such as Life Skills, AIDS "Toto"clubs, Youth Alert, and community youth clubs, are a reflection of the influence of nation-wide HIV/AIDS campaign in schools. But like awareness of their vulnerability to HIV/AIDS, awareness of the programmes is not translating into behavioural change among adolescent learners and they continue to put themselves at risk of HIV/AIDS infection.

#### *7.2.2.2 Reasons for low levels of participation in the programmes*

The study has also found that the level of participation in these programmes by learners is generally very low, which is attributed to lack of interest and commitment by both learners and teachers, and also to when and how these programmes are delivered. It was found that both learners and teachers are preoccupied with subjects that are tested during the examinations and since HIV/AIDS and Life Skills are not examinable, they receive less attention. And because HIV/AIDS programmes operate like a club, activities are done after class hours when learners are tired and so many do not participate. The study further found that the motives for joining AIDS club are not necessarily to acquire skills for behavioural change, but to enjoy travels ("school outings"), and that if these are not organised by the clubs, learners easily give up. This lack of commitment might also imply that they do not see a need for the programmes or that they feel there is too much information about HIV/AIDS around and have developed "AIDS fatigue". There is need for attitude change because unless both teachers and learners see the need for intervention it is unlikely that any behavioural change will be noticed among adolescents. Also, the times when programmes are delivered and the mode of delivery need to be reviewed to establish times that are convenient and programmes that appeal to all learners in a school.

#### *7.2.2.3 Learners' experiences of the programmes,*

It has been found in this study that while those who participated in the intervention programmes reported positive experiences with the programmes, such as making some behavioural changes, they also reported negative experiences with the programmes, mostly regarding the manner in which the programmes are delivered. It was found that teachers were not relating their lessons to real life situations about HIV/AIDS, and that at times were not open enough to explain issues of sexuality and HIV/AIDS, presumably due to shyness, or because such discussions were contrary to the

values they hold. Consequently adolescents' responses to the intervention programmes in schools has generally been negative. Dissatisfaction with the delivery of the programmes could also be a reflection of either lack of commitment as noted above (see 7.2.2.1) or that teachers are overburdened by their teaching loads. With such experiences it is inconceivable that much can be achieved in the way of behavioural change among adolescent learners in schools. These findings also have implications for teacher education and development, namely a perceived to orient them towards appropriate skills for effective delivery of HIV/AIDS and life skills curriculum.

#### *7.2.2.4 Participants' voices of what could and should be done about the programmes*

The voice of the participants in this study was that life skills and HIV/AIDS should be made compulsory and examinable subjects, in order to instil commitment in both teachers and learners. These sentiments are a reflection of the attitude that learners have, namely that unless a subject is examinable, no learning takes place, but they fail to recognise that there are a lot of things that we learn which are not examined that are very useful in everyday life. For example the adoption of a healthy lifestyle does not require a certificate and as alluded to (see 2.3.6), programmes that are taught like other academic subjects will not necessarily effect behavioural change although they might increase knowledge about the pandemic. Participants also expressed the need to relate intervention programmes to real life situations by involving adolescents actively in the programmes and by involving people who are positively living with AIDS, to enhance their commitment to behavioural change. The study further established that adolescent learners understand the significance of engaging in sports as an alternative exercise to sexual activities. The need for activities and for real life situations is a reflection of this developmental stage when adolescents want to be doing things and not just listening; they are also inquisitive to find out why things happen the way they do. It is probably for these reasons that they

seek interactions with PLWA namely to learn from them what happened to them and why they find themselves in such a situation.

#### *7.2.2.5 Concluding remarks on adolescents' experiences of the HIV/AIDS intervention programmes*

The study has found that awareness of the HIV/AIDS intervention programmes available in schools is equally very high, and that those who are participating in them have experienced some behavioural change. The study has however established that lack of commitment by both learners and teachers and lack of effective delivery of the programmes limit their potential for behavioural change among adolescent learners.

## 7.3 Implications of This Study for Policy and Practice on Vulnerability of Adolescent Learners to HIV/AIDS and Interventions in Schools

### 7.3.1 Adolescents' awareness of their vulnerability to HIV/AIDS

Adolescents understand themselves as being vulnerable to HIV/AIDS in a number of contexts compared with other members of society. There is also relatively high awareness among adolescents of how they can contract or avoid contracting HIV/AIDS, as shown by their ability to pinpoint contexts that might put them at risk of contracting HIV/AIDS, such as having unprotected sex with an infected person, and practices that might help them avoid contracting the virus, such as abstinence. Adolescents have demonstrated that they are quite aware of the consequences of contracting HIV/AIDS, such as withdrawal from school, being discriminated against in society, long illnesses and suffering and eventual death. They also are aware of the various environments that can put them at risk and which are safe. Unfortunately this awareness of their vulnerability to HIV/AIDS seems to be shrouded in misconceptions about the disease and also overshadowed by their attitude of "othering" the disease. The findings point to the need for a review of the

practice of interventions at school level, to make them more informative, practical and realistic. In particular, programs ought to address this attitude of othering or distancing themselves from the disease by enabling adolescent learners to accept that the pandemic is amongst them, requiring that they adopt a new language of optimism and of the affirmation of the possibility of change and of the centrality of compassion and concern, as they engage with the HIV/AIDS pandemic (Cook, Fritz & Mwoya, 2003). These findings also have implications for government to change the mind-set of the society when talking about HIV/AIDS.

Relative to what constitute safe and unsafe environment, the findings of this study have shown that adolescents consider the location of schools surrounded by thick bushes, or far from homes, as posing a risk for day scholars who commute from home to school. Participants singled out girls as being particularly at risk of sexual harassment by men and fellow boy learners on their way to and from school. This observation has implications for the choice of site for new schools, suggesting that before establishing a school, it is necessary to take into consideration the physical location of the school, including the distance from homes. In this regard boarding schools for girls should be considered. It has also been established that locating homes close to bars or rest houses poses risks to adolescents. This too has implication for municipal authorities to consider when planning residential and business plots, so that residential plots are not close to bars or rest houses, as these put adolescents at risk of contracting HIV/AIDS.

### 7.3.2 Adolescents' perception of HIV/AIDS risky situations

The study has observed that while adolescents consider their sexuality development a normal phenomenon they also perceive it as putting them at risk of contracting HIV/AIDS. Adolescents perceive themselves as deficient in exercising control over their sexual desires, arising from their sexuality development. These observations have implications for the way sexuality

education is taught. Sexuality education ought to include skills in impulse control. Parents should also be encouraged to talk openly about sexuality issues with their children.

A number of school-related aspects, which predispose adolescents to the dangers of contracting HIV/AIDS, such as inter-schools meetings, peer pressure and sexual harassment, have been highlighted in this study. Adolescents think that their risky sexual behaviour is often as a result of pressure from peers to conform, or just imitation. The notion of masculine hegemony associated with peer pressure by boys, this study has found, has serious implications for adolescent vulnerability to HIV/AIDS as they maybe inclined to engage in unprotected sex with their partners or engage with multiple sexual partners to fulfil peer expectations. Also the findings that girls are pressurised to engage in sexual activities just to please a boyfriend, have implications for the girl's capacity to negotiate safe sex and this places her at risk of HIV/AIDS. While inter-schools meetings are considered healthy for social development, they are considered a risk factor as adolescents tend to use such opportunities to fulfil their sexual desires, engaging in unplanned and unprotected sex. These have implications for school management and government, to make schools safe places for adolescents, especially girls. In particular, school management should review their practice with regards to inter-school meetings, either for educational purposes or for sports, since these have been reported to provide potential risk to learners who engage in risky sexual activities. Although sexual harassment by teachers was not prominent in the study, the fact that it was mentioned is indicative enough of its existence. A recent condemnation of the practice by the president should be followed by action against teachers who perpetrate this practice on girl learners. Also the findings that homes provide unsafe spaces for adolescents, and that they the latter good role models have implications as to where and how adolescents are raised, sometimes putting them at risk of contracting HIV/AIDS.

Poverty has repeatedly been mentioned as a motivating factor in engaging in risky sexual behaviour, especially by girls. This ought to be weighed against the consequences of contracting HIV/AIDS which this study has demonstrated are well known by adolescents. These findings have implications for adolescents' themselves, parents, and society in general. The fact that parents are involved in encouraging daughters to engage in transactional sex, calls for serious questions about the moral responsibility of parents towards their children. These findings have serious implications for adolescents' rights and parents' responsibilities towards the safety of their children.

This study has found that various cultural practices in Malawi such as initiation rites, widow inheritance, and widow sexual cleansing rites, predispose adolescents to risk of HIV/AIDS. These findings have implications for the way society looks at cultural practices in the context of HIV/AIDS. It is therefore incumbent on traditional leaders who are the custodians of culture, to seriously review all the harmful practices, but any change will require the support of government and other stakeholders.

While this study has not established a positive link between the media and HIV/AIDS, and while the media has been associated with risk behaviour, the observation that the media has been instrumental in the success story of slowing down the pandemic in Uganda (see 2.2.10), has implications for the HIV/AIDS campaign in Malawi. Bearing in mind that the media seems to be the main source of information for adolescents, it has the potential for behavioural change and its influence requires a review of in Malawi.

### 7.3.3 Some controversies regarding what constitutes risky situations

This study has established that adolescent learners have mixed views regarding a variety of issues in school and debates have ensued about issues such as co-education and single sex schools, relationships between boys and girls in schools, and dressing, which some learners view as risk factors. The

issue of relationships in schools has implications for intervention programmes where issues such as abstinence, sexuality, gender equity and gender equality could be discussed. I draw on Everett's (1998) concept of the 3 Rs which must always be stressed: one's rights, one's responsibilities and one's rewards associated with boy-girl relationships (cited in Steyn et al., 2005). Such debates can demonstrate the level of understanding among adolescents of what constitutes a risky or safe context and should be encouraged so that in the process of discussions and interaction they acquire decision-making skills, and skills in self control.

### 7.3.4 Voices of participants regarding what could and should be done to reduce the risk of adolescents' vulnerability to HIV/AIDS

Participants view abstinence and adherence to religious and moral codes as being the surest way to reduce adolescents' vulnerability to HIV/AIDS, and condemn the promotion of condom use. In view of the contradictions demonstrated by adolescents where they acknowledge the difficulty of abstinence until marriage but at the same time show negative attitude towards condom use thereby aggravating the spread of HIV infection among the youth especially in schools there is need for a strong advocacy on the use of condomds as preventive measures against unwanted preganancies, STI's including HIV/AIDS.

Participants also call upon parents to talk openly about sexuality and HIV/AIDS issues with their children and call upon government to provide more, and effectively implemented, HIV/AIDS programmes in schools. Religion seems to play a crucial role in adolescents' understanding of their vulnerability to HIV/AIDS; this has implications for the coordination between religious institutions and civil society organisations and government. Adolescents' voices require a listening ear from the stakeholders concerned as that is the surest way of succeeding with any interventions that involve them because they feel they are part of the plan.

### 7.3.5 Awareness of various programmes offered in schools

As alluded to in the previous section (see 7.2.2.1), adolescents are quite aware of the intervention programmes available in schools. Unfortunately, this awareness rarely translates into behavioural change. These findings have implications for adolescents' vulnerability to HIV/AIDS, as they continue to put themselves at risk of HIV/AIDS. The findings also have implications for the types of programmes offered to learners in schools, namely whether or not they appeal to adolescents.

### 7.3.6 Reasons for low levels of participation in the programmes

While findings show that adolescent learners receive enough information regarding HIV/AIDS at school, the majority of learners do not participate in the programmes for various reasons. The times when programmes are delivered is seen to be a deterrent to many learners. Also the manners in which the programmes are delivered tend to discourage participation. These findings point to the need for a review of the policies regarding HIV/AIDS programmes to accommodate all learners at school. The position of Life Skills in the school curriculum, and the manner in which it is delivered, also requires serious review. "EDZI Toto" clubs which are mostly peer driven and which are volitional also need some review because as this study has demonstrated, most adolescent learners do not participate in the clubs, and yet the clubs have great potential for effecting behaviour changes. Based on the influence that peers have on each other, interventions should capitalise on this and institute more peer-based programmes which, however, must be closely monitored. The findings of this study also point to some serious deficits by teachers to handle issues of sexuality and HIV/AIDS, either out of ignorance, pressure of work, or negative attitude about discussing them with adolescents. This calls for either skills training or re-orientation of teachers' attitudes towards HIV/AIDS. Facilitators of HIV/AIDS programmes or sexuality

education must be people who are ready and willing to deliver such programmes to adolescents.

### 7.3.7 Learners' experiences of the programmes

Findings of learners' mixed responses to the HIV/AIDS programmes offered in schools have their own implications for the delivery of the programmes. For example, learners indicated negative experiences in the form of poor delivery of the programmes by teachers, such as teachers' failure to relate to real life situations, and lack of openness in discussing issues of sexuality and HIV/AIDS. From the findings of this study, effective delivery of intervention programmes should involve active participation by adolescent learners; programmes should be able to appeal to adolescents, and must include play, music, drama, poems and external guest speakers. To make HIV/AIDS programmes more realistic and practical, arrangements could be made for adolescent learners to visit hospices such as the "Rainbow House" or "Lighthouse" clinics where HIV/AIDS patients are treated. As my participants have intimated, this might assist them to internalise their responsibility in terms of the prevention of HIV transmission. Making use of people living with AIDS seems to support the role of cues in the health belief model, which it is believed could trigger preventive action in adolescents (Kelly, 2001). Such initiatives may also correct the many myths about HIV/AIDS among adolescents and increase their awareness of the realities of the pandemic. In this regard, I would like to argue with Schenker and Nyirenda (2006), who maintain that such an approach might arouse fear in learners. On the contrary it will help them see the reality of the disease; this study has established that adolescent learners are quite aware of the disastrous consequences of contracting HIV/AIDS, and so fear is not unknown. Such interaction might be used to reinforce their knowledge.

From the findings of this study and its implications, it is obvious that the study has contributed something to the academic fraternity and the general

practitioner. I now turn to what contribution the study has made to knowledge.

## 7.4 Contribution of the Study

### 7.4.1 Theoretical contribution: Revolving vulnerability to HIV/AIDS

This study has specifically contributed knowledge to the field of educational psychology, in particular, adolescents' social behaviour in the context of HIV/AIDS pandemic.

Although this study does not claim to have discovered new knowledge as regards contexts that predispose adolescents to HIV/AIDS, the study has established that the mediating factors of adolescents' vulnerability to HIV/AIDS are more complex than has been thought, and that no single model can meaningfully explain their motives for engaging in risky sexual behaviour, or why the current intervention programmes are seemingly not working. For example, unlike in the past when vulnerability was considered a personal trait and the social context disregarded, we understand that the phenomenon of vulnerability is a dynamic and interactive process (Normand, 2007). I therefore argue that through the use of the ecosystemic framework and other complementary models and theories, such as the Bishop-Sambrook's pathway model, psychological theories, and health behaviour models, the study has increased our understanding of adolescent learners' vulnerability to HIV/AIDS. As Blum, McNeely and Nonnenmaker (2002) posit, the ecosystemic framework helped me to understand vulnerability, not as discrete inter-psychic factors, but as interlocking sets of factors that are influenced by the context within which the adolescent lives. Furthermore, I argue that the ecosystemic framework has helped me to understand vulnerability as developing through both internal and environmental factors, and that adolescent risk factors are not characteristics of adolescents in isolation. Therefore any attempts at exploring adolescent vulnerability

including the  the design of interventions that do not take into account their social context, are bound to fail.  What follows therefore, is an explanation of the contributions that highlight adolescents' vulnerability.

#### *7.4.1.1 Understanding adolescents' vulnerability to HIV/AIDS*

Drawing from the ecosystemic perspective, it emerged from my study that an understanding of adolescents' vulnerability to HIV/AIDS and their response to interventions should be viewed first from the individual level, where knowledge, attitudes, and beliefs are crucial in determining behaviour, and then from the interpersonal level, comprising the family, peers, school, community and society at large, as other major determinants of their behaviour.  We are now more aware that Malawian adolescents are vulnerable to HIV/AIDS arising from internal factors such as their sexuality development, and also from various external factors such as peer influence, poverty and cultural practices. The implication of these findings is that the onus is first on the individual adolescents' willingness to effect behavioural change because, as I have argued elsewhere (see 6.2.2.4), unless they see the need for behavioural change, they will continue to be vulnerable. This study has established that attitudes, lack of skills in impulse control, decision-making and self-efficacy, and low self-esteem, seem to be important internal factors in adolescents' continued engagement in risky behaviour. Based on my findings, I tend to agree with Bandura as cited in Maluwa-Banda (1999), that the reasons that adolescents do not change their risky sexual behaviour, even with the full knowledge of the consequences of HIV/AIDS, is because they lack self-efficacy to manage situations effectively. I therefore subscribe to Maluwa-Banda's (1999), view that intervention programmes in schools should increase or reinforce adolescents' self-efficacy by making sure that they possess the required communication, negotiation and problem solving skills. I further subscribe to the view by Siqueira and Diaz (2004), that adolescents who possess the assets of self efficacy, self worth and hopefulness, are more likely to resist negative peer influence.

Indeed, as Swartz et al. (2004) argue, in view of the absence of a vaccine for HIV/AIDS, reducing high risk sexual behaviour remains the principal strategy. Drawing on Van Dyk (2001), the use of psychological perspectives in this respect has been helpful in providing an explanation of why individual adolescents behave the way they do and might be useful in predicting adolescents' behaviour and facilitating our understanding of the intra-personal and inter-personal factors relating to HIV/AIDS. Although Parker (2004), argues that psychological models do not provide an adequate framework for bringing about behavioural change, especially when applied to the African context, I argue that in the context of my study psychological theories shed some light on my understanding of adolescents' vulnerability to HIV/AIDS. For example, in this study high levels of awareness of adolescents themselves as a risk group, awareness of what constitutes a safe or unsafe environment, and awareness of the consequences of contracting HIV/AIDS, could be used to predict behaviour.

Findings of this study have helped us develop a greater understanding of how prone adolescents are to sexual impulses and why, if not controlled, these can make them vulnerable to HIV/AIDS. The findings suggest the need for raising self esteem and the development of skills in risk and impulse control among adolescents. It has also become clearer from my findings that adolescents have difficulties in relationship building, especially with the opposite sex, and are easily influenced by peer pressure. I therefore subscribe to the view by Field and Hoffman (2002), that there is a need to develop self-determination among adolescents so that they can become independent and critical and be able to make informed choices in pursuing healthy life styles. This in turn will promote hope for the future of the concerned adolescents. These findings have implications for the promotion of self-determination, not only in adolescent learners, but in all members of the school community so that they can provide appropriate support to adolescents to make them less vulnerable to HIV/AIDS.

Through the findings of this study we are quite aware of the extent of adolescent understanding of the consequences of HIV/AIDS in shattering their hopes for the future, but it is also clear from the study that adolescents seem to have problems in participating in interventions, because they have lost hope in their usefulness. The study has also shown that adolescents have problems in charting their futures and establishing goals for themselves in life. It is these inadequacies that place adolescents at risk of HIV/AIDS. Drawing from the work of Harris et al. (2002), interventions should address adolescents' realistic goal setting, development of pathways (a kind of thought reflecting a person's capacity to produce cognitive routes towards desired goals), and agency cognition (thoughts that people have regarding their ability to begin, and continue movement, on selected pathways towards those goals). Harris et al. (2002), further argue that high hope adolescents, relative to low hope adolescents, are most likely to engage in health enhancing activities such as exercises, and to practise safer sex since these adolescents are likely to possess high levels of self efficacy. Indeed my findings have shown that idle bodies, as in the absence of activities, tend to place adolescents at risk of HIV/AIDS; all they think about is how to engage themselves in sexual activities.

Furthermore, drawing on the work of Van Dyk (2001), and using behavioural models, we have become more aware that adolescents realise the consequences of engaging in risky sexual behaviour; the need to change behaviour; have knowledge of which specific behaviours need to be changed; acknowledge the need for support from friends or adults in the process of behaviour change, and have knowledge about the benefits of adopting new behaviours such as use of condoms. For example, an understanding of Social Cognition Theory which deals with aspects of cognition and emotion, has provided useful insights into understanding how adolescents acquire and maintain certain behavioural patterns including risky sexual behaviour. Unfortunately, as has been pointed out, they do not seem to have sufficient self efficacy to adopt new behaviour, and this puts them at risk of HIV/AIDS. The assumption in health behaviour models that

individuals make rational decisions is not always correct; adolescents, especially with regard to sexual behaviour, tend to be influenced by peers. For example, my findings indicate that adolescents at times engage in sex, including un-protected sex, spontaneously under pressure, and in this regard they corroborate the view held by Vanlandingham et al. (1995), that adolescents tend to be under intense pressure from peers, leading them to make irrational decisions which make them vulnerable to HIV infection. Below I show a brief overview of how the ecosystemic framework has contributed to our understanding of adolescent vulnerability to HIV/AIDS at both individual and interpersonal levels.

*At the individual level*

During adolescence sexuality develops in youth, triggering intense sexual feelings towards members of the opposite sex. Unfortunately, as explained (see 3.2.3), their problem is to satisfy their sexual needs in socially acceptable ways. In Malawi this is compounded by the societal link between sex and reproduction, namely that sex is for procreation, to the exclusion of sex for pleasure. These societal expectations coupled with the taboo placed on discussing sex and sexuality, tend to encourage sexual experimentation among adolescents placing them at risk of HIV/AIDS. At the individual level, understanding of adolescent vulnerability to HIV/AIDS is concerned with individual characteristics that influence behaviour, such as knowledge, attitudes and beliefs. For example, the findings of this study have made us more aware how their limited knowledge, negative attitudes, and skewed beliefs about condom use place adolescents at risk of contracting HIV/AIDS. Based on my findings it seems clear that sexuality development is a risk factor in adolescents' vulnerability to HIV/AIDS, and I subscribe to the view held by Huitt (2005), that vulnerability to HIV/AIDS is indeed determined at the individual biological level.

### *At the interpersonal level*

While in the preceding section I have described how this study has helped us understand adolescents' vulnerability at the individual biological level, I have now become more aware that personal/internal factors (i.e. cognitive, affective and biological), behaviour, and environmental influences are highly interactive, and create what Bandura (1994), calls "triadic reciprocal causation" (as cited in Kelly et al., 2004, p.13). I now turn to these environmental influences on adolescent sexual behaviour and consequent vulnerability to HIV/AIDS.

### *Peers*

Although peer influence on adolescents' risk taking behaviour is not a new phenomenon, this study has increased our understanding of masculine hegemony among adolescents as a serious factor in adolescents' vulnerability to HIV/AIDS. Also it has reinforced previous studies which indicate that pressure from peers to engage in sexual intercourse, either to conform to peer norms, or to please a boyfriend, places adolescent learners at risk of HIV/AIDS.

### *The family*

While I am in agreement with the view held by Donald et al. (2000), that the family is the basic source of security and support, and consequently provides a safe environment for adolescents, I am now more aware that poverty can, at times, drive parents to force their daughters into early marriages or prostitution thereby putting their daughters at risk of contracting HIV/AIDS. It has also become clear to me that lack of openness on the part of parents to talk about HIV/AIDS and sexuality issues places adolescents at risk of HIV/AIDS. What is not clear though is whether or not parents place their daughters at risk out of ignorance of HIV/AIDS or if they are indeed motivated by poverty, but in view of the high prevalence rate of HIV/AIDS in the country, it is doubtful that they do not know about AIDS. Perhaps some

parents are still in denial about the disease and, like my participants, tend to externalise it.

### *The School*

As my findings indicate schools generally provide learners with safe environments such as HIV/AIDS and life skills programmes which according to Donald et al. (2000), are crucial for solving social and interpersonal problems, including HIV/AIDS. Through this study it is becoming clearer that lack of good role models by teachers and facilitators of HIV/AIDS programmes, especially those that visit schools from community-based HIV/AIDS organisations, puts adolescents at risk of HIV/AIDS. Using Bishop-Sambrook's (1993) model, I am able to see how the presence of good role models can contribute to risk reduction in adolescents, through observing how their role models, whether infected or not, are managing or coping with the impact of HIV/AIDS. I would like to agree with Donald et al., (2000), that role models are vital in transmitting values that shape adolescent learners. The findings that HIV/AIDS and life skills programmes are not taken seriously by both learners and teachers, are of concern. This attitude, coupled with the lack of role models in schools, places adolescents at risk of contracting HIV/AIDS. As explained (see 7.2.2.1) it is not clear whether it is out of lack of interest, or pressure of work, that teachers do not take HIV/AIDS and life skills seriously.

### *Community/ Society*

According to Family Health International (FHI) (2006), at this level, values, beliefs, and attitudes held by the community are vital in shaping individual adolescents. Similar to observations by FHI (2006), my findings indicate that many adolescents in Malawi are at risk, due to some beliefs and practices held by the community/society. For example, beliefs like having sex with a virgin or an albino cures AIDS, and practices such as wife inheritance, use of surrogate husband ("Fisi"), and initiation rites, place adolescents at risk of HIV/AIDS. These findings have serious implications for policy at both community and society levels, and although I do not propose their abolition, I

tend to be in agreement with the suggestion by Swartz et al. (2004), towards influencing changes in some harmful cultural practices. The study has revealed the position of adolescents on cultural practices, who have made a strong plea to government and traditional leaders to consider legislation that would regulate or abolish some harmful practices in Malawi.

Having established that the mediating factors of adolescents' vulnerability to HIV/AIDS are more complex than has been thought, and that no single model can meaningfully explain adolescents' motives for engaging in risky sexual behaviour, or why the current intervention programmes are seemingly not working, I therefore theorise a new perspective of looking at the phenomenon, to be called "revolving adolescents' vulnerability to HIV/AIDS", illustrated in figure 33 below. In this diagram I propose that adolescents' vulnerability to HIV/AIDS can best be viewed from the perspective of multiple theoretical lenses, in which the adolescent interacts with protective and risk factors, both from within and without, in order to effect behavioural change. The diagram has brought together all the theories I applied in this study, and shows the interrelatedness of these models in relation to the adolescent. Below is a full explanation of the diagram.

#### *7.4.1.2 Diagram of Revolving Vulnerability to HIV/AIDS*

In trying to visually illustrate how the theoretical frameworks support my findings, I offer the following diagram based on the revolving of the earth around the sun, for illustrative purposes.

Figure 33. A diagram of revolving adolescents' vulnerability to HIV and AIDS

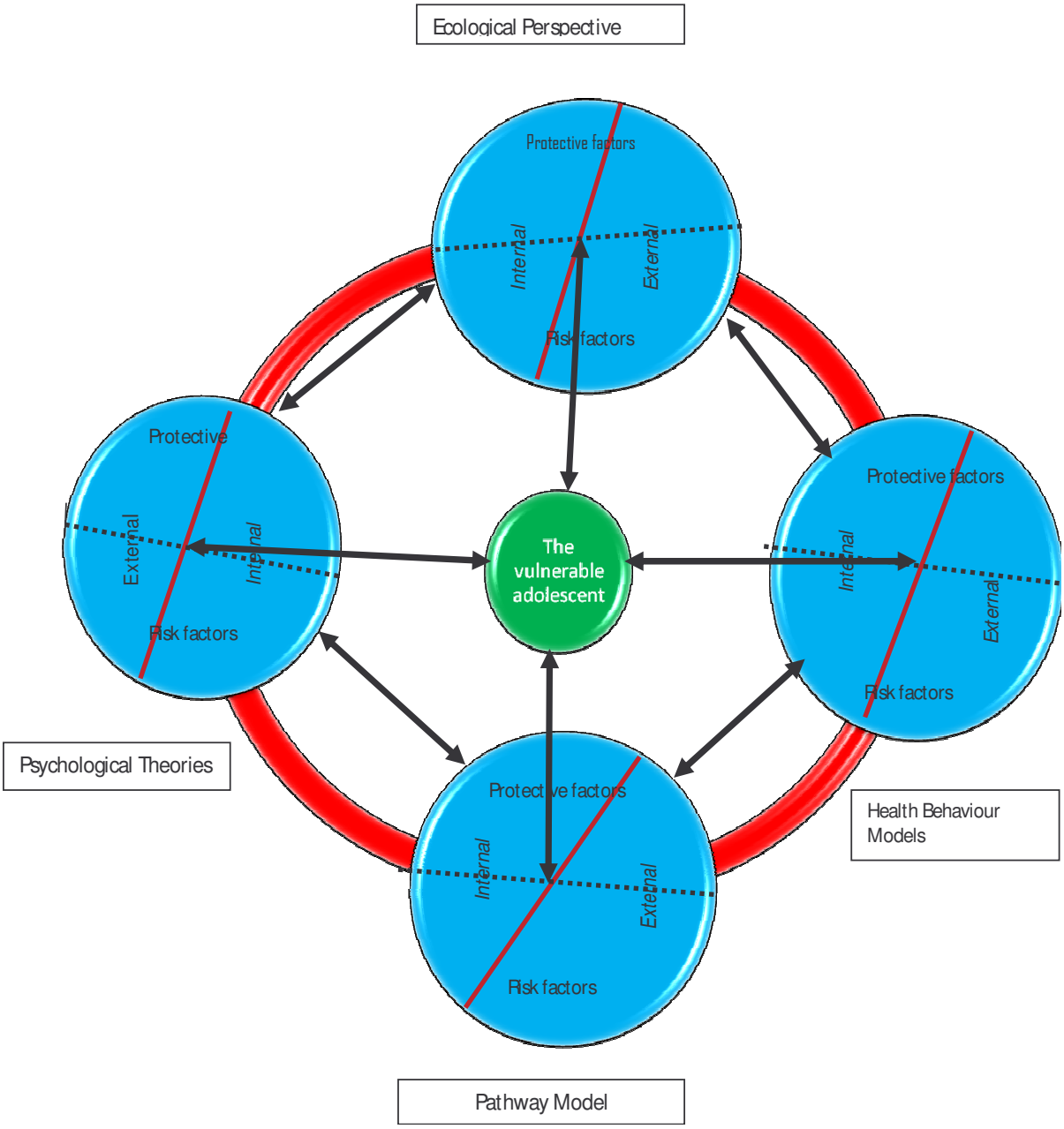



**Figure 33: Diagram of adolescents' revolving vulnerability to HIV/AIDS**

The diagram shows four spheres, representing the four theories and models used in the study, with a small circle in the middle representing the 'adolescent'. The four spheres revolving around the adolescent illustrate the use of multiple theoretical lenses to understand adolescent vulnerability. It also demonstrates the inadequacy or elusiveness of the use of a single theory to offer an explanation of adolescents' vulnerability to HIV/AIDS.

Each sphere is divided into two, the upper and lower. The upper semi-sphere represents protective factors, and the lower, risk factors. The dotted line separating protective from risk factors is an indication that protective factors could, under certain circumstances, percolate to become risk factors, and vice versa. A north–south axis further divides the sphere into inner and outer semi-spheres. The inner semi-sphere which is close to the adolescent represents the adolescent's personal factors, while the outer or external semi-sphere represents adolescent's interpersonal or environmental factors. The arrows indicate the interrelatedness of the adolescent and the various protective and risk factors, and between theories/models themselves. The point of intersection between protective and risk factors and between internal and external factors is considered the prime point for HIV/AIDS interventions. This is the point at which the adolescent is actively engaged with various contextual factors, both within himself/herself, and the social environment. In terms of interventions, the adolescent is not a mere passive recipient, but an active co-creator of these interventions, and therefore should be involved.

The following scenario presents a practical application of the model to HIV/AIDS.

An adolescent learner is first and foremost an individual and then a member of the social group that is, the family, the peer group, the school, the village community, the religious group etc. If she encounters a risk factor such as sexual harassment by teachers at school, it becomes an external risk factor. She is vulnerable as a member of a social group, and in this case, an

adolescent girl learner. In this instance the adolescent girl learner is vulnerable to HIV/AIDS resulting from her lack of power to fight intruders.

Sexual harassment as an external risk factor may trigger internal risk factors, for example, the negative belief that sexual advancement by teachers may bring personal benefits in the form of financial awards or help with school work or even marriage to the teacher. In most cases these irrational beliefs are a result of lack of self-esteem, self–efficacy, and self determination. To address this risk factor, the adolescent learner will require the application of both internal protective factors (communication, refusal, negotiation and decision-making skills) as well as external protective factors (i.e., supportive policies, professional ethics, and good role models).

Therefore interventions aimed at addressing adolescent vulnerability to HIV/AIDS arising from sexual harassment should look at the interrelatedness between internal (protective as well as risk) factors and the external (protective as well as risk) factors. An understanding of this interrelatedness is drawn from the different theories such as psychological theories, health behaviour models and the pathway model.

The revolution also reflects change of contextual factors in the adolescent's vulnerability over time. For example, an adolescent who has just been orphaned, will over time be subjected to different contextual factors, both internal as well as external, predisposing him/her to different dangers of HIV/AIDS than is the case at the present moment, hence the theories 'revolve' around the adolescent.

### 7.4.2 Methodological contribution: Photovoice as tool to uncover 'hidden reality'

Methodologically, I argue that this study further lends support to the fast growing body of knowledge about photovoice as a method of research, particularly so with youth. My findings support the view by de Guzman (2001),

that participatory visual methodology helps participants to analyse their own vulnerability to HIV/AIDS. As Royce et al. (2006, p.81) intimate, "adolescent participation in this research served as the eyes, ears and voice of the research." Through photovoice participants were able to explore their own behaviour and lifestyle choices and identify what behaviour and lifestyle patterns make them vulnerable.

Through the photos they took and the photo-essays they created some important perceptions that adolescents hold of their vulnerability to HIV/AIDS have been highlighted.

Additionally, the study has demonstrated that photovoice has the potential to deepen understanding of social issues, like HIV/AIDS, that confront society, which the textual or numerical cannot adequately do. For example, in this study, considering that accessing adolescents' understanding of their vulnerability and sexuality is difficult, especially for a researcher of my age and status, photovoice provided the freedom to choose which photographs to take and which to speak to, and the concreteness of the photograph, allowed them easier expression of their understanding. Here I am inclined to agree with Van der Riet, Hough and Killian (1994), as cited in De Lange and Stuart (2008), that photographs provide ways in which participants can express their understanding and experiences without solely relying on verbal communication. In this study, where individual interviews preceded photovoice, it provided the participants with an alternative way of expressing their understanding of vulnerability. In a country like Malawi where talk of sexuality and HIV/AIDS is still shrouded in taboo and myths, photovoice facilitated expression. In this respect I support Pink's (2005), argument that words and photos do not express the same thing. What words cannot express photos can, and I propose that a "hidden reality" arises from the potential that photovoice has, in researching sensitive and complex issues such as HIV/AIDS.

Photovoice was a novel experience for many adolescents. They took a variety of pictures, including pictures of their peers and family members. I was not surprised that at the end of the photo elicitation exercise they were anxious to get back some of the photos to keep. For me this was important, allowing them ownership of the data. Putting together their photo essays was another creative process. They had to decide which one of the many photos that they took best responded to the prompt. This facilitated the process of knowledge production, as opposed to knowledge gathering, as is the case with other methods.

Furthermore, the participants greatly enjoyed the photovoice exercise and appreciated being valued for their insights and contributions. Gibbs (1998), as cited in Farrell (2005), states that valuing participants' informed contributions is essential to promoting ethical research collaborations. Even teachers were quite curious to see how the photovoice could be a method of research as they were accustomed to surveys and interview methods. For example, they asked questions such as "how does a photo become a method of research"? After listening to the photo essays during participant validation forums, teachers were convinced about its potential and indicated that they would continue the exercise with other students, using the photos left at the schools.

Finally, the unintended outcome of this study has been the empowerment of my participants. I say unintended because as I had indicated in my focus (See 1.6) the purpose was to explore how adolescents understand their vulnerability to HIV/AIDS. Yet remarks like, "….*this is only one way we young people are talking our minds…"* is a recognition of how voiceless they are as adolescents on issues like HIV/AIDS, and how photovoice has empowered them. My participants went about taking photographs and making different types of decisions like planning what photos to take, where, how, and with what consequences; a process that increased their decision-making skills. My findings concur with De Lange and Stuart's (2008) view, that the doing itself,

in the visual participatory methodology, is an intervention, and engaging the youth gives them a voice in their own health and sexuality.

### 7.4.3 Concluding remarks on the contribution of this study

Although mediating factors in adolescents' vulnerability to HIV/AIDS are complex and no single model is able to explain adolescent risk taking behaviour or their responses to interventions, this study has increased the understanding of adolescents' vulnerability to HIV/AIDS through the use of an ecosystemic framework and other related models and theories. In particular, the study points to the fact that an understanding of adolescents' vulnerability to HIV/AIDS should be viewed firstly from individual and secondly from interpersonal perspectives, and that interventions should be aimed at increasing individual decision-making skills while at the same time considering all the other people whom adolescents interact with in their environment namely parents, peers, teachers, and significant others in the community.

At the methodological level, this study has lent additional support to participatory visual methodologies, especially photovoice, as having the potential for understanding social issues like HIV/AIDS, and the need to involve adolescents in research that affects their lives. Visual methodologies have the power to unlock the "hidden reality" in our quest to understand most social issues that confront humankind.

## 7.5 Limitations of the Study

Marshall and Rossman (2006), state all research projects have limitations which may derive from the conceptual framework or the study's design.

While a small sample of schools is good for an in-depth study, its findings may not readily be generalisable, but according to Guba's (1981) model cited in Krefting (1991), transferability is possible. (See 4.8).

It is likely that as a "human research instrument" (Somekh and Lewin, 2005, p.16), I might have brought my own biases into the study which could influence the findings. This cannot be ruled out completely because as a human being I have my own way of interpreting phenomena drawing on my own cultural orientation. However, I continually reflected and analysed my points of view and feelings, to ensure that they did not hinder the process of understanding my participants (Neuman, 2006). I tried to bracket my feelings, experiences and opinions.

I was limited in terms of when I could carry out my research activities since schools have their own programme of activities which meant that I had to negotiate time schedules. I also had to plan data generation outside school schedules, putting strain on my participants who had to come after school hours, over the weekends or during holidays.

The use of photovoice was a novel experience for both my participants and me, and I was therefore concerned about the potential ethical risks. This method requires caution and I am still not sure what unanticipated ethical implications it might have had.

## 7.6 Suggestions for Further Research

This study involved a few selected schools and while it has provided some insights into adolescents' understanding of their vulnerability to HIV/AIDS, it is suggested that similar studies should be conducted in each of the six education divisions in the country, using the same methodologies.

Since the voice of the teacher is missing in this study, it might be necessary to research teachers in order to solicit their views and experiences with regards to adolescents' vulnerability to HIV/AIDS and interventions in schools.

Cultural practices have been highlighted in this study as being responsible for placing adolescents at risk of HIV/AIDS. It might be useful to conduct studies

to establish the extent of this influence on adolescent vulnerability to HIV/AIDS.

In view of adolescents' negative views on condom use, it might be useful to further explore their perceptions of condom promotion and use as protective measures against teenage pregnancies and sexually transmitted infections including HIV/AIDS.

This research has established the existence of transactional sex by learners from both poor and rich families. The premise so far has been that girls from poor families practise transactional sex in order to obtain basic needs, but what is the real motive for girls who come from rich families to practise transactional sex? A study could be conducted to explore this phenomenon. It has also been found that some parents drive their daughters out of school into prostitution as a way out of poverty, but Winskill and Enger's (2009), argument that poverty is not the real driving force behind prostitution and that girls or women practise prostitution voluntarily calls for more studies to determine the real motives for engaging in prostitution.

Following the success of photovoice in this study, and also in view of the findings of negative attitudes against the media, it might be advisable to conduct a study using the existing visual HIV/AIDS media campaign materials to assess adolescents' understanding of the messages contained in the material.

This study has been about adolescents' understanding of vulnerability to HIV/AIDS, and the focus has been on what systemic factors predispose adolescents to HIV/AIDS. There are some adolescents who, however, are sexually resilient and it might be useful to conduct a study to learn from them how they remain, or are able to remain, sexually resilient.

## 7.7 Final Reflections

> *"This is only one way we young people are talking our minds, because monga kunoko, tilibe chodalira cheni cheni kuti ma youth amayankhula, nkuti (like here we don't have any means that we youth can rely on to speak out so that) the Government can get the ideas, so only the bigger people and the rich ones speak about HIV/AIDS."* (Female participant during focus group discussion)

This study has demonstrated that it is not easy to explain adolescents' motives for engaging in risky sexual behaviour through the use of a single theoretical lens; using multiple lenses has increased understanding of adolescents' vulnerability to HIV/AIDS. The study has demonstrated that using the ecosystemic perspective together with theories from the fields of psychology and health has enhanced our understanding of adolescents' vulnerability to HIV/AIDS. We are now more aware that adolescents' vulnerability to HIV/AIDS in Malawi, arises from internal factors at a personal level (such as knowledge, attitude and belief) and from various external factors at the interpersonal level (such as peer influence, family, school, community, and society at large). I therefore cautiously suggest that interventions should address knowledge, attitudes and beliefs at the individual level, and socio-cultural practices, beliefs, gender disparities, and resource provision at the interpersonal level. I further suggest that adolescents be included in the design and implementation of intervention programmes.

This phenomenological study has demonstrated that adolescents are not passive recipients of information or intervention programmes on HIV/AIDS, but that they too can, and need, to have a voice. This has been demonstrated through valuable suggestions they have made through speaking their minds to fellow adolescents, parents, community leaders and the government (see 5.2.1.4). The study provided participants with an opportunity to express themselves on an issue that seems important to them. I am inclined to believe

that although this study was not meant to effect social change in the participants, it has unintentionally done so as the following sentiments expressed by them, demonstrate, which to me epitomise the essence of this research, hence its appearance in the title.

The study has further demonstrated that participatory visual methodologies such as photovoice in research with and about adolescents, especially on issues such as HIV/AIDS can be creative, interesting, reflexive and empowering.

I conclude by cautiously proposing a new way of looking at vulnerability as "revolving vulnerability" to HIV/AIDS which requires multiple theoretical lenses to be understood and I propose the involvement of adolescents in the design and implementation of interventions. I offer this as a proposition that is subject to academic debate.

# Reference list


Aggleton, P., Chase, E., & Leavy, P. (2006). Bridging the gap between adolescent sexuality and HIV/AIDS risk: The urban Malaysian perspective. *Singapore Medical Journal*, 47(6), 482-490.

Aggleton, P., Chase, E., & Rivers, K. (2004). *HIV/AIDS prevention and care among especially vulnerable young people: Framework for action*. London: Institute of Education, University of London.

Amuyunzu-Nyamongo, M., Biddlecom, E.A., Ouedroaga, C. & Wood, V. (2005). *Qualitative evidence on adolescents' views of sexual and reproductive health in Sub-Saharan Africa.* New York: The Allan Guttmacker Institute.

Anfara, V. A., & Mertz, N., T. (Eds.) (2004). *Theoretical frameworks in qualitative research.* London: Sage Publication.

AVERT.ORG (2009). Worlwide HIV&AIDS statistics: global HIV &AIDS estimates, end of 2007. Retrieved on 2009/03/27 from http://www.avert.org/worldstats.htm.

Awoyemi, S.M. (2008) Role of religion in the HIV/AIDS intervention in Africa: A possible model for conservation biology. *Conservation Biology, 22* (4), 811-813.

Ayikukwei, R., Ngare, D., Sidle, J., Ayuku, D., Baliddawa, J. & Greene, J. (2008). HIV/AIDS and cultural practices in western Kenya: The impact of sexual cleansing rituals on sexual behaviours. *Culture, Health & Sexuality,* 10(6), 587-599.

Babbie, E., & Mouton, J. (2001). *The practice of social research.* Cape Town: Oxford University Press.

Bailey, C. A. (2007). *A guide to qualitative field research* (2nd Ed.). Thousand Oaks: Pine Forge Press.

Baxen, J., & Breidlid, A. (2004). Researching HIV/AIDS and education in sub-Saharan Africa: Examining the gaps and challenges. *Journal of Education, 34*, 9-25.

Bennell, P., Hyde, K., & Swainson, N. (2002). *The impact of the HIV/AIDS epidemic on the education sector in sub-Saharan Africa: A synthesis of the findings and recommendations of three country studies.* Sussex: Centre for International Education, University of Sussex.

Bertrand, I. & Hughes, P. (2005). *Media research methods: Audiences, institutions and texts.* Oxford: Palgrave Macmillan.

Best, R. (2006). Deliberate self-harm in adolescence: A challenge for schools. *British Journal of Guidance and Counselling, 34*(2), 161-175.

Bhana, D., & Epstein, D. (2007). 'I don't want to catch it'. Boys, girls and sexualities in an HIV/AIDS environment. *Gender and Education, 19*(1), 109-125.

Bishop-Sambrook, C. (2003). HIV/AIDS susceptibility and vulnerability pathway: A tool for identifying indicators, role models and innovations. Unpublished Paper presented at a Technical Consultation Meeting in Johannesburg. Food and Agriculture Organization (FAO).

Blake, J. (1990). *Risky times: How to be AIDS-smart and stay healthy*. New York: Workman Publishing Co.

Botchway, A. (2004). Parent and adolescent male's communication about sexuality in the context of HIV/AIDS: a study in the Eastern Region of Ghana. An unpublished MPhil thesis in Health promotion, University of Bergen, Norway

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*, 77-101.

Bronfenbrenner, U. (1979). *The ecology of human development: Experiments by nature and design.* Cambridge: Havard University Press.

Bronfenbrenner, U. (1994). *Ecological models of human development. In International Encyclopedia of Education*, Vol.3, (2nd Ed.). Oxford: Elsevier.

Bryman, A. (2004). *Social science methods*. New York: Oxford University Press.

Burke, C. (2008). Play in focus: Children's visual voice in participative research. In P. Thompson (Ed.), *Doing visual research with children and young people*. London: Routledge.

Central Intelligence Agency (CIA) (2009). The World fact book: Country comparisons- HIV/AIDS adult prevalence rate. Retrieved 2009/03/27 from http://www.cia.gov/library/publications/the-world-factbook/rankorder/255rank.html.

Chirwa, W. C. (1997). Migrant labour, sexual networking and multi-partnered sex in Malawi. *Health Transition Review, Supplement 3 (7)*, 5-15.

Cook A.S., Fritz, J.J., & Mwonya, R. (2003). Understanding the psychological and emotional needs of AIDS orphans in Africa. In A. Singhal & W.S. Howard (Eds.). T*he children of Africa confront AIDS: From vulnerability to possibility.* Athens: Ohio University Press.

Creswell, J. W. (2002). *Research design: Qualitative, quantitative, and mixed method approaches.* (2nd Ed.). London: Sage Publications.

Creswell, J.W. (1998). *Qualitative inquiry and research design: Choosing among five approaches.* Thousand Oaks: Sage Publications

Creswell, J. W. (2007). *Qualitative inquiry and research design: Choosing among five approaches* (2nd Ed.). Thousand Oaks: Sage Publications.

Creswell, J. W., & Clark, V. L. P. (2007). *Designing and conducting mixed methods research*. Thousand Oaks: Sage Publications.

De Guzman, A. (2001). Reducing social vulnerability to HIV/AIDS: Models of care and their impact in resource-poor settings. *AIDS Care, 13*(5), 663-675.

De Lange, N., Olivier, T., & Wood, L. (2008). Participatory video documentary: Just for whom? *Education as Change, 12 (2),* 109-122.

De Lange, N., & Stuart, J. (2008). Innovative teaching strategies for HIV/AIDS. In L. Wood (Ed.), *Dealing with HIV/AIDS in the classroom,* edited by L. Wood. Cape Town: Juta

Donald, D., Lazarus, S. & Lolwana, P. (2002). *Educational psychology in social context.* Cape Town: Oxford University Press Southern Africa.

Ebersohn, L., & Eloff, I. (2006). *Life skills and assets*. Pretoria: Van Schaik.

Epstein, D., Morrell, R., Moletsane, R. & Unterhalter, E. (2004). Gender and HIV/AIDS in Africa south of the Sahara: Interventions, activism, identities. *Transformation, 54*, 1-19.

Esere, M. O. (2006). HIV/AIDS awareness of in-school adolescents in Nigeria: implications for adolescence sexuality. *Journal of Psychology in Africa,* (2), 253-258.

Farrell, A. (2005). *Ethical research with children.* Maidenhead: Open University Press.

FHI. (2006). *Building a better future for youth: Learning from experience and evidence. Africa regional youth reproductive health and HIV, June 6-9, 2006, Dar es Salaam, Tanzania*. Geneva: World Health Organization.

Field, S., & Hoffman, A. (2002). Preparing youth to exercise self-determination: Quality indicators of school environments that promote the acquisition of knowledge, skills and beliefs related to self-determination. *Journal of Disability Policy Studies, 13*(12), 113-123.

Field, S., Hoffman, A., & Posch, M. (1997). Self-determination during adolescence: A developmental perspective. (Electronic Version). *Remedial and Special Education*, 18. Retrieved 2007/05/04 from http://web.ebscohost.com/ehost/detail?

Fisher, J., Fisher, W., Bryan, A., & Misovich, S. (2002). Information-Motivation-Behavioural Skills Model-based HIV/AIDS risk behaviour change intervention for inner-city high school youth. *Health Psychology, 21*(2), 177-186.

Flick, U. (2006). *An introduction to qualitative research* (3rd Ed.). London: Sage Publications.

Fortenberry, J. D. (1998). Alcohol, drugs and STD/HIV among adolescents. *AIDS Patient Care and STDs. 12*(10), 783-786.

Foster, G. & Williamson, J. (2000). A review of current literature of the impact of HIV/AIDS on children in sub-Saharan Africa. *AIDS 2000*, 14, 275-284.

Francis, D., Muthukrishna, N., & Ramsuran, A. (2006). Deconstructing participatory research in an HIV/AIDS context. *Journal of Education, 38*, 139-157.

Frankham, J.O. (1998). Peer education: The unauthorized version. *British Educational Research Journal*, 24 (2), 179-193.

Franzkowiak, P., & Wenzel, E. (1994). AIDS health promotion for youth: conceptual framework and practical implications. *Health Promotion International, 9*(2), 119-135.

Gallant, M., & Maticka-Tyndale, E. (2004). School-based HIV prevention programmes for African youth. *Social Science and Medicine, 58*, 1337-1351.

Galvaan, R. (2008). Getting the picture: The process of participation. In N. De Lange, C. Mitchell & J. Stuart (Eds.), *Putting people in the picture: Visual methodologies for social change*. Rotterdam: Sense.

Geldard, K., & Geldard, D. (2004). *Counselling adolescents: The proactive approach.* London: Sage Publications.

Gibson, R., & Mitchell, M. H. (2003). *Introduction to counselling and guidance* (6th Ed.). Upper Saddle River: Merrill Prentice Hall.

Global AIDS Link (2007). Telling the story: Media and HIV/AIDS. Geneva: *Global Health Council*.

Govender, A. (2007). *Adolescent suicidal behaviour: A desperate cry for help.* Unpublished PhD thesis, University of KwaZulu-Natal, Durban, South Africa.

Greene, S., & Hogan, D. (Eds.). (2005). R*esearching children's experience: approaches and methods.* London: Sage Publications.

Groce, N., Mawar, N., Macnamara, M. (2006). Inclusion of AIDS education messages in rites of passage ceremonies: Reaching young people in tribal communities. *Culture, Health and Sexuality* 8 (4), 303-315.

Griffiths, J. (2005). *HIV/AIDS intervention programs in Africa: The role of grassroots soccer. UN published M.Ed thesis.* Stanford University, Stanford

Guba, E. (1990). *The paradigm dialog.* London: Sage Publications.

Harrison, A., Xaba, N., Kunene, P., & Ntuli, N. (2001). Understanding young women's risk for HIV/AIDS: Adolescent sexuality and vulnerability in rural KwaZulu-Natal. *Society in Transition, 32*(1), 69-78.

Hartell, C. G. (2005). HIV/AIDS in South Africa: a review of sexual behaviour among adolescents. *Adolescence, 40*(157), 171-181.

Henning, E. (2004). *Finding your way in qualitative research*. Pretoria: Van Schaik Publishers.

Henderson, N. & Milstein, M. (1996). *Resilience in schools: Making it happen for students and educators.* Thousand Oaks: Cowin Press.

Hesse-Biber, S.N. & Leavy, P. (2006). *The practice of qualitative research.* London: Sage Publications.

Horne, F. (2004). Some aspects of AIDS-related discourse in post-apartheid South African culture. *Alteration, 11*(2), 401-419.

Huitt, W. (1995). A systems model of human behaviour (Electronic Version). Retrieved 2004/03/01 fromhttp://chiron.valdosta.edu/whuitt/materials/sysmdlo.html.

Izugbara, C.O., Undie, C., Mudege, N.N., & Ezeh, A.C. (2009). Male youth and voluntary counselling and HIV-testing: The case of Malawi and Uganda. *Sex Education, 9*(3), 243-259.

Jackson, H. (2002). *AIDS Africa: A continent in crisis.* Harare: SAFAIDS.

James-Traore, T., Finger, W., Ruland, C., & Savariaud, S. (2004). *Teacher training: Essential for school-based reproductive health and HIV/AIDS education, focus on sub-Saharan Africa*. Washington: Family Health International.

Johnson, K. (2008). Teaching children to use visual methods. In P. Thompson (Ed.), *Doing visual research with children and young people*. London: Routledge.

Kadzamira, E. C., Chibwana, M.P., Chatsika, M., & Khozi, J.L. (1999). *Gender and primary schooling in Malawi*. Sussex: Institute of Development Studies, University of Sussex.

Kadzamira, E. C., Maluwa-Banda, D., Kamlongera, A., & Swainson, N. (2001). *The impact of HIV/AIDS on primary and secondary schooling in Malawi: Developing a comprehensive strategic response.* Zomba: Centre for Educational Research and Training.

Kaljee, L., Genberg, B., Riel, R., Cole, M., Tho, L., & Thoa, L. (2005). Effectiveness of a theory-based risk reduction HIV prevention programme for rural Vietnamese adolescents. *AIDS Education and Prevention, 17*(3), 185-199.

Kamal, S. & Ng, C. (2006). Bridging the gap between adolescent sexuality and HIV/AIDS risk: The urban Malaysian perspective. *Singapore Journal,* 47(6), 482-490.

Karim, Q. A. (2005). Heterosexual transmission of HIV- the importance of a gendered perspective in HIV prevention. In S. S. A. Karim & Q. A. Karim (Eds.), *HIV/AIDS in South Africa*. Cambridge: Cambridge University Press.

Karlsson, J. (2008). The novice visual researcher. In N. De Lange, C. Mitchell & J. Stuart (Eds.), *Putting people in the picture: Visual methodologies for social change*. Rotterdam Sense.

Kelly, K. (2006). From encounter to text: Collecting data in qualitative research. In M.Terre Blanche, K. Durrheim and P. Desmond (Eds.), *Research in practice: Applied methods for the social sciences*. Cape Town: UCT Press.

Kelly, K., Parker, W., & Lewis, G. (2001). Reconceptualising behaviour change in the HIV/AIDS context. In C. Stones (Ed.), *Socio-political and psychological perspectives on South Africa*. London: Nova Science.

Kelly, M. J. (2003). Reducing the vulnerability of Africa's children to HIV/AIDS. In A.Singhal, & W.S. Howard, (Eds.), *The children of Africa confront AIDS: From vulnerability to possibility*. Athens: Ohio University Press.

Key, J.P. (1997). Research design in occupational education. Oklahoma State University. (Electronic version) Retrieved on 2007/10/05 from http://www.okstate.edu/ag/agedcm/aged5980/newpage21.htm

Killian (2005). Risk and resilience. In G. Foster, C. Levin & Williamson (Eds.), *A generation at risk: The global impact of HIV/AIDS on orphans.* Cambridge: Cambridge University Press.

Kim, Y., Kols, A., Nyakauru, R., Marangwanda, C., & Chibatamoto, P. (2001). Promoting sexual responsibility among young people in Zimbabwe. *International Family Planning Perspectives, 27*(1), 11-19.

Krefting, L. (1991). Rigor in qualitative research: The assessment of trustworthiness. *The American Journal of Occupational Therapy, 45*(3), 214-222.

Kuthemba-Mwale, J. B., Hauya, R., & Tizifa, J. (1996). *Secondary school discipline study: Final report.* Zomba: University of Malawi. Centre for Educational Research and Training.

Labuschagne, A. (2003). Qualitative research: Airy or fundamentals? Qualitative Report, 8(1). Retrieved on 2007/10/05 from http://www.nova.edu/sss/QR/QR8-labuschagne.html.

Leedy, P. D., & Ormrod, J. E. (2005). *Practical research: Planning and design.* (8th Ed.). Upper Saddle River: Pearson Prentice Hall.

Lerner, R. M. (2005). *Promoting positive youth development: Theoretical and empirical bases*. Paper presented at the Workshop on the Science of Adolescent Health and Development. Medford: Tufts University.

Lwanda, J. L. (2004). *Politics, culture and medicine: An unholy trinity? historical continuities and raptures in the HIV/AIDS story in Malawi*. Oxford: Blackwell.

Maharaj, S. (2006). The chosen voices in HIV/AIDS in education: An exploration of how primary school educators communicate about HIV/AID*S.* Unpublished PhD thesis. University of KwaZulu-Natal, Durban, South Africa.

Maluwa-Banda, D. (1999). *Adolescent sexuality and HIV/AIDS in Malawi: Knowledge, attitudes and behaviour of secondary school students.* Unpublished PhD thesis, University of Alberta, Canada.

Maree, K. (2007). *First steps in research.* Pretoria: Van Schaik.

Marshall, C., & Rossman, G. B. (2006). *Designing qualitative research*. Thousand Oaks: Sage Publications.

Mason, J. (2002). *Qualitative researching.* (2nd Ed.). London: Sage Publications.

Mawadza, A. (2004). Stigma and HIV/AIDS discourse in Zimbabwe. *Alternation, 11*(2), 420-435.

McAuliffe, E., & Ntata, P. (1994). *HIV/AIDS prevention through information and education for youth in Malawi.* Zomba: Centre for Social Research/UNICEF.

McNeely, C.A., Nonnenmaker, J.M., & Blum, R.W. (2002). Promoting school connectedness: Evidence from the national longitudinal study of adolescent health. *Journal of Health,* 72(4), 138-146.

Measor, L. (2004). Young people's views of sex education: Gender, information and knowledge. *Sex Education, 4*(2), 153-166.

Measor, L. (2006). Condom use: A culture of resistance. *Sex Education, 6*(4), 393-405.

Mitchell, C., de Lange, N., Moletsane, R., Stuart, J., & Buthelezi, T. (2005). Giving a face to HIV/AIDS. *Qualitative Research in Psychology, 2*, 257-270.

Mohangi, K. (2008). *Finding roses amongst thorns: How children negotiate pathways to well-being while affected by HIV/AIDS.* Unpublished PhD thesis, University of Pretoria, Pretoria, South Africa.

Moyo, J. (2007, September 20). Malawi consults on HIV/AIDS legislation. *Nyasa Times.* Retrieved 2007/09/28 from http://www.nyasatimes.com/index.php?news.

Mudaly, R. (2006). *Empowering secondary school learners to explore risk perceptions and the role of gender among young people in the context of HIV/AIDS*. UN published DEd thesis, University of KwaZulu, Durban, South Africa.

Mufune, P. (2008). Stakeholder perceptions and attitudes towards sexual reproductive health education in Namibia. *Sex Education*, 8 (2), 145-157.

Mugambe, L. (2006). Rethinking culture in the face of HIV/AIDS in East Africa. *Agenda,* 68, 73-78.

Munthali, A. C., Chimbiri, A., & Zulu, E. (2004). *Adolescent sexual and reproductive health in Malawi: A synthesis of research evidence*. Washington: The Allan Guttmacher Institute.

Muthukrishna, N., & Mitchell, C. (2006). Researching HIV/AIDS and education in sub-Saharan Africa: Examining situated spaces. *Journal of Education, 38*, 1-2.

Muula, A. S. (2006). Condom and sexual abstinence talk in the Malawi National Assembly. *Journal of African Health Sciences, 6* (1), 21-26.

Mwamwenda, T. S. (2004). *Educational psychology: An African perspective* (3rd Ed.). Sandton: Heinemann.

Mwenyemasi, P. & Kapakasa, N. (2008, July 3). HIV, AIDS goes hip-hop. *The Nation,* p.23.

NAC. (2003). *Information, education and communication: implementation plan for working with key social groups in Malawi on behavioural change*. Lilongwe (Malawi): National AIDS Commission.

NAC (2004). *The Malawi bridge project*. Lilongwe: Johns Hopkins Centre for Communication Programmes.

Neuman, W. L. (2006). *Social research methods: Qualitative and quantitative approaches.* (6th Ed.). Boston: Pearson Education.

Normand, C. (2007). *Exploring the resilient attributes of youth in a high risk community. Unpublished M. Ed. thesis,* Stellenbosch University, Stellenbosch, South Africa.

NSO (2008). *2008 (Malawi) population and housing census: Preliminary report*. Zomba: National Statistical Office.

Nyambedha, E. O. (2008). Ethical dilemmas of social science research on AIDS and orphan hood in western Kenya. *Social Science and Medicine,* 67, 771-779.

Ojo, O. D., & Fasubaa, O. B. (2005). Adolescent sexuality and family life education in south western Nigeria: Responses from focus group discussion. *Journal of Social science,* 10 (2), 111-118.

Olivier, T., Wood, L., & De Lange, N. (2007). Changing our eyes: Seeing hope. In N. De Lange, C. Mitchell & J. Stuart (Eds.), *Putting people in the picture: Visual methodologies for social change*. Rotterdam: Sense Publishers.

Omorodion, F. I. (2006). Sexuality, lifestyles and the lures of modernity: Participatory rural appraisal of female adolescents in Niger Delta Region of Nigeria. *Sexuality and culture,* 10 (2), 96-113.

Opie, C. (2004). *Doing educational research: A guide for first time researchers.* London: Sage Publications.

Parker, C., & Finger, W. (2005). *School-based reproductive health and HIV education programs: An effective intervention*. Washington: USAID/Family Health International.

Parker, W. (2004). *Rethinking conceptual approaches to behaviour change: The importance of context*. Pretoria: Centre for AIDS Development, Research and Evaluation.

Patterson, A.S. (2003). AIDS, orphans and the future of democracy. In A. Singhal & W.S. Howard (Eds.), *The children of Africa confront AIDS*. Athens: Ohio University Press.

Pattman, R. (2006). Making pupils the resources and promoting gender equality in HIV/AIDS education. *Journal of Education, 38*, 89-113.

Pereira, B., & Reece, M. (2006). Sexual behaviour of young adults in SRI LANKA: Implications for HIV prevention. *AIDS Care, 18*(5), 497-500.

Perez-Jimenez, D., Ineke, C., Serrano-Garcia, I., & Ortiz-Torres, B. (2007). Construction of male sexuality and gender roles in Puerto Rican heterosexual college students. *Men and Masculinity, 9*(3), 358-377.

Pier, C & Parathasarathy, P. (2004). *Photovoice: Giving local health departments a new perspective on community health issues.* Martinez, California: Contra Costa Health Services.

Piercy, F., Fontes, L. A., Choice, P., & Bourdeau, B. (1998). HIV risk and the freedom to act without thinking: Alcohol use and sexual behaviour among adolescents on probation. *Child and Adolescent Social Work Journal, 15* (3), 207-226.

Pink, S. (2007). *Doing visual ethnography*. London: Sage Publications.

Prata, N., Morris, L., Mazive, E., Vahidnia, F., & Stehr, M. (2006). Relationship between HIV risk perception and condom use: Evidence from population-based survey in Mozambique. *International Family Planning Perspectives, 32*(4), 192-200.

Ragsdale, K., Difrancesco, W., & Pinkerton, S. D. (2006). Where the boys are: Sexual expectations and behaviours among young women on holidays. *Culture, Health and sexuality, 8*(2), 85-98.

Reddy, S. (2002). *Troubling sexualities: Young adults' sexual identity constructions within the context of HIV/AIDS.* Unpublished PhD thesis, University of KwaZulu-Natal, Durban, South Africa.

Reddy, S. (2005). It's not as easy as ABC: Dynamics of intergenerational power and resistance within the context of HIV/AIDS. *Perspectives in Education, 23*(3), 11-19.

Regnerus, M.D. & Salinas, V. (2007). Religious affiliation and AIDS-based discrimination in sub-Saharan Africa. *Review of Religious Research,* 48(4), 385-400.

Reijer, P., & Chalimba, M. (2000). *Going to scale: Sustained risk reduction behaviour for youth. Evaluation report for Government of Netherlands and UNICEF.* Lilongwe: UNICEF Malawi.

Rissel, C. E., Perry, C. L., & Wagenaar, A. C. (2001). *Empowerment, alcohol, 8th grade students and health promotion*. Camperdown: Central Sydney Area Health Service.

Rivers, K., & Aggleton, T. (1999). *Adolescent sexuality, gender and the HIV/AIDS pandemic*. London: Institute of Education, University of London/UNDP.

Robson, S., & Kanyanta, B. S. (2007). Orphaned and vulnerable children in Zambia: The impact of the HIV/AIDS epidemic on basic education for children at risk. *Educational Research, 49*(3), 259-272.

Rochart, T., & Hough, A. (2007). *Enhancing resilience in children affected by HIV/AIDS: Children's views and experiences of resilience enhancing family and community practices. Durban:* Human Sciences Research Council.

Rodham, K., Brewer, H., Mistral, W., & Stallard, P. (2006). Adolescents' perception of risk and challenge: A qualitative study. *Journal of Adolescence, 29*, 261-272.

Rosenstock, I., Strecher, V., & Becker, M. (1994). The Health Belief Model and HIV risk behaviour change. In R. DiClemente & J. Peterson (Eds.), *Preventing AIDS: Theories and methods of behavioural interventions*. New York: Plenum Press.

Ross, E., & Deverell, A. (2004). *Psychosocial approaches to health, illness and disability: Reader for health care professionals.* Pretoria van Schaik publishers.

Royce, S. W., Parra-Medina, D., & Messias, D. H. (2006). Using photovoice to examine and initiate youth empowerment in community-based programmes: A picture of process and lessons learned. *Californian Journal of Health Promotion, 4* (3), 80-91.

Ryan, G.W. & Bernard, H.R. (2003). Techniques to identify themes. *Field Methods,* 15(1): 85-109

Sabola, T (2008, September 10). Fighting AIDS in informal sector. *The Nation*, p.25.

SABC (2009 March 5). Newsbroadcast: Minister of Education statement regarding condom distribution in South African schools. SAFM News at 13.00hrs.

SAHRC (2008, March 12). Rape games played at South African schools. *Mail & Guardian*.

SAHRC (2008). Public hearing on school-based violence. (Pretoria): *South African Human Rights Commission.*

Samuelsen, H. (2006). Love, lifestyles and the risk of AIDS: The moral worlds of young people in Bobo-Diolasso, Burkina Faso. *Culture, Health and sexuality, 8*(3), 211-224.

Sathiparsad, R., & Taylor, M. (2006). Diseases come from girls: Perspectives of male learners in rural KwaZulu-Natal on HIV infection and AIDS. *Journal of Education, 38*, 116-133.

Schenker, I., & Nyirenda, J. (2006). *Preventing HIV/AIDS in schools*. Geneva: UNESCO.

Seidman, I. (1998). *Interviewing as qualitative research: A guide for researchers in education and the social sciences* (2nd Ed.). New York: Teachers College Press.

Sekeleza, C. (2008, June 26). Can the youth make a difference? *The Nation*, p.19.

Sarantakos,S. (2005). Social research. (3rd Ed.). Houndsmill: Palgrave Macmillan.

Sharon, F., & Hoffman, A. (2002). Preparing youth to exercise self-determination: Quality indicators of school environments that promote the acquisition of knowledge, skills and beliefs related to self-determination. *Journal of Disability Policy Studies, 13*(6), 113-122.

*Shorter Oxford English dictionary on historical principles*. (1973). (3rd Ed.). Oxford: Clarendon Press.

Sieving, R. E., Eisenberg, S. P., Pettingell, S., & Skay, C. (2006). Friends' influence on adolescents' first intercourse. *Perspectives on Sexual and Reproductive health, 38*(1), 13-19.

Simwaka, J. (2008, July 11). Hope amid HIV, AIDS woes. *The Nation*, p.23.

Siqueira, L. M., & Diaz, A. (2004). Fostering resilience in adolescent females. *The Mount Sinai Journal of Medicine, 71*(3), 148-154.

Somekh, B., & Lewin, C. (2005). *Research methods in the social sciences*. London: Sage Publications.

Squire, (2007). *HIV in South Africa: Talking about the big thing*. London: Routledge.

Steven, S., & Miriam, B. (1995). Sexuality, contraception and the media (Electronic Version). *Pediatrics*, 95. Retrieved on 2007/05/21 from htt://www.aa.f528.mail.yahoo.com/ShowLetter?

Steyn, H., Mayburgh, C., & Poggenpoel, M. (2005). Male adolescents' view on sexual activity as basis for the development of AIDS-prevention programmes (Electronic Version). *Education*, 125. Retrieved 2007/03/30 from http://web.ebscohost.com/ehost/detail?

Strasburger, V.C, Wilson, B.J., & Jordan, A.B. (2009). *Children, adolescents and the media.* 2nd ed. London: Sage.

Swartz, L., de la Rey, C., & Duncan, N. (2004). *Psychology: An introduction*. Cape Town: Oxford University Press Southern Africa.

Synder, C. R., Feldman, B. D., Shorey, H. S., & Rand, K. L. (2002). Hopeful choices: A school counsellor's guide to hope theory. *Professional School Counselling, 5*(5), 298-307.

Terre Blanche, M. T., & Durrheim, K. (Eds.). (1999). *Research in practice: Applied methods for the social sciences.* Cape Town: University of Cape Town Press.

Terre Blanche, M. T., & Durrheim, K. (Eds.). (2002). *Research in practice: Applied methods for the social sciences.* Cape Town: University of Cape Town Press.

Terre Blanche, M. T., Durrheim, K., Kelly, K. (2006). First steps in qualitative data analysis. In M. Terre Blanche, K. Durrheim and Kelly, K (Eds.). *Research in practice: Applied methods for social sciences* (2nd Ed.). Cape Town: UCT.

Tiessen, R. (2005). Mainstreaming gender in HIV/AIDS programmes: Ongoing challenges and new opportunities in Malawi. *Journal of International Women's Studies, 7*(1), 8-25.

Timmermann, G. (2004). Adolescents' psychological health and experiences with unwanted sexual behaviour at school. *Adolescence, 39*(156), 817-820.

Trinitapoli, J. (2006). Religious responses to AIDS in sub-Saharan Africa: An examination of religious congregations in rural Malawi. *Review of Religious Research*, 47(3), 253-270.

Ulin, P. R., Robinson, E. T., Tolley, E. E., & McNeill, E. T. (2002). *Qualitative methods: A field guide for applied research in sexual and reproductive health*. Research Triangle Park: Family Health International.

UNAIDS (2001). The HIV/AIDS Epidemic in Malawi: The situation and the response. Unpublished Monograph. National AIDS Secretariat.

UNAIDS (2001). The media and HIV/AIDS: Making a difference. Geneva: Global Media Initiative.

UNAIDS (2006). Preventing HIV/AIDS in young people: A summary of the WHO Technical Report (Electronic Version). Retrieved 2007/03/29 fromhttp://www.who.int/child-adolescent-health/publications/ADH/.

UNAIDS/WHO (2004). UN Epidemiological fact sheet on HIV/AIDS and sexually transmitted infections, Malawi. (Electronic Version). Retrieved 2007/09/20 fromhttp://www.avert.org/aids-malawi.htm.

UNESCO (2009, June-July). Newsletter: UNESCO HIV/AIDS Education Clearinghouse: Special issue on Teachers and HIV/AIDS, 1-14.

UNESCO (2009, September-October). Newsletter: UNESCO HIV/AIDS Education Clearinghouse, 1-9.

UNDP (2002). *The impact of HIV/AIDS on human resources in the Malawi public sector.* Lilongwe: United Nations Development Programme.

UNFPA (2008). Adolescents and youth (Electronic version). Retrieved 2008/02/22 from http://unfpa.org/adolescents/FinalsKS/defining-adolescence.htm.

UNICEF (2006). HIV/AIDS: Speak out and act now: Prevention among young people (Electronic Version). (Electronic Version). Retrieved 2007/03/29 from http://www.unicef.org/aids/index-preventionyoung.html.

UNICEF/UNFPA/WHO. (1989).The reproductive health of adolescents (Electronic Version). Retrieved 2008/02/22 fromhttp://www.unfpa.org/adolescents/FinalKS/defining_adolescence.htm.

USAID. (2004).*The Safe Schools Program, Malawi Assessment Report* (No. GEW-1-02-02-00019-00). Washington: DEVETCH Systems Inc.

Valerian, D. (2007). Is circumcision a strategy to prevent HIV transmission? (Electronic version), *AIDS United.com*. Retrieved 2007/11/03 from http://www.aidsunited.com/prevention-circumcision.php.

Van der Riet, M & Durrheim, K. (2006). Putting design into practice. In M.Terre Blanche, K. Durrheim and D. Painter (Eds.), *Research in practice: Applied methods for the social sciences*. Cape Town: UCT Press.

Van der Riet, M., Hough, A., & Killian, B. (2005). Mapping HIV/AIDS as a barrier to education: A reflection on the methodological and ethical challenges to child participation. *Journal of Education, 35*, 75-98.

Van Dyk, A. (2001). *HIV/AIDS care and counselling: A multidisciplinary approach.* Cape Town: Pearson Education South Africa.

Vanlandingham, M. J., Suprasert, S., Grandjean, N., & Sittitrai, W. (1995). Two views of risky sexual practices among Northern Thai males: The health belief model and the theory of reasoned action. *Journal of Health and Social Behaviour, 36*, 195-212.

Visser, M. (2007). HIV/AIDS prevention through peer education and support in secondary schools in South Africa. *Journal of Social Aspects of HIV/AIDS, 4*(3), 678-682.

Walker, J., & Milton, J. (2006). Teachers' and parents' roles in the sexuality education of primary school children: A comparison of experiences in Leeds, UK and Sydney, Australia. *Sex Education,* 6(4), 415-428.

Wayne, E. (2006). *Africa* (11th Ed.). Dubuque: McGraw-Hill.

Webb, D. (1997). *HIV/AIDS in Africa*. London: Pluto Press.

Wekwete, N., & Madzingira, N. (2005). *Adolescent girls 'susceptibility and vulnerability to HIV/AIDS: the case of Murewa district, Zimbabwe*. Paper presented at the HIV/AIDS Challenge in Africa Dissemination Workshop for OSSREA funded projects. Harare: University of Zimbabwe.

WHO (2006). *Preventing HIV/AIDS: Evidence from developing countries on what works*. Geneva: WHO/UNICEF/UNFPA/UNAIDS.

Winskell, K. & Enger, D. (2009). A new way of perceiving the pandemic: The findings from participatory research process on young Africans' stories about HIV/AIDS. *Culture, Health and Sexuality,* 11(4), 453-467.

Wood, L. (2008). Sociocultural factors. In L.Wood (Ed.), *Dealing with HIV/AIDS in the classroom.* Cape Town: Juta.

Wood, L. & Hillman, S. (2008). The impact of HIV/AIDS on education in Africa. In L. Wood & S. Hillman (Eds.), *Dealing with HIV/AIDS in the classroom.* Cape Town: Juta.

Zwane, I. T., Mngadi, P. T., & Nxumalo, M. P. (2004). Adolescents' views on decision-making regarding risky sexual behaviour. *International NURSING Review,* 51, 15-22.

## Appendix A: Ethical clearance certificate

UNIVERSITY OF
KWAZULU-NATAL

RESEARCH OFFICE (GOVAN MBEKI CENTRE)
WESTVILLE CAMPUS
TELEPHONE NO.: 031 – 2603587
EMAIL : ximbap@ukzn.ac.za

20 OCTOBER 2009

**MR. DM NDENGU (206520789)**
**EDUCATION STUDIES**

Dear Mr. Ndengu

**ETHICAL CLEARANCE APPROVAL NUMBER: HSS/0265/08D**

I wish to inform you that your application for ethical clearance has been granted full approval for the following project:

**"Adolescents' understanding of their vulnerability to HIV/AIDS in the context of existing intervention programmes in Malawi"**

**PLEASE NOTE: Research data should be securely stored in the school/department for a period of 5 years**

I take this opportunity of wishing you everything of the best with your study.

Yours faithfully

.....
**PROFESSOR STEVEN COLLINGS (CHAIR)**
**HUMANITIES & SOCIAL SCIENCES ETHICS COMMITTEE**

cc. Supervisor (Prof. N de Lange)
cc. Ms. R Govender

## Appendix B:

## Letters of consent

B1: Letter requesting permission from the Ministry of Education, Lilongwe, Malawi

B2: Letter from the Ministry of Education, Lilongwe, Malawi granting permission.

B3: Letter of consent from participating schools

B4: Letter of consent from participants

B5: Letter of consent from parents/guardians

B6: Letter of consent from research assistants

B7: Participants' biographical form

## Appendix B1: Request for informed consent from the Ministry of Education- Malawi


**To:** The Principal Secretary,

Ministry of Education and Vocational Training,

Private Bag 328, Capital City, Lilongwe, Malawi.

**RE- REQUEST FOR PERMISSION TO CONDUCT RESEARCH IN SECONDARY SCHOOLS IN NKHATA BAY DISTRICT.**

I am presently reading for my PhD degree (Education) through the University Of KwaZulu-Natal South Africa, and as such I am required to carry out research to write up a thesis.

The title of my research is, 'Adolescents' understanding of their vulnerability to HIV/AIDS in the context of existing intervention programmes in Malawi'. The aim of this study is to gain an understanding of adolescents' own understanding of their vulnerability to HIV/AIDS. The second aim is to explore adolescents' experiences of the HIV/AIDS intervention programmes available in schools and how they have been able or not able to change their lifestyle choices and behaviours positively.

I intend to carry out my research in four secondary schools, all located in Nkhata Bay District. I hereby request permission to carry out my research in secondary schools in the Nkhata Bay District.

The study will be carried out when the schools are in session but all research activities will be done outside school hours and during weekends. Research activities will be done within and around the school environment but with the knowledge and permission of head teachers. Each school will provide 10 participants to be identified by the head teachers and class teachers. Criteria for participation include: willingness to participate voluntarily, ability to express oneself clearly, being an adolescent in Forms 3 and 4, and knowledge of or participation in HIV prevention programmes offered by the school. Initially there will be one-to-one interviews with participants of each school and a semi-structured interview guide will be used. The purpose of the interviews is to give students an opportunity to describe their understanding of HIV/AIDS and how vulnerable they think they are to HIV infection and its impact. Each session will last between 45 minutes to one hour. The second activity will involve photovoice. In groups of five, participants from each school will take pictures of situations which they consider might make them vulnerable or not vulnerable to HIV/AIDS infection and its impact. They maybe asked to stage a scene depicting such a situation. Participants will be given a prompt for this activity. The film will then be developed by me, photos returned to participants, and participants will pick five photographs to analyse in terms of how they depict their vulnerability to or safety from HIV/AIDS infection and impact. Participants will be provided with cameras, trained in how to use them, and in the ethics of taking photographs. This activity will last four weeks.

The last activity will be a focus group discussion to be held at each school. The focus group discussions will provide an opportunity for students to discuss their experiences with the current HIV/AIDS programmes in schools: how effective or ineffective they have been in changing adolescent risky sexual

behaviour and why they are responding to them the way they do. Students will also be provided with an opportunity to suggest how the programmes can be strengthened and what schools could do to slow down the rate of HIV infections among adolescents. Participants will also be allowed to raise issues of their vulnerability to HIV/AIDS which they were unable to raise during interviews. Each focus group discussion will last about 1 hour 30 minutes to 2 hours. All interviews and focus group discussions will be tape recorded but only with the consent of the participants. During the project, I will be assisted by research assistants from Mzuzu University who are also adolescents from Nkhata Bay.

Participation is purely voluntary and therefore participants are at liberty to withdraw from the study at any time if they so wish and no harm will befall them. Participants' anonymity and confidentiality throughout the project, as well as in the reporting of the findings, is assured. For any further information, I enclose the contacts of my supervisor and another independent person below.

I trust that my request is acceptable

Yours sincerely

DOMINIC MAPOPA NDENGU (206520789)

(Candidate)

Cell. No: 0027781072524

E-mail: dmndengu@yahoo.com

206520789@ukzn.ac.za

**SUPERVISOR:**

PROF. N. DE LANGE

Tel No: 031 260 1342

E- mail: delangen@ukzn.ac.za

PHUMELELE XIMBA

Tel No. 031 260 3587

E-mail: ximbap@ukzn.ac.za

## Appendix B2: Letter from Ministry of Education, Lilongwe, Malawi, granting permission to carry out research

Telegrams: MINED, Lilongwe
Telephone: (265) 01 789 422/ 01 789404
Telex: 44636
Fascimile: (265) 01 788 064

MINISTRY OF EDUCATION
AND VOCATIONAL TRAINING
PRIVATE BAG 328
CAPITAL CITY
LILONGWE 3
MALAWI

MINISTRY OF EDUCATION
SCIENCE AND TECHNOLOGY
2008 -01- 21
PRIVATE BAG 328, LILONGWE 3

**Ref. No. C31/1/1**

**21st January, 2008**

**Mr Dominic Mapopa Ndengu**
University of Kwazulu – Natal
Faculty of Education,
Private Bag X03
Ashwood 3605
Duiban
**South Africa**

**PERMISSION TO CONDUCT RESEARCH IN SECONDARY SCHOOLS IN NKHATA-BAY DISTRICT**

The bearer of this note, Mr. Dominic M. Ndengu, a Senior Lecturer at Mzuzu University is currently studying for his Ph.D at University of Kwazulu- Natal. As part of fulfillment of award of his Ph – D he has to conduct research in some Secondary Schools in Nkhata-Bay District.

This letter authorizes him to conduct research in the following Secondary Schools.

Please give him all the assistance you can.

C.P. Inani

For: **SECRETARY FOR EDUCATION, SCIENCE AND TECHNOLOGY**

## Appendix B3: Informed consent from schools


**To:** The Headmaster/Headmistress,

_____

Dear Madam/Sir

**RE- REQUEST FOR PERMISSION TO CONDUCT RESEARCH AT YOUR SCHOOL**

I am presently reading for my PhD degree (Education) through the University of KwaZulu-Natal, South Africa, and as such I am required to carry out research to write up a thesis.

Your school has been chosen to participate in this research project. The title of my research is, 'Adolescents' understanding of their vulnerability to HIV/AIDS in the context of existing intervention programmes in Malawi'. The aim of this study is to gain an understanding of adolescents' own understanding of their vulnerability to HIV/AIDS. The second aim is to explore adolescents' experiences of the HIV/AIDS intervention programmes available

in schools and how they have been able or not able to change their lifestyle choices and behaviours positively.

The study will be carried out when the schools are in session but all research activities will be done outside school hours and during weekends. Research activities will be done within and around the school environment but with the knowledge and approval of head teachers. Each school will provide 10 participants to be identified by their head teachers and class teachers. Criteria for participation will include: willingness to participate in the study voluntarily, ability to express oneself clearly, participation in or knowledge of existing HIV/AIDS programmes in the school and being an adolescent in forms 3 or 4.

Initially there will be one-to-one interviews with participants of each school and semi-structured interviews will be used. The purpose of the interview is to give students an opportunity to describe their understanding of their vulnerability to HIV/AIDS infection and its impact. Each session will last between 45 minutes to one hour. The second activity will involve photovoice. In a group of five, participants from each school will take pictures of situations which they consider might make them vulnerable or not vulnerable to HIV/AIDS infection and its impact. They will be given a prompt for this activity. The film will then be developed and participants will pick five photographs to analyse in terms of how they depict their vulnerability to or safety from HIV/AIDS infection and its impact. They will then write a photo essay on each of the photograph. Participants will be provided with cameras, trained in how to use them and in the ethics of taking photographs. This activity will last for two weeks.

The last activity will be a focus group discussion to be held at each school. The focus group discussions will provide an opportunity for students to discuss their experiences with the current HIV/AIDS programmes in schools: how effective or ineffective they have been in changing adolescent risky sexual behaviours and why they are responding to them the way they do. Students

will also be provided with an opportunity to suggest how the programmes can be strengthened and what schools could do to slow down the rate of HIV infections among adolescents. Participants will also be allowed to raise issues of their vulnerability to HIV/AIDS which they were unable to raise during interviews. Each focus group discussion will last about 1 hour 30 minutes to 2 hours. All interviews and focus group discussions will be tape recorded but only with the consent of the participants.

During the project I will be assisted by research assistants from Mzuzu University who come from Nkhata-Bay.

Participation is purely voluntary and therefore participants and/or schools are at liberty to withdraw from the study at any time if they so wish and no harm will befall them. Participants' anonymity and confidentiality throughout the project, as well as in the reporting of the findings is assured. For any further information, I enclose the contacts of my supervisor below.

I trust that my request is acceptable

Yours sincerely

DOMINIC MAPOPA NDENGU (206520789)

(PhD – Education)

Cell. No: 0027781072524

E-mail: dmndengu@yahoo.com

206520789@ukzn.ac.za

**SUPERVISOR:**

PROF. N. DE LANGE

Tel No: 031 260 1342

E- mail: delangen@ukzn.ac.za

PHUMELELE XIMBA

Tel. No: 031 260 3587

E- mail: ximbap@ukzn.ac.za

## DECLARATION

(To be completed by the head of the school)

I _____ (Full names of the officer), hereby confirm that I understand the contents of this document and the nature of the research project, and I give consent for our school's participation in the project.

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

OFFICIAL DATE STAMP OF THE SCHOOL

## Appendix B4: Informed consent from participants


Dear student

**RE- REQUEST TO PARTICIPATE IN A RESEARCH PROJECT**

I am presently reading for my PhD degree (Education) through the University of KwaZulu-Natal, South Africa, and as such I am required to carry out research to write up a thesis.

You are one of the students that have been selected to participate in this research project The title of my research is, 'Adolescents' understanding of their vulnerability to HIV/AIDS in the context of existing intervention programmes in Malawi'. The aim of this study is to gain an understanding of adolescents' own understanding of their vulnerability to HIV/AIDS. The second aim is to explore adolescents' experiences of the HIV/AIDS intervention programmes available in schools and how they have been able or not able to change their lifestyle choices and behaviours positively. As an adolescent yourself, I hope you will be able to contribute your views on the topic and that the research will be able to positively change your lifestyle and behaviour as well as those of other adolescents.

The study will be carried out when the schools are in session but all research activities will be done outside school hours and during weekends. Research activities will be done within and around the school environment but with the

knowledge and approval of your head teachers. There will be 10 participants from your school identified by your head teachers and class teachers. Criteria for participation include: willingness to participate in the study voluntarily, ability to express oneself freely, participation in or knowledge of existing HIV/AIDS programmes in the school.

Initially there will be one-to-one interviews with participants and a semi-structured interview will be used. The purpose of the interview is to give students an opportunity to describe their understanding of their vulnerability to HIV/AIDS infection and its impact. Each session will last between 45 minutes to one hour. The second activity will involve photovoice. In a group of five, participants from each school will take pictures of situations which they consider might make them vulnerable or not vulnerable to HIV/AIDS infection and its impact. They will be given a prompt for this activity. The film will then be developed by me and participants will pick five photographs to analyse in terms of how they depict their vulnerability to or safety from HIV/AIDS infection and its impact. They will then write a photo essay on each of the photograph. Participants will be provided with cameras, trained in how to use them, and in the ethics of taking photographs. This activity will last four weeks.

The last activity will be a focus group discussion to be held at the school. These focus group discussions will provide an opportunity to students to discuss their experiences with the current HIV/AIDS programmes in schools: how effective or ineffective they have been in changing adolescent risky sexual behaviours and why they are responding to them the way they do. Students will also be provided with an opportunity to suggest how the programmes can be strengthened and what schools could do to slow down the rate of HIV infections among adolescents. Participants will also be allowed to raise issues of their vulnerability to HIV/AIDS which they were unable to raise during interviews. Each focus group discussion will last about 1 hour 30 minutes to 2 hours. All interviews and focus group discussions will be

tape recorded but only with the consent of the participants. During the project I will be assisted by research assistants from Mzuzu University who are also adolescents from Nkhata-Bay.

Participation is purely voluntary and therefore participants are at liberty to withdraw from the study at any time if they so wish and no harm will befall them. Participants' anonymity and confidentiality throughout the project, as well as in the reporting of the findings is assured. For any further information, I enclose the contacts of my supervisor and another independent person below.

I trust that my request is acceptable.

Yours sincerely,

DOMINIC MAPOPA NDENGU (206520789)

(Candidate)

Cell. No: 0027781072524

E-mail: dmndengu@yahoo.com

206520789@ukzn.ac.za

**SUPERVISOR:**

PROF. N. DE LANGE

Tel No: 031 260 1342

E- mail: delangen@ukzn.ac.za

PHUMELELE XIMBA,

Te. No: 031 260 3587

E- mail: ximbap @ukzn.ac.za

## DECLARATION

(To be completed by participant)

I _____ (full name 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 project and the use of data for research purposes.

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

Participant's Signature: _____Date:_____

## Appendix B5: Informed consent letter from parents/guardians


Dear parent/guardian

**RE- REQUEST FOR PERMISSION TO ALLOW YOUR WARD TO PARTICIPATE IN A RESEARCH PROJECT.**

I am presently reading for my PhD degree (Education) through the University of KwaZulu-Natal, South Africa, and as such I am required to carry out research to write up a thesis.

Your ward is being asked to participate in this research project. The title of my research is, 'Adolescents' understanding of their vulnerability to HIV/AIDS in the context of existing intervention programmes in Malawi'. The aim of this study is to gain an understanding of adolescents' own understanding of their vulnerability to HIV/AIDS. The second aim is to explore adolescents' experiences of the HIV/AIDS intervention programmes available in schools and how they have been able or not able to change their lifestyle choices and behaviours positively.

The study will be carried out when the schools are in session but all research activities will be done outside school hours and during weekends. Research activities will be done within and around the school environment but with the knowledge and approval of head teachers. Each school will provide 10 participants to be identified by their head teachers and class teachers.

Criteria for participation will include: willingness to participate in the study voluntarily, ability to express oneself clearly, participation in or knowledge of existing HIV/AIDS programmes in the school and being an adolescent in forms 3 or 4.

Initially there will be one-to-one interviews with participants of each school where a semi- structured interview will be used. The purpose of the interview is to give students an opportunity to describe their understanding of their vulnerability to HIV/AIDS infection and its impact. Each session will last between 45 minutes to one hour. The second activity will involve photovoice. In groups of five, participants from each school take pictures of situations which they consider might make them vulnerable or not vulnerable to HIV/AIDS infection and its impact. They will be given a prompt for this activity. The film will then be developed and participants will pick five photographs to analyse in terms of how they depict their vulnerability to or safety from HIV/AIDS infection and its impact. They will then write a photo essay on each of the photograph. Participants will be provided with cameras, trained in how to use them, and in the ethics of taking photographs. This activity will last for two weeks.

The last activity will be a focus group to be held at each school. The focus group discussions will provide an opportunity to students to discuss their experiences with the current HIV/AIDS programmes in schools: how effective or in effective they have been in changing adolescent risky sexual behaviours and why they are responding to them the way they do. Students will also be provided with an opportunity to suggest how the programmes can be strengthened and what schools could do to slow down the rate of HIV infections among adolescents. Participants will also be allowed to raise issues of their vulnerability to HIV/AIDS which they were unable to raise during interviews. Each focus group discussion will last about 1 hour 30 minutes to 2 hours. All interviews and focus group discussions will be tape recorded but only with the consent of the participants. During the project I will be assisted

by research assistants from Mzuzu University who are also adolescents from Nkhata-Bay.

Participation is purely voluntary and therefore participants are at liberty to withdraw from the study at any time if they so wish and no harm will befall them. Participants' anonymity and confidentiality throughout the project, as well as in the reporting of the findings is assured. For any further information, I enclose the contacts of my supervisor and another independent person below.

I trust that my request is acceptable

Yours sincerely

DOMINIC MAPOPA NDENGU (206520789)

(Candidate)

Cell. No: 0027781072524

E-mail: dmndengu@yahoo.com

206520789@ukzn.ac.za

**SUPERVISOR:**

PROF. N. DE LANGE

Tel No: 031 260 1342

E- mail: delangen@ukzn.ac.za

PHUMELELE XIMBA,

Tel. No: 031 260 3587

E-mail: ximbap@ukzn.ac.za

## DECLARATION

(To be completed by the parent/guardian)

I _____ (full name of parent/guardian) hereby confirm that I understand the contents of this document and the nature of the research project, and I consent to the participation of my daughter/ward: _____ _____ (full name/s of children) in the project and the use of data for research purposes.

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

Parent's/Guardian's Signature_____Date:_____

## Appendix B6: Informed consent from research assistants


To: ----------

**RE- REQUEST TO PARTICIPATE IN A RESEARCH PROJECT**

I am presently reading for my PhD degree (Education) through the University Of KwaZulu- Natal South Africa, and as such I am required to carry out research to write up a thesis.

You have been selected as one of my research assistants. The title of my research is, `Adolescents' understanding of their vulnerability to HIV/AIDS in the context of existing intervention programmes in Malawi'. The aim of the study is to gain an understanding of adolescents' own understanding of their vulnerability to HIV/AIDS. The second aim is to explore adolescents' experiences with the existing intervention programmes available in schools and how they have been able or not able to change their lifestyle choices and behaviours positively.

The study will be conducted in four schools in NKhata Bay and will involve secondary school learners. Research activities will include: one-to-one interviews, focus group discussions and photovoice. You will particularly be involved in conducting focus group discussions. You will receive initial training

in the research activities. All research activities will be done during week-ends (Saturdays and Sundays) and during holidays. The research project will last approximately six months during which the project will take care of all costs during field work which will include: transport, meals and accommodation where necessary. At the end of the project you will receive an allowance of MK10, 000 (approximately R500.00).

Please note that participation is voluntary and therefore you are at liberty to withdraw from the project at any time you so wish and no harm will befall you. Participants' anonymity and confidentiality throughout the project as well as in the reporting of the findings is assured. For further information, I enclose the contacts of two people, my supervisor and another independent person below. Please complete the declaration slip attached and return it to me.

Yours sincere,

DOMINIC MAPOPA NDENGU (206520789)

(Candidate)

Cell No. 0027781072524

E-mail: dmndengu@yahoo.com) or

206520789@ukzn.ac.za

SUPERVISOR:

PROF. N. DE LANGE

Tel. N0: 031 260 1342

E-mail: delangen@ukzn.ac.za

PHUMELELE XIMBA,

Tel. No: 031 260 3587

E-mail: ximba@ukzn.ac.za

**DECLARATION**

(To be completed by research assistant)

I_____ (full name of research assistant) hereby confirm that I understand the contents of this document and the nature of the research project, and I consent to participating in the project and the use of the data for the research purposes.

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

Research assistant' signature _____ Date_____

## Appendix B7: Participants' biographical form

| Name | Gender | Age | Class | District of origin |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

## Appendix B8: Details of study participants

| No. | Name of participant | School | Gender | Age | class | District | Region |
|---|---|---|---|---|---|---|---|
| 1 | Hlupe | Ulemu Private Girls | Female | 17 | 4 | Kasungu | central |
| 2 | Ngesi | Ulemu Private Girls | Female | 16 | 4 | Lilongwe | Central |
| 3 | Nene | Ulemu Private Girls | Female | 15 | 3 | Lilongwe | Central |
| 4 | Phindile | Ulemu Private Girls | Female | 16 | - | Zomba | South |
| 5 | Sindi | Ulemu Private Girls | Female | 18 | 4 | Mzimba | North |
| 6 | Zizwa | Ulemu Private Girls | Female | 14 | 3 | Lilongwe | Central |
| 7 | Nelisa | Ulemu Private Girls | Female | 15 | - | Lilongwe | Central |
| 8 | Serena | Ulemu Private Girls | Female | 15 | 3 | Lilongwe | Central |
| 9 | Lungile | Ulemu Private Girls | Female | 16 | 4 | Lilongwe | Central |
| 10 | Sibongile | Ulemu Private Girls | Female | 15 | 4 | Lilongwe | Central |
| 11 | Thandie | Ulemu Private Girls | Female | 17 | 4 | Blantyre | South |
| 12 | Dingase | Ulemu Private Girls | Female | 15 | 3 | Mzimba | North |
| 13 | Nelie | Ulemu Private Girls | Female | 15 | 4 | Lilongwe | Central |
| 14 | Dlamini | Chaphuka Government Boys | Male | 18 | 4 | Lilongwe | Central |
| 15 | Jabulani | Chaphuka | Male | 17 | 4 | Lilongwe | Central |
| 16 | Themba | Chaphuka | Male | 16 | 3 | Nkhata-Bay | North |
| 17 | Khoza | Chaphuka | Male | 17 | 4 | Mzimba | North |
| 18 | Shivani | Chaphuka | Male | 17 | 4 | Nkhota-kota | Central |
| 19 | Kamashu | Chaphuka | Male | 19 | 4 | Nkhata-Bay | North |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 20 | Nikwe | Chaphuka | Male | 19 | 3 | Nkhota-Kota | Central |
| 21 | Sipho | Chaphuka | Male | 17 | 3 | Mzuzu | North |
| 22 | Thabo | Chaphuka | Male | 18 | 4 | Karonga | North |
| 23 | Bongani | Chaphuka | Male | 17 | 4 | Nkhata-Bay | North |
| 24 | Kabela | Chaphuka | Male | 15 | 3 | Chitipa | North |
| 25 | Sonia | Solola Community Day | Female | 16 | 3 | Nkhata-Bay | North |
| 26 | Nomsa | Solola Community Day | Female | 18 | 4 | Nkhata-Bay | North |
| 27 | Ntsele | Solola Community Day | Female | 19 | 3 | Mwanza | South |
| 28 | Vuyi | Solola Community Day | Female | 17 | 3 | Nkhata-Bay | North |
| 29 | Bruno | Solola Community Day | Male | 18 | 4 | Nkhata-Bay | North |
| 30 | Thabani | Solola Community Day | Male | 19 | 3 | Mulanje | South |
| 31 | Lindiwe | Solola Community Day | Female | 19 | 4 | Nkhata-Bay | North |
| 32 | Zondi | Solola Community Day | Male | 17 | 3 | Dowa | Central |
| 33 | Duma | Solola Community Day | Male | 17 | 4 | Nkhata-Bay | North |
| 34 | Zola | Solola Community Day | Male | 17 | 4 | Nkhata-Bay | North |
| 35 | Karen | Jenjewe Community Day | Female | 18 | 4 | Mchinji | Central |
| 36 | Thabie | Jenjewe Community Day | Female | 16 | 4 | Mwanza | South |
| 37 | Sarisha | Jenjewe Community Day | Female | 16 | 2 | Nkhata-Bay | North |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 38 | Salifya | Jenjewe Community Day | Female | 16 | 4 | Nkhata-Bay | North |
| 39 | Melisa | Jenjewe Community Day | Female | 17 | 4 | Nkhata-Bay | North |
| 40 | Perani | Jenjewe Community Day | Female | 18 | 3 | Nkhata-Bay | North |
| 41 | Gumede | Jenjewe Community Day | Male | 17 | 2 | Karonga | North |
| 42 | Perani | Jenjewe Community Day | Female | 18 | 2 | Rumphi | North |
| 43 | Bongani | Jenjewe Community Day | Male | 17 | 4 | Salima | Central |
| 44 | Sipho | Jenjewe Community Day | Male | 18 | 4 | Nkhata-Bay | North |
| | | | | | | | |

# Appendix C

## Data generation tools

C1: Individual interview guide

C2: Focus group discussion interview guide

C3: Photovoice prompt

C4: Photovoice journal

C5:  Photovoice elicitation (Photo essay form)

## Appendix C1: Individual interview guide

(Order may change during interview)

**Core question:**

Tell me about being an adolescent in the age of HIV/AIDS.

*(Tandiuza kukhala wa chinyamata mu nthawi ino ya HIV/AIDS)*

**Probing questions depending upon the response to core question**

There is growing problem in secondary schools of students engaging in risky sexual activities. Why do you think they do so? Which behaviours that you see in boys and girls are risky behaviours?

Do you think you can get/contract this disease? In what ways can you contract this disease here at school? How do you think you can avoid contracting the disease? How can you contract this disease outside the school?

How does your home environment encourage/discourage irresponsible/unsafe sexual practices? How does your religion influence your sexual behaviour? What other situations put you at risk of contracting HIV? In your view, what should be done to avoid the spread of HIV/AIDS among the youth?

## Appendix C2: Focus group discussions interview guide

(Order may change during discussions)

**Introductory questions (approx. 10 minutes)**

Introduction of participants: self-introduction.

Questions about sports, politics.

Questions about school life: subjects, career aspirations.

Research assistants talk about life in the university.

**Core question:**

Tell us about HIV/AIDS programmes in your school.

*(Tatiuzani za ma purogiramu a EDZI amene muli nao pasukulu yanu pano).*

**Probing questions depending upon responses from the core question:**

How do you think these programmes have been able to change your lifestyle/behaviour positively? In your view, what programmes seem to be working and why? Which ones are not working and why? Which ones are most popular among students and why? Which ones are not popular with students and why? In your view, how can these programmes be improved to meet the needs of adolescents in changing their sexual behaviour?

**Concluding questions (to complement responses to research question one)**

What is your idea of a good time here at school? What situations or places in the school or around the school can place you at risk of contracting HIV/AIDS? In your own view, what should schools do to prevent the spread of HIV/AIDS? Apart from the school, who else can help youth to avoid contracting HIV/AIDS? How? What can you say about today's discussions?

What is your impression? Would you recommend that such discussions be extended to the rest of the school learners? Why?

## Appendix C3: Photovoice prompt:

"Take photographs of situations where you could consider yourself at risk or not at risk of contracting HIV/AIDS"

*(Tajambulani zithunzi za malo kapena khalidwe zosonyeza kuti apa mukhoza kutenga kachilombo ka EDZI kapena ai)*

Caution: Get permission from photographic subjects before you take any picture. Musanajambule zithunzi, pemphani kaye chilolenzo kwa anthu mukufuna kuajambula'wo)

## Appendix C4: Photovoice Journal

| Shot Number | What is the photo about and why did you take it? | Consent to take photograph |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

## Appendix C5: Photovoice elicitation (photo essay form):

Frame Number: _____ Date:_____

Description of the photo:

_____
_____
_____
_____
_____
_____
_____
_____
_____

What does the photo mean to you? What message can your photo convey to others about adolescents' vulnerability to HIV/AIDS?

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

_____

_____

Possible caption/ title of your photo essay:

_____

_____

_____

# Appendix D

## Participant validation

### Chaphuka Secondary School

Facilitator (after reading the FGD report to participants): … so that was the end of our discussion that day. Now I want to know if these were the things that were said that day or not. You are free to express your comments in English, Chichewa, Chitumbuka or Chitonga.

Participants in chorus: Ndizomwezo tinakambirana! (That's indeed what we discussed!).

Facilitator: Is there anything that you can add on what you said that day?

Participant B (Male): Monga masiku ano amati ukakhala....., amene apangidwa castrated/ sterlized amati mwai otengera AIDS ndi ochepa. Njira zimenezi zimawapanga encourage, as a result ndizimene zimawapanga anthu kuti atani? Kuti apange plain, osagwiritsa ntchito kondomu, nkutenga matenda'wa. Kukufunika kuti mwina afufuze bwino –bwino zinthu zimenezo, (Nowadays people say that if a man is sterilised/castrated, they say his chance of getting AIDS are slim; these are some of the misconceptions that encourage people to have unprotected sex and so get AIDS. There is need for research on such issues).

Participant D (Male/Female?): Palinso ma rumours oti ngati munthu ali mu blood group 'O', ukatenga ka chilombo sikamapanga multiply mu thupi, si kamafala. Ndiye ngati munthu information yotere anguimva monga mwa mobenthulidwa chabe, maybe akudziwa category yake kuti ndi 'O' azingopanga za chiwerewere kugonana ndi akazi ati kuti blood group yawo ndi ya mphamvu, moti sangatenge kachirombo. Ndiye kumafunika real information kuti ndizoona kapena ai kuti blood group yikhoza kumuteteza munthu akagonana ndi mkazi kapena mwamuna. (There is also a rumour

circulating that if one's blood is group 'O' even if s/he gets the HIV it cannot multiply in his/her body. So such kind of information, may lead a person who has group 'O' blood to engage in unprotected sex, thinking that the blood group is protecting him/her. There is need for accurate information as to whether this is true or not.)

Participant E (Male): Komanso ndinenepo pa nkhani ya kuchipatala, akuti munthu odwala akatenge achibali ake oti mwina akhoza kudzamupatsa munthu uja magazi. Akamuyesa magazi, nkupeza ndi kachirombo ka HIV amangoti iwe uli ndi malungo chani, chani m'malo momudza choona kuti munthu uja akasinthe khalidwe lake; ndiye amachoka ku chipatala ndi maganizo oti amupeza ndi malungo. (Let me also talk about cases at the hospital. They may ask someone to donate blood to his sick relative. After testing his blood and finding that he is HIV positive, they just tell him that we can't use your blood because you have malaria etc. etc. instead of just telling him the truth. So such person leaves the hospital thinking he has just been found with malaria).

Participant F (Male): Koma pali anthu ena amati ukagonana ndi ma albino si ungatenge matenda. Apaso pofunika kuti pakhale umboni weni-weni, chifukwa ndinzonso zimapangisa kuti atani? Kumagwilira ma albino aja kapena kuwakwatira kumene poganiza kuti lwo sangatenge matenda. (And there are some people who spread false beliefs that when you sleep with an albino you cannot get AIDS. This too needs real evidence, because these too are the ones that make people to do what? To rape albinos thinking that they do not have AIDS).

Participant (Male): Kumaonekaso monga ku ma co education schools kuti aphunzitsi amafunsira a tsikana ndiye anthu ngati amenewa akufunika kuwapatsa uphungu kuwaudza kuti chimene akupanga akuwaphera anawa tsogolo lawana'wa. Chifukwa kuti mphunzitsi was chimasomaso azati lero

nkugona ndi uyu, mawa ndi uyo; amakhala kuti akuwanamiza kuti ndi kuudza mayeso kapena ndidzakuphunzitsa pa wekha, kumene ndi kutani? Nkuwaonongela tsogolo lawo. (It looks like, for example in co-education schools, there are certain teachers who propose love to school girls, so such people need serious talk with them, to remind them that what they are doing is destroying the future of these girls. Because such reckless teachers will sleep with this one today, tomorrow with another, lying that they will reveal examinations to them or will give them private tuition, which is just destroying their future).

Facilitator: Thank you for your participation and for your comments. We hope to come again, this time with a full report of the findings of the study.

## Solola Community Day Secondary School

Researcher: Good afternoon everyone. Thank you for welcoming me. The purpose of my trip today is to give you back what you said during the project so that you can accept that this is what you said or add or subtract accordingly. We call this verification. I want to verify that what I recorded is what you actually said. What I am going to read is a report representing what I generated from interviews, focus group discussions and photovoice from all the four schools involved. Wherever necessary feel free to stop me to make a comment if you want, okay!

Researcher reading transcripts and showing some photographs. So this is what I recorded, now let me ask you, is this you said, and what you photographed and said about your photos?

Participants (All): Inde! (Yes, that's it!)

**Figure 34: Participants attentively listening to the transcripts as they are being read**

Zondi: Yeah! It's really what we said and what was photographed, and I just want to add something on..... You talked about awareness. Ah! Yeah! Awareness is very important, more especially to inform about those people much behind about the pandemic. But the most important is what we call 'self awareness'. Self awareness is much important because it's knowledge about oneself, what protects your body or health condition, yeah!

So another thing you have talked about 'peer pressure'; now you have just read about peer pressure but not the solutions. So I have two of resisting peer pressure. The youth should behave confidently so that you achieve what you want. If you want to achieve something you cannot go other way round of what your friends are saying so that you should be accepted by them, by that group, but just behave confidently so that you achieve what you want in life.

**Figure 35: A participant emphasising a point from the transcripts**

And also resisting social pressures. Someone talked about going to sports, yeah! ..... and being in the bars and so forth. So it's better to prevent those things because they can put you at high risk of having sex with prostitutes. So it's better to prevent those social pressures.

And another one is sexuality; yes sexuality is one of the major problems we have, like we youth, yeah! That can lead us to contracting of HIV/AIDS and other STIs, and solutions to sexuality is to have critical thinking of yourself; that you should know the negative and positive results of what you want to do. So if you are having those problems, you will check that this is bad, that is bad, let me do these things which are positive to me. And also by what we call.... hmm! What.....!

Researcher: If you have forgotten, you can come back to it later!

And also you have read about parents forcing us to this pandemic- rather they force us into prostitution, like they do chase, like girls from home and these girls they don't know where to go and they just turn to bars to be bar girls, yeah!

And also on cultural practices, yeah! These also can lead to we youth to be exposed to that pandemic because we cannot say we don't want to do them, so we are forced to follow them, so there are some of them cultural practices that are much affected to HIV/AIDS. We are much, I can say, we are at highly risky to contract HIV/AIDS.

Ah! What I can say lastly is on relationships- having relationships. To me I think it's not good, some of the youth are cheated by what we call courtship by having courtship, they don't know the rules, I can say. So rules of how to follow that courtship. Someone said to go with your boy friend in a bushy area that there is no one there, yeah! So we adolescents our hormones are becoming active so we cannot resist when we are there with our partners, yeah! That's it!

Participant B (Male): Yeah! I would like to talk much concerning about one, concerning about co-education centres that's as part of safe environment. You have just read that those people that are in a co-education centres are vulnerable that they can even contract HIV /AIDS, but when we consider much about co-education centres, somehow they can even contribute to the positive aspects in as far as contraction of HIV/AIDS is concerned. What I am trying to say is that whenever you are studying at an co-education centre, it may happen that, for example, I can talk of maybe if you are eating nsima with vegetables everyday for lunch, that means you are always used to vegetables, that means ukhala ukukhutisidwa kuti ndizingodya zomwezo (you will be like you are used). So the very same thing happens at school, ndiye kuti (and so) you are much used to chat with girls that means you cannot have that intention to propose love from them in a co-education centre.

Concerning poverty, eeh! Poverty HIV/AIDS, but maybe in addition to that one it may happen that your parents, both of them died of HIV/AIDS but then they were parents of well to do in so far as the rich are concerned, and again it might happen that due to their death it may lead to the orphans maybe aah! Maybecome destitute and that they can be left with no any means of survival and as a result they can just move up and down so they should have the ways of surviving, and maybecome prostitutes- that's what I wanted to add!

Participant C: (Male): I am Shivani, I just want to add to what we said previously. I just wanted to add about ignorance. Aah! Eeeh! I think ignorance is also one thing which I can make the youth to be attempted to sexual intercourse. This is happens when pamene anthu ena ake abwera kudzakatiphunzitsa ifeyo (when other people come to teach us) because of misconstrueness efeyo (us), we do things in improper way as such we youth are tempted to sexual intercourse eeh! I just wanted to add that.

## Concluding Remarks:

Participant (Male): Ifeyo tikukuthozani chifukwa chakubwera kwanu kudzakationa kuno'ko. M'mene last year munadzabwera ndikuchoka takhala tikufunsa a phunzitsi kuti ah! anthu aja sabwera kudzakationa? Ndiyebe momwe mwabwerera'mu, talimba mtima kuti ai! mwakumbukira kuti tikawaone ana asukulu aja. Mwachoncho tikukufuniraninso inu umoyo wabwino ndinso kuyenda kwabwino, ndi ntchito yanu. Tathokoza! (We thank you because of your coming to see us here. Since you came here last year, we have been asking our teacher that ah! Will those people not come to visit us again? So your coming has given us hope and confidence that at least you have remembered to come and visit us. Therefore we wish you good health, safe journey and success in your work. We thank you!)

Participant (Female): Tinganene kuti kubwera ndi project yanu kwatipangisa kuti pasukulu pano tikhale ndi makilabu a Edzi Toto. Inde yinalipo kale koma kungoti mphamvu yaonjezekera chifukwa amene munasankha kuti mudzigwirizana nawo ndiwonso a director wa kilabu yimeneyi, ndiye zimene tikuphunzitsana pano ndizimene timaphunzitsananso ku ma kilabu athu. Zikomo kwambiri! (We can say that your coming with this project has made us to have more AIDS clubs. Of course the club was there but now it has been rejuvenated and made stronger because the teacher that you had chosen

to work with you in the project is also our director of the club. So what we share here are the things we share at club level. Thank you very much!)

# Appendix E

## About the study location: Malawi

E1: Location of Malawi in  Sub-Saharan Africa

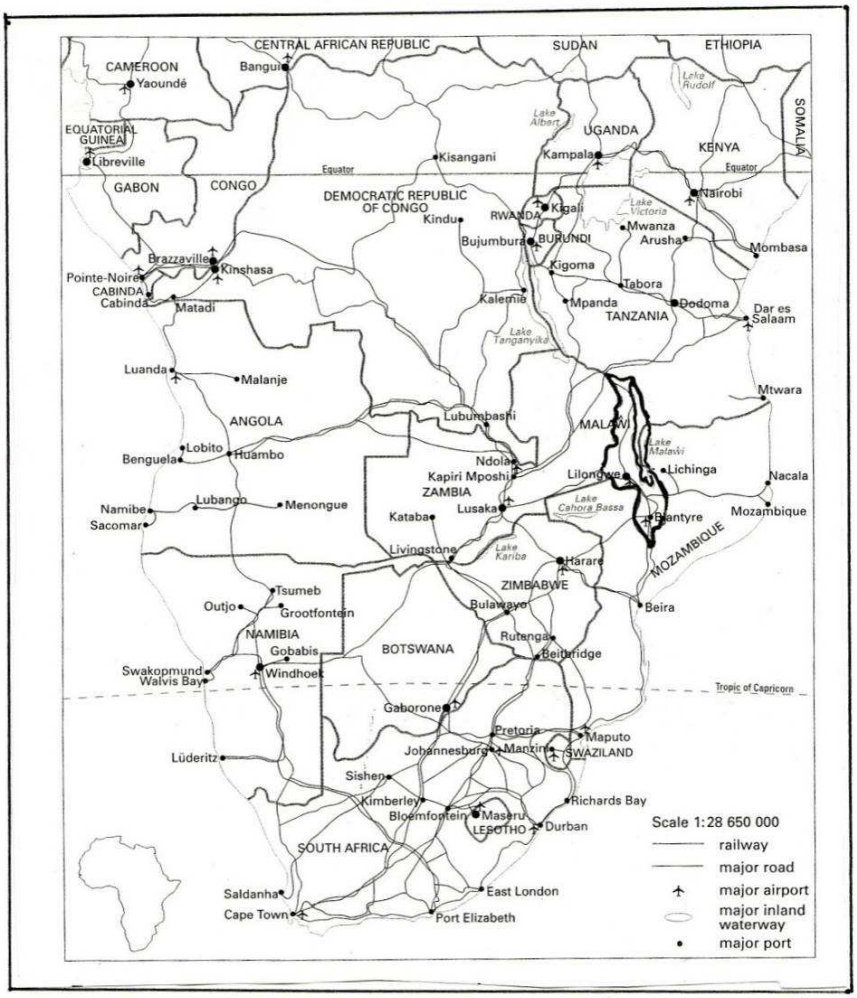
E2: Map of Malawi

E3: Malawi National Flag and National Anthem

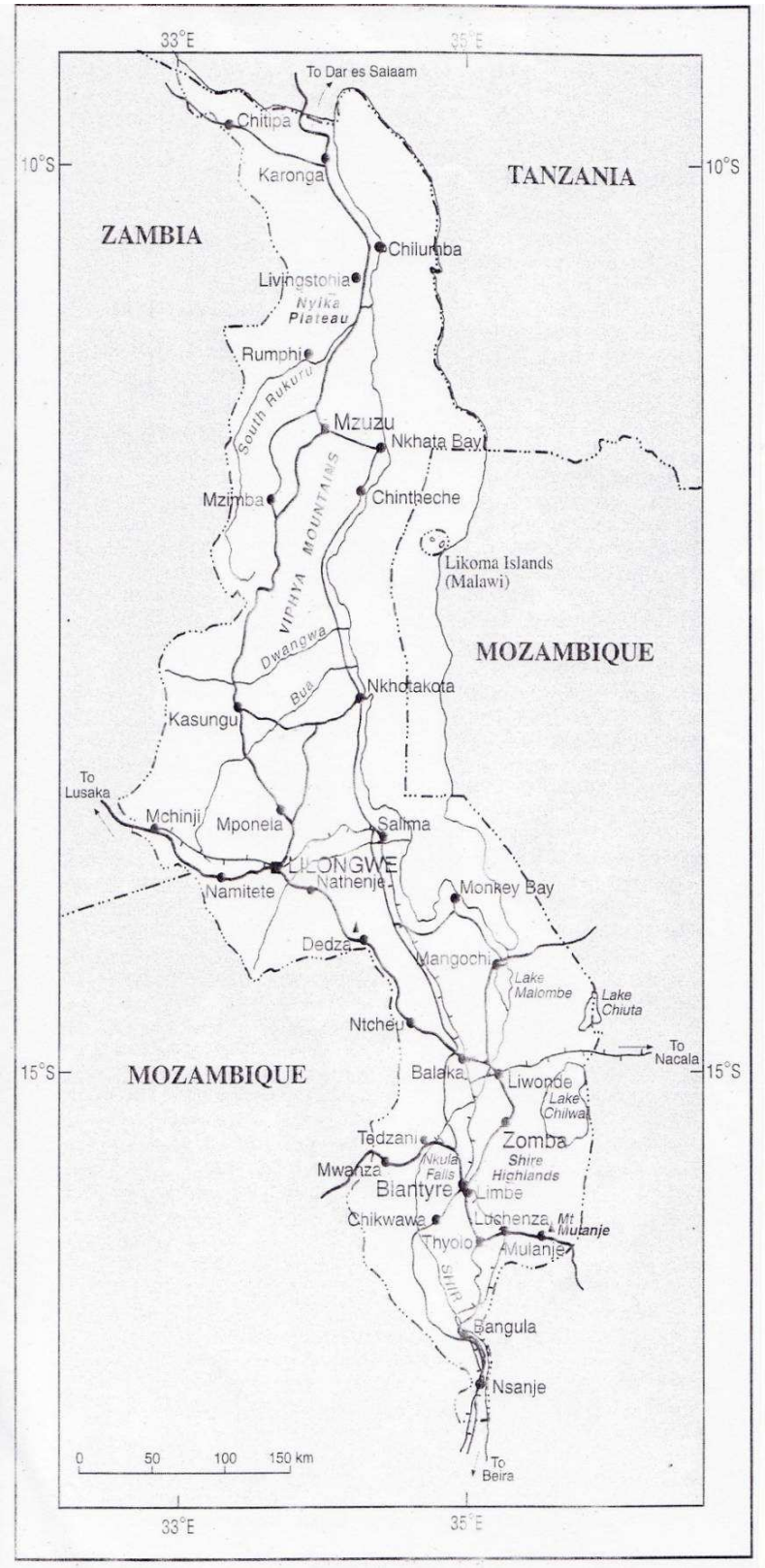
## Appendix E1:

## Map showing the position of Malawi in Sub-Saharan Africa

Adapted from Oxford Senior Atlas for Southern Africa (2001)



## Appendix E2: Map of Malawai



## Appendix E3: Malawi National flag and anthem

**The Malawi National flag and Anthem**

" Oh, God, Bless our...land of Malawi,
Keep it a land of peace.
Put down each and every enemy,
Hunger, disease and envy.
Join together all our hearts as one,
That we'll be free from fear.
Bless our leaders, each and every one.
And Mother Malawi.
*(First verse)*