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Struggling with growing bodies within silence and denial: Perspectives of HIV and AIDS among youth in Rural Zimbabwe

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Abstract

Concerns regarding HIV and AIDS were elicited from 546 school youth (51% female, age range 9–25 years) in a Zimbabwean rural district, through a self-generated question writing process. Concerns emerged around how to avoid infection at a time when they were undergoing secondary sexual development, had growing feelings for love and were even engaging in sexual activity, but had limited access to preventive methods due to denial by the adult world. Fears were expressed regarding how to tell one's HIV status, even just after sex. HIV and AIDS were visualised in terms of suffering, loneliness, quarantine and death. The youth stressed they would have difficulties communicating with other people should they suspect or find they are infected with HIV, as this would imply they had been sexually active. They seemed to have knowledge around HIV and AIDS that either was incomplete, or they could not apply given a context of silence and denial around their sexuality. Some of the knowledge was coloured with misconceptions, suggesting contradictory information from multiple sources. After more than two decades, the scenario portrayed raises questions about interventions targeting young people. The question is why is their situation in this state when several stakeholders are actively participating in debates and interventions around their well-being? Campaigns and interventions may need to consider young people's complex social contexts, the factors generating and sustaining their situation, and what role diverse actors and social change processes play in this.

Keywords

Adolescents; school youth; sexuality; sex education; sexual and reproductive health; social change; qualitative methods

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Introduction

This paper is based on a study that used a self-directed question writing process to elicit concerns of people young regarding sexual and reproductive health (SRH) matters, and focuses more specifically on those concerns expressed on HIV and AIDS. Our use of the self-generated question method permitted emergence of issues, including what seemed to be a complex sexual health context for young people, in ways traditional approaches to health research may not have.

Early SRH and HIV and AIDS research among young people in Zimbabwe, for instance, largely utilized quantitative survey methodologies to establish knowledge, attitudes and behaviour, and to determine risk (see for example, Campbell & Mbizvo, 1994; Duncan, Tibaux, Pelzer, Mehari, Peutherer, Young, *et al.*, 1994; Kasule, Mbizvo, Gupta, Rusakaniko, Mwateba, Mpanju-Shumbushu, *et al.*, 1997; Rusakaniko & Padayachy, 1997; Siziya, Rusakaniko, Marufu, Matchaba, Mudyarabikwa, & Gwanzura, 1998; Zimbabwe National Family Planning Council (ZNFPC), 1998). Several authors observe too that the focus then was on determining aetiology and identifying “risk groups” (Ankrah, 1989; Packard & Epstein, 1991; Schiller, Crystal & Lewellen, 1994; Green, 2003a). The concept of “risk group” implied that the epidemic did not affect the general population, when in fact transmission of the virus occurs following exchange of fluids at the personal level, and not based on the risk category of a person (Schiller *et al.*, 1994).

The biomedical approach to HIV/AIDS is criticised for several other reasons, including that KAP surveys commonly used assumes a linear association between knowledge and attitudes on the one hand, and behaviour change on the other. This, thus, ignores contextual and historical factors influencing behaviour (Vance, 1991; Warwick, 1993; Kelly, Parker & Lewis, 2001). The assumption knowledge generated using KAP surveys reflects the truth has also come under scrutiny especially regarding sensitive and complex topics such as HIV and AIDS (Hauser, 1993; Warwick, 1993; Huygens, Kajura, Seely & Burton, 1996; Kelly *et al.*, 2001).

Nevertheless, analyses that pay greater attention to context and make use of the more flexible qualitative approaches are increasingly used. Many studies illuminate the role of micro-level interactional dynamics in unsafe sexual behaviour (see for instance, Gold, Karmiloff-Smith, Skinner, & Morton, 1992; Taylor, 1995; Sherman & Bassett, 1999; Campbell, 2000; MacPhail & Campbell, 2001; Nyanzi, Pool, & Kinsmann, 2001). For Zimbabwe (Langhaug, Cowan, Nyamurera, & Power, 2003; Marindo, Pearson, & Casterline, 2003; Pattman, 2007) as well as internationally (Kopp, 2000; Green, 2003a; Green, 2003b; Rivers, 2004), discourse focusing on wider contextual issues has also shed light into the controversies among actors and agencies involved in HIV and AIDS education and service provision for young people. Conflicts among different actors often arise in areas of condom use, and the extent to which SRH services generally should be made available to unmarried young people.

The controversies have affected the implementation of policies targeting the young people, for example The AIDS Action Program – a life skills education program for schools in Zimbabwe. The program was launched in 1992 and addressed themes such as relationships, growing up, life skills, and health (World Bank, 2003). Although condom use was not mentioned in the program, some parents, churches and teachers felt it was too explicit and advanced for primary school pupils (UNICEF, 1996). Pattman also observed that, even though booklets on life skills had been produced for Zimbabwean schools by UNICEF, the teachers were not sure how to the subject, were embarrassed by it, and tended to emphasise the negative consequences of sex. UNICEF (1996) furthermore observes that the Catholic

Church in Zimbabwe forbade its schools from using a government HIV/AIDS textbook because the book supposedly ignored Christian values. The Central Statistical Office (CSO) & Macro International (2000) also report from the 1999 Demographic and Health Survey a general lack of support for teaching young people aged 12-14 about condom use. Similar opposition is reported for school-based educational programs elsewhere in the region (Nduati & Kiai, 1999). It has also affected research on young people, as was the case when the Ministry of Education refused to grant permission to researchers on a UNICEF project to interview schoolchildren under 16 years of age on issues about sexuality on the grounds “this might make them sexual” (Pattman, 2007, p. 37).

Contradictions and conflicts are also noted in legal and other policy areas focusing on young people. The National HIV/AIDS Policy (GoZ, 1999) for example, recognizes the vulnerability of sexually active young people, including those below 16 years of age. Accordingly, young people who may be concerned about or actually have a sexually transmitted infection (STI) have the right to receive counselling and care services. On the other hand, the Centre for Reproductive Law and Policy & Child Law Foundation (CRLP & CLF) (2009) highlights how another law states that a girl aged below 16 years is too immature to consent to sex, and having sex with her constitutes statutory rape. Some health workers were thus found to report STI in young people to the police as suspected cases of sexual abuse (Langhaug *et al.*, 2003).

Langhaug and colleagues (2003) used qualitative methods to identify factors that prevent young people from accessing services. Confusion about legal and policy issues among health workers, lack of privacy, inappropriate opening times, consultation costs, fear of negative staff attitudes, and staff assuming parental identities when required to professionally assist adolescents, were among barriers noted. Similar findings are reported from other studies in Zimbabwe (Mashamba & Robson, 2002; Erulkar, Karueru, Kaggwa, Nzioki, & Nyagah, 2005) and on the continent (Nare, Katz, & Tolley, 1997). Although these studies reiterate dilemmas experienced by adolescents’ service providers emanating from policy contradictions, analyses that dig deeper and attempt to unravel the controversy-ridden contexts of young people’s sexuality are limited.

Intervention trials have similarly been limited to school or localised community settings (Kasule *et al.*, 1997; Sherman & Basett, 1999; Cowan, Langhaug, Mashungupa, Nyamurera, Hargrove, Jaffar *et al.*, 2002). Whereas confining interventions to school settings does not in itself constitute a limitation – several school-based programmes are observed to have generated positive indicators (Cortina, Kahn, Fazel, Hlungwani, Tollman, Bhana *et al.*, 2008) – the focus is often on solving one problem at a time. For the broad and complex areas of SRH and HIV/AIDS, this limits the support for programs from parents, religious organisations and other stakeholders, which in turn threatens the sustainability of positive programme dividends.

Interdisciplinary research approaches are critical to move beyond the traditional behavioural approaches and address the broader social and structural change dynamics (Parker, Easton, & Klein, 2000). Effective prevention efforts, as Schiller and colleagues (1994) argue, require understanding complex contexts of risky behaviour. We present in this paper accounts written by young people depicting a sense of fear, confusion, and struggle around HIV and AIDS. Through locating the accounts of the young people within family, community and the national socio-historical processes, we examine how the scenario we have described above is shaped and why it persists when there is at the same time is public acknowledgement of the need to address young people’s issues.

Methodological issues

Design

An understanding of the perspectives of young people and their concerns on SRH matters was sought as part of a larger study on male perspectives to abortion and contraceptive use (Chikovore, Nystrom, Lindmark, & Ahlberg, 2003). In the larger study, the participants had described in focus groups and individual interviews the violence inflicted on girls by relatives and partners, in case of pregnancy, or being engaged in sexual activity or using contraceptives before marriage. The violence was reportedly inflicted on the girls' mother too, for allegedly failing to control a daughter's sexual behaviour. These insights prompted inclusion of young people to explore how the projected scenario might affect them. Thus, we studied young people in what is called an iterative research process (Lincoln & Guba, 1985; Hudelson, 1994), where early leads or what Agar (1996) would call rich points, are used to guide subsequent stages of a research process.

Setting

The study was carried out in ward 14, one of the 30 administrative divisions in Chiredzi 60 kilometres northeast of the Chiredzi Town, the district headquarters. In terms of human settlements, the district comprised mainly communal and resettlement areas; the latter were newer and had been established after independence. The major economic activity of the district was irrigation-supported sugarcane farming, and the district headquarters was established around the sugar plantations. There was also extensive wildlife management within the district. Within the communal areas, people would migrate to the sugar estates and mills and to surrounding wildlife parks for employment. A large proportion of young, some elderly, men crossed the border into South Africa in search of employment, some staying away for as long as 5–10 years at a time. A survey indicated that 37% of men had lived outside the study area for at least a month in the preceding year (PLAN International, 1999).

In this rural setting, health workers, non-governmental organisations (NGOs), and a local primary health centre were among the official sources of SRH and other health information for local people. An NGO had been working in the area in collaboration with the ZNFPC for three years prior to our fieldwork. Its activities included contraceptive promotion, although this was targeted only at the married adults. According to local teachers and other adults, the teaching of life skills was opposed in this community as it was viewed to promote premarital sex. It also emerged that parents were worried because they considered that the schools were providing condoms to their school going children.

In the absence of the men, women were largely responsible for upkeep of their families through income-generating activities such as moulding bricks, growing and selling vegetables, but also doing casual work on adjacent commercial. A shopping centre, where the local health clinic was also located, was busy with long distance buses and trucks driving through and here, women also vended vegetables and engaged at times in commercial sex work.

Social and economic relations observed in the study setting seemed related to processes initiated in part at colonization, for example, the forced male labour migration resulting in long periods of spousal separation. This means increased difficulties for women balancing the twin demands of family and economic survival while experiencing shortage of land but also having less access to agricultural support and training than do men (UNAIDS, 1999). Commercial sex work often becomes one of the means of survival for women and young girls. At the same time, men, who had become emasculated by the loss of status and prestige within the colonial interface (Epprecht, 1998; Silberschmidt, 2001), are under pressure to

maintain control over their families, including sexuality of female members. Being constrained from doing this because of migration, men may turn to violence as an option. The men in the study area were described to react violently, for instance, to any evidence or suggestion that their wives used contraceptives while the men were migrating. The men felt such use helped women to conceal their extramarital sexual activities. At the same time, it was said the men wished to keep their wives pregnant as often as possible to limit chances of getting involved sexually with other men. On the other hand, women felt the need to limit the number of children given their husbands, being away most of the time and without sending remittance, did not maintain them. However, some women were said to use contraceptives in instances of extramarital sexual activity during their husbands' absence (see Chikovore, Nystrom, Lindmark, Mbizvo & Ahlberg, 2002).

Initiation rituals for both boys and girls, still conducted in the study area, are another institution that reflects a combination of both tradition and the modern. Local teachers described the rituals as very secretive; those among them from outside would not have any knowledge of what the rituals entailed. They however described they could tell which girls were newly initiated through change in behaviour. Such girls would become more arrogant and also less attentive in class, or they would form new friendships. School dropout, particularly among girls was also said to be seasonal and associated with the initiation rites. Although one of the authors, JC, witnessed an emergence ceremony for girls who had been initiated, further inquiries seemed to yield little more. We have described elsewhere (Chikovore *et al.*, 2003) that the ritual was for preparing young people for adulthood, and that premarital sex was strictly discouraged, although there are now few mechanisms to support the initiated to avoid premarital sex. The way the ritual was conducted, and how it was perceived by outsiders suggest a traditional institution that has been modified by change processes, including schooling (Ahlberg, 1994; UNAIDS, 1997). More crucially, there seems to be a conflict between the schooling system and the parents. On the one hand, the teachers appeared to despise the initiation ritual, citing its interference with schooling, and that it inculcated values that were not compatible with education, resulting in many of those initiated dropping out of school. Parents, on the other hand, considered that the school system supplied condoms to their children, and taught them about sex contravening the values they instilled through the initiation ceremonies.

Population and procedure

The larger study had received ethical clearance from research ethics committees in Zimbabwe and in Sweden. Further permission to involve the school youth was obtained from educational authorities and school heads. Data was collected in 2001 from students and pupils from one secondary and two primary schools. The schools were all located in the same area as the study of men and women had been undertaken. We felt the scenario described by adults was likely to be more relevant for young people who lived in the same area.

Concerns of young people regarding confidentiality in interviews, and the ambiguities that surround interviewer-generated questions are reported in the literature from Zimbabwe (Kim, Marangwanda, & Kols, 1997; Cowan *et al.*, 2002; Mavhu, Langhaug, Manyonga, Power, & Cowan, 2008). We used what we termed the self-generated question approach in an attempt to circumvent some of the pitfalls reported around the face-to-face interviewing of young people on matters of sexuality. Pupils were invited to ask questions on issues around growing up or those questions that they could not ask their parents, teachers or other adults for fear or shame. We asked them to write their questions anonymously, but indicate their age, sex and class. They could use the language they felt most competent in expressing themselves.

All primary school pupils from the fifth to the seventh grade were included on the assumption they could better follow instructions. Moreover, pupils from fifth grade upwards, aged from about 11 years, were likely to have begun physical maturation and would therefore be a rich source of information and experiences on issues of sexuality and pregnancy. All secondary school pupils, that is, from the eighth (Form 1) to the eleventh (Form 4) years, were included.

The exercise took place in the classrooms. The first author (JC) and the last (BMA) authors conducted the exercise, firstly introducing themselves as social researchers from the University of Zimbabwe, and then explaining that what we would learn would be brought to the attention of authorities to help them better address the concerns of young people. At this stage, the aim was to understand how the prohibitions and violence described by adults might affect the young people. HIV/AIDS was not specifically mentioned to the pupils, and the questions written on HIV/AIDS therefore emerged rather spontaneously. Although we had stressed the importance of privacy in writing the questions, this did not deter the pupils from giggling and whispering perhaps due to the congested sitting arrangement, or excitement for having a rare opportunity to write on taboo subjects within a formal setting, or simply to write back to people of authority while maintaining anonymity. The teachers had also been curious and tried to gaze at the questions being written, but we politely requested them to not move around in the classroom or to leave the room while the pupils wrote their questions. The influence these dynamics may have had on the information obtained cannot be ascertained. However, the phrasing and the breadth of the questions, which covered some very personal and intimate issues, suggest any such influence might have been minimal. The exercise took about thirty to forty minutes to complete for each class that was visited.

Data analysis

Five hundred and fifty-six forms with questions, each form representing a pupil, were collected. Ten were excluded for being either illegible or missing data on the sex of the pupil; we considered that the latter would be difficult to analyze and interpret. Of the 546 question sheets analysed, 51% were from girls. Primary school pupils were aged 9–18 years (median=13) and secondary school pupils 13–25 years (median=16). A total of about 3 000 questions and statements were written.

We transcribed all the text and translated the non-English texts verbatim, keeping the translation close to the original text in an attempt to retain the meanings. Questions originally written in English were retained with minor grammatical editing. JC did the initial coding which involved reading the text thoroughly, picking key words, or phrases and sentences with meaning, and assigning codes to them (Krueger, 1998). Codes were at this stage largely descriptive and closely linked to the text. For example, a question or statement where HIV/AIDS was mentioned would be coded 'HIV/AIDS'. A single question could be assigned more than one codes, where multiple concepts were reflected. It is necessary to highlight that we were handling a large volume of volunteered data, in which individual participants also wrote on a variety of issues. This necessitated organising the data early in the process of formal analysis. We thus kept the initial coding at a descriptive level to permit organisation and grouping of the data pending more analytical coding (Strauss & Corbin, 1998).

Text with similar codes was then grouped, leading to nine preliminary categories namely HIV/AIDS, pregnancy and reproduction, sexuality, maturation, STIs and genitourinary, abortion, contraceptive use, marriage, and education. To determine the percentage of pupils mentioning issues under these categories, descriptive statistical procedures were conducted. HIV/AIDS had the highest percentage (75% of all pupils). The text under the nine categories

was re-read, and the deeper meanings in the statements were extrapolated. The data was thus broken down in more abstract ways, and simultaneously theoretical connections were established between the categories, leading to further re-reading and theoretical coding, or what is referred to as axial coding (Krueger, 1998; Strauss & Corbin, 1998). As is typical in an iterative research process, data were viewed and coded on the basis both of themes identified earlier in the research, and themes and concepts emerging in the index texts. Thus, as the HIV/AIDS sub-themes took shape, theoretical connections were sought between these and other categories, so emerging concepts could be enriched. Hence, the data presentation which follows includes questions and statements where HIV/AIDS may not have been explicitly mentioned, but a conceptual link was ascertained nonetheless. At all stages, BM and LN also read the original data, coded separately, and also traced the coding and analysis by JC. Their additional perspectives and critique were adopted and used to view the dataset in alternative ways and build on the emerging themes, until a fitting model of the data was generated. We present the themes emerging from the analysis process in the following section.

Findings

This section focuses on the ways young people expressed concern on HIV and AIDS. The first is about their perceptions of their susceptibility. They considered themselves to be highly vulnerable, partly because their bodies were sexually maturing and they anticipated or already engaged in sexual activity, were sexually abused, but were denied service nevertheless. The second theme is about fears and anxieties regarding being infected or ill, particularly the stigma and isolation expected, and the difficulties envisaged in communicating with health care providers and other adults. The final theme highlights young people's knowledge and views regarding HIV and AIDS transmission and symptoms, and who is at risk.

Young, vulnerable and willing to avoid HIV and AIDS

Statements from young people highlighted how they felt vulnerable, as girls, but also as young people and adolescents generally.

'We children are finished by HIV.' (girl-12)

'Children are growing up already infected with AIDS.' (boy-12)

'Why do we girls catch AIDS so much?' (girl-13)

'Why is it it's mainly adolescents who get AIDS?' (boy-13)

'Why do we have children dying of AIDS so much in Zimbabwe?' (girl-18).

Part of the vulnerability seemed to arise from witnessing or experiencing sexual abuse in one of several forms. The young people felt, for example, that they were exposed to rape [*'If I'm raped by father or an elderly person who has Aids, what do I do and who do I tell?'* (g-12)], or predatory sexual behaviour by adult men [*'Especially girls, they love sugar daddies due to economic problems. It then gets to an extent where they just do what the sugar daddies want because they will be thinking that their poverty problems will end. At the same time they will be creating unwanted pregnancies and more problems. This will also cause the spread of Aids and STDs?'* (b-17) *'Why do adults want to nyenga [sex] small children?'* (g-12)]

The sexual abuse, including rape sometimes by relatives, as well as forced marriage seemed to concern the girls more, even though boys expressed concern about it too:

'If you marry young do you get AIDS?' (girl-13)

'If I'm a girl of 14, and I am raped by a man of thirty, what do I do?' (g-15)

'Some parents arrange marriages, even when I do not like the man. These days there is Aids, but they say "go, if you don't we kill you".' (g-17)

'Some problems with STD in us young children come from our relatives who have sex with us, so what can we do to prevent these problems.' (boy-17)

The accounts of young people illuminated how they felt they were maturing sexually and experiencing sexual desire as a result.

'When a person is said to be grown up, what happens? Like me for instance, if I want to have sex with my boyfriend, what do we do to prevent AIDS, which is said to be untreatable?' (girl-14)

In contexts where their sexuality was socially sanctioned, this seemed to generate stressful feelings. The failure by society to acknowledge that young people are sexual beings and therefore provide them access to service and information was a worry for the young people.

'What can we do to avoid liking girls? What can one do to avoid arousal? These things began long ago, and they exist, so what can we do to avoid feeling aroused?' (b-14)

'Is there anything wrong if you love a boy, I don't think to love someone is a crime but others say when you fall in love with someone you will be a prostitute. Is it true? I am worried about these problems.' (g-15)

'My problem is that, it is said that all students must not practice sexual intercourse. For the student to think about it, it is not his/her problem but it is the problem of nature that if a person reaches the age of about 15, his penis erects and he has wet dreams during the night. If the person is a girl, she starts to feel shy and have respectful behaviour. For sexual intercourse... it is leisure to those who have reached that age. To prevent its consequences just give us advice though it is not done by our fault but by the problems of nature.' (b-18)

Of particular concern was how to satisfy or even manage the sexual desires and feelings of love while simultaneously negotiating around the deadly HIV/AIDS, all under the prohibitive social norms.

'What can we do so that we don't contract the deadly disease?' (girl-12)

'How can we protect our bodies from AIDS?' (girl-15)

'What can I do to avoid sexual feelings which cause me to have sex with someone I don't know whether they are HIV positive or not?' (boy-16)

'When you eventually have sex with a girl you hear her say, "We did it because it had pressed so much". Because, you know, the girl also wants to be "sexed" and both of you do not know the consequences. The only thing we will be afraid of is AIDS. Even when you insert the penis it is quite painful. When you give each other love like that you are not aware of what will happen; you just think you are playing.' (b-16)

'When a schoolgirl has a boyfriend who wants to sleep with her, how can she protect herself?' (girl-17)

'What can I do if I want to avoid diseases, because sexual intercourse is caused by nature and it is difficult to live without?' (boy-18)

The youth described how they innovatively dealt with failure to access sexual health services, for example, through engaging in self-medication in the event of STI [*'In our area,*

those responsible for distributing condoms, they refuse to give school children. As a result I can have sexual intercourse unprotected, after that if the girl has STD she can also infect me. I fear to tell my parents and in the end I will take my different types of pills to cure this disease and it will not work.’ (boy-18)]

While expressing concern on lack information and service, the school youth also provided ideas about how service and information could be made more accessible to them. Given the difficulties of accessing SRH services at the primary health care centres, they suggested using the school as an alternative channels such as schools.

‘We kindly request you to provide condoms and family planning to schools since we are too afraid and shy to make known our behaviour at the nearby health centre or clinic.’ (boy-16)

‘Another problem that disturbs my learning is that I don’t know whether I have disease or not because no blood tests are done in my school. If I had a boyfriend or girlfriend, would it be advisable to go to the hospital for a blood test?’ (boy-17)

‘Why doesn’t the government give us books with advice on AIDS?’ (boy-17)

‘Isn’t it possible to give pupils things to protect themselves from disease and pregnancy?’ (boy-19)

Interestingly, despite concerns expressed about feeling vulnerable and being denied services, the youth seemed to also view the people who get infected with HIV from a moralistic perspective. They described AIDS as being associated with the ‘bad’ behaviours of having (early) sex, or having sex with many partners. There seemed to be gender differences, where girls displayed more moralizing attitudes about AIDS, a possible sign of greater societal pressure for them to be morally upright and naïve about sexuality compared to boys.

‘AIDS is a disease you catch on your own. When you have AIDS, who do you tell? Isn’t it lack of control that causes this disease?’ (girl-12)

‘If you do bad things with a man and he gives you HIV, what happens to you?’ (girl-12)

‘If you’re 12 and then have sex with many boys, do you get AIDS?’ (girl-12)

‘A little child is not supposed to get that disease. That sort of disease is for adults, not the young, because it’s bad.’ (girl-13)

Life after infection with HIV and AIDS

The accounts of the young people illuminated further their worries about life when infected with HIV, particularly the stigma and discrimination. For the young people, being HIV positive appeared to evoke images of quarantine, isolation and certain impending death.

‘Where is a person with AIDS kept?’ (girl-11)

‘When you have AIDS, are you allowed to live with others? Are you allowed to eat from the same plate as others, can you greet other people?’ (girl-13)

‘If a person has AIDS, how does he feel and how is he treated?’ (boy-13)

‘If you get AIDS, what do you do when they tell you there is no medicine?’ (girl-12)

‘Does a person with AIDS necessarily die?’ (boy-12)

‘Why do adults say if you get AIDS you’re dead?’ (boy-12)

'If I catch AIDS what do I do?' (girl-13)

'If I get AIDS does that mean I'm dead?' (girl-13)

'When you catch AIDS, you just have to die?' (boy-13)

'When one gets AIDS, his or her friends shun him or her.' (girl-13)

'If you get it, can you survive?' (boy-15)

The silence and denial that surrounds sexuality, and the stigma of HIV and AIDS, were evident in the description of difficulties anticipated in informing parents, health care providers or even friends should they be infected with HIV.

'If you go to the hospital and you know you have AIDS, what do you say when you get there?' (girl-12)

'AIDS is a very bad disease. It's embarrassing to tell people about. If I have AIDS, is it okay to tell my mother?' (boy-12)

'Should I go to the hospital (with AIDS), what must I say is my problem?' (girl-13)

'If I get the disease that has no cure, would they question me and tell me I'm a hure [prostitute]?' (girl-15)

Worries about a current or future infection with HIV, without ability to share or seek help, seemed to overwhelm the young people even to a point where they considered committing suicide.

'If I find I'm not feeling well in my body, I'm shy and afraid to tell mother, father or the teacher. Maybe I have AIDS, and I see that I'm just wasting away, but I don't know who to tell.' (girl-16)

'What can I do if I'm HIV positive and am afraid to tell my parents about this? This worries me. Will some of my friends laugh at me if I have AIDS? At times I think of killing myself so that I can rest.' (boy-16)

Ideas about risk, transmission and symptoms

HIV transmission and what constitutes risky behaviour have been at the centre of education campaigns. However, after more than two decades of the campaigns stressing, among others, that HIV has a long incubation period, the way the questions were phrased suggests the young people were concerned about how to tell whether one was infected immediately after sexual intercourse. They also expressed concern over whether they could tell, just by looking, who was infected, or by feeling where the virus was lodged in their own body. The boys in particular seemed to expect symptoms to appear on the penis.

'If you've AIDS, which part of the body has pain first? Can a healthy person have AIDS?' (girl-11)

'If you've AIDS, how do you feel it?' (boy-13, boy-12)

'When a penis gets painful, is it because of AIDS?' (boy-12)

'What are the clear symptoms of AIDS? Can you say whether a person is HIV positive within a week?' (boy-15)

'What happens to the penis when it has AIDS?' (boy-15)

'What are the clearest symptoms of AIDS? Can a person see if they have AIDS within a day?' (boy-16)

'How can I know if my boyfriend is HIV positive before having an AIDS test?'
(girl-19)

Questions on whether walking together, kissing, fondling breasts, or sharing same breath, footpaths, food, clothes, and toilets can transmit the virus, would cause AIDS were asked. The youth asked how long a sex act must last to result in infection. Interestingly, these questions have persisted despite educational campaigns about how HIV is and is not transmitted. Furthermore, the young people asked about whether the pathogens staid in reproductive organs, and their mode of moving between partners during sexual intercourse. The questions indicated that the information reaching young people may have generated more confusion than educated them.

'What makes one get AIDS when one sleeps with a man?' (girl-11)

'If a girl has an AIDS germ, how does it catch onto the boy?' (boy-13)

'How do our bodies get disease from boys?' (girl-13)

'Does sperm consist of bacteria that cause disease? I don't know why sexual intercourse causes diseases because sperm don't contain any bacteria.' (boy-13)

'When a man and a woman have sex, how does the disease reach the other person?'
(boy-14)

'If a person is infected with syphilis, does the syphilis turn into AIDS or does the syphilis stand on its own?' (girl-19)

The accounts further suggest young people still associated HIV infection with being part of a defined 'risk group', in this case, prostitutes and people with many partners. Also considered at risk were people who travelled to or between cities and towns, mirroring the manner in which these places were considered epicentres of HIV and AIDS early in the pandemic. The youth seemed to feel that as long as they did not have a partner they could define as 'prostitute' (*hure*), or did not view their own sexual behaviour as 'prostitution' (*hura*), they were safe. The statements however, suggest that these perceptions were more common among the younger groups.

'If a man and a woman sleep together, just the two of them, do they get AIDS?'
(boy-10)

'If a woman sleeps with more than five men, does she get AIDS?' (girl-10)

'Does a person who has slept with a hure [prostitute] catch the disease?' (boy-10)

'If you have many girlfriends, do you get AIDS?' (boy-13)

'If a man goes to Chiredzi Town Centre and he marries a hure without knowledge about her background, is this what causes AIDS?' (boy-13)

'Is this (AIDS) caused by kupindapinda [promiscuity]?' (girl-13)

'Why is it a person with different partners develops AIDS?' (girl-13)

'If a boy keeps marrying and rejecting women, does he get AIDS?' (boy-13)

'I don't hura too much because I'm scared of AIDS.' (boy-13)

'If you sleep with many men you get AIDS. If you sleep with one in Chiredzi, and you go to Harare and sleep with another one you get AIDS.' (girl-15)

'If I hura do I get AIDS?' (girl-15)

'Does AIDS affect only pfambi [prostitutes]?' (boy-15)

Another area of concern appeared to be the safety of condoms. The questions illuminated a discourse that questioned the effectiveness of condoms, and the innovations employed to enhance the safety, such as wearing two condoms:

'Do condoms give 100% protection? How can I use a condom?' (girl-13)

'Do condoms prevent this disease?' (girl-14)

'Can a condom effectively prevent AIDS?' (boy-15)

'If I used two condoms at once and had sex with a person who is HIV positive, would I get it?' (boy-15)

'If you have sex with a boy who has AIDS and use a condom, do you get AIDS?' (girl-17)

'Can AIDS pass through a condom that doesn't have any holes?' (boy-19)

Discussion

When this study was carried out, both the discourse around, as well as the use of anti-retroviral therapy (ART) were in their early phases, and have since grown markedly. In theory, this would have been significant – the availability of ART was initially expected to herald the reduction of HIV/AIDS stigma (Piot, Kazatchkine, Dybul, & Lob-Levyt, 2009). In practice, however, no significant shifts have occurred, partly because in low-income settings, ART remains largely unavailable to many people who need it, and also because HIV/AIDS stigma is itself a phenomenon extremely complex to tackle (Roura, Urassa, Busza, Mbata, Wringe & Zaba, 2008; Pearson, 2008; Piot *et al.*, 2009). In 2005, an estimated 342 000 people were in urgent need of ART in Zimbabwe, while the target for the government was to have only 60 000 on treatment by the end of the year (MoH/WHO, 2005). Similarly, only six per cent of HIV-infected pregnant women received ART for the prevention of mother-to-child transmission in 2005 for Tanzania (Leach, 2007). Under such circumstances, the concerns the school youth express in this study over imminent death and stigma if one contracts HIV may still be relevant even today.

The questions in this study emerged from a research process where the young people were invited to ask questions on growing up or those questions they could not freely discuss with adults. The activity was carried out within a systematic research process that encompassed triangulation of data sources, methods, and analysts. In the end, the research process strove to maximize accuracy in the observations made. The scripts generated around HIV/AIDS and presented here may therefore mirror closely the visualisations and worries these young people had about the nature and consequences of this disease, despite prior interventions.

The accounts depict a youth struggling with growing bodies within a silence and denial of their sexuality by the adult world and society generally. These young people were aware of HIV and AIDS, wanted to avoid it but felt helpless in the face of abuse by adults, and given the way their sexuality was socially obliterated. One may ask what this implies about research and interventions targeting young people so far. The AIDS Action Program had been implemented in schools in Zimbabwe for over a decade prior to this study. It does, however, appear the program which was meant to impart skills to deal with relationships and maturation among others may have had a limited effect in addressing the needs of these young people. Family life programs have been shown to experience operational problems (Nduati & Kiai, 1999), and schools have been observed to issue commandments about sexuality rather than assist the young people in developing the critical skills necessary to make informed decisions and choices (Schatz & Dzvimbo, 2001; Pattman, 2007). Claims by adults and parents in our study community that schools encouraged sexual activity and

supplied their children with condoms are an indication of a lack of community support for life skills education. Combined with judgmental attitudes from health service providers, these contextual factors seem to imply that what knowledge young people may have becomes burdensome where their ability to apply it to protect themselves it is limited.

This scenario of a young people struggling can partly be understood from a historical perspective. In pre-colonial times in Zimbabwe and other countries in Africa, structures and support systems existed that regulated the transition from childhood to adulthood. Besides ensuring control over sexuality and procreation (Setel, 1996), pre-colonial organization guaranteed economic security for unmarried women (Peters & Peters, 2003). This changed when colonial policies of taxation and land alienation impoverished Africans and dispossessed women of livelihood (Van Onselen, 1976). Sex became commoditized as husbands and wives were separated, while prostitution was encouraged around white-owned enterprises in a process meant to ensure a constant supply of African male labour (Van Onselen, 1976; Peters & Peters, 2003).

With social structures for socialization thus distorted, dealing with premarital sex and sexuality has fallen on the nuclear family. The nuclear family is itself not readily available to play that role due to work and schooling (Sherman & Bassett, 1999). In this situation different agencies, with conflicting aims, have become increasingly involved in adolescent SRH education, adding to the complexity (Sherman & Bassett, 1999). More and more, young people rely on different sources of information such as friends, and media (Sherman & Bassett, 1999). All this seems to generate a burdensome experience for young people. The burden is seen in the worries expressed about health and the body and how to protect it, about how to negotiate social sanctions on sexuality including denial of service and information, about how to manage consequences of sexuality such as HIV and AIDS and pregnancy, and about how to interpret and use the different types of information reaching them.

In addition, the young people indicated how they still had poor, conflicting or inconsistent knowledge about HIV and AIDS. They still associated HIV infection with specific groups such as prostitutes or people considered to have casual sex. This is not surprising given the manner in which early in the pandemic the concept of “risk group” was widely used in AIDS education (Schiller *et al.*, 1994). Of concern here is the persistence of these associations after more than a decade of life skills and AIDS education. When individuals do not perceive themselves to be in the specific “risk groups”, they consequently may not take necessary precautions (Gavin, Galavotti, Dube, McNaghten, Murwirwa, Khan, *et al.*, 2006).

Historical and contemporary factors may indeed have contributed to the scenario portrayed (see Richter & Panday, 2007), in particular the plural societies where multiple and sometimes contradictory perspectives co-exist. What is perplexing, though, is the absence of intense efforts to make young people’s situation visible and open to public debate, even as studies repeatedly report young people’s failure to access services. We consider that a deeper engagement with this question may be key to unlocking what appears to be a stalemate around young people’s SRH. What value, for instance may scholarship that draws parallels between young people’s situation (their exclusion or participation) and the way women, minorities, the disabled and other groups have been and continue to be marginalised (Matthews, Limb & Taylor, 1999) add to making sense of this scenario? What implications do persisting tendencies to locate adolescence as a period of upheaval requiring control and guidance, and to cast children as social problems needing to be protected (Shanahan, 2007) carry for how their issues are solicited and addressed? Additionally, how significant is adult ambivalence towards the youth – “... our desire for them to act responsibly, balanced in equal measure by our inability and perhaps reluctance to give young people opportunity to

assume responsibility” (Richter & Panday, 2007, p. 292) – to their situation? Related to this, to what extent have methods that are used to explore adolescents’ experiences embraced a democratic and participatory ethos, without seeking to confirm pre-held notions about young people (Shanahan, 2007) or treating them as passive objects for study (Bhana, 2007)? It is also important to examine how keeping young people at the periphery, even whilst appearing to be working to improve their situation, serves to entrench the positions and interests of different actors in contemporary societies – government sectors, NGOs, religious circles” and even parents, among others.

Conclusion

This study generated a form of ethnographic account, in the way described by Parker & Ehrhardt (2001). They described ethnography as “a range of methods that can be employed in building up an ‘ethnographic record’ (or description of a particular culture or cultural context”. The young people seem to be placed in a specific context which, while not a neatly bound and distinct society, is marked by conflicts, suspicions, and ‘hybridity’ or the intertwining of the old and the new, generating specific forms of identity or ways of seeing and doing (Agar, 1996). These broad social contours seem to frame the ways young people in this community experience and negotiate issues of HIV and AIDS.

It appears that dealing with young people’s SRH situation and addressing their concerns around HIV and AIDS requires tackling the various questions raised above, as well as critically examining the complex and shifting contexts in which they live, and what constraints this places on the options available to families, governments, and communities in dealing with adolescent SRH. There is a need to raise debate around young people’s situation and the roles of various actors around them. Frameworks such as the youth development framework may also be a valuable tool in approaching the question of how to deal with young people’s issues. This framework came into being to address what was referred to as one-dimensional and vertical approaches to ‘fixing’ youth problems. It acknowledges a multi-dimensional and integrated understanding of youth, not separating issues of unemployment, education, security, health families and opportunities (Richter & Panday, 2007) all which thus require an interdisciplinary approach. It moreover assumes a holistic approach to solving young people’s problems rather than pursuing solutions aimed at one problem at a time. The framework further recognises the diverse experiences and states of youth, and links development and well-being of young people to contexts they live in (Richter & Panday, 2007). Ultimately, efforts to address young people’s situations need to be evaluated using approaches that allow the voices of young people to express themselves. The self-generated question method provided insights on the situation of the youth in ways survey studies could not have.

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