Published in final edited form as:

Sex Educ. 2018 ; 18(1): 1–13. doi:10.1080/14681811.2017.1370368.

HIV Knowledge and Risk among Zambian Adolescent and Younger Adolescent Girls: Challenges and Solutions

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Abstract

In sub-Saharan Africa, young women are at the highest risk of HIV infection. Comprehensive sexuality education (CSE) and open parent-child communication about sex have been shown mitigate risky sexual practices associated with HIV. This study aimed to identify sources of HIV prevention knowledge among young women aged 10–14 years and community-based strategies to enhance HIV prevention in Zambia. Focus group discussions were conducted with 114 young women in Zambian provinces with the highest rates (~20%) of HIV. Discussions were recorded, transcribed and coded, and addressed perceived HIV risk, knowledge and access to information. Participants reported that limited school-based sexuality education reduced the potential to gain HIV prevention knowledge, and that cultural and traditional practices promoted negative attitudes regarding condom use. Parent-child communication about sex was perceived to be limited; parents were described as feeling it improper to discuss sex with their children. Initiatives to increase comprehensive sexuality education and stimulate parental communication about sexual behavior were suggested by participants. Culturally tailored programmes aiming to increase parent-child communication appear warranted. Community-based strategies aimed at enhancing protective sexual behaviour among those most at risk are essential.

Keywords

HIV; knowledge; risks; girls; adolescents; Zambia

Introduction

Approximately 15.1% of women in Zambia are HIV-infected, compared to 11.3% of men (UNAIDS, 2015). Sexual debut during early adolescence is common in Zambia (Richter et al. 2015; Siziya, Muula, Kazembe, & Rudatsikira, 2008), and heterosexual intercourse accounts for approximately 90% of all HIV infections among women in the country (UNAIDS, 2015). Among young people aged 15 to 19 years old, the prevalence of HIV is 4.4% (Zambia Ministry of Health, 2015), highlighting the need for HIV prevention strategies in this age group. Sexual debut prior to age 14, is a risk factor for HIV infection in girls in

sub-Saharan Africa (Stöckl et al. 2013; Fleishman & Peck, 2015) and has been linked to sexual behaviours such as having multiple partners, unprotected sex, and sex while under the influence of alcohol or drugs (Richter et al. 2015). Sexual initiation ceremonies, rituals conducted during puberty that herald girls' sexual maturity and provide instruction on marital and sexual practices and counsel from peers, are major sources of sexuality education for young women in Zambia but may not provide comprehensive or accurate information regarding HIV risk or prevention. In fact, some initiation ceremonies may provide instruction on sexual practices that increase the risk of sexually transmitted infections (STIs) and HIV (Alcaide et al. 2014). In previous research, 43% of Bemba, Nyanja, Tonga, and Lozi participants reported attending a sexual initiation ceremony before the age of 15; nearly half of the individuals leading initiation training were extended family members and one-quarter were non-family members (Kapungwe, 2003).

It is not culturally acceptable for Zambian parents to discuss sexual issues with their children; communication on topics of sexuality has traditionally been the responsibility of same-sex members of the extended family, such as aunts, uncles, and grandparents (DiIorio, Pluhar, & Belcher, 2003). Lack of accurate knowledge and limited pathways for information may thus increase HIV rates among Zambian youths. The acceptability and uptake of HIV education and information strategies that may not be culturally sanctioned, such as parent-child communication and school-based comprehensive sexuality education, has been explored among older adolescents aged 13 to 19 years old in Zambia, but not among younger adolescents aged 10 to 12 years (Agha, & Van Rossem, 2004; Denison et al. 2011). HIV prevention strategies in this age group may help promote the adoption of safer sex practices early on, thereby contributing to HIV prevention efforts in Zambia (UNAIDS, 2015).

Community-based participatory research methods rely on a community partnership to enhance the cultural and social congruence of research. By working with the affected community, community based research better reflects life as people experience it. In partnership with researchers, the local population participates in the elucidation of the problem and in its solution, ultimately generating information that can be translated into programmes or policies more acceptable to the community, resulting in improved uptake and greater likelihood of enhancing health outcomes (Viswanathan et al. 2004; Israel et al. 2001).

This study used one frequently employed aspect of community-based participatory research, focus group discussions, to explore HIV knowledge, prevention information and perceptions of risk among Zambian adolescent and younger adolescent girls, and to identify strategies to enhance HIV prevention knowledge. It was believed that better understanding of community perspectives on acquisition of HIV and prevention knowledge could guide the creation of supported, community congruent strategies to reduce HIV risk among Zambian girls.

Methods

Prior to study commencement, approval was obtained from the University of Miami Institutional Review Board and the Research Ethics Committee at the University of Zambia.

Written assent to participate was obtained from all enrolling participants as well as informed consent from a parent or guardian for all participants.

Participants were compensated for their time with 50 Zambian Kwacha (~ \$5 USD) each. Data were collected from May 2016 to July 2016, as part of the ongoing Zambian Community HIV Prevention Project (ZCHPP). Nine districts with the highest HIV prevalence in three provinces were selected for data collection – Southern Province: Livingstone and Mazabuka Districts; Copperbelt Province: Chingola, Kalulushi, Kitwe, Mufulira, Ndola, and Chililabombwe Districts; Lusaka Province: Lusaka District. Primary and middle schools, churches, community centres, and local organisations where youth congregate (e.g., YWCA and YMCA) were accessed as a means of recruitment.

School and facility heads from which the pool of participants were chosen were briefed on the study's objectives and asked to refer prospective participants; they were not compensated as they played a minimal role in the research. The schools that were used for participant sampling were all public and government run, which allowed for recruitment of participants from varying socioeconomic backgrounds. Purposive sampling was utilised for participant selection; further detail on participant recruitment by district can be found in Table 1.

After providing assent and parental/guardian consent, participants (n=114; girls aged 10–14 years) were provided with an appointment to attend a group discussion. Focus groups contained 6 participants each, and were conducted by trained study staff, all of whom were Zambian and employed by the University of Zambia, in private spaces at community centres, schools, and local organisations. Focus group discussions were audio recorded by study staff and field notes were made by these staff during FGDs. No identifiable participant characteristics were retained in the FGD transcripts other than the name of school or facility. The parents/guardians of participants were not present during FGDs as the goal of the study was to elicit open and candid responses from participants. However, comprehensive information about the study was provided to participants and their guardians. The lead FGD facilitator (AK) held a Masters degree in public health, and had previous experience with FGD organisation and facilitation from the larger ongoing study; she was also the Zambia team's project coordinator. The project coordinator's (AK) involvement may have enhanced participant responses as she had greater depth of knowledge regarding the issues. However, participant responses were similar between interviewers. All FGD facilitators were female and under 35 years of age. Focus group topics addressed HIV-related risk factors for adolescents, particularly adolescent girls, and attempted to elicit from participants, strategies that they thought could assist with HIV prevention in their age group (See Appendix 1 for FGD question guide).

The focus group discussion guide was written at a 6th grade level (11–12 years) in order to ensure participants understood what they were being asked. The FGD framework was adapted from previous research (Jones, Weiss, and Chitalu, 2014; Vamos et al. 2013), and developed by the University of Miami/University of Zambia collaborative team, which included psychologists, infectious diseases physicians, paediatricians, social workers, psychometricians, and an adult education teacher. Stem questions were created using an iterative, collaborative process. Proposed questions were reviewed and refined by the entire

team, and presented as open-ended questions during FGDs. Time was available in FGDs to address additional topics as they arose. Each FGD lasted approximately one and a half hours.

Coding

FGD audio recordings were reviewed by the Zambian team in local languages; Tonga, Lozi, Nyanja, and Bemba. Recordings were then translated and transcribed into English. The analytic process included open coding, which involved identifying the properties and dimensions in the data, as prescribed by grounded theory (Service, 2009; Glaser, Strauss, & Strutzel, 1968). Preliminary themes were identified from the first three transcripts. Additional themes were identified and incorporated based upon three subsequent transcripts (themes are summarised in Table 2). Using the final themes, the Miami and Zambian teams coded the remaining transcripts. During the coding process, two senior coders (SB and JL) from the Miami team were administered intensive training on coding strategies, by the study's primary investigator; a licensed clinical psychologist and grounded theory/coding expert. The two senior coders reviewed all previous coding to resolve any thematic disagreements between coded data. The same procedure was repeated with a third coder (VJR), reviewing 6 transcripts. Coding and thematic disagreements were discussed among the three senior coders until consensus was reached. In addition, meetings were conducted regularly with the entire coding team to discuss and redefine codes and themes. Community summaries were also developed by the Zambian team to ensure concurrence between teams.

Results

Sources of Information on Sex and HIV

Although HIV sensitisation campaigns, some of which include giving HIV talks at schools, were described as widespread, schools themselves seemed to lack comprehensive sexuality education programmes. It was apparent that the closest thing to sex education in schools were the “safe” clubs where girls could receive information on safer sex and discuss sensitive issues. However, joining these “safe clubs” was described as optional and not mandatory for all students. Information on sex was primarily obtained by girls from initiation ceremonies, peers, and relatives who were not parents; this led to inaccurate information and misconceptions about relationships, sex, and safer sex practices, such as the belief that certain tattoos function as a “love spell” to secure relationships or that having sex in general was an amoral behaviour:

In some school[s], there are clubs which talk about HIV, like at our school, there is safe club, it talks about how to prevent ourselves from HIV, and prevent being a teenage mother. (Mining Community, Chililabombwe)

During initiation ceremonies, we are taught how to please men in bed, also there are tattoos given to us in our waist so that when a man touches a girl, he will never leave a woman [the girl with the tattoo that was touched] (Libuyu, Livingstone)

We share stories with each other, some are bad things like having sex (Kaonga, Mazabuka)

In addition, attitudes and normative beliefs towards condom use were negative. Misconceptions about inability to achieve sexual satisfaction when using condoms, as well as a lack of condom use efficacy were described by participants, and suggested as motivation to engage in unprotected sex. Male preference for condomless sex was also said to negatively influence safer sex practices.

Women don't know how to use female condoms (Libuyu, Livingstone)

It is true they [boys] are not willing [to use condoms]. I stay in a rural compound area and there I experience a lot of things... they say, it doesn't feel good when you are having sex to use a condom. It is good for them to do it [engage in sex] directly [without using a condom], so a lot of them in Chililabombwe, they don't like to use condoms. (Mining Community, Chililabombwe).

HIV-related knowledge

Community Challenges—HIV-related knowledge was relatively general, and specific knowledge on HIV acquisition and prevention seemed to be lacking. All participants knew that HIV could be lethal when left untreated, that there are steps that can be taken to remain healthy after seroconversion, and ways to avoid transmission. However, there was an abundance of misconceptions related to HIV prevention, modes of transmission, and side effects of antiretroviral medications.

I have heard that when a person test for HIV and found with the virus they will die (Libuyu, Livingstone)

The ARVs can choke people that is why they don't get treatment (Libuyu, Livingstone)

When a man dispose of a condom in the road and a child picks it and plays with his/her mouth they can get infected with AIDS. (Chilenje, Lusaka)

Community Solutions—Government-funded school programmes, such as HIV prevention clubs and safe spaces for girls to address issues pertinent to them, were described positively. The incorporation of programmes into the school curriculum that delivered accurate information on HIV, sex, and safer sex practices was also illustrated. In addition to school-based comprehensive sexuality education programmes, community outreach activities related to safer sex and HIV education were also suggested.

The syllabus should be revised [to counteract] what is taught during girl initiation ceremonies by older women (Libuyu, Livingstone)

In schools, the government should put in place clubs that educate others on how to avoid peer pressure, early pregnancies; especially peer pressure, it is a factor, because you would be following what your friend was doing. (Mining Community, Chililabombwe).

Just the government can get some volunteers, they [can] go 'round the community to teach us, continue [to] educate the community about HIV and AIDS, what you can do and how to prevent it. (Makeni, Lusaka)

Parent - Child Communication

Community Challenges—Parent - child communication was described as limited; girls asserted that they primarily spoke with their parents about school and church. Girls avoided discussing topics of sex or sexuality; it was perceived to be more comfortable or culturally congruent to discuss such sensitive issues with other relatives. When the topic of sex arose, parents were reported to emphasise abstinence; very little communication on safer sex practices took place. Participants described communication with fathers as declining after puberty.

Girls should be tougher than boys because if a boy touches your shoulder and you laugh about it the next time he will touch your breasts and what are you going to do, so my mother tells me to be tough, you can laugh and joke with them but no touching the body (Mufulira)

We should be listening to what our mothers tell us and not to be misbehaving with like having boyfriends, exchanging with guys like in the morning you sleep with this one, afternoon you sleep with this one, today tomorrow and the other day. (Chilenje, Lusaka)

Boyfriend issues, I ask my friend or sister not parents because they will think otherwise, if I am pregnant I can't tell them because they [will] evict me, out! (Mutende, Kitwe)

When you reach the stage of puberty, we can't go to our fathers, we tell our mothers, for those [girls] that don't have mothers, they can go to female neighbours. (Chilenje, Lusaka)

Community Solutions—Participants desired open communication with their parents. They believed this to be protective, and essential to HIV prevention. Girls perceived that parents could and should act as barriers between children and high-risk situations. Parents were seen to be a reliable source of information on sex and HIV when they were willing to communicate, and to encourage children to stay in school.

Not only clubs, parents should sit us down and discuss with us about the dangers of HIV/AIDS (Libuyu, Livingstone)

Just as we are seated, we could be talking with our parents, they would be cautioning us about how to behave well, what to avoid and how to concentrate at school and be well behaved. (Mushili, Ndola).

I think the parents should block the websites that show pornography and things like that, and they should also spend time with their families, tell them what's good and bad (Chilenje, Lusaka).

Poverty

Community Challenges—Parents were described as prioritising basic needs over education, increasing their motivation to marry off their daughters before they could complete schooling. Destitute parents with no economic opportunities were forced to seek financial support by prostituting their daughters.

Early marriages occur when there is poverty in the house, they do not sponsor you at school, so some parents, not only step mothers but even your real parent, they could have an idea of marrying you off when you are in grade 12, about 15 years old. Since she is matured, they would marry them off at any time, she knows how to take care of the house, how to cook, or something like that. That is why you find that maybe a young girl is married off. (Mining Community, Chililabombwe).

Like for us youths, the poor people, the only job that they can find is prostitution, that's the only job they can find, where they can get money without being educated so it can be difficult to change that. (Mufulira).

Poverty & Sexual Exploitation

Community Challenges—The sexual exploitation of school going girls by predatory authority figures was reportedly common, particularly by male head-teachers. Male faculty were described as leveraging girls' inability to pay tuition to coerce girls into exchanging sex to remain in school.

Maybe for example at your school, the principal is a man, when they chase you, they tell you that come into my office, you tell them that you haven't paid the school fees, then they tell you to have sex with them so that that person cannot chase you from school (Mushili, Ndola).

The possibility for HIV infection in the school set up is very high for the girl child, especially due to the financial hardships the families are going through. The caregivers in these schools are always in a hurry to put the girls up for sexual favors. (Libuyu, Livingstone).

Community Solutions—The re-introduction of government funded education was proposed to reduce financial barriers to completing school, as well as scholarships for young people to reduce school dropout rates. Participants shared beliefs that teachers should regularly stress the importance of completing school to their students, and that this could positively influence school attendance, which could reduce sexual exchange.

I would encourage them not to stop school because education is important. Teachers should also find out why some children drop out of school and see how they can help. (Mufulira)

I think the government should put more money in the education sector, so that those stopping school due to lack of sponsorship could also go back to school even though there is no sponsorship, they can also be sponsored by the government. (Mining Community, Chililabombwe).

Discussion

This study explored risk factors and challenges to HIV prevention, and identified community-based solutions to prevent HIV among younger Zambian girls. Primary outcomes highlight that a lack of school-based sexuality education was associated with deficiencies in knowledge regarding safer sex practices, and that communication between

parents and children about sex was needed. In addition, poverty was found to increase early sexual debut among girls, and resulted in survival-based sex exchange.

Study findings were consistent with those of previous studies suggesting that communication about sex between parents and adolescents is limited (Dilorio, Pluhar, & Belcher 2003), and as such, communication on sexual issues may be restricted to discussions with extended same-sex family members and peers who may not have accurate information. Although young peoples in this study expressed discomfort in discussing sex with their parents, they suggested that provision of information on sex and HIV by parents would be welcome. In traditional sub-Saharan African communities, such as those in Zambia, safer sex practices may have been associated with the erosion of traditional values. Therefore, discussion of these matters between parents and children may not have been embraced as appropriate (Eshetu, Zakus, & Kebede 2017; Wilson, et al. 1995).

To facilitate more open communication between parents and children, a cultural shift in perspectives related to sexuality and values may be needed. Changes regarding parent-child communication on safe sex may not occur in elder and current parental generations. However, participants in this sample seem to be more tolerant of non-normative sexual ideals, suggesting that Zambian youth could be receptive to change. This receptivity also suggests that interventions to improve knowledge of safer sex practices and HIV among Zambian youth would be appropriate. Strategies that include messages that educate not only on abstinence, but also on sex and safer sex practices, including the prevention of risk-related sexual behaviour and the consistent and correct use of condoms, were suggested by participants and are supported in previous literature (Sutton, et al. 2014; Fonner et al. 2014).

Strategies that teach those parents who are willing to communicate with their children on sexual matters to use effective communication skills were also warranted. A cluster randomised controlled trial conducted in three sub-Saharan African locations found a culturally tailored intervention geared toward healthy sexual practices (i.e., delayed sexual debut, and consistent condom use) to have a significant impact (Namisi et al. 2015). The intervention used an intervention mapping approach, a systematic method based on behaviour change theory, empirical evidence, and formative research, to tailor interventions to the populations they served (Bartholomew, Parcel, & Kok 1998). The intervention was school-based and administered by specially trained teachers, but involved homework assignments, which required parental involvement, thus encouraging communication on sensitive topics between parents and children. A similar approach could be used in Zambian settings.

While effective communication on sex can be provided to young people by parents, school-based comprehensive sexuality education/HIV programmes are also needed, especially for those whose parents lack accurate information or who are unwilling to communicate on the topic. Receiving sexuality education before sexual debut has been found to mitigate risky sexual behaviours in youth (e.g., Lindberg & Maddow-Zimet, 2012; J. Jemmott, L. Jemmott & Fong, 2010), yet very few participants reported having received sexuality education as a part of their school curriculum. A systematic review by Paul-Ebhohimhen, Poobalan & Van Teijlingen, (2008) identified four studies conducted in sub-Saharan Africa that demonstrated

comprehensive sexuality education can have positive outcomes regarding condom use. This review also identified another sub-Saharan African study that illustrated positive outcomes within its comprehensive sexuality education intervention group, such that there was a reduction in number of sexual partners (Fawole et al. 1999). Interventions such as these however come at a cost.

The train the trainer model for widespread dissemination of communication workshops has been previously used in Zambia (e.g., Jones et al., 2012; Weiss et al., 2014) and is a potential strategy for use in this setting. In the absence of school based comprehensive sexuality education and communication on sex from parents, gaps in young people's knowledge develop regarding safer sex practices. Although a comprehensive sexuality education curriculum has been developed for the Zambian education system (Rasing, 2003), results suggest that efforts to increase its implementation are needed and may require local intervention or influence at the ministerial level.

The link between poverty and sexual risk has been well established (Madise, Zulu, & Ciera, 2007; Jukes, Simmons, & Bundy, 2008; Muzyamba, Broaddus, & Campbell, 2015), and was supported by the current study. Sexual exchange for tuition when parents cannot afford school fees, early marriage for girls to relinquish parents from financial responsibility, and promotion of commercial sex work to support the family were commonly reported by participants in this sample. Alleviating poverty by the provision of scholarships and the enforcement of laws to protect young people from sexual exploitation were suggested by this study, and supported by previous literature (Jukes, Simmons, & Bundy, 2008). Providing cash transfers to make money available for families to afford school tuition together with interventions that directly pay school tuition (i.e. government funded scholarship programmes) have been shown to be viable strategies for reducing school dropout rates, reducing early marriage, and reducing HIV/STI-related risk (Jukes, Simmons, & Bundy, 2008; Hallfors et al, 2011; Pettifor, MacPhail, Nguyen, & Rosenberg, 2012). Intervention by policy makers, government agencies, and NGOs should also continue to provide and scale up income generating alternatives for families and girls.

Zambia's cultural practices are slowly evolving; traditional initiation ceremonies that involve pubescent girls are less widespread and more common in rural areas. There are still, however, hybrid ceremonies which take place before a woman is married. These ceremonies continue to encourage the submissiveness of wives to their husbands and teach intravaginal practices that may increase risk of HIV transmission (Alcaide et al. 2014). If appropriately extended, these more modern ceremonies present an opportunity to implement strategies focused on renegotiation of cultural practices to include less risky forms of sexual behaviour, without the complete abandonment of associated traditions.

Our study has limitations worth noting. All data were self-reported, and may have been subject to social desirability bias, especially as young women are more susceptible to this bias when reporting sexual behaviour (Kelly et al. 2013). The current sample was also comprised of individuals belonging to a very specific HIV risk group, and findings may not be generalisable to other populations. As the data incorporates only FGDs, there was no triangulation of data sources. The indirect method used to assess some constructs during

FGDs may have lessened the experiential value of findings, and other relevant topics may have been excluded. Lastly, as the study used open coding, the subjective nature of this qualitative data analysis may have resulted in coding bias.

Communication between parents and children has been associated with reduced sexual risk, delayed sexual debut and protective sexual behaviours, e.g. condom use and assertiveness in sexual negotiation, in young people (Kajula, et al. 2014). Reducing young people's sexual risk behaviour in Zambia and sub-Saharan Africa by way of school-based comprehensive sexuality education and communication with children on safer sex, whether by way of a parent or a well-informed trusted adult, can have a major impact on HIV transmission. Strategies to ensure the provision of CSE in the school curriculum, facilitate communication with parents, and ensure government support to keep girls in school may therefore play an important role in reducing rates of HIV infection. Community supported and developed programmes to address the social, economic, and cultural context in which sexual behaviour and sexuality education occur have the potential to maximise the impact of strategies for HIV prevention in Zambia.

Acknowledgements

This study was funded by a grant from USAID through Pact, AID61181600001. Activities were conducted with the support of the University of Miami Miller School of Medicine Center for AIDS Research, NIH grant, P30AI073961.

Appendix

Appendix 1.

Focus group discussion (FGD) question guide.

Facilitator prompts

What do parents know about children?
 What do parents talk about with their children?
 What do families do together?
 How much time do children spend with their parents?
 What kinds of things can you talk with parents about?
 Who can you ask questions that you might not ask your parents? Friends? Family?
 Neighbours? Teachers? Nurses? Doctors?
 Where can you go to talk with someone if you have a problem?
 Where is a safe place to go?
 How do children get by when there is not enough money at home?
 What kinds of jobs do they get?
 What have you heard about children missing/skipping school, or dropping out of school?
 Why do children miss school or drop out?
 What could be done to stop children from leaving school?
 What happens when children are held back/retained in school? (fall behind in school)
 What have you heard about children who have problems at home?
 What kinds of problems? (violence, abuse, neglect)

Facilitator prompts

What have you heard about children going to parties?

What have you heard about children drinking alcohol?

What do they do when they are drinking beer or shake-shake or other types of alcohol?

Where do they get alcohol?

What have you heard about children using drugs?

What do they do when they are using drugs, like smoking marijuana?

Where do children get drugs?

What do children look at on the internet or on mobile phones?

What have you heard about HIV?

How do people get infected with HIV?

How do children learn about HIV in your community?

What have learned about HIV at school?

What have you learned about HIV from friends? family?

What have you heard about the chances of getting HIV for young girls or boys?

How do you stop the chances of getting HIV from another person?

What do you know about using condoms for protection?

Do people use them very much to prevent HIV?

What have you heard about VMMC to prevent HIV?

What have you heard about HIV testing? Where can you get tested?

Why do some people not get tested for HIV? Or not get treatment for HIV? (Youth friendly? Stigma? Someone finds out?)

Where can you go to get help if you get sick? Where can you see a doctor or nurse about a problem?

How old are boys and girls when they first have sex?

How do girls stop boys who want them to have sex?

How do girls keep from falling pregnant? What have you heard about using condoms?

What have you heard about people who force girls to have sex? What kind of people do this?

What have you heard about girls who have sex for school fees, transport, drinks, food, money?

What happens when children are living on the street?

What have you heard about young girls getting married? How young are they?

What have you heard about boyfriends and girlfriends fighting? What about slapping or hitting?

How do girls make boys more respectful? How do girls stop boys from beating them?

What have you heard about taxi drivers, bus drivers, foreigners, teachers having sex with girls?

How are girls supposed to behave, compared to boys?

What do girls learn from others about their role?

Who guides girls as they get older, telling them how to behave? Alangizis? Family? Friends?

Whom do girls talk to about growing up?

How does peer pressure affect boys? How does it affect girls?

What could be done to help boys and girls stay safe from violence?

How could parents help?

How could churches help children? How can schools help?

What kinds of things are needed for boys and girls? Recreation?

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Table 1.

Distribution of focus group discussions by district.

Province and district	Number of FGDs	Number of Participants
<i>Lusaka</i>		
Lusaka district	7	42
<i>Copperbelt</i>		
Ndola	2	12
Kalulushi	1	6
Mufulira	1	6
Kitwe	1	6
Chingola	2	12
Chililabombwe	1	6
<i>Southern</i>		
Livingstone	2	12
Mazabuka	2	12
Total	19	114

Table 2.

Summary of arising themes.

Themes	Challenge	Solution
Sources of information on sex and HIV	Young people received information on sex primarily from peers and initiation ceremonies, which led to inaccurate and sometimes harmful instruction. There seemed to be a lack of sexuality education in schools, and condom acceptability was reported to be low	Implementation of consistent sex and HIV education into the school curriculum was strongly suggested. Emphasis was placed on the scaling up government initiatives to regularise and make mandatory sex education programs such as Anti-AIDS clubs or sex education classes
HIV knowledge	HIV knowledge among girls was basic. Knowledge on modes of HIV transmission, living with HIV, HIV prevention and medication side effects was lacking	
Parent child communication	Parents were reluctant to engage in open communication about sex with their children as this was thought to be improper. Parents stressed practicing abstinence and conversed minimally on topics of safe sex. Thus, participants felt more comfortable discussing sensitive topics with friends and relatives that were not their parents	Participants believed that significant involvement of parents in the lives of their children, as well open and constant communication about sex and HIV prevention between parents and children could encourage children to adopt protective behaviours
Poverty	Scarcity of basic needs was said to negatively affect school dropout rates and increase high-risk behaviours, as well as create potential for high risk situations. Withdrawing from school was also associated with early sexual debut, early marriage, sex work, and sexual exchange	Introducing government-funded education and scholarship/ sponsorship programmes could reduce financial barriers to completing school. It was believed that teachers should consistently stress the importance of education to motivate their students to complete school
Poverty & sexual exploitation	Inability to procure school fees due to poverty lead to predatory male school heads/authority figures leveraging sexual favours from girls for these girls to remain in school	