

University of St Andrews



Full metadata for this thesis is available in
St Andrews Research Repository
at:

<http://research-repository.st-andrews.ac.uk/>

This thesis is protected by original copyright

**‘They’ll Tell Us We’re Still Young Children!’
HIV/AIDS Related Knowledge And The Extent And Nature Of The
Sexual Knowledge And Behaviour Of Primary School Children In
Zimbabwe.**

Thesis submitted to the University of St Andrews for the degree Doctor of Philosophy



Fungisai Puleng Gwanzura-Ottmoller

School of Geography and Geosciences, University of St Andrews, September 2005



Th F262

I, Fungisai Puleng Gwanzura-Ottemoller, hereby certify that this thesis, which is approximately 93 240 words in length, has been written by me, that it is the record of work carried out by me and that it has not been submitted in any previous application for a higher degree.

date: 28/04/06 signature of candidate:

I was admitted as a research student in September, 2001 and as a candidate for the degree of PhD Geography in September, 2005; the higher study for which this is a record was carried out in the University of St Andrews between 2001 and 2005.

date: 28/04/06 signature of candidate:

I hereby certify that the candidate has fulfilled the conditions of the Resolution and Regulations appropriate for the degree of PhD Geography in the University of St Andrews and that the candidate is qualified to submit this thesis in application for that degree.

date: 28/04/06 signature of supervisor: /

In submitting this thesis to the University of St Andrews I understand that I am giving permission for it to be made available for use in accordance with the regulations of the University Library for the time being in force, subject to any copyright vested in the work not being affected thereby. I also understand that the title and abstract will be published, and that a copy of the work may be made and supplied to any bona fide library or research worker.

date: 28/04/06 signature of candidate:

Abstract

This thesis examines the HIV/AIDS related knowledge, attitudes and sexual behaviour of Zimbabwean primary school children. Zimbabwe has the third highest HIV rate in the world: 25% of adults are HIV positive. Forty-five percent of Zimbabweans are under 15 years but these children are largely missing from HIV/AIDS research. Children aged 6-14 have the lowest HIV rates in the population. They do not yet have established sexual behaviours and may thus be more amenable to practising safer sex. *Children's geographies* perceives children as competent social actors able to represent themselves. These important principles have not been used to address HIV/AIDS and the sexual behaviour of children because the majority of research is conducted in the global North. This thesis attempts to redress these research gaps.

Data was collected from an urban primary school using mixed methods. One hundred and eighteen children aged 9-14 responded to a multiple-choice HIV/AIDS knowledge, attitude and behaviour questionnaire. Qualitative data was elicited from a sub-sample of 36 children using diagramming techniques and individual interviews.

Quantitative results revealed that most participants had good knowledge about transmission and prevention of HIV. Statistically significant differences were found between levels of knowledge and attitude, information and behaviour variables. Qualitative data highlighted the children's in-depth awareness of risk and preventative factors, and of the importance of HIV testing. The results indicated that a minority of primary school children were sexually active.

This thesis addressed the research gaps by showing the levels of HIV/AIDS knowledge held by primary school children; illustrating the nature of their sexual behaviour and the extent to which it takes place; and establishing the feasibility of conducting in-depth research with children on sexual issues. It demonstrates the importance of targeting children for HIV/AIDS prevention to perceive how they construct their knowledge and behaviour within this context.

Table of contents

Acknowledgements	x
1. Introduction.....	1
1.1. Definition of terms	1
1.2. Background	3
1.2.1. Children on the margins	3
1.3. Background: the situation in Zimbabwe	5
1.4. Outline of the thesis chapters	9
1.4.1. Literature review: Conceptualising Childhood and the New Children's Geographies	9
1.4.2. HIV/AIDS research with children	10
1.4.3. Research with children: epistemology, methodology and methods	11
1.4.4. Quantitative results: children's levels of knowledge about HIV/AIDS	13
1.4.5. Qualitative results: the extent and nature of children's sexual knowledge and behaviour.....	14
1.4.6. Discussion and Conclusion.....	14
2. Conceptualising Childhood And The New <i>Children's Geographies</i>.....	16
2.1. Introduction	16
2.2. Western historical conceptualisations of childhood.....	17
2.2.1. The representation of children through medieval art	17
2.2.2. European classical philosophers' conceptualisations of childhood.....	19
2.2.3. Developmental psychologists' influences on conceptualisations of childhood	20
2.3. The development of childhood studies within sociology.....	23
2.3.1. Theorising the child in the New Social Studies Of Childhood	24
The socially constructed child.....	25
The tribal child.....	26
The minority group child	26
The social structural child	27
2.4. <i>Children's geographies</i>	28
2.4.1. <i>Children's geographies</i> research in the global North.....	29

2.4.2. <i>Children's geographies</i> research in the global South.....	30
2.5. The social construction of childhood in sub-Saharan Africa	33
2.5.1. The conceptualisation of the Shona child.....	35
2.5.2. Children and social status	35
2.5.3. Children and religious belief	37
2.5.4. Children as material and economic assets	38
2.6. HIV, sexual behaviour and children's geographies	40
2.7. Conclusion.....	44
3. HIV/AIDS research with children	46
3.1. Introduction	46
3.2. The need for early intervention	49
3.2.1. Early sexual debut	50
3.2.2. Age of primary school children.....	53
3.2.3. Openness to behaviour change	53
3.3. Risk Factors for Children contracting HIV/AIDS	55
3.3.1. Biological risk factors.....	55
3.3.2. Economic.....	56
3.3.3. Socio-cultural	60
3.3.3.1. Cultural practices	60
3.3.3.2. Forced sex	61
3.3.3.3. Peer pressure	64
3.3.3.4. Myths	65
3.4. The nature of adolescent sexual relationships.....	67
3.4.1. Children's sexual partners	67
3.4.2. Number of sexual partners.....	69
3.4.3. The spatiality of sexual activity.....	70
3.4.4. The context specific nature of gender roles in sexual relationships	72
3.4.5. Sexual pleasure.....	74
3.5. Sex education	76
3.5.1. Traditional sex education in East and Southern Africa.....	77
3.5.2. The impact of colonialism on sex education	78
3.5.3. The change in family responsibilities.....	82
3.5.4. The role of the formal education system	82
3.6. Targeting primary school children for HIV/AIDS research.....	83

3.6.1. Life skills and the Zimbabwean AIDS Action programme.....	84
3.7. Summary	88
4. Research with children: Epistemology, Methodology and methods	90
4.1. Introduction	90
4.2. Applying feminist epistemology to child research.....	91
4.3. Methodology	95
4.3.1. Adopting a mixed method approach.....	99
4.3.2. Adopting a participatory action research (PAR) approach.....	102
4.4. Research design.....	104
4.4.1. Study site	105
4.4.2. Gatekeepers: Tsungirirai and the school	106
4.4.3. Phase 1: Virtual participatory research design-January 2002-December 2002	107
4.4.4. Phase 2: Face to face participatory research design with Tsungirirai – January 2003-February 2003	108
4.4.5. Phase 3: Pilot study – January 2003	109
4.4.6. Phase 4: Choice of school – January 2003	110
4.4.7. Phase 5: The main study – February 2003-March 2003.....	113
4.4.7.1. Sampling frame.....	113
4.4.7.2. Sampling bias.....	114
4.4.7.3. Two stage sampling procedure	115
4.4.7.4. Field instruments and data collection	116
HIV/AIDS quiz	116
(Alternative) diagramming sessions.....	119
Diagramming tools.....	122
4.4.7.5. Individual interviews	128
4.4.8. Phase 6: Dissemination/Feedback	128
4.5. Reflecting back on the research experience	130
4.5.1. Reflexivity	130
4.5.2. Characteristics of Participants and group dynamics.....	134
4.5.2.1. Group work	134
4.5.2.2. Interviews.....	142
4.5.3. Positionality.....	143
4.6. Methods of data analysis	146

4.6.1. Quantitative Data analysis	146
4.6.2. Qualitative data analysis	148
4.6.2.1. Data transcription and translation	148
4.6.2.2. Data analysis	151
4.7. Summary	155
5. Quantitative results: children’s levels of knowledge about HIV/AIDS	156
5.1. Introduction	156
5.2. Study sample	157
5.2.1. Gender	157
5.2.2. Grade and Age	158
5.2.3. Orphans	159
5.2.4. Socio-economic status	160
5.3. The AIDS Quiz	161
5.3.1. HIV-related knowledge	161
5.3.2. Knowledge levels	168
5.3.3. High scorers	174
5.3.4. Low scorers	175
5.3.5. Lifesaver questions	177
5.3.6. Lifesaver high scorers	178
5.3.7. Lifesaver low scorers	179
5.3.8. Comparing knowledge total scores and lifesaver scores	180
5.4. One-way analysis of variance test results	182
5.4.1. Knowledge and attitudes	182
5.4.2. Knowledge and information sources	185
5.4.3. Knowledge and Behaviour	187
5.4.4. Lifesaver variable	188
5.5. Summary	190
6. Qualitative results: the extent and nature of children’s sexual knowledge and behaviour	192
6.1. Introduction	192
6.2. Knowledge related themes	193
6.2.1. Catching HIV/AIDS	193
Cultural constructions of reproduction	197
Rape/ forced sex	201

6.2.1.1. Preventing HIV/AIDS.....	208
Condoms	208
HIV testing.....	215
6.2.2. Children's sexual behaviour.....	219
6.2.2.1. How children learn about sex	219
Parents.....	220
Older siblings	221
Television.....	223
Eavesdropping.....	226
School.....	228
6.2.2.2. The nature of children's sexual behaviour.....	229
Petting	229
Still young.....	233
Sexual partners.....	236
Peer pressure	240
Places where sex takes place.....	242
No sex before marriage	246
6.3. Summary	247
7. Discussion and Conclusion	248
7.1. Introduction.....	248
7.2. Conceptual/theoretical contributions.....	249
7.3. Epistemological and methodological contributions	252
7.4. Policy recommendations	257
7.5. Limitations of the research process	260
7.6. The way forward	261
7.7. Summary	262
8. Bibliography	265
Appendices.....	287
Appendix 1. Map of Zimbabwe	288
Appendix 2. HIV/AIDS questionnaire.....	289
Appendix 3. HIV/AIDS Quiz answer sheet	297
Appendix 4. Semi-structured interview	299
Appendix 5. Feedback letter to the school head teacher	301
Appendix 6. Feedback report to Tsungirirai	303

Appendix 7. Questionnaire: Socio-Demographic information codes	307
Appendix 8. HIV/AIDS quiz - Attitude, information and behaviour question codes.....	310
Appendix 9. Questionnaire HIV/AIDS quiz – knowledge question scores	313
Appendix 10. MAXqda screenshot	315
Appendix 11. Example of thematic chart.....	316

Acknowledgements

There are many people I would like to thank who have assisted and supported me in the past four years and enabled me to complete this thesis. This has been a challenging, frustrating and yet rewarding journey and I have learnt many things along the way.

Heartfelt thanks go to my supervisor Dr Mike Kesby. Reading one of his papers motivated me to apply for a PhD position at St Andrews, and this has culminated in the opportunity to fulfil one of my long held aspirations. Mike has always been supportive and easily approachable. I have learnt a great deal from him and I hope we will continue to collaborate in the future.

I would also like to thank the School of Geography and Geosciences for giving me the opportunity to study in the department; for the financial and administrative support they have provided over the years.

Grants from the Antipode Graduate Student Scholarship and the Russell Trust enabled me to travel to Zimbabwe to conduct my data collection and I am most grateful to these organisation for recognising and acknowledging the importance of my research.

My sincere thanks go to the people in Zimbabwe who supported me during my field visit: my warm appreciation goes to the former director of Tsungirirai for welcoming me into her organization. I admired the passion she had for helping disadvantaged children and she has been an inspiration. I would also like to thank the staff who helped me during my field visit, especially the deputy director who took the time to ferry me about and introduce me to the school, and with whom I became good friends. I would also like to thank the children at Tsungirirai who participated in the pilot study. I am extremely grateful to the head of the school where I conducted my research for her cooperation and interest in this work. She was accommodating and supportive and it was much appreciated. I would also like to thank all the children in the grades five, six and seven classes that were involved in the research they were all great. Special thanks go to children who were involved in the qualitative part of this research; they were a wonderful group who made the experience truly memorable and enjoyable. I hope they go forward to be successful in their lives.

My thanks also go to Irene Tawengwa for assisting me with the data collection; she was truly a gem and a partner in this process; I could not have managed without her. I would also like to thank Caroline Maposhere for her invaluable advice and support.

My sincere gratitude goes to my colleagues and friends David Manley and Iain Atherton for their invaluable support particularly with the quantitative analysis. They were always ready to read my work, give feedback and often provide some light relief.

I thank my parents for always having supported and encouraged me in all my academic endeavours: my father, who, although he did not live to see me achieve this, always believed in me and I know he would have been very proud of me; my mother, who has taught me to be patient and tolerant and is a wonderful person. My son Thabo, for bearing with me all these years, especially for putting up with being neglected in the last few weeks. And most importantly, my husband Lars who has been my rock in the past four years. I would not have managed to study and to complete this thesis without his support.

Finally I would like to thank my Lord and God for sustaining me throughout this process and keeping me strong.

1. Introduction

This thesis investigates the HIV/AIDS related knowledge, attitudes and sexual behaviour of Zimbabwean primary school children. There is a large amount of literature on HIV/AIDS in sub-Saharan Africa, which covers the medical, epidemiological, behavioural, social and cultural aspects of this pandemic in a variety of populations, and yet children are largely under-represented in this literature. This is remarkable since children constitute a significant demographic group in this region: up to 50% in many populations. Children also have the lowest HIV rates and are the section of these populations most likely to adopt safe sex behaviour. The sub-discipline of *Children's geographies* has two key failings in relation to children in this region: first, its research and conceptualisations of children have been predominantly focused on children in the global North – although this is now beginning to change with new emphasis on 'other childhoods' (see special forthcoming issue in the journal *Children's geographies*); secondly, 'other' other childhoods like sexuality (see Kesby *et al*, forthcoming) have often not been directly addressed. The harsh empirical reality of the HIV/AIDS pandemic in sub-Saharan Africa demands that this research gap be addressed. This thesis begins the process of addressing the research gap using a small-scale multi-method project focused on revealing how children's experiences and views in relation to HIV/AIDS and sexual behaviour are constructed within this context. Thus, the project addresses two very straightforward but vitally important issues:

- 1) What are the levels of knowledge about and attitudes towards HIV/AIDS among children aged 9-14?
- 2) What is the extent and nature of their sexual knowledge, attitudes and behaviour?

1.1. Definition of terms

Age: In this thesis young people aged 14 years and under will be referred to as children; aged 15-18 years as adolescents; and those between the ages of 19-25 as

youths. The generic term young people will also be used when referring to all these age groups. I prefer to use the term 'life stages' (see Midwinter, 2005) rather than age. The term age gives an impression of fixed categories, which are essentialist and universal; it is often arbitrarily used to classify people and determine their competencies. Life stage however is a broader term that does not have fixed or rigidly demarcated categories, and is more subject to socio-cultural interpretation; in many cultures in the global South human maturation is conceptualised through life stages. However, for the purposes of clarity and because this study also aims to inform policy and practice, I will adhere to the numerical norms. The terms, children, adolescents, youths and young people are used in a broad sense in this thesis; I am aware that these are not homogenous groups, but that the formation of their identities are subject to the social, cultural and economic contexts they inhabit; furthermore, I acknowledge that they have their own individual opinions, characteristics, needs and desires.

Knowledge: The term knowledge is used widely in the thesis and mainly defined in two ways. The first is in line with a dictionary definition of the term *i.e.* 'understanding of or information about a subject, which has been obtained by experience or study' (Cambridge Advanced Learner's Dictionary, 2006). This refers to the empirical approach of knowledge that has been learnt and that can be quantified and in this thesis refers to children's biomedical knowledge of HIV/AIDS as measured by a questionnaire.

The second definition is linked to feminist theory and the idea that knowledge is socially constructed and that there are different ways of knowing. This thesis privileges children's knowledge of their own lives and experiences over that of adults on issues such as HIV/AIDS and sexual behaviour where adults are often seen as experts. As stated by Mayall:

The word knowledge implies something derived from experiences in the past; people reflect on these, build on them and arrive at a body of understanding, commonly in the process of revision; and an important means of refining and enlarging our knowledge is through verbal interactions with others. It is part of our new conceptualisations of children, therefore, that we credit them with knowledge, rather than with the relatively transient and flimsy 'perspective', 'view', or 'opinion'. I argue that through conversing with children we can learn about what they know, and to some extent, how they learn. (Mayall, 2000: 120)

The quotation sums up how the term knowledge is applied in the thesis where there is an attempt to understand what the children know about HIV/AIDS and sexual behaviour. Although there are many philosophical discussions on the definition of knowledge, in this thesis the term will be understood according to the above definitions.

Risk: The issue of risk and HIV is a complicated one that this thesis does not explore in detail. There is discussion of the factors that put children at risk of contracting HIV, but no in depth analysis of this term. Thus risk is used in a descriptive rather than an analytical manner. It is understood as ‘the potential harm that may arise from some present process or from some future event’ (Wikipedia, 2006). This definition is sufficient for the purposes of this thesis because although there was an attempt to understand the children’s awareness or perception of whether they were in danger or at risk of contracting HIV, there was no deliberate attempt to measure their risk assessment.

1.2. Background

1.2.1. Children on the margins

In November 1989 the United Nations General Assembly agreed to adopt the Convention on the Rights of the Child: a child being defined as any person under the age of 18 (UNICEF, 2005).

The most powerful change wrought by the Convention is the way in which children have become visible. Politicians, media, NGOs and broader civil society feel a clear obligation to include children in their respective public domains, interventions, dialogues, debates, mandates. You can't ignore children any longer and get away with it. The Convention has raised consciousness in dramatic fashion. – excerpt from speech by **Stephen Lewis**, Deputy Executive Director, UNICEF, at the Commission on Human Rights, 1999 (Global Movement for Children, 2006)

The convention has since been ratified by 192 out of the 194 members of the UN General Assembly indicating that governments of most countries recognise that children are significant members of the global community and should be duly recognised. This global move at the United Nations Assembly coincided with a

recognition in the social sciences that not only did children have the right to dignity, freedom, justice and peace, but that they were also entitled to be included in research for academic scholarship; not as adults-in-the-making, but as individuals and social actors in their own right.

Despite the noble statements of the convention and its ratification by governments, children are still largely viewed as incompetent. Within each society the construction of their incompetence takes different forms, but there is one commonality, that children will only be complete when they become adults. The sub-discipline of *Children's geographies* challenges this view by researching children's experiences as competent social actors in their environments (Holloway & Valentine, 2000a). *Children's geographies* developed out of the recognition that children are capable members of society and as such, should be fully involved in research in the same way as adults so that their views and opinions can be heard, and a better understanding of how culture is reproduced or changed through children can be gained (Aitken, 1994 in Johnston *et al.*, 2000). Social researchers recognised that we can only begin to gain insight into our social worlds if we include all the different actors in society in our investigations. Nevertheless, although *Children's geographies*, aims to focus on children and listen to their voices, it has largely relegated the voices of children from the global South to the periphery by focusing on children in developed world contexts. This has had the effect of privileging their voices, needs and experiences over those of children in the global South. This situation is reminiscent of the way ethnic 'minority' women were marginalized during the early years of the second wave feminist movement and the lessons from that experience need to be learnt quickly by children's geographers and addressed in their own field. Academics should thus reflect on the massive global socio-economic inequalities and the associated imbalances in resource allocation, and attempt to resist reproducing these in their own work.

The phenomenon of HIV/AIDS has been widely studied in the attempts to stem its spread and the misery it has brought to large sections of the global population. Millions have died and millions more are infected by this virus. Life expectancies in sub-Saharan Africa, the worst affected region in the world, have dropped dramatically and countries that were making good progress economically are

now struggling as young adults die and they lose the productive sector of their populations. This bleak scenario has prompted a vast amount of research in both the medical and social sciences. In this desperate situation where every possibility should be investigated, there has been silence regarding HIV prevention research with children. Although those aged above 15 years have been included in research and their needs are being addressed, an even more significant group of children has largely been ignored: those at the life stage described as middle childhood, preadolescence or early adolescence. Children aged between six and fourteen years of age have the lowest HIV/AIDS rates in all populations. Because they are either not yet sexually active or are in the early stages of sexual activity, their behaviour may be more malleable to change and to the uptake of safer attitudes and sexual behaviours and thus, these children may be a solution to the pandemic.

1.3. Background: the situation in Zimbabwe

In 1980 Zimbabwe gained majority rule after 20 years of civil war. The new government proceeded to improve access to education, health and social care for the disenfranchised black Zimbabweans, particularly those in rural communities (Sibanda, 2000). Free education for all primary school children was introduced and adults were given access to adult literacy programmes, resulting in the Zimbabwean population having the highest literacy rates in Africa; currently 90% (UNDP, 2005). Child mortality rates dropped with improved access to health care and there was a decline in fertility due to one of the most successful family planning programmes on the continent (Sibanda, 2000; Goliber, 2004). The country looked set to be one of Africa's success stories.

In 1986 the first case of HIV/AIDS was diagnosed in Zimbabwe; in 1993 Zimbabwe was ranked as having the sixth highest HIV/AIDS prevalence in Africa; currently it has the third highest HIV/AIDS prevalence in the world (Munodawafa & Gwede, 1996; UNAIDS, 2004). An estimated 25% of the adult population aged 15-49 years are HIV positive and this rate rises to an alarming 45% amongst pregnant women (UNAIDS, 2004). The Zimbabwean government was slow to react to the pandemic and by the time they acknowledged the presence of HIV/AIDS in the population, it had already taken a firm hold (Sibanda, 2000). The impact of

HIV/AIDS on the country has been devastating: life expectancy at birth has dropped alarmingly from 55 years in 1980 to 37 in 2004, a decline that can solely be attributed to HIV/AIDS; infant and under five mortality rates have increased; almost a million children have been orphaned; and the Zimbabwean economy has also suffered through the loss of the educated and productive workforce in the 15-49 age cohort (UNAIDS, 2004; World Bank, 2005). Although the HIV/AIDS pandemic can be blamed for part of Zimbabwe's decline, bad governance has also played a significant role resulting in the rise of poverty, unemployment and political instability. School fees have been reintroduced and many primary school children have had to drop out. There has been a general rolling back of all of major developments that were achieved in the past 25 years. Sadly, all these socio-economic difficulties have only exacerbated socio-economic causes of rapid HIV transmission in the country.

Despite the Zimbabwean government's delayed reaction to the pandemic the early 1990s saw many HIV/AIDS awareness and prevention programmes being implemented across the country. Initial research efforts focused on commercial sex workers and truck drivers who were constructed as the main vectors of the virus (Wilson *et al.*, 1989; Civic & Wilson, 1996; Ngugi *et al.*, 1996). However it soon became apparent that focusing on these high risk populations was not enough and the general adult population was also at risk; thus prevention and research efforts concentrated on adults (Adamchak *et al.*, 1990; Pitts *et al.*, 1990, 1991, 1995; Wilson *et al.*, 1991; Adebowale, *et al.*, 1993; Moyo *et al.*, 1993; Vos *et al.*, 1994; Runganga & Kasule, 1995; Mercer *et al.*, 1996; Gomo *et al.*, 1997; Gregson *et al.*, 1998; Laver *et al.*, 1997; Machekano *et al.*, 1998, 2000; Ray *et al.*, 1998; van de Wijgert *et al.*, 1999; Kesby, 1994, 1999, 2000). As the extent of the pandemic became more apparent, it was clear that not only adults were at risk, but also young people. Thus research and prevention work was extended firstly to young people in University, colleges and out-of-school youths, and then to adolescents in secondary schools (Wilson *et al.*, 1990; Pitts *et al.*, 1991; Pitts & Jackson, 1993; Munodawafa *et al.*, 1995; Kim *et al.*, 1997; Vernier *et al.*, 1998).

Thus there seemed to be extensive HIV/AIDS prevention research coverage of the population. However, not all sections of the population were involved in the research; approximately half of the Zimbabwe population, children under the age of

15 were excluded (Munodawafa *et al.*, 1995; Bassett & Kaim, 2000; World Bank, 2001). Despite the general acknowledgement that children, as well as adolescents, are at risk of contracting HIV/AIDS, there have been no research studies focusing on primary school aged children in Zimbabwe. This is a dangerous omission because they are a significant demographic group, as intimated above; they are on the brink of sexual debut or already sexually active; behaviour change is proving very difficult to instigate among adults with established patterns of behaviour and locked into socio-cultural structures, and children may be more adaptable.

While they have been left out of academic research, this cohort has been included in HIV/AIDS prevention policy initiatives. In 1993 the Zimbabwean Ministry of Education Sport and Culture, together with UNICEF, launched the National AIDS Action Programme for Schools. This programme is part of the national curriculum and uses participatory learning techniques to impart information as well as promote values (Bassett & Kaim, 2000). The AIDS Action programme was initially aimed at pupils in grade seven¹ to form four, but has been extended to begin with pupils in grade four (Bassett & Kaim, 2000). Thus children are given HIV/AIDS, sexual and relationship education from the age of nine. There are also a range of other intervention, prevention and education projects being carried out by governmental and non-governmental organisations (NGOs), but the AIDS Action School Programme is the only one that is available nationally (Bassett & Kaim, 2000).

Reviewing existing HIV/AIDS research that has been conducted in Zimbabwe reveals that early studies involving adolescents (but not children) were predominantly quantitative and examined young people's knowledge, attitudes and practices (Wilson *et al.*, 1990; Ndlovu and Sihlangu, 1992; Nyachuru-Sihlangu & Ndlovu, 1992; Wilson & Lavelle, 1992; Campbell & Mbizvo, 1994; Munodawafa *et al.*, 1995; Rusakaniko *et al.*, 1997; Vernier, *et al.*, 1998; Schatz & Dzvimbo, 2001). This work

¹ The Zimbabwe school system consists of seven years of primary school education (grades one to seven) for children aged approximately six to twelve years; and four to six years of secondary education (forms one to six) for children aged approximately 13 to 18 years.

was useful in identifying the patterns of behaviour among adolescents and the extent of their sexual and reproductive knowledge. However, after programmes based on quantitative studies failed to yield behaviour change, researchers and practitioners acknowledged that the medical approach was not sufficient to tackle behaviour and there was a need to understand the social and cultural contexts within which behaviour develops and takes place. This called for methods that elicited in-depth information from respondents and thus researchers began to conduct qualitative studies. Qualitative methods enable researchers to gain insight into adolescents' sexual behaviour through listening and talking to them and actively involving them in assessing their own needs (Sherman & Bassett, 1999). This ensures that prevention programmes target young people's expressed needs and are informed by the young people themselves rather than by what adults perceive to be their needs (Munodawafa *et al*, 1995; Kim *et al*, 1997; Kaim *et al.*, 1997; Sherman and Bassett, 1999; Kaim & Ndlovu, 2000). While these studies have been groundbreaking and some have led to more targeted interventions with adolescents (Sherman & Bassett, 1999; Kaim & Ndlovu, 2000), there has still been no research with children of primary school age.

A significant reason for this lack of work with children is that despite the implementation of the AIDS Action programme in primary schools, the Zimbabwean government is still reluctant to allow researchers into the schools claiming that the children do not know about sex (UNICEF ESARO, 2003). Furthermore, the government has stipulated that key aspects in HIV/AIDS prevention such as contraception, sexually transmitted infections (STIs), the social context of sexual activity and the use of condoms should be omitted from primary school programmes (Bassett & Kaim, 2000). This raises questions as to the nature and quality of the HIV/AIDS prevention education children are receiving if sex related issues cannot be discussed in a society where HIV/AIDS is predominantly acquired through heterosexual sex. Therefore, researchers are not given the opportunity to determine the sexual knowledge and behaviour of this largely 'HIV free' cohort, but must wait until the children reach secondary school. Since children who attain this are in the minority, especially under the current economic climate, this is of great concern. It is also not enough to assume information from research with adolescents will be relevant to primary school children, particularly because they are at different life stages (Midwinter, 2005) and may thus have different needs. To ensure that the

programmes being provided are effective in helping children protect themselves from HIV, more qualitative research is urgently needed that consults children directly in order to establish their knowledge, perspectives and needs regarding issues around sexual health. The thesis attempts to open up this field using a small mixed method study in a single location and addressing three broad questions. The depth of illustrative data generated by this research is valuable in itself and provides many useful insights into these issues; moreover, it shows that research on this difficult topic can be done with children and invites others to follow and expand this field.

1.4. Outline of the thesis chapters

1.4.1. Literature review: Conceptualising Childhood and the New Children's Geographies

Chapter two begins by introducing the concept of childhood developed primarily in the European arena. Despite the regional focus of this thesis it is necessary to review European based literature because it is this scholarship that has formed the foundation of *Children's geographies* and influences how we conduct research with children. The chapter discusses how the European concepts of childhood emerged in the 16th and 17th centuries through the influence of classical philosophers. It then discusses how psychologists researched children and childhood by categorizing human maturation through cognitive development and argues that their theories dominate child-related policy and practice to this day. The next section presents the development of childhood studies in sociology and discusses how this led to a new multidisciplinary field called the *New Social Studies Of Childhood* that recognized children as social beings, competent and worthy of recognition in their own right. I discuss how the child is theorized in this discipline and comment on whether these concepts can be applied to my work. The next section introduces *Children's geographies* and talks about its development as a geographical sub-discipline of the *New Social Studies Of Childhood* but with a focus on children's interaction with their environment. It then discusses *Children's geographies* research and argues that this has mainly focused on children in the global North. The chapter presents data highlighting the large numbers of children that constitute populations in

the global South in contrast to developed regions. I thus assert that this imbalance has resulted in the under-representation of a large proportion of the world's children in *Children's geographies* and this needs to be addressed. The next section discusses some of the limited but rapidly growing number of studies that have been conducted by children's geographers in the global South, emphasizing their importance but also critically assessing their shortcomings. The chapter then discusses the social construction of childhood in sub-Saharan Africa focusing specifically on conceptualisations of childhood among the *Shona*², the Zimbabwean ethnic group on which this thesis focuses. It discusses the traditional construction of childhood among the *Shona*, the way children are positioned within those societies and play a vital role both culturally and socially; more so than in most developed region contexts. The following section introduces HIV/AIDS commenting on the little attention it's been given by children's geographers despite its' massive impact on the lives of most children in sub-Saharan Africa. The chapter presents the few studies that have been conducted which relate to HIV/AIDS and children. I argue that although these are relevant and significant studies that have done much to bring the experiences of these marginalized children to the attention of *Children's geographies* research, they are limited by a failure to directly address children's HIV/AIDS related knowledge and sexual behaviour. I conclude this chapter by discussing children's sex education and the school as a context for education and socialization. Thus this chapter presents the sub-discipline of *Children's geographies* and outlines where my research is placed in this discipline and what contributions it will make to conceptual understandings of Zimbabwean children growing up in the era of HIV/AIDS.

1.4.2. HIV/AIDS research with children

Chapter three reviews the second area of literature relevant to this study; HIV/AIDS research with adolescents and children. The chapter opens by presenting the extent of the pandemic in sub-Saharan Africa to emphasize its magnitude in the sub-continent in relation to the rest of the world. It highlights how children have the lowest HIV rates on the sub-continent and yet are placed at the margins of research. It

² The Shona are the majority ethnic group in Zimbabwe.

presents several possible reasons why many researchers have not made concerted efforts to target children in their research efforts. The chapter largely reviews studies that have been conducted with adolescents in East and Southern Africa and highlights the dearth of material specifically focused on children. The next section underscores why it is important to target children for HIV/AIDS prevention using literature from regional research. It examines the socio-cultural factors that put children at risk of contracting HIV/AIDS. These factors highlight that it is naïve and dangerous not to target children for HIV/AIDS and sexual behaviour research because of an assumption that they are not sexually active, as this puts them more at risk. The nature of adolescent sexual relationships is then presented to gain some understanding of the situation and to enable comparison with my research. The next section discusses the issue of sex education beginning with the traditional methods of education in the region. It then moves on to discuss the impact of colonialism on sex education and how this resulted in limitations and changes in the ways young people were initiated and counselled in most contexts. This is followed by discussion of the role of schools in sex education and the targeting of children for HIV/AIDS prevention in primary schools. The section then focuses on the situation in Zimbabwe and presents details of the AIDS Action Programme for Schools. It concludes by highlighting the weaknesses of the otherwise commendable Zimbabwean HIV/AIDS prevention efforts and again draws attention to the lack of information on the experiences of primary school children, which could help to improve delivery of the HIV/AIDS and sex education.

Thus, chapters two and three provide the background as well as the rationale for this study and the contributions it will make to academic knowledge, policy and practice.

1.4.3. Research with children: epistemology, methodology and methods

Chapter four presents the theoretical background for this study, the methodology used, and describes the data collection process. It begins by laying out my epistemological standpoint and the effect this has had on the research. It outlines the influence of this standpoint by two feminist theories: feminist empiricism and

feminist standpoint theory. The section discusses how each of these theories is compatible with my epistemological standpoint and highlights aspects of these theories that I do not agree with. The next section presents the methodology arguing that this was influenced by my epistemological standpoint and explaining why I feel that feminist ideas of how to conduct research are relevant to doing research with children. It also discusses the various approaches to doing research with children and I critically assess them outlining and justifying the approach that I took in my research.

The next two sections discuss the mixed method approach, my attempt to conduct participatory action research, and to what extent this was achieved. The following section deals with the research design and introduces Tsungirirai the local NGO partners who were involved in this research. I then describe the data collection process in detail in order to present a thorough account and to help illuminate the results obtained. These are followed by a presentation of issues relating to reflexivity and positionality and a definition of these concepts and their purpose in research. I reflect back on the data collection process in a critical and reflexive way presenting insights that arose once that stage of the research process was complete. This is followed by descriptions of the participants, their characteristics and their interaction with each other and with the researchers during the diagramming sessions. Analysing the group dynamics is an important part of the research process; it sheds light on the production of the results and enables examination of any similarities, contrasts and peculiarities that arise. I also discuss my positionality in relation to the study participants and why it is important that I acknowledge this and was aware of this throughout the research process.

The chapter concludes with a section on methods of data analysis. This begins by describing how the quantitative data were analysed in order to provide some insight into the production of the results. It points out that this was a descriptive analysis and explains why this was sufficient for the purposes of this thesis. The next section presents the qualitative data analysis. It begins by presenting and examining the data translation and transcription process. Because the data were collected in *Shona*, the children's indigenous language, it was necessary to translate it for ease of analysis and presentation. Thus I present how the data were translated and

transcribed, the choices I made during this process, and the implications these have for the results. The next section discusses the data analysis, the analytic method chosen for the task and why it was most appropriate. It gives a breakdown of the steps taken during the analysis to demonstrate the reliability of the research.

1.4.4. Quantitative results: children's levels of knowledge about HIV/AIDS

Chapter five presents results from the HIV/AIDS questionnaire. This questionnaire aimed to determine the knowledge levels of the children and to address the first research question. The chapter presents the socio-demographic data describing the children in the study sample and their characteristics. The next part of the chapter introduces the results from the questionnaire. The first section discusses the initial descriptive results of the children's answers to the questions making critical comments about the effectiveness of the questionnaire in measuring knowledge, and interpreting the results. The following section presents data on the children's knowledge levels: this begins with a preliminary discussion of how these were measured by assigning scores to each knowledge question, adding these scores and using the total as an indication of the level of HIV/AIDS related knowledge. These knowledge data were then scrutinized further in order to get better insight into the scores by dividing the sample into low and high scorers to see whether there were any demographic differences or differences in attitudes or behaviour. The final section presents data from the application of a statistical analysis test. This test was used to determine whether there were any significant differences between knowledge and attitudes, as well as knowledge and behaviour. Although the questionnaire did not have many behaviour related questions, there was one that tried to ascertain whether the children would partake in a list of behaviours, including sex, in exchange for money or a gift. The results in this chapter begin to give an indication of the children's HIV/AIDS related knowledge and the quality of teaching of the AIDS curriculum in the study school which may be illustrative of the situation in primary schools in the country. It also raises questions that are addressed in the next chapter as intended in this multi-method research.

1.4.5. Qualitative results: the extent and nature of children's sexual knowledge and behaviour

Chapter six builds on the quantitative results by presenting in-depth data from the qualitative diagramming sessions and the interviews. The data presented was elicited from 36 children selected from the main sample. The results are presented in two parts: the first part addresses HIV/AIDS related knowledge and the second focuses on behaviour and information sources. The first section builds on the questionnaire results to get deeper insight into how the children understood the modes in which HIV/AIDS is contracted and prevented. This data is presented as themes using quotations from the diagramming sessions and the interviews in an effort to include the children's voices as illustrations of the themes. The section covers issues that had previously been identified from the questionnaire as well as those emerging from the data. Not all themes that were initially identified in the analysis are presented. Those presented have been selected because they were either topics that were brought up by all groups, addressed the main themes of this research that children can talk about HIV/AIDS and they know about sex, or were unexpected and interesting themes that bring new knowledge into the field. The second section focuses on behaviour as well as attitudes and sources of information linked to behaviour. Again themes that are prevalent amongst all the groups or that highlighted particular ideas that have not been identified in existing literature from studies with adolescents are presented. This section is significant as it highlights children's knowledge and experience of sexual behaviour. Although there was only one child who had a sexual experience, the participants knew about dating and sex and could discuss these issues in detail and at length. This section concludes by pointing out the significance of these data for *Children's geographies* scholarship and for HIV/AIDS prevention policy and practice in Zimbabwe.

1.4.6. Discussion and Conclusion

The final chapter in the thesis brings together all the material that has been discussed and emphasises how the concepts highlighted in the literature review and the rationale of the research have been addressed and how this research has achieved its aims. It examines the relevance of the research results and addresses their bearing

on *Children's geographies* research and HIV/AIDS prevention research, policy and practice.

It begins by discussing the contribution of the findings to the conceptual/theoretical understanding of children, HIV/AIDS and sexual behaviour in Zimbabwe. This is then followed by a section on the application of a feminist epistemological framework and a methodology that used elements of participatory action research. The chapter discusses the findings in light of these approaches and whether they were useful in addressing the research aims. The findings are then discussed in broader terms in a section on policy recommendations that makes suggestions on how the results from the research can be applied to HIV/AIDS prevention education and policy. The limitations of this research and how these could have been addressed are then outlined, followed by a section that examines how future research could address these limitations. The chapter concludes by stating the contribution this research has made and what new knowledge it has brought to the field of *Children's geographies*.

2. Conceptualising Childhood And The New *Children's Geographies*

2.1. Introduction

This thesis examines the lives, experiences and needs of Zimbabwean children within the context of HIV/AIDS, and the sub-discipline of *Children's geographies* has been a major influence in exploring these themes. *Children's geographies* focuses

...on how children's perceptions, experiences and opportunities are socially and spatially structured, and ... examines the reproduction of culture and social life through children. (Aitken, 1994 in Johnston *et al.*, 2000: 78).

The study of *Children's geographies* emerged as part of the *New Social Studies of Childhood*. In turn, the *New Social Studies of Childhood*, was developed by sociologists who realised that childhood is a socially constructed phenomenon rather than simply a natural one, and that children should be studied as social actors in their own right instead of as "adults in-waiting" (James & Prout, 1997; James *et al.*, 1998; Holloway & Valentine, 2000a). As such this new way of studying childhood is extremely important to this thesis because it explores the experience of childhood across space, time and place.

Children's geographies as a discipline is developing rapidly in the Western Europe and North America. I will thus begin the literature review by examining how childhood has been conceptualised over time in these regions. I will consider how philosophers, psychologists and sociologists have influenced contemporary conceptualisations of childhood, and how this affects the way we conduct research with children. The *New Social Studies of Childhood*, although multidisciplinary, evolved out of sociology and thus sociologists have been at the fore of theorising childhood. I will therefore briefly review the development of sociological theory on childhood culminating with the current thinking which influences *Children's geographies* research. I will then discuss the contemporary themes in *Children's*

geographies and review some of the research, beginning with research conducted in Europe and North America and then comparing it with the much smaller volume of work that has been conducted in the global South. I will critique how the agenda for *Children's geographies* research is set in the global North, although the majority of children live in the global South, and how this influences the production and control of knowledge, with particular reference to sub-Saharan Africa. I will conclude this chapter by setting out where my research on HIV-related knowledge and sexual behaviour in Zimbabwe fits into *Children's geographies* and how it will make a contribution to theory and practice by broadening the parameters of the types of issues researched in this discipline.

2.2. Western historical conceptualisations of childhood

The conceptualisation of children in the global North has changed over time. Although this is not a homogenous region and notions of childhood differ both between and within countries, the purpose of this review is to give a general overview of the development of concepts of childhood in the global North. These concepts influence our ideas of childhood today, either through our rejection of them as inadequate understandings of childhood, or by our continued acceptance of them, albeit in adapted forms. Most of the literature on *Children's geographies* has focused on the global North and before contemplating how and whether these approaches assist our understanding of children in Zimbabwe, I will review the debates that have arisen within work focused on the Northern context.

2.2.1. The representation of children through medieval art

Childhood is not simply a biological fact but is also, to a large extent, a social construct that provides an interpretive framework for understanding the early years of human life (James & Prout, 1997). Aitken (2001) describes childhood as:

... a social, political, economic and moral construction and it always relates to particular cultural histories and geographies.

Therefore since the construction of childhood is intricately linked with 'cultural histories and geographies' it is necessary to examine early representations and conceptualisations of children and childhood in order to understand how the discipline has arrived at where it is now.

Some of the earliest ideas about children and childhood are based on the work of the French historian Philippe Aries. Aries' work is well known and revolutionary because it stimulated historians' interest in the study of children. Researchers working with children are also interested in his work because it provides some historical background to the conceptualisation of childhood. Aries traced the emergence of childhood through historical artefacts and introduced ideas about the *absence* of childhood in medieval times (Holloway & Valentine, 2000a: 2). In his book 'The Centuries of Childhood' Aries analysed the representation of children through art. He describes how children were not accurately depicted in medieval paintings because 'there was no place for children in the medieval world' (Aries, 1962: 33). According to Aries' interpretation of the paintings, medieval children were not conceptualised as children but as little adults and this was reflected by artists' representations of them in paintings (Aries, 1962: 38-39):

An Ottonian miniature of the twelfth century provides us with a striking example of the deformation which an artist at that time would inflict on children's bodies. The subject is the scene in the Gospels in which Jesus asks that little children be allowed to come to him. The Latin text is clear: *parvuli*. Yet the miniaturist has grouped around Jesus what are obviously eight men, without any of the characteristics of childhood; they have simply been depicted on a smaller scale (Aries, 1962: 33).

Children began work from an early age and were thus considered fully competent beings. In support of this missing stage of childhood, Aries cites paintings, in which there are pictures of babies but none of children aged seven to fifteen (Aries, 1962: 38-39). Although Aries' ideas were based on French artists' work they have been generalised to the rest of Western Europe as an example of the situation during medieval times. What this work reveals is how children were not seen as different, but were a productive part of society. They may have been disadvantaged because of their smaller size, but this was not related to their being considered as adult

becomings. What Aries' work also reveals is the social construction of childhood through art. Because society did not consider the concept of childhood to exist as a significant or different phase of life, they simply constructed children as mini adults.

Although the medieval concept of childhood continued to a certain extent up until the nineteenth century, it was in the late 16th century that children began to be conceptualised as different from adults (Holloway and Valentine, 2000a: 3). James *et al.* (1998) refer to this period as the *presociological stage* of childhood. This stage includes a set of models of childhood predominantly influenced by classical philosophy and developmental psychology. What all these models had in common was that they did not consider the effects of social and cultural context on the construction of childhood but presented the phenomenon of childhood as having universal and natural characteristics (James *et al.*, 1998).

2.2.2. European classical philosophers' conceptualisations of childhood

One of the earliest conceptualisations of children was that they had an essentially evil nature. They were considered naughty, bad, unruly, undisciplined beings that had to be 'broken in' like wild animals into the proper way of behaving (James *et al.*, 1998; Holloway and Valentine, 2000a; Aitken, 2001):

... the classical age discovered the body as an object and target of power. It is easy enough to find signs of the attention then paid to the body – to the body that is manipulated, shaped, trained, which obeys, responds, becomes skilful and increases its forces. (Foucault, 1977: 136 in James *et al.*, 1998: 10)

This attitude towards children was strongly influenced by the puritan Christian tradition of the 17th century and later, in the 19th century, influenced childrearing attitudes that involved strict discipline. High child mortality rates engendered the belief that if children were taught to be good and all their evil nature removed at an early age, if they died young their souls would go to heaven (Schnucker, 1990 in Holloway & Valentine, 2000a: 3). It was therefore adults' moral and religious duty to ensure that the children were disciplined from an early age. This model of children as inherently evil or anarchic beings requiring discipline, control and containment is still prevalent in contemporary attitudes towards children and youths (James *et al.*, 1998:

10). The model of the *evil child* (James *et al.*, 1998: 10) presents the child as different from adults and with predetermined characteristics. It also introduces notions of power and control reflected by the adult need to train and break the will of this wild being. Children at this time were considered as being at the mercy of their natural desires and thus requiring constraint.

A second model emerged during the enlightenment in the mid 18th century, which regarded the child as innocent and pure; children were born pure of heart and 'angelic' (James *et al.*, 1998: 13; Holloway & Valentine, 1999). This model arose from the works and ideas of Jean-Jacques Rousseau (1712-1778). Rousseau perceived children as essentially good before they were corrupted and spoiled by the evil of the world. He wanted their innocence to be protected and for adults to cherish and idolise the innate values children brought into the world instead of punishing them (James *et al.*, 1998: 13; Holloway & Valentine, 2000a). His ideas were important because they heralded the beginnings of concern for the welfare of children. Rousseau's model promoted a more caring and protective attitude towards children through seeing them as innocents to be shielded from the bad things of this world. He also introduced the conceptualisation of the child as a person 'with needs and desires and rights' thus paving the way for contemporary views of children as individuals (James *et al.*, 1998: 13).

2.2.3. Developmental psychologists' influences on conceptualisations of childhood

James *et al.* (1998) describe three other models of childhood that have influenced the way we think about children today. Developmental psychology has been at the forefront of child-related research and practice. John Locke's (1632-1704) ideas, although he was not a psychologist but a philosopher and empiricist, provided a foundation for the psychological theory of behaviourism (Graham, 2002). His work emerged in the late 17th century, and acted as a blue print for Rousseau's *innocent child* (James *et al.*, 1998: 15). Locke neither prescribed to Rousseau's idealism, nor to the disciplinarian puritanical attitude towards children at that time. He considered the child as a blank slate that would be shaped by experience, and did not believe that children had any innate capacities. Locke believed that through education children

would become rational members of society (James *et al.*, 1998: 16). He also believed that children had innate mental potential, which was dormant but would be unlocked by education and would result in the child developing into a rational being. Locke introduced the idea that the child did not have a predetermined nature but that the development of the child is through experience (James *et al.*, 1998: 16). He still however did not credit children with agency, he acknowledged there was potential within the child, but claimed the child needed to be moulded by external influence.

Jean Piaget (1896-1980) a developmental psychologist is the most influential figure in the field of child development. Piaget constructed a model of a *naturally developing child* that defined children as ‘...a natural rather than a social phenomena’, and ‘that part of this naturalness extends to the inevitable process of their maturation’ (James *et al.*, 1998: 17). Piaget’s model is different from the philosophers’ models because it was based on his work in genetic epistemology and biology and was thus empirical rather than ideological (James *et al.*, 1998: 18). His work still has significant influence in how childhood is conceptualised and has made a major contribution to contemporary models of education. His theories focused on how every child went through stages of development and achieved certain developmental milestones before moving onto the next stage. Piaget did not consider the influence of nurture or social context on the child’s development. His theories were applied universally because it was assumed that all children proceed through the same stages of development and thus similar models of education and welfare could be applied globally. Piaget’s work is important and useful for understanding cognitive development at the early stages of life. Nevertheless, his lack of consideration for the effects of culture and social context ignored the reality that children not only develop biologically, but that within each culture the child’s body is inscribed with the social codes particular to that context and this has an effect on the way the child understands and interacts with the social world. Piaget also did not acknowledge that children have agency within and can shape their world, but presented them as bodies at the mercy of the forces of nature.

The third significant psychological model of child development emerged in the early 20th century; this was the model of the *unconscious child*, based on Sigmund Freud’s (1856-1939) psychoanalytical theory (James *et al.*, 1998: 19). Freud studied

childhood through the lens of the recalled memories of adults. He claimed that human maturation was based on the development of three elements that were central to psychological development and present within the child at birth: the id, the ego and the super ego. The id is the selfish element within us that all children are born with, it is concerned with self-gratification and has no consideration for anyone else (Heffner, 2001). The ego develops a few years into childhood as the child becomes more aware of his/her environment and begins to interact with others: it enables the child to realise that other people have needs as well. The superego is the stage where the child begins to develop a moral awareness based on the constraints from caregivers: it therefore acts as the conscience (Heffner, 2001). Freud believed that these elements are in conflict within the child and that their integration and control were central to the process of maturation and the development of adult status and behaviour (James *et al.*, 1998). Although Freud did not consider the interaction of the child and his/her environment, his theories were still based on the premise that a child is born with certain innate qualities that govern the development of his/her personality and behaviour. His theories were also based on his studies with adult women and what interested him was how childhood experience affected adult neurosis. Childhood itself was not the key factor, but its impact on adult behaviour.

The models I have summarised so far are not the only models that have influenced how childhood is conceptualised today, but they are an example some of the more dominant ideas of childhood. Although I have presented these models as a *historical* background of the conceptualisation of childhood, the ideas in all the models are still very much at work today both in practice and in theory (James *et al.*, 1998). What is relevant to the research undertaken is that none of these models considered the child as an active social agent. They either regarded the child as being born with innate qualities, or as a blank slate waiting to be written on by society. These models of childhood are essentialist, universalistic and represent children as passive unfinished beings, needing to be moulded and/or protected by adults, with no control over their destinies. These concepts of childhood have been constructed with no active input from children but as passive objects of theory and research.

2.3. The development of childhood studies within sociology

The brief summary above illustrates that the study of children was initially the domain of philosophers and then subsequently, of developmental psychologists. This field is still dominated by psychologists focusing on children's cognitive maturation (James & Prout, 1997; James *et al.*, 1998: 3), and the majority of research and theories on children and childhood are based on psychological research. However, the contemporary studies of childhood including the development of the sub-discipline of *Children's geographies* have emerged out of advances within sociology.

In the 1970s in reaction to criticisms of the established positivistic paradigm in British sociology, and as a result of growing awareness that certain population groups had hitherto been largely ignored by social scientists (Bailey, 2005), sociologists began to acknowledge the lack of research on children and childhood in their discipline. This realisation led to the development of sociological studies of children and childhood (James *et al.*, 1998: 23). This new discipline was influenced by socialisation theory, whose philosophy is similar to the dominant paradigms in developmental psychology. Socialisation theory presented children as 'human becomings rather than human beings' (Holloway & Valentine, 2000: 5). It focused on social context and the agents of socialisation such as the school and the home, and how they shaped children in order to socialise them into adults (James *et al.*, 1998: 25; Holloway & Valentine, 1999). Studies in this discipline did not consider children's agency within these contexts, but focused on how the contexts shaped the children. These sociologists were not researching children as social actors in their own right, but there was movement away from essentialism and the study of childhood as a universal phenomenon, to an approach that was more contingent on social, historical and geographical context. In doing this, sociology opened up the possibility for an acknowledgement of the heterogeneity of the childhood experience.

The sociologists were not disputing the biological character of human beings but were also interested in the role society plays in shaping the individual. They were challenging the focus on materiality and biological determinism and developing a

social constructionist vision of childhood. Nevertheless, childhood was still seen only as a process of socialisation, a transition stage before adulthood (Holloway and Valentine, 2000a). Children were still perceived as being in the process of development and as “incomplete”, thus their experiences per se did not receive much attention except in relation to their contribution to the understanding of adult behaviour (James & Prout, 1997; James *et al.*, 1998; Holloway & Valentine, 1999; Holloway and Valentine, 2000a).

2.3.1. Theorising the child in the New Social Studies Of Childhood

In the 1980s some sociologists recognised that the sociological studies of childhood needed to go a step further and to disentangle the socialisation of children from the developmental stages of psychological theories (James *et al.*, 1998: 25; Oakley, 1994 in Holloway and Valentine, 2000: 5). They acknowledged that rather than being a universal experience, childhood was a social construction and as such its meanings and characteristics changed over time and space. Thus childhood had a history, sociology, anthropology and a geography that was worthy of research in its own right. In addition these sociologists acknowledged that children had an agency of their own (Mayall, 2002), and could not simply be studied from a distance via adult memories or developmental theories of behaviour that claimed to explain their behaviour, motivations and intentions. It was thus crucial to study children as competent social actors, instead of only as adults in the making (Holloway and Valentine, 2000a).

This novel way of investigating the phenomenon of childhood was called the *New Social Studies of Childhood*. According to James *et al.* (1998) in the *New Social Studies of Childhood*,

...the child is conceived of as a person, a status, a course of action, a set of needs, rights or differences – in sum as a social actor...this new phenomenon, the ‘being’ child, can be understood in its own right. It does not have to be approached from an assumed shortfall of competence, reason or significance.

The change in terminology also took into account that in studying the social construction of childhood, sociologists would need to work and exchange ideas with

academics from a variety of social science disciplines in order to get a holistic view of the experiences of childhood (Holloway & Valentine, 1999).

This new discipline identified several ways in which children can be theorised and James *et al.*, (1998: 26) in their book 'Theorising Childhood', place these approaches under the term, 'The Sociological Child'. Their intention, in presenting four ways in which the child can be constituted sociologically, was not to define four distinct and separate perspectives, but to 'sketch in some of the commonality between these approaches as well as their differences while, at the same time acknowledging that...' they '...do not occur in an intellectual vacuum' (James *et al.*, 1998: 26). I will therefore briefly outline these four approaches in order provide the conceptual background to the current thinking underlying the *New Social Studies of Childhood* and subsequently *Children's geographies*. I will also comment on the relevance of these approaches to my research.

The socially constructed child

This concept has already been mentioned in 2.1 but I will briefly reiterate the central aspects driving this conceptualisation of the child. Social constructionists encourage the suspension of the conventional ways in which we view childhood. They argue that childhood does not exist in a 'finite and identifiable form' but develops in relation to the social, political, historical and moral context (James *et al.*, 1998: 27). This approach therefore encourages researchers to consider the plurality of childhood and its diverse constructions and rejects the concept of the universal child posited by the *presociological* models presented earlier (James *et al.*, 1998: 27). Although this approach plays a crucial political role in the study of childhood by releasing children from biological determinism and placing them in the social realm, there is still a danger of focusing too much on the theoretical understandings of the child and ignoring 'the embodied material child' (James *et al.*, 1998: 28). This concern is particularly relevant to my research because the notions of materiality and the physical body are central to research on HIV/AIDS. Therefore, although I subscribe to the notion of the child as socially constructed, I am aware that the embodied reality cannot be ignored.

The tribal child

The second approach considers children's social worlds as real and relevant. It acknowledges children's views and opinions and does not disregard them as fantasy, poor imitations of the adult world, or inadequate (James *et al.*, 1998: 28). This view respects children as thinking, feeling human beings in their own right, and recognises that they inhabit independent communities such as the worlds of the schoolyard, the playground, the club and the gang. Even though these communities are not unaffected by the adult world, they are '...nevertheless artfully insulated from the world of adults' (James *et al.*, 1998: 29):

What this approach encourages is an emphasis on children's social action as structured, but within a system that is unfamiliar to us and therefore to be revealed through research. (James *et al.*, 1998: 29)

It therefore encourages adults not to take children's experiences for granted or assume that they understand children's worlds, but to approach research with children in anticipation and with open minds. Conversely, James *et al.* (1998: 30) warn of the danger of the 'threat of increased strategies of control' that this adult incursion into children's worlds may bring with it (James *et al.*, 1998: 30). Thus, as we enter into research with children, it is important to be reflexive about our intentions for conducting the research and whether our aim is to understand children for their benefit or so that we can impose further controls on them. Within the context of my research this approach has an important role to play because it is only by listening to children and gaining some understanding of their world that we can examine whether they are at risk of contracting HIV/AIDS and what strategies they have and need to protect themselves.

The minority group child

The concept of the minority group child has arisen from modern sociology challenging the thinking that defined certain areas such as race, sex, sexuality, age and physical and mental ability as 'natural' or 'only human nature' (James *et al.*, 1998: 31). These areas have 'all been shown to derive their meaning and routine practices from their social context', and childhood has now been added to this group (James *et al.*, 1998: 31). The parallels that this approach to childhood has with the women's movement show both its strengths and weaknesses. The strength is that the

approach is dedicated to children's interests and rights, and the weakness is that there is a risk, as there was with women, of homogenising childhood. By focusing on children as a minority group, this approach promotes their rights, but it also ignores the differences within their various childhoods (James *et al.*, 1998: 31). In my research this approach is useful for bringing forward and emphasising that children have the right and need to be included in HIV/AIDS prevention research, but it also challenges the homogenisation of childhood by questioning the focus of childhood research on the experiences of children in the global North.

The social structural child

Children are conceptualised within this approach as a social category. They are a 'constant feature of all social worlds, and as such are typical, tangible, persistent and normal' (James *et al.*, 1998: 32). They may be different from one society to the next but this approach states that children are the same within societies. It does not consider children as incompetent, but as a 'body of social actors that have needs and rights' (James *et al.*, 1998: 32). This model therefore conceptualises childhood as a universal category, within their various social contexts. Advocates of this approach claim that because there is homogeneity within contexts and the children within each given area are exposed to the same economic, political, social and environmental parameters, it is therefore possible to compare childhoods internationally and interculturally (Qvortrup, 1994: 5-6 cited in James *et al.*, 1998: 32-33). They also demonstrate that although children have different competencies from adults 'all of which are recognisable features of the social structure', they occupy the same status as research subjects. What this approach highlights is that we cannot research children outside their social context and we have to take into account the influence of the social parameters in any given society (James *et al.*, 1998: 33).

The models I have briefly presented exhibit the current sociological conceptualisations of children and childhood and they also provide the platform from which *Children's geographies* researchers have started to explore childhood. Geographers have adopted and adapted elements of these sociological concepts and used them to investigate childhood from a geographical perspective.

2.4. *Children's geographies*

While there is now a growing body of geographical research involving children, this has been a recent development. Children's geographies as a sub-discipline developed as a result of the shift in human geography over the past 20 years which was influenced by a number of social theorists questioning the grip of absolutist and empiricist thinking on geographical theory and research (Bailey, 2005: 111, 152). The ideas of social theorists such as Derrida, Bourdieu, Foucault and Lefebvre, influenced human geographers to consider new ways of thinking about space, time, progress and politics (Bailey, 2005). This led to realisations that the social world did not necessarily consist of absolutes but that knowledge was relational. These theoretical developments in human geography have been associated with feminism and the cultural turn, which have 'further considered the implications for thinking about context, and for thinking about the links between power and creating knowledge' (Bailey, 2005: 111).

As in sociology, children had not been a focus of research within human geography until a few studies in the early 1970s began to investigate children's environments, children's spatial mapping abilities and their access to, use of and attachment to space (Blaut *et al.*, 1970; Blaut & Stea, 1971; Bunge, 1973; Blaut & Stea, 1974; Bunge & Bordessa, 1975; Hart, 1979; Holloway & Valentine, 1999; Liben & Downs, 2003). Other researchers conducted work on *Children's geographies* in the late 1970s and 1980s but the rest of the academic geography community largely ignored their work. The development of the multidisciplinary *New Social Studies of Childhood* led to a breakthrough in the 1990s that resulted in the escalation of interest in *Children's geographies*. This breakthrough was accompanied by an increase in publications, conferences and seminars on the subject, in both Europe and the United States (Holloway & Valentine, 1999; Matthews *et al.*, 1999).

The increase in childhood research did not produce a unified group of children's geographers but gave rise to two main schools of thought. The first school utilises psychological theories such as Piagetian models of child development to understand children's spatial cognition and mapping abilities (Liben & Downs, 2003). The second, influenced by feminist and post-structuralist theories and linked to the

New Social Studies of Childhood, considers children as social actors within their environments and utilises child-centred methodologies to conduct research with, rather than on children (Holloway & Valentine, 2000a). My research is positioned within the latter group and I will review some of the existing literature within this school in the following section.

2.4.1. Children's geographies research in the global North

Children's geographers have contributed to the *New Social Studies of Childhood* by conducting research on children's use of space and their conceptualisations of space. They recognise that, in contrast to child psychology's linear stages of development, childhood is made and remade in and through space. This thinking has parallels with developments in the study of gender. Feminist geographers revealed how the concept of gender was made through space by the relegation of women to the private sphere of the home. However, over time the concept of gender was reconstructed as a result of the movement of women from the private space of the home to the public, and once masculine, spaces of the work place; this changed the way gender is conceptualised (Mayall, 2002). The reverse has happened with children in the global North, during medieval times they were free to roam and work alongside adults. However, when adults began to conceptualise children as something separate and different from themselves, they relegated them to the private or domestic space, where they could be protected and contained (James *et al.*, 1998: 53).

Children's geographers have therefore theorised and researched how control of space results in control of the body and vice versa by examining a broad range of issues. Research themes have included children at play (Matthews, 1994); the effect of adults' control of public space on children's mobility (Valentine, 1997a, 1997b; O'Brien, *et al.*, 2000; Collins & Kearns, 2001); gender issues in care taking and child care (Sibley, 1991; Valentine, 1997a; Aitken, 2000; Beazley, 2000); children's participation and representation in society (Matthews *et al.*, 1999; Holloway & Valentine, 2000b); children and the natural world (Valentine, 1997b; Jones, 1999; Kong, 2000); children and school (Fielding, 2000; Gagen, 2000; Smith & Barker,

2000; Holt, 2004); children and technology (Holloway *et al.*, 2000); and children's fear of crime (Nayak, 2003).

The list above illustrates that *Children's geographies* research in the global North is both pertinent and wide-ranging. Children's concerns and their opinions are now being included more and more in mainstream research, and policy makers are beginning to pay attention to young people's opinions. Due to the influence of sociological and post-structural feminist theories, *Children's geographies* research has been neither essentialist nor universalist. There has been a clear distinction that the experience of childhood varies even within small geographical areas. Nonetheless, the majority of research on *Children's geographies* is concerned with issues relevant to Western Europe and the United States (Punch, 2003). Therefore, the studies and their underlying assumptions about children are predominantly guided and strongly influenced by these regions' theoretical understandings and social priorities. Children are not only found in these regions and to focus our understandings of children on studies based in a small (albeit economically powerful) part of the world is to do *Children's geographies*, and children themselves, an injustice. There is thus a need for more research to be conducted in non-Western countries and cultures so as to gain a more representative view of the experience of childhood. Given that the universal vision of childhood has been undermined, it is necessary to investigate the regionally specific construction of childhood in the global South, which must surely have dimensions that are significantly different to those thus far observed in the global North (Kamp, 2001). Gaining a deeper understanding of the lives and experiences of children in the global South will not only enrich our theoretical understandings of childhood but will also have practical implications on education, health and legal matters.

2.4.2. *Children's geographies* research in the global South

Although some research has been conducted with children in the global South, it has been extremely limited compared to the volume of work conducted in the global North (Robson, 2004). This is remarkable since the majority of children are found in the global South, and many of these countries' have populations where

almost 50% are young people under 18 years. In stark contrast, most countries in the global North have declining fertility rates and ageing populations (World Bank, 2004, see Table 1.).

Table 1. Regional average annual population growth and population age composition adapted from the World Bank’s 2004 World Development Indicators

Region	% Average annual population growth rate		% Population age composition in 2002		
	1980-2002	2002-2015	0-14yrs	15-64yrs	65+yrs
Middle-low income regions					
East Asia & Pacific	1.4	0.8	26.3	67.2	6.5
Europe & Central Asia	0.5	0.1	20.9	67.9	11.2
Latin America & Caribbean	1.8	1.3	30.9	63.6	5.5
Middle East & N. Africa	2.6	1.7	35.3	60.7	4.0
South Asia	2.0	1.4	34.2	61.2	4.6
Sub-Saharan Africa	2.7	1.9	43.8	53.3	3.0
High income regions/ countries					
Europe (European Monetary Union)	0.3	0.0	16.0	67.2	16.8
Canada	1.1	0.5	18.4	68.8	12.8
Japan	0.4	-0.2	14.3	67.6	18.1
Singapore	2.5	1.1	21.1	71.4	7.5
United States	1.1	0.8	21.1	66.4	12.5

Of those who have researched children in the global South, Cindi Katz (1993) conducted one of the first and therefore groundbreaking studies on *Children’s geographies* in a developing region in 1981. She examined how ‘social power is reflected in and exercised through the production and control of space’ in Sudan (Katz, 1993). Her cross-cultural research focused on how children’s use of and access to public space is gendered and changes with time by comparing the experiences of children in rural Sudan and the urban United States of America (USA) (Katz, 1993). She commented on how pre-pubescent girls in an Islamic village in Sudan spent time

outside the home either collecting wood for fuel or selling water, wood and food to earn cash for their families. Katz (1993) related how this freedom was withdrawn once the girls reached puberty, and they were then restricted to the private space of the home (*purdah*) where they could only be seen by other women or the male members of their families. She compared the Sudanese children's experiences with those of children in the USA, who, because of parental fears for their safety, had fewer opportunities to explore their environment. Katz (1993) likened the restricted movement of children in the USA to the Islamic *purdah*. She discussed how scholars from the global North focus on the withdrawal of young Muslim women from the public space at puberty, yet ignore the curtailing of girls and women in the USA's access to public space because of fears for their safety (Katz, 1993).

It took almost two decades after Katz's (1993) study before other geographers began to conduct research with children in the global South. Punch (2000, 2003) explored rural Bolivian children's work and play through examining 'how children use spaces of work and school to negotiate time for play' and how this increased their spatial and temporal autonomy (Punch, 2000). Beazley (2000) conducted a study in Indonesia focusing on children living and working in the streets. She examined their concepts of home and how that was tied in to their notions of identity (Beazley, 2000).

Ansell (2001, 2002) conducted several studies in Lesotho and Zimbabwe that dealt with issues of education and gender in secondary schools. The first study examined the interpretations attached, by secondary school students, to the practice of *lobola* (bride price) (Ansell, 2001). The second, examined how schools are an important space for the (re)construction of gendered identities among rural girls (Ansell, 2002a). The third study analysed the educational needs of rural girls (Ansell, 2002b). Other research conducted in the global South (Young & Barrett, 2001; Robson & Ansell, 2000; Robson, 2000a, 2001, 2004; Ansell & Young, 2004) will be reviewed later in the chapter.

While there are exceptions (Katz, 1993; Punch, 2000, 2003; Ansell, 2001, 2002a, 2002b), research conducted in the global South has tended to focus on children in especially difficult circumstances such as street children (Beazley, 2000; Young and Barrett, 2000), orphans (Ansell and Young, 2003) and child carers

(Robson, 2000a, 2001, 2004; Robson & Ansell, 2000). This work is vital and illuminating, but it is in contrast to the global North where research is centred on children's every day lives and experiences (Robson, 2004). Conducting research primarily with disadvantaged children risks inaccurately representing the experience of childhood in the global South as predominantly one of suffering, and portraying these children only as victims of their circumstances.

Much child research in Latin America, Africa and Asia continues to remain strongly focused on children in exceptionally difficult circumstances or especially disadvantaged children such as child prostitutes, child soldiers, street children, child labourers and child slaves...Despite dispelling many of the misplaced assumptions that majority world children are merely passive exploited victims, such research still concentrates on the child's work. ...an exclusive focus on their working lives has led to an obfuscation of more ordinary everyday aspects of majority world children's childhoods. (Punch, 2003: 281)

The significance of conducting work with disadvantaged children is obvious, but as stated above, it is equally important to understand the geographies of children leading 'normal' lives in order to gain an in-depth and more balanced insight into the experience of childhood in the global South. As geographers we are interested in listening to the voices and perspectives of these children, through mapping their everyday geographies. By focusing our efforts on disadvantaged children, these ordinary lives are relegated to the margins of research, unrecorded and unrecognised. The next section will therefore begin to lay the groundwork for this thesis by discussing the conceptualisation of children and childhood in sub-Saharan Africa with specific reference to Zimbabwe.

2.5. The social construction of childhood in sub-Saharan Africa

Since the beginning of the 20th century, childhood in the global North has predominantly been conceptualised as a stage when children should be carefree with no responsibilities, looked after by their parents or guardians (Matthews, 1999; Aitken, 2000; Kamp, 2001; Punch, 2003). Childhood is a time for playing and learning demarcated by biological maturation and chronological age. These demarcations are arbitrary and often still conceived in fairly well-defined age phases

rather than a blurred continuum (Bailey, 2005). They have been influenced by the work of developmental psychologists, especially Jean Piaget whose research on children's cognitive processes led him to develop a model of four stages of intellectual growth determined by age and time (Valentine, 1997a; James et al., 1998). Although feminists and post-structuralists have since criticised Piaget's model on both empirical and theoretical grounds (Valentine, 1997b), these categories are often accepted as natural and absolute. Age categories are useful for institutions such as schools and for grouping together information for research purposes. Nevertheless, geographers have shown that childhood is not only about physical, emotional, social and intellectual development over time, but also within a set of spaces that are both conceptual and material. What is deemed to be appropriate behaviour for a child in one social space may be totally unacceptable in another. The assumption that a child should have a responsibility free childhood is an ideal, it is not a universal experience or aspiration. Indeed within countries in the global North not all children have responsibility free childhoods, this is a predominantly white, middleclass concept that dominates the perspectives of both policy makers and academics (Matthews, 1999).

Turning our attention to "the social construction of childhood in sub-Saharan Africa" we must of course first recognise that Africa is a large continent with a rich diversity of cultures and ethnic groups both between and within countries. Just as childhood is constructed in many different ways within the global North, we should be careful about making generalisations about what constitutes childhood across the African continent. Nevertheless, one generalisation that is usually valid is that in the vast majority of sub-Saharan African countries children are considered as a form of wealth, and procreation is both a sacred process and a necessary element to developing full adult identity. Procreating is what gives both men and women status in society. Children are not just born into families but lineages (Gelfand, 1979), and this in itself makes the childhood experience quite different from that of societies in the global North. The African child is linked to a large and diverse number of people who may have direct and indirect responsibility for socialising the child. Bringing up a child is not only the remit of parents but also of a host of other relatives some of whom may have formal responsibilities for major elements of the child's social education. The African child is not only an integral part of the social fabric because of

the lineage but also because children contribute both materially and economically to their families.

2.5.1. The conceptualisation of the Shona child

This thesis will focus on children in Zimbabwe and will specifically concentrate on how they are constructed and conceptualised amongst the *Shona*. Although in this section I will use the broad term *Shona* children, I acknowledge that there are differences between these children. *Shona* is a term that was coined by colonialists to describe communities of ethnic Zimbabweans who speak the same language, although they have differing dialects, and follow similar traditions (Shire, 1994: 148). The *Shona* are in no way homogenous and their traditions evolved within the social and geographical spaces they settled. Therefore my reference to *Shona* children will be as a general term used for convenience, but with an acknowledgement that there are differences between and within these groups. My use of the word children in this section is also broad and ranges from infants to young adults. As in most other African cultures, children are highly valued in *Shona* society, not only because they bring status to their families but also as a material resource. Children are constituted between three key phenomena in *Shona* culture: social status, religious belief, and material/economic necessity.

2.5.2. Children and social status

Children, in *Shona* society, are a medium by which other agents in society gain status. Both men and women do not reach adulthood until they have had their first child (Kesby, 1999). This is in contrast to societies in the global North where age and legal standing determine maturity. Although such legal mechanisms now operate in Zimbabwe, to a large extent they work in parallel with traditional mechanisms that still retain great importance.

In *Shona* society the geography of marriage is highly gendered. Bride price is paid for the woman by the man's family in order to compensate them for the loss of her labour as well to pay for reproductive rights ensuring that the children his wife bears will belong to his lineage. *Shona* society is patrilineal and male children are

especially important because they ensure continuation of the man's family (Hansson, 1996; Kesby, 1999). The woman's role in marriage is therefore well defined, and her security is determined by her ability to fulfil these roles, the most important of which is the ability to bear her husband heirs. Childbearing is a crucial part of marriage and children are constructed as primarily the product of the man's seed and the woman is merely the vessel in which his seed develops (Runganga & Kasule, 1995). Thus the woman's role in reproduction is minimised. Both women and men need to have children in order to attain adult status and gain recognition in the community. A couple is addressed by the man's surname until they have their first child, and then for the rest of their lives, they will be addressed as mother/father of their child. Thus, the construction of their identities (the woman's in particular) is closely linked to that of their child. For women, giving birth not only confers status, but also security within marriage for being fertile. The more children a woman can bear her husband, the more secure she is. Women have been labelled as barren for having only one child. Usually when there is no child in a marriage it is blamed on the woman, and the man is expected to find himself another wife who can bear his children and carry on the family name. This was not only the norm in traditional *Shona* society but can also be the case in modern day Zimbabwe. While the prevalence of polygamous relationships has declined, men with infertile wives are not frowned upon by society if they have children outside marriage.

Children do not only endow status to their parents but also to extended members of the family. An example is the paternal aunt or *vatete*: she initially gained status when her brothers married, through the power she was given over her sisters-in-law. Furthermore, with the birth of her siblings' children the paternal aunt's position was strengthened. She had responsibility for the sexual education and guidance of her nieces, and to some extent her nephews, and played a very central role especially during puberty and at marriage (Shire, 1994: 153). Children therefore were the link that forged and strengthened bonds between family members. Their role however was still a passive one, and their existence was all that was needed for others to achieve social status.

In *Shona* society even after a person has attained adulthood, the bonds of childhood between parents and the adult child remain for life. The hierarchical and

respect systems within the family remain operational and the child will always remain subordinate to the parents. On reaching adulthood, offspring do not become equals in the way they do in the global North. Traditionally, even in death, the parent was (and still is) revered and it was believed that they would continue to watch over their children's families. Although financial independence and education has wrought some changes within *Shona* society many still conform to societal hierarchies. The notion of respect is central to societal relationships, and is linked to social status and the conceptualisation of childhood (Pearce, 1990).

Although in Zimbabwe age demarcations are used in a similar way to the global North, there are still some fundamental differences linked to the cultural constructions of childhood. After attaining independence in 1980 the Zimbabwean government brought in the Legal Age of Majority Act stipulating that a young person becomes an adult when they reach the age of 18 (Kesby, 1999). This legislation was the culmination of a long process by which the colonial state increasingly codified African custom and attempted to change the mechanisms through which identities and subject positions were produced. The new independent government continued in this vein using modern legal mechanisms to create generational identities. Although this legislation gave young people adult status at the age of 18, in line with the International Convention on the Rights of the Child, this did not necessarily mean that society viewed them as adults. This age demarcation has been perceived by the older generation of Zimbabweans as an imposition of a foreign ideal onto Zimbabwean society. Older people blame this legislation for causing what they see as the breakdown of traditional culture and values resulting in young people losing respect for their elders. In spite of the legislation and adult misgivings, cultural constructions of childhood and adulthood are still very much alive and active in Zimbabwe; it is often not unusual to hear young people in their early twenties, who in the global North would be considered adults, being referred to as youths.

2.5.3. Children and religious belief

Children are intricately linked with traditional religious beliefs based on ancestor worship. Because the continuation of a lineage is based on the clan's ability to reproduce, it is constructed as disaster both socially and spiritually if a person is infertile (Sibanda, 2000). An infertile person is perceived as doomed to become an

unsettled spirit because s/he will have no children to leave behind to remember her/him and make offerings to her/him. This belief is central to the desire to have children because no one wants to be a restless spirit that wanders around causing trouble, instead of resting peacefully and being benevolent to its descendants. Ancestors act as intercessors to God for their descendants, and therefore when there is trouble in the family, there will be an assumption that the ancestors are angry and have turned their backs on the family. The family will then try to find out where they have gone wrong and plead with the ancestral spirits to mediate on their behalf so that good fortune can return. Thus, in relation to religious beliefs children again play a passive role, but are an integral part of the belief system and social fabric.

2.5.4. Children as material and economic assets

Many children in urban and rural areas work to help their families (Gelfand, 1979). Historically *Shona* children were not only a source of pride as evidence of a man's virility and his ability to procreate, or joy at the continuation of the lineage, but they were also a source of labour. Children's labour was gendered and gender was constructed in space (Kesby, 1994: 215). From the age of about 6 years children took on chores within the household (Gelfand, 1979). Boys were predominantly responsible for herding animals an activity that could take them far from the home and away from parental surveillance. During these periods their masculinities were constructed as they protected their animals from predators, had mock fights with each other and real fights with herd boys from other villages (Shire, 1994: 155). Girls were kept closer to the home helping with domestic chores such as cleaning the house, cooking, fetching firewood, looking after younger siblings and fetching water from rivers (Gelfand, 1979; Kesby, 1994: 215; Kamp, 2001). There was nothing unusual about the children having responsibilities and they got time to play during and when they had finished their chores. The children were therefore assets and played an important role in the everyday running of their households.

Modern *Shona* children, although many now attend school, are still performing similar roles to their predecessors. There are differences between rural and urban children, with rural children still being involved in herding and working in the fields, whilst urban children carry out domestic chores, run errands or do vending work. This is in contrast to the majority of children in the global North, who, with the

introduction of universal schooling, were removed from the work place. However, in Zimbabwe there are also differences due to socio-economic status, parents' level of education and child rearing practices: some children 'work' more than others do. So although the situation of *Shona* children has changed over time with the introduction of formal schooling, most children are still expected to do chores of some sort. In urban areas, children may help their parents by selling goods either in the local market, around their neighbourhoods, or at bus stops/terminals. They thus make a contribution to the economy of their household, although they generally have no say in how the money is spent. Children are thus active social agents, participating in adult spaces and interacting freely with adults. They have more spatial freedom than most children in the global North because social space in Zimbabwe is structured in such a way that children can and do engage in income-generating activities as there is no effective social security system. There is therefore nothing unusual about seeing children roaming around confidently, in what would be seen as adult spaces. Despite this spatial freedom, adults do not consider these children as equals, they cannot engage in 'adult behaviours' such as smoking, drinking, having sex and they still have to show due respect and deference to the adults they interact with (Pearce, 1990). The public space is therefore still controlled and policed by adults, and children who are caught transgressing the social codes are punished.

The difference between how childhood is socially constructed in Zimbabwe and in countries in the global North is thus based on traditions, cultural beliefs and economic necessity. Childhood in Zimbabwe is, in general, not a responsibility free stage of life, but one where children are perceived, and perceive themselves, as productive members of society. A family with no children has no helpers and no one to look after them in their old age (Hansson, 1996). However, as mentioned at the beginning of this section, it is important not to essentialise *Shona* children's experiences of childhood. As with other societies, there are differences between children's experiences and even during pre-colonial times, some families were more privileged than others. Since the mid 20th century there has been a steady growth of a small but significant middleclass in Zimbabwe. This has developed with urbanisation, access to education and good jobs. These changes and the effects of globalisation have produced wealthy urban middle-class children similar, in many ways, to middle-class children in the global North. Although they are a minority, these privileged

children's childhoods probably have more in common with children from the global North than with their poorer compatriots. The social construction of their childhoods is very different from their cousins in the rural areas because they have been constructed in different geographical and social spaces. However, this is not to say they have nothing in common with poorer rural and urban children because despite their economic advantage they are still products of a specific social space and their upbringing is infused with the same cultural messages and codes of conduct. Links with the extended family reinforce these codes of conduct and ensure that children maintain the respect culture and do not become overly 'Westernised'.

This section has shown that within the *Shona* society children are constructed in two ways. Firstly, as relational, their identity is formed in relation to their parents and relatives and vice versa. They are however at the centre of these relationships as their existence constructs links between family members within the extended family. From this perspective children in the global North do not play the same complex role or occupy such a central position in the construction of the family, as Zimbabwean children. This role is however a passive one. Secondly, children are active social agents within society. This is portrayed by the role they play as income generators and helpers to their families. The centrality and active role of *Shona* children within their societies does not, however, indicate that they are any less marginalized than their Northern counterparts. They are important and valued, but they are still under the control and surveillance of adults and because of the way childhood is constructed, their child status continues long after their counterparts from the global North have 'become' adults.

2.6. HIV, sexual behaviour and children's geographies

HIV/AIDS is the greatest and most devastating challenge currently faced by the sub-Saharan African region. It is also one of the most preventable. Southern African countries have the highest HIV/AIDS rates in the world. As was shown in Table 1, sub-Saharan African countries, unlike those in the global North, have young populations with roughly half under the age of 18 (World Bank, 2004). The lives of

these young people are filled with many challenges and remaining HIV negative is one of the biggest trials they face, especially as it is predominantly spread through heterosexual contact. Children in sub-Saharan Africa are dying from HIV: the under fives contract it perinatally and those aged 15 and above contract it through sexual intercourse. There is however an age group that remains largely uninfected: children aged six to 14 years. Not much is known about this group's HIV/AIDS and sexual knowledge and behaviour. Furthermore, these children, although currently uninfected with HIV, may be on the brink of sexual behaviour or, in some cases, be already sexually active. Children at this stage of life may also be more amenable to internalising safe sex messages and thus adopting protective behaviours, as has been shown by prevention research on risky health behaviours such as smoking (Aarø & Gwanzura-Ottemøller, 2000). It is therefore vital that, in order to preserve the future of this sub-continent and prevent further suffering, we as researchers must engage more actively with young people in the 'HIV-free' age group to help address their needs and to raise their profiles in HIV prevention.

While there is a substantial amount of literature on adolescent sexuality in various world regions, the contribution to this body of knowledge by children's geographers has been limited. Moreover, few of the studies on sexuality contemplate the spatial dimensions of sexual knowledge, behaviour, negotiation and practice. The lack of focus on sex/sexuality related issues in the global North indicates that *Children's geographies* researchers may not consider these issues a priority. HIV/AIDS, however, is a major health, economic, social and political priority in sub-Saharan Africa, which permeates every aspect of society. It should therefore be a central theme for researchers trying to understand the situation of children in this region because HIV/AIDS is threatening to shorten many children's lives as well radically changing their experience of childhood. Children are having to care for dying parents, experience abandonment, orphanhood and neglect by extended families who in the past would have cared for them without a second thought. They also have to care for themselves and younger siblings when parents have died, think seriously about their future sexual behaviour and whether they will have a future, and face the reality of death either in their families or in their neighbourhoods on an almost daily basis. This is the everyday reality of most children in sub-Saharan Africa, and to ignore it is to overlook a significant aspect of their childhoods.

Having said this, some children's geographers have conducted HIV/AIDS related research in sub-Saharan Africa. Their work has been instructive, but the focus has been on the consequences of HIV/AIDS rather than on prevention. Robson's (2000a, 2001, 2004; Robson & Ansell, 2000) groundbreaking research in Zimbabwe is a good example. Her work is important in that it looked at the experience of children as carers of parents or relatives with HIV/AIDS. Care giving has always been an aspect of sub-Saharan children's childhood experience, but in previous times it was predominantly confined to helping their parents look after younger siblings or sick and elderly grandparents. With the spread of HIV, children are increasingly the *sole* carers of their sick parents and relatives as the epidemic takes its toll of the productive and childbearing adult population (Robson, 1999). The care these children give remains unacknowledged in most cases, and they are in a sense 'invisible carers'. Consequently, Robson's (2001) work performed the crucial role of acknowledging children's work. Her research however, did not consider the sexual dimension of the spread of HIV and what impact being a caregiver may have had on a child's view of their own current or future sexual relationships; it only focused on the consequences of AIDS.

Young & Barrett (2000) conducted a study with street children in Kampala, Uganda. This study was significant in that it portrayed how these children occupied a social space in which they were neither children nor adults; the breakdown of their families due factors such as HIV/AIDS had driven them to live in the streets. However, Young & Barrett did not examine the children's susceptibility to HIV/AIDS within this context. They mentioned that the HIV/AIDS pandemic was one of the factors responsible for the rise in the numbers of street children in Kampala, Uganda (Young & Barret, 2000). Thus, HIV/AIDS was mentioned in this study but only because the phenomenon they were researching was partly a product of HIV/AIDS.

Young & Ansell (2003) considered children's migration in southern Africa. Their research was based in Malawi and Lesotho, and they discuss how, although migration has always been a feature of societies in this region, it has predominantly involved adults. The advent of HIV/AIDS however has caused the fragmentation of families resulting in children having to move households after the death of their

parents (Young & Ansell, 2003). Their work explored the impact this movement had on young migrants and the households they joined (Young & Ansell, 2003). Again, these are important studies, but they only focus on the effects of HIV/AIDS on children. None of the children's geographers have yet explored how children perceive and learn about sex and HIV/AIDS within the context of the pandemic.

Medical professionals, epidemiologists and psychologists have largely dominated the majority of HIV/AIDS prevention work with young people. They have used statistics and theories of behaviour in their attempts to understand young people's sexual behaviour. They have also tried to empower young people by providing them with skills that may help protect them from contracting HIV (Feldman *et al.*, 1997; Basset & Kaim, 2000; Kaim and Ndlovu, 2000). There has been a realisation of the importance of consulting young people about their needs and experiences instead of only teaching them what adults think is best for them. The focus of HIV/AIDS prevention research has nevertheless been on older adolescents (aged 15+) or secondary school children and there has been little work with younger children. This research will be reviewed in more detail in Chapter three.

There has been much talk about why young people engage in sexual relationships and what type of sexual practices they engage in. There has not been much research on the spatial dimensions of the acquisition of sexual knowledge and sexual behaviour; only recently has there been discussion about the context within which young people learn about sex *and* have sex, that is, the influence of social context on sexual behaviour (Matthews *et al.*, 1995; Basset & Kaim, 2000). In Zimbabwe all children in primary schools are supposed to receive HIV prevention education (see 3.6). Thus the school is the space where formal knowledge about HIV and how it is prevented is acquired. When the school day is over the children move into a social and spatial context where they pick up messages about HIV/AIDS and sexual behaviour via the media, older adolescents and adults in an informal and unstructured way. This information is neither controlled nor censored like that given at school and may or may not be directly targeted at them. Although there is a concerted effort by adults to control children's acquisition of knowledge about these issues, this cannot work because HIV/AIDS has become an everyday reality within this context permeating every aspect of society. There is thus a need for us to

understand how children acquire and process the knowledge they obtain from their social contexts and what effect this knowledge has on their current or intended behaviour.

The school is an institution that has been important in research in the global North (Fielding, 2000; Smith & Barker, 2000; Holt, 2003, 2004), and also in the global South (Ansell, 2001, 2002). Its role is to socialise children so they will grow up into responsible and productive adults who will contribute to society. Because school environments (both physical and social) are compartmentalised and segregate children from each other (according to age) and from teachers, schools have contributed to the conceptualisation of children as incompetent, vulnerable, passive and still in the process of developing (Valentine, 2001: 143). The classroom is a space of power where the teacher has control over the information s/he gives to the children. Nevertheless, schools exist within the larger context of society. The boundaries between school and society are permeable with information flowing in and out. Teachers and children also reproduce and reinforce social practices and norms within the school context (Valentine, 2001: 144). It is therefore important to understand whether children accept the messages they receive in the school unquestioningly or whether they produce their own meanings of what is taught in school, together with what they see and hear in the wider context of their social worlds. Until very recently, there has been a distinct silence in HIV/AIDS research with regard to primary school aged children. This has mainly been due to adults' belief that children under 15 years are too young to talk about sex related issues (Gwanzura-Ottemöller & Kesby, 2005). Within *Children's geographies* however, children are not only considered as social actors, but also as capable of representing themselves. Thus using these concepts, this research will provide an arena in which children's voices will be heard not only within HIV prevention in Zimbabwe but also within the sub-discipline of *Children's geographies* itself which, has been slow to address HIV/AIDS prevention related issues.

2.7. Conclusion

In this chapter, I have reviewed the historical background of the childhood phenomenon, in the global North. I began by discussing how children began to be

conceptualised as something different from adults in the 16th century. I then briefly presented the various *presociological* models of childhood, and examined sociology's entry into the study of childhood and how that has evolved over the last few decades of the twentieth century. The result of this evolution being the *New Social Studies of Childhood*, which have culminated in children being regarded as beings in their own right and not just apprentice adults. This sociological discipline, together with new theoretical developments in human geography, led to the emergence of the sub-discipline of *Children's geographies*. One outstanding feature in this review has been the dominance of Western theory and research in this field. Few studies have been conducted in non-Western countries to examine how childhood is constructed in other cultural contexts. It is essential that more work be conducted in the global South in order to see how global and local forces are working in different countries. It is also necessary to show what comparisons can be made across cultures, in order to gain a fuller understanding of the experiences and the constructions of childhoods all over the world, rather than limiting our knowledge to the experiences of a minority of children in one part of the world.

3. HIV/AIDS research with children

3.1. Introduction

At the end of 2004 the number of adults and children living with HIV/AIDS in the world was estimated to be 39.4 million: 37.2 million adults (15-49 years) and 2.2 million children (under 15 years) (UNAIDS, 2004). The devastation caused by this pandemic has been particularly terrible in the sub-Saharan African region (Table 2 below), which has by far the highest HIV/AIDS rates in the world (UNAIDS, 2004). Particularly alarming is that in this region HIV infection is increasing amongst the younger age cohort of adults; of 11.8 million young people aged 15-24 globally living with HIV, 8.5 million live in sub-Saharan Africa (Aggleton *et al.*, 2004). The future of this sub-continent is precarious as the pandemic wreaks havoc and life expectancy rates plummet: the average life expectancy rate was 45.8 years in 2002, falling to as low as 34 years in countries like Zimbabwe (World Bank 2004; UNAIDS, 2004). The implications this has for the development of the region both economically and socially will be catastrophic if more is not done to arrest the spread of HIV. With this in mind, it is important to note that in sub-Saharan Africa there are fewer children (aged 0-14) with HIV/AIDS than adults (aged 15-49) because HIV/AIDS is mainly spread through heterosexual contact. On closer inspection of individual country data, those under five years make up the majority of the 2.2 million HIV positive children (UNICEF, 2004). This is due to mother-to-child transmission of HIV during pregnancy, labour, delivery and breastfeeding which means that usually children do not survive beyond five years of age (UNAIDS, 1998). Therefore children aged 6-14 have the lowest HIV/AIDS rates in this region (WHO, 2000; IDS, 2003; Todd *et al.*, 2004). Although this provides a reason for cautious optimism we must not overlook the virus's long incubation period of 5 years or more; this indicates that youths who are developing AIDS related illnesses aged 15 years were most likely infected with HIV in childhood or early adolescence (Basset & Mhloyi, 1991). Nevertheless, HIV/AIDS rates among 15 year olds are still the lowest in the 15-49 cohort.

Table 2. Regional HIV/AIDS statistics and features, end of 2004 (UNAIDS, 2003)

Region	Adults & children living with HIV/AIDS	Adults & children newly infected with HIV	Adult prevalence (%)*	Adult & child deaths due to AIDS
Sub-Saharan Africa	25.4 million	3.1 million	7.4	2.3 million
North Africa & Middle East	540 000	92 000	0.3	28 000
South & South-East Asia	7.1 million	890 000	0.6	490 000
East Asia	1.1 million	290 000	0.1	51 000
Oceania	35 000	5 000	0.2	700
Latin America	1.7 million	240 000	0.6	95 000
Caribbean	440 000	53 000	2.3	36 000
Eastern Europe & Central Asia	1.4 million	210 000	0.8	60 000
West & Central Europe	610 000	21 000	0.3	6 500
North America	1.0 million	44 000	0.6	16 000
TOTAL	39.4 million	4.9 million	1.1	3.1 million

*The proportion of adults (15-49 years) living with HIV/AIDS in 2004, using 2004 population numbers (UNAIDS, 2004).

It is significant to note that adolescents aged 15 and above are categorised as adults in HIV/AIDS statistics and yet these young ‘adults’ are the ones chosen to represent children in HIV/AIDS research. Moreover, the reasons for the lack of research specifically focusing on children under 15 years of age are unclear. I suggest three possible reasons for this neglect: first, the difficulty in gaining access to children because of the sensitive nature of the subject; second, researchers’ reticence about working with children on the difficult subjects of sex and HIV/AIDS; third, the general assumption that children are not sexually active and thus cannot provide much useful information on sexual behaviour. The issues of access and researchers’ reluctance to talk to children about sex are legitimate barriers, as studying children brings with it serious ethical considerations because of their status as minors. These include a) the possibility of adult researchers abusing the children they are researching, b) researchers’ fear of being accused of wrongdoing even when their motives are genuine, and c) power and control issues relating to the positionality of the researcher as an adult in relation to child respondents (see chapter 4. for detailed discussion). Researching children may also be complicated by adult gatekeepers’ reluctance to allow children access to sexual knowledge, and their determination to

control and limit the nature, extent, tone and morality of that knowledge (Power *et al.*, 2004; Gwanzura-Ottmöller & Kesby, 2005). The open, frank, clinical and unjudgemental nature of much sexual health research is seen as too explicit. Nevertheless, these challenges should not deter researchers from conducting ethical research with children, which is accountable and transparent. Given that the age at sexual debut is low (Klepp *et al.*, 1994) and that even if children are not sexually active, they may be on the threshold of becoming so, research with them will help us obtain a clearer understanding of their needs and desires. This in turn will provide opportunities to raise their awareness of the responsibilities and consequences that come with sexual relationships so they can make informed and safe choices (Todd *et al.*, 2004; Plummer *et al.*, 2004).

Therefore, the aim of this chapter is to further develop the argument that it is important to include HIV/AIDS in *Children's geographies* research by highlighting the small number of HIV/AIDS studies that include primary school children. I will continue to clarify the rationale for my research by discussing issues that put children at risk of contracting HIV/AIDS with reference to research conducted in sub-Saharan Africa. The dearth of HIV-related research with primary school children in sub-Saharan Africa means that this review principally consists of studies with adolescents aged 15 years and above. Some of these studies do include younger adolescents aged 13 and 14 years, but very few studies include children younger than 12 years. Age demarcations do not necessarily mean that behaviours that are prevalent among older adolescents are not found among primary school aged children. Life stages (Bailey, 2005) are not rigidly confined to age boundaries but are fluid and overlapping, therefore, issues relevant to older adolescents can be relevant to their younger peers. These young people live in the same socio-cultural contexts and thus face similar challenges. Thus reviewing studies carried out with adolescents aged over 15 years is relevant and useful for the purposes of this thesis.

The review will first outline the factors that put children at risk of contracting HIV/AIDS and that influence children's sexual behaviour, by focusing on studies conducted in east and southern African countries, where the HIV pandemic is most severe. These studies will provide a background of the situation among young adolescents in these regions. Countries in these regions are also culturally and

historically similar to Zimbabwe and thus provide useful comparisons and contrasts. On a positive note, this region has also seen examples of a dramatic drop in HIV rates as displayed by Uganda, thus providing a local example for 'best practice'. This existing literature contains quantitative studies with large numbers of children and adolescents that reveal generalizable patterns of behaviour (Ndeki *et al.*, 1994; Klepp *et al.*, 1995; Campbell & Mbizvo, 1997; Feldman *et al.*, 1997; Matasha *et al.*, 2000; Jewkes *et al.*, 2001; Magnani *et al.*, 2002; Todd *et al.*, 2004); and more significantly, qualitative studies that provide in depth perspectives of the various aspects of child and adolescent sexual behaviour in the different contexts (Nyachuru-Sihlangu & Ndlovu, 1992; Meursing *et al.*, 1995; Shah & Nkhama, 1996; Feldman *et al.*, 1997; Kaim *et al.*, 1997; Nnko & Pool, 1997; Matthews *et al.*, 1998; Wood *et al.*, 1998; Sherman & Bassett, 1999; Nyanzi *et al.*, 2000; Bassett & Kaim, 2000; MacPhail & Campbell, 2001; Nhundu & Shumba, 2001; Silberschmidt & Rasch, 2001; Lindegger & Maxwell, 2004; UNICEF ESARO; 2004). I will then present the historical context of sex education in the region, the effects of colonialism on traditional methods of sex education and the impact these changes have had on current practice. The next section will discuss the role of the school in sex education and the impact HIV/AIDS has had on the provision and content of sex education. This will include presentation and discussion of the Life Skills curriculum and the Zimbabwe AIDS Action Programme. I will conclude the chapter by critiquing the research that has been done and discussing how my study will further contribute to the existing large volume of HIV/AIDS and sex education research by focusing specifically on primary school children.

3.2. The need for early intervention

The slow change in adult sexual behaviour plus demographic and epidemiological data reflecting children's low HIV/AIDS prevalence rates, have finally alerted governments, international donor agencies and local voluntary organisations of the need to target children under 15 years for HIV prevention in an attempt to slow the spread of HIV. In contrast, academic researchers seem reticent to engage children in HIV and sexual behaviour research because of the reasons given above (see 3.1). Although governments and donor agencies are developing and

implementing HIV/AIDS prevention programmes in sub-Saharan African, these programmes will not be effective if children are not included in research that informs their development. In order to appreciate the sexual health education needs of children, researchers need to develop projects that specifically target children instead of merely including them in research aimed at adolescents. For example, Todd *et al.* (2004) conducted a cross-sectional survey on knowledge and attitudes towards sexual health issues and the sexual experience of primary school pupils in 20 rural communities in Mwanza, Tanzania. Out of the 17 084 respondents in years four to six (ages 9-22 years) enrolled in the schools, the researchers chose to only include pupils aged 14 years or older. The researchers stated that they did this research because they recognised the need to deliver 'sexual and reproductive health messages before sexual debut' (Todd *et al.*, 2004: 35); thus considering this study was aimed at primary school children who were not supposed to be sexually active it is difficult to understand why the researchers chose to only include older children and adolescents who were more likely to have already had sex (Todd *et al.*, 2004). This example may indicate that researchers think that children are not yet sexually active and they do not think or know about sex and thus targeting them will not yield any useful information.

3.2.1. Early sexual debut

Researchers are not the only ones who may be operating with this assumption and it may be one of the main reasons why governments and other organisations were slow to include children in HIV prevention and why some of the programmes aimed at children do not include information about sex or condoms (Power *et al.*, 2004). This has been the case in Zimbabwe. Recently a UNICEF team conducted research on gender, sexual identities and HIV/AIDS education in east and southern African countries with children and adolescents aged six to eighteen years (UNICEF ESARO, 2004). In Zimbabwe this team was not allowed to interview children under sixteen years because Ministry of Education officials claimed that 14-16 year olds were not having sex or even thinking about sexuality (UNICEF ESARO, 2004). As the results from my study and those from the review below will show, this was an erroneous assumption and in the UNICEF study resulted in the voices of a large and significant group of young Zimbabweans being excluded from vital policy relevant research.

Although the majority of children may not be sexually active, this is not a valid reason for excluding them from HIV/AIDS research; they may still be on the threshold of sexual debut. Some research has indicated that in sub-Saharan Africa the age at sexual debut is dropping with adolescents reporting their age of first sexual contact at about 13 or 14 years and at times even as early as 9 years (Wood *et al.*, 1998; Zabin & Kiragu, 1998; Best, 2000; Rivers & Aggelton, 2000). Stewart (2001) challenged this evidence with her research in Uganda; she claimed that this type of evidence is based on demographic studies that are 'ahistorical and acultural' (Stewart, 2001: 124). Her study examined the age at sexual debut of three generations of Ugandan women and revealed that this had not changed in 40 years (Stewart, 2001). Stewart (2001) thus contends that the drop in age at sexual debut is more myth than reality and a reflection of adults' feeling of loss of control over the younger generation. If this is the case for the rest of the sub-continent then it is important to understand the historical and cultural contexts within which sexual behaviour is embedded and to accept children's sexuality as a reality; only then can any kind of significant progress be made in preventing the spread of HIV/AIDS. Demonising sexually active children only serves to make them conceal their behaviour and subsequently increase the risk of abuse, disease, early pregnancy and abortion all of which can be life threatening.

Many commentaries and reviews on adolescent sexuality in this region have indicated that children are sexually active (Wood *et al.*, 1998; Zabin & Kiragu, 1998; Best, 2000; Rivers & Aggelton, 2000) and several research studies have also provided evidence of this. Matasha *et al.* (1998) conducted a quantitative survey of reproductive health among primary and secondary school pupils in Mwanza, Tanzania. Their study reflected that the median age at first sexual intercourse was 15 years for primary school children (range 10-18 years) and 16 years for those in secondary school (range 12-19 years) (Matasha *et al.*, 1998). This illustrates the negligible difference between age at sexual debut in primary and secondary schools. In Lusaka, Zambia, a quantitative study by Magnani *et al.* (2002) on reproductive health risk and protective factors among 2 328 youths aged 10-24 revealed that although 15 years was the median age at first intercourse, approximately 10% of the 10-14 year-olds had had sexual intercourse. In Zimbabwe, a quantitative study by Campbell and Mbizvo (1994) on sexual behaviour and knowledge of HIV risk with

511 rural and urban male pupils found that 21% of the 12 year-olds were already sexually active. Furthermore, Jewkes *et al.* (2001) conducted a quantitative study in Cape Town, South Africa, on relationship dynamics and teenage pregnancy with 544 sexually active girls under the age of 19; all the girls in the study reported having had sexual intercourse for the first time at a mean age of 14 years. Qualitative studies have also provided information on age at sexual debut. Shah & Nkhama (1996) conducted a participatory appraisal on adolescent sexual and reproductive health with school-going and out-of-school adolescents (ages 8-17 years) in Lusaka, Zambia. During focus group discussions participants revealed that most girls had their first sexual experience by age 12 and boys by age 14, but that some adolescents had their first experience as early as at 8 years of age (Shah & Nkhama, 1996). These findings were supported by the UNICEF (2004) east and southern African study, where researchers discovered that Zambian children as young as six years old were having sexual intercourse. Zimbabwean adolescent boys interviewed by the UNICEF research group also boasted of having had sex with ten and eleven-year-old girls (UNICEF ESARO, 2004). Although other qualitative Zimbabwean studies alluded to children's early sexual debut their focus was on secondary school students or youths and it was unclear at what age the adolescents had become sexually active (Kim *et al.*, 1997; Pitts *et al.*, 1997; Bassett & Kaim, 2000).

These studies indicate that many children are indeed sexually active before the age of 15 and thus targeting them for HIV/AIDS prevention at age 15 or later may prove too late for any substantial and life saving change in their sexual behaviour. While the studies above did include children, their main focus was adolescents and they were predominantly conducted in secondary schools. Whether these studies imply that children have sex regularly or that they have had a sexual experience early in life, having a single or limited number of early sexual experiences still places them at considerable risk because of the high rates of HIV in this region. This emphasises the need to include children in HIV/AIDS research. If they are beginning to have sex aged 15/16 years, it is better to target them before this age so they can either choose to delay sexual debut or be better equipped to practice safe sex (Grunseit, 1997).

3.2.2. Age of primary school children

It is also not valid to focus HIV/AIDS and sexual behaviour research on adolescents in secondary school because they are older and therefore more likely to be having sex. Children in many sub-Saharan African primary schools tend to be older than those in North American and European schools. There is often quite a broad age range with some pupils above 20 years still in primary school (Matasha *et al.*, 1998; Todd *et al.*, 2004). There are several reasons for this phenomenon: firstly, pupils' education can be disrupted for various social or economic reasons (e.g. illness in the family and the need for extra labour at harvest time) (Robson & Ansell, 2000). Although the children may return to school when the situation improves, if this happens several times during their school career it delays their progress. Secondly, the lack of free education means that children sometimes start school later than the officially stipulated ages of six or seven because their parents cannot afford to send them to school (Feldman *et al.*, 1997). Thirdly, both repeated disruptions and family responsibilities result in children being unable to attain the required levels of knowledge and being forced to repeat a grade and subsequently being older than their peers. These physically and emotionally more mature children may become sexually involved with their much younger classmates. Three Tanzanian studies illustrate this point: Klepp *et al.* (1994) conducted a quantitative survey on knowledge, perceived risk of AIDS and sexual behaviour among primary school children in Poli and Bukoba. The average age of the 1 119 standard five to seven pupils was 14.7 (range 11-18 years); Matasha *et al.* (1998) noted that the median age of their respondents in Mwanza was approximately 14 years (range 12-20 years); in their cross-sectional survey of primary school pupils Todd *et al.* (2004) found that the age ranges of those who were enrolled in years four to six, were 9-22 years. Considering that this is common in many sub-Saharan African schools, it is remarkable that so few studies have focused on primary school children.

3.2.3. Openness to behaviour change

Children in this age cohort (6-14 years) may be more receptive to adopting new behaviour than either adults or adolescents (Grunseit, 1997; Aarø & Gwanzura-Ottemøller, 2000). As people get older their behaviour patterns become more

established, which is why it is more difficult to change the sexual behaviour of adults (Rivers & Aggleton, 2002). Those who are sexually active may also be fatalistic about HIV/AIDS because they suspect themselves already infected and will therefore consider behaviour change pointless (Ray *et al.*, 1998; Stewart, 2001). However, given that the majority of children aged 6-14 are not yet sexually active and may only be starting to think about sex, they may be more malleable to adopting safe sex and healthy reproductive behaviour (Fuglesang, 1997; Grundseit, 1997). Thus, giving children the correct information and equipping them with the appropriate skills may enable them to adopt protective behaviour (Fuglesang, 1997; Rivers & Aggleton, 2002).

Children aged six to fourteen years are also at the life stage (Bailey, 2005) where they still respect adult advice unlike older adolescents who are more influenced by peer norms and tend to challenge adult values. Research on risky health behaviours such as smoking has shown that early intervention with children aged 10-12 years results in children either not adopting the behaviour or in delayed uptake of the behaviour and a reduced chance of addiction (Aarø & Gwanzura-Ottømøller, 2000). Studies in the global North on sexual health and sexual behaviour have also shown that condoms and other forms of contraception are more likely to be used if sexual debut is delayed, and that sexual health education is more effective if given prior to first sexual contact (Zabin *et al.*, 1992; Jorgensen *et al.*, 1993; Grunseit, 1997). Such data counters the widely held belief, both in the North and South, that talking to children about sexual issues will only serve to encourage them to go out and have sex (Grunseit, 1997). The Ugandan experience further reinforces this point. In the early 1990s the Ugandan AIDS Commission developed a National Operational Plan that trained teachers to deliver sexual education and to promote mutual faithfulness and delayed sexual debut as priority strategies for 11-20 year olds (Hogle, 2002; James-Traore *et al.*, 2004). In 1994 the African Medical Research Foundation (AMREF) together with Soroti District Administration conducted a two-year school based project in Soroti District in north-eastern Uganda that targeted children in their final year of primary school (ages 13-14 years) (Kaleeba *et al.*, 2000). The project trained school heads, teachers, peer educators, tutors, and trainee teachers on sexuality related issues and also involved parents and local communities (James-Traore *et al.*, 2004). Results from the AMREF project indicated that sexual

debut within the intervention group had declined from 43% in 1994 to 11% in 1996 while there had been no significant change within the control group (Hogle, 2002; James-Traore *et al.*, 2004). A post intervention report in 2001 found further declines in sexual debut. Children in the intervention group reported an increase in communication amongst themselves as well as with their teachers and parents. The study also found that 98% of the girls interviewed in the first cohort were not sexually active in 2001 compared to 66% in 1994 (James-Traore *et al.*, 2004). Therefore, it is probable that early intervention programmes among children have contributed to Uganda's reduction of recorded adult HIV prevalence rates from 15% in 1991 to 5% in 2001 (Hogle, 2002).

3.3. Risk Factors for Children contracting HIV/AIDS

Section 3.2 has exposed the reasons for excluding primary school children from HIV/AIDS research as largely invalid. This section will discuss the factors that put children at risk of contracting HIV/AIDS and why children are susceptible to them. These factors are not independent of each other; they interact and overlap. However for the purpose of clarity I will endeavour to present these factors separately. Gender will not be examined separately because it is difficult to isolate it from other factors; its effects are inherent within the context of HIV/AIDS in sub-Saharan Africa. Thus the gender implication of the various factors will be discussed in each section.

3.3.1. Biological risk factors

Before any other issues are considered, it is important to highlight the biological vulnerability of girls and women. Firstly, women and girls' reproductive anatomy makes it easier for the virus to enter their bodies because of the delicacy of the vaginal lining and the larger surface area of tissue exposed to their partner's sexual fluids (WHO, 2004). Secondly, 'semen has a higher viral content than vaginal fluids' and more fluids are transferred from men to women during sex (WHO, 2004). Pre-pubescent girls are at even greater risk because their physically immature

reproductive tracts are not yet ready for sexual contact (Zabin & Kiragu, 1998; WHO, 1999; Best, 2000; UNAIDS, 2004). Girls who have their first sexual contact with physically mature adolescent boys or men, risk damaging their reproductive organs because of the incompatible sizes of their sexual organs; the resulting tearing or bruising makes them more susceptible to infection with STIs or HIV if their partner is infected (Matasha *et al.*, 1998). The greater biological vulnerability of girls to HIV infection is reflected by the gender differences in HIV infection rates in young people aged 15-24; double the number of women than men are infected with HIV (UNAIDS, 2004). A study conducted in South Africa illustrates this disparity: among the 15-24 year olds in the group surveyed, one-in-four women was HIV positive compared to one-in-thirteen men (UNAIDS, 2004). Girls may also engage in sex with little knowledge of HIV and how it is transmitted, and if their partner is older, there will be little chance of negotiating condom use.

3.3.2. Economic

Economic factors play a very significant role in the spread of HIV/AIDS in sub-Saharan Africa. Girls and women occupy marginal positions in society partly because of limited access to financial resources (Ray *et al.*, 1998). In most sub-Saharan societies girls and women's economic survival usually depends on a male relative. Gender imbalances begin in childhood and set the pattern for unequal access to resources later on in life. Boys have more spatial freedom and thus it is easier for them to generate opportunities to access resources (Kaim *et al.*, 1997; Nyanzi *et al.*, 2001; Weiss *et al.*, 2000). Girls' movements are more restricted and they tend to be more subject to parental surveillance and censure. The heavy load of domestic chores they undertake also limits their access to income generating activities. Although both boys and girls may attend school during the day, when they return home the girl is expected to help with domestic chores while the boy may be sent to run errands or to go out and play. These early gender divisions set the standard for adult life, with boys having better access to and control of their environment. With the limited choices presented to them, girls learn to use the one asset they have, their bodies, to gain access to resources (Smith, 2002). In some African cultures, the girl child's time with her biological family is considered temporary because she will marry and move away to become part of another lineage (Kesby, 1996). To invest too many resources in a

girl child is thus not a good investment for parents, and the most important thing is for her to grow up to be a good wife (Weiss *et al.*, 2000; Izugbara, 2004)

In many African countries poverty is a reality for many people. Within most sub-Saharan African contexts sex has a strong transactional element. Before marriage lovers exchange gifts but the onus is on the man in the relationship to give gifts to his partner; the man pays bride price to his wife's family in exchange for sexual and reproductive rights; in marriage, women consider financial stability more important than fidelity (Basset & Mhloyi, 1991; Sibanda, 2000). The situation is no different in adolescent relationships. The importance of exchanging money or gifts for sex has evolved from the cultural construction of masculinity where men are primarily perceived as providers for their partners (Lindegger & Maxwell, 2003). In the West these transactions would be viewed as forms of prostitution or even abuse, and granted, in some situations there may be abuse, especially in unequal adult/child relationships (Basset & Mhloyi, 1991). However, in sub-Saharan African contexts girls and women are pragmatic and even in relationships where there is emotional attachment, there is an understanding that the boy/man will provide some kind of economic or material incentive to his partner (Basset & Mhloyi, 1991). As with many social relationships in traditional society, gift giving is also associated with respect and tribute, thus if a boy respects a girl he will give her a gift. This is in contrast to Europe and North America where giving someone a gift or money for sex shows disrespect or desperation. Giving a girl/woman a gift or money in return for sex is not viewed as anything shameful in sub-Saharan Africa, it is expected (Basset & Mhloyi, 1991). It is more shameful to give sex for nothing and it may either cause the boy/man to despise the girl as cheap or easy or to suspect her having of HIV (Shah & Nkhama, 1996; Nnko & Pool, 1997; Nyanzi *et al.*, 2000). Thus sex and economics are closely linked.

Several studies illustrate the transactional nature of sex in young people's relationships. In Lusaka, Zambia, Shah & Nkhama (1996) discovered that poor girls had many partners and their main reason for sexual enjoyment was money. Conversely, poor boys had few sexual partners because they did not have the resources to attract girls (Shah & Nkhama, 1996). Nnko & Pool (1997) conducted a qualitative study in Magu District Tanzania, to chart and understand forms of sexual

risk behaviour among school pupils aged 13-18. Their results revealed that the main motivation for girls having sex was money and that they tended to find out-of-school youths more attractive as sexual partners because they had jobs and therefore more money (Nnko & Pool, 1997). In another Tanzanian study, Matasha *et al.* (1998) asked their respondents why they had sex; 41% of the primary school girls and 12 % of the boys said 'to get money' or 'to get a present'. Among the girls, money was the most important reason for having sex (Matasha *et al.*, 1998). These responses are consistent with adult behavioural norms and reflect the effects of social context on young people's behaviour. Nyanzi *et al.* (2000) reported that over half of their Ugandan participants said sex was a major source of income for girls. The participants stated that adolescent girls needed items such as clothes and cosmetics but were too afraid or embarrassed to ask their parents because they usually came from poor, large families (Nyanzi *et al.*, 2000; Silberschmidt *et al.*, 2001). Thus, the girls resorted to selling sex as a commodity to supplement their income, because they knew the boys wanted it and would pay for it (Nyanzi *et al.*, 2000). The participants also reported that boys received more pocket money than girls and additionally had opportunities to earn money from doing odd jobs (Nyanzi *et al.*, 2000). Furthermore, MacPhail & Campbell (2001) conducted a study in Khutsong, South Africa that used focus group discussions to highlight factors that militate against condom use among adolescents aged 13-25; boys were cited as being in relationships for sex and girls for the money. The participants claimed that girls engaged in sexual relationships in exchange for lifts home from school, gifts and cash. Studies carried out in Zimbabwe have reported similar findings: Kaim *et al.* (1997) conducted participatory reflection and action research (PRA) with 40 rural secondary school students to explore their views on sexual and reproductive health. When asked why they had boy/girlfriends and sex, the girls' most important reason for having sex was 'for money', and the boys reported having girlfriends when they had 'lots of money' (Kaim *et al.*, 1997). These results indicate that having cash is an integral part of dating. With two thirds of the Zimbabwean population living under the official poverty line in 1998 (CSO, 1998 in Bassett & Kaim, 2000) and the economic situation having deteriorated considerably since then, the majority of young people come from poor homes. So far my review suggests that having money equates to having power to buy sex, but in a regional study by UNICEF (2004) girls from Botswana implied that girls exerted power over boys by expecting presents, if the boy did not provide then he was at risk

of being dumped, so he had to 'bribe' the girl and this reflected his 'lack of power'. This was a significant example of how young people are active social agents and even in seemingly exploitative situations gender relationships are not always what they seem, in this instance girls could turn the transactional nature of relationships to their advantage and exert some control over boys. The same idea was presented by Nyanzi *et al.* (2000) who reported that Ugandan girls negotiated sex even with older men and at times succeeded in tricking the men out of money without having provided sexual favours. This shows that girls are not just victims of circumstances, but can also construct ways of getting what they want within those circumstances.

In contexts where poverty is commonplace girls are also more easily tempted by older men to have sex with them in exchange for material goods (Silberschmidt & Rasch, 2001; Lindegger & Maxwell, 2003). In east and southern Africa these men are often referred to as *sugar daddies* (Basset and Mhloyi, 1991; Stewart, 2001). The *sugar daddy*, regardless of his economic status, will usually have better access to resources than young girls and thus have something to offer them (Bassett & Kaim, 2000; Best, 2000; Rivers & Aggelton, 2000). Although there are no studies to document the prevalence of the sugar daddy phenomenon in this region, several studies have shown that girls do have relationship with older men. Participants in Nyanzi *et al.*'s (2000) study reported that girls had sex with *sugar daddies* for financial support and material benefits; some girls would date both a *sugar daddy* and a peer and share the money obtained from the *sugar daddy* with the boyfriend. These results indicate the complexities of the transactional nature of sex in this context because girls may have sexual relationships with those who offer the best material resources (Nnko & Pool, 1997). This may give adult men an advantage over boys but also serve to put young girls at greater risk of contracting HIV from more sexually experienced men. A study by Feldman *et al.* (1997), involving focus group discussions with in-school and out-of-school adolescents aged 14-20 in Lusaka, Zambia, learnt that girls also had relationships with *sugar daddies* for financial security. The participants reported that if a girl became pregnant, an older man would be financially better able to support the baby than an adolescent boy (Feldman *et al.*, 1997). This indicates a very practical attitude to relationships reflecting that though these relationships are socially constructed as abusive, the girls are not always victims but active agents who *choose* to fall in love with older men. Socio-structural factors

such as poverty and gender may place them in situations where they need to use their bodies to get money, but many still choose to be in those relationships and some do have the power to negotiate transactions. Acknowledging that young girls are actively involved in relationships with older men will help us to begin to understand the mechanisms at play in these relationships. Boys are also at risk of contracting HIV because they use the money they earn in exchange for sex (Kaim *et al.*, 1997; Nyanzi *et al.*, 2001). Having sex with girls from their peer group is not necessarily safe because the girls may also have had older and possibly HIV positive sexual partners (Nyanzi *et al.*, 2000; Nnko & Pool, 1997). Boys are also reported to have sexual relations with sex workers as a way to prove their masculinity and gain sexual experience (Aggleton *et al.*, 2004). Therefore, economic factors whether as a result of gender inequalities or socio-cultural practices have a significant impact on the vulnerability of young people contracting HIV/AIDS. These factors are not only confined to the sub-Saharan African context but, regardless of the moral or ethical questions they raise, they are more dangerous within these contexts because of the high rates of HIV.

3.3.3. Socio-cultural

3.3.3.1. Cultural practices

Some cultural practices also put young people in sub-Saharan Africa at risk of contracting HIV. These are practices that are usually associated with gender roles or the position of women in society and different ethnic groups have different practices. Some of these socio-sexual practices served specific purposes in traditional society but have lost their significance in contemporary times. *Chiramu* is one such practice that is still common amongst the *Shona* in Zimbabwe (Sibanda, 2000). This practice makes it acceptable for a brother-in-law or uncle (paternal aunt's husband) to make sexual advances or to have sex with his sister-in-law or niece (Kaim & Ndlovu, 2000). Traditionally men had the potential to be polygamous if they had the resources and status to achieve this – and of course – doing so was an eco-social-political strategy for attaining status and resources. A man with many wives had status because it indicated that he was wealthy and virile, and helped him to forge kinship links with the wives' families to strengthen his position socially and politically. Thus

polygamy has always been an aspiration of most men even though only a minority achieved it. A man could take a sister-in-law or niece as a wife if his partner was infertile because marriage between individuals constituted a contract and alliance between two families. Thus an infertile wife would be joined by her sister/niece as a gesture by the wife's family of honouring the obligations of bride wealth that included the woman's labour and reproductive capacities. A man could also marry his sister-in-law/niece if his wife died or if he simply desired the girl and as a way to strengthen the bond between the families (Basset & Mhloyi, 1991). This has meant that sexual relationships between men and their sisters-in-law/nieces have always been a potential possibility. Since marriage was a process, sexual relations often instigated the marriage; thus a man seducing his sister-in-law/niece may have been rationalised as a prelude to a more legitimate relationship. Polygamy is not illegal in modern Zimbabwe and so aspiring to marry your sister-in-law or niece is still socially acceptable. In these situations it is difficult for girls to resist their male relatives' advances because a) such advances are still normal or acceptable to society and b) in most African cultures young people are taught to respect their elders and not question their authority (Pridmore, 2003). This makes it difficult for them to report incidences of sexual abuse. Moreover, whereas in traditional times a man having sexual relations with a young girl would be pressured to marry her (if that was not his initial intention) because of the social control measures in place, such controls are no longer as effective. It is also common practice in most sub-Saharan African cultures to send children to live with relatives either for schooling, to assist the other household, or to receive assistance. The child becomes the responsibility of the male head of that household and if he takes advantage of his powerful position and makes sexual advances, the girl may have no choice but to comply (Rivers & Aggelton, 1998).

3.3.3.2. Forced sex

The issue of forced sex is one that many young people in sub-Saharan Africa, especially adolescent girls, experience. Forced sex can take many forms; from slight pressure (show me you love me) (Kaim *et al.*, 1997), to coercion (I helped you with your home work give me something in return), to violent rape (Nnko & Pool, 1997; Nyanzi *et al.*, 2000). It is an unpleasant but common feature of most sexual relationships in this region because of the subordinate position of women and the

dominant socio-cultural construction of femininity as passive, and of masculinity as forceful (Meursing, 1995; Wood *et al.*, 1998). Sexual violence also arises as a result of general violence in society. An example is South Africa, which is an extremely violent context as a result of decades of state sponsored brutality during the apartheid system and reactive community insurrection (Jewkes *et al.*, 2002). This, coupled with cultural constructions of successful masculinity as the ability to control one's wife/girlfriend, has resulted in sexual violence against women and girls. Wood *et al.* (1998) examined male violent and coercive practices dominating sexual relationships with 24 pregnant South African Xhosa³ adolescents (aged 14-18); most of these girls reported that they had been deceived or coerced into having sex. They said that refusing to have sex with their boyfriends resulted in being threatened with violence or assaulted (Wood *et al.*, 1998). In the South African context violence seemed to be the norm in relationships and the informants stated that girls who claimed they had never been beaten by a boyfriend were lying (Wood *et al.*, 1998; Jewkes *et al.*, 2002). Twenty-two percent of the girls in another South African study by Jewkes *et al.* (2001) reported that their first sexual experience was either forced or could be classed as rape. When asked if they had ever experienced coercive sex, 45% of the respondents said they had had sex against their wishes, 9% had been raped and 57% had been beaten by boyfriends (Jewkes *et al.*, 2001).

In Tanzania, Matasha *et al.* (1998) observed that primary school girls were three times more likely to have been forced the first time they had sex, than boys. In addition more girls (28%) than boys (14%) reported ever having had forced sex; these experiences were either with a teacher or with a fellow student (Matasha *et al.*, 1998).

In Zimbabwe, Kesby (2000) has shown that forced sex is prevalent among adults in married or permanent relationships. Boys also tend to pressurise girls to have sex once a couple starts dating; they ask girls to show their love for them by having sex and end the relationship if the girls refuse to comply. On the other hand, girls are under societal pressure to remain virgins until marriage; they are not only expected to control themselves, but the boys as well, since it is believed that boys

³ The Xhosa are one of the ethnic groups in South Africa.

cannot control their physical urges (Sherman & Bassett, 1999; Schatz & Dzvimbo, 2001). This puts girls under increased pressure because cultural norms stipulate that they should remain chaste until marriage, and yet their boyfriends say if you love me you will have sex with me (Kaim *et al.*, 1997). Meursing *et al.* (1995) elicited information on child sexual abuse in Matebeleland from a variety of sources that included focus group discussions with secondary school pupils. They observed that participants seemed to agree that if a man found himself sexually excited he had to find a way to release his sexual tension and that masturbation was not an option. Men were described as being at the mercy of their sexual urges and that at times they may be forced to rape, although raping prepubescent girls was considered repugnant (Meursing *et al.*, 1995). It was also mentioned that girls were culturally obliged to say no to sex even when they were interested and this led men or boys to force them assuming that 'no' really meant 'yes' (Meursing *et al.*, 1995).

A quantitative study was conducted by Nyachuru-Sihlangu & Ndlovu (1992) with 478 students from high schools in Mashonaland and Matebeleland, on factual knowledge about AIDS and dating practices. The results revealed that more girls than boys (60% versus 40%) would continue dating a boy/girl who said 'no to sex', whereas fewer girls than boys (19% versus 40%) would not be willing to continue with the relationship (Nyachuru-Sihlangu & Ndlovu, 1992). Although it seems positive that a large number of boys said they would still continue dating a girl if she refused to have sex with them, this does not mean that they did not hope that she would change her mind. There were also reports of girls being tricked or manipulated into having sex (Nyachuru-Sihlangu & Ndlovu, 1992). This was supported by information from Kaim *et al.*'s (1997) study that if a boy gave a girl money, food or gifts he would expect to be repaid with sexual favours if the girl did not have the resources to pay him back. Nhundu & Shumba (2001) carried out a study on teacher perpetrated child sexual abuse in rural primary schools in Zimbabwe and found that girls aged 11-13 were most vulnerable to sexual abuse. Male teachers abusing their power over the young girls within the school setting is common and may be a reflection of a patriarchal society where the social constructions of masculinity are used as an excuse to take advantage of their positions of power (Nhundu & Shumba, 2001; Power, 2004). This also highlights how the African culture of respect can be exploited by older men taking advantage of their positions and forcing young girls to

have sex with them, knowing they will be too afraid to resist or even report them (Meursing *et al.*, 1995)

3.3.3.3. Peer pressure

Adolescents often begin to engage in sexual activity due to the compulsion to conform to peer norms. As mentioned earlier, in these contexts masculinity is synonymous with virility; this puts pressure on boys to get sexual experience to prove their manliness (Rivers & Aggleton, 2002; Lindegger & Maxwell, 2003). Generally speaking “real men” are sexually active, and boys admire peers who have many partners (Rivers & Aggleton, 2002). Boys also tend to ridicule peers who are not sexually active by calling them “women” (Kaim *et al.*, 1997). It is obviously a slight to a boy’s manhood to refer to him as being passive like a woman and lacking in male potency. For example, when girls in the Zambian sample of the UNICEF (2004) study suggested that girls prefer older men because they were more likely to sexually satisfy them, boys became anxious and upset and tried to dismiss this by saying the girls liked older men for their money. Boys found it discomforting to have their sexual prowess questioned because it meant their ‘sense of being powerful men’ was being challenged (UNICEF ESARO, 2004). In many cultures sex is a rite of passage from childhood to adulthood. Boys who are still virgins will be seen by their friends as still being children, not ready to do what men do, i.e. have sex. There are both corporal and social implications for this view. The corporal is related to the actual physical act of having sexual intercourse, the penetration of the female body by the male culminating in ejaculation; sex without ejaculation is not considered full intercourse (Talle, 1995; Malungo, 1999). Socially, accomplishing the physical act gives the boy manhood status among his peers. Thus although some boys may not want to have sex they feel pressured and do not want to be seen as weak or unmanly. This need to prove their manliness is congruent with the social construction of masculinity in many sub-Saharan African cultures. Girls also experience peer pressure to be sexually active, partly because of the material gains, but also because their peers are having sex and they don’t want to be left out (Wood *et al.*, 1998; Nyanzi *et al.*, 2000; Matasha *et al.*, 2000; Jewkes *et al.*, 2001). Research in Zimbabwe and South Africa found that non-sexually active girls were marginalized during discussions about sex because their friends thought they had nothing to

contribute and also that they might report them to adults (Kaim *et al.*, 1997; Wood *et al.*, 1998). Lindegger & Maxwell (2003) observed that in South Africa some girls dated older rich men because of the status that gave them among their peers; these men drove expensive cars and provided the girls with mobile phones and new clothes. In Tanzania, just under half (43%) of the respondents in Matasha *et al.*'s (1998) study said they had sex because 'friends do' it. In Zimbabwe, Sherman & Bassett's (1999) qualitative study on a school-based approach to HIV prevention with secondary school pupils aged 14-19, revealed that one of the reasons boys had sex was for peer acceptance and recognition. Kaim *et al.* (1997) also observed that the influence of peer pressure was present amongst both girls and boys with responses like 'imitating others', 'being influenced by others', 'wanting to appear mature', and 'for prestige' being given as reasons for being sexually active. This reflected young people's need to be accepted or admired by their peers (Kaim *et al.*, 1997).

Reports of the prevalence of peer pressure in the different contexts shows that not only are young people exposed to the norms of the adult society but they are also influenced by norms and pressures from within their own contexts which govern what is normal, acceptable or desirable behaviour. Peer pressure can work for the good or to the detriment of young people. Because the studies reviewed here have been conducted with adolescents rather than primary school aged children, it will be interesting to explore whether children are subject to similar pressures. Understanding the pressures young people experience is crucial because it will then be possible to encourage them to critically consider the negative consequences of some of these norms. If young people begin to question the efficacy of their peer norms it may lead them to develop normative behaviours that encourage safer sexual behaviour as the norm rather than risky behaviour and to take more responsibility for their general well-being. Adults can only act as facilitators to this process, in order for behaviour change or adaptation to be sustainable, the answers have to come from young people themselves.

3.3.3.4. Myths

Most cultures in sub-Saharan African countries are deeply spiritual and spiritual beliefs co-exist with scientific knowledge. One belief that has been linked with HIV/AIDS is that if an HIV positive man has sex with a virgin this will cleanse

him and he will be cured (Stewart, 2001). This myth has resulted in HIV infected men raping young girls (Rivers & Aggleton, 2000; UNICEF, 1999; Stewart, 2001). Traditional healers have been blamed for advising men with STD's to have sex with virgins in order to get cleansed. This was corroborated by respondents in Matabeleland, Zimbabwe, telling Meursing *et al.* (1997) about children they knew who had been victims of sexual cleansing and were later found HIV positive. Although this practice may seem bizarre to people from the global North, it is linked to beliefs in ancestral spirits. Malungo *et al.* (1999) state that the Tonga people in Zambia believe that when a person dies they leave behind two spirits, one becomes the ancestral spirit which can protect or harm and which is dependant on the devotion of the living for its existence; the other is a ghost which is considered evil and which brings misfortune and disease. Therefore when an adult dies, it is necessary for someone to have sex with the remaining spouse in order to chase away this evil ghost so it does not bring misfortune (Malungo *et al.*, 1999). This sexual cleansing ritual may be the forerunner to the belief that sleeping with a virgin will cleanse a man from HIV. In Zimbabwe, Meursing *et al.* (1997) also claim that traditional healers have been widely known to advise men who wish to be successful in business to have sex with a very young girl, usually a relative or daughter. This seemingly unnatural act, in a society that considers incest taboo, will confer luck and power onto the man. Similarly, having sex with a virgin is believed by some to have some magical powers that cleanse, possibly by chasing away evil disease causing spirits. In many of these cultures explanations of illness are never purely biomedical, there are also social explanations of misfortune. It is unclear just how pervasive the virgin myth is, but considering that many people in sub-Saharan Africa still subscribe to traditional religion it is likely that those who have AIDS may be desperate enough to try anything to cure themselves, including putting young girls' health at risk.

In conclusion to this section it is necessary to remember that a caveat to the problems addressed above is to not only see children, especially girls, as victims. Children are active social agents who interact with their environment (Nnko & Pool, 1997; Nyanzi *et al.*, 2000). They have their own opinions on how things should be, their views are not always compatible with adults' views and at times are more progressive (Ansell, 2001). It is thus important to have dialogue with children in order to get insight into their views and listen to their solutions to the challenges they

face instead of always dictating what we think is right. Adults tend to tell their children not to have sex in a didactic and authoritarian way and this is not effective (Power, 2004). It is imperative to empower through the provision of knowledge and skills that enable them to either choose to abstain because they are fully aware of the implications of early sexual activity, or to negotiate safe sex and use protection. In order to provide this information it is necessary to have some understanding of how young people conduct their sexual relationships.

3.4. The nature of adolescent sexual relationships

3.4.1. Children's sexual partners

As well as identifying that children are sexually active at young ages it is important to determine whom their sexual partners are i.e. whether they are having sexual relations with their peers, older adolescents or adults. The assumption is that sex with peers may tend to be more consensual and present less risk for contraction of HIV because both partners will be young and sexually inexperienced. Sex with adults, especially between young girls and adult men, is more risky because of potential physical injury during sexual intercourse, and also because of unequal power relations between an adult and a child (UNAIDS, 2004). This is not to say that inequalities between boys and girls are non-existent (see section 3.2.), but that the power differentials between adults and children are far greater. Although children can also be infected with STIs and HIV, statistics indicate that because adults are more sexually active and have easier access to opportunities to engage in sex than children, they are more likely to carry STIs including HIV (UNAIDS, 2004).

Several studies have elicited information about young people's sexual partners. In Zambia, Magnani *et al.* (2002) inquired about the age of the adolescents' last sexual partner. Of the 10-14 year olds in their sample the majority of boys had younger partners whilst more girls had older partners: three quarters of the boys and about a tenth of the girls (11%) had sexual partners in their age group; 25% of boys compared to 72% of girls had partners aged 15-19; and some girls (16.7%) but none

of the boys had partners older than 19 years (Magnani *et al.*, 2002). Among the sexually experienced primary school pupils in Matasha *et al.*'s (1998) Tanzanian study, more boys (75%) than girls (54%) had sex only with peers. Meanwhile, more girls (11%) than boys (4.5%) had experienced sex with adults such as teachers, relatives and strangers (Matasha *et al.*, 1998). Results from Nyanzi *et al.*'s (2000) study in Uganda indicated that in general the adolescents had sexual relations with their peers. However, girls tended to have concurrent relationships with older men or *sugar daddies* such as taxi drivers, businessmen, teachers, out of school youths, married men and widowers (Nyanzi *et al.*, 2000). In Khayelitsha, South Africa, Wood *et al.*'s (1998) respondents said their first and subsequent sexual partners were about 5 years older than them. Sherman and Bassett (1999) observed that Zimbabwean girls in their sample preferred dating older boys and that boys preferred dating younger girls. The average age difference between partners was 3-4 years (Sherman & Bassett, 1999). In both cases the boys would not only be older, but could also be more sexually experienced and the combination would make it easier for them to coerce the girls to have sex. Kaim *et al.* (1997) observed that although it seemed as if adolescents in their qualitative study were mainly having sex with their peers, the boys hinted that some girls had sex with older men. The girls however did not mention this during their group sessions and this could be attributed to shyness or secretiveness. This is in contrast to the study in Uganda in which all adolescents were open about the girls' relationships with older men or *sugar daddies* (Nyanzi *et al.*, 2000).

Although these studies were conducted in different social contexts there is a clear indication that girls tend to have older sexual partners. In the main, boys have sex with younger girls or their peers; but the phenomenon of older women seeking out boys for sexual favours and of some boys being interested in sleeping with older women or *sugar mummies* also exists (UNICEF ESARO, 2004). Zambian boys indicated to the UNICEF (2004) research team that these women would manipulate boys into having sex with them. There was no indication of force, but the boys stated that once they were sexually aroused, they could not resist the women (UNICEF ESARO, 2004). The boys were thus exhibiting their masculinity by confessing their inability to control their strong sexual urges. These findings have implications for HIV transmission because, as discussed earlier, of the ubiquity of force in sexual

relationships which may be exacerbated by girls having older partners (UNAIDS, 2004). Some of the older women dating boys may either be widowed or divorced with a high chance of being HIV positive and thus the boys' sexual urges may be putting them at risk (Best, 2000).

3.4.2. Number of sexual partners

If sexually active children are having sexual relations with their peers as well as with adult men and women it is important to understand both the number of sexual partners they have and the nature and complexity of sexual networks. Although it is possible to contract HIV at first sexual contact with an infected partner, the risk of infection is increased by unprotected sexual contact with multiple partners (UNAIDS, 2004). Risk of spreading HIV is further increased if young girls are having relationships with older men *and* their peers as this increases the likelihood of the virus being brought into an age group with very low prevalence rates (Nyanzi *et al.*, 2000).

Magnani *et al.* (2002) observed that among young sexually active adolescents (ages 10-14) the mean number of sexual partners was 3.7 for boys, and 1.6 for girls. During focus group discussions, the boys and girls (ages 14-18) reported to Nyanzi *et al.* (2000) that it was common to have many sexual partners. The boys' reasons for this were to gain prestige with peers and to attract more girls; the girls' reasons were to gain sexual experience for marriage and to find a suitable marriage partner (Nyanzi *et al.*, 2000).

Silberschmidt & Rasch's (2001) qualitative study on adolescent girls, illegal abortions and *sugar daddies* in Dar es Salaam, Tanzania, found that among the 51 girls (aged 15-19) interviewed, the number of sexual partners ranged from two to eight, with many girls reporting that they had several partners simultaneously. In South Africa, Wood *et al.*'s (1998) participants reported having had one to three sexual partners and participants in Jewkes *et al.*'s (2001) study reported having had between one and six. The general consensus among Zimbabwean adolescents interviewed by Sherman & Bassett (1999), was that boys had many sexual partners but girls would or should only have one partner. Of the 118 sexually active boys in Campbell & Mbizvo's (1994) quantitative study, 63% had had more than one partner,

with an average of three partners (range 1-15). Zimbabwean boys are less reticent about their sexual exploits and may even exaggerate, whereas girls tend to be more reserved and to either claim to have only one partner or to be a virgin (Munodawafa *et al.*, 1995; UNICEF ESARO, 2004). This is because of the cultural constructions of masculinity and femininity in Zimbabwe, which praise male sexual prowess, and female chastity (Sherman & Bassett, 1999; Schatz & Dzvimbo, 2001). In a quantitative study by Nyachuru-Sihlangu & Ndlovu (1992) more girls reported monogamy (53%) than boys (33%). There was also uncertainty among both girls and boys as to whether their partner had another partner simultaneously, and the authors suggested that the concept of multiple partners was not only common but also expected and accepted by both genders (Nyachuru-Sihlangu & Ndlovu, 1992). These studies thus reflect that adolescent sexuality in sub-Saharan African communities is similar to that of adults in that it is common to have multiple partners. This is not surprising because young people are growing up within the same socio-cultural contexts as adults and therefore adopt the same behavioural norms; also, the gap between the onset of puberty and marriage has lengthened and thus there are more opportunities for having multiple sexual partners.

3.4.3. The spatiality of sexual activity

The spatial dimension of sexual activity, i.e. where adolescents are having sex, is not often analysed (see Kesby *et al.*, 2003 for a discussion of this in the UK context). It is crucial to identify the contexts within which young people have sex, and what effects these have on their ability to use protection. A few of the studies reviewed in this chapter have referred to spatial issues but there is a lack of in-depth discussion. This is probably because the studies were conducted within fields such as psychology and epidemiology whose interest in spatial issues is limited.

Of those who refer to the spatiality of sexual relationships, Matasha *et al.* (1998) asked their respondents about places where sexual intercourse takes place. Considering the risk of detection it was surprising that in this study over a third of the participants said sex took place either 'at home' or 'at some other house' (Matasha *et al.*, 1998). Around a quarter of the sample reported that they had sex at 'traditional dance places' and on the way to school or to fetch water/firewood. The adolescents also had sex in guesthouses (10%), and at school (5%) (Matasha *et al.*, 1998). This

study presents a variety of spatial contexts but because the data was collected using a questionnaire there was no opportunity to probe and find out why sex took place in these specific places and who suggested the venue. Details of the partners they have sex with in the different places would have also given more depth to this question. It may be assumed that adolescents were having sex with adults when they responded at home, in a house or in guest houses because of the risk of getting caught by parents or relatives, whereas they could have sex with an adult in his or her home (Nnko & Pool, 1997). This type of information is significant but it only provides us with preliminary ideas of where young people have sex, it is important to conduct more in-depth qualitative studies to acquire more insight and understanding into what really happens within these contexts.

The qualitative study by Wood *et al.* (1998) provided more information about what happened in places where sex took place. The young women in this study all had sexual intercourse in the men's homes and once they had entered these spaces they were expected to give in to the men's sexual demands (Wood *et al.*, 1998). Having sex in the men's rooms increased the women's vulnerability and the man's sense of power. The men concluded that by agreeing to enter their domain the women were consenting to have sex and resorted to violence if the women resisted their advances (Wood *et al.*, 1998). One informant went to a man's room during the day and did not expect him to make sexual advances because she assumed that sex only took place at night (Wood *et al.*, 1998). This highlights the issue that sex is not just about perception of space but also of time; the young woman felt safe visiting her boyfriend during daytime only to learn that sex could take place at anytime of the day (Wood *et al.*, 1998). These findings are also significant because they reveal the power relations at play in certain spaces and the unspoken messages that are relayed once they are entered.

Silberschmidt & Rasch's (2001) respondents said that their sexual encounters were carried out in secrecy, often after school for school-going respondents. They reported that they would change out of school uniform into casual dress and their partner would rent a room in a lodging where intercourse would take place (Silberschmidt & Rasch, 2001). The respondents claimed that in most cases intercourse took place in a great hurry because of fear of discovery, and it is thus

unlikely that sex was protected (Silberschmidt & Rasch, 2001). In addition, male participants in MacPhail and Campbell's (2001) study stated that since they lived at home their opportunities to have sex were constrained by their parents. They did not bother using condoms during sex when their parents were not at home because it would be a waste of valuable time (MacPhail & Campbell, 2001). This shows that sex in the context of the family home tends to be unprotected because of the risk of being caught. Since boys or men initiate sexual relationships it is likely that they decide or organise where it takes place and thus have control over the act, which limits the girls' control (Shah & Nkhama, 1996).

Zimbabwean studies have mentioned where young people have sex but there has been no discussion of what this means in terms of power relations and the ability to use contraception. In Kaim *et al.*'s (1997) study the respondents referred to going with a boy to a secret place in the bush to have sex as 'picnics'. Some of Sherman & Bassett's (1999) respondents mentioned that it would be nice to have sex in a bed rather than in the bush or behind a building. These results indicate that within this context adolescent sexual activity usually takes place outside, and most probably in a hurry for fear of being discovered because the young people will know that what they are doing is 'wrong' i.e. not socially acceptable. Despite the knowledge that adults disapprove of their sexual activity adolescents still manage to find ways and places to engage in sexual activity. This lack of acceptance of young people's sexuality puts them at even more risk of pregnancy, STIs and HIV/AIDS as they engage in rushed and unprotected sex.

3.4.4. The context specific nature of gender roles in sexual relationships

Although, many societies in sub-Saharan Africa are patrilineal and patriarchal which is reflected by the way children are socialised and gender roles defined from a young age (Feldman *et al.*, 1997; Nyanzi *et al.*, 2000), this review has nevertheless revealed disparities in gender relations between the different countries. Among the Ugandan adolescents represented in Nyanzi *et al.*'s (2000) study, sex was negotiated whereas the female Xhosa adolescents in Wood *et al.*'s (1998) South African study were coerced or forced into having sex. The differences observed remind us firstly,

that the sexuality of African adolescents is not homogenous; and secondly, that these studies do not necessarily represent the entire Ugandan and South African adolescent experience. Nevertheless, they do provide some insight into child and adolescent sexual behaviour as well as the differences between contexts, and allow us to begin to come to some conclusions as to the causes of the differences. A possible reason for the disparities between these contexts could be that Ugandan adolescents were mainly having sex with peers whereas the South Africans were having relations with older boys or men (Wood *et al.*, 1998; Nyanzi *et al.*, 2000; MacPhail & Campbell, 2001). Nevertheless the Ugandan girls also seemed to negotiate sex with older men (Nyanzi *et al.*, 2000). They seemed to accept that both boys and girls were sexually active and the boys were aware that the girls sometimes had relations with older men as well as themselves and were reported to accept this (Nyanzi *et al.*, 2000). This was not the case with South African men and they did not accept their girlfriends having other partners, even when they themselves may have had more than one girlfriend (Wood *et al.*, 1998; MacPhail & Campbell, 2001). However, MacPhail and Campbell (2001) reported that a minority of boys in their study supported the idea of women carrying condoms and thought that sex should be negotiated and mutually agreed upon rather than forced. Significantly these boys belonged to religious organisations, which may have encouraged mutual respect between the genders, and although they were a minority they had strong opinions and resisted their society's stereotypes of masculinity (MacPhail & Campbell, 2001). Thus even within one context sexual relationships can be constructed differently and though social constructions of masculinity are powerful, they can be resisted.

As mentioned earlier, the general attitude in Zimbabwean society is that girls should be chaste and control boys by saying no to sex because boys are driven by their desire and have no self-control (Meursing *et al.*, 1995; Sherman & Bassett, 1999). This was reflected by 60% of the respondents in Schatz & Dzvimbo's (2001) study stating that a married man could have extra-marital affairs but a woman could not. In the same study 80% of the students believed that most boys wanted to marry virgins and 44% believed that girls wanted to marry virgins (Schatz & Dzvimbo, 2001). These figures show the kind of unrealistic expectations adolescents are brought up to have of the opposite sex. Furthermore, the majority of Schatz & Dzvimbo's (2001) respondents believed that if girls behaved properly then boys

would be able to control their sexual desires, and they stated that most girls did not know how to say no to sex. Almost half of the students (47%) agreed that the girl makes the final decision about having sex, but of those who disagreed (37.6%), the majority were girls (Schatz & Dzvimbo, 2001). This demonstrates the contradictory nature of sexual relationships and the mixed messages young people are getting from the adults (Kaim *et al.*, 1997). It also shows that boys/men take no responsibility for their behaviour but put the responsibility for avoiding sex onto girls/women without giving them the power to act. This is in contrast to Uganda where according to Nyanzi *et al.*, (2000) girls were not only expected to be sexually experienced, but they used their premarital sexual activity to find themselves a suitable (sexually proficient) mate.

The differences found in Uganda, South Africa and Zimbabwe indicate that within sub-Saharan Africa sexual behaviour and gender norms are context specific and adolescent sexuality should not be a blanket term covering all adolescents in all countries (MacPhail & Campbell, 2001). This is important in HIV prevention because programme developers need to be aware of the differences within and between contexts in order to develop effective and appropriate programmes that address young people's specific needs. This can only be done through engaging young people directly and allowing them to express the types of challenges they face (Gwanzura-Ottemöller & Kesby, 2005).

3.4.5. Sexual pleasure

So far my discussion has focused on the negative aspects of adolescent sexual relationships but this is not the complete picture. Young people also *choose* to have sexual relationships because it gives them pleasure; their sexual experiences are not only about abuse, coercion or as an economic survival strategy. They can have pleasurable consensual sex within committed loving relationships, as well as sex for physical gratification. Boys are usually more likely to admit to having sex for pleasure because it is culturally acceptable for them to satisfy what are perceived as their natural physical needs. However, in most patriarchal sub-Saharan African societies it is deemed unseemly for a girl to openly express her enjoyment of sex and those who do so are labelled promiscuous (Basset & Kaim, 2000). Thus girls may

tend to equate sex with love in order to dissipate any discordant feelings they may have about having sex for pure physical pleasure.

Shah & Nkhama (1996) reported that both boys and girls preferred having sex with their peers rather than older men or women because it was more pleasurable. This may have been because they felt more in control and able to negotiate how and where the sex took place. Some girls in Nyanzi *et al.*'s (2000) study stated that they did not only have sex for money but for pleasure. These girls were not attracted to a boy because of his financial resources but were attracted by good looks, intelligence and good behaviour, and reported that these relationships lasted longer (Nyanzi *et al.*, 2000). Sixty four percent of the young women in Jewkes *et al.*'s (2001) study reported that one of the main reasons for having sex was love. In Nnko & Pool's (1997) study, girls preferred dating older youths because they had 'superior sexual experience'. Even young children have sex because it is pleasurable: six-year-old Zambian children in the UNICEF (2004) study said they had sex because it 'felt nice'. Within the Zimbabwean context Sherman & Basset (1999) found that girls equated having sex with showing love and boys saw the sexual experience as something that brings physical pleasure.

The inability or lack of freedom to express sexual desire is not only limited to the sub-Saharan African region. Studies with adolescents in the USA have revealed similar findings. Tolman (1994) reported that when American girls enter the period of adolescence they 'come under cultural pressure to be "nice girls and ultimately good women"'. She states that despite the feminist revolution, the patriarchal society in the USA still manages to silence and denigrate women's sexual desire (Tolman, 1994). In her qualitative study in the USA focusing on how girls' social environments shape their understanding of their sexuality, Tolman (1994) found that the girls had discordant feelings about sexual desire because there was conflict between their 'embodied sexual feelings' and their social and relational contexts i.e. what they had been (or not been) taught to feel. The girls also stated that women had never talked to them about sexual pleasure or desire and Tolman (1994) interpreted this as the patriarchal society's way of keeping 'girls and women from their own desire' because acknowledging this desire 'can instigate demand for social change'. She suggests that girls should be empowered to know and act on their desire instead of being offered

what she terms as ‘simplistic strategies for avoiding boys’ desire’ as emphasised in the ‘just say no’ curriculum (Tolman, 1994). She stresses that keeping girls in the dark about their sexuality as a way to protect them prevents them from knowing that they have the power to choose and thus puts them more at risk. Girls with a stronger awareness and trust of their minds and bodies however, may have an enhanced ability to make safe sex decisions (Tolman, 1994).

Sexual pleasure or desire is not discussed in detail in the African studies reviewed; because the studies focus on HIV, there is generally more discussion on the dangers of adolescent sexuality rather than acknowledging young people’s desire. Tolman’s insights, although based on experiences in a Western and industrialised society, are extremely relevant to the sub-Saharan African context. It is important for young people, especially girls, to have knowledge of their bodies and to understand that sexual desire is natural and not wrong or dangerous (in itself). Understanding and accepting their desires will give them greater control over their bodies and the confidence, as suggested by Tolman (1994), to make safe sex decisions. It is also important to deconstruct cultural understandings of the body, which construct the woman’s body as a vessel to contain and nurture the man’s seed (Basset & Mhloyi, 1991; Kesby, 1999). By reducing the significance of women’s role in reproduction these cultural constructions not only take away women’s power but also their ability to have and acknowledge sexual desire.

3.5. Sex education

Sub-Saharan African countries have different indigenous, colonial and postcolonial histories, which have shaped how their traditions have evolved (van de Walle & Franklin, 1996). A large number of people in central, eastern and southern African countries belong to a linguistic group classified as Bantu (Bantu, 2005) These ethnic groups have similar ancestry although their ancestors migrated and settled in different parts of the region and their languages have evolved accordingly (Wikipedia, 2005). Because of their common ancestry these ethnic groups also have some similarities in their traditional beliefs and cultures (for example ancestor worship) (van de Walle & Franklin, 1996). The British Empire also had a significant impact on this region; the colonialists carved up the region, putting borders where

there were previously none and restricting the ethnic groups within arbitrary new boundaries for their own convenience and without the consent of the local people. Because most eastern and southern African countries were either British colonies or protectorates they have similar colonial histories, which have had an impact on the changes that have occurred in their indigenous cultures and traditions. All these factors have had an impact on children's sex education and also on the spread of HIV/AIDS within this sub-continent.

3.5.1. Traditional sex education in East and Southern Africa

Initiation rites or rites of passage heralded puberty in many traditional African societies. These varied from large scale affairs involving groups of boys and girls of the same age cohort being taken to separate secluded camps for instruction, to one to one counselling sessions over several years (Fuglesang, 1997; Zabin & Kiragu, 1998; Rivers and Aggelton, 2000). The main purpose of these initiation rites or sessions was to teach children their society's rituals and customs in relation to their bodies, sex and marriage and to prepare them for their transition from childhood into adulthood (Heguye, 1995; van de Walle & Franklin, 1996). In societies where sex education was conducted through group initiation, the withdrawal of the children to secluded places away from the homesteads symbolised a retreat to spaces outside mainstream society and when they emerged from these spaces they had forged new embodied identities as adults. Most cultures separated children into same gender groups and this served to socialise and reproduce gender stereotypes through the teaching of traditional customs and norms governing sexual behaviour and relationships (Grundfest Shoepf, 1995: 33; Ndeki *et al.*, 1995). The training sessions usually culminated in celebration and welcoming the children back into the community and into their new status as young adults.

In other societies, such as among the *Shona* in Zimbabwe, there was no formal initiation ceremony and initiation into adulthood took the form of informal counselling sessions (Gelfand, 1979). Girls received instruction from their paternal aunts or grandmothers and boys from their uncles or grandfathers on sexual development and their roles in marriage (Vos, 1994; Gelfand, 1979; Muyinda *et al.*,

2001). The children received information on the sex act and girls were taught about menstruation, feminine hygiene, the ways to treat her husband socially and sexually, womanhood and marriage (Muyinda *et al.*, 2001). They were taught the correct and acceptable gendered behaviour. They were not taught about safe sex because procreation was (and still is) one of the most important functions of marriage. Girls were taught the appropriate ways to address their husbands, but there was no emphasis on open communication. Instead of spouses talking to each other, men would consult their sisters or aunts on important matters because they were from the same lineage and it was thus appropriate for them to talk to each other more openly; women in turn would use their sisters-in-law as go betweens with their husbands and this put the paternal aunt or *vatete* in a powerful position (see 2.5.2) (Shire, 1994; Kesby, 1999). These counselling sessions began at onset of puberty and continued right up until marriage and the birth of the first child or even later, and thus gave the aunt or uncle extended influence over the children as they were the main source of information about puberty and sexuality (Muyinda *et al.*, 2001). The girl child especially would look to her aunt for advice as she grew up and went through the various stages of physical and social development (Muyinda *et al.*, 2001). Amongst the Shona, boys were not encouraged to be sexually active and were warned against sex before marriage, and girls had regular virginity tests once they had started menstruating up until they got married (Gelfand, 1979; Sibanda, 2000). The period between reaching puberty and getting married was very short for girls as they were generally married between the ages of 13 and 15; there was thus not much time for sexual experimentation. Boys probably had more time to experiment because they could only marry once they had accumulated enough wealth to pay bride price; young men who had not accumulated enough would have to work for their in-laws until the debt was paid (Kesby, 1996). Young people grew up in a very close family homesteads surrounded by their kin so it was easy for information to be passed on regularly from the elders to the children and there were very clear rules on what was expected from them.

3.5.2. The impact of colonialism on sex education

The advent of colonialism sparked a change in the traditional way of life. Control of the land was taken over by the white colonialists who expropriated the best

agricultural land for themselves and relegated inferior sections to the indigenous Africans (Basset & Mhloyi, 1991; Kesby, 1999). The colonialists needed labour on their farms, in their factories, businesses, mines and homes and assumed that the indigenous populations would be eager to work for them. When the majority of people showed no interest, the colonialists introduced a hut tax payable in cash and this forced African men to migrate from their rural homesteads to cities or mines to find jobs and earn money to pay the tax (Basset & Mhloyi, 1991; Kesby, 1999; Rivers & Aggleton, 2000). The rules and regulations imposed by the colonial powers caused the traditional laws to become codified rather than remaining flexible and also caused them to be interpreted through Western understandings (Shire, 1994). This was particularly the case with women who became socially and spatially marginalized and lost many of the rights they had possessed within the traditional systems (Basset & Mhloyi, 1991; Heguye, 1995; Jeater, 2000). The movements of African people were restricted and men's families were not permitted to go and live with them in the cities or near the mines. This was not only a function of the colonial powers but also of African men who wanted to keep urban spaces as masculine spaces in order to maintain some vestige of the power that had been taken away from them by the white settlers (Kesby, 1999; Jeater, 2000).

Since men lived without their families this created artificial settlements; some women migrated from the rural areas into the cities and towns and cohabited with the men as casual sex partners, girlfriends or informal wives (Basset & Mhloyi, 1991; Sibanda, 2000). There was societal prejudice towards these women because of the idea that women belonged in the rural areas, and they were constructed as immoral women who were 'out of place' (Jeater, 2000). This resulted in racialised and gendered geographies (Kesby, 1999) where the indigenous people were restricted to living either in the rural areas or in temporary urban dwellings away from the white settler minority. Urban space was white space and Africans could not own land within these areas; their residence was temporary and their permanent place was in the rural areas (Shire, 1994; Jeater, 2000). While men worked for the white settlers, the women cultivated the land, tended the livestock and brought up the children (Kesby, 1999). Colonialism undermined African men's masculinity because even though they had hierarchies and power structures within their lineages, that was within systems they were born into and understood and where they had the potential to rise within the

ranks; within the colonial structures they were not only subordinate to the white males, but also to white women and children (Shire, 2000; Kesby, 1999). The advent of colonialism thus heralded the disintegration of the traditional social structures and the beginning of a new era in indigenous cultures.

As urbanisation increased and more cities were built in the 1970s, political pressure for independence and an end to racial and spatial segregation also increased. Restrictions to women's movements were removed and more families migrated to cities to take advantage of the opportunities there, moving 'away from the sphere of influence of their elders' (Shire, 1994; Kesby, 1999). This resulted in the subsequent weakening of the extended family structure (Kesby, 1999; Rivers & Aggleton, 2000). Strong ties still existed between extended family members, but distance caused a shift in these relationships. Geographical distance made it difficult for families to have frequent contact and for regular traditional sex education to be given to children because the aunt/uncle or grandparents lived in other parts of the country (Bassett & Kaim, 2000). Because identity is produced in space, young people growing up in urban areas were socialised differently from those in the rural areas; they were not subject to the direct control of the extended family and the behavioural sanctions that were imposed and easily policed within the rural family homestead. In the city families lived amongst strangers and thus social control took on alternative forms and was imposed through legal structures rather than traditional sanctions. Access to education and jobs, and the change from a barter system to a cash economy meant that people in the cities usually had better access to resources than those in rural areas. There were subtle changes in the social positions occupied by family members with those who had jobs and education having a higher status than those who did not. Although large numbers of the indigenous population moved to urban areas the majority stayed in the rural areas with many families still divided. Since independence a new phenomenon of seasonal migration has been noted where the wife and children live in the rural areas during planting and harvesting season, and in the urban area the rest of the year. Thus changes and migration into the cities has not meant a complete break with culture and tradition and there still is a great deal of movement between cities and rural areas with extended families continuing to exert some influence.

The effects of migration and the loosening of the extended family's control had implications for children's general as well as sexual education. In pre-colonial society, children received all their education within the extended family community (Heguye, 1995). Before the colonial governments were set up in sub-Saharan Africa Christian missionaries came to the continent and set about converting and educating the local people. The establishments of the colonial powers led to the institutionalisation of education and the missionaries were responsible for building many schools for indigenous African children in order to educate them out of their traditional beliefs and practices and into Western Christian ways (Heguye, 1995). The new forms of education did not however provide sex education for children because the strong Christian and Victorian influences meant that the government and the churches felt it was immoral to teach children about sex (Heguye, 1995). This was in contrast to the traditional construction of sex as something natural, pleasurable and important (Muyinda, 2001). With all these changes, the kinship links that gave paternal aunts and grandparents authority over children were weakened and a gap emerged in children's sexual socialisation and education (Bassett & Kaim, 2000). The gender and generational structures within the extended family were affected by the education of the children into a different way of life from that of their relatives. For example, attempts by an uneducated rural paternal aunt to give sexual education to her urban educated nieces would not be well received because they would consider it old fashioned and obsolete (Meursing *et al.*, 1995; Bassett & Kaim, 2000).

The gap left by the extended family's loss of influence now meant that parents had to step in and provide their children with information about sex and reproduction. The majority of parents have found this difficult because of the traditional/cultural taboos of parents speaking to their children about sexual matters, embarrassment, and fear that talking about sex will encourage experimentation (Meursing, *et al.*, 1995; Shah & Nkhama, 1996; Fuglesang, 1997; Stewart, 2001; Gwanzura-Ottmöller & Kesby, 2005). Thus most parents resort to making statements like 'stay away from boys/girls' to their children or giving out vague messages that often leave their children confused (Sherman & Bassett, 1999; Muyinda, 2001). This reluctance and inability to engage with their children on these issues results in children getting most of their information from peers, the media or practical experience (Meursing *et al.*, 1995; Wood *et al.*, 1998; Buseh *et al.*, 2002). Information from peers tends to be

unreliable, inaccurate and based on myths or hearsay (Muyinda, 2001); the media will usually give out information that is aimed at adult audiences and that may be misunderstood or misinterpreted by children; and sexual experience in the absence of an understanding about safer sex is risky (Gwanzura-Ottmöller & Kesby, 2005). The unidirectional nature of media information means that the children cannot ask for further clarification. There is thus a need for a forum that addresses children's needs, and where they can ask questions and receive accurate information.

3.5.3. The change in family responsibilities

Just as the advent of colonialism and migration to cities shifted the majority of agricultural work on the family land from men to women, the HIV/AIDS epidemic has also caused changes in society by shifting family responsibilities from adults to children and/or the aged. Although children have always had responsibilities within the household, with many parents becoming ill and dying, and with extended family support systems breaking down due to financial constraints, some children are now shouldering all family responsibilities (Foster, 1998; Foster & Williamson, 2000). The social, emotional and financial burdens orphaned children have to bear make them more vulnerable to sexual exploitation as they try, by whatever means, to provide for themselves and their siblings. Selling sex can become a means to securing food, money and shelter and the threat of HIV/AIDS may seem relatively minor compared to the immediate need to secure these resources. While grandparents take responsibility for grandchildren, they are sometimes elderly and at the age where their own children would be caring for them, and are therefore ill-prepared. This situation is difficult to remedy in countries without (or with poor) state sponsored social security structures. In the absence of responsible relatives, it is up to local communities to care for these children and they do not always have the resources or the desire to do so.

3.5.4. The role of the formal education system

Education has wrought changes in sub-Saharan African societies by creating and extending the period of adolescence, and weakening the controls that society and the family had on young people (Fuglesang, 1997; Sibanda, 2000). Traditionally the transition from childhood to adulthood was governed by corporeal measures; it was

not based on age but on puberty, marriage and childbirth (see 2.5 for details). Because the onset of puberty meant the beginning of the journey into adulthood many young people did not have a long period of adolescence and opportunities to experiment sexually. Most African governments have attempted to provide primary school education for all children (with varying success between countries). The shift of education from the arena of the family/home to the school environment has weakened the family's control of the information in general and sexual information in particular. Furthermore, apart from control of knowledge adults have also lost some of their control over children's bodies. Young people sometimes have to leave their homes to gain access to education either by attending boarding schools, living with relatives or living alone in lodgings (Zabin & Kiragu, 1998; Basset & Kaim, 2000). This movement away from the spaces where cultural norms and controls prevail gives children greater freedom than they would have had in pre-colonial times and subsequently, autonomy over their own behaviour (Shah & Nkhama, 1996). Furthermore colonial legislation on child marriages as well as other factors such as the rise in the cost of living, and the inflation of bride price has delayed the age at which young people marry (Basset & Mhloyi, 1991). Thus the life stage of adolescence, which did not exist in traditional society, has emerged; today young people remaining single for longer periods and their identities are forged in a variety of spaces. Adolescence provides opportunities for young people to have premarital sexual relationships that do not necessarily culminate in marriage (Fuglesang, 1997).

3.6. Targeting primary school children for HIV/AIDS research

When researching the behaviour of school going youth, primary schools are an important resource because although school enrolment is low in many sub-Saharan countries, the majority of children who do make it to school will be found in primary schools. Literacy rates for those aged 15 and above in the region range from 42% in Angola to 90% in Zimbabwe (UNDP, 2004). Primary school enrolment in 2001 in sub-Saharan Africa was 87% compared to 26% in secondary schools in 1996 (World Bank, 2004). Many children tend to drop out after primary school and only a

minority, with the financial means or outstanding ability, continue on to secondary school (Ndeki *et al.*, 1995).

In the case of Zimbabwe, enrolment levels are high because the post independence government instituted free primary school education for all and built many new primary schools, which, since 1980, have improved access to education for many children in rural areas. Enrolment in secondary schools has also increased greatly with 90% of urban and 55% of rural primary school children attending secondary schools (Central Statistical Office, 1992 in Sherman & Bassett, 1999; Sherman & Bassett, 1994 in Bassett & Kaim, 2000). In 2001, primary school enrolment was 99% compared to 44% in secondary schools (World Bank, 2004). This high provision of education has resulted in a large proportion of children in the population having 11 years of schooling. Zimbabwe has the highest literacy rate in sub-Saharan Africa: in 2002 90% of the adult population (aged 15 and above) were literate as a result of the education policies of the 1980s (UNDP, 2004; World Bank, 2004). However, during the 1990s, economic problems and the pressures of the structural adjustment programme caused the Zimbabwean government to reintroduce school fees in primary schools. Enrolment in schools in some areas has dropped as a result, but children are still more likely to attend primary schools than secondary schools. This means that the situation is becoming similar to that in other sub-Saharan countries, and that targeting children for HIV/AIDS prevention while they are in primary schools may be the most effective strategy. It is vital to reach the majority of children and to equip them with knowledge and skills that they can use if they have to drop out.

3.6.1. Life skills and the Zimbabwean AIDS Action programme

With the global realisation that adolescents and children were not only at risk of contracting HIV/AIDS but could potentially be the solution to stopping the spread of the epidemic, governments and organisations began to develop and implement HIV/AIDS prevention programmes targeting young people. Life skills education is one of the significant ways in which young people are being equipped to deal with the various challenges they face in life:

Life skills are abilities for adaptive and positive behaviour that enable individuals to deal effectively with the demands and challenges of everyday life (WHO definition). In particular, life skills are a group of psychosocial competencies and interpersonal skills that help people make informed decisions, solve problems, think critically and creatively, communicate effectively, build healthy relationships, empathise with others, and cope with and manage their lives in a healthy and productive manner. Life skills may be directed toward personal actions or actions toward others, as well as toward actions to change the surrounding environment to make it conducive to health (Aldinger *et al.*, 2003: 8).

Life skills education differs from the traditional health education methods because it actively engages children through using interactive and participatory teaching methods. This encourages them to think critically about issues as well as to practice communication skills for decision-making and negotiation (Aldinger *et al.*, 2003). Life skills education programmes have been introduced in schools in many countries around the world and one of their aims in sub-Saharan Africa is to educate children about their sexual health. In Zimbabwe, the Ministry of Education, Sport and Culture with the assistance of UNICEF, responded to the increase in HIV rates by launching a mandatory AIDS education curriculum in 1993 called the 'Zimbabwean National AIDS Action School Programme' (Chifunyise *et al.*, 2002; James-Traore *et al.*, 2004). The AIDS Action Programme was initially aimed at pupils in grade 7 (last year of primary school) to form 4 (fourth year in secondary school), but has been extended to include primary school pupils in grades 4, 5 and 6 (9-12 year olds) (Bassett & Kaim, 2000)⁴. This programme is part of the national curriculum and uses participatory learning techniques to impart information as well as promote values (Bassett & Kaim, 2000). The materials utilised in this programme are thorough, comprehensive and age specific (Ministry of Education and Culture, 1993). They do not only deal with issues about HIV/AIDS but also address relationships, growing up, Life skills and health thus encompassing the variety of challenges young people face (Ministry of Education and Culture, 1993). The materials are meant to be administered in a participatory way so that young people do the exercises in groups, work out solutions to the various situations that are presented in the material, and

⁴In Zimbabwe children begin school aged 6/7 years; they spend 7 years in primary school and then four to six years in secondary school.

have discussions on their own and with their teacher (Ministry of Education and Culture, 1993). The potential for this type of programme to have an impact on children and adolescents' attitudes and behaviour is enormous. The effectiveness however is partly dependent on how well the curriculum is administered; teachers are therefore an important resource. With this in mind, in 1994 the Zimbabwean Ministry of Higher Education and Technology embarked on a joint nationwide project with UNICEF to train student teachers in STI and HIV/AIDS prevention (Chifunyise, *et al.*, 2002).

Conducting HIV/AIDS prevention in schools is not unproblematic. First, some important areas have been left out of the Zimbabwean curriculum: human reproduction is not covered in the Life skills course but in biology lessons; contraception and STIs along with the social context of sexual activity are not included and neither is information on the use of condoms (Bassett & Kaim, 2000). These are crucial topics, which if discussed within the context of the Life skills curriculum would have a significant impact; omitting them leaves major gaps in the children's education. Second, the school is embedded in society and as such is a context infused with societal norms and values, thus the open and participatory methods advocated by the Life skills curriculum may be difficult for teachers with conservative attitudes to administer (Chifunyise, 2002). Teachers' attitudes towards children, their use of corporal punishment as well as their inappropriate sexual advances/abuse of children put them in a position where they may not be trusted by the children; heads of schools may choose to only include aspects they feel are appropriate for children and omit other significant issues (Power *et al.*, 2004); some of the teachers' lifestyles may be incompatible with the safe sex message they are supposed to teach; and parents may not want their children to be taught about sexual matters at primary school age (Power *et al.*, 2004). Third, many Zimbabwean schools are overcrowded and may not have the adequate resources to carry out the programme efficiently and teachers may also lack training in skills required to administer the materials (Kaleeba *et al.*, 2000). Fourth, the Life skills curriculum is not examinable therefore teachers who are under pressure to produce good exam results under extremely difficult conditions may choose to concentrate on teaching academic subjects rather than Life skills (Bassett & Kaim, 2000; Power *et al.*, 2004).

Interventions by NGOs have reflected some positive results and shown how local research can be used to develop context specific prevention projects. Sherman and Bassett (1999) implemented an intervention project as a result of findings from a qualitative study with 100 secondary school students (aged 14-19) in the greater Harare area. The results from this research indicated that adolescents were sexually active and would benefit from a forum where they could safely ask questions about sex, express their feelings, and learn appropriate communication skills (Sherman & Bassett, 1999). The intervention involved training 67 male and female teachers from 37 schools, to facilitate group discussions on sexuality by simulating real-life experiences through decision-making games, role playing and other interactive exercises (Sherman & Bassett, 1999). Five two-day workshops were held with the teachers and written and oral evaluations indicated that the participants had gained valuable experience, knowledge and skills from the workshops. In addition to the workshops, follow-ups were made providing more information and support to the teachers. The results showed that the intervention provided a forum where adolescents could discuss issues related to sexuality and learn communication skills, and that both the students and teachers were enthusiastic and positive about the intervention (Sherman & Bassett, 1999).

Furthermore, the study by Kaim *et al.* (1997) (described earlier in this chapter) led to the development of a reproductive health education pack called 'Auntie Stella'. This education pack is based on stories, experiences and needs expressed by the adolescents themselves and uses the question and answer format of letters to an 'agony aunt'.

It is a classroom based activity pack for secondary school pupils aged 14 and above which, consists of 33 question and answer cards, the questions are supposedly written by adolescents seeking information and/or advice on a number of topics. The answer cards give Auntie Stella's reply. The topics covered include normal reproductive development, social and economic pressures to have sex, gender roles, forced sex, communication in relationships and with parents, depression, wanted and unwanted pregnancy, infertility, cervical cancer, HIV/AIDS and sexually transmitted diseases. The cards are discussed in small groups, which are usually of single-sex with minimal intervention by the teacher (Kaim & Ndlovu, 2000: 46).

The Auntie Stella pack was implemented in several schools in one region and evaluated after a few months. The students stated that as a result of this intervention

there was an increase in communication with their parents, community members and their peers. They claimed to have greater confidence and an increased ability to make informed decisions and take initiative. The students also felt they were more capable of advising their peers on reproductive health issues (Kaim & Ndlovu, 2000).

These interventions (Bassett & Sherman, 1999; Kaim & Ndlovu, 2000) show the importance of using local research as a base for formulating interventions and also the importance of using participatory qualitative methods to elicit information from adolescents to make programmes addressing their expressed needs. Studies in Zimbabwe and Uganda show that although cultural taboos may initially make pupils uncomfortable talking about sex within the school context, well-trained teachers make good facilitators and with time the students relax and open up (Kaleeba *et al.*, 2000). In order for teachers to be more effective sexual health educators, there is a need for a shift to a school environment where children are respected and supported more than they are punished and beaten.

3.7. Summary

This review has shown how the HIV/AIDS pandemic in sub-Saharan Africa has brought to the fore young people's sexual and reproductive health. It has shown the importance of addressing young people's sexual health, not only because they are at risk of contracting HIV/AIDS but also because of the other risks of STIs, early pregnancy, abortion and infertility (Zabin & Kiragu, 1998; Silberschmidt & Rasch, 2001). Up until recently the focus has been on reproduction and contraception. The advent of HIV/AIDS has brought about the need to talk about sex, not just as a means for reproduction but also as a pleasurable experience, and the importance of using protection such as condoms. The epidemic also highlights the reasons young people have sex. Although this is difficult for adults to accept, especially with regard to children, it encourages a more holistic discussion of sexuality, not one only limited to biology and reproduction. The epidemic has forced adults to accept that young people need to learn about their sexuality and sexual and reproductive health so that they can make safe choices and have healthy and fulfilling sexual relationships. In terms of research, the biggest gap is the lack of studies with children. As the age group with the least HIV infections, it is vital that they are included in HIV research so that

programmes are developed that target their expressed needs. By waiting until children are 15 years or older, the research community may be missing opportunities to make an impact on the sexual behaviour of this group. Although significant research, prevention and education work addressing adolescents' sexual health education needs has been conducted in Zimbabwe illuminating many critical issues concerning adolescent sexuality, there is still room for improvement. Regional studies have also provided insight into certain aspects of adolescent sexuality. Whether these issues are relevant to children requires more research specifically focusing on children rather than relying on knowledge acquired from adolescents.

The majority of children (aged 6-14) remain relatively 'AIDS free'. In order to maintain this healthy status, more research is needed to understand their sexuality and the societal, spatial and temporal influences at work in their lives. Continuing to focus research on adolescents will not only perpetuate society's neglect of children's sexual education needs, but will also result in losing the opportunity to nurture a generation that can build a society free from HIV/AIDS. This research will therefore take up the challenge of engaging primary school children aged nine to fourteen years in discussions about their HIV/AIDS-related knowledge, their attitudes towards the disease and how this knowledge together with their attitudes impact or will impact on their sexual behaviour. The focus of this study will be on the children's experiences and on listening to their voices, as well as stimulating them to view their own attitudes and behaviour critically, and maybe begin a process that will lead some of them to adopt protective behaviour.

4. Research with children: Epistemology, Methodology and methods

4.1. Introduction

This chapter is divided into three sections. The first section will deal with epistemological issues and how these have influenced my choice of methodology and subsequently the methods I have used in this research:

... in all research, what is important is that the particular methods chosen for a piece of research should be appropriate for the people involved in the study, its social and cultural context and the kinds of research questions that have been posed. (Christensen & James, 2000: 2)

The chapter will outline my particular approach to research and why this belongs within a specific epistemological framework. Chapter 2 described the theoretical or philosophical ideas that have influenced this research and how these can be applied to studies with children. I will thus elaborate on this further by explaining how these theories place my research within a particular epistemology. I will also discuss how this has led to the utilisation of a specific methodological approach and why the methods used in this research were selected (see Graham, 1999).

The second section will describe and discuss the research design and my attempts to apply the epistemological and methodological concepts discussed in section one, during the data collection process. Fieldwork is an ongoing process that began before I travelled to Zimbabwe and that is still continuing as I analyse my data and write this thesis (see Katz, 1994). The final section will discuss the data analysis methods used. It will begin by discussing the quantitative data analysis i.e. the methods applied to this process and why they are most appropriate for the study. The qualitative data analysis will then be presented beginning with discussion of the data transcription and translation. This is an integral part of the process of research and of the production of results and it is important to outline the steps taken clearly. Baxter and Eyles (1997) argue that 'it is necessary to elaborate how data get transformed into concepts' as part of the demonstration rigour in qualitative research. The analysis of

the diagramming and interview transcripts will then be presented outlining the method of analysis used.

4.2. Applying feminist epistemology to child research

There are parallels between the increase in feminist research as a result of the realisation that women were under-represented in research studies (Gilbert, 1994; Nast, 1994), and the rise of childhood studies due to the recognition that children have been under-represented in social science research (Christensen & James, 2000; Woodhead & Faulkner, 2000). Or, more accurately, that children's voices have been muted in research and they have been treated as objects rather than thinking feeling beings. Chapter 2 suggested that feminist theories are most applicable to this research and this section will discuss how this has led me to adopt a feminist epistemological framework. I will thus begin by defining the term epistemology:

Epistemology is a 'theory of knowledge and should therefore concern the principles and rules by which you decide whether and how social phenomena can be known, and how knowledge can be demonstrated'. (Mason, 2002: 16).

By adopting a feminist epistemology I am asserting that feminism has developed 'principles and approaches' which best 'fit' my beliefs of how we can better understand issues related to children, sexuality and HIV/AIDS in Zimbabwe. There is no single feminist epistemology, just as there is no single feminist theory. However, one thing all feminist epistemologies have in common is that 'they recognise women's lived experiences as legitimate sources of knowledge' (Campbell & Wasco, 2000: 778). This is compatible with the ethos of *Children's geographies* which recognises that children are competent social actors capable of representing themselves in research, and that they have been marginalized by researchers and treated as a minority group in an 'adultist world' (Holloway & Valentine, 2000: 8-9). Because I regard childhood as a social construct, the aim in this research is to understand the ways Zimbabwean children negotiate their sexuality within their social spaces thereby reproducing or deconstructing and contesting the realms of childhood that society has constructed. Sex, sexuality and HIV/AIDS are sensitive topics and

feminist approaches are best suited to researching them because feminist geographers have explored similar issues with women (see Gilbert, 1994). Research on women's fear of sexual violence in public space is one example; engaging in studies that explore sensitive matters has led feminist researchers to develop or adapt appropriate ways of researching these issues (Valentine, 1992; Koskela, 1997). Campbell and Wasco (2000) outline three types of feminist epistemology: feminist empiricism, feminist standpoint theory and postmodernism. This study adopts an epistemology based on all three.

Feminist empiricism reflects a union of post positivist realism and liberal feminism. Because neither of its traditions calls for structural changes either in science or society this epistemological framework focuses on how to make our theories of knowledge less susceptible to gender bias. Feminist empiricism is based on the ontological assumption that a real, objective world does exist. ... (Campbell & Wasco, 2000: 781)

I am critical of feminist empiricism's focus on gender bias and its' disregard of the need for structural change which is imperative if there is to be any lasting change in society. Nevertheless, my work deals with issues of sexual health and HIV/AIDS. HIV/AIDS is not a social construct or an abstract idea but a concrete biomedical condition resulting in illness and eventually death (Young, 1982). Therefore when dealing with this material fact one must accept the notion that a real objective world does exist. Without acceptance that HIV/AIDS is a tangible phenomenon, little progress can be made in treating or preventing it.

Feminist standpoint theory is based upon postpositivist critical theory informed by the traditions of radical and socialist feminism ...working from the ontological assumption that that there is no single objective truth, this theory claims that class, race, gender, and sexual orientation structure a person's understanding of reality. To survive, less powerful groups must be attuned to the culture of the dominant group. In fact, these individuals have the potential for a more complete and less distorted view of social reality precisely because of their disadvantaged position...(Campbell & Wasco, 2000: 781).

Although, from the definition above, feminist standpoint theory seems to contradict feminist empiricism, I would like to argue that they are both compatible within *my* epistemological framework. HIV/AIDS is a biomedical phenomenon that falls within the realm of natural science, however, it is also synonymous with human behaviour, relationships, society and culture which are the remit of the behavioural

and social sciences. Therefore it is not incorrect to say that there is a real objective scientific world of viruses and disease that we cannot deconstruct away (Young, 1982). The language used to describe HIV/AIDS may be dependent on societal and cultural constructions but these do not change the disease or the physiological effects it has on human bodies (Young, 1982). It is tangible, real and objective.

On the one hand, feminist standpoint theory claims that 'class, race, gender, and sexual orientation' as well as culture and generation 'structure a person's understanding of reality' (Campbell & Wasco, 2000: 781). Children experience the world differently and therefore perceive it differently from adults and, in order to understand the construct of childhood and appreciate the experiences of children we need to listen to their conceptualisations about their lives and how they construct reality. As a group they are less powerful than the adults who control many aspects of their lives, but within this adult controlled world children still interpret the world around them in their own way. This is not to say these interpretations are not influenced by their interaction with adults, but that they are not always the same (Harden *et al.*, 2000). Therefore, this thesis will try to determine how well they understand the biological reality of HIV/AIDS, as well as the ways in which they construct meanings of the world around them in relation to sexuality and sexual behaviour. Campbell & Wasco (2000) state that within the epistemology of standpoint theory, oppressed groups are encouraged to think about their situations in relation to their oppressors thus, creating the potential to raise their consciousness and think more critically about their situation. Children are under the constant surveillance and control of adults, and this can be understood as a kind of 'oppression'; therefore applying ideas of consciousness raising in this research with children is appropriate within this context. This study aims not only to gather information but to also stimulate children to begin thinking critically about their views and attitudes towards sexual behaviour and HIV/AIDS, how these have been constructed and the effect they will have on the decisions they make or will make in their lives (Ansell, 2001).

The third feminist epistemology presented in this thesis is postmodernism. Postmodernism asserts that there is no single truth or reality and rejects attempts to discover absolute truths (Campbell & Wasco, 2000; Kitchin & Tate, 2000). It is a

way of thinking that offers useful insights into this research because it is based on the idea that no discourse is superior or dominant to another, and that no voices should be excluded from dialogue (Kitchin & Tate, 2000). The oppression of children, mentioned above, is not only about the control adults have over them, but also about how children are oppressed by the discourses or practices of childhood i.e. the way adults are positioned or position themselves as superior to children. Thus adult views and knowledge are privileged over those of children. In relation to sexual matters and sexual behaviour there are stark differences between what adults think is true and right for children and what children themselves think or do. According to Campbell and Wasco (2000: 782) feminist postmodernists 'view the world as endless stories and texts, many of which serve to sustain the status quo of power and oppression'. Therefore, this research adopts a postmodern approach in its attempts to deconstruct the adult view of children as asexual and instead trying to understand how they view their own sexuality. By linking children, HIV/AIDS and sexual behaviour my research breaks away from the status quo of only attributing HIV infection in children to mother and child transmission and thus denying that children are sexually active. I attempt to access the voices of children who have been left out of the 'dialogue' on HIV/AIDS; and I acknowledge that expert researchers do not have all the answers.

While I accept that HIV/AIDS is a real and objective biomedical condition, my epistemological framework rejects the positivist way of conducting research. Positivists assert that in order for research to be reliable and valid it has to be carried out objectively, i.e. the researcher has to remain neutral and maintain a distance at all times from the research subjects so as not to contaminate the research (England, 1994; Harden *et al.*, 2000; Mohammad, 2001). It is not possible to be neutral and impartial when dealing with the social world. Because my epistemological framework considers people's social reality as socially and culturally constructed, the researcher is therefore part of that social construction (Harden *et al.*, 2000). When conducting research one has attitudes and opinions about the research project and towards the people involved and can thus not be objective, at least not in the placeless value free way advocated by positivistic tradition:

The openness and culturally constructed nature of the social world, peppered with contradictions and complexities, needs to be embraced and not dismissed. (England, 1994: 81)

Therefore, I view people as experts of their own lives in contrast to positivist epistemology that sees the researcher as the expert who is in control of passive research subjects and the research process (England, 1994). I may be an 'expert' in academic terms having formulated the research study, but the children involved in this study are the 'experts' of their own lives (Campbell & Wasco, 2000). Their knowledge of their environment and experiences is superior to mine and I thus rely on them to share this with me and in a sense, educate me (Holmes, 1998: 19). This does not preclude me from questioning their perspectives or gaining insights into their lives of which they, in their subjectivity may not be unaware, but encourages a reciprocal relationship, which is more symbiotic than parasitic. As England (1994) states:

... those who are researched should be treated like people not as mere mines of information to be exploited by the researcher as the neutral collector of facts. (England, 1994: 82)

Thus a feminist approach to research encourages respect for the researched and a certain amount of humility from the researcher. It encourages researchers not to go out to acquire knowledge of people's lives in a purely extractive manner, but to acknowledge that research is not a monologue with information moving in one direction, but a dialogue where there is a flow of ideas between researcher and researched (Skelton, 2001). These theories of how knowledge can be gained have therefore influenced my choice of a methodology that will best serve my attempt to apply feminist ideas to research with children.

My epistemological framework is one that therefore juggles the acceptance of the objective reality and threat of biomedical disease on the one hand, with how this interacts with the socially constructed realities of childhood, culture, sexuality and behaviour. My methodology will take all this into consideration in order to develop some understanding of the situation.

4.3. Methodology

While feminists may adopt many approaches and use many different techniques:

The overarching goal of feminist research is to capture women's lived experiences in a respectful manner that legitimates women's voices as sources of knowledge. In other words, the process of research is of as much importance as the outcome. (Campbell & Wasco, 2000: 783)

Within research there are always power implications between the researcher and the researched, whether explicit or implicit (Ansell, 2001; Holt, 2004). These are even more apparent when applied to adults conducting research with children because of the way children are socially constructed in space and the adult hegemony within societies (Harding *et al.*, 2000). It was therefore important to adopt a methodology that enabled me to work within the ethos stated in the quotation above. It was impossible to remove the embodied reality of my adult status, that I was older, bigger, from a different social class and more powerful (socially) than the child participants (Holmes, 1998: 19); but I could adopt a methodological approach that would acknowledge these differences and attempt to mitigate them and not emphasise them in the way that 'expert' hierarchical approaches do.

Kitchin & Tate (2000: 6) define methodology as 'a set of coherent rules which can be used investigate a phenomenon or situation'. Working with children presents obvious challenges, but these are more to do with the social construction of children's position in society, than with any limitations within the children themselves. Children are not incompetent but their competencies are different from adults'; they are thus perceived as incapable because their competencies are measured according to adult standards (Harden *et al.*, 2000). Therefore, if as researchers of *Children's Geographies* we regard children as competent social actors (Valentine & Holloway, 2000), this should also be applied to the methodology we use when studying children.

In order to be more inclusive and to ensure that children's voices are heard in research, it has been advocated that efforts should be made to minimise the gap between the researcher and the child/ren. Some researchers claim that by adopting various roles in relation to children: the 'friend role', the 'least adult role', the incompetent adult role, the gap between the adult and the child is minimised (Holmes, 1998: 17; Corsaro & Molinari, 2000; Holt, 2004). Holmes (1998) advocates adopting the 'friend role' when conducting research with children. She believes that such a role 'attenuates the researcher's authority that is implied inherently in the social status of grown up' (Holmes, 1998: 17). In performing this role in her research in schools, she

asked the teachers to treat her in the same way as the children, caught the school bus with them, attempted to learn the children's communication cultures, played with the children etc (Holmes, 1998). Although I understand the usefulness of her approach, especially since her research was predominantly with kindergarten aged children and involved participant observation, I am uneasy with this approach. Firstly, there are ethical concerns that arise from a researcher befriending children in order to acquire information from them. There will obviously be some negative consequences when he/she leaves the 'field site' and if the children have formed a strong attachment to their new friend. The children may be left with a sense of abandonment and some children may be more vulnerable to this than others. As researchers, especially when using ethnographic or qualitative methods, we occupy an unusual and in some ways artificial role in people's lives. We enter their lives for a specific purpose, give them our undivided attention for often long periods of time and then leave, in many cases never to return. Gilbert (1994) describes how she developed feelings of friendship and intimacy with the women she was researching, but acknowledges that at the end of it all she walked away. She admits that the interview experience was not always a pleasant one for the women involved, and that as researchers adopting feminist epistemologies we have to be careful when using ethnographic or qualitative methods because the openness fostered by these methods may result in harm (Gilbert, 1994; England 1994). Therefore, although a natural attachment may arise between a researcher and his/her participants it is important to always remember that we enter people's lives for only a brief period and specific purpose, and to make this clear to them (Holt, 2004). In most cases, the research or the main aim of the research will be to enhance our careers (Katz, 1994), and though the participants may benefit, we are the ones that receive all the credit. The 'friend role' as advocated by Holmes (1998) seems to ignore the embodied reality of the difference between children and adults and the power relations inherent in adult-child relationships. She seems to consider that by acting and being treated like a child, she somehow becomes one of them.

Secondly, Berry Mayall (2000: 121) describes the 'least adult role' as 'blending into the social world of the children, not siding with adults, operating physically and metaphorically on the children's level in their social world'. This is very similar to the friend role, but does not necessarily mention making friends with the children and I will thus present it separately. Although again, I can understand

why researchers would attempt this role, I agree with Mayall (2000) who perceives it as unsustainable, and who has been informed by children in her research projects that they are always aware of the power adults have over them. Ansell is critical of the 'least adult role' and asserts that:

Attempting to adopt a 'least adult role' in research with children, however neglects the fact that the researcher is inevitably seen/treated by children according to their own conception of child/adults relations. (Ansell; 2001: 109)

This highlights a key point that most researchers still need to get over the politics of trying to be the same as respondents in order to research them. A similarity with the researched can help but does not guarantee results (see Mohammed, 2001). There are always differences, not least that the researcher is there to conduct research – and this applies even in deep covert observation.

The third role is the 'incompetent adult role' (Corsaro & Molinaro, 2000). This is illustrated by the experiences of Corsaro during his ethnographic research with Italian preschool children. Because Corsaro was not fluent in Italian, was unfamiliar with the workings of the school, and had problems communicating with teachers, the children took him under their wing and decided they were better at teaching him the local culture than the teachers were (Corsaro & Molinaro, 2000). He was indeed incompetent in relation to the children within this context and his role was not only appropriate and honest, but it very explicitly acknowledged the expertise and valuable knowledge of children.

By being critical of the roles some researchers advocate in doing work with children, I am not promoting a positivist approach of distance and objectivity. I am only trying to present what I perceive as doing research responsibly and the importance of being aware of the effects our actions may have. Fulfilling all the correct ethical procedures will be meaningless if we leave behind children we have befriended and then abandoned.

Children are perceptive and they know when someone is sincerely interested in what they have to say, even if that person does not necessarily engage in childlike behaviour. They are not a homogenous group, therefore can also tell the difference between adult researchers whose role is predominantly to listen and learn from the

children and teachers who are there to talk and teach (Mayall, 2000:121). It is necessary to establish rapport with child participants, but trying to achieve this by being their 'friend' or adopting a 'least adult role' is not always the solution. Researchers should be honest in acknowledging their adults status and the inherent power and privilege that brings, but temper it with the respect and sincere interest they have for the children they work with (O'Kane, 2000; Holt, 2004). By taking this stance I may be accused of reproducing adult hegemony over children (Ansell, 2001). This, to some extent is true, but what is most important is fulfilling the ethos of the *New Social Studies of Childhood* by 'studying children as social actors in their own right' through being open, honest and taking children's experiences, views and opinions seriously (Holloway & Valentine, 2000: 5; O'Kane, 2000) and accepting them as legitimate sources of knowledge (Mayall, 2000:122; Ansell, 2001). This in itself is revolutionary within the disciplinarian patriarchal Zimbabwean context and I am destabilising the power discourses within that context by treating children as 'competent persons' (Ansell, 2001). I, therefore, adopt what Kim England calls researcher-as-suppliant:

Fieldwork for the researcher-as-suppliant is predicated upon an unequivocal acceptance that the knowledge of the person being researched (at least regarding the particular questions being asked) is greater than that of the researcher. Essentially, the appeal of supplication lies in its potential for dealing with asymmetrical and potentially exploitative power relations by shifting a lot of power over to the researched. (England 1994: 82)

So although I may know more about HIV/AIDS, from a biomedical perspective, the children's knowledge about what they learn, their social contexts, their lives and experiences, is far superior to mine. They have their own 'unique knowledge' (Mayall, 2000) about what it means to be a child growing up in Zimbabwe.

4.3.1. Adopting a mixed method approach

Campbell & Wasco (2000) dispute the assertion of some feminists that there are feminist methods especially designed for research with women. They claim that although feminists may have adopted and adapted certain methods; these methods are not new (Campbell & Wasco, 2000). A similar issue has emerged with regard to

children; researchers have been encouraged to use more *task* centred rather than *talk* centred methods with children (James *et al.*, 1998). This assumes that the children may not cope well with questionnaires or interviews. Task centred activities, for example asking children to express themselves through drawing, work on the adult assumption that all children enjoy drawing (Harden *et al.*, 2000). This reinforces the essentialist view of children as a homogenous mass. However, some children may not be competent at drawing and therefore find this type of expression frustrating (Harden *et al.*, 2000). Thus, it is necessary to adopt our methods according to the context and the participants (Graham, 1999; Prout, 2000). It is not a case of which methods we use in our research with children, but how we use these methods grounding them in our epistemological frameworks.

Using a mixture of methods in research with children serves to make the research more interesting because of the variation, and is also useful for triangulation of data. Triangulation is 'the use of multiple sources to enhance the rigour of the research' (Robson, 2002: 174). My research used two types of triangulation: methodological triangulation, by combining qualitative and quantitative approaches; and data triangulation, by using more than one method of data collection (questionnaire, participatory diagramming, drama, and interviews) (Robson, 2002). Both the methodological and data triangulation worked in a complementary way and built on each other as the research proceeded (see 4.4.7.4). A multiple-choice questionnaire was used to gather information that, early in the data collection, would give a general idea of the children's knowledge and understanding of HIV/AIDS. This information would also indicate, because of the sensitive nature of the topic, the appropriateness of the qualitative methods i.e. what kind of materials could be used. Therefore, instead of the questionnaire being a tool for objectivity, distance and neutrality, it helped to sensitise me to the depth with which I could approach discussions about HIV/AIDS and sexual behaviour. The group diagramming facilitated in-depth discussions about behaviour and attitudes and also helped to gain further insight into some of the answers given in the questionnaire. The interviews at the end gave an opportunity for the expression of individual opinions and experiences and also assisted in examining whether what was said in the group context was similar to what the individual said when alone.

There is a long history of quantitative studies measuring knowledge, attitudes and behaviour/practice in HIV/AIDS research. These studies dominated early HIV/AIDS research, but with the realisation that HIV/AIDS was about context rather than just behaviour, and there was a need to get deeper understanding of people's motivations and what led them to practice unsafe sex, more qualitative studies were conducted (Carrier & Bolton, 1992; Munodawafa *et al.*, 1995). Quantitative studies still dominate HIV/AIDS research although they may be supported by qualitative data. There are several reasons for this. Firstly, more weight is given to statistical data than to data that contain people's personal accounts of their experiences. Secondly, policy makers are more convinced that an issue is important if numbers rather than quotations support the research. Thirdly, quantitative data can be collected relatively quickly through surveys and questionnaires and provide a good overview of knowledge, attitudes and behaviour, and also information on trends within a given population. Therefore as this study not only aims to gain better understanding of the experiences of children but also to inform policy and practice it is necessary to include a quantitative component which provides data that is easily comparable and methods that are replicable. This is not to say that qualitative methods are not replicable but the nature of quantitative methods encourages replication. It is also necessary to provide quantitative data on the HIV/AIDS knowledge of this little studied group of children.

Research on sex, sexuality and HIV/AIDS requires sensitivity not only towards the research participants but also a sensitivity that takes into account that sexual behaviour is a social and cultural construct as well as a private and personal activity (Hugyens, 1996). Thus the use of qualitative methods was especially appropriate within the context of this research:

Qualitative methods are concerned with how the world is viewed, experienced and constructed by social actors. They provide access to the motives, aspirations and power relationships that account for how places, people, and events are made and represented (Johnston *et al.* 2000).

Therefore a mixed method approach to my research was useful in providing a more holistic picture or more complete answers to the questions I was asking. Use of both qualitative and quantitative methods reflects that as researchers we are no longer

restricted to using only one or the other. However we still have to be aware that we may have to confront our epistemological choices if the different methods we use produce conflicting results and decide which results we place more emphasis on and why. Thus it is important for research to be firmly grounded in an epistemological framework.

4.3.2. Adopting a participatory action research (PAR) approach

One of the research aims was to include local stakeholders as much as possible so as to develop research questions that would generate information useful not just to myself but also to those in Zimbabwe undertaking HIV/AIDS education and prevention with children. I also aimed to try and stimulate the children, through discussions, to look critically at their own attitudes and behaviours in order to hopefully generate change, where appropriate, in HIV/AIDS and sex related knowledge, attitudes and behaviour. Therefore, the research was placed between conventional research's aim to 'generate knowledge for understanding' (Cornwall & Jewkes, 1995: 1667) and participatory action research (PAR)'s aim to:

...attempt to address the problems of representativeness and unequal power arrangements between researcher and researched within social research by fully integrating research subjects into the research process...the role of the academic becomes enabler or facilitator: the academic takes a supportive position and seeks to inform and impart knowledge and skills to the research subjects. (Kitchin & Tate, 2000: 25)

Therefore the goal of PAR is not only to describe social reality but to also change it (Johnston *et al.*, 2000; Kesby *et al.*, 2005). My research was framed within the principles of participatory action research but did not involve 'deep' participation (Kesby *et al.*, 2005). It partly adopted a PAR approach and utilised participatory techniques during data collection. These techniques belong to a family of diverse and often experimental tools developed and/or utilised in developing countries (Kesby, 2000). The techniques were developed specifically for use with people with low levels of literacy and are thus predominantly visual (Cornwall & Jewkes, 1995). Participatory diagramming is one such technique: it was developed in such a way that it could be used anywhere with whatever materials were available: sticks, stones,

bottle tops, beans etc can be used as research materials (Kesby, 2000). This makes it ideal for use in Zimbabwe with children who may be literate but not be used to articulating their needs; diagramming takes the focus away from the children and puts it onto the diagram thus facilitating discussion based on the diagram (Kesby *et al.*, 2005). The techniques 'focus on visual methods of communication, which are not exclusive and enable those whose voices are rarely heard to actively participate' as well as enabling researchers to gain insights into the contexts of children's lived experiences (Jones, 1995; Young & Barrett, 2001).

Participation is an important concept to consider because it connotes involvement and action. Calling someone a participant instead of a respondent gives an indication of the goals of the research. A participant is actively involved in the research, contributing to the development of the research process and with stakes in the outcome. A respondent or informant responds to questions and their role is to provide answers (Kesby, 2000). This has power implications: traditionally research has been *on* children, studying their development, observing and measuring them (Mayall, 2000; Woodhead & Faulkner, 2000) and in this type of research the children are already at a disadvantage because adults assume that they know more and thus there is an instant power imbalance. Using participatory techniques puts the adults in the back seat and hands the power over to the children (Young & Barrett, 2001) by acknowledging that they are experts of their own lives. The techniques enable the adult researcher to work *with* the children through attempting to enter their world of understanding and experience, thus the researcher's understanding and agenda may be modified through the research experience (Mayall, 2000). Asking the children to share and explain their understanding of the world with the researcher causes a shift in the balance of power and creates a space where children can speak up and be heard (O'Kane, 2000).

As stated earlier, this study was not fully participatory action research. Although the aim was to share power with the children through consulting them, the ultimate power rested with me. Hart (1992) designed a ladder of participation as a guide to thinking about the extent of young people's participation. The ladder has eight rungs; the bottom rung is labelled 'manipulation', this is where there is no consultation or understanding of the issues by the young people and therefore no

participation. The eighth and top rung represents full participation, where young people initiate the project and decisions are shared with adults (Hart, 1992). My research would fit in rung five which is 'consulted and informed' meaning the project is designed and run by adults but the young people understand the process and their opinions are treated seriously (Hart, 1992). The agenda for my research came predominantly from me, in fully PAR the agenda would come from the participants. I controlled the data, analysed it and, while my results have and will be shared with the participants, I am ultimately responsible for the presentation of the information gathered. Although the data will be used in an ethical way I have gained more from this experience than they have, through advancing my career. This lesser degree of participation was also because this was PhD research and therefore limited in time and resources.

Although this research has limitations as PAR, the use of participatory techniques still resulted in the research experience being a transformative one for the participants and for myself (Nast, 1994). This is not to claim that the short time I spent with the research participants changed their lives profoundly, but that the engendering of dialogue through using diagramming techniques encouraged interaction, discussions and the exchange of ideas amongst the children, and between the children and myself. This process resulted in change in knowledge and understanding within the children, as well within myself (Gatenby & Humphries, 2000). An important aspect of using participatory techniques is their active involvement of participants in a range of activities that can be enjoyable. This is beneficial when working with children because if they are interacting with the researcher in a fun yet challenging way the whole process is more likely to be positive. These techniques may help to minimise the effects of the generational gap and help to balance power differentials.

4.4. Research design

So far this chapter has outlined the approach adopted in this research; this section will now outline in detail the research design, methodology and techniques. The research was conducted in five phases all of which had participatory elements to

them. This section will therefore present the application of my epistemological framework and methodological approaches to the actual research process.

4.4.1. Study site

The study was conducted in a small urban area 40km south of Harare, the capital city of Zimbabwe. The area is situated off the main highway that connects the two major cities, Harare and Bulawayo (see Appendix 1). Although this area is urban it is surrounded by commercial farms and placed near two large lakes that have hotels and holiday resorts. It is also in close proximity to rural areas. The residential areas here are predominantly high density with some lower density residences on the periphery of the town. This area was chosen as the study site because: -

- The majority of the Zimbabwean population live in the rural areas. To select an urban sample, especially one from the capital city Harare, would have been convenient in terms of accessibility, but not illustrative of the general population. In order to be more illustrative, it would have been necessary to select a rural sample and this was not possible because of time limitations, and the unstable political situation in the country at that time. As a woman, an outsider and an academic, I was insecure about my safety in rural areas and did not wish to take unnecessary risks. Thus, this area was a good compromise because it is urban but in close proximity to farming and rural areas. It thus provided an urban and rural mix that is illustrative of the general population.
- The people in this area are of a predominantly low-income status as are the majority of people in the country. Therefore the experiences of the small sample involved in my study were illustrative of the sorts of issues and problems facing the majority of children in the country.
- An additional attraction to this area was the presence of Tsungirirai, a non-profit organisation that runs an orphan drop-in centre and carries out HIV/AIDS prevention and care work in the surrounding communities.

- Finally as stated above, this area is close to Harare and therefore had good transport links, which made it more accessible as I was living in Harare.

4.4.2. Gatekeepers: Tsungirirai and the school

Tsungirirai was established in 1996 with the vision of providing support and care to people infected and affected by HIV/AIDS (Ekhaya, 2003). Tsungirirai's main office is at its' orphan drop-in centre located in the study site, and it also has three satellite offices in the surrounding rural areas. Tsungirirai means to 'persevere and have courage' (Ekhaya, 2003; Tsungirirai, 2004); it seeks to strengthen the local communities' awareness and action by facilitating HIV/AIDS prevention programmes. In order to achieve its vision, staff at Tsungirirai work in partnership with the communities who are the beneficiaries of their programmes (Ekhaya, 2003). Tsungirirai's orphan and vulnerable children care programme identifies children who are living in extremely difficult circumstances and have either lost one or both parents, and assists them by paying their school fees, providing food and medication and giving them psychosocial support.

The school of geography and geosciences had links with Tsungirirai via my supervisor Dr Mike Kesby who had previously worked on research projects with them. Since we already had an existing good relationship with Tsungirirai, they were an ideal organisation to work with because they could introduce me into the community and also benefit from my research. Their work with children also made their centre an ideal base from which to launch my research. The study site is within the province of Mashonaland, which is a *Shona* speaking region. The local dialect in this region is *Chizezuru*; this is my dialect and therefore it was easier for me to communicate and to understand the various nuances within the language.

The school where the data collection took place also acted as a gatekeeper. Although Tsungirirai facilitated access to the area and the school; the school enabled me to gain access to the children.

4.4.3. Phase 1: Virtual participatory research design- January 2002-December 2002

Working with Tsungirirai provided the main part of the participatory component in the research. Since the organisation could potentially benefit from the results, its input was necessary in informing the design stage of the research especially in relation to whether the research idea was important and relevant. Therefore, contact was made with the then director of Tsungirirai months before embarking on data collection to determine:

- a) If there was a need for research on the HIV/AIDS and sex related knowledge, attitudes and behaviour of primary school children;
- b) If they would be interested in being involved in this project.

The director responded positively emphasising that there was a real need for research with younger children and they were interested in being involved. She informed me that the organisation had only been doing HIV prevention work with secondary school children and that the proposed research would inform future projects with primary school children. The organisation had intended to work with primary school children but had not had the time or resources to do so. Thus, over the months preceding travel to Zimbabwe, the director and I corresponded regularly. This was the beginning of collaborations and relationships that helped to fulfil the participatory ethos of the research.

Before travelling to Zimbabwe part of the research design had already been developed. However, this was only a preliminary design and the intention was to develop the methods further together with the Tsungirirai staff and children so as to obtain as much local input and knowledge as possible. HIV/AIDS and sexual behaviour are sensitive and potentially explosive topics and it was crucial to approach them as carefully as possible; thus working with Tsungirirai would provide with the guidance needed. Despite being Zimbabwean, having not lived in the country for some years and having little knowledge of the area, put me at a disadvantage. I had also had very little experience of working directly with children within the research context: this consisted of half a day collecting data from secondary school pupils in

the UK, as part of a week long course on participatory appraisal. Therefore, I relied on Tsungirirai to provide advice based on their expertise with children. Even though I was the 'expert' researcher, my 'expert' knowledge was good in theory, but limited where the practicalities of working with children were concerned.

4.4.4. Phase 2: Face to face participatory research design with Tsungirirai – January 2003- February 2003

On arrival at Tsungirirai the directors and the staff reiterated that the proposed research would be valuable and would benefit Tsungirirai's work. It was decided that for ease of access into the community and for obtaining research clearance from the District Education Authorities, and as my research results would be used directly by them, I would be introduced into the community as a Tsungirirai researcher. The research design phase with Tsungirirai involved meetings with some of the members of staff to discuss the aims of the study. Although a draft questionnaire had been developed prior to the fieldwork, this was revised together with the staff members and was translated into *Shona* to make sure the right terminology was used. These meetings also determined whether the tools proposed were appropriate for the target age groups, which questions or issues Tsungirirai wanted to be included in the study, and what was locally appropriate language. Tsungirirai also assisted in getting permission to work in the school by writing a letter to the District Education Officer. Although the plan was for me to be introduced to the community leaders, unfortunately I did not get the chance to meet them, but they were informed about the research. Working under the banner of Tsungirirai also provided easy access to the schools because they are a well-known and respected organisation. Entering the community as an individual researcher would have made it very difficult to gain access to the children for research purposes. The political situation in Zimbabwe made people wary because any type of gathering could be misconstrued as a political meeting.

4.4.5. Phase 3: Pilot study – January 2003

When the questionnaire and some of the diagramming tools were finalised they were tested to determine the suitability of the materials for the various age groups, the ease with which they could be administered, and whether the questionnaire was clear and easy to understand. Two adolescents (a boy aged 16 and a girl aged 17) were asked to check whether the language used in the questionnaire was appropriate and would be understood by children. They both found the questions clear. The children who attended Tsungirirai were used as a pilot group in an attempt to involve children in the development of the materials. However, it would have been more in line with the participatory action approach if they had been involved during the development of the materials, instead of only at the end of the process.

Most of the Tsungirirai children attended a local primary school where children from particularly poor backgrounds were over-represented. This school was therefore excluded from the sample population and Tsungirirai children who attended the school were included in the pilot study. This would prevent those children from doing the research activities twice or having to be excluded because they had already taken part in the pilot. The intention was to have approximately 24 children aged 10-14 participate in the pilot study and separate the children into same gender and grade groups during the piloting of the diagramming materials. However, because of confusion between the staff and myself, the day of the pilot study coincided with school sports practice, so only a few children could attend. Therefore the pilot group consisted of 10 children (six girls and four boys) aged 10-15 years. The session began with an explanation of the study; this was followed by the questionnaire, which was read out in both English and *Shona*. When the children had completed the questionnaire they were asked for feedback, and they said they had found most of the questions clear and easy to use. They had a few suggestions, which were incorporated in the final version of the questionnaire.

The children were then asked to take part in the diagramming session. This did not go very well and only the first two diagrams were piloted. This was because the boys and girls were not separated into same gender groups as we had little time; the children started arguing about one of their diagrams and I lost 'control' of the whole exercise. Eventually I sat back and listened while they argued over what was

acceptable gendered behaviour and attitudes. It was very interesting but it also demonstrated how important it is to work with the two genders separately, something I intended to do in the actual study. I also decided to change one of the diagramming techniques because it did not work very well. One issue that has been widely commented on is the tendency of boys to be a lot more vocal than girls and to intimidate them in group settings (UNICEF, 2005), however there was no sign of that in this group. Some of the girls were even more vocal than the boys, especially during the argument. It was amusing because when I did try to intervene, the boys accused me by of taking the girls' side (which I did because I agreed with their position) because I was a woman. Although I lost 'control' of this session it was enjoyable because the children had very strong views that they expressed vehemently and were not at all intimidated by my presence.

4.4.6. Phase 4: Choice of school – January 2003

Tsungirirai staff heavily influenced the choice of school because they were responsible for putting me in contact and introducing me to the head teachers. This was necessary because of the sensitive and suspicious political climate that prevailed in Zimbabwe, especially towards teachers and other educated professionals who the government suspected of being members of the opposition party. Thus, head teachers might have been unwilling to work with an unknown researcher who nobody could vouch for. However, approaching them through Tsungirirai placed me with a known and trusted local organisation that they could hold accountable if anything went wrong. The disadvantage was that I relinquished control over the selection of the school. There are six primary schools in this area and two were excluded: one is a private school which has children from wealthy backgrounds and would not have been illustrative of the general population; the other, mentioned earlier, was attended by children from the poorest backgrounds including many of the Tsungirirai children. This left four schools to choose from. It was decided that it would be best if the deputy director contacted the schools in the first instance as he had been already known by the school heads. He would tell them about the research and ask whether we could visit the school. He had problems contacting two of the head teachers, and the third was known to be uncooperative and unwelcoming to researchers and so was not contacted, the fourth head teacher was happy to talk to us. Because I was aware of

how busy the Tsungirirai staff was and appreciated the sacrifice they were making giving up their time and resources to assist me, I did not assert myself as I should have done, and insist we visit all the schools. Visiting all the primary schools in the area that were eligible for my study would have strengthened the research and enabled me to implement a purposive sampling strategy. However, I allowed Tsungirirai to guide me towards the school that had a cooperative head teacher and thus my sampling strategy was a convenient one.

The deputy director and I met with the head teacher, described the study and gave her a copy of the research proposal. She was very positive and receptive and saw this as an opportunity for her school to get some extra help with their Life Skills and HIV/AIDS education curriculum. She was ready to consent to the school's participation in the study, subject to us obtaining written permission from the District Education Officer. She had hoped that the research would include the whole school including the teachers, who she felt could learn something from me, and was disappointed when told that this was a small study. Nevertheless, I did state that I would share my findings with the school and give them some feedback.

Although we received permission from the District Education Officer to conduct the research in the school, I was concerned about getting parental consent and consulted the head teacher on the matter. She assured me that since the research was taking place at the school, they were responsible for giving consent and that she would inform the parents and let them know that the research counted as part of the HIV/AIDS education programme. This emphasised the importance of choosing a school as a study site because it would have been complicated to recruit participants by going to their homes asking parents if we could talk to their children about HIV/AIDS and sexual behaviour. Parents and guardians would have most likely been suspicious and maybe even hostile. However, if the parents were told by the school that the research project was useful and legitimate and in line with their own programme of teaching, then they would be more likely to allow their children to participate in the research.

The intention had been to hold focus group discussions with teachers from the school, to determine the content of the AIDS Action curriculum. On mentioning this to the Tsungirirai director it was suggested that I assess the situation at the school first

and consult the head teacher as the teachers would be very busy at the beginning of a new school year. On visiting the school it was clear how difficult this would have been because the school practised 'hot-seating'. This is a common practice in Zimbabwe where schools are not large enough to accommodate all the pupils at once so the children come to school in two groups: one in the morning and one in the afternoon. The same teachers taught these two sets of children, and were always in a hurry to get home by the end of the day. It was therefore unlikely that any would want to take time to talk to me after their long school day⁵. I managed to talk to the head teacher, her deputy, a senior teacher and the three class (grades five, six and seven) teachers of the children in the sample. This was unfortunate because speaking to teachers would have been a useful way to gauge their attitudes towards sex and to examine how the children were being socialised within the school context. This would have provided some insight into the underlying messages being passed on to the children when they are acquiring sex and HIV/AIDS related knowledge in the school, and how this may affect their ability to act upon the knowledge. During the meeting with the three class teachers I informed them about the study and asked about the curriculum. They taught the Life Skills and AIDS Action curriculum which consisted of discussions about moral issues. This subject was taught in one half hour slot per week. They also stressed that they incorporated HIV/AIDS related material in other subjects such as social studies, environmental science and counselling and guidance. The grade seven teacher, a man, was confident and seemed to be comfortable about teaching this curriculum although he stated that he didn't have enough text books to go around. He said he improvised by bringing in newspaper articles to stimulate discussion. He also said that his students were interactive and not embarrassed to ask questions. The grade six teacher, a woman, was also confident and said she had used questionnaires during her classes to assess the children's knowledge; she also stressed that the children were interactive and very inquisitive. The grade five teacher, again a woman, was not so confident and didn't seem as comfortable with the subject, she said her class found the topic embarrassing, were

⁵ The school day began at eight o'clock in the morning and ended at four o'clock in the afternoon..

shy and did not participate. I wondered whether it was partly because she herself was shy and uncomfortable with the subject. It would have been useful to sit in the classes and observe but I felt that this would make the teachers feel pressured as though they were being assessed. The teachers were also asked if there were any particular issues they wanted explored which would be useful in their teaching. They wanted to know how the children reacted to using different activities in class as learning aides, such as questionnaires and drama. I also asked them which term they used for the word *sex*, and they informed me that they used the English word *sex* and that the children were comfortable and familiar with it.

4.4.7. Phase 5: The main study – February 2003- March 2003

4.4.7.1. Sampling frame

Using schools as a sampling frame has been discussed in Chapter 3 within a broader context, however, the reason for focusing this research on school going children was due to two main practical reasons:

- i. Accessibility: the relatively young ages (9 -14 years) of the children in the study sample meant that they would most likely be attending school. Taking into consideration that the unstable economic and political situation in Zimbabwe is exacerbating poverty and therefore preventing many children from going to school; most children who did manage to go to school would be found in primary schools (see UNDP, 2005).

- ii. Time: due to the limited time (three months) available for data collection, it would have been time consuming (and probably unsuccessful) to go from house to house trying to convince parents to allow access to their children. It was not possible to recruit children through out of school clubs because children of this age group who could not attend school due to poverty would be unlikely to attend clubs.

The aim was to conduct the study in a school that had a mix of children from a variety of socio-economic backgrounds and from rural and urban areas. Out of the four suitable primary schools in the study site that met these criteria, Dzidzai⁶ School had a mix of children from urban, rural-communal lands and rural-commercial farms backgrounds. It had been decided to focus on only one school because this would still enable comparisons between the children's knowledge and behaviour at three different stages in school since children from three grades (five to seven) would be included.

4.4.7.2. Sampling bias

Doing research in a school introduces sample bias because only children whose parents or guardians can afford to pay school fees will be involved in the study. Those children who are too poor to afford school fees are left out of the study and they may be the most vulnerable. However, conducting the study in this way was justified because:

- This was a small PhD study and thus had certain limitations attached as stated in point ii) above;
- Part of Tsungirirai's remit involves paying school fees for children whose parents or guardians cannot afford to do so, thus the study did reach some disadvantaged children in this area in a way that would not have been possible in other areas;
- The research was partially participatory action research and disseminating the results to Tsungirirai meant that they could develop and conduct projects to reach out of school children. The findings will also be disseminated to other organisations such as the Southern African HIV and AIDS Information Dissemination Service (SafAIDS), the University of Zimbabwe and the Training and Research Support Centre (TARSC), to raise awareness of the dearth of knowledge about this age group and encouraging them to conduct work with out of school children.

⁶ Not real name of school

4.4.7.3. Two stage sampling procedure

Stage 1: The initial plan was to include all children at Dzidzai primary school in grades five, six and seven (ages 9-14) in the main sample. Only children in these grades would be sampled because the AIDS Action curriculum taught in Zimbabwean schools begins in grade four. Since the study was at the beginning of a new school year children in grade four would have just started the programme so it was decided to not include them in the study. Instead the sample included grade five children who had already received a year of HIV/AIDS education. Another reason for only including children that already had some HIV/AIDS education was my inexperience with children; because of the sensitive nature of the topics, I was not confident about discussing these issues with children who may have had little or no knowledge and no experience of discussing them. This may be a weakness in my research design and a reflection of my bias through constructing these younger children as incompetent. However, with hindsight it was the correct decision because children in grade 5, especially the boys were very shy and not very comfortable with the subject. Younger children may have found it even more embarrassing and awkward. The purpose of my study was to engage children and find out what they know and do, and not to traumatise them. My main sample eventually included children from three classes. This was because the school is very big with six classes in each year group and approximately 40 children per class. The head teacher thought this would present complications and suggested the selection of one class from each year group. So a purposive sample of three classes was selected as the main sample and all the children in those classes that were present at school on the day the questionnaire was administered were included. Those who were absent from school on the day the questionnaire was administered were automatically excluded from the study.

Stage 2: The children agreeing to take part in the first phase were asked to complete a self-administered HIV/AIDS knowledge quiz in the form of a questionnaire with multiple-choice answers (Appendix 2). Before the questionnaire was administered a systematic sub-sample of 36 children (18 girls and 18 boys) was selected from the main sample, by selecting every second name from the class registers. The sub-sample included an equal number of boys and girls because it was important to get the views of both genders. Many HIV prevention studies focus on

girls and women because they are more vulnerable to contracting HIV, however boys and men make the majority of decisions in relationships (UNICEF ESARO, 2003). In order to understand how boys are socialised and in order to be able to influence them positively to be responsible and respectful partners, they must be fully included in research on sexual behaviour.

Consent: In the first part of the study (questionnaire survey), consent for participation was covered by the group consent given by the head teacher. The children selected for the sub-sample were then taken aside and asked if they are willing to participate in the next phase of the research after receiving a clear explanation of what the study involved. They were told that they did not have to consent, and could withdraw from the activities at any time, with no negative repercussions. It was stressed that we wanted them to be involved and to enjoy the activities and if they felt uncomfortable or bored they were free to leave. Each child was asked in turn if they were willing to participate in the study and they all consented. There was no need to ask the parents to give consent for their children to be involved in the study because this research was conducted in collaboration with Tsungirirai, who already had permission to conduct research in the community and was thus covered by their consent agreements.

4.4.7.4. Field instruments and data collection

HIV/AIDS quiz

The questionnaire consisted of 17 questions on demographic details and 22 questions on HIV/AIDS related knowledge, attitudes and sexual behaviour with multiple-choice answers (see Appendix 2). Some of the HIV-related questions were adapted from other questionnaires that have been used with children from this age group (AVERT, 2002), and the attitude, information source and behaviour questions were developed together with Tsungirirai. The knowledge questions selected were basic questions about HIV/AIDS infection and prevention. The attitude questions dealt with myths and common beliefs about HIV/AIDS, and the behaviour questions focused on sexual activity. The multiple choice format was chosen because it would be easier for children who were less literate to identify letters and circle them as all the answers were read out. Children with low literacy levels would at least know the

alphabet and be able to identify it. A 'don't know' option was included in all the questions to help identify the number of children with no knowledge at all versus those with partial knowledge. The questions were originally written in English and then translated into Shona by Tsungirirai staff and myself. The final version had the questions in both Shona and English (see Appendix 2). The questionnaire would give the research team an idea of the familiarity of the children with issues related to HIV/AIDS, and inform the types of tools that could be used during diagramming.

My field assistant and I administered the questionnaire to the grade five class first during lesson time to establish how we would implement it and be uniform in the methods we used with the other two classes. My assistant Irene was a schoolteacher with research experience. We began by introducing ourselves, after asking the class teacher to leave because this was confidential. The participants were then told the purpose of the study and that some of them would be asked to take part in further activities. They were also told that they would have an opportunity to ask us questions at the end of the session. Icebreaker activities were conducted before the questionnaires were given out. Thorough instructions were given on how to answer the multiple-choice questions (a technique they were all familiar with). It was explained that the questionnaires were totally confidential and the participants should try to be as honest as possible, they did not have to write their names on the questionnaire. This was to instil confidence so the participants could respond truthfully knowing they could not be identified. It was also emphasised that those who were selected for the sub-sample had been selected randomly from the school register before the beginning of the study. This was to avoid stigmatising these participants and any suspicions of their being selected because they were sexually active or HIV positive. Each question was read out slowly twice, in both English and *Shona* to make sure the children understood, and then the multiple choice answers were read out.

The first part of the questionnaire comprised socio-demographic questions (see Appendix 2). After this section was completed it was emphasised that the HIV quiz was not a test but a way to find out how much they knew about various issues so they could be given more information. The confidentiality and anonymity of the information provided by them in the questionnaires was again emphasised. The

participants were asked to look over the quiz questions and given the opportunity to ask for clarification, they were told request clarification at any stage, and to refrain from consulting their neighbours. The questionnaire took 20 minutes to administer and the participants did not have any problems completing it.

When the questionnaires had been collected I went through the knowledge-based questions and asked the children for the answers. This was useful because there was now more interaction with the children as they excitedly gave us their answers. They were then given the answer sheets with all the correct answers to the knowledge questions to take away with them. Only answers to the knowledge questions (see Appendix 3) were given and not the attitude and practice questions because these are the only ones with clear right or wrong answers. Attitudes and behaviours would be explored during the diagramming sessions. The participants were asked whether they had any further questions and were informed that we would be available afterwards if there were any questions they wanted to ask in private. The participants were given feedback after the questionnaire session to enable those children who had not been selected for the sub-sample to get correct information and to give them the opportunity to ask questions. This was a way of partly fulfilling the research design's action orientation. It was also a way of getting an idea of where the children obtained incorrect information from and to begin to develop an understanding of how incorrect knowledge on HIV is spread. Giving immediate feedback instead of waiting until the data collection was completed was important because it would have more of an impact straight after the questionnaire while the issues were fresh in the participants' minds, rather than weeks later when they had forgotten. It would have been unethical to ask them to answer the questionnaire and then leave without supplying them with the correct information, thus missing an opportunity to correct misconceptions especially since this study was not governed by positivistic concerns of bias and contaminating data, but by feminist and participatory action research principles which consider the welfare of the participants before the purity of the data.

After the session was over the children selected for the next phase were taken outside, given more information about the study and asked individually if they wanted to be involved. The boys in this group were rather subdued, and I was unsure of whether they were interested in being involved. They were told that they were not

under pressure and should not be afraid to refuse consent. It was emphasised that they could quit the study at any time and there would be no repercussions. All the children consented to participate.

Irene and I administered the questionnaire to the grade six and seven classes simultaneously on the same day. After my sessions with the grade six participants, I asked those who had been selected for next two phases to come outside so I could give them more information and obtain consent. Many of the other children were eager to be involved and rushed out of the classroom, begging me to include them as well. I explained that we could not include every body but they were persistent and eventually the class teacher had to come and help. I was surprised and pleased by their enthusiasm and sorry that I could not include more children in the research.

(Alternative) diagramming sessions

This phase took place outside school hours, either before or after the children had classes depending on whether the children had classes in the morning or in the afternoon. The school day started at 8am until 1pm for one group of children and then 12.30pm to 4pm for the next group; the timetable alternated each week. The head teacher and the class teachers were given a research timetable for this phase of the study so they could inform the participants of when they were required.

The head teacher had given permission for the activities to be conducted on the school premises, which was useful because it was secure environment and the participants were familiar with the surroundings. It had also been advised that parents might not want their children to be seen at Tsungirirai because of the nature of its work, and the stigma still prevalent within the community. The sessions took place either in the school board room or the school library. The school board room was more convenient because it was mainly for staff meetings and thus afforded more privacy. There were only interruptions when the teachers came in at break time. The library was more public and both teachers and pupils often came in and out. This was problematic and we would either stop what we were doing until they had left or ask them to leave if they did not really have to be there. The concern was that the children would be daunted by the presence of teachers, but when teachers walked in mid

discussion, the children would continue the animated discussion loudly and I would usually have to ask them to stop until the person left.

Another problem was that the head teacher or her deputy had not informed all the teachers of our presence and research as promised and this was surprising and frustrating. On occasion, I had to explain the nature of the study and the need for privacy to teachers before they would leave the room. They were usually accommodating and supportive once they knew what we were doing. We were as polite and compliant as possible. For example, during the first diagramming session we were still working at 4pm when the deputy head teacher walked in. She told us that it was four o'clock, she wanted to lock up the school and leave and we should stop our activities immediately. She was annoyed and rather brusque, but we explained that we were unaware that they locked up promptly at 4pm, apologised and quickly packed our materials. This experience alerted the participants to our position as outsiders in the school subject to disapproval and censure from the school authorities, and may have helped them to identify with us a little more (Ansell, 2001). This is not say we were on the same level as the children but because we did not belong in the school and were therefore not always aware of the rules and regulations, the participants' knowledge and familiarity with the workings of the school environment gave them an advantage over us. We did not adopt a 'least adult' role (Holt, 2004), but occasionally we were ignorant adults with the children as our guides. After that encounter we made a point of stopping our activities before four o'clock.

The participants were put into same age and gender groups for the diagramming session. This is something that has been suggested as a way to avoid embarrassment and domination by older children or boys (Ansell, 2001), and also because people usually feel more comfortable discussing sex-related issues with others of the same gender (UNICEF ESARO, 2005). The unsuccessful diagramming pilot with the Tsungirirai children also reinforced that this was the best technique. Nevertheless, the plan was to bring boys and girls from each grade group together for the final diagramming session so there could be an exchange of ideas. Although I attended a participatory appraisal training course, Irene, my field assistant had more

practical experience using the methods in research and teaching and she assisted in developing the diagramming tools.

Each session began with an icebreaker facilitated by Irene, with both of us as participants. These were usually lively and at times had an HIV/AIDS related theme. We then all sat on the ground and, in the first session, we again explained what the study was about and that they were free to leave at any time. Confidentiality and their anonymity were again emphasised. They were also asked to maintain confidentiality about the issues discussed and it was stressed that they should not repeat what others in the group had said within the research context. It was expressed that we were non-judgemental and they should feel free to ask us about anything; we would endeavour to give them the correct information and if we did not know we would find out. The attempt here was to emphasise, both verbally and non-verbally, during the diagramming sessions that although we took the role of responsible adults, we were not taking a traditional disciplinarian adult role. Obviously there was need to maintain some kind of order so the sessions did not descend into chaos, but this was only necessary once when the grade five boys become a little unruly.

The participants were informed of the necessity to record the discussions using a tape recorder to facilitate our interaction with them and asked if they had any objections. None objected; they were excited at the prospect of being taped and fascinated when snippets of the discussions were played back to them. I facilitated all the discussions while Irene wrote notes and occasionally joined in the discussion.

Each session was one and a half hours long and if the activity was not completed by the end of the time slot, it continued at the next meeting. Although we learnt all the participant's names we decided for ethical and confidentiality reasons to give each participant a number instead of using their names, this made it easier to identify the voices during transcription because I had a clear picture of the participant related to each number. The girls were assigned G1 to G6, the boys B1 to B6 with the exception of the grade five boys who were accidentally assigned the letters A to F. The children were given badges to wear with their assigned number so they could be easily identifiable. We explained why we were doing this and they accepted it so wholeheartedly that they ended up calling each other by their assigned code during the sessions.

Diagramming tools

Tree diagrams

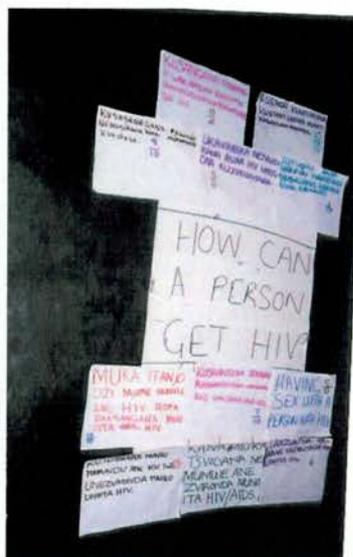


Figure 1. Grade six boys tree diagram

In this first diagramming session the children were asked to make a ‘tree diagram’ (Kesby, 2000b) representing HIV risk. The diagram had ‘roots’ leading into risk showing all the ways ‘a person catches HIV’; while the branches leading away from risk showed all the ways ‘a person can protect him/herself from catching HIV’ (Figure 1). The children were asked to discuss the ways a person can catch HIV and to write down all their ideas on pieces of paper using coloured felt tip pens, arranging the papers on the ground to form the tree diagram (Figure 1). Once their diagram was completed we joined them and proceeded to interview the diagram through asking them to read out what they had written and discussing their ideas.

Once this was done they were asked to rank each risk factor out of ten in order of its importance as a facilitator of HIV transmission (the highest risk factor warranting ten points, the lowest one or no points). This was a way of getting them to think through their answers and for us to gain more of an understanding about they how they understood these issues. They also had to try and come to a consensus about the ranking. We sat apart from them, observing and writing notes on the process. The reasons for their ranks were then discussed; the same procedure was followed for the second question, ‘how can a person avoid catching HIV’. This activity helped clarify

the children's understanding of HIV/AIDS and its causes as well as how they conceptualise it. It provided further insight on the responses the children had given in the questionnaire.

Body maps

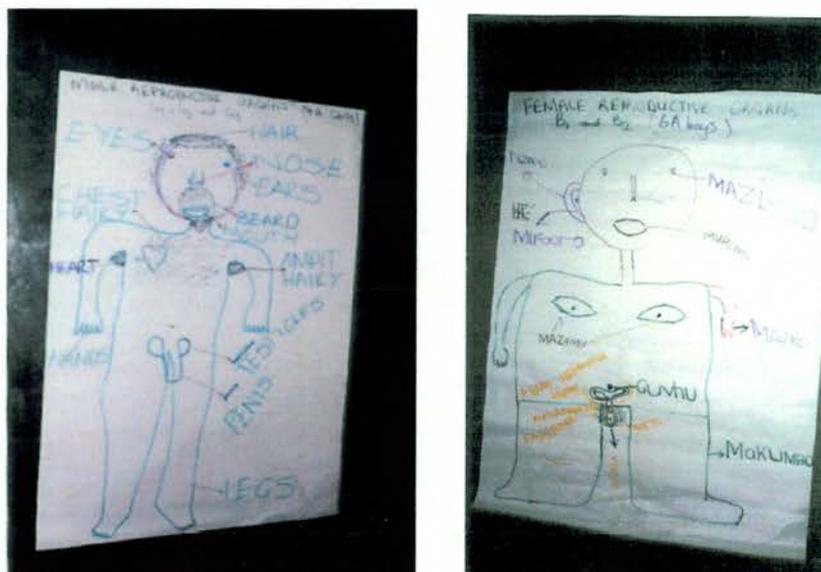


Figure 2 Grade seven girls' male body map and grade six boys' female body map

In this session the participants were split into two groups of three; one group was asked to draw an anatomically correct body of a woman and the other of a man showing the reproductive organs so we could see where babies come from and how HIV is transmitted (Figure 2). Initially I was unsure whether this activity should be placed early in the diagramming or later on because of its potentially sensitive and embarrassing nature. However, after the tree diagram sessions it was clear the children knew quite a lot about the body and were capable of discussing issues about sex and HIV. Once they had finished drawing the body maps they were asked to explain what they had drawn. The group that was not responsible for the diagram was also involved in interrogating the diagram. This was very interesting and there was a lot of giggling and embarrassment. We gave the participants euphemisms to use for the genitals because some of them were too shy to say penis or vagina. This was primarily the case with the younger participants; the grade seven boys and girls had no problems using the English words for the genitals. However, all the children were

uncomfortable using the Shona terms. This may be because English is their second language and the English terms are thus viewed in a more abstract way and not as loaded with cultural meanings as the *Shona* terms. After interviewing the diagrams the children were then asked to explain how HIV was transmitted using the body maps. When these sessions were over they were shown anatomically correct drawings, compared these to their body maps and the reproductive system was explained. This session helped to clarify how much the children understood about the mechanics of sex and reproduction and what would lead to pregnancy and HIV transmission. The children were given opportunities to ask questions. This was always done at the end of each session and sometimes during the session because of the participatory action orientated ethos of the study.

Spider diagrams



Figure 3. Grade seven boys' spider diagram of 'what is sex'

Building on what had been discussed during the body maps, this activity focused more on relationships and sexual behaviour. There was an effort here to clarify what the children understood as sexual intercourse. Firstly, each child was given a piece of paper and asked to find a spot in the room away from the others and to write down what they considered as sexual intercourse. They were not allowed to discuss because the point of this activity was to elicit individual opinions. The papers with their written answers (or spider legs) were then added to the body of the spider, which had the question *what is sexual intercourse* written in it (Figure 3). Each person was asked to read out what they had written; the diagram was interviewed and

attempts were made to clarify the answers given and where the information came from. They developed the second spider diagram as a group and presented behaviours that are not sex (see Figure 24); these were behaviours that took place between couples but were not considered as sex. This was to determine how they understood the difference between behaviours that were considered as sex and those that were not. The diagram was interviewed, detailed explanations of the behaviours were sought and the contexts within which they took place were also discussed. The participants were then asked to take the second spider's legs and make two columns; the first constituting behaviours that adults thought were acceptable for them to engage in and the second, behaviours adults considered unacceptable for them to engage in. These were further discussed and the same exercise was done again but this time regarding behaviours that *they* thought were acceptable or unacceptable. This was to examine whether the rules they had for themselves were different from those adults had for them, to what extent they were influenced by or conformed to adult opinions and why. There was also discussion of whether some of these behaviours could lead to HIV transmission, STIs or pregnancy. This exercise served to investigate their attitudes towards sexual behaviour, the norms within society and how the children understood and translated the messages being transmitted to them by society.

Picture/story cards and drama

In this final session with the separate grade and gender groups the participants were presented with six drawings, asked to select four and make up a story related to the scene in the picture. The drawings showed ambiguous situations and it was interesting to see how the children would interpret the scenes in light of what had been discussed so far. Picture one was of a girl and an older man outside a hut: the man was sitting on a stool talking to the girl who sat the ground. Picture two showed a boy talking to an older well-dressed woman; picture three, a girl and a boy walking into a house; picture four, a well dressed man standing by a large car talking to a girl coming from school. Picture five, a girl sitting on the floor and a man on a chair in a house, with a woman framed in the doorway walking away; picture six, a young man offering a girl a gift over a fence. The stories constructed by the children would indicate whether the children could identify situations that led to sexual behaviour or sexual abuse and knew how to deal with these situations. The participants' stories

usually had negative endings, thus they were asked to make up alternative endings to their stories, as a way of getting them to look at different possibilities and solutions to situations. They were then asked to select one story and act it out as a short play. This was done in order to provide a change in activity as well as to see how they represented the characters in their stories through drama. These sessions facilitated further discussion on sexual behaviour, as well as the contexts both social and spatial within which sexual activity takes place. It also gave an indication of what the children know about controlling or avoiding sexual activity.

Bridge diagram (mixed sessions)

The children were brought together into grade groups and this session was used to sum up all the activities that have been done. The bridge diagram (Figure 4), which was based on the stepping stones diagram (see Kesby *et al.*, 2005), was based on a series of diagrams that were put together to facilitate discussion of all the issues we had covered. Firstly, the boys and girls separated into same gender groups and created wheelbarrow diagrams showing why girls/boys their age have sex and who their sexual partners are (Figure 4). Each group presented their diagram which was then interviewed. The next diagram, the river of consequences, represented the negative consequences of early sexual behaviour; the third diagram, the bridge of avoidance, was built over the river of consequences and represented strategies to avoid falling into the river.

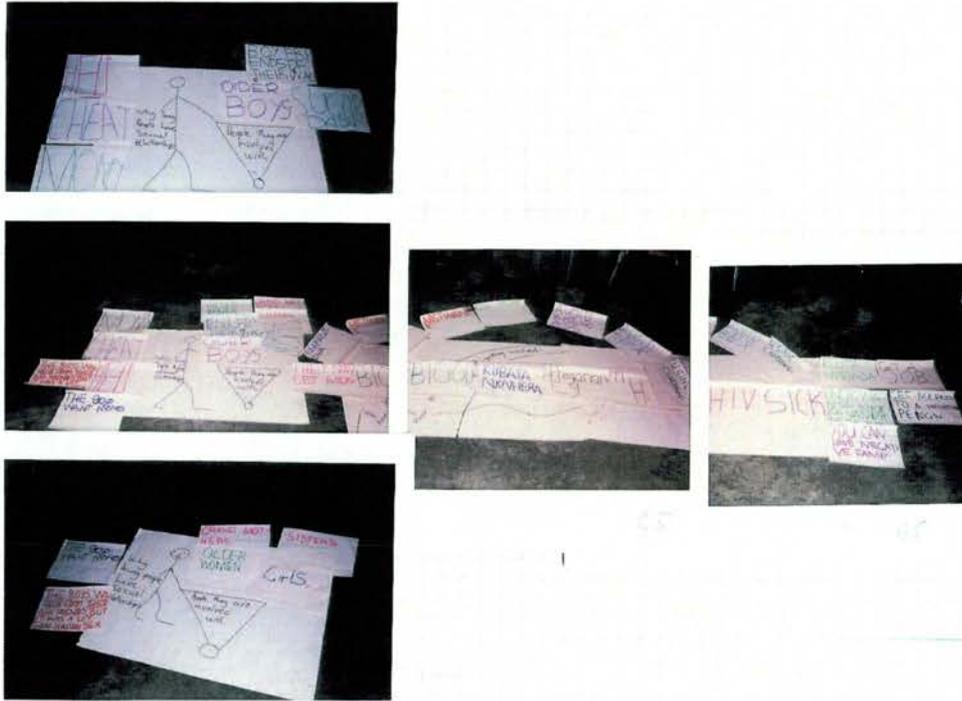


Figure 4. Grade five participants' bridge diagram

When the diagram was complete, the participants were asked what they thought their future would be if they crossed the river successfully and avoided the consequences of early sexual behaviour. This session facilitated further in-depth discussion on sexual behaviour, the causes and consequences and whether the children can act on the knowledge they had acquired in school and elsewhere. It helped to clarify whether the knowledge they were acquiring in the school was actually relevant to what they experienced outside or whether the social context outside the school is what determines their behaviour.

To conclude these sessions the participants were asked what they had thought of the research, whether they would like to learn more and what they wanted more information on. All the groups stated they had enjoyed the sessions and were keen to be involved in similar activities; they felt they still had a lot to learn and more questions to ask. After each diagramming session the children had been provided with refreshments of orange squash and biscuits. When the diagramming sessions were completed we thanked them for their involvement and participation and gave each of them a gift of stationery. In Zimbabwe children have to buy their own stationery thus it was appropriate to give them something practical and useful as a way to show our

appreciation for their participation. At this point they were also asked if they would be willing to participate in the interview phase and they all agreed.

4.4.7.5. Individual interviews

The interviews provided the opportunity to talk to individual participants alone and to build on what had been done so far in the study by focusing on personal sexual experience or the sexual experience of friends or peers. As we were interviewing all 36 participants, Irene was also involved in conducting interviews and therefore it was necessary to use a semi-structured interview (developed by myself) to ensure that we asked the same questions and to guarantee comparable responses (see Appendix 4). The interview schedule consisted of seven main questions and ten sub-questions; depending on the answer to the main questions, the participants would not necessarily answer all of them. The interviews took place at the school during lesson time and the participants were given permission to leave the classroom; they ranged from five to ten minutes in duration. Participants were interviewed in the library, in the boardroom, and outside in the school grounds. The interviews were all tape-recorded.

Before the interview began the purpose of the interview was explained to the participants; their consent was sought; the confidential nature of the discussion was emphasised; permission to use a tape recorder was requested. The interviews were left until the end of the data collection because it was hoped that the participants would be more familiar and relaxed with the research team and be able to communicate on a one to one basis. The purpose of the interviews was to find out whether what had been said within the group contexts was the same as what was said when the individual was alone. The interviews also gave the participants an opportunity to share information about personal sexual experiences that they could not share in the group context.

4.4.8. Phase 6: Dissemination/Feedback

The participatory aim of giving the findings back to the participants so they could use them (Kesby *et al*, 2005) was partly fulfilled through holding a meeting with the head teacher, the deputy, the participants' class teachers and a senior teacher.

Each group's bridge diagram had been reproduced and these drawings were presented to the class teachers. They were pleased to have them and said they would use them as teaching aides. A preliminary report of the findings based on recollections from the data collection, and highlighting what were considered important points for action was presented (Appendix 5). The teachers were very receptive and pleased about the research and reiterated that it would have been good if all the children could have been involved.

They also reported that the study participants seemed to have enjoyed the process. The grade six teacher told me that when she had asked the participants from her class about the activities they said they were not allowed to tell. It was significant that the children had taken our confidentiality agreement so seriously and this again reflects how competent and capable children are in taking responsibility and being involved in research. The teachers also expressed admiration at our ability and confidence to discuss these sensitive issues in such depth; the grade six teacher stated that she could never do that. This was informative because it reflected the lack of training teachers have in discussing these issues. Earlier in an unrelated discussion with a teacher from a primary school in Harare, I had been told that the Ministry of Education provides teachers with an information pack and asks them to teach the AIDS Action curriculum without any training or support. This presented difficulties for them because not everyone is comfortable or capable of talking about sexual issues with children; thus teachers would avoid those topics and focus on less sensitive issues. Although teacher training schools now provide training on how to teach the Life skills course, older teachers have not had this training.

As a token of appreciation for allowing the research to take place in the school, a donation was made to the school. The head teacher decided to use this money to help pay school fees for the term for orphaned children who had not yet paid the term's fees and were going to be excluded from school⁷. This was a practical

⁷ This is common practice in Zimbabwean schools. Parents and guardians are given a few weeks at beginning of term to pay the school fees and if these are not paid by a certain date the children are excluded from school until payment is made. Children can also be excluded for not having school uniforms.

and positive use of the funds. The head teacher sent me a list of the children who had been assisted by the donation and I noticed that two of them were from my sub-sample; an unexpected and gratifying side effect of the research. Furthermore, it was significant that these two were amongst the most articulate and well-informed children in the group; the boy was being brought up by his mother (paternal orphan) and the girl by her grandmother and despite their financial constraints, these caregivers seemed to be managing to communicate some good information to the children.

Financial donations were also made to Tsungirirai towards their work with orphaned children. A meeting was held with the director to give her a report of the preliminary findings with suggestions for action, and to discuss my experiences (see Appendix 6). She said that they would make more of an effort to get into primary schools and use some of the tools they were using in secondary school to generate discussion. Plans were made for continued communication and the sharing of the research results as they were generated.

4.5. Reflecting back on the research experience

This section will be presented in two sections. The first section discusses what is meant by reflexivity in the context of this study and then presents some reflexive accounts of the data collection process. The second section is a presentation of the participants from the sub-sample, and provides details of the interactions of the children within the groups as well as reflections of my interactions with the different groups.

4.5.1. Reflexivity

An important component of research based on feminist epistemology is the need to be reflexive throughout the research process. According to England,

... reflexivity is self-critical sympathetic introspection and the self-conscious analytical scrutiny of the self as researcher. Indeed reflexivity is critical to fieldwork; it induces self-discovery and can lead to insights and new hypotheses and research questions. (England, 1994: 82)

This challenges the notions of neutrality and objectivity that encourage the researcher to maintain a distance from the researched in order to avoid contaminating the research findings through bias (Kitchin & Tate, 2000). Research is not a static process with unchanging goals and objectives, but a fluid one, connected to the research context within which it is situated. Thus the Academy, the 'field' and the researcher's own personal circumstances, are part of and affect the research process (England, 1994; Mohammad, 2001). Being reflexive therefore requires me to acknowledge my influence on the research process and take into account my own personal culture and the effects this has on my interaction with the participants and on my interpretation of the fieldwork process. By attempting to be reflexive I will be exposing my biases and the limitations of my research and thus legitimising my work (Mohammad, 2001). The process of being reflexive encourages the researcher to not only look outward, but to also look inward; therefore, the research process produces not only knowledge about those being researched but about the researcher her/himself. I acknowledge that it is not possible to be fully reflexive or fully transparent (Rose, 1997) because my view of others and myself is always partial and incomplete. Nevertheless by attempting to be reflexive I am acknowledging my presence in the research process and avoiding the illusion of objectivity, thus validating my work.

This chapter already contains some reflexive accounts and this section will attempt to reflect more on my experiences and how they affected the research process. Firstly, the fieldwork experience emphasised the difference between the expectations one has of the data collection process and the reality of the field site. Being Zimbabwean, I had travelled to the country with many preconceptions about what the experience would be like. In some ways I was apprehensive and in other ways I had underestimated just how challenging the whole process would be. For example, there was a severe petrol shortage in the country for the duration of my field visit, which impacted greatly on my mobility and reduced the time I had at the study site.

Because of the difficult situation in Zimbabwe and the hours spent in petrol queues, I was physically, mentally and emotionally exhausted by the time the data collection was completed. Although I managed to stay calm and patient during the diagramming sessions, there were occasions when I was tired and irritable.

Nevertheless I made an effort not to take out my exhaustion on the participants. However, listening to the tapes, I can identify times when I was tired and somewhat impatient: one grade six girl had a tendency to repeat what someone else had just said and initially I had no problems with this and would patiently let her talk. However, towards the end of the fieldwork I was less tolerant and when she indicated wanting to say something, I would ask if she really had something new to add.

Another episode that caused some anxiety involved the issue of condoms and the head teacher. During the diagramming sessions the participants often talked about condoms. However, despite most of them having seen used condoms discarded on the streets, many had not actually seen unused condoms. The grade six girls were particularly eager to see condoms and seemed to have some misconceptions about where and how they are worn. It was therefore decided that we would ask the head teacher for permission to show the children both male and female condoms and maybe even demonstrate how they are worn using health education materials. We did not anticipate any resistance because the AIDS Action Programme was being implemented in the school and the head teacher fully supported the research. However, when asked about the possibility of showing the children condoms as part of the action-research orientated feedback sessions she strongly objected and stated that the school's policy was to promote abstinence. Moreover, she suggested that the children were too young to be shown condoms 'because they might go out and use them'. The irony of these statements was that we then proceeded to have a long conversation in which she and the deputy head teacher relayed information about primary schoolchildren who were sexually active and some who were being sexually abused by parents or relatives. I was incensed that these women who were clearly aware of how much children are at risk were willing to withhold knowledge that might help save their lives (obviously not in abuse situations). I also had conflicting feelings because my loyalty was first and foremost to the children and not to the adult teachers. Everything they had said had gone against everything I believe. I wondered whether or not it was ethical for me to ignore the children's request knowing full well that the teachers' concerns were not based on any real evidence but their own prejudice.

After some agonising and discussion with Irene, who felt as I did, we decided that we would go ahead and only show the children male condoms as most of them had already seen them on the road and thus we would not be showing them anything new. However we would not show females condoms or demonstrate how condoms are worn. We only showed the grade six group since they had asked to see condoms. During the session, which was held in the school library, one of them found a book in with illustrated instructions on how wear a condom, which they all had a look at. This book was a surprising find in a school that promoted abstinence and further contributed to the contradictory messages within the school.

A few months later, back in Scotland at a postgraduate training weekend, I brought up the issue during a discussion on ethics to see what others thought. One participant said what I had done was wrong because if the children told their parents, the head teacher would be in trouble. This was an issue I had not considered, and it made me wonder whether I had put my own agenda forward by not respecting the wishes of the head teacher and thus behaved unethically. I also remembered that her husband was the District Education Officer and that she could have been advocating the official policy and not wanting to jeopardise her husband's position. However, although I now have a better understanding of her position, I still do not agree with it. I would have felt hypocritical telling the children that we could not show them condoms because the teachers thought they were too young and irresponsible. This would have made us the same as every other adult that imposes their own rigid morality on their lives. By meeting their request and trusting they would maintain the confidentiality we had agreed on, I hope our actions did not have any repercussions for the head teacher or Tsungirirai. I realise now that as researchers it is easy for us coming from a different context and not having the day-to-day responsibilities and constraints that the teachers have to face every day, to be critical and judgemental of their attitudes.

These few reflections indicate how different the reality of actual data collection can be from expectations. I had thought that working in Zimbabwe and in a school would make the research experience straightforward and easier to manage. I was naïve and have learnt not to take anything for granted regarding the research

process. Thus, I will not only endeavour to be reflexive in this section but throughout this thesis.

4.5.2. Characteristics of Participants and group dynamics

4.5.2.1. Group work

This section will briefly describe each group and outline the group dynamics as well as the development of the relationship between the participants and the research team, to provide further insight into the data collection process. I will reflect on my own my feelings and attitudes towards the groups, which may have influenced my interactions with them. Although I attempted to interact with them all in the same way, qualitative research is by nature a dynamic social interaction. Thus, the outcome of the meetings varied and we developed a better rapport with some participants and groups than others. The 36 participants in the sub-sample were divided into six groups by gender and grade, and then three mixed gender groups by grade. Each group was distinct in character dependant on the personalities of the children making up the group.

Group 1-Grade 5A boys: There were four boys in this group aged 11 years and two aged 10 (information on age was obtained from the school register). The boys' knowledge, as displayed during the tree diagram sessions, was generally fair but their understanding of the body was poor. This was the most difficult group to work with because most of the boys were shy and quiet. We also had some difficulties with attendance in this group, which raised concerns about the boys' interest in participating in the project. We spoke to the boys about this and reiterated that they were free to leave the study at anytime if they were not enjoying the activities.

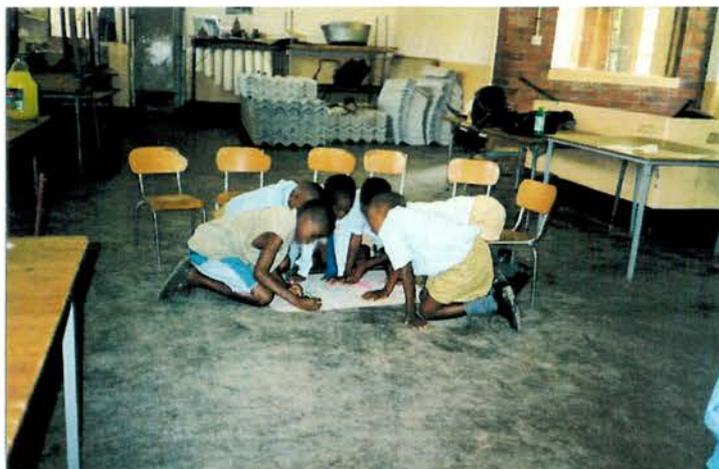


Figure 5. Grade five boys making a diagram

We also consulted them on whether the meeting times were inconvenient for them and whether they had any other problems that were affecting their attendance. They all responded that they enjoyed the research and were keen to remain in the study. Having that discussion helped improve attendance and also facilitated better communication about when they could not attend. It also demonstrated to the boys that although we were adults and authority figures, in the research context, their needs came first and we were willing to compromise if necessary. During the diagramming sessions the boys would produce a diagram by themselves and then we would interview it together with me asking questions to facilitate discussion. In this group one boy (B-5A) tended to do most of the talking; he was not a domineering character but seemed more confident than the others and would often speak up when the others did not respond. Listening to the tapes it was clear that there were often long gaps of silence. I found this very difficult and at times frustrating, and tried to encourage them to speak up. I knew they were capable of discussing these issues because on their own they had lively exchanges, but once they came together with us they were shy and seemed intimidated. This group would often initially say they did not know, and then later on come up with an explanation:

Researcher: What is being raped [asking A], you don't know? Tell him. You wrote this together didn't you so you should have explained to each to each other when you were writing this.

Researcher: Is that rape? What is rape?

[Some giggles]

Researcher: *He (A-5A) said he doesn't know so we can't just say 'to rape' when he doesn't know what rape is. Do you know what rape is [B-5A nods]? So please explain?*

B-5A: *We just wrote it down we don't really know what it is.*

Researcher: *You don't really know? What about you?*

A-5A: *I know what happens but I can't explain it.*

Researcher: *You can't explain it?*

A-5A: *No.*

Researcher: *Why can't you explain it? You just need to say what happens. Remember we said you shouldn't be shy.*

B-5A: *To sleep with your parents or someone older than you and they'll be forcing you.*

(Excerpt from tree diagramming session with grade five boys)

Although I initially worried about one boy dominating the discussions, I realised that the whole group created the diagram with everyone participating equally. In a session where B-5A was absent, the others participated more because they could not rely on him to do all the talking, this seemed to give them confidence and after that there was improved interaction. One boy (C-5A) hardly spoke at all and when he did contribute, he spoke in a whisper; he was very vocal when the boys were on their own. This group also tended to work very slowly and would usually not finish the task within the time allocated for the diagramming session.



Figure 6. Grade five girls making a tree diagram

Group 2-Grade 5A girls: In this group four of the girls were aged 10 years and two aged 11 years. These girls were a huge contrast to their male classmates; they were more confident and relaxed, and their discussions both amongst themselves and with us were lively. They seemed to have a clearer understanding and knowledge of how HIV/AIDS can be transmitted or prevented than the grade five boys did, and at

times demonstrated a sophisticated understanding that we found surprising. The only session in which this group lacked confidence was in relation to body maps; it was clear that they did not really have much understanding of the male and female anatomy, and this is partly explained by the fact that they are taught about the human body in grade six. These sessions were usually full of laughter, the girls were always punctual, they seemed to enjoy the activities and we developed a good rapport. There were no dominating characters and only one girl did not contribute much during the sessions; she was however fully involved during the development of the diagrams.



Figure 7. Grade six boys making a tree diagram

Group 3-Grade 6A boys: Similar to the grade five girls, four boys were aged 10 years and two aged 11 years. This was another lively group, with very interesting insights and the boys were confident and opinionated. They argued constructively and challenged each other's statements making for very enjoyable sessions. We would occasionally go off topic as they became engaged in telling us about something totally unrelated to the session. We developed a very good rapport with the boys in this group and I considered this as our most successful group and an ideal example of how group discussion sessions should work. The boys were all fully engaged in both the development of the diagram and the interview of the diagram with us. They were not particularly shy or embarrassed by the topics, and there were often moments of hilarity during the sessions. Although they challenged each other and often disagreed, there was never any aggression or unpleasantness.

Researcher: Ok. What else is there to say about on your drawings?

B4-6A: [Referring to the body map of the woman] Here, you put too many holes.
 [B2 giggles]
Researcher: There aren't so many holes?
Several-5A Boys: There aren't so many holes, there's only one!
Researcher: But earlier you said there is one for urine, one for having sex and one for having the baby.
B4-6A: There is only one!
B3-6A: There will be only that one then there'll be three dots
 [Cross talk]
Researcher: What about the three dots?
 [More arguing]

B4-6A: There is one.
Researcher: There is one? So-
B1-6A: There are three!
B3-6A: There aren't three, there can't be three holes!
Researcher: So waste and the baby, they all come out of the same hole.
B3-6A: Because the baby-
B1-6A: I don't believe you-
 [Cross talk]
B4-6A: There is one!
Researcher: There is one?
B2-6A, B3-6A, and B4-6A: Yes!
 (Excerpt from Body map session: boys discussing the female body map)

Only one boy was quieter than the rest and this was not because he was shy but because he had a stutter, he did contribute though and when he did, it was with confidence. The boys also tended to ask many questions during the sessions. The transcripts from these discussions are the longest out of all the groups. They generally exhibited good knowledge about HIV/AIDS contraction and prevention, although like all groups, they had some misconceptions.



Figure 8. Grade six girls making a tree diagram

Group 4-Grade 6A Girls: There were four 10 year olds and two 11 year olds in this group. This was a more complicated group that presented an example of how one person can dominate. One girl in this group (G2-6A) was clearly more articulate, intelligent and knowledgeable than the others. She was confident and very opinionated which was noticeable early in the first session, and thus we made a point of not letting her dominate. She would put others down by criticizing their spelling when developing diagrams, or by belittling their comments. She tended to challenge the others when they said something she did not agree with.

G3-6A: I think that the male organ, when they are having sex, it will go into the woman then blood will come out. That's when AIDS can be caught.

Researcher: Ok, so it'll be blood that'll be coming from the man going into the woman. Ok G2?

G2-6A: I want to ask how the blood will go into the woman? Because some men will have...and washed.

Researcher: You can explain G3.

G3-6A: Umm maybe he'll have gone and washed but it (blood) may come out again when they are having sex.

(Excerpt from body map session with grade six girls discussing how HIV is passed from a man to a woman)

Fortunately most of the others were strong willed and would persist with their viewpoint regardless, which was encouraging. Although we had encouraged the children to question each other we had to remind G2-6A at one point that she should not only focus on interrogating the others but also share her opinions. One girl in this group was almost completely silent both during the development of the diagrams and during the interviewing of the diagram. She was always present at the sessions on time but came across as very shy, I tried to get her more involved in the sessions but when asked a direct question she would usually respond by saying 'I don't know'. This group had reasonable knowledge of HIV/AIDS, but again their knowledge of the anatomy was poor.



Figure 9. Grade seven boys making the bridge diagram

Group 5-Grade 7A boys: There were two 13-year-old and four 12-year-old boys in this group. I had expected older boys to be confident and full of stories about their sexual exploits, but these boys contradicted my stereotypical preconceptions; they were initially very shy and quiet. They spoke quietly amongst themselves with lots of giggling, and the initial interviews of their diagrams required a lot of probing to get responses. They did not seem very confident, but as we spent more time together, their confidence grew and they interacted more freely with us. They were more knowledgeable than the grade five boys but seemed on par with the grade six boys; however they had far better knowledge and understanding of the body having previously undertaken biology lessons at school. They interacted well together and all of the boys contributed during the sessions.



Figure 10. Grade seven girls making a tree diagram

Group 6-Grade 7A girls: There were three 13-year-old and three 12-year-old girls in this group. The girls were quietly confident and interacted well together. They had good knowledge both of HIV/AIDS and of the body and expressed themselves well. They sometimes challenged each other and did not always agree on issues. Sometimes we felt that they were holding back, and unlike the younger girls who were very open about what they knew, this group was more reserved and they seemed to think more about how much they should share with us. This could be an indication of the growing influence of socio-cultural behavioural norms since most of them were at the pubertal stage. Literature from Zimbabwe indicates that adolescent girls tend to be more reserved when discussing sexual issues than adolescent boys because it is unbecoming for a girl to be sexually knowledgeable (Kaim *et al.* 1997). Nevertheless, they had good knowledge about HIV/AIDS and also had the clearest understanding of the body and how HIV can be contracted.

Group 7-Grade 5A mixed gender session: This final session were mixed and brought the children from the same grade (class) together was quite illuminating, at the beginning of the session the boys were very lively, talking loudly and giggling; the girls on the other hand were very quiet and subdued and seemed intimidated by the boys' behaviour. Nonetheless once we began diagramming with the boys and girls working on the same task but in different groups, the girls regained their confidence and displayed superior knowledge to the boys. Both genders worked well together and occasionally challenged each other.

Group 8-Grade 6A mixed gender session: These two groups worked very well together and the sessions were lively full of debate and argument as they challenged and disagreed with each other. The sessions went very well and generated much information. From our interactions with all the groups, this was the most inquisitive group always wanting to know more and asking many questions. In all my interaction with the grade six children (including when I administered the questionnaire to the whole class) the responses of the children made me feel this is a key stage for giving information and teaching skills that may have a positive impact on their sexual behaviour.

Group 9-Grade 7A mixed gender session: Out of all the combined groups this group was the least lively; the participants came up with few ideas for their

diagrams and needed constant probing. The discussion did get eventually get going and there were some interesting comments and insights but generally, in contrast to the grade six children, these participants did not have too much to contribute.

Generally our adult status and gender did not seem to have much impact on most of our interactions with the participants. The majority were relaxed and spoke confidently when discussing issues. Any difficulties that we had with the participants were generally due to the personalities of the children, and were usually attributable to shyness. The grade five boys were the most difficult group to interact with and this may be attributed to our gender, both being women old enough to be their mothers. However, this did not deter the grade six boys, who were of the same age. Moreover, UNICEF ESARO (2003) conducted similar research with children as young as six years in Zambia, and these young children were able to discuss sex-related issues showing that it was most likely that the grade five boys' shyness could not be attributed to their age.

4.5.2.2. Interviews

The one-to-one interviews were mixed in quality and the range of information obtained. All the participants from the group work phase were interviewed except three grade five boys who were not at school on the day scheduled for interviews. On reflection, it is clear that the limited information obtained from most of these interviews was primarily a result of poor preparation on my part. The interviews had been left until last because of the assumption that the participants would now be familiar with us and be willing to talk openly.

This was not the case in many of the interviews and there are several reasons for this: the first failing related to the context in which the interviews were conducted. The interviews took place either in the library, the boardroom or outside; all the interviews I conducted were in the library and I will only comment on these. We sat in a corner at the far end of the library so that the librarians could not overhear us. Sitting alone in corner with an adult asking questions may have proved intimidating, and it would have been better if we had gone for a walk around the school grounds, and the interviews had taken the form of an informal chat. Second: I did not take enough time to put the interviewees at ease. After giving a short introduction, I

launched into the interview and although I made every attempt to be sensitive, with hindsight, having an informal chat with the children may have helped them relax before I began asking about their sexual behaviour. Harden *et al* (2000) state that children are often not exposed to situations where they have to give accounts of themselves to adult strangers; their exposure to adult experts (e.g. doctors) is usually mediated by other adults e.g. parents. Thus although the children had spent several weeks talking to me it had been in supportive group environments and being alone with me could have been unsettling; this shows the importance of socio-spatial context when conducting research. I was particularly surprised that some of the more vocal grade six boys became very shy (B1-6A and B2-6A). However, not all the children were subdued; the girls seemed more comfortable during the interviews than the boys, which may have been an effect of my gender. The grade seven boys however were relaxed and confident.

My concern that the data from the interviews lacked depth because some of the children did not say much is challenged by Harden *et al.*'s (2000) assertion that 'the interview is an interaction in which narrative accounts are created by the participants'. They argue that researchers tend fall into trap of positivist thinking which constructs the interview as an exercise in collecting objective facts. Harden *et al.* (2000) claim that the interviewer and the interviewee are both active participants in a social (and spatial) process and that just because children may talk less than adults in interviews, this does not make the data produced any less valuable. Thus, what I interpreted as reluctance to communicate may have been a true representation of the reality of the child's experience: they had little to say on the topic of sexual activity because they were not sexually active. This reflects the ever-present risk that if we, as researchers, allow our preconceived ideas and expectations to intrude on the research process, it may result in the neglect of issues that may not be obvious, but may still be significant. Thus my impression that the interviews were shallow could have resulted in their omission from my analysis and a wealth of data would have been lost.

4.5.3. Positionality

In the process of being reflexive I also have to consider my positionality in relation to the children I worked with (England, 1994). Positionality has a bearing on

who we are, how we do our research and how others perceive us. As mentioned previously I had chosen to carry out this research in Zimbabwe partly because of my familiarity with the language and the culture of the people I would be working with. However I was also aware that I am middle class, well educated and would be wealthier than most of the people I would encounter during my data collection. Having lived outside Zimbabwe for six years I could not ignore that certain things would have changed particularly because of the economic situation and political instability. Reports of teachers in rural areas being targeted for attack and the fear that I would be too visible and would make an easy target for troublemakers influenced my decision not to do research in a rural area.

Being a mother, I expected that working with children close to my son's age would be an advantage. My attitude was that interacting with them in the same open way I interact with my son would help, and to some extent it did. I found that I related best with the grade six boys, who are in the same age group as my son. This did not remove the fact that I am an adult and they are children, which put me automatically in a position of authority. I made it clear that we were responsible for them while they were with us but we were not in the same position as the teachers, we were there to listen to them and we respected their views.

We informed them that if they had any problems or were subject to abuse and had no one to turn to they could go to Tsungirirai and they would get help. I was aware that although my research had participatory elements and was action orientated, it was still a postgraduate study and not deep participatory action research and there were limitations to what I could achieve. I had an ethical obligation to ensure that I did not make promises I could not keep. Because I was researching sexuality and sexual behaviour, I was prepared to deal with sensitive issues and the children's welfare was more important than my research.

I am a committed Christian, something that influences my world view. My research assistant was a committed Christian as well and initially I was concerned that she might be conservative. But having been involved in HIV research projects she was open-minded and practical. I do not feel that my Christian views overly affected my research. I do not think children of primary school age should engage in sexual relationships because they may struggle to deal with the social, health, and

practical repercussions of early pregnancy and also because they have no access to contraception and are thus at risk of STIs and HIV. I was initially uneasy about discussing condoms because of the conservative context I was working in and I did not want to be seen advocating condoms to young children. Nevertheless, I am well aware that abstinence only teaching is unrealistic and not the solution. In a crisis situation such as the one in sub-Saharan Africa, we do not have the luxury of being moralistic. I decided to take my cue from the children and when they brought up various issues such as condoms and abortion, we discussed them.

I was sensitive to cultural norms such as dress. I am most comfortable in trousers and the nature of our work, which involved sitting on the ground doing diagrams, made this the most sensible form of dress for me. The situation would have been different had I been in the rural areas where people are generally more conservative. However, because of my casual dress and 'youthful' appearance people thought I was young and treated me accordingly. Having been often irritated by Zimbabwe's respect culture I did not expect this to bother me, but it did. I was offended when a boy at Tsungirirai referred to me as 'sisi', a respectful term used to address an older sister or an *unmarried* young woman. I felt that by referring to me using that term he was not acknowledging my status as a respectable married woman and mother. My indignation surprised me. My reaction may also have been due to past experiences of when I had lived in Zimbabwe with the stigmatised status of being a single parent. Although I was never ashamed of this, being now married and having achieved that 'coveted' social status I, unconsciously, felt the need for this to be recognised. This experience emphasised the different identities we perform in different contexts and revealed to me that the 'Zimbabwean' norms that I have been resisting for more than 20 years are more engrained in me than I suspected.

The research experience was positive and I often negotiated my insider-outsider status. With the children I was an outsider because I was an adult and not from the area, but I was an insider because they shared their knowledge with me in a way they probably do not do with other adults. I am Shona speaking and could therefore understand everything that was being said around me and thus communicate easily, but I was still an outsider because I live outside Zimbabwe and therefore do not share the every day struggles of trying to make a living in that context. Working

with the children was more enjoyable and rewarding than I had expected, they were open, interactive and less intimidated than anticipated. I had the preconception that because Zimbabwean children are taught to be respectful of adults, this meant they would be unable to talk openly with adults. I was wrong, and with a few exceptions, they were very vocal. I also felt despair and hopelessness at the situation in Zimbabwe and at how bleak the children's futures seemed. However, I realised that if being involved in the research had made an impact on one child's life then it was all worth it.

4.6. Methods of data analysis

4.6.1. Quantitative Data analysis

The questionnaire data was analysed using SPSS quantitative data analysis software. The main aim of the quantitative questionnaire was to find out the participants' levels of knowledge about HIV/AIDS thus it was necessary to determine the most effective way to achieve this. I therefore decided to code the knowledge questions separately from the attitude and behaviour questions because the former questions have definite right/wrong answers and would be used to measure knowledge levels. Although the questionnaire provided some indication of the participants' attitudes, sources of information and behaviour, trying to measure these variables using a simple questionnaire would have been problematic, thus they were subsequently explored in detail using the more appropriate qualitative methods. At this initial stage of the data analysis it was more important to determine what the participants knew about HIV/AIDS. Therefore sequential codes ranging from zero to 25 were assigned to each demographic, attitude, information source and behaviour variable (see Appendix 7 and Appendix 8) and analyses were conducted to produce data to describe the sample.

There were 12 knowledge-based questions (1-10, 12, 15 see Appendix 9) and a score was assigned to each of these. Correct answers were awarded a score of four points; obviously incorrect or don't know answers, were awarded minus four points. It was decided that a 'don't know' answer was as bad as a wrong answer. Partially accurate answers were given a score based on the level of correct knowledge shown,

a subjective measure in this otherwise quantitative analysis. Each participant's score was then calculated to give his or her 'knowledge total'. After exploring the data further and looking for patterns within the knowledge total variable, bivariate analyses were conducted using a one-way analysis of variance test (ANOVA) to assess whether or not there were statistically significant relationships between the attitude and behaviour variables and the knowledge total variable. This was to determine if levels of knowledge had any relationship to certain attitudes, sources of information and behaviour. The analysis of variance (ANOVA) was used instead of the t-test because it can measure differences between independent variables in which there are three or more levels whereas the t-test is limited to measuring only differences between two groups (Field, 2005: 309). For example, the data had variables such as grade, which consisted of three levels (five, six and seven) and in order to determine whether there were statistically significant differences between the three samples, the ANOVA was the most appropriate test to apply.

The sample was also divided into quintiles in order to compare knowledge total scores, and to determine whether participants whose scores were in the uppermost quintile and those in the lowest quintile had any particular characteristics. Next, a new 'lifesaver' variable was created based on the participants' scores on seven knowledge questions (Questions 4, 5, 6, 7d, 8c, 9, 10; see Appendix 9). The assumption was that knowing the correct answers to these questions could potentially save a participants' life although knowledge is of course no guarantee, but a vital first step. It is evident that other factors have to be taken into consideration when assessing a child's ability to protect him/herself, however having the correct knowledge is a good starting point. An ANOVA was also conducted with the lifesaver variable and the demographic data and other non-knowledge questionnaire variables to look for significant relationships, and to ascertain whether the same variables that had significant relationships with the knowledge total variable emerged significant with the lifesaver variable. The data was further explored by comparing the knowledge total and lifesaver high and low scorers to distinguish whether the same participants consistently scored high or low and if they shared any particular characteristics.

This analysis only used descriptive statistics and these were sufficient because the questionnaire was utilized as a tool to get an idea of the children's levels of

knowledge so that this could inform the next phase of the study. The main aim of this study was to gather deep qualitative data on the children's HIV/AIDS related knowledge, attitudes and behaviour. The quantitative data was based on a small sample (118) which further justifies the use of descriptive statistics. Applying inferential statistics would not have been appropriate because the purpose of the questionnaire was not to generalize and make estimates about children in Zimbabwe.

4.6.2. Qualitative data analysis

4.6.2.1. Data transcription and translation

As described in chapter four (see 4.4.7.4 Alternative diagramming sessions) the qualitative data consisted of audio taped discussions, photographs of diagrams, drawn copies of diagrams in notebooks, and written notes. The audio data was transcribed using Express Scribe transcription software that can be downloaded from the internet (NCH Swift Sound, 2003). Using this software made it easier to transcribe, as there was no need for an additional transcribing machine; once all the recordings had been transferred from tapes and digitised using Express Scribe, the data was readily accessible through a computer. Most of the audiotape material was clear but the sensitivity of the tape recorder sometimes recorded all the background noise. Therefore, recordings that were made during school break times were sometimes very difficult to make out. Fortunately, notes taken by my research assistant during the diagramming sessions supplemented the recordings and these were useful in clarifying poor recordings.

The qualitative data collected was largely in *Shona* so it was necessary to translate it into English for analytical purposes. Birbili (2000: 1) emphasises the 'need for social researchers who have to translate data from one language to another to be explicit in describing their choices and decisions, translation procedures and the resources used'. Transcribing the material in *Shona*, and then translating it into English would have been time consuming because a) the transcripts would have had to be written out twice, and b) although I am a fluent *Shona* speaker, I am not used to writing the language. Writing out all the material in *Shona* would also have served no useful purposes for the research as the majority of the audience who will read this thesis are English speakers, therefore I simultaneously translated all the material into

English during transcription. The weakness of this method is that the richness of Shona expression is lost in translation, and there are some words or phrases that are almost impossible to translate well (Birbili, 2000). In Zimbabwe, children are taught in English from the beginning of primary school and are thus, to some extent, bilingual. Their command of English varied from very poor to fair. Although we used *Shona* and English words interchangeably, as is typical in the conversations of most young Zimbabweans, the participants were encouraged to predominantly speak in *Shona* as they were far more articulate in that language. Occasionally the participants used words that were unfamiliar to me and I either asked for clarification immediately or consulted my research assistant afterwards. There were a few words that none of us could translate and these words were left in the original *Shona* in the transcripts. On returning to Scotland there were times during transcription that I was unsure of the correct translation for a word or phrase. Fortunately, one of my colleagues is a Shona speaking Zimbabwean and I was thus able to consult her. Nevertheless, this reveals the importance of making the effort to transcribe data (where possible) as it is being collected and whilst there are opportunities to return to the participants for clarification.

The qualitative data presented in this thesis are also to a large extent my representation and interpretation of the participants' views and opinions because I am the only person who has listened to *all* the tapes and translated them. I made efforts to translate the discussions as literally as possible, but at times literal translation has been sacrificed for intelligibility, and some of the Shona sayings have required interpretation into the English equivalent. Therefore, although the views presented in the excerpts in this chapter are largely those of the children, it is important to take into account that they are not in the original language and thus have elements of my personal interpretation in them. Thus, this account is not only a representation of what the children said, but is also a reflection of my worldview. I will however attempt to be as transparent and reflexive as possible when presenting these results (Baxter & Eyles, 1997). I am not an expert in linguistics, have not studied Shona in any great depth and there are limitations to my understanding of the nuances within the language. Given that a language is constantly developing and changing and that I have been living outside Zimbabwe for nearly ten years, there are certain developments within the language that I am unaware of. Moreover, had I not left

Zimbabwe, there are still aspects of the language and of the youth culture that I, as an adult living in a different context, would not know.

A way to avoid some of these complications would have been to hire a trained *Shona* translator to transcribe the data. However, this in itself would have led to several problems: firstly I would have breached my confidentiality agreement with the children that the tapes would only be listened to by those present at that the discussions or interviews; secondly, using a professional translator would not have resulted in obtaining objectively translated material but would have brought in yet another person's perspectives and representations. 'Objectivity' could only have been achieved by having multiple translations and back translations by several bilingual experts, and this would have been time consuming and expensive (Birbili, 2000). Since the aim of this study was not to achieve linguistic perfection, and my epistemological standpoint questions the idea of objectivity (see 4.2), I thus contend that my translation methods are adequate for this study. The majority of the data were collected by myself and I was thus aware of the interactions between the participants. It may be argued that I have certain biases because I am too close to the data, but my efforts to be reflexive throughout this thesis will help to counter any biases I may have or had. Thus although my translations are not perfect, they provide a thorough representation of what took place. As qualitative researchers it is important for us to be aware that the data we gather are representations, and that perfect translation is still inadequate because it does not necessarily reflect the meaning behind what a person says. Therefore in our quest to uncover meaning through research the best we can do is acknowledge our limitations and clearly outline the process that brought us to our conclusions.

All the data were anonymised, a process that began during the data collection process (see 4.4.7.4); the translation of the discussions and interviews into English affords further anonymity to the participants. This anonymity however comes at a price. The movement from the original *Shona* into English text coupled with the absence of their real names results in the participants becoming disembodied voiceless entities that could be anyone from anywhere. I have chosen not to use pseudonyms because I am uncomfortable with the idea of replacing someone's name with a random name that I have selected. I could have avoided this by asking the

participants to select their own pseudonyms during the data collection, but instead we allocated them numbers or letters (see 4.4.7.4). It may be argued that this is even more impersonal, but because both the participants and the research team used these 'labels' throughout the data collection process, I can counter that argument and say that they became comfortable with those labels. I would have preferred to ask the participants whether they wanted to be anonymised or not because I feel that not using their real names contradicts our attempts as researchers to give voice to children (Grinyer, 2001). However, because the participants are minors and the research topic dealt with sensitive material, it was ethically sound to anonymise the data.

4.6.2.2. Data analysis

Once the task of transcribing and translating was complete, the next stage of the process involved reading through the transcripts several times, making corrections and familiarising myself with the data. Each diagramming session had been transcribed into separate word documents; these were then merged into one document according to grade and gender groups for ease of coding. The interviews were kept in separate files for each person interviewed. Thus there were six diagramming files for separate grade and gender groups and three files for the final joint grade groups and 33 one-to-one interview files. Data analysis was conducted using MAXqda qualitative data analysis software (Verbi, 2003). Altogether, nine diagramming texts and 33 interviews were imported into MAXqda in rich text format. This software was chosen because it supports documents written in rich text format and enables the researcher to view the text browser, document system, code system and retrieved segments all on the screen at the same time (see Appendix 10). This makes it easy to view retrieved segments in their original context if necessary during analysis. MAXqda was mainly used for the organisation, coding and retrieval of data.

The process of qualitative data analysis involves description, analysis, interpretation and production of theory (Pope *et al.*, 2000; Lacey & Luff, 2001). The aims of this study were firstly, to generate some new conceptual understanding about children and HIV/AIDS in relation to *Children's geographies*; secondly, to contribute information about the sexual behaviour and HIV/AIDS related knowledge of primary school children to the field of HIV/AIDS prevention research; and thirdly to inform

policy and practice relating to HIV/AIDS prevention and the sexual education of children.

Thus, my aims guided my choice of method when analysing the data. The analysis uses elements of framework analysis. Framework analysis was developed explicitly for applied and policy-relevant qualitative research and it uses both inductive and deductive approaches to analysing data (Pope *et al.*, 2000). Because it is predominantly used in projects with short timescales and whose aims and objectives are set by funding bodies, framework analysis begins deductively by identifying *a priori* concepts. As the analysis progresses, new concepts that emerge inductively from the data are included (Lacey & Luff, 2001). Table 3 shows the key stages of framework analysis outlined by Pope *et al.*, (2000).

Table 3. Key stages of Framework analysis (Pope *et al.*, 2000)

Framework analysis	Description
Familiarisation	Immersion in the raw data, listening to tapes, reading transcripts, studying notes in order to list key ideas and recurrent themes
Identifying a thematic framework	Identifying key issues, concepts and themes by drawing out <i>a priori</i> issues and questions derived from the aims and objectives of the study, issues raised by the respondents, and views and experiences that occur in the data.
Indexing	Applying thematic framework or index systematically to all data in textual form by annotating transcripts with numerical codes.
Charting	Rearranging data according to the appropriate part of the thematic framework to which they relate and forming charts
Mapping and interpretation	Using charts to define concepts, map the range and nature of phenomena, create new typologies and find associations between themes with a view to providing explanations for findings

As one of my aims is to inform practice and policy, there were certain concepts that I was interested in examining and my analysis was initially deductive. However, once the data familiarisation process was complete, I identified answers to questions that were posed during each diagramming session. These sessions were designed to build on each other: information acquired in the first session was

developed further in subsequent sessions and issues were explored in depth as the research progressed. This ensured that some of the participants' statements were checked and clarified and their understanding of various issues was also verified to determine whether they fully understood what we had explained to them or if more clarification was needed. Because of the nature of this topic, the objective of the study was not only to explore the participants' views and experiences but to also provide correct knowledge where appropriate and answer questions as they arose. This approach enabled us to determine the depth of the participants' understanding of the issues discussed. Each group performed the same tasks and were asked similar questions when interrogating their diagrams so that a clear picture of the views, knowledge and experiences of each group could emerge and be compared to the other groups. A semi-structured questionnaire was used during the interviews and therefore all the participants were asked the same questions with room for probing and further discussion. The use of two different methods also helped to demonstrate the rigour of the research by providing the opportunity to cross check participants' responses during the group sessions with those in the interview.

The first step in the analysis process was to go through all the transcripts and identify the answers to various parts of the diagramming sessions and code them accordingly. At this familiarisation or open coding stage other concepts began to emerge inductively. Once this phase was complete the next task was to identify themes in the data. These were grouped under five categories, actions, actors, attitudes, contexts and emotions (Levy, 2002). The themes were then further examined and those relating to similar phenomena were grouped together under main themes as sub-themes (see Table 4).

Table 4. Examples of categories, main themes and sub-themes in the code system

Category	Main themes	Sub-themes
Actions	Dating	Hugging
		Kissing
		Touching
	Sex	Being propositioned
		Sexual decision making
		Self control
Actors	Adults	Parents,
		Sugar daddies
		Teacher
	Children	Of your age
		Friends
		Boyfriend
Attitudes	Reasons for not having sex	Sex only when adult
		Fear of disease
		Not interested in sex
	Transactional sex	Poverty
		Money
		Resist temptation
Contexts	Hidden places	Bushes
		In the grass
		Street corner by a wall
Emotions	Reactions	Fear
		Anger
		Suspicion

There were often overlaps as text segments coded under one theme could also be coded under another. When this process of coding was complete and all possible codes, both from *a priori* issues and emerging issues, had been exhausted, the codes were exported from MAXqda into Microsoft word documents. This was to enable progression to the next step in analysis, ‘charting’ (see Table 3; Pope *et al.*, 2000). Thematic charts were developed which contained quotations related to all the coded themes from both the diagramming and the interviews (see Appendix 11 for example of thematic chart). First the quotations were organised according to category and theme, and then they were later organised according to diagramming group or individual (for the interviews). This change facilitated the mapping and interpretation phase of the analysis by diagramming group and interview. This phase involves searching for patterns, associations and concepts in the data in order to determine the

range and nature of phenomena, create typologies and provide explanations (Luff & Lacey, 2001). Once this phase was completed I identified key themes that were prevalent throughout the discussions and interviews and which were linked either to the quantitative results, the literature or which presented concepts that gave new insight to the subject under examination.

4.7. Summary

This chapter has presented a detailed discussion of the methodological process beginning with the choice of epistemological framework based on feminist theory and culminating in the methods used in data analysis. The purpose of this chapter was to clearly outline the methodological process and link that to the epistemological framework to provide an understanding of how the results emerged out of this process. Although quantitative methods were used in this study, it was predominantly qualitative and governed by principles of the feminist approach to research in which the process is as important as the outcome (Campbell & Wasco, 2000). Thus in order to establish rigour in qualitative research it is imperative that the researcher is transparent about the research process. Rigour in quantitative research is taken to mean validity, reliability and objectivity (Baxter & Eyles, 1997). However, in the context of this study's epistemological framework, rigour is interpreted as 'academic integrity including responsibility and honesty: dimensions of self-reflection...' (Baxter & Eyles, 1997: 506). Therefore the detail included in this chapter lays the foundation for the following two chapters by illuminating the process which led to the results.

5. Quantitative results: children's levels of knowledge about HIV/AIDS

5.1. Introduction

This chapter will present and discuss the results from the HIV/AIDS questionnaire. The purpose of this quantitative component in an otherwise qualitative study was to obtain an overview of the participants' HIV/AIDS related knowledge and attitudes. Ascertaining the participants' knowledge and attitudes was a good starting point for this research because first, so little work had been done with children regionally and none nationally; and second, although there is no assumption that knowledge affects behaviour, it is still an important factor to examine.

The chapter contains results from the 118 children in the main sample; there is no identifiable data from the sub-sample, as the participants were not asked to identify themselves for ethical reasons (see 4.4.7.4). The results will be presented in two sections. The first section will present the demographic data providing a description of the sample. Some of these data will be compared with national statistics from a UNICEF (2005) database to get an idea of how comparable this sample is to children in Zimbabwe as a whole. The second section will discuss the results from the HIV quiz in two parts: the first will provide a general overview of the children's knowledge, along with some discussion and interpretation of this data; the second part will recount the attempt to measure the knowledge levels, the methods used in this endeavour and the results produced. The second section will also present data from the statistical tests conducted and the significance of these data will be examined. The chapter will conclude with a discussion of what the quantitative data reveals about the knowledge levels of the sample and how this will be augmented by the qualitative data.

5.2. Study sample

5.2.1. Gender

The sample consisted of 118 participants aged nine to fourteen and had virtually equal numbers of boys and girls (Table 5). The same pattern emerged when the sample was divided by grade; grade five had slightly more boys than girls (20 vs. 16) but both grade six and seven had slightly more girls than boys (22 vs. 19). However, there were a few children absent from school in all the classes whose presence would likely have balanced the numbers in each grade equally. Thus this sample provided a good representation of the study population in the school. Finding equal numbers of boys and girls was unexpected because in sub-Saharan Africa, boys tend to be prioritised for schooling especially during difficult times such as the current economic climate in Zimbabwe (Feldman *et al.*, 1997). However, comparing my data to national statistics obtained from UNICEF and UNDP databases indicates that there is a slightly higher ratio of girls to boys in Zimbabwean primary schools and thus the sample is illustrative of the general population (see Table 5; UNICEF, 2005; UNDP, 2005).

Table 5. Demographic data of the study sample I

Variable	Responses	N	%
Gender	Boy	58	49.2
	Girl	60	50.8
	Total	118	100
Grade	5	36	30.5
	6	41	34.7
	7	41	34.7
	Total	118	100
Age	9	6	5
	10	30	25
	11	32	27
	12	37	31
	13	6	5
	14	7	6
	Total	118	100
National data (UNICEF, 2005)			%
net primary school attendance, male (1996-2003)			84
net primary school attendance, female (1996-2003)			86

This finding supports earlier assertions (see 3.5) that primary schools are the best places to target children for research because when they, particularly girls, do attend school it is more likely to be at primary level (World Bank, 2004). The large number of children enrolled in this school (approximately 1 680) implied that primary school enrolment was still high despite the economic problems.

5.2.2. Grade and Age

It was unusual that the ages of the participants corresponded with the grade they were in and there were no participants who were 'old' for their class (Table 5). In sub-Saharan African schools it is not uncommon to find children who are two, three or more years older than their classmates (see 3.2.; Feldman et al., 1997; Matasha et al., 1998). The sample did not contain any participants over 14 years. This finding could be an indication of the good education system in Zimbabwe and the determination of parents to send their children to school at the right time. It may also be an indication of the urban context because children are less likely to be taken out of school to work in the fields unlike in rural areas. Alternatively it could be the result of a policy to put children into the stipulated grade for their age regardless of whether they have reached the educational milestones for that class or not. This may be supported by the information from the grade six teacher that six children in her class had very low literacy levels. Ordinarily in the Zimbabwean system these children would have been kept back in a lower grade, regardless of age, until they had 'passed the tests' for that grade. The Zimbabwean educational system focuses on academic attainment, which is measured using tests and examinations from an early age. During the qualitative diagramming sessions the participants mentioned situations where a child would be older and more mature than his/her classmates because of having been kept back; although it was not clear if they were talking about children in their school it may illustrate that the situation is still prevalent and my sample was the exception rather than the norm.

5.2.3. Orphans

The number of children who had lost either one or both parents may reflect the reality of HIV/AIDS in this society. The questionnaire did not ask whether the parents had died from an AIDS-related illness, but considering the age of the children and the large number (Table 6) whose parents had died it was likely that many may have died from AIDS-related illnesses. Certainly, this assumption could be supported by just under half of the participants reporting that they knew someone who had died from AIDS. The large number of orphaned children in the sample is higher than the national average of children orphaned by all causes, including HIV/AIDS (Table 6), however this percentage is for children aged 0-17 (UNICEF, 2005) and my sample only included children aged 9-14, therefore if the age range was the same, the percentages would most likely be similar.

Table 6. Demographic data of the study sample II

Variable	Responses	N	%
Parents alive	Yes –both	87	73
	Mother only	15	13
	Father only	8	7
	No	8	7
	Total	118	100
Anyone in family with job	Yes	95	80
	No	23	20
	Total	118	100
Do you work	Yes	15	13
	No	102	86
	Total	117	99
Do you receive help from Tsungirirai	Yes	6	5
	No	94	80
	Don't know	12	10
	Total	112	95
National data (UNICEF, 2005)			%
Children (0-17 years) orphaned by AIDS 2003 (estimate)			15
Total children (0-17 years) orphaned by all causes 2003 (estimate)			20
Children (5-14 years) in child labour (1999-2003)			26

5.2.4. Socio-economic status

Eighty percent of the participants had a family member living with them who had a job, which at first glance seems to indicate that they came from stable economic backgrounds. However, the question had classified a job as any kind of income generating activity including vending (see Appendix 2); so although the family had an income, answering this question in the affirmative did not necessarily indicate that the participants came from economically stable backgrounds. Nevertheless, the very presence of these children in school meant that their families had access to funds because education is no longer free in Zimbabwe. This school was also not the most economically marginalized in the area (see 4.4.6), which may account for the high employment figures: only 20% of the sample came from homes where nobody worked or had a job in contrast to the national unemployment figure of 75% (IRIN, 2004). Socio-economic background was also determined by a question on whether the participants themselves worked for money. Only 13% responded positively to this question. Out of the 15 participants who worked, 11 reported that they used the money earned to buy school supplies or pay fees, and four to buy food either for themselves or for their families. Only five out of these 15 participants seemed to work because nobody else in their family had a job, however, the money these five earned was for their own use. Nationally 26% of children were involved in child labour⁸ (UNICEF, 2005). This obviously includes children from rural areas, which may explain why my predominantly urban sample had a much lower percentage. This may also be an indication that the participants were from better off homes in general.

⁸ **Child labour** – Percentage of children aged 5 to 14 years of age involved in child labour activities at the moment of the survey. A child is considered to be involved in child labour activities under the following classification: (a) children 5 to 11 years of age that during the week preceding the survey did at least one hour of economic activity or at least 28 hours of domestic work, and (b) children 12 to 14 years of age that during the week preceding the survey did at least 14 hours of economic activity or at least 42 hours of economic activity and domestic work combined. (UNICEF, 2005)

UNICEF's definition of labour is not strictly comparable with mine because I did not ask for the number of hours the children worked; however I did ask about the frequency of this work (see Appendix 2), which gives an indication of the amount of time spent in labour. A question about Tsungirirai was also asked to determine how many children in the sample had thus identified by Tsungirirai as requiring assistance (see 4.4.2); six children said Tsungirirai was helping them.

5.3. The AIDS Quiz

5.3.1. HIV-related knowledge

Initial exploration of the questionnaire data revealed that this group of 9-14 year olds had some knowledge of HIV/AIDS. Just over half of the participants correctly identified HIV as a virus (Table 7). However, only a few knew that AIDS is a syndrome of different illnesses. This question was asked because it is important for people to differentiate between the two and to be aware that a healthy looking person can be HIV positive. It is particularly vital that children (especially girls) be clear on this given the common phenomena of adult men offering inducements to young girls for sex (Gwanzura-Ottmöller & Kesby, 2005). The concern here was that because the two terms are often run together (HIV/AIDS) or used interchangeably in information materials and everyday conversation, there is potential that children may become confused. Fortunately, despite their lack of definitional clarity, more than half of the participants did understand that looking healthy did not necessarily mean a person's status was negative.

Nevertheless, this left a third of the sample (32%) unclear about this critical point (Gwanzura-Ottmöller & Kesby, 2005). On the other hand almost three quarters of the participants (Table 7) knew that a fat person *could* be HIV positive. This is important because traditionally, in sub-Saharan African societies, being fat has been associated with good health, and this has become even more significant during this era of HIV/AIDS as people associate weight gain with being HIV negative. It means that the children will not unquestioningly accept seemingly good health as sign that a person does not have HIV. This may also indicate that children have a more positive attitude to the idea of living positively and staying healthy even when HIV

positive. The majority of the participants knew that children, not just adults, could ‘get HIV/AIDS’ and also that there is no cure.

Table 7. Knowledge about HIV/AIDS

Variable	Responses	N	%
What is HIV?	a) A collection of illnesses	6	5
	b) A virus	68	57
	c) A bacteria	13	11
	d) Don't know	37	31
What is AIDS?	a) A collection of illnesses	17	14
	b) A virus	36	31
	c) A bacteria	17	14
	d) Don't know	48	41
Can a healthy looking person be infected with HIV?	a) Yes	67	57
	b) No	23	20
	c) Sometimes	14	12
	d) Don't know	14	12
A fat person cannot be HIV positive.	a) True	15	13
	b) False	90	76
	c) Don't know	13	11
Is there a cure for AIDS?	a) Yes	33	28
	b) No	85	72
Can children your age get HIV/AIDS?	a) Yes	93	79
	b) No	25	21

The participants possessed good knowledge about methods of protection from HIV. Abstinence and condoms were both identified as modes of protection, with more children selecting the latter over the former (Table 8). Given the tendency for parents and teachers to repeat the ‘total abstinence’ message whenever they talk to children, it was significant that more children identified condoms than abstinence as the most effective means of protection against HIV infection. The later qualitative sessions shed more light as to why condoms were perceived as more effective protection than abstention (see 6.4.1.2.)

More participants also thought that having few sexual partners would be more protective than avoiding prostitutes (Table 8). This result may reflect the children’s social or general knowledge that prostitutes are not the only ‘vectors’ of HIV but that

it is prevalent in the general population and it is thus necessary to limit sexual contacts rather than just avoiding prostitutes.

Table 8. Protection from HIV/AIDS

Variable	Responses	N	%
How can people protect themselves from getting HIV? (Circle all possible answers)	a) Avoid sexual intercourse	51	43
	b) Limit number of sexual partners	75	64
	c) Use condoms during sex	86	73
	d) Avoid sex with prostitutes	67	57
	e) Take antibiotics prior to sexual contact	14	12
	f) Have sex only with healthy persons	47	40
Which one of these protects you most effectively against HIV infection?	a) Contraceptive pill	9	8
	b) Condoms	62	52
	c) Not having sex at all	27	23
	d) Don't know	20	17

Some of the participants thought taking antibiotics prior to sex was a protective factor. This confusion may have arisen because there is no specific word for antibiotics in Shona so the word used is the generic term tablet or pill. Alternatively they may have understood what an antibiotic was and been aware that this type of medication can be used to cure STIs and subsequently reduce the chances of contracting HIV. A small number of participants stated that the most effective protection against HIV/AIDS was the contraceptive pill. Although few believed this (Table 8), it is a dangerous misconception, which would be dispelled by a clear understanding of the body and of how people become infected with HIV.

Several questions in the quiz attempted to determine the types of behaviours the children thought led to someone contracting HIV/AIDS. The majority of children knew that HIV could not be contracted from mosquitoes, fleas and bed bugs or toilet seats (Table 9). Nevertheless there were still a few participants who thought it was possible, and considering that HIV/AIDS education was part of the school curriculum, this should not have been happening. A large proportion of the participants knew that HIV could be contracted through sharing razorblades, needles or injections. Razorblades have been highlighted in the anti-AIDS campaign in

Zimbabwe because of the practice of scarification, carried out by traditional healers, which involves making small cuts in the skin using razorblades.

Table 9. Variables related to contracting HIV/AIDS

Variable	Responses	N	%
How can a person get HIV? (Circle all possible answers)	a) From mosquitoes, fleas or bed bugs	10	9
	b) From having sex	56	48
	c) From a toilet seat	13	11
	d) From having unprotected sex with a person infected with HIV	101	86
	e) From sharing razorblades, needles and injections	91	77
	f) Don't know	3	3
Can a person get HIV the first time they have sex?	a) Yes	12	10
	b) Yes, if their partner is infected	68	58
	c) No	17	14
	d) Don't know	21	18
People get AIDS if they: (Circle all possible answers)	a) Go to beer halls	26	22
	b) Drink dirty water and eat dirty food	5	4
	c) Have multiple sex partners	91	77
	d) Are polygamous	26	22
	e) Go out with sugar daddies or sugar mummies	79	67
	f) Play with the opposite sex	13	11
	g) Have unprotected sex with a person infected with HIV	102	86
	h) Don't know	6	5

Less than a quarter of the children thought that people who go to beer halls are more likely to contract HIV, which was unexpected considering the prevailing attitudes in Zimbabwe that bars and beer halls are 'dens of iniquity'; this finding will be further discussed in relation to the knowledge total scores. Over three quarters of the participants did not equate polygamy with risk for contracting HIV, but many did consider dating sugar daddies/mummies and having multiple sex partners as risk factors for contracting HIV (Table 9). This may indicate the normative status of polygamous relationships within this society resulting in their being perceived as stable and safe. This finding also highlights that public health messages to avoid having many sexual partners as well as consorting with sugar daddies or mummies are getting through to the children. An encouraging finding was that over half of the

children knew that HIV can be contracted during the first sexual encounter (Table 9); it would have been even more encouraging if more children had been aware of this because, as with pregnancy, it is important for children to know that ‘doing it just once’ can be enough to catch the virus.

The questionnaire also aimed to find out from where the children received their HIV related knowledge. Given this town is a low-income area, it was surprising that most children seemed to have access to television; it was the most frequently cited source of information, closely followed by radio. This is not unexpected because many families own radios (

Table 10). The results illustrate that the media plays a significant role in relaying information about HIV/AIDS in Zimbabwe. Teachers and parents/guardians or relatives also featured as major sources of information. A weakness in this quantitative questionnaire was that a question to determine the quality of the information received from the various sources was not included; however, to some extent, this was covered during the diagramming sessions.

Table 10. Sources of information about HIV/AIDS

Variable	Responses	N	%
From which sources of information did you learn about HIV/AIDS? (Circle as many as are relevant)	a) radio	88	75
	b) TV	92	78
	c) Newspapers/magazines	64	54
	d) Poster/pamphlet	6	5
	e) Government health worker	75	64
	f) School teacher	83	70
	g) Friends	37	31
	h) Boy/girlfriend	12	10
	i) Parent/guardian/relative	78	66
	j) Other	16	14
	k) Don't know	1	0.8

When asked from where they had obtained *most* of their knowledge about HIV/AIDS, teachers were most frequently cited, followed by television (Figure 11).

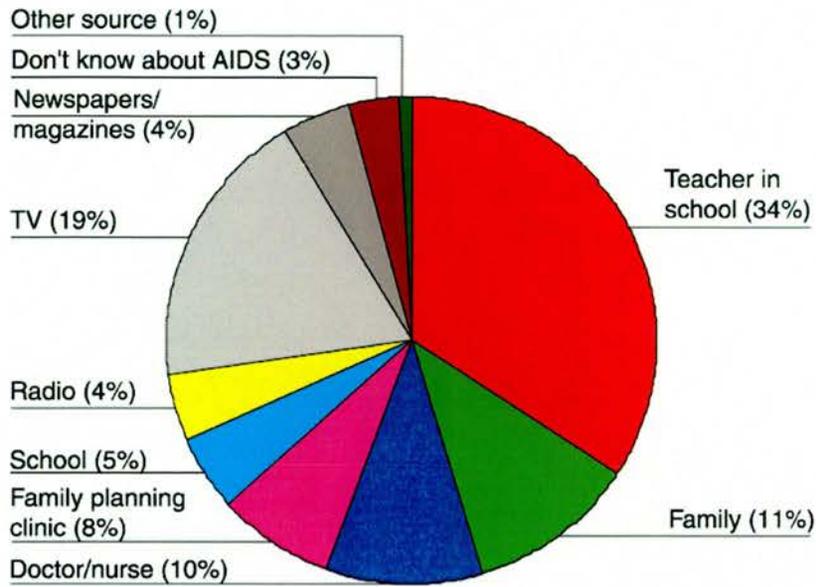


Figure 11. Source of most information about HIV/AIDS

However, parents were cited more often than teachers when the participants were asked who they would ask if they had questions about HIV/AIDS (Table 11). This enlightening result shows that although the participants had stated that they received more information from teachers than parents (Figure 11), they preferred to communicate with their parents about these issues. This is supported by their responses to another question that asked who they thought should tell them about sex, HIV and pregnancy; almost half of the children thought adults at home, which may mean parents, relatives or guardian, should provide this information (Table 11). This may be an indication that the way teachers deliver this information makes children afraid to ask questions. The desire to be advised by parents may also imply that children think they are the appropriate adults to convey this advice, and that the home is the right context for sex education. They may also feel that the school is too impersonal a context for this information to be conveyed, especially in a class full of other children. It was also interesting that more children selected health care professionals over teachers and parents when reporting whom they would ask about HIV/AIDS (Table 11). A possible reason for this could be that the children consider

HIV/AIDS as a medical issue and therefore see health professionals as being most knowledgeable.

Table 11. Sources of Information about HIV/AIDS II

Variable	Responses	N	%
If you had a question about HIV/AIDS who would you ask? (Circle one only)	a) School teacher	10	9
	b) Parents	31	26
	c) Sister or brother	3	3
	d) Doctor or nurse	36	31
	f) Family planning clinic nurse	27	23
	g) Don't know	7	6
	h) Other	3	3
	Who do you think should tell young people like yourself about sex, HIV/AIDS and pregnancy?	a) Teachers at primary school	23
b) Teachers at secondary school		10	9
c) Adults at home		53	45
d) Don't know		21	18
e) Other		6	6

The final question was designed to ascertain the transactional nature of sex among the children, which would subsequently be explored in more detail in the diagramming sessions. This question asked the participants if they would engage in various behaviours for money or a gift (see Appendix 2). There were three possible answers, yes, no and maybe (Table 12).

Table 12. Behaviour-related variables

Variable	Responses	N	%
Would you go for a walk with someone for money or a gift?	a) Yes	38	32
	b) No	32	27
	c) Maybe	41	35
Would you go to see a film with someone for money or a gift?	a) Yes	39	33
	b) No	52	44
	c) Maybe	23	20
Would you let someone touch your private parts for money or a gift?	a) Yes	31	26
	b) No	75	64
	c) Maybe	10	9
Would you have sex with someone for money or a gift?	a) Yes	37	31
	b) No	65	55
	c) Maybe	13	11

Generally over half of the participants gave a negative response to most of the options presented. The exceptions were the questions about going for a walk and going to see a film where over a third said yes they would do those things for money or a gift (Table 12). This may indicate that the participants saw these activities as relatively safe (unlike kissing or holding hands). However, further exploration of these issues during the diagramming sessions saw the children presenting alternative points of view about these activities and considering them as risky for forced sex or rape. This shows the weakness of a quantitative questionnaire and how results can be easily misinterpreted and highlights the significance of mixing qualitative and quantitative methods to obtain a more holistic perspective. It was surprising to discover that a quarter of the children said they would let someone touch their private parts for money or a gift and a third said they would have sex for money or a gift. Nevertheless the difficult economic situation in Zimbabwe and the widespread poverty are likely to drive desperate children to engage in risky behaviour. As indicated in the literature review, poverty puts girls at particular risk of sexual exploitation. The results thus support and emphasise my argument that children of this age are at risk of contracting HIV and should thus be fully involved in HIV and sex education related programmes that meet their expressed needs.

5.3.2. Knowledge levels

Once the initial exploration of the data was completed and no differences had been identified by gender, grade or age, the knowledge total variable was developed to measure the participants' knowledge levels (see 5.2.). Statistical tests were also applied to determine whether there are any statistically significant relationships between knowledge and attitudes or behaviour.

The highest possible knowledge total score that could be attained by answering all the knowledge questions (only knowledge related questions were included in the knowledge total) in the questionnaire correct was 67. None of the participants achieved this: the highest score attained was 55 while the lowest was minus 16 (see Figure 12 for full range and distributions). The median score was 29 and just over half (53 %) of the participants had scores above the median. Figure 12 illustrates that the score distribution is negatively skewed which means that more participants tended to have high scores than low scores. Nevertheless, because a) the

questions in the AIDS quiz were not complicated, and had been developed to measure basic knowledge about HIV/AIDS; and b) and the school taught the AIDS Action curriculum and also covered HIV related topics in other lessons, a larger majority of participants were expected to have scores above 29.

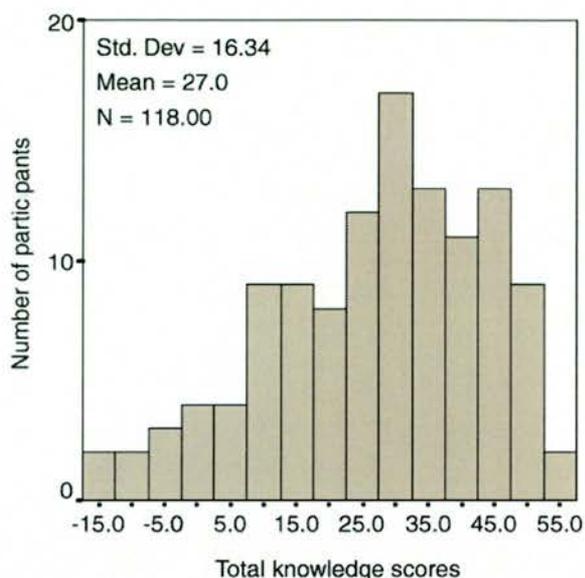


Figure 12. The participants' total knowledge score distribution

In order to determine whether there were any differences within the distribution the sample was divided by grade and gender.

a) Grade: Knowledge total mean scores were higher amongst the older children and lower amongst the younger ones (grade seven mean = 30, grade six mean = 28, grade 5 mean = 23). The averages for grade six and seven children were above the overall group mean, and the mean for the grade fives was lower; this could be explained by the fact that the older children had been having HIV-related education for longer, whereas the youngest group had only had a year's instruction. This is further emphasised by the median scores, which showed even greater gaps between the grades (grade seven = 33, grade six = 29, grade 5 = 22), especially between the grade five group and the other two grades. Due to the size of my sample it is difficult to make any definite inferences, but there was a difference between the three samples: whereas the grades five and six groups showed roughly normal distributions (Figure 13 and Figure 14), the grade seven group had a negatively

skewed distribution with more participants scoring higher, but a few tending to score very low (Figure 15).

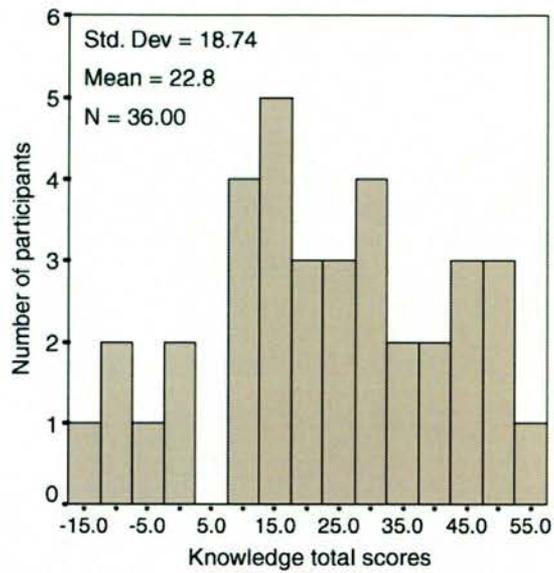


Figure 13. Grade five knowledge total distribution

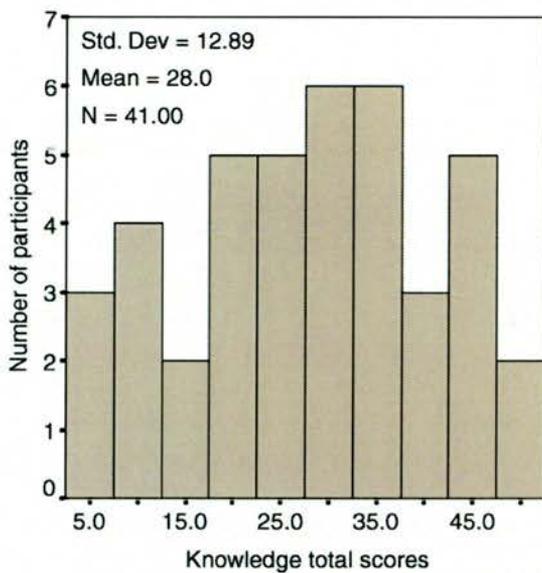


Figure 14. Grade six knowledge total distribution

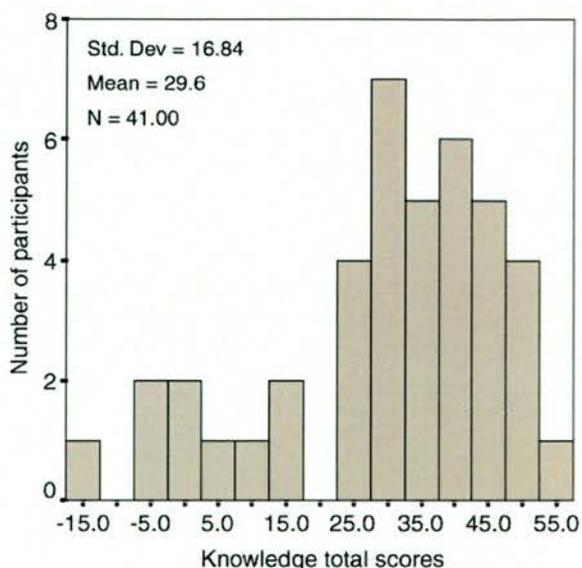


Figure 15. Grade seven knowledge total distribution

Because all the participants in this sample had been receiving HIV/AIDS education, this pattern may indicate the progression and increase of their knowledge levels that culminate in the higher levels exhibited by the grade sevens. As they come to the end of primary school, the majority have good knowledge about HIV/AIDS its causes and effects but there is still a small minority that have somehow not picked up the messages. Although these results are in no way conclusive and are a suggestion of what may happen, they do raise further questions: do the children have varying levels of knowledge before they become involved in the formal school curriculum; how does this develop over their years in primary school; and why do these differences persist through the course of their education. The data is insufficient to address these questions and it is unlikely that the qualitative data can shed more light, but it is still important to raise these issues for the purposes of future research. Children in the grade seven will either progress on to secondary school or leave school altogether; either way there is greater potential for them to become involved in sexual relationships. Moreover, the small group with poor knowledge may have limited understanding of their sexuality and therefore be at greater risk of contracting HIV.

b) Gender: When the sample was divided by gender, girls and boys had almost identical mean and median scores, and very similar knowledge total score distributions (Figure 16 and Figure 17).

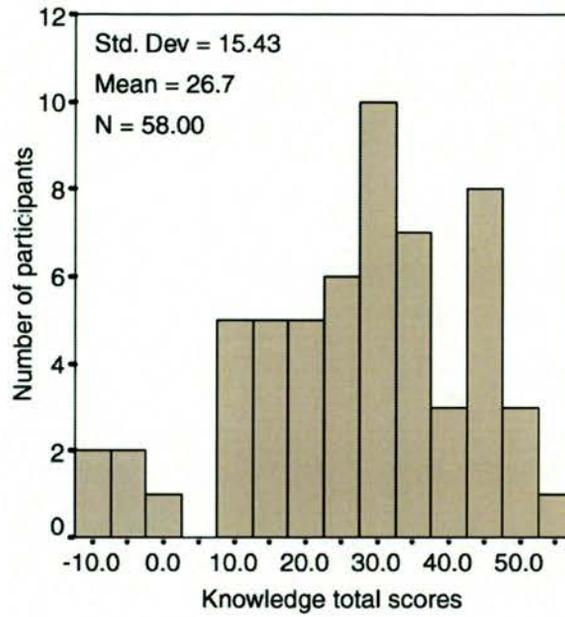


Figure 16. Boys' knowledge total distribution

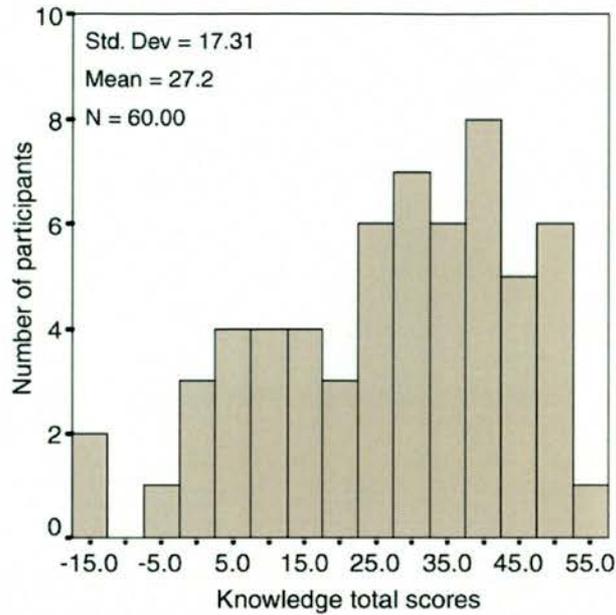


Figure 17. Girls' knowledge total distribution

The lack of any noticeable difference between genders was unexpected because usually girls tend to perform better than boys in primary school, although there were more girls with very low scores than boys, more girls than boys had high scores. Overall there were no statistically significant differences in levels of knowledge between the different grades and genders. I therefore infer that the sample reflects the situation in the population of children in their school as a whole and that there are no large differences in the HIV/AIDS knowledge levels between boys and girls in grades five, six and seven. These conclusions will however be further 'tested' by my qualitative data to ascertain whether this apparent uniformity in my sample actually exists or whether it was the result of the questionnaire design. This uniformity also brings into question the tendency to focus on girls in HIV/AIDS prevention, and may support the idea of working with both genders from an early age in order to foster more egalitarian attitudes that will be continued into later adolescence and adulthood.

5.3.3. High scorers

In order to gain more insight into the characteristics of the sample in relation to their knowledge scores, the knowledge total variable was divided into five roughly equal groups. This was to try and determine what differences there were between those who scored highest and those who scored lowest.

Table 13. Socio-demographic variables of knowledge total high scorer

Variable	Responses	N
Gender	Boy	11
	Girl	10
	Total	21
Grade	5	7
	6	7
	7	7
	Total	21
Age	9	1
	10	6
	11	6
	12	7
	13	1
	Total	21
Parents alive	Yes –both	16
	Mother only	3
	No	2
	Total	21
Number of children in family	1-2	5
	3-4	13
	5-6	3
	Total	21
Anyone in family with job	Yes	18
	No	3
	Total	21
Do you work	Yes	4
	No	17
	Total	21
Do you receive help from Tsungirirai	No	19
	Don't know	1
	Total	20

Those who scored the highest had scores of 44 and above (Table 13). All the grades were equally represented in this group. There were no 14 year olds in the

group, 12 year olds had a slight majority and both genders were almost equally represented (Table 13). Most of the participants had both parents still alive, and they came from families with 3-4 children, but there were none who came from very large families with 7 or more (Table 13). The almost equal representation of boys and girls in this group is important because it seems to indicate that at this life stage both genders have more equal access to HIV/AIDS related knowledge, and it may thus be a good time to target girls, together with boys, before they become marginalized in society during later adolescence. The majority had someone in the family with a job, indicating some economic stability, but about a quarter of the children also worked (Table 13). None of the children reported receiving help from Tsungirirai. This may indicate that generally these children were from better off families.

Out of the six children who got scores above 50, five were girls. However a 10-year-old grade five boy had the highest overall score of 55. In relation to sexual behaviour 10 of the 25 high scorers said they would let someone touch their private parts for money or a gift. Rationally it is expected that children who exhibit good levels of HIV/AIDS related knowledge are more likely to engage in protective behaviour. These results remind us that human behaviour is not often based on logic but on socio-cultural factors and that knowledge alone does not influence or translate into behaviour. They also illustrate why epidemiological studies using quantitative methods to try and understand behaviour failed because their approach was ahistorical and acultural and could thus not understand that people did not always change their behaviour even when they possessed the correct knowledge. Two of the high scorers also said that AIDS could be cured by having sex with a virgin, another unexpected finding that will be discussed in more detail later in this chapter.

5.3.4. Low scorers

Amongst the participants there were 23 children with scores below 13.6 and this was the group with the lowest scores. The lowest score attained in this group (minus 16) was by a 12 year-old grade seven girl. There were no grade six children with minus scores. Grade five was slightly over represented and grades six and seven had equal numbers in this group (Table 14). All age groups were represented among the low scorers with the exception of nine year olds; the group was made up of mainly ten year olds and twelve year olds. There were more girls in this group than

boys (Table 14). Most of the participants had both parents who were still alive and who resided with them. Slightly under half of the participants in this group came from large families with 5 or more children (Table 14). There was someone working in most of the participants' families and only one child in this group had a job. Two children in this group said they received help from Tsungirirai.

Table 14. Socio-demographic variables of knowledge total low scorers

Variable	Responses	N
Gender	Boy	10
	Girl	14
	Total	24
Grade	5	10
	6	7
	7	7
	Total	24
Age	10	10
	11	4
	12	8
	13	1
	14	1
	Total	24
Parents alive	Yes –both	16
	Mother only	4
	Father only	4
	Total	24
Number of children in family	1-2	4
	3-4	9
	5-6	8
	7+	2
	Total	23
Anyone in family with job	Yes	18
	No	6
	Total	24
Do you work	Yes	1
	No	22
	Total	23
Do you receive help from Tsungirirai	Yes	2
	No	17
	Don't know	3
	Total	22

The majority of the children (n=16) in this group did not know what HIV is, three thought it was a bacteria and only four answered this question correctly. None of them knew that AIDS is a collection of illnesses. However, unlike some of the high scorers, none of the low scorers thought AIDS could be cured by sleeping with a virgin. Nevertheless, three said they would let someone fondle them for money or a gift, and six said they would have sex for money or a gift. This group had very poor scores and there is nothing remarkable in their demographic profile to explain this poor performance. They may be slow learners who have not responded well to Zimbabwe's mass-based education and have thus become casualties of an overloaded system that has overcrowded classrooms and overworked teachers. Alternatively there may be a key variable such as starting school late, which was not measured by the questionnaire and which may account for their lack of knowledge.

Except for family size there are no differences between the socio-demographic indicators of the low and high scorers that give insight into why one group scored so much better than the other. There seems to be a tendency for low scorers to be younger, to be girls and to come from large families but with such a small sample and without more detailed information, it is difficult to come to any definite conclusions.

5.3.5. Lifesaver questions

Having determined the profiles of the low and high scorers, a number of knowledge questions (questions 4, 5, 6, 7d, 8c, 9, 10) were selected and computed into a variable called 'lifesaver'. These were questions that were assumed to have the *potential* to 'save the children's lives' if they knew the correct answers to them, or put another way, that incorrect knowledge on these issues was 'life threatening' (assuming a hypothetical direct link between knowledge and action). The assumption was that if a child had a low lifesaver score they were more at risk of contracting HIV, i.e. that high knowledge leads to potentially safe behaviour and ignorance to risky behaviour. As stated earlier, I do not believe that knowledge necessarily influences behaviour, but an awareness of what is and is not dangerous is a good starting point. The highest lifesaver score that could be attained was 28 and the lowest was minus 16; unlike the knowledge total results, some of the participants got all the lifesaver answers right (Figure 18). The median score was 18, and again the

distribution was negatively skewed (Figure 18). In general the participants had better knowledge of answers to the lifesaver questions than the knowledge total questions.

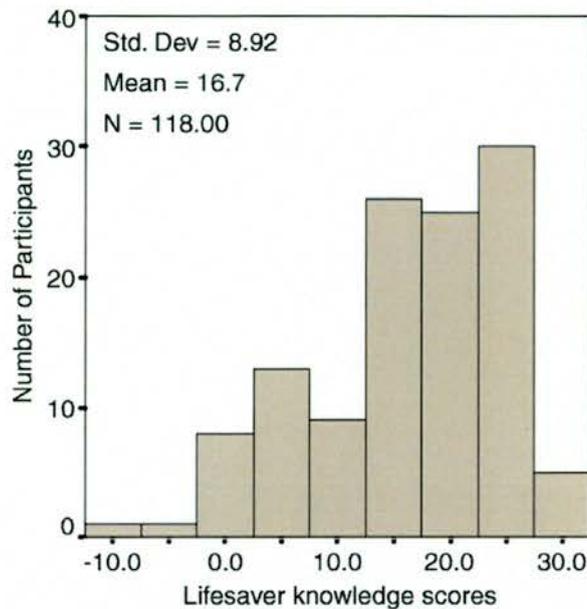


Figure 18. Lifesaver knowledge score distribution

Any gendered differences in lifesaver scores were negligible (boys mean = 17, girls = 16). The same pattern emerged for grade with grades six (mean=18) and seven (mean=19) having similar mean scores and grade five having a lower score (mean=13).

5.3.6. Lifesaver high scorers

The lifesaver variable was divided into quintiles to ascertain whether participants with particular characteristics tended to score either very high or very low. The 25 highest scorers had scores of 26 to 28. They were split almost evenly between the genders and there was almost equal representation of grades seven and six, but few grade fives (Table 15). The majority said their parents were alive, but those participants who had one parent alive were all paternal orphans (Table 15). Most of the participants in this group were aged 12 and none came from families with seven children or more. Nearly all had someone in the family with a job and only one

child in this group worked (Table 15). There were no children in this group receiving help from Tsungirirai.

Table 15. Comparison of socio-demographic variables for lifesaver high and low scorers

Variable	Responses	High scorers	Low scorers
Gender	Boy	12	10
	Girl	13	13
	Total	25	23
Grade	5	4	10
	6	11	6
	7	10	7
	Total	25	23
Age	9	1	0
	10	4	7
	11	6	7
	12	13	7
	13	1	1
	14	0	1
	Total	25	23
Parents alive	Yes –both	20	16
	Father only	0	2
	Mother only	5	5
	Total	25	23
Number of children in family	1-2	7	5
	3-4	15	9
	5-6	3	7
	7+	0	1
	Total	25	22
Anyone in family with job	Yes	21	17
	No	4	6
	Total	25	23
Do you work	Yes	1	1
	No	24	22
	Total	25	23
Do you receive help from Tsungirirai	Yes	0	1
	No	20	18
	Don't know	2	2
	Total	22	23

5.3.7. Lifesaver low scorers

Twenty-three children had lifesaver scores that ranged from minus 10 to 7. They were again almost evenly split by gender. There were more grade five children

in this group and similar numbers from grades six and seven (Table 15). The majority had both parents alive. Most had someone in the family with a job and again only one child in this group worked. One participant in this group received help from Tsungirirai.

Comparing the two groups reveals that there were no major differences between low and high scorers, except that more participants from grade five tended to score low (Table 15). This could be because they had been having HIV/AIDS education for only one year. The lack of differences may also show that education in school is not the only factor affecting levels of knowledge but that the social environment outside of school also contributes to their knowledge.

5.3.8. Comparing knowledge total scores and lifesaver scores

The profiles of the knowledge total and lifesaver low and high scorers were very similar and it was necessary to check whether the same children were consistently scoring very high or very low. Eighteen participants were found in the lowest scoring groups for both lifesaver and knowledge total (Table 16). Looking closely at their answers, this group tended to select the 'don't know' option, which accounts for their low scores. There was also consistency in the answers given by this group.

With the high scorers 14 participants were in the highest scoring groups for both knowledge total and lifesaver. An interesting finding within this group was that nine out of these fourteen consistent high scorers said they would have sex (n=6) or let someone touch their private parts (n=5) for money or a gift.

Table 16. Comparison of the socio-demographic characteristics of knowledge total and lifesaver low scorers

Variable	Responses	Knowledge total low scorers	Lifesaver low scorers
Gender	Boy	10	10
	Girl	14	13
	Total	24	23
Grade	5	10	10
	6	7	6
	7	7	7
	Total	24	23
Age	10	10	7
	11	4	7
	12	8	7
	13	1	1
	14	1	1
	Total	24	23
Parents alive	Yes –both	16	16
	Mother only	4	2
	Father only	4	5
	Total	24	23
Number of children in family	1-2	4	5
	3-4	9	9
	5-6	8	7
	7+	2	1
	Total	23	22
Anyone in family with job	Yes	18	17
	No	6	6
	Total	24	23
Do you work	Yes	1	1
	No	22	22
	Total	23	23
Do you receive help from Tsungirirai	Yes	2	1
	No	17	18
	Don't know	3	2
	Total	22	23

Although certain children consistently scored high and others consistently scored low, there is no clear indication that a particular socio-economic background makes a child more likely to know more or less about HIV/AIDS. This is a positive finding because it indicates that background and family circumstances do not necessarily affect a child's ability to pick up information about HIV/AIDS. Therefore, the mode of delivery may be more of deciding factor. This finding is not conclusive

because of the size of my sample, and it would be useful to conduct studies with larger samples and with children from rural backgrounds in order to determine the effect of socio-economic background on levels of knowledge. It is also significant to note that not all children learn in the same way but it is likely that information is delivered in only one way. This puts the onus for change not on those who are receiving the knowledge but those who deliver it. Effective use of participatory methods such as those contained in the Life skills programmes may ensure that all children pick up not only HIV/AIDS related knowledge but sexual negotiation skills as well.

5.4. One-way analysis of variance test results

An ANOVA test was used to check for statistically significant relationships between knowledge totals and the attitude, information source and behaviour variables. This was to determine whether children's levels of knowledge (as measured by the knowledge totals) had any relationship with the non-knowledge variables, that is, whether scoring high or low was linked to the selection of particular responses. This would indicate if poor or good knowledge was related to having certain attitudes, obtaining information from certain sources or partaking in particular behaviours. Although there was no expectation of conclusive results, these results were useful for beginning to build a picture of other factors' interaction with knowledge. Only eight variables had statistically significant relationships at the 0.05 level (Table 17).

5.4.1. Knowledge and attitudes

Table 17. Significant attitude related variables from a one-way ANOVA (analysis of variance) test with knowledge total scores

Variable	F	*Sig.
People get AIDS if they have multiple sex partners	8.5	.004
People get AIDS if they go to beer halls	4.2	.041
People get AIDS if they drink dirty water and eat dirty food	4.8	.031
People get AIDS if they have unprotected sex with an HIV+ person	12.0	.001
Aids can be cured by sleeping with a virgin	10.9	.000

*Sig. \leq 0.05

There were several variables measuring the participants' attitudes that had statistically significant relationships with knowledge levels. Participants who thought that people who have multiple sex partners get AIDS had higher knowledge scores than those who thought otherwise. It is correct that the more sexual partners people have the more they are at risk of contracting HIV, but it is also true that it can only take one HIV positive partner to infect a person with HIV. It was positive that the participants were aware that multi-partnering does increase risk, but it is also important for them not to assume that 'sticking to one partner' will necessarily protect them from HIV. This has been one of the slogans of the Zimbabwean anti-AIDS campaign, but what that slogan does not reveal is that being monogamous may lead to *serial* monogamy where mutually faithful partners may have had other partners before. Without being tested for HIV one cannot know whether one's faithful partner is HIV positive or not, thus although monogamy reduces risk it does not eliminate it. Therefore although it may seem that this is good information for the children to be aware of, it does not necessarily translate into protective action. Input from the qualitative component of the study was particularly important here because during the discussions, the participants in the sub-sample clearly expressed that being faithful to one partner would be ineffective if both partners had not been for HIV testing and were unaware of their HIV status (see **6.2.1.1**).

Participants who believed that people who go to beer halls were more likely to catch AIDS had lower knowledge scores than those who did not agree with this statement. Research has shown that those patronising beer halls and bars can be at risk of contracting HIV because intoxication may lead to the reduced likelihood of using condoms during casual sexual encounters (Ray *et al.*, 1998). Anti-AIDS slogans have also portrayed beer halls as risky spaces. The results indicate that the majority of participants, however, were aware that not everyone who patronises beer halls would catch AIDS. It is important that children do not uncritically accept simplistic messages about geographies of risk; these messages may lead them to perceive certain spaces as safer than others when it is not necessarily the case. Nevertheless, during the qualitative diagramming some participants did identify beer halls as being risky and immoral spaces (see **6.2.2.2**).

Only five participants thought that drinking dirty water or eating dirty food causes HIV/AIDS. Not surprisingly, these children had lower levels of knowledge than those who thought otherwise. The statistical significance from this result shows that there was a small core group of children who really had very little knowledge about these issues (Table 17). All children within this context should know that food and drink have nothing to do with contracting HIV/AIDS. It is fortunate that the majority knew this, but still raises concerns about those who seem to be missing the messages that are being relayed all around them.

The same concerns are raised by the finding that 16 children, with low knowledge scores, did not consider having unprotected sex with an HIV positive person a risk factor for AIDS (Table 17). This minority exhibits an alarming lack of knowledge. Although it can be argued that this was a leading question, it was included specifically to identify complete lack of knowledge or understanding about HIV/AIDS. All the children were expected to get this question right and yet some did not. This emphasises the significance of this study and the need to evaluate the impact of the AIDS curriculum in schools.

Seven participants were responsible for the significant relationship between knowledge levels and the statement that AIDS can be cured by sleeping with a virgin. These participants agreed with this statement *and* had higher knowledge levels than those who responded negatively to this statement. This question was included in the questionnaire to check whether children pick up the myths being propagated in society. This myth is particularly dangerous because it has led to HIV positive men raping young children in the belief that they will be cured. The fact that these few participants, with relatively high levels of knowledge (their knowledge total scores ranged from 25-55, and lifesaver scores from 7-27; one was a knowledge high scorer, one was a lifesaver high scorer and a third scored high in both variables), believed this myth is difficult to comprehend. However, most of them were grade fives (n=4) and aged 10 or younger (n=5) so being younger could partly explain this misconception. This finding also underscores the point made earlier that children who are well informed may have gained their knowledge from a variety of sources and this knowledge may not be organised in the logical way assumed by epidemiologists.

People often think and act in seemingly illogical ways and it is important for health researchers to be aware of this.

5.4.2. Knowledge and information sources

Five information source variables had significant relationships with knowledge levels. Firstly, participants who selected newspapers or magazines as one of their sources of information about HIV/AIDS had higher knowledge levels than those did not select this option. This information may have been from lifestyle magazines or local newspapers and in the form of articles or anti-AIDS inserts. Unfortunately the question did not ask for details of the newspaper/magazine so it is not clear whether this was material aimed at adults or children.

Table 18. Significant information source and behaviour related variables from a one-way ANOVA (analysis of variance) test with knowledge total scores

Variable	F	*Sig.
Learnt about HIV/AIDS from magazines	12.0	.001
Learnt about HIV/AIDS from posters/pamphlets	4.5	.037
Learnt about HIV/AIDS from a school teacher	11.6	.001
Who would you ask about HIV/AIDS	6.9	.002
Who should tell you about AIDS	4.4	.003
Would you let someone touch your private parts for money/gift	6.4	.002

*Sig. ≤ 0.05

Secondly, teachers were another source of information selected by children with higher knowledge scores. School is a major source of information about HIV/AIDS for children of this age in Zimbabwe therefore it is no surprise that teachers were significantly associated with higher levels of knowledge. This finding is encouraging and supports the implementation of HIV/AIDS and Life skills education in primary schools.

Thirdly, six participants reported that they had learnt about HIV/AIDS from posters or pamphlets. The questionnaire did not ask about the type of posters or pamphlets but there are certainly many HIV/AIDS prevention materials that are exhibited on billboards and on walls in all communities in Zimbabwe.

The fourth significant variable asked the participants who they felt should give them information about sex, HIV/AIDS and pregnancy. Those who said they did not know had significantly lower knowledge scores than those who responded identifying someone, e.g. teachers or parents, as a potential source of information. This could be an indication of a lack of confidence about HIV-related issues leading to them being unsure of the appropriate person to ask. This finding provides some support for the use of participatory methods that encourage children to interact and engage actively with their peers and teachers in the classroom; this type of teaching may be useful in helping children to gain the confidence to ask questions, and to not remain ignorant and in danger of misconceptions and deception. The qualitative diagramming sessions displayed the importance of providing forums where children can talk freely and also how their lack of knowledge and their misconceptions can be dealt with within that forum (see Chapter 6).

The fifth variable showed a significant relationship between knowledge levels and the question about whom the participants would *ask* if they had a question about HIV/AIDS. Initially it was not clear from the data why there was a significant result because of the long list of information sources (see Appendix 2). It was therefore necessary to recode the variable and collapse the sources of information into three distinct groups: formal sources (teacher, doctor, nurse) informal sources (family members and friends) and don't know.

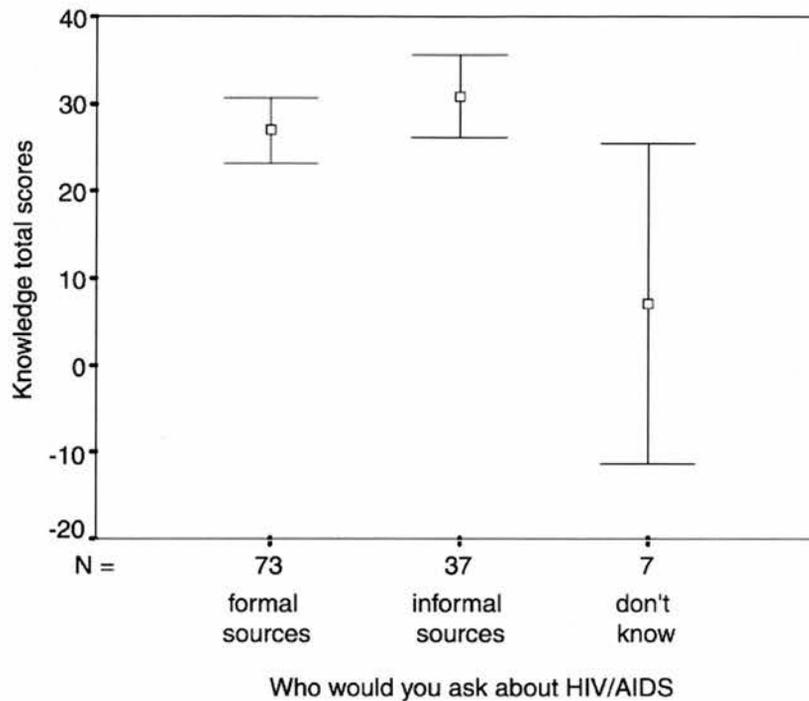


Figure 19. Error bar graph showing relationship between lifesaver scores and who the participants would ask if they had a question about HIV/AIDS

This produced a clearer picture of the data and as Figure 19 shows, those who selected formal and informal sources of information had higher scores than those who said they did not know who to ask. This again indicates that most participants had thought about these issues and were aware of them, but there was a small minority that either felt there was no one they could talk to about HIV/AIDS or had not given the issues much thought. This finding also indicates that children who have the opportunity to discuss these issues with either friends or family have higher knowledge levels. This could be a signal of dialogue where the children have opportunities to ask questions and engage in discussion with family members, thus resulting in better understanding of the issues surrounding HIV/AIDS. The qualitative results will discuss this issue in detail (see 6.2.2.1)

5.4.3. Knowledge and Behaviour

Only one behaviour variable had a significant relationship with knowledge (see Table 18). Participants who said they would let someone touch their private parts for money or a gift, had higher knowledge scores than those who responded no or

don't know. This was puzzling because it might be expected that participants with good knowledge about the dangers and risks of HIV/AIDS would know that accepting financial or material incentives in exchange for letting someone fondle them would be risky behaviour within this context. An explanation for this unexpected response could be that these participants felt confident enough to want to engage in this behaviour and, because of prior experience, knew that fondling would not necessarily lead to sexual intercourse. Alternatively, this finding is accounted for by a large proportion of grade seven boys (45%) who may be more likely to be sexually adventurous and feel less at risk of sexual exploitation. However, this evidence of the children's willingness to exchange sexual favours for material gain was consistent with the behaviour of adolescents and adults where transactional sex is the norm. It is again an indication of the weaknesses of medical models that assume that rational knowledge leads to rational behaviour. This also may also indicate that the way in which children are learning about HIV/AIDS does not integrate discussions on real life situations that they may face. Aspects related to this finding were explored in more detail during the qualitative phase (see 6.2.2)

5.4.4. Lifesaver variable

Most of the variables that had a significant relationship with knowledge totals also showed significance with the lifesaver variable when tested with the ANOVA. Exceptions were 'people who go to beer halls get AIDS' and 'who would you ask about HIV/AIDS', both these variables did not have a significant relationship with the lifesaver variable. A further four variables also emerged as significant (Table 19).

Table 19. Additional variables from a one-way ANOVA (analysis of variance) test with lifesaver total scores

Variable	F	Sig.*
People get AIDS if they play with the opposite sex	4.4	0.039
Learnt about HIV/AIDS from parents/relatives/guardian	4.1	0.05
Learnt about HIV/AIDS from friends	6.8	0.010
Where did you learn the most about HIV/AIDS	2.1	0.037

*Sig. \leq 0.05

From the attitude variables, participants who thought that if you ‘play’ with the opposite sex you get AIDS had lower lifesaver knowledge scores than those who disagreed with this statement. This question was meant to check how children understood the use of the word ‘play’ and whether it could be a euphemism for sex. Only thirteen participants responded in the affirmative to this question showing that the majority understood the word play, as non-sexual.

Three additional information source variables emerged as significant. Participants who said they had learnt about HIV/AIDS from parents, relatives or guardians had higher lifesaver scores than those who said they had not. This is positive because it seems to show that communication between children and their carers about HIV/AIDS related issues has a positive effect on the children’s levels of knowledge. The questionnaire did not have a supporting question on the type of information given, and the way it was given, but this was explored during the qualitative sessions (see **6.2.2.1**).

The second significant variable was that participants who said they had learnt about HIV/AIDS from friends had higher scores than those who said they had not. Again it was not clear what kind of information was being relayed amongst their peers, but since those who selected this option had higher scores than those who did not, the information may have been accurate. More details on the type and accuracy of information were obtained during the qualitative sessions and will be discussed in the next chapter.

The final variable that was significant was the source from which children had learnt most about AIDS. Participants who had selected family as their most important source of information had higher knowledge scores than those who had selected other sources of information. This finding is significant and together with the one above indicates the important role that family members can play in relaying information to children of this age. Primary school aged children are still at a stage where they look up to adults and therefore if the adults can make the effort to communicate HIV/AIDS related information in a clear way that encourages dialogue, these results indicate that it may make some difference to children’s knowledge levels.

5.5. Summary

This chapter has presented the results from the knowledge, attitudes and behaviour questionnaire and raised some salient points as to the knowledge levels of the research participants. It reveals that the participants had a wide variation of knowledge about HIV/AIDS related issues that was generally good. But the findings also show that a large proportion of them had fair to very poor knowledge, which is surprising because the government's AIDS Action curriculum was taught at the school. The children with poor knowledge may not have picked up the HIV/AIDS prevention messages being relayed within the school context because of the way this information is given. The AIDS Action curriculum is based on the Life skills education programme and on paper, it is a thorough comprehensive syllabus that aims to provide information about HIV/AIDS related issues and to address the challenges young people face. The curriculum is meant to be taught in a participatory manner that actively involves and engages children (see 3.6.1), but in most schools this is not been done as teachers have neither the resources, the confidence, the time nor the inclination to deal with these issues using these methods (Bassett & Kaim, 2000; Kaleeba *et al*, 2000; Power *et al*, 2004). This results in the materials being administered in a didactic way that may not encourage questions and thus leaves those who have difficulty understanding the issues with no opportunity to request clarification. Thus a potentially effective curriculum, which could be the only way some children receive correct and detailed information about HIV/AIDS, may be failing to reach them.

The data also revealed, significantly, that there were equal numbers of boys and girls in the sample (which may indicate that this was the same in the school), and there was parity in knowledge between the genders. The analysis found no significant gendered differences in knowledge levels, attitudes or behaviour. This was an encouraging finding within this context because it indicates that primary school girls have the same opportunities for learning about HIV/AIDS as boys. However, the continuing spread of HIV/AIDS shows that the ability to convert knowledge into practice is uncertain since it is dependant on the opportunity to exercise choice in sexual decision making, and girls may still be at a disadvantage as has been

emphasised in the literature (see 3.3.3.3); this will be discussed further in the following chapter.

The quantitative data also begins to show evidence of children's agency. In Zimbabwe most adults do not approve of children being taught about condom use. This has been demonstrated by the government's removal of this aspect of HIV/AIDS prevention from the curriculum, and also from first hand experience of the headmistress' negative attitude towards condoms (see 4.5.1). Despite this adult resistance the children still knew that condoms are an effective way of preventing HIV infection, furthermore a majority thought that condoms afforded better protection from HIV than abstinence - the school's prevention method of choice. Thus from these results it is already apparent that: children cultivate their own knowledge and opinions about sexual health and do not simply parrot those of their parents; they have ways of gaining access to knowledge that is forbidden; and finally, children may be developing a greater acceptance of condom use than has thus far been recorded among adults (Gwanzura-Ottmöller & Kesby, 2005).

Lastly, the results indicated that children display the inclination to engage in risky behaviour even when they have high levels of HIV/AIDS prevention knowledge. This is a factor that has been observed among adolescent and adult populations throughout the era of HIV/AIDS behaviour research. Although the medical model of behaviour assumes that good knowledge should lead to protective behaviour it overlooks the fact that behaviour is socially and culturally constructed and even though a person may hold the right kind of scientific or rational information they may engage in behaviour that defies logic (Campbell & Williams, 2001). For any kind of impact to be made on behaviour there needs to be understanding of the culture in which this behaviour is constructed, and an emphasis on tackling these issues at the societal as well as at the individual level. Therefore, this chapter has provided insight into the HIV/AIDS related knowledge of the participants and raised issues that will be further explored using the qualitative data in the next chapter.

6. Qualitative results: the extent and nature of children's sexual knowledge and behaviour

6.1. Introduction

This chapter presents and discusses the results from the qualitative phase of the research that consisted of diagramming and individual interviews (see 4.4.7.4 and 4.4.7.5). These results will be presented as themes and will incorporate both the group discussions and the individual interviews in order to compare, contrast, support or build on the ideas presented by each form of data. The qualitative results not only add to the understanding of the phenomena identified in the previous chapter but also develop them further. This chapter goes beyond the quantified identification of children's HIV/AIDS related knowledge to present an in depth discussion of the quality and acquisition of this knowledge, as well as the extent and nature of their sexual behaviour. The presentation of qualitative data requires extensive use of quotations, and in this chapter I have used a large number of quotations to illustrate the themes identified from the data and to include, as much as possible, the voices of the children involved in this study. This is significant because children have been marginalized in HIV/AIDS research, and their voices have been excluded from *Children's geographies* on the topic of HIV/AIDS and sexual behaviour. I acknowledge that this is not a flawless process because the quotations or voices included in this chapter have been selected to meet my own requirements, but the inclusion of the quotations is an attempt to balance this. The chapter will therefore move between description (presentation of quotations) and analytic interpretation of the data as well as my own personal reflexive comments on the research process.

The results in this section address the second research question in this thesis *i.e.* determining the extent and nature of primary school children' sexual behaviour and knowledge. However, this chapter will also address HIV/AIDS related

knowledge building on from the quantitative results. The questionnaire gave an overview of the levels of knowledge but without much detail and depth. Thus, the qualitative data from the early diagramming sessions tried to uncover more in-depth information from the participants about their knowledge and understanding of how HIV/AIDS can be contracted and prevented. The diagramming sessions, and in particular the tree diagrams and the body maps (see 4.4.7.4), provide detailed information that was lacking in the quantitative results and serve to afford more insight into some of the issues raised in Chapter 5.

The first part of this section will thus deal with themes related to HIV/AIDS knowledge, in particular how well the participants understood issues about a) transmission of HIV, and b) prevention of HIV. Data presented here will mainly deal with *a priori* issues that had either been identified before the data collection began or that arose from the questionnaire responses (see 4.6.2.2). There will also be discussion of emergent themes identified from the diagramming discussions. The second results section will focus on the participants' understanding, perception and experience of sexual behaviour, taking into account *a priori* issues identified from the literature (see 3.2 and 3.3) as well as emergent themes from the discussions.

The quotations included in this chapter illustrate the themes identified during the coding and analytical processes (see 4.6.2.2). I have attempted to capture the voice of the participants, however as discussed above, not all participants chose to - or could voice their opinions (see 4.5.2); an inevitable limitation that should be borne in mind by all readers. But all research is compromise therefore, I state that the quotations presented below represent most but not all the participants, and hope that since they were all involved in developing the diagrams they are still represented albeit in a less conspicuous way.

6.2. Knowledge related themes

6.2.1. Catching HIV/AIDS

Tree diagrams were used to determine whether the participants knew of the ways that HIV can be contracted and how exactly (physically) this happens. Although

the children might have been taught about HIV risk factors, this may not have been detailed and they may have lacked understanding of the physical and biological mechanisms involved. For knowledge to be of any use, it is necessary to have a practical understanding of how the virus gets into the body so that there can be better comprehension of the importance of safe sexual behaviour. These issues formed part of the questionnaire (see Appendix 2) and we had given feedback and correct information after that phase as part of the action orientated/ethical approach adopted. Not surprisingly therefore, many of the ways in which participants in the group sessions suggested that HIV/AIDS is contracted were similar to those in the questionnaire and feedback sessions. This could be criticised as contamination of the data, but the questionnaire only presented options of how HIV can be contracted and it did not present explanations (Gwanzura-Ottmöller & Kesby, 2005). During the interviewing of the diagrams the participants were required to explain their choices and how these factors put a person at risk of HIV. Knowledge displayed by the participants ranged from poor to good, and there was incomplete understanding of the mechanisms in some cases, which may be evidence of a lack of in-depth coverage of these issues in the school curriculum.

The participants understood that HIV was present in the blood and confidently explained situations that resulted in HIV infection such as sharing razor blades with an HIV positive person and through injuries sustained during car accidents:

All-5A Boys: [Reading out from their diagram] 'To use razors which have been used by a person with the HIV virus'.

RESEACHER: So how do catch the virus from the razor?

B-5A: You will be using a razor that's been used by someone else, the blood will be fresh and then you'll cut yourself and get it [HIV].

(Excerpt from Tree diagramming session with grade five boys)

B6-6A: [Reading out from their diagram] 'If you have an accident together with a person with HIV and your blood mixes you will get HIV.'

RESEACHER: Ok please explain so we can fully understand. *You* explain [speaking to B6-6A].

B6-6A: Lets say a car overturns. If you get cut and he also gets cut and his blood flows and gets into you, you'll also get it.

RESEACHER: Aha.

B3-6A: If he has AIDS, and his blood mixes with yours you'll also get the disease.

(Excerpt from Tree diagramming session with grade six boys)

Their understanding of how HIV is spread through bodily fluids other than blood was partial. All the participants knew that the virus is contracted during sexual intercourse, but most understood the virus as being contained in blood that is present during sex, and they seemed to have limited or unclear understanding of seminal fluid:

RESEACHER: Ok. But from where in the body will the virus be coming from so that it goes into the woman.

F-5A: I think it comes out through the penis.

RESEACHER: Through the penis? In what, in water, or urine or what? That the virus comes out?

A-5A: I'm not sure.

RESEACHER: You're not sure. What about the others?

E-5A: I think it'll be blood.

(Excerpt from body map diagramming session with grade five boys)

G1-5A: ... So if you are having sex with your husband and your husband has HIV. Blood will come out of him and then his blood will go into you and then you'll get infected.

(Excerpt from body map diagramming session with grade five girls)

RESEACHER: ... Lets now talk about the HIV virus, how do you think it gets from a man to a woman? When they are having se-[x] uhu?

B2-6A: They will be...the disease will be in the sperms, that's what I think.

RESEACHER: Ok, so the disease will be inside the sperms?

[...]

B3-6A: Maybe blood comes out when a man and a woman have sex.

RESEACHER: Really, does the blood come out with sperms or on it's own?

B3-6A: I don't know.

RESEACHER: So you're just guessing. Ok. What do you others think about this? What do think happens?

B4-6A: It can be passed on through the urine because a man may have bilharzia so his urine will have blood in it so when he's having sex with a woman he will urinate into her.

RESEACHER: Really? So you say that urine may come out while they are having sex. What about you two, busy smiling [the boys giggle]?

B2-6A: What he said is what I wanted to say.

RESEACHER: About urine?

B2-6A: Yes. I think the urine and the sperms come out and mix then the disease is passed on.

(Excerpt from body map diagramming session with grade six boys)

The grade sevens had better understanding of how HIV is passed on with the girls having very good knowledge of the mechanics of reproduction. Nonetheless, some of the girls were confused as to whether HIV is passed from a man to a woman

in seminal fluid or in blood. This may indicate that there is an emphasis on contraction of HIV from blood when there are discussions about HIV either during class or in the media:

RESEACHER: ...So when the sperms come out of the father and go into the mother what will they- will it be blood?

G1-7A: No it will be watery stuff.

RESEACHER: Like water?

G1-7A: Yes because it will be whitish.

...

RESEACHER: ... What about when we are being given HIV. Lets say this man has HIV [pointing to the male body map], how will he give the virus to his wife or girlfriend?

G5-7A: There comes out blood, which will have the HIV virus.

RESEACHER: So this blood will be where there are sperms and the fluid that was mentioned earlier.

G5-7A: Yes.

RESEACHER: Ok.

G1-7A: No! I disagree with her. The sperms are carried in the same fluid that virus is carried in, so when it goes into the woman that is how AIDS is spread.

RESEACHER: Ok. Is there anyone else who wants to say something?

Several-7A Girls: No.

RESEACHER: No. So who do you agree with this one G-?

G5-7A: Five.

RESEACHER: With G5 or G1? She says they (sperms) come out in blood, and she (G1-7A) says no the fluids will have HIV, they carry the HIV? G1, what about you G1 as well?

G6-7A: I think G5.

G2-7A: G1.

RESEACHER: So that's four against two. So you are saying blood [G5-7A and G6-7A] and you [G1-7A, G2-7A, G3-7A, G4-7A] are saying no it's the fluids [that carry the virus from the man to the woman].

All-7A Girls: Yes.

(Excerpt from body map diagramming session with grade seven girls)

Thus although the participants knew that HIV is contracted through sexual intercourse most of them were still not clear on exactly how this happens which was surprising since they were receiving instruction on HIV/AIDS prevention in school. HIV/AIDS education was part of the curriculum but the children's lack of understanding might suggest that there were holes in the curriculum or the way it was taught.

Cultural constructions of reproduction

Body maps proved to be very useful tools for clarifying how well the children knew and understood their bodies. Cornwall (1992) states that this visual representation of the body focusing on the reproductive system helps to clarify ambiguities and provides a rapid, shared reference point. As adults we have reasonable knowledge of the body and the mechanisms of sex and reproduction, however it was important to understand what the children knew about their bodies in order for us to get better insight into their explanations and perceptions. Because the project attempted an element of action research it was also important to correct the children's misconceptions (see 4.4.7.4 Body maps). Below are the photographs of two body maps drawn by girls in grades five and seven (Figure 20). The drawing on the left by the grade five girls illustrates their limited understanding of the reproductive anatomy and their lack of knowledge as to where reproductive organs are placed in the body. The diagram by the grade seven girls however, shows a more anatomically correct representation and displays their superior understanding of the female anatomy.



Figure 20. Female body maps by grade 5 girls and grade 7 girls

The theme relating to cultural constructions of the reproductive system emerged during interviews of the body maps. This was the only time during the

research process that a significant difference in knowledge and understanding between the grades was exhibited. The quantitative data had shown no significant differences in knowledge levels between the children in the different grades and generally there were no outstanding differences in understanding in the diagramming sessions, with the sole exception of the body map sessions.

As discussed in chapter 2 (see 2.5.1), in the traditional *Shona* worldview children are constructed as a product of the man's seed while the woman's body or womb is understood as a vessel for containing the man's seed (Runganga & Kasule, 1995). Sex during pregnancy is seen as a way of the man nourishing his progeny with his sperm and thus strengthening the foetus. One might expect this conceptualisation to be more strongly held by the older generation and possibly by those living in rural areas. Nevertheless, the body mapping sessions among these urban children revealed that participants in three groups (grade five boys and girls and grade six boys) held similar traditional understandings of the body and of reproduction. For example grade five and six boys expressed the views that eggs/babies come from men:

B4-6A: When the man produces sperms, and they go into the woman, and the sperms group together, where they are gathered that's where they'll produce an egg.

RESEACHER: Really, so you're saying that the baby comes out from the father.

B4-6A: Yes.

(Excerpt from Body map diagramming session with grade 6 boys)

B4-6A: [speaking in English] It is used to make a baby?

RESEACHER: [speaking in English] How?

B4-6A: By having sex.

RESEACHER: So the baby will be coming out of there [penis]?

B3-6A: No!

RESEACHER: That's what I want to know.

B4-6A: [speaking in English] The penis will go into the vagina...the woman and the sperms will make an egg.

RESEACHER: The sperms will make an egg?

B4-6A: Uhu.

(Excerpt from Body map diagramming session with grade 6 boys)

F-5A: I think the baby will be in the man's penis. The penis carries it [the baby].

RESEACHER: Oh. What will it be, a sperm or what?

F-5A: I don't know.

RESEACHER: You don't know. So when they have sex is that when the baby goes into the mother?

F-5A: Yes.

(Excerpt from Body map diagramming session with grade 5 boys)

The grade five girls said that when the man and a pregnant woman had sex, the man would be strengthening the egg:

G4-5A: The father strengthens the egg.

RESEACHER: How does he strengthen it?

G4-5A: By having sex.

G4-5A: By having sex.

RESEACHER: So what happens during sex which makes a child strong?

[Long pause]

RESEACHER: You're not sure?

All-5A Girls: Yes.

(Excerpt from Body map diagramming session with grade 5 girls)

RESEACHER: ... So will there be one egg?

G6-5A: Yes it will be only one.

RESEACHER: So how can people have seven children? So where will these eggs be coming from?

G6-5A: Ummm. When the father is strengthening it with his penis the egg- the mother and the baby's stomachs will be joined together so this will cause the egg to grow.

RESEACHER: Oh. So when the mother and father have sex is that what causes the egg to come out? In the meantime the eggs will be sitting somewhere?

G5-5A: The egg will be growing when the father strengthens it.

RESEACHER: Oh. Ok.

RESEACHER: You didn't answer the question of where the egg comes from.

RESEACHER: Yes where will it come from we said, lets say in your families there are two or three or five children and some have ten children. So where will the ten eggs come from? You are saying that there is one egg. So where will ten eggs come from?

G1-5A: If one child is born the egg will be finished, when the father has sex with a woman then another egg will appear.

RESEACHER: But where will it come from?

Several-5A Girls: Aaaaaaaah?

RESEACHER: You keep saying it comes, but you're not saying from where. Does it come from outside the body? Or is there some where inside where there'll be eggs?

G6-5A: I think it'll be inside.

RESEACHER: Does the egg come from the father's penis?

G6-5A: Yes.

RESEACHER: Oh so does the egg come from the father as well?

All-5A Girls: Eeeeeeh, no!! [Laughter]

G6-5A: There I don't know.

RESEACHER: You don't know.

G6-5A: Yes.

(Excerpt from Body map diagramming session with grade 5 girls)

The girls could not really explain or qualify some of their statements which gave the impression that they were repeating information that they may overheard from adult discussions and only partially understood. Generally the participants exhibited a mix of biological and traditional knowledge and were not really secure in either of these knowledge bases. Their partial understanding of sexual and reproductive issues was partly a product of parents and other adults' reluctance to talk openly and honestly with children about sex and reproduction. The participants were also caught between two contexts that presented alternative views of reproduction: biological and traditional. At school they would receive the western scientific discourse on sex and reproduction and at home an often more traditional rendition. Thus, as was displayed in the body map sessions, the participants had difficulty rationalising the two systems and ended up mixing the two. This was exacerbated by my questioning: at school they might have felt that all they had to do was to give the scientific answer, and at home they would give the traditional answer thus reflecting the contextual nature of knowledge. The research created another socio-spatial context outside of the spaces the children usually negotiate. Within this context, where they could speak freely without fear of censorship, I was asking them to explain their attitudes and think about why they held these beliefs, which may have been a new and confusing experience for them. That said, it is probable that children in most contexts will experience confusion about how to unite two clearly different and opposing forms of knowledge – both of which are given by trusted and respected sources. It is important for children especially girls to understand their bodies, so they can avoid early pregnancy and contracting HIV. Lack of understanding about reproduction leads to lack of understanding about how contraception works, and they may thus fall prey to misinformation and misunderstandings (see Cornwall, 1992). It also has an impact on gender relations and women's self-perception about their worth and their role in reproduction (Kesby, 1999). The participants' cultural constructions of reproduction emphasise that they are products of their socio-cultural contexts and as such are subject to the misconceptions that permeate these contexts. Thus, as active social actors, children are constantly processing information that is present within their contexts.

Rape/ forced sex

This was a dominant theme, introduced by the participants in connection with contraction of HIV/AIDS and discussed throughout the diagramming sessions. The children had a heightened awareness of the dangers of rape and how that increased the chances of contracting HIV. Initially I was not sure whether they truly understood what happened during rape, and whether it was something they had heard about from the media and adult discussions.

Grade five girls exhibited in-depth understanding of what happens during rape, and explained the difference between consensual sex and rape and why the latter was more of a risk factor for contracting HIV:

G6-5A: Because if you are raped by a person with AIDS at the time you are raped you will bleed so you will catch the disease AIDS.

RESEACHER: Ok, do you want to add anything, okay...So when you bleed what will have happened what will cause you to bleed?

G2-5A: You will have been raped.

RESEACHER: Because you will have been raped?

G1-5A: Yes.

RESEACHER: So-

G1-5A: You'll start to bleed.

RESEACHER: Because you will have been treated in what way?

[Whispers]

RESEACHER: ... will you have been treated well or...

G1-5A: Badly.

(Excerpt from Tree diagramming session with grade 5 girls)

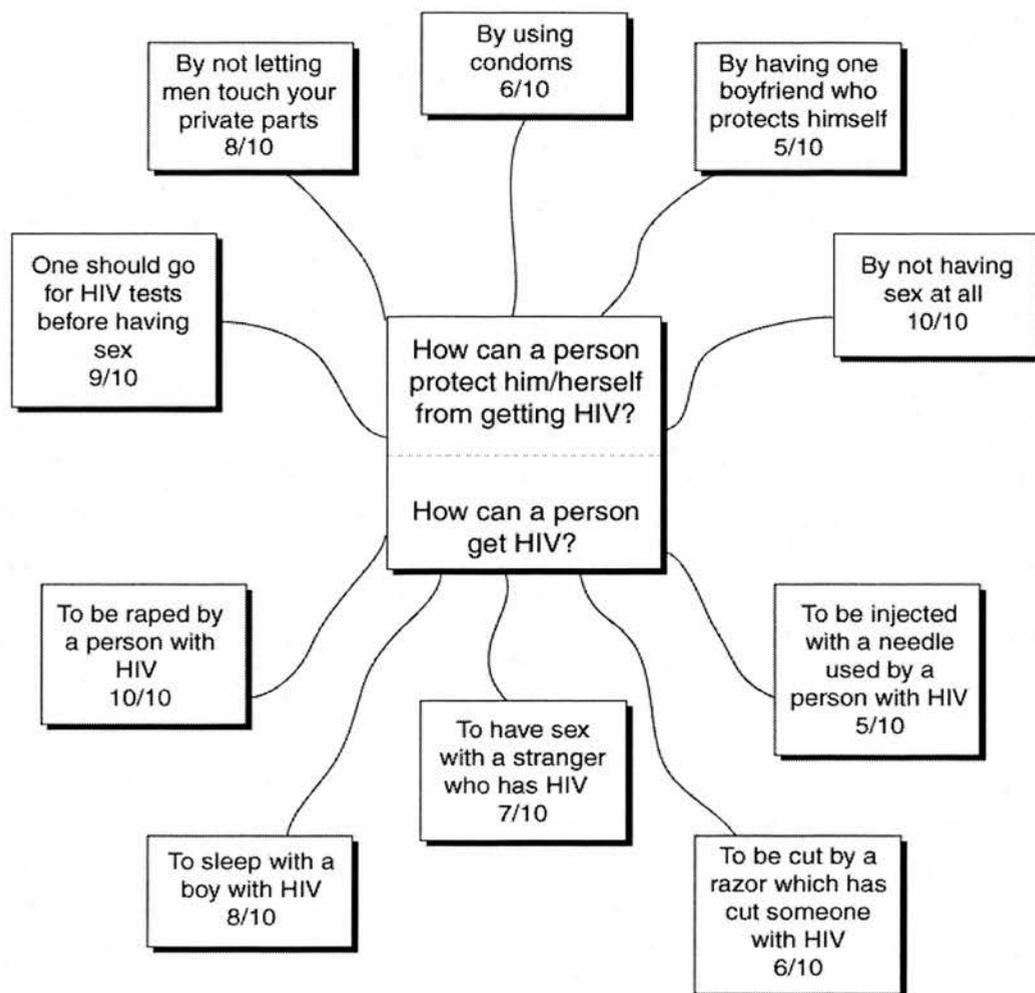


Figure 21. A representation of the tree diagram developed by grade five girls (Gwanzura-Ottmöller & Kesby, 2005)

The tree diagram above (Figure 21) shows the modes of HIV contraction and prevention that were presented by the grade five girls. The ways in which HIV can be caught are represented as the roots leading into risk and flowing into the trunk; the ways in which HIV can be prevented are the branches growing away from the trunk and from risk (Gwanzura-Ottmöller & Kesby, 2005). The participants also ranked their ideas according to risk assessment of the behaviour or the protective factor (see 4.4.7.4 Tree diagrams). The discussion below was based on the ranking of the roots (ways of catching HIV) in this diagram. I was attempting to determine whether they fully understood why they had ranked ‘to be raped by a person with HIV’ higher (and as more risky) than ‘to sleep with a boy with HIV’.

G6-5A: Aaah the other one is more important!

RESEACHER: The other one is more important? Why because on the other one you can bleed?

G6-5A: Yes!

RESEACHER: Whereas here you'll be in love?

All-5A Girls: Yes!

[Cross talk]

G4-5A: Here you wont be in love!

G6-5A: Here you'll be in love!

RESEACHER: So what makes it different?

G4-5A: Because, because here you'll be attacked...here [pointing to 'sleeping with a boy'] you'll be doing it daily, and here it'll be once in a while that you get raped, so the man may infect you with the germ - the virus then you'll catch HIV.

RESEACHER: What about the boy, won't he infect you?

G4-5A and G6-5A: He can, he can also infect you.

RESEACHER: So what's the difference? That's what I want to know.

G6-5A: Here you will love each other and know each other, whereas here-

G4-5A: Maybe you won't know each other maybe you will know each other.

RESEACHER: Aha, so you're saying that the sex is different?

Several-5A Girls: Aha!

RESEACHER: That's what I really want to understand.

G1-5A: Here it's sleeping [pointing to 'sleeping with a boy'], here its being attacked, [pointing to 'being raped'] you'll be attacked walking along and you'll get grabbed in the grass. Here you'll go into the house and lie down.

[Laughter]

RESEACHER: That's what I wanted to clarify because you're saying that here you'll be treated in a violent way?

All-5A Girls: Yes!

RESEACHER: Whereas here you'll be happy?

G1-5A: So you won't know he's slept with other girls with HIV/AIDS.

RESEACHER: Okay.

G6-5A: Here you'll get it done to you 'heavily' (violently), and here...(inaudible due to loud laughter)-

RESEACHER: No go ahead and talk.

G6-5A: Here you'll get it done heavily because it'll be once and you'll bleed, but here it'll-

G5-5A: Be every day!

G6-5A: -you'll be sleeping and it won't be the same as being attacked!

[Giggles]

(Excerpt from Tree diagramming session with grade 5 girls)

The participants demonstrated a sophisticated understanding of what happens during rape and what makes it dangerous that was unexpected in such a young group, especially considering the attitudes adults have towards discussing these issues with children. They showed that they not only knew about these issues but were also capable of discussing them in an articulate manner. They may have gleaned their

information from older siblings (Kcsby *et al.* forthcoming), but the issue of their information sources will be discussed later in this chapter. The grade five boys however, initially claimed that they did not know what rape is even though they had written it down on their tree diagram, however with a bit of probing they revealed that they understood:

RESEACHER: Oh. What is rape?

A-5A: To have sex with someone but being forced.

(Excerpt from tree diagramming session with grade five boys)



Figure 22. Grade five boys’ spider diagram showing their explanations of ‘what is sex’

Nevertheless they seemed confused about the difference between rape and sex. When asked to write down what they thought sexual intercourse was during the spider diagramming sessions (Figure 22) some of the boys described it as rape or forced sex (see 4.4.7.4 spider diagrams). These sessions came after the body mapping which involved in-depth discussion of the reproductive system. The first spider diagram thus built on the discussion of the anatomy by asking the participants to describe what they understood as sexual intercourse. The aim of this was to try and get an idea of the language used to describe sex and how it was related to the children’s actual understanding of the act. This is because in Zimbabwean society adults often use riddles and vague language when referring to sex. This leads to misunderstandings as to what constitutes sex as was expressed by these grade five boys:

F-5A: [reading out from the spider diagram] It means the mother and father will be raping each other.
(Excerpt from spider diagramming session with grade five boys)

A-5A: [reading out from the spider diagram] Having sex is sleeping with someone being forced and not wanting to.
(Excerpt from spider diagramming session with grade five boys)

RESEACHER: Ok. So what you're written, maybe you can explain what these two couldn't explain. You said 'having sex means the mother and father will be raping each other'. What do you mean by the words 'raping each other'? That the mother and the father will be raping each other? Can you explain to us what happens when they are raping each other?

A-5A: I think that when they are raping each other the mother and father will be in bed so the vagina and the penis will join together.

RESEACHER: Ok. So what is raping each other? Where did you hear that word?

A-5A: This one [rape]?

RESEACHER: Yes.

A-5A: I have heard people saying that it can happen that if a husband and wife divorce, but they still love each other. The father may go to the beer hall/bar to look for another woman so when the vagina and the penis join then they will be raping each other.

RESEACHER: So when it's the father and a woman from the beer hall, when they are having sex it's called raping each other. Ok, what do you others think about this? I want to hear your opinions about what he said about raping each other? Do you agree with it? Who agrees with it?

A-5A: I think rape is the same as what's written here [pointing to the spider's body]. That's what I think.

RESEACHER: So when a girl and a boy, or a man and a woman are in love, and they have sex would you say that they are raping each other?
[Long pause]

RESEACHER: Go ahead.

F-5A: [Unclear segment] they may love each other but I think that it's just the same as raping each other (having sex).
(Excerpt from spider diagramming session with grade five boys)

This showed that the boys had overheard these issues being discussed without fully understanding the meaning, and would pass their partial knowledge on to their friends. This leads to misconceptions being spread around the peer group without any opportunities for them to ask adults for clarification or to determine whether the information is accurate. The results also indicate the misunderstanding that results from adults' inability or reluctance to explain sex to children and how this leads to some children being unable to differentiate between a consensual and pleasurable experience and a degrading act of violence.

Perpetrators of rape were initially presented as strangers and usually adult men, and the contexts where rape took place were bushes or forests:

G3-7A: ...a girl from secondary [school] may visit her friend then she'll be late going home, and when she's going home she may be told [by a man] to get into the car and I'll give you a lift, and she gets into the car, so she'll know that she's not being taken home but being taken to the bush/forest and she'll be raped there.

(Excerpt from tree diagramming session with grade 7 girls)

Initially it seemed as though the participants were subject to the fear of 'stranger danger' that is often portrayed in Western media, and were unaware that rape is more likely to take place within the perceived safe context of the home and perpetrated by someone who is known or trusted. However, as the research progressed the participants revealed that they were fully aware of the different contexts within which rape could occur. These scenarios were presented in the participants' stories during the picture/story diagramming sessions (see 4.4.7.4 picture/story diagrams):

B4-7A: This is Sekai's father, Sekai's mother and Sekai. Sekai's Mum is going to the city to visit her brother, so she wants to take Sekai with her but the father says no. So he is left with her and they spend time together until he forces her to sleep with him.

(Excerpt from picture/story diagramming session with grade seven boys)

Getting the participants to make up these stories was a springboard, which was used to facilitate further discussion on issues they presented. In this case the boys stated that they had heard of incidents where fathers had raped their daughters, indicating that these were not just fanciful stories but representations of real life situations that took place within that context:

RESEACHER: So this story that you've told us does this kind of thing happen often?

All-7A Boys: Yes.

RESEACHER: Have you ever heard of this happening?

B1-7A and B4-7A: Yes.

RESEACHER: In the neighbourhood or somewhere else?

B4-7A: I have heard about it in the neighbourhood.

B5-7A: Also on TV.

(Excerpt from picture/story diagramming session with grade seven boys)

RESEACHER: So do you think this issue of being raped by adult relatives happens often?

G5-5A and G6-5A: Not often.

RESEACHER: You are saying often, these two are saying not often.

G4-5A: It happens a lot.

(Excerpt from picture/story diagramming session with grade five girls)

Forced sex is an issue that has been presented in much of the literature on adolescent sexual behaviour and HIV/AIDS (see 3.3.3.2). It was thus interesting to hear the participants raise similar issues relating to coercion and forced sex. Grade seven girls raised the issue in relation to primary school girls dating older boys:

G1-7A: You may be dating a boy who's big, who's in form four, whilst you're in grade seven. Then he may force you to have sex with him...

(Excerpt from picture/story diagramming session with grade seven girls)

These participants seemed to feel that their peers would be less likely or less successful in forcing girls of the same age have sex:

RESEACHER: Do you think girls are pressurised by boys, when they've been given gifts, to sleep with them?

All-7A Girls: Yes

RESEACHER: Girls of which age?

G2-7A: Secondary school.

RESEACHER: So do you think this doesn't happen to girls in primary school?

G1-7A: It can happen because she may have a boyfriend in secondary school whilst she's in primary school.

RESEACHER: Does this usually happen when the boy is older?

G1-7A: Yes.

RESEACHER: What about when the boy is the same age?

G6-7A: It doesn't usually happen.

(Excerpt from picture/story diagramming session with grade seven girls)

Although these girls did not think that force was common with peers, this does not mean that it may not happen between two primary school children, especially if the boy is older than the girl. The participants also responded that the best way to avoid getting into situations where sex could be forced was to avoid certain contexts such as going into a house alone with a boy:

RESEACHER: Do you think that if a girl has been tricked and locked in by a boy can she scream for help?

B3-6A: Yes.

B6-6A: It doesn't happen very often.

RESEACHER: Why do you say it doesn't happen often?

B6-6A: Because girls these days are clever, they know about risky situations they are taught at school that if someone asks you to get into house you must refuse and run away.

(Excerpt from picture/story diagramming session with grade six boys)

This indicates that the children are being taught about ways to avoid putting themselves at risk. However, this does not reveal whether they are actually being taught the negotiation and avoidance skills or just being given verbal advice of what to avoid; since abstinence is the key message being given in schools it is more likely that the latter is true. Because children have largely been left out of HIV/AIDS research it has not been clear whether they are subject to the same challenges that adolescents face, but these data show that the issues faced, even at this early stage of life, are similar. The children are clearly aware of factors that put them at risk of HIV/AIDS although they may not always understand how these factors work. This is not their fault but a failing of the adults who provide them with only partial information. Significantly the data also show that children are fully aware that they are at risk of contracting HIV and that it is not only a disease that affects adults.

6.2.1.1. Preventing HIV/AIDS

The themes around preventing HIV also revealed a range of knowledge that was often good, sometimes incomplete or partial and sometimes poor. As with the theme of contracting HIV/AIDS the participants presented many ideas that had been in the questionnaire. The two main themes that will be presented here have been selected because they exhibit children's resistance to the norms set for them by adults, and their ability to resist the imposition of adult values. They also indicate that children's thinking is often more progressive than that of adults and that children may be the most realistic option for stopping the spread of HIV/AIDS provided they are equipped with adequate knowledge and skills.

Condoms

Quantitative results revealed that most children considered condoms as a more effective method of protection from HIV than abstinence (see 5.3.1). The participants presented both issues again during the diagramming sessions and this gave us the opportunity to discuss and determine what the children knew about condoms, whether they were using them or intending to use them, and what would facilitate or obstruct

these intentions. Considering that this was a school that the headmistress stated 'promoted abstention', the children knew a great deal about condoms and had generally positive attitudes towards condom use:

B3-6A: You may, go and get checked. If one of you has the virus, you can have sex wearing condoms, knowing that you are protecting yourself.

(Excerpt from tree diagramming session with grade six boys)

RESEACHER: Ok. What's another way [to protect yourself]?

G6-6A: [Reading from the digram] 'To wear a condom properly when having sex'.

RESEACHER: Ok. To wear it properly how?

G6-6A: Because you don't know what kind of disease a person has, because you can wear the condom properly when you want to have sex then you won't get the virus.

(Excerpt from tree diagramming session with grade six girls)

They were aware that condoms can burst if they are not worn properly or if they are of poor quality:

G2-7A: Using condoms with 100% protection. I think that when you use a condom you shouldn't use one that you've picked up [off the street], you should buy your own and when you've used it you should throw it away.

(Excerpt from tree diagramming session with grade 7 girls)

Despite their good knowledge about condoms and condom use, grade seven children also came up with the very unusual idea that condoms could be washed and reused. This was rather worrying, especially as the boys had stated that they had seen many used condoms lying on the road. It raised concerns as to whether some children were actually picking up used condoms, cleaning them and reusing them:

RESEACHER: Have you ever seen a condom?

Several-7A Boys: Uhu.

RESEACHER: You've seen one?

All-7A Boys: Yes...we've seen them on the road.

RESEACHER: On the road?

All-7A Boys: Yes.

RESEACHER: Who puts them on the road?

B4-7A: There'll be lots of them!

RESEACHER: There'll be lots?

B4-7A: Yes!

B6-7A: They'll be used (condoms).

(Excerpt from tree diagramming session with grade seven boys)

B2-7A: What if a person with AIDS uses a condom and forgets to throw it away then he washes it and uses it again.

(Excerpt from tree diagramming session with grade seven boys)

G2-7A: Sharing condoms which have been used by other people.

G3-7A: They are shared...

RESEACHER: How are they shared...we talked about blowing them up?

G3-7A: Boys, for example boys can be mischievous and use a condom then they give their friend and say go and use it as well.

RESEACHER: So you think a condom can be used more than once?

[Cross talk]

G5-7A: I don't think it can be used many times!

G4-7A: It can only be used once.

G5-7A: It can only be used once then thrown away.

RESEACHER: Is that right? So that can't happen can it, sharing condoms?

[Uncertain murmurs again]

G3-7A: Some can...

RESEACHER: You're not sure? Huh?

G3-7A: Some can do it.

RESEACHER: How? Have you ever seen a condom? [speaking in English] Have you ever seen a condom?

[Laughter]

[Cross talk]

RESEACHER: Yes?

G1-7A: They are thrown away on the road and there'll be lots of them!

G2-7A: The dustbin collectors will be going past with their trucks and they [condoms] fall off.

(Excerpt from tree diagramming session with grade seven girls)

It was surprising that this issue only came up with the oldest group of children whose knowledge should have been better. None of the younger groups mentioned reusing condoms. This again shows the danger of not presenting children with adequate knowledge, but censoring what they should know in the misguided attempt to protect their innocence. Another worrying misconception regarding condoms was highlighted by a grade six girl's comment:

G6-6A: We hear people saying they are worn as wellies.

RESEACHER: Some people call them (condoms) wellies.

G5-6A: If you wear it (condom) on the feet how does it fit?

RESEACHER: So you could be lied to by a boy saying that he's wearing the condom and then he puts it on his foot and you would think you're protected because you don't know how its worn?

[Giggles]

RESEACHER: When we think back to our other diagrams how do you think a condom is worn?

G6-6A: It's worn the way you wear your panty.
G1-6A: I have heard its worn here [pointing to the pubic area].
G2-6A: On the engine (penis).
G3-6A: It is worn on the engine (penis).
RESEACHER: Ok.
(Excerpt from picture/story diagramming session with grade six girls)

The use of euphemisms such as 'wellies' for condoms can be confusing for children who have no practical understanding of condoms and how they are used. I pointed out to the grade six girls that this ignorance could put them at risk. A man or older boy may tell a girl he is wearing a condom but if she is not clear about where it should be she could easily be deceived that a condom has been used when it has not. This highlighted the need not only for children to touch condoms and know how they feel, what they look like and how/where they are worn, but also for them to understand their own and each other anatomies. In this way, when they do eventually engage in sexual intercourse they are fully aware of what is happening. Body mapping revealed to us that both boys and girls had better understanding of the male anatomy than female.

Whether condoms are better protection than abstention was also discussed during the sessions particularly as the children tended to rank condoms higher (as better protection) than abstention. I often challenged them on this issue to determine whether they fully understood the difference between the two modes of protection, or whether they were repeating condom-friendly messages they may have heard. The grade six and seven boys both ranked condoms higher than abstention, and when challenged on their decisions, both groups stuck to their choices. The grade six boys said they had rated condoms as better protection than abstention because 'not many people abstained from sex'; this was a mature reflection on reality:

RESEACHER: So do you think that if you don't have sex at all- ... - do think it's not as good as the ones you've given ten [indicating condoms on their diagram]?
B4-6A: Yes!
RESEACHER: Why? Here you've already had sex wearing condoms.
B4-6A: Because not many people abstain from sex.
(Excerpt from picture/story diagramming session with grade six boys)

It was important that the boys stood by their decision because this showed that they were thinking through the choices they were making as they developed their diagrams and could thus not be swayed by any counter arguments I presented them. It

also indicated the participants' self-confidence, their knowledge and their competence as social actors. On the other hand the grade six and grade seven girls ranked abstinence higher than condoms. The tree diagram below (Figure 23) shows that the grade six girls ranked abstinence as the most effective HIV prevention method giving it ten points (out of ten) and condoms second with nine points.

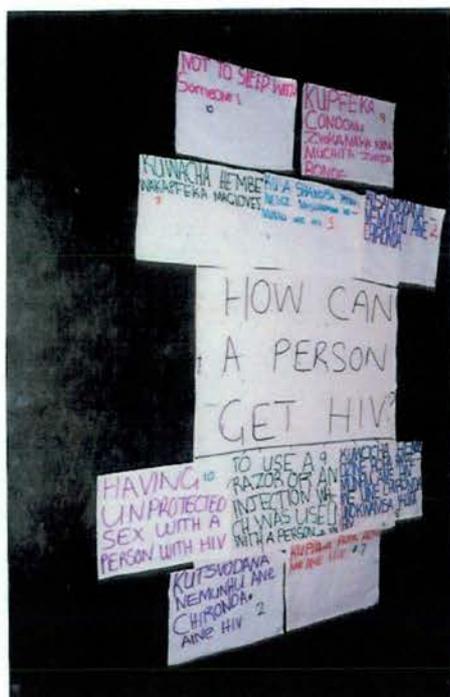


Figure 23. The grade six girls' tree diagram

G2-6A: [Reading out from the diagram] 'To not sleep, to not have sex with someone' because that is the best way. Because if you don't sleep with anyone and abstain from sex, you won't catch it (HIV) unless you've used razors and needles but if you protect yourself from sleeping with someone you will have protected yourself much more than the one who'll be using a condom.

(Excerpt from tree diagramming session with grade six girls)

The difference between the girls and the boys ranks may be indicative of societal norms which emphasise that girls should abstain from sex, but give boys leeway to have sex and gain experience (see Chapter 3). It may also illustrate their awareness of the realities for the different genders that condoms are a realistic option for boys because it acceptable in society for men to buy and carry condoms, whereas this is not the case for women and thus abstaining from sex is the more realistic

option. Grade five girls had initially ranked condoms higher than abstention but after I questioned their choice they decided to lower their condom ranking.

The issue of children's ability (or lack of) to access condoms was also raised; there was unanimous agreement that although condoms were protective, children their age could not get access to them and did not often use them:

RESEACHER: If children your age are having sex do you think they use condoms?

G3-6A: No.

RESEACHER: Why not?

G3-6A: They are too embarrassed to be seen by other people buying them.

G6-6A: Some think that they [condoms] are not useful.

RESEACHER: So they wont understand how they work or what they are used for?

G6-6A: No they wont know, they may have heard that you shouldn't use condoms because they have...

RESEACHER: They have what?

G6-6A: They can get torn.

G2-6A: Some think they can't get AIDS.

(Excerpt from picture/story diagramming session with grade six girls)

The reasons given above were also compounded by adults' refusal to sell condoms to children and the unwillingness of clinic nurses to acknowledge children's sexuality:

G1-6A: The shopkeeper may refuse to sell the condoms to children our age so they can send their little brothers to buy the condoms...

RESEACHER: So if you went to a clinic and asked the nurse for condoms what would the nurse say?

G1-6A: She won't give you because she'll suspect you want to have sex.

G5-6A: They refuse to give you.

RESEACHER: So when they refuse will they explain to you what nicely?

G1-6A: They will refuse and...they will threaten to tell you parents.

G3-6A: Some will speak to you nicely and tell you they don't have any.

G6-6A: They will look at your age-

RESEACHER: Your age.

G6-6A: Ah, they will shout at you and say what do you want to use them for.

RESEACHER: So you think its correct for them to shout at you?

G1-6A: Yes its okay because what will children want to use them for these condoms?

G5-6A: Some speak nicely some shout. Most of them shout because they'll think you're not of the age to use condoms.

G1-6A: Some won't shout they'll speak to you nicely and say they don't have any.

RESEACHER: What do you think most nurses would say if you asked for condoms?

G3-6A: Shout.

G6-6A: They would ask do you even know how the condoms are worn?
[Giggles]

(Excerpt from picture/story diagramming session with grade six girls)

The participants were thus fully aware of the negative reaction they would get from adults if they tried to access condoms. Moreover they agreed that it was correct for adults to bar their access to condoms. This reflects the contradictions that children within this context have to face. They have access to knowledge about safe sex and yet adults constantly tell them they should not be thinking about sex. This results in confusion, and limited use of condoms by those already having sex. The fear that children will go out and experiment sexually if they are given too much sex education also manifests the society's view of young people as irresponsible and out of control. They do not credit children with the ability to reason and to be responsible, and thus think it better to keep them ignorant. The result is that young people are misinformed by peers and the media and are more at risk than they would be if they were provided with clear and accurate information about how their bodies work and about sexual behaviour and contraception (Kaim & Ndlovu, 2000). In a study with sexual health care providers, Pitt *et al.* (1996) found that although the care providers did not approve of young people having sex, most of them indicated that they would rather give the young people contraceptives and make sure they were having protected sex than be moralistic and send them away without any protection.

During the interviews, most participants who knew of children who were sexually active thought they should be using condoms to protect themselves from pregnancy or HIV, but they also admitted that they didn't think their peers were using condoms:

RESEACHER: Do you think they use condoms?

G2-7A: I don't think they use them.

RESEACHER: Why not?

G2-7A: Maybe they'll be scared that when they go to buy them they'll be asked who sent them to buy, because they'll still be young.

RESEACHER: Do you think they should use them?

G2-7A: They shouldn't do it at all.

(Excerpt from interview with G2-7A)

RESEACHER: So when they do this do you think they use condoms?

B5-6A: I don't think so.

RESEACHER: Why not?

B5-6A: Children can't get them.

RESEACHER: So its because they can't get them? Would they want to use them, or wouldn't they even think of using them?

B5-6A: They wouldn't even think of them.

(Excerpt from interview with B5-6A)

Thus, condoms were something that the children were aware of and very curious about. The grade six girls even brought up the issue of female condoms:

G6-6A: If a girl wants to have sex can you get condoms for girls?

RESEACHER: Yes you can get them but they are not as easy to get as condoms for men.

(Excerpt from picture/story diagramming session with grade six girls)

The fact that girls were interested in condoms for themselves was really a perfect opportunity to introduce them to female condoms so that they would know about them and could maybe access them in the future, but due to the headmistress' reservations about the research team bringing condoms into the school we decided not show the participants female condoms (see 4.5.1). This was unfortunate because femidon is a female controlled mode of contraception, which these young girls should be aware of as a viable option of protection. On reflection I feel that we missed a vital opportunity, within the action research element of the project, to provide the girls with detailed information about female condoms.

HIV testing

The discussions with the participants revealed their heightened awareness of the importance of HIV testing. This was an unexpected finding especially with children of this age, but it emphasised just how much HIV/AIDS is a reality and part of life in Zimbabwe. Testing and the intention to be tested was a theme that was prevalent throughout the diagramming sessions and also came up during the interviews. This was not something that had been part of the questionnaire and was thus a significant emerging theme. The media had obviously an important part to play in raising the profile of HIV testing through television advertisements and billboards encouraging young people to be tested before embarking on sexual relationships. The extent to which the participants had taken this message to heart was significant and

very encouraging. Coupled with the positive attitude towards use of condoms, this generation is certainly better equipped, than the older generation, to face the challenges of HIV/AIDS. While intention does not predict actual uptake of safe sex behaviour, it is an encouraging start and something on which those working in HIV prevention programmes with young people can build. The participants displayed a sophisticated understanding about the wisdom of getting tested before getting involved in sexual relationships:

B-5A:...And also when you decide to date you should start by going for testing so you can see whether you have the virus or not.
(Excerpt from tree diagramming session with grade 5 boys)

B4-6A: You will- have gone to the 'New Start Centre' to check whether you have AIDS or not. Then you will have a relationship with only her.
(Excerpt from tree diagramming session with grade six boys)

Moreover, not only did they understand the need for testing but they also understood that one test was not enough and that having had one negative test was not necessarily fool proof:

G2-7A: Or they'll go for tests and find out they're negative then from there he'll go and do something, then he gets AIDS and you have been tested already so you'll think he's still negative.
(Excerpt from tree diagramming session with grade seven girls)

G1-7A: The girl will have her card saying she is negative she'll have been misbehaving and she'll have AIDS, then she'll say to the guy you go this is my card I am negative. The boy will then go and test negative, so the girl will give the boy AIDS.
(Excerpt from tree diagramming session with grade seven girls)

This indicated that their understanding was not superficial and they were not just repeating messages they had heard from adults and the media, but had understood the complexities involved in HIV testing. They also indicated that it was now common practice to get tested, something which is encouraging. Whether this was their perception because of the high profile of HIV testing in the media, or it was the reality, it was still significant because testing behaviour seemed to be the norm amongst young people, and would hopefully become an accepted precursor to relationships:

B4-6A: [reading from their diagram] 'To go and get checked at the start centre before having sex'. We gave it ten because it often happens that people go to the start centre before they have sex.

Researcher: It's happening?

B4-6A: Yes.

Researcher: [slightly surprised] Really? As far as you know?

B4-6A: Yes.

(Excerpt from tree diagramming session with grade six boys)

G2-6A: That won't happen because the person you marry will say let's go and get tested first at the 'New Start Centre' then if you're found to be HIV positive then you won't marry them.

B3-6A: Do you think everyone who wants to get married goes for tests?

G2-6A: Yes. I said if you want to get married because you won't want to get married to someone who's not been tested...Because they won't get married then get tested. Many people have sex then get married.

(Excerpt from bridge diagramming session with grade six boys and girls)

The issue of the risks involved in *serial* monogamy was also linked to this theme of HIV testing (see 5.4.1; Gwanzura-Ottmöller & Kesby, 2005). The participants were aware that having multiple sexual partners was risky for contracting HIV as indicated in Chapter 5, but they were also aware that the well-broadcasted message of sticking to one faithful partner (which underplays the way in which most monogamy is *serial*) was not necessarily safe and that the only way to ensure that your faithful partner is an HIV positive partner was to be tested:

B4-6A: We gave it five because you can be faithful to a girl but you'll have the virus. Then you'll sleep with her while you have the virus and then you'll both have it and won't be sure who initially had it.

(Excerpt from tree diagramming session with grade six boys)

Most participants interviewed also stated that they would get tested before having sex:

G1-6A: ...but before we have sex we should go to the 'New Start Centre'.

Researcher: To do what?

G1-6A: To get tested to see whether or not he has HIV.

(Excerpt from interview with G1-6A)

Researcher: You won't have ever slept with a girl so will you suspect her of sleeping with other boys or men?

B6-6A: I'll start by taking her to the 'New Start Centre' so we can see if she has it [HIV] and if she has it then I'll break up with her.

(Excerpt from interview with B6-6A)

G5-7A: We'll start off by getting tested, then if we're both negative then we'll go forward [with the relationship].

(Excerpt from interview with G5-7A)

There was however an exception to the this, which was enlightening because the boy speaking took into account the practicalities of being tested:

Researcher: So do you think you'll go for tests?

B4-6A: I don't think so.

Researcher: Why not?

B4-6A: Maybe it'll have gone up?

Researcher: What'll have gone up?

B4-6A: The bus fares, it will be expensive to travel far.

Researcher: So you think they [test centers] may be far?

B4-6A: Yes.

(Excerpt from interview with B4-6A)

Although he did go on to say that they would try and find money to travel to have tests when they decided to have children, B4-6A presents a very important point: the practicalities of going for tests and the accessibility of the centres. The centres are not very widespread, are mostly based in urban areas supported by mobile units that move around the country, and although young people may want to be tested, accessibility and cost may be major deterrents. This boy showed that he was thinking beyond the ideal of getting tested and he was also not assuming that when he grew up he would be able to afford testing.

Thus these results show that children do not blindly accept the abstinence only message that is being promoted in schools and that adults impose, on them but are also aware of the importance of using condoms and having HIV tests. They realise that sex is a reality which they will have to deal with sooner or later and want to be prepared when they decide to have sexual relationships. Bearing in mind that this age cohort has the lowest HIV/AIDS rates in the country it is positive that they are exhibiting such positive attitudes to condoms and HIV testing. These data also reveal

the children's agency, which emphasises why they should be fully included in HIV/AIDS research. The fact that they are more forward thinking than adults on these issues means that allowing the children's voices to be heard is crucial to the future of the country.

6.2.2. Children's sexual behaviour

This section will explore data relating to the participants' attitudes towards sexual behaviour, this does not only mean sexual intercourse but also dating behaviour and relationships with the opposite sex. It will explore the impact of adult influences on children's sexual behaviour. The diagramming sessions and interviews produced a large amount of data relating to this theme, all of which cannot be covered in this thesis. However, this section will include themes that address the question on the extent and nature of children's sexual behaviour, that shed more light on the experiences and attitudes of these primary school children particularly in relation to the literature on adolescent sexual behaviour, and emergent themes relating to this group. The data revealed that children of this age group are sexually active although only one participant admitted to having had sexual intercourse, three others said they had been propositioned.

6.2.2.1. How children learn about sex

In order to understand children's sexual behaviour it is important to first understand how they learn about sex, from whom, and what kind of messages they pick up about sexual behaviour and relationships. In the previous chapter (see 5.4.2) there was discussion on information sources about HIV/AIDS and sex. The school and the media emerged as the most important sources of information about HIV/AIDS; however, the participants stated that they would prefer to learn about these things from their home environment. So although teachers and the school context have largely taken over the role of sex educator, it is the family that young people prefer to hear these messages from. This is not only the case in Zimbabwe but has also been recorded in the UK (BBC News, 2005), with reports from the Teenage Pregnancy Unit that young people who can talk openly with their parents about sex are more likely to delay sexual debut and practice safe sex when they do have sex. Thus, it was important to determine what kind of communication there was between

children and parents regarding sexual behaviour, and what were their main sources of information.

Parents

The participants received their information from a variety of sources; parents were a significant influence on the participants' attitudes towards sexual behaviour. Mothers featured as sources of information, but fathers were hardly mentioned:

Researcher: So have you heard the words having sex or having sexual intercourse?

G6-5A: We heard it from you.

Researcher: Really you heard it from us?

G4-5A: No we heard it before.

RESEARCHER: Where did you hear it?

G4-5A: At home from my Mum.

Researcher: Did she say having sex or sex? Did she use the English word or the Shona words?

G4-5A: English, no *Shona*.

(Excerpt from spider diagramming session with grade five girls)

G5-6A: I was told by my Mum.

Researcher: ... Did she explain exactly what happens?

G5-6A: Yes.

Researcher: Really? With all the details of the *kwekwe* (vagina) and the *engine* (penis)?

G5-6A: No she didn't tell me those things.

[Laughter]

(Excerpt from spider diagramming session with grade five girls)

B1-7A: I think that if there is stuff about sex that you don't understand, come and ask me.

Researcher: Who says this, your parents?

B1-7A: Yes. So they are the ones I ask if I'm not sure about the things I have heard [from other boys].

(Excerpt from spider diagramming session with grade seven boys)

Parents seemed to give the children some information but not in much detail; most of the information was given out in reaction to something that had happened and as a warning or threat. The information seemed mainly to be unidirectional and vague:

Researcher: So you are not allowed to do this?

B4-7A and B6-7A: No!

Researcher: Why not? Were you told that we don't want to see you doing this [sex] by your parents?

All-7A Boys: Yes!

(Excerpt from spider diagramming session with grade seven boys)

G6-7A: They say- they don't say having sex and really explain. They just say when a child has grown up, she should get married then you have children, and they stop there.

Researcher: So they don't give you details as to where the children will be coming from?

All-7A Girls: No!

(Excerpt from spider diagramming session with grade seven girls)

Parents are authority figures and they use fear of punishment as a way to control children's sexuality. Children fear getting involved with the opposite sex because they will be severely punished if they are caught behaving in inappropriate ways. This will be discussed in more detail later in this section in relation to dating behaviour. The participants often said they had not had sex or engaged in certain types of behaviour because their parents had told them not to. This type of deterrent may work while they are still young but as they approach adolescence they may begin to question these rules. Telling children not to engage in sex 'because its bad' is not an effective form of sex education, clearly there needs to be more open dialogue, but from these data it does not seem that parents feel equipped to discuss these issues. Even when parents have received training (see Kesby *et al.*, 2002) they still revert to messages such as 'stay away from boys', showing that there are cultural taboos relating to talking about sex in general, and talking about sex to children in particular which still have a strong hold on adults and need to be broken down:

B3-6A: ...and also our parents always tell us to stay away from girls

(Excerpt from spider diagramming session with grade six boys)

Older siblings

Within the family, besides parents, older siblings were a significant source of information. Among the girls, older sisters seemed to give more detailed and better quality information than parents:

G5-6A: I was told by my sister.

Researcher: ...How old is she? Is she an adult or a teenager or-?

G5-6A: She's a teenager.

Researcher: Ok. So does she really explain things to you or does she just say 'people sleeping with each other'?

G5-6A: I had read it [about sex] in a book and I didn't understand it so I asked her to explain and she explained to me.

(Excerpt from spider diagramming session with grade six girls)

G5-5A: Older sisters. They are the ones that tell us these things [about sex].

Researcher: So do they tell you stories about their boyfriends or will they be telling you stories about other people?

G6-5A: They'll be talking about themselves.

G4-5A: They'll also talk about other people.

Researcher: They'll be telling you what they'll be doing?

G1-5A: Yes!

[Giggles]...

G6-5A: Sometimes you'll be embarrassed then you say... then they start to explain to you properly in detail.

Researcher: So you learn about sex from your older sisters?

All-5A Girls: Yes!

Researcher: They are the ones you'll say are number one in giving you information.

All-5A Girls: Yes.

(Excerpt from spider diagramming session with grade five girls)

It is difficult to determine the quality of the information these older sisters were providing but from the sophisticated understanding that the girls often exhibited about issues related to sexual behaviour, it is fair to assume that most of the information was good. The girls also tended to watch their sisters' behaviour with their boyfriends and this was another source of information about dating behaviour, which will be discussed later in this section. On the other hand older brothers were not a source of useful information but were usually perceived as a bad influence:

RESEACHER: When you were told what had happened?

B5-7A: They were just giving us advice.

B6-7A: They had seen my older brother with a girl and they said don't imitate him! They said don't do what your brother does!

RESEACHER: How old is your brother?

B6-7A: He's 19.

(Excerpt from spider diagramming session with grade seven boys)

B6-7A: I once heard my brother talking to my aunt saying that 'if I have sex with a girl then I no longer love her and I will look forward to the next one'.

RESEACHER: Really? What did you think of this?

B6-7A: I thought you'll be in trouble. You'll get AIDS!

(Excerpt from spider diagramming session with grade seven boys)

In this case the younger brother seemed to have a more responsible attitude towards sex than his older sibling. The seemingly bad influence of older brothers is a worrying factor though because most boys will idolise and look up to their older brothers and see their behaviour as something to emulate:

B4-7A: They'll be imitating their older brothers or their friends.

RESEACHER: We've talked about friends so lets discuss the issue of brothers.

B4-7A: Some of the brothers will be sleeping with girls, so the brother may say you should get involved with girls if you don't watch out. Then the boy will listen or he'll see his brother with girlfriends then he imitates that.

RESEACHER: But won't he see that his brother has grown up and he's still young?

B6-7A: He will be foolish [unclear segment]

B1-7A: Some of them will be in grade seven, our age, then he'll say I'll do what my brother does. ...

[Giggles]

B2-7A: The older brother may say come and meet my girlfriend, then they'll go together and then he'll ask him if he also wants a girlfriend, then he'll say I don't want. Then the big brother will look for a girl for him and persuade him.

RESEACHER: So the older brothers can also influence.

All-7A Boys: Yes.

(Excerpt from bridge diagramming session with grade seven boys and girls)

Television

The other significant source of information, as indicated in the quantitative data was the media, in particularly television (TV). Much of the information on HIV/AIDS was sourced from TV programmes, either talk shows or locally made soap operas. It was not clear whether all these programmes were aimed at children or adults. One talk show I briefly watched 'The Mrs Chisamba Show' was an adult programme discussing social issues, a Zimbabwean version of the Oprah Winfrey Show. Some of the participants had watched this and gleaned some of their information from discussions in the show:

RESEACHER: ... Ok, where did you hear about that?

G3-7A: We have seen it on TV on some shows...where they talk about AIDS, and they talk about ummm I don't know some other things.

G4-7A: And also Mrs Chisamba [talk show host on ZBC].

RESEACHER: What will Mrs Chisamba be saying?

G4-7A: She'll be talking about ummmm finding each other [relationships], and also other things such as mmmmm, people will find each other right, then the man may misbehave and goes to another woman. Now this woman will have AIDS, then they sleep together, then the woman catches...the man will then also catch AIDS. Then both of them the woman and the man will die.

(Excerpt from tree diagramming session with grade seven girls)

Studio 263 is a local soap opera that was probably aimed at family viewing due to the early time slot. This programme is aimed at young people and tackles issues that young Zimbabweans face such as love, relationships, family matters and HIV/AIDS (Soul Beat Africa, 2004) which is probably why it was widely watched by the participants and often quoted as a source of information:

G1-7A: No sex before marriage, this means that if I find myself a boy with a Benz [Mercedes Benz] and I think that he has money...not knowing that he already has AIDS or not, he'll lie saying that he is negative, like what's been shown on 'Studio 263'...the best way is to go to the 'New Start Centers' and get checked, if you are both negative then you can start to plan your marriage...

RESEACHER: Okay. So do you get a lot of information from the New Start Centre (NSC) and the TV programmes?

All-7A Girls: Yes!

(Excerpt from tree diagramming session with grade seven girls)

Although generally the information from these programmes seemed accurate, especially as they sometimes used real life professionals from the HIV testing centres, they sometimes misinformed the children or were misunderstood by them:

RESEACHER: So why did *you* [G6-7A] say it is usually found in people from the rural areas? What will these people be like for them to have it?

G6-6A: They will be rural people.

RESEACHER: What are rural people like?

G6-6A: They will have the disease.

RESEACHER: So don't urban people get it?

G6-6A: Ah, urban people seldom get it.

RESEACHER: Where did you hear this?

G6-6A: I saw it, Reg said it.

RESEACHER: Who?

G6-6A: Reg.

RESEACHER: Who's Reg?

G3-6A: He's from Studio 623 [TV drama].

(Excerpt from picture/story diagramming session with grade six girls)

In the excerpt above, we were discussing STIs and G6-6A had said that STIs were usually found in people from rural areas. She claimed to have heard this on the TV programme; she may have misunderstood what was meant or the person in the drama may have portraying someone with prejudices, nevertheless she accepted it as the truth. The risk of relying on media information lies in its predominantly unidirectional nature, which does not give children the opportunity to ask questions or obtain clarification (see Gwanzura-Ottmöller & Kesby, 2005). Parents in this situation would then be the ideal people to talk to their children about issues raised in the shows if watching them together, but within the Zimbabwean context, the majority of parents would not invite in-depth discussion on sexual issues.

G1-7A: Usually on the informative programmes such as ‘This is Life’ there’ll be doctors and teachers and others who talk about what they know. So they will be discussing what is sex ... so that’s where we can also get information.

RESEACHER: Ok, that’s good. What about your parents do they talk to you about sex, do they explain things to you, telling you what happens? Have you been told anything? Or are you told ‘I don’t want to see you doing this!’

[Laughter]

G1-7A: They’ll be embarrassed because we’ll know that is what they did.

(Excerpt from spider diagramming session with grade seven girls)

This is a major problem as information is constantly being relayed to children but they do not have opportunities to discuss it further with knowledgeable adults who may help facilitate the conversion of this knowledge into protective behaviour. The children are growing up in a context that is awash with good information about sexual behaviour and HIV/AIDS but opportunities that may enable this information to be turned into protective behaviour are often missed because of social and cultural taboos or adult reluctance to see children as sexual beings (Kesby *et al.*, forthcoming). Local children’s programmes that discuss HIV and sex related issues also tend to have moralistic undertones. In a children’s programme I watched while I was in Zimbabwe, the presenters encouraged children and young people to abstain from having sex until marriage, and then added ‘for those of you who can’t control themselves and wait until marriage, make sure you use condoms’. Thus, the message

being relayed to young people was that those who have sex before marriage have no self-control. This kind of message is counterproductive as it may prevent children who are sexually active from seeking advice on contraception and blocks any potential for open discussion of the challenges they face because of the stigma attached.

Eavesdropping

The participants also sourced information about sex through listening in to other people's conversations. These ranged from adults' discussions, to those of adolescents in high school. Sometimes the children would be included in the discussions but most of the time they would overhear what was being said:

B1-6A: We hear it in the neighbourhood people saying 'they are sleeping together because they are dating'.

RESEACHER: So when you say in the neighbourhood is it from children your age, or teenagers or adults?

B1-6A: It starts at 18 years.

RESEACHER: Ok what do the others say?

B2-6A: From form ones.

RESEACHER: From form ones?

B2-6A: They discuss these things.

RESEACHER: And you'll be listening?

B2-6A: Yes.

RESEACHER: Will they be telling you or will they be talking amongst themselves?

B2-6A: They'll be talking and as we pass we'll hear it [what they are saying].

RESEACHER: Ok, where do the rest of you hear these things? What about from home, do you ever hear it at home?

B1-6A: We hear it sometimes from home they'll be saying someone was made pregnant by the teacher.

RESEACHER: Will this be a discussion amongst grown ups?

B1-6A: Yes!...

RESEACHER: But you usually hear it from the neighbourhood as people talk whilst you're passing?

All-6A Boys: Yes!

B3-6A: Or if they are sitting relaxing and chatting about these things and if you're going past you'll hear what they are saying.

RESEACHER: Will you understand what they are talking about?

All-6A Boys: Yes.

(Excerpt from spider diagramming session with grade six boys)

RESEACHER: Ok what about the others? Where did you learn about this?

G5-7A: We hear it in the neighbourhood.

RESEACHER: In the neighbourhood do you hear it from your friends, or adults or teenagers, girls in form four, two or three?

G5-7A: Girls who are in forms one or two, they are the ones who discuss these things.

RESEACHER: will they be telling you or will they be discussing amongst themselves and you'll be listening?

[Giggles]

G5-7A: Sometime they'll be telling us. Or they will be talking amongst themselves.

RESEACHER: What will they be telling you?

[Long pause]

RESEACHER: Will they be doing it [having sex] or will they just be talking about it?

G5-7A: They'll just be talking about it.

(Excerpt from spider diagramming session with grade six boys)

The participants also felt that they had to eavesdrop to obtain information about sex because adults would not talk openly to them about it. The eavesdropping also extended to spying on their siblings, parents or relatives when they are having sex:

RESEACHER: So do you have people like your older brothers or your uncles and grandfathers who tell you about these things? Who say that when I'm with my girlfriend we do this and that, or do you only see it?

B6-7A: They won't want to tell us.

RESEACHER: They won't tell you.

B6-7A: They think that we'll go out and try it out if they tell us. We have to hide if we want to see them.

(Excerpt from spider diagramming session with grade seven boys)

G1-5A: I peeped once.

RESEACHER: You peeped, and what did you see?

[Giggles]

G1-5A: I was hiding...then I put my head through the door, and they asked me why I was doing that, and I saw they were lying down.

RESEACHER: They were just relaxing-

G1-5A: Yes!

G6-5A: I once peeped when I was younger, and I saw my aunt.

RESEACHER: *You* [G1-6A] saw your Mum and Dad lying on the bed?

G1-5A: Yes. Also my sister and her husband.

G6-5A: I was peeping through the window, when the curtain moved I opened it a bit then I looked through and I saw them kissing without wearing anything.

(Excerpt from spider diagramming session with grade six girls)

Children, like most people, are inquisitive and if sex is made to seem as if it is something mysterious they will want to know more about it and will find ways to acquire that information. Demystifying sex will not only remove its allure, but also foster a healthy attitude towards it. Kesby *et al.* (forthcoming) argue that children are sexual beings and as such have an innate interest in sex and thus telling them that they are too young to be thinking about sex will not deter them from finding out more. Although the participants at times exhibited embarrassment and there was a lot of giggling and laughing during the diagramming sessions, because we were consistently candid and relaxed about the issues we discussed, and we talked about sexual matters without showing any embarrassment, they soon realised that they could talk to us openly and ask questions that they would most likely have not asked other adults.

School

The results from the questionnaire had indicated that the school was a major source of information about HIV/AIDS, and yet teachers were not mentioned much in the diagramming discussions either as a source of information about HIV/AIDS or sex. School was only mentioned twice as a source of information:

RESEACHER: Where you are now, do you think you have the skills to cross the bridge and avoid the pressures of sex?

All-7As: Yes.

RESEACHER: Where did you get them [the skills] from?

B4-7A: We hear from others and at school.

RESEACHER: Where do you learn this?

B4-7A: In class.

RESEACHER: What kinds of things are you taught?

B1-7A: About being well behaved, and to not get involved with girls whilst you're still young. You'll see that you should finish school and that marriage is not something to rush into because there are many women!

[Laughter]

(Excerpt from bridge diagramming session with grade seven boys and girls)

From the quotation above it is clear that the kind of messages being relayed in the school were based on abstinence and 'good moral behaviour'. This is not to say that abstinence is the wrong message to give to young people particularly in a context with high levels of HIV/AIDS, however it is an incomplete message that leaves

children with many more questions than answers, or put another way, answers to only some of the possible questions. Teaching abstinence only does not protect those who do become sexually active, and at some point in their lives most children will have sex. This is not to say that the children are not active social agents who can avoid contracting HIV/AIDS, but to highlight that in a high risk context where a quarter of the population is infected with HIV, not being equipped with the right skills will make it much more difficult for them to practice either abstinence or safe sex.

6.2.2.2. The nature of children's sexual behaviour

Petting

In a paper, which presented preliminary results from this study, we were unsure about the prevalence of a petting culture among Zimbabwean youth (Gwanzura-Ottemöller & Kesby, 2005). The participants seemed to have the impression (or were given the impression by adults stressing abstinence) that any kind of petting behaviour would lead to sex, and there was no in-between stage (Gwanzura-Ottemöller & Kesby, 2005). Further analysis of the data has revealed that petting does take place among young Zimbabweans, but it is severely frowned upon by adults. Adults try to instil fear of punishment, rape and even arrest into children in their attempts to deter them from engaging in this kind of behaviour:

B1-6A: But if you're caught by the police ...you'll be arrested!

RESEACHER: ... what will they say?

B1-6A: Its not allowed for children to touch each other's breasts and buttocks?

RESEACHER: You'll get arrested by the police?

All-6A Boys: Yes!

RESEACHER: Really, is that what you know?

All-6A Boys: Yes!

(Excerpt from spider diagramming session with grade six boys)

Adults use this form of social control to inhibit child sexuality by making the consequences of being caught engaging in petting as extreme as possible. Obviously children are not arrested for petting but they are told that will be the consequence if they are caught petting. Spider diagrams were also used to uncover the types of non-sexual dating behaviour that children engage in Figure 24. As mentioned in the section on rape/forced sex, the first spider diagram focused on 'what is sex'; on the second diagram the children were asked to make lists of behaviours that took place

between dating couples but were not sex (see 4.4.7.4 spider diagrams). They were then asked which of these behaviours they were allowed to engage in and it was evident from the quotations that not much petting was allowed:

RESEACHER: Ok what about kissing?

G5-5A: That is really not allowed, if you're caught you'll get hit with a belt!

G6-5A: Not even a belt, a walking stick (wooden)!

RESEACHER: What about sleeping in one bed?

G5-5A: That's not allowed.

G5-5A: You'll really get killed (by parents)!

[Laughter]

(Excerpt from spider diagramming session with grade five girls)



Figure 24 Grade six girls spider diagram of ‘what is not sex’

RESEACHER: So nothing is allowed. Why not what about hugging, what's wrong with it?

[Giggles]

G5-7A: You will be chased with a stick!

RESEACHER: Why will you be chased with a stick.

G5-7A: They will think you're dating.

RESEACHER: That you're dating?

All-7A Girls: Yes.

RESEACHER: That you have a boyfriend.

All-7A Girls: Yes.

(Excerpt from spider diagramming session with grade seven girls)

Beatings by parents or guardians were obviously a more realistic form of punishment than arrest. Moreover, the children seemed to accept that these were acceptable penalties for contravening the moral code that says children should not engage in *any* kind of sexual behaviour. Considering the extreme nature of the

punishment a child would receive for engaging in petting, if caught, it is likely that children would rather risk getting beaten after having at least had penetrative sex than for only kissing. Thus in this context petting becomes risky behaviour because it may directly lead to sex, an effect of the rigid social and moral controls imposed on children. Sadly these controls, which are sincere attempts to protect children from the dangers of sex (real and imagined), end up producing the kind of behaviour parents fear.

Children were also told myths to scare them and stop them from getting involved in petting:

RESEACHER: What about this one about touching private parts, is it not allowed?

All-7A Boys: No its not allowed.

RESEACHER: Why not?

[Cross talk]

B6-7A: You might harm her.

RESEACHER: Really? Because you'll have touched her breasts?

[Giggles]

B6-7A: Some say that if you touch her breasts they'll burst.

RESEACHER: He says that is you touch her breasts they'll burst?

[Laughter]

RESEACHER: Does that happen?

B2-7A: Maybe he's done it before!

RESEACHER: Have you done it before?

B6-7A: I was just told by others!

RESEACHER: Really! You were told? Do you think they'll want to scare you?

All-7A Boys: Yes.

(Excerpt from spider diagramming session with grade seven boys)

Nevertheless the participants could not only cite many types of petting behaviour (Figure 24), but had numerous examples of young people they had seen, both of high school age, and primary school children, engaging in petting behaviour. The participants cited certain spots in some neighbourhoods where young people were often seen kissing and fondling.

RESEACHER: Are there children of your age who kiss, children in primary school? Who you know? F, you say yes?

F-5A: Yes.

RESEACHER: It happens.

F-5A: Yes.

RESEACHER: What about the rest of you?

A-5A: It happens [kissing] but not much.

F-5A: Ok. So those who are doing it (kissing) are they in the lower grades, lets say grades one, two three, four? Or will be those in grade six or seven, or there's no difference?

A-5A: I think some will be in grades six and seven.

RESEACHER: They will be the older ones?

A-5A: Yes.

(Excerpt from spider diagramming session with grade five boys)

RESEACHER: So when you've seen them kissing will they be just giving each a peck or will they kiss for a long time?

G1-5A: Really snogging!

RESEACHER: Really snogging.

G5-5A: Hugging each other!

RESEACHER: Do you see all this happening in your neighbourhoods?

[Cross talk: Girls talk about where they've seen people kissing]

G1-5A: We see them many times when we go past in the morning to buy bread. Most of them stand by a secluded corner by a wall where people go to kiss.

RESEACHER: So this corner is where people go to kiss?

All-5A Girls: Yes.

(Excerpt from spider diagramming session with grade five girls)

This contradicts the message from adults that one should wait until marriage before engaging in such behaviours and exposes their view of children as non-sexual, as unrealistic. Although the participants were largely disapproving of these behaviours it is unlikely that many of them will continue to disapprove for very long and at some point they themselves will begin to engage in similar behaviour. Because they were talking to us as adults within a moralistic social context, it is unlikely that they would have openly voiced interest in engaging in petting. Nevertheless there were certain types of behaviour that some thought were acceptable:

RESEACHER: Ok what about kissing?

B5-6A: Kissing is not allowed.

RESEACHER: Not even kissing on the cheek?

B1-6A: It's allowed, it's allowed!

RESEACHER: Its allowed?

B1-6A: Yes its allowed!

RESEACHER: This will be a girl, for you to kiss a girl?

[Cross talk: lots of disagreement]

RESEACHER: Lets hear one person.

B4-6A: It can happen lets say you're running in a team competition. If you win you can hug each other and some will kiss each other.

[Laughter]

RESEACHER: Will you be dating?

B3-6A: You'll be in love with that kissing you'll be doing.

(Excerpt from spider diagramming session with grade six boys)

The grade six boys disagreed on this matter with some saying kissing on the cheek was acceptable and some saying it was not. Some of the boys were contesting the norm of no physical contact with the opposite sex by saying that there were situations in which a kiss on the cheek was allowed. This illustrated that children can contest adult norms and resist norms prevalent among their peers. The quotations also revealed the spatial nature of petting with the children reporting that there were certain places where young people would go to pet. This may indicate that although petting in this context was not acceptable behaviour, young people would still create spaces of their own where they could engage in these practices.

Still young

One of the main reasons presented by most participants for not engaging in petting behaviour or sex was because they were too young or they were not of the age. They had obviously internalised adult messages about what was appropriate and inappropriate behaviour. This was also evidence of the effects of social context and societal norms on attitudes and behaviour:

RESEACHER: Is having sex bad?

G2-7A: If you're young its bad.

(Excerpt from bridge diagramming session with grade seven girls and boys)

F-5A: No I said it's allowed.

RESEACHER: [speaking to C-5A] Why do you say no [hugging is not allowed]?

C-5A: Because we will not have reached the age [for hugging].

(Excerpt from spider diagramming session with grade five boys)

There seemed to be a general consensus among the children that when they reached a certain age they would be able to engage in these behaviours. However the age varied:

G5-5A: You'll really get hit!

RESEACHER: So you'll be afraid of your parents?

G5-5A: Yes.

RESEACHER: So that's why you don't do it?

G4-5A: But you'll also see for yourself that this is not really appropriate at my age!

RESEACHER: So at what age should you do it?

G6-5A: In form six.

RESEACHER: Why?

G6-5A: We're still young!

...

RESEACHER: So you really don't like that? So you'll wait until you're- until you've finished school?

G4-5A: I'll wait till I'm 20 something, 21.

RESEACHER: You'll wait till you're 21?

G6-5A: 21! You'll be old!

[Laughter]

(Excerpt from spider diagramming session with grade five girls)

RESEACHER: So when will it be the right time [to hug]?

B6-7A: When you're teenager.

B4-7A: Or when you're 18.

B1-7A: When you finish school.

RESEACHER: Which school primary or secondary?

B1-7A: Secondary.

B4-7A: Some will go onto A-level, some stop after O-level.

(Excerpt from spider diagramming session with grade seven boys)

The participants thus had some vague idea about when they should start dating. They had internalised the messages that behaviour associated with dating was bad and risky, without really having thought or been advised of ways in which they could date members of the opposite sex without engaging in risky practices. It was a case of all or nothing and thus a scenario that would probably serve to put them more at risk due to lack of experience in relationships:

B1-7A: It's not decent to touch a girl's breasts whilst you're still young.

There is no purpose to that.

RESEACHER: Really, what if it's your girlfriend?

B1-7A: Ah, your girlfriend whilst you're young?

RESEACHER: Don't you have girlfriends?

B1-7A: No!

B4-7A: We have friends.

(Excerpt from spider diagramming session with grade seven boys)

RESEACHER: Kissing?

[Some say yes]

G6-7A: No, it's not acceptable.

G1-7A: On the cheek is okay.

G6-7A: No it's shameful...

(Excerpt from spider diagramming session with grade seven girls)

A grade seven girl did however bring up the issue of beginning to date early to make sure one had a boyfriend to marry. This relationship would be chaste with no physical contact and would continue right through school until time for marriage. This was a rather idealistic and probably unrealistic way of looking at relationships showing the kind of unrealistic standards adults cultivate in young people:

G6-7A: You can be in form one and boys keep coming to you, when you get to form six you may find that those boys are marrying others then you be able to find one for yourself [boyfriend].

[Others laugh and disagree]

RESEACHER: So what should you do then?

G6-7A: You have your boyfriend-

RESEACHER: Yes, in what form?

G6-7A: Even in form one! But then you will continue dating until you finish school.

RESEACHER: So what will you be doing [when you're together]?

G6-7A: You'll be like friends, that what you should do.

RESEACHER: You'll be laughing with each other, and chatting and walking together but without touching, without holding hands?

Several-7A Girls: Yes.

RESEACHER: Will the other girls know that he is your boyfriend? Or will it be a secret.

G2-7A: It will be a secret between the two of you.

RESEACHER: Whilst you're in form one until you get to form six or form four? Do you think this will work?

Several-7A Girls: Yes.

RESEACHER: Don't you think it may be difficult?

Several-7A Girls: It may be difficult?

RESEACHER: Why?

G1-7A: Its necessary to know the guy well and know his background.

RESEACHER: Do you think the boy will be happy to just smile at you and walk together and chat?

G5-7A: He won't be happy.

RESEACHER: Why not?

G5-7A: He will want to have sex with you, that's what he'll want.

RESEACHER: What do the rest of you think?

G1-7A: If he's a boy who's interested in you, he will wait until you've finished [school], and he will be happy to do that.

RESEACHER: The way you see boys do you think they can do it, and wait for you if they love you?

G2-7A: If he really loves you he'll wait for you.

(Excerpt from spider diagramming session with grade seven girls)

The denial of sexual desire and attraction and the inability to date openly is more likely to lead to clandestine sex, whereas allowing young people to date and knowing who they are dating may tend to be more protective. It is easier to give advice and guidance if adults are aware of the types of relationships children are

engaging in. In the present context these relationships are driven underground. The girls in the quotation above were aware that others would be dating and getting involved in relationships whilst they waited for the right time/age; they reconciled this with the idea that they could have a secret platonic relationship with a boy that would ultimately culminate in marriage.

Sexual partners

Although only one girl admitted to having had sexual intercourse, the participants knew children of their age who were engaging in sex. The majority of these were in grade seven but some grade six children were mentioned as well. The grade six girl who reported during the one-to-one interview that she had had a single sexual experience, had not been in a sexual relationship with the boy who had one day pulled her into his house:

RESEACHER: Have you ever had sex?

G5-6A: I did it a long time ago.

RESEACHER: Ok, who did you do it with?

G5-6A: With a certain boy.

RESEACHER: What was he like?

G5-6A: My age.

RESEACHER: How old were you then?

G5-6A: I was ten years old.

RESEACHER: Who said lets go and do it, you or the boy?

G5-6A: He pulled me.

RESEACHER: Then what happened?

G5-6A: Then he started to pull of my clothes.

RESEACHER: Then what happened?

G5-6A: Then people came and they saw me and they took me to my dad and he beat me.

RESEACHER: So did he pull you into the house or where?

G5-6A: He pulled me into the house, into the kitchen.

RESEACHER: Where were his parents?

G5-6A: They weren't there.

RESEACHER: [unclear segment]

G5-6A: I'm not sure because I heard people say he took me into the kitchen and then he started taking off my clothes.

RESEACHER: So he wasn't your boyfriend?

G5-6A: No.

RESEACHER: He just grabbed you?

G5-6A: Yes.

(Excerpt from interview with G5-6A)

She seemed rather vague about the experience as if she hasn't really been sure of what was happening when they had sex. She was beaten by her father but not told why she was being beaten. So although punishment was meted out for 'bad behaviour', there was no discussion as to why the behaviour was bad, and how she should avoid it in the future. From the responses of the participants and consistent with studies from the region, it seemed that girls tended to have sex with older boys or their peers, and boys tended to have sex with their peers and younger girls.

G5-5A: A girl in primary school grade five may have an affair with a grade seven.

RESEACHER: Ok, can a grade five or six girl date a secondary school boy?

G1-5A: Yes, a form one boy.

G5-5A: A grade six can date a form four boy.

G6-5A: Or form one.

(Excerpt from bridge diagramming session with grade five boys and girls)

The bridge diagramming sessions were the final sessions in which the boys and girls created and interviewed diagrams together (see 4.4.7.4 bridge diagrams). This session served to summarise all the elements that had been discussed up to that point and bring the group data collection exercise to a conclusion. This diagram was a representation of the sexual behaviour of children portraying who children's sexual partners were, the reasons children had sex, the negative consequences, ways to avoid these consequences, and what would happen if the path through sexual behaviour was negotiated safely (through avoiding early sex or practising safe sex) (see Figure 25 below).



Figure 25 Grade six participants' bridge diagram

The participants claimed that girls had relationships with sugar daddies, and the grade seven boys stressed that these were the most common partners for girls. Girls did not agree with this and stated that they would prefer boys their age to sugar daddies:

RESEACHER: So the boys think that girls sleep with sugar daddies. You said it's a lie?

G5-7A: Yes.

RESEACHER: Why?

G5-7A: They sleep with boys their age.

RESEACHER: Why do you say that?

G5-7A: Sometimes they say that he's (sugar daddy) older and grown up so I want someone who's still fresh!

[Laughter]

RESEACHER: So won't an older man be fresh?

G5-7A: Not at all!

[Laughter]

RESEACHER: So girls sleep with boys their own age because they won't want finished old men?

All-7AGirls: [Laughing] Yes!

RESEACHER: Do you disagree with her?

G2-7A and G6-7A: No.

RESEACHER: But do you still think sugar daddies?

G6-7A: Yes, the sugar daddies will have money and jobs and cars, whereas school kids will be given money by the parents so if their parents don't give them money they won't have any. So the girls will go with the sugar daddies.

(Excerpt from bridge diagramming session with grade seven boys and girls)

The issue of sugar daddies introduces the concept of transactional and intergenerational sex. Having sex to get money or gifts was not only widely reported in studies with adolescents, but was also suggested in the quantitative results (see 5.4.3). These data illuminated the questionnaire findings further by revealing that although girls did have sex for fun and experimentation, they were mainly perceived as having sex for money either out of poverty or greed:

B2-6A: Maybe they'll be having a hard life so they'll need money.

G6-6A: Some will be poor so that evening she'll go to the bar and will go with any boy and then she'll be given maybe five thousand dollars then she'll go and buy a shirt that she wants or anything else she wants.

RESEACHER: So she'll have gone to the bar to look for someone to sleep with?

G6-6A: Yes.

G3-6A: Some will want to go for a trip and then they'll meet with a man then he'll say lets sleep together and I'll give you the money you need to go for your trip or for food, then she'll agree.

(Excerpt from bridge diagramming session with grade six boys and girls)

RESEACHER: Ok out of the reasons that you wrote down of why girls have sexual relationships, which do you think is the most common that causes girls your age to have sex?

G3-7A: Money!

RESEACHER: Money, do you think that the most common reason? Do you think that's what causes most girls your age to sleep with boys?

All-7A Girls: Yes!

RESEACHER: Boys what do you think? The girls think money?

B6-7A: I think its friends' influence.

B1-7A: Money.

B4-7A: Money.

RESEACHER: So money is what is coming out the most here. What do the rest of think?

B4-7A: Money.

(Excerpt from bridge diagramming session with grade seven boys and girls)

The participants reported many incidences of transactional sex, which indicates that this is as prevalent in relationships among primary school children as it is in adolescent relationships, again as an effect of the socio-cultural context. It was also interesting that the majority of participants of both genders saw girls as having sex mainly for money. The girls did not contest this normative view indicating that they were constructing sexual relationships in the same way as adults. Sugar mummies were also mentioned as boys' sexual partners but the participants were

unclear on this issue and some boys claimed that sugar mummies would be more interested in older boys:

B3-6A: The sugar mummies won't want boys our age they'll be interested in those aged 15 or 19.

(Excerpt from bridge diagramming session with grade six boys and girls)

My impression was that sugar mummies were not as much of a reality as sugar daddies. Girls reported incidences of men propositioning them, yet boys had not experienced being approached by older women:

RESEACHER: So are you proposed to?

[Embarrassed giggles]

RESEACHER: On the road?

G1-7A: Sometimes if you're walking past the gate, some old man...

RESEACHER: So what do you do?

G1-7A: I run away.

[Giggles]

G1-7A: Lots of men do it (propose to the girls), especially the taxi touts, when you go to the shops they whistle at you.

RESEACHER: Ok.

G6-7A: If you ignore them they'll look like they are talking to themselves.

RESEACHER: So you feel that you can deal with what they'll be doing, you can just ignore them?

G2-7A: Or you'll shout at them.

[Laughter]

RESEACHER: What will you say to them?

G1-7A: I'll say I'm not a dog call me by my name (when they whistle).

(Excerpt from spider diagramming session with grade seven girls)

Although men made passes at the girls, they seemed to handle these advances well and resist them with confidence. Whether this confidence was a result of the skills and advice they received in school was not clear. But it was significant that they acknowledged that it was inappropriate for the men to approach them in those ways, and they also knew what the men wanted from them.

Peer pressure

As with adolescents, primary school children were also reported to engage in sex because of peer pressure. This seemed particularly prevalent among the older

children in grade seven and they indicated that both boys and girls were vulnerable to peer pressure:

B5-7A: Maybe she'll have been forced and maybe her friends will say to her that she is stupid because she doesn't want to have sex with boys, then she'll end up having sex.

RESEACHER: So now you're beginning to talk about being pressurised, you (girls) have thought of that haven't you? Can you read out which one it is?

G2-7A: Peer pressure.

RESEACHER: Yes.

G2-7A: They will be saying to you that you're foolish come and see.

[Giggles]

RESEACHER: Come and see what?

G2-7A: Come and see what we do. They'll be telling her to come and see what they do, then she'll follow them and copy them. They'll tell her that if she refuses she is foolish and they won't play with her anymore at school, then she'll agree.

(Excerpt from bridge diagramming session with grade seven girls and boys)

RESEACHER: Why do boys have sex?

B5-7A: They will be influenced by their friends to have sex.

RESEACHER: They'll be influenced?

B5-7A: Yes.

RESEACHER: So what happens? When they are being influenced?

B1-7A: They will be told that if you don't have sex you're...

B5-7A: They'll be told that if you don't sleep with girls you're stupid because the done thing these days is to sleep with girls.

RESEACHER: Even though they'll be at primary school and your age?

G2-7A: They'll be told that if you don't sleep with her (girlfriend) you'll lose her so you should watch out!

[Laughter]

(Excerpt from bridge diagramming session with grade seven girls and boys)

Thus this phenomenon is not only prevalent in high school but also in primary schools and needs to be tackled within this context as well. It seemed to be more prevalent among older primary school children and was discussed most during the grade seven diagramming session. It was not clear whether this suggests that peer pressure begins to manifest itself during the late stages in primary school or whether it is an issue that is targeted for discussion when the AIDS curriculum is taught at school. Whatever the reason, the participants suggested that the strategy to avoiding peer pressure was by avoiding friendships that were a negative influence:

RESEACHER: Do you think it's easy to avoid friends who are a bad influence?

B2-7A: It's easy!

RESEACHER: It's easy? Do you all think everyone can manage it?

B6-7A: Some can manage.

B3-7A: Some won't manage.

RESEACHER: What about the one who says to himself no this isn't right, but when he is pressured he gives in? What makes him give in even though he knows what he is doing is not right?

B1-7A: He can say to them 'guys what you're doing is bad' then he'll start ignoring them and refuse to be friends with them. So when he's at school he'll hang around with different boys and when he's going home he'll walk with different boys. Then they [bad boys] will see that he doesn't want to hang around with them.

(Excerpt from picture/story diagramming session with grade seven boys)

Thus, they exhibited agency and the ability to think independently and decide what is best for them. Encouragingly the participants also emphasised the importance of good friendships and positive influences. However, they stated that friendships that were a negative influence were more common:

RESEACHER: So when boys hang around in gangs, they influence each other and pressurise each other to do those things?

B1-7A: There are some who will have good friendships and there are some who will be a bad influence on each other.

RESEACHER: From what you see around you in your age group, what is more common, friendships which are a bad influence or good friendships which have a positive influence.

B4-7A: Good friendships.

RESEACHER: What did you say B1?

B1-7A: Friendships which are a bad influence.

RESEACHER: Ok and B4?

B4-7A: It depends on the people involved and what they think.

RESEACHER: Yes, but from what you usually see, I know it depends, but what do you usually see?

B4-7A: Bad influence!

(Excerpt from picture/story diagramming session with grade seven boys)

Places where sex takes place

Information about the contexts within which sex takes place is not widely available in literature on adolescent sexuality in sub-Saharan Africa. During the diagramming sessions and the one-to-one interviews efforts were made to elicit this type of information and to also obtain information about sexual negotiation and decision making within these contexts. Because the majority of participants said they had not had sex, most of the information obtained was related to people they knew

who were sexually active or people they had heard about. Thus this information is not evidence of the true situation but it is illustrative of the situation amongst children. Earlier in the chapter when discussing the issue of petting, it was suggested that children indicated that their peers and adolescents often engaged in petting in street corners or along the road at night time. Generally petting and sex happened in hidden places:

RESEACHER: In what context will this be happening? Will you be standing at a corner whilst the boy touches your breasts, or where will you be, what will you be doing?

G3-7A: By a corner at night.

G5-7A: By a hedge

[Laughter]

G1-7A: In alleyways.

(Excerpt from spider diagramming session with grade seven girls)

Sex also took place in grassy places or in fields with long grass as well as in houses:

RESEACHER: If a boy says come and have sex with me does it usually take place in his house?

[Cross talk and laughter]

G2-7A: It happens in the fields.

G1-7A: In the long grass.

G1-7A: It happens in boys' houses.

(Excerpt from picture/story diagramming session with grade seven girls)

These contexts are obviously ideal for having sex because of the forbidden nature of child sexual relationships. However, the likelihood of safe sex taking place is drastically reduced because the activity usually takes place in a hurry due to fear of being discovered. If sex is taking place with older partners there is also more opportunity for force and not much room (or time) for negotiation. During the interviews the participants were asked who they thought made the decision to have sex and decided where it should take place; there were mixed responses:

RESEACHER: [Laughs] Ok, when they have sex who do you think says lets go and do it, the boy or the girl?

B3-6A: The boy.

RESEACHER: Why?

B3-6A: Because he's the one who'll want to sleep with her.

RESEACHER: So he'll ask her and organize it. Where do they have sex?

B3-6A: In the forest, or behind the gardens.
(Excerpt from interview with B3-6A)

RESEACHER: Who chooses the place where they do it?

G3-6A: The boy

RESEACHER: Why?

G3-6A: Because he is the one that goes around a lot so he'll know the hidden areas.

RESEACHER: The girls don't go around a lot?

G3-6A: There are some who aren't allowed out of the gate by their parents.

RESEACHER: So where do they usually do it here in this town?

G3-6A: Here, they do it in the forest or in the grassy areas.

(Excerpt from interview with G3-6A)

The majority of participants said the boy would initiate sexual relations and therefore would decide when and where they would have sex. This would mean that the girl would be at risk of getting coerced into having sex against her will. The participants' responses are in line with the socially accepted view that the boy initiates sex and the girl agrees and again reveals the influence of social context on attitudes and behaviour. The grade seven girl quoted below went as far as to say that it was 'shameful' for a girl to be the initiator.

RESEACHER: Who says lets do it.

G3-7A: The boy.

RESEACHER: Why?

G3-7A: Because a boy is the one who usually thinks of it, it doesn't do for a girl to ask a boy that.

RESEACHER: Really? What if the girl wants to do it?

G3-7A: If you're a girl?

RESEACHER: Yes.

G3-7A: [laughs] That's shameful!

RESEACHER: So when they're doing it will there be force or will they both want to do it?

G3-7A: They'll have agreed.

RESEACHER: You don't think sometimes the girl is forced or the boy?

G3-7A: No.

(Excerpt from interview with G3-7A)

Some participants however resisted the this normative view and said that the boy and the girl decided together:

RESEACHER: So who do you think is initiating the sex, the girl or the boys?

B4-7A: I think all of them.

RESEACHER: So they are deciding lets go and do it.

B4-7A: Yes.

(Excerpt from interview with B4-7A)

RESEACHER: So when they decide to have sex, who says lets go and do it?

B6-7A: They can both decide.

RESEACHER: So it just depends?

B6-7A: Yes.

RESEACHER: When they have sex where will they be doing it?

B6-7A: They will do it in the grassy areas.

RESEACHER: [laughs] In the grassy areas do you know where this place is?

B6-7A: Yes they do it in the grassy areas and in the bushes.

(Excerpt from interview with B6-7A)

This was significant because if children can learn to question negative social mores and accept that both partners should be involved in sexual decision-making, this will go a long way to stopping the spread of the disease. Forced sex and the inability of women to negotiate safe sex are key factors to the higher prevalence of HIV among women in the region. Thus it was encouraging to hear boys saying that the decision to have sex could be mutual. During the individual interviews the participants were asked whether it would be possible for a girl to refuse to have sex once she was within this context. Most of the participants said this would not be possible, but some said it would be possible. One girl in particular related a situation in which she refused to have sex. This was also an example of the Shona tradition of *Chiramu* (see 3.3.3.1):

RESEACHER: [laughs] In the next question I want to ask about *you*. Has anyone ever asked you to have sex?

G1-7A: Yes.

RESEACHER: What had happened?

G1-7A: He's my in-law so he said to me that I was also his wife.

RESEACHER: What kind of in-law is he, your sister's husband?

G1-7A: Yes.

RESEACHER: So what did you say?

G1-7A: It was new year's eve then we were watching TV and my sister went to bed, so we were sitting on a bed and my little sister was there sleeping. So I was feeling sleepy and I also lay down. Then he came close to me and said lets have sex you're also my wife, so I told him I didn't like what he was doing and I got up and left the room and I told my grandma, then he was chased away from the house.

(Excerpt from interview with G1-7A)

It was a clear indication of the continuing pervasiveness of this practice and of how men will use it as an excuse to take advantage of young girls. It is was positive how the family effectively dealt with the situation, and the girl's confidence in immediately reporting the incident to her grandmother. When asked directly about their ability to refuse sex, all the girls said that it would be easy for them to say no if they were propositioned:

RESEACHER: Do you think that if someone asked you to have sex with them would you be able to refuse?

G5-7A: It's easy to say no.

RESEACHER: Why?

G5-7A: Because I won't want to.

(Excerpt from interview with G1-7A)

They were confident that they would be able to refuse; this may have been because most of them had not been in that situation, and it was an abstract idea to them. It was not clear from their responses if they were being taught any negotiation skills to get out of those situations.

No sex before marriage

Finally, when asked about their future intentions to have sex, all except two of the participants said they would wait until marriage before having sex. These were noble intentions but I wondered just how realistic they were and whether the children were being truly honest or were telling us what they thought we wanted to hear. It had been hoped that after our frank and open discussions during the diagramming sessions the children would feel relaxed enough to be honest, but I am not sure that this was always the case. I may be wrong and the children truly intended to wait until marriage, but with the school's emphasis on abstinence and the general moralistic tone of society, it is reasonable to expect them to repeat the messages that are constantly relayed to them. The reality though may be a different matter. As Pridmore argues children can be used as 'megaphones for adult messages' (Pridmore, 2003: 3). Therefore, although we endeavoured to foster an open, honest and secure environment for the participants during the research and they responded well to that, it would probably have taken more time to really gain their trust.

6.3. Summary

These results give a detailed account of the extent and nature of the sexual knowledge and sexual behaviour of a small group of urban Zimbabwean primary school children that may be illustrative of the general situation in Zimbabwe. The data from the diagramming sessions provided in-depth insight into the quantitative results particularly in relation to HIV/AIDS knowledge. They showed that although the children had a mixed range of knowledge most of it was good. The qualitative data also revealed that although there were a few differences according to grade, there were none according to gender. This is a significant finding, which again emphasises the importance of focusing HIV prevention and sex education efforts at this stage. Primary school children are still relatively malleable and open to adopting safer sex behaviours and egalitarian attitudes. The data also demonstrates the effect of socio-spatial context on children's access to information about sex and HIV/AIDS. It reveals that despite adults' attempts to control and censor this information children still manage to find ways to obtain it.

There are three key points that stand out from these data: first, children can talk openly and frankly about sex and should be given more opportunities for their voices to be heard; second, children are sexually active or on the brink of becoming so and thus need to be more fully involved in HIV/AIDS research and sex education; and third, children are active social agents who despite the strong social controls in Zimbabwean society still maintain their own views and opinions which are not only worthwhile, but often more advanced than those of adults. These data indicate the real need for comprehensive HIV/AIDS and sex education forums where these children can access accurate and uncensored information and acquire skills that will enable them to have safe and fulfilling sexual relationships free from coercion and HIV risk.

7. Discussion and Conclusion

7.1. Introduction

This thesis aimed to make contributions to the conceptual understanding of childhood in the field of *Children's geographies* and HIV/AIDS prevention research by exploring the experiences and views of Zimbabwean primary school children in order to provide insights into the HIV/AIDS and sex related knowledge, behaviour and attitudes of this little researched group. The thesis also aimed to provide information, which can be utilised by policy makers and practitioners in HIV/AIDS prevention work. It aimed to address the research gap in *Children's geographies* research in relation to the lack of work on HIV/AIDS and sexual behaviour, and to add to the limited HIV/AIDS prevention research with primary school children. Thus the aims of the research were addressed by two questions:

What are the levels of knowledge about HIV/AIDS among children aged 9-14?

What is the extent and nature of their sexual knowledge, attitudes and behaviour?

A research study was conducted with children aged nine to fourteen years attending a primary school based in a small urban area in Zimbabwe. It consisted of five phases, which used a questionnaire to examine the children's HIV/AIDS knowledge, attitudes, and to a lesser extent behaviour; and qualitative methods to ascertain the details of their HIV/AIDS related knowledge as well as their attitudes, experience and understanding of sexual behaviour. The study also provided a secure space in which the children could communicate in an open and frank way, where their opinions were respected and they could talk frankly about the taboo issues of sexual behaviour and ask questions knowing they would receive truthful answers. It is unusual for children of this age to have the opportunity to talk openly with adults about sex and it was a rare experience for a group whose access to information is often censored.

Therefore, this chapter will conclude the thesis by ascertaining whether the findings from this study, as presented in Chapters 5 and 6, adequately answered and addressed the research questions and the contributions they have made to academic knowledge and practice as well as recommendations for policy. The chapter will outline and discuss the main findings highlighting their contributions as well as analysing the weaknesses of the research process by focusing on three main aspects: the theoretical or conceptual understandings of childhood that have been added to *Children's geographies* by the study, the epistemological and methodological contributions and whether these were the correct choices for this research, and how the findings can be applied to HIV/AIDS prevention policy. The limitations of the study will also be discussed and the chapter will conclude with suggestions for future research that can build on the results of this study.

7.2. Conceptual/theoretical contributions

One of the main contributions the findings of this research have made to the sub-discipline of *Children's geographies* is through the presentation of how childhood is conceptualised within a different context and particularly focusing on the under researched aspect of HIV/AIDS, sexuality and sexual behaviour. Children from the global South have been underrepresented in *Children's geographies* research and there is a danger of conceptual understandings of childhood being applied universally based on research in the global North. This study counters that by adding to the small but growing body of research with children in the global South. It goes beyond what other children's geographers working in the global South have done by introducing the sensitive issue of HIV/AIDS and children's sexual behaviour that have hitherto not been addressed in *Children's geographies* research.

The HIV/AIDS pandemic is making a great impact on the lives of children in the global South and particularly in sub-Saharan Africa. It is thus imperative not only to understand how childhood is constructed within this context, but whether the HIV/AIDS pandemic has resulted in any changes in the construction of childhood. Valentine (2001: 33) states that the body is a surface on which cultural values and morality are inscribed and thus children's bodies are mapped as asexual until a certain age. This is particularly true within the Zimbabwean context; children are viewed as

asexual and those who show interest in sexual matters are viewed as displaying unchildlike behaviours and punished accordingly. Zimbabwean society's lack of acceptance of children's sexuality is clearly displayed by the omission of certain aspects related to sexual behaviour such as contraception, STIs and the social context of sexual activity from the Life skills education (see 3.5.4).

The findings showed that although Zimbabwe is in a crisis situation because of the pandemic, there has been little or no change in the socio-cultural constructions of children as asexual. Although Life skills and HIV/AIDS prevention education were taught in primary schools signalling a change in adult conceptions of children, the omission of information on STIs, contraception and the social context of sex indicated that there was still no acceptance of children's sexuality. This study's findings contested the view of children as asexual and clearly portrayed that children know about sex, can talk about it and are sexually active. Children were thus competent social actors contesting society's conceptualisations of them as innocent asexual and incapable of discussing these issues. They did not passively internalise adult messages about their identities, but developed their own identities within and outside of adult conceptualisations. This is not to say that the children's knowledge was not influenced by the socio-cultural context, but that the children went beyond what adults presented them with and displayed attitudes and thinking that was more advanced than that of adults.

This was portrayed by their attitudes towards condoms and HIV testing (see 6.2.1.1). Children's access to condoms and their access to information about condoms is restricted because of prevailing attitudes that knowing about condoms will result in sexual experimentation. However, during the study condoms were consistently mentioned as an effective way of HIV prevention. Furthermore, the participants demonstrated that they were not only parroting media based HIV/AIDS prevention messages, by displaying an understanding of how condoms are used (see 6.2.1.1). This indicates that children find ways of accessing prohibited information, and restricting their access to it does not mean they will not find out. The participants' knowledge of and positive attitudes towards HIV testing were another indication of these young people's agency. They were aware that having been tested for HIV was

not fool proof unless one practiced safe sex, and that a person's HIV negative status was only as good as their last HIV test.

One of the main tenets of *Children's geographies* is to listen to children's voices because children are capable of representing themselves. The study clearly illuminated this view within this context, showing that it is not only children in the global North that deserve to have their voices heard, but all children. The participants represented themselves and spoke with confidence on sensitive topics that many adults would have problems discussing, particularly in a context where open and frank discussion of sexual issues is taboo.

This thesis began with the assumption, promoted by *Children's geographies*, that children have agency. This proved to be a well founded assumption and the participants represented themselves as active social actors in many ways thus clearly refuting one of the possible reasons why researchers have not been conducting HIV/AIDS and sex related research with children: *i.e.* the fear that children are too young to discuss these sensitive issues (see 3.1). The thesis confirmed that it is possible to conduct in-depth research with children on these sensitive topics. In a context where children are expected to be passive because the strong emphasis on respect for elders constrains their ability to speak freely to adults, the participants displayed remarkable abilities to discuss sensitive issues such as rape (6.2.1). They showed that they could contravene social boundaries that attempt to control the information they can access by actively seeking out information they want in often-subversive ways. They are by no means as 'innocent' or as ignorant as adults construct them. This is encouraging because the kind of 'innocence' that adults want to impose puts the children at great risk; not least from adults themselves who are often the sexual predators.

The thesis's contribution to conceptual understandings of Zimbabwean children's sexuality in *Children's geographies* was even more important because the work was conducted by an African academic. Most *Children's geographies* research conducted in the global South is done by researchers from the global North. It is thus important that this study which introduced new insights into the field was conducted by a researcher from within that context. This not only provides insights that an outside researcher may not have, but also helps to adjust the imbalance in academia

as most research in this discipline is conducted by those from the global North whose perspectives are influenced by their social contexts.

7.3. Epistemological and methodological contributions

The epistemological framework for this study was based on feminist theory. The focus of this study was not on applying a single feminist approach to research with children, but on utilising a combination of different feminist theories (see 4.2). Therefore, this section will firstly discuss how these theories were adapted for the purposes of the study, whether a theoretical framework based on feminism was appropriate for research with children, and whether the combination of theories worked. Secondly, it will discuss the methodological approach, how that was linked to the epistemological framework and the usefulness of this in addressing the aims of the study.

Elements of three feminist theories were used in this research: empiricism, standpoint and postmodernism (see 4.2 for details). Feminist empiricism informed my approach towards HIV/AIDS as a disease that has a tangible effect on the physical body. It was thus necessary to determine the children's understanding of HIV/AIDS as a disease particularly in relation to its prevention. This approach influenced the use of body maps during the diagramming sessions to stimulate in depth discussions on the mechanics of sex and on how HIV could be contracted (see 4.4.7.4 and 6.2.1).

However, utilising this approach exposed its Western bias and medicalised approach to the body. It revealed that, although they were being taught about these issues at school through a curriculum strongly influenced by Western ideas, the participants' knowledge of the body, sex and reproduction was not only influenced by biological explanations but also by cultural conceptualisations. In *Shona* culture, the body is not only a physical entity but also a spiritual one. When someone is ill, they often consult a medical doctor to cure the physical side of the illness and simultaneously consult a traditional healer to deal with any spiritual elements to their illness, particularly if the illness is severe or chronic. Therefore, as products of this cultural context, some of the participants' explanations of sex and reproduction

displayed cultural understandings that were not necessarily compatible with biological explanations. When discussing reproduction and sex some of the participants talked about the man's seed nourishing the baby in womb during sex and the baby being a product of the man's blood (see 6.2.1). A Western, biomedical approach would dismiss these as misconceptions, but within this specific cultural context where children belong to their father's lineage and their identity is tied to him and his ancestral line, they make sense. In order to make any kind of impact on people sexual behaviour to prevent the spread of HIV/AIDS it is important to understand their conceptualisations and then work within those structures instead of dismissing them. Thus an empirical approach that presents these phenomena as universal was inadequate within this context.

This emphasises the usefulness of having an epistemological framework based on several conceptual approaches. Thus applying concepts from the feminist standpoint theory such its ontological assumption that about the lack of a single objective truth, and its claim that a person's understanding of reality is structured by class, race, gender and, in this study, generation, compensated for the shortcomings of feminist empiricism. The study examined how the participants constructed meanings of the world around them in relation to HIV/AIDS, sexuality and sexual behaviour in a context where most of their knowledge was filtered through adults. The participants illustrated that they did not only pick up messages that adults had filtered for their consumption, but also acquired and sought information they wanted or needed regardless of adult approval or disapproval. By actively interacting with their environment the children knew and understood more than adults gave them credit for. Thus the children interacted with two cultures, the dominant adult culture and their own culture and, as stated in feminist standpoint theory, had 'a type of double vision and hence a more comprehensive understanding of social reality' (Campbell & Wasco, 2000: 781). Because the children did not unquestioningly accept the status quo, they developed more progressive attitudes towards contraception and HIV testing than has been shown in research with adults within this context.

Including elements of feminist postmodernism in this study further developed my approach of seeing childhood as a social construct contingent on the social and historical context within which children live, and influenced by the power structures

within this context. This research deconstructed the dominant discourse, within this context, of children as asexual by acknowledging their sexuality through conducting a study on HIV/AIDS and sexual behaviour with children. Children have been left out of research on these issues in Zimbabwe. Thus, conducting work that not only includes but also focuses on their knowledge and understanding of HIV/AIDS and sexual behaviour destabilises adult discourses that children should not and cannot know and talk about sex. The findings further deconstruct this dominant discourse by revealing children's ability to articulate their knowledge and views of these sensitive topics in often sophisticated ways (see 6.2.1). For example, the participants displayed a deep level of understanding of why HIV/AIDS was more likely to be contracted during sexual contact where force was used such as rape, than where it was consensual. Their responses to probing questions on this topic showed that this was not superficial repetition of what they had heard or been told (see 6.2.1). The research also serves to subvert the adult-child binary, which posits the adult as knowledgeable and the child as ignorant. This was achieved by giving children voice on sexual matters and exposing that they not ignorant and can often be more knowledgeable or forward thinking than adults, thus dislodging hierarchies, which are based on knowledge and access to knowledge (see Lennie, 1999).

Using a feminist based epistemology, and particularly postmodern feminism, in a study about children in the global South was an innovative approach that may not have been perfect, but was useful in beginning to expose what Kesby *et al.* (forthcoming) call 'other' dimensions of childhood. This study applied theories developed within a Western context to try and gain an understanding of the social construction of childhood and sexual behaviour within an African context. It did not discuss the ideas of African philosophers and consider the contribution they could have made to the epistemological framework. In this sense the study adopted a universal approach by utilising Western feminist theory rather than a culturally relative approach that would have developed a conceptual framework based on the work of African philosophers. Utilising these ideas could have been more relevant and appropriate than applying feminist theories and would have further enhanced the pertinence of this research to African academic practice.

The feminist epistemological framework influenced the type of methodology used in the research. The research used mixed methods to collect data within a methodology guided by the tenets of participatory action research (PAR). This is not to say that this research was PAR but it adopted an action oriented philosophy to go beyond simply describing the participants' social world (Cameron & Gibson, 2005). The study applied a PAR approach through valuing the children's knowledge of their context and the issues pertinent to their lives and trying to use this as a base on which they could develop an improved understanding of HIV/AIDS and sexual behaviour that would benefited them in a tangible way.

Working with a local organisation, such as Tsungirirai, that was grounded within the community was also a useful component of the PAR approach. They were aware of the work being done in the community and of whether this research could make a significant contribution to this work. Thus, not only myself, the academic researcher, but also members of the community in which the study was conducted, identified it as important. Moreover, the organisation was involved in the development of the questionnaire so that issues that were of interest to them could be identified.

The fact that this was not true PAR, but only an attempt at including elements of PAR, is revealed by the limited participation of children in the development of the study. However, the use of diagramming methods, which enabled them to interact and discuss sensitive issues in depth, was useful in facilitating good interaction. The visual and varied nature of the diagramming tools, and the focus on the diagrams rather than individuals was a useful technique for discussing sensitive issues (see 4.4.7.4). The techniques were also implemented in ways that presented opportunities for the participants to ask for clarification of issues they did not understand. This was not only done by the research team but the participants often corrected and provided explanations for each other. This was an important aspect of the research as it encouraged the participants to articulate what they knew and had learnt, and thus further internalise HIV/AIDS prevention and safe sex messages.

The application of the methods was structured in such a way that they built on each other and stimulated the children to examine their existing knowledge and attitudes through each stage of the research, consolidating what they already knew,

and adding or clarifying where they were uncertain. Thus the methodology helped to fulfil the aims of this research by illuminating the participants' lived experiences.

The research had ethical procedures in place but on reflection, more could have been done to display a high level of ethical awareness and commitment to conducting ethical work. There was a high level of confidentiality throughout the research from the anonymity of the questionnaires to the lack of use of children's names during the diagramming. The confidentiality agreement also involved the children to prevent them from repeating what was said by others in the group outside the research context. Consent was sought from the school, the educational authorities and the children but not from the parents, as this was deemed not necessary by the headteacher. Nevertheless, the research team should have sent a letter to the parents of the children involved in the qualitative part of the study informing them about the study and requesting their consent. As the children were minors this would have fully covered any concerns about parental consent and any negative effects the research may have had on the participants.

As a Zimbabwean citizen I was not required to submit my research proposal to the Medical Research Council of Zimbabwe, but it would have been good practice to inform the council of the work being conducted. Although there was every effort to be sensitive to the children's feelings and they were informed that they could withdraw from the study if they were at all uncomfortable, there were no structures in place to give them support after we had left. Tsungirirai had a counsellor who would have assisted us if any of the participants had approached us with a problem during the data collection. However, once the study was over, although we had told the participants that they could approach Tsungirirai for help or advice, because of the high profile of the HIV/AIDS prevention and support work the organisation conducts, it is unlikely that the participants would have been comfortable visiting the centre. It would have been better to have held debriefing sessions with the participants before we left to make sure we had really done no harm.

7.4. Policy recommendations

The results from this study have implications for policy as well as academic practice. At the beginning of this research it was not clear what the levels of knowledge about HIV/AIDS were amongst primary school children. The findings revealed that children do know about HIV/AIDS and that their levels of knowledge range from being very good to poor. The second research question sought to determine the extent of their sexual knowledge and behaviour, and again they not only knew about sex but could also talk about sex and what happens in sexual relationships. Evidence on the extent of their sexual behaviour was more anecdotal than from personal experience (with one exception), but the experiences of girls being propositioned by older boys or men indicate that children are indeed sexually active, as proposed in Chapter 3, and if not already active may be on the brink of sexual activity (see 6.2.2.2).

Thus this research has shown that children are ready and willing to discuss these sensitive issues as well as being at risk of contracting HIV through sexual contact. They should be fully involved in HIV/AIDS prevention activities. Issues that have been left out of the HIV/AIDS and Life skills education such condom use should be included in their education so that they have a good understanding of the ways HIV can be prevented. Therefore, the education authorities should be encouraged to allow teachers to include teaching on condoms in the HIV/AIDS and health studies curricula. The Life skills curriculum should also be made into an examinable subject so that it receives the same thorough attention as other subjects and is not perceived as a marginal topic. It may be the most important thing that children learn if they are adequately equipped with the knowledge and skills to avoid contracting HIV. There is also a need for teachers to get more support and training in teaching the HIV/AIDS curriculum, so that they become confident in facilitating more interactive learning.

The findings reflected no discernible gender differences in knowledge about and attitudes towards HIV/AIDS and sexual behaviour. This is a significant result that needs to be highlighted. It may indicate that targeting HIV/AIDS prevention messages at children, who are at a life stage where socio-cultural gender norms have not yet become an established part of their identities, may foster protective sexual

behaviour. The finding also illustrates the difference between children and young people at the adolescent stage where there are more marked gender differences because of the stronger influence of socio cultural norms. Therefore it is important that work conducted with adolescents is not applied to children but that children should be involved in research that can inform the development of prevention projects tailored to their needs.

The findings also highlighted the limitation of the school as a context for learning about sexual behaviour and schoolteachers as sex educators. The participants seemed to feel that learning about sexual behaviour is something that is personal and belongs within the private space of the home. Responses to the questionnaire clearly indicated that family members were the preferred sources of information about sexual issues (see 5.4.2). During the diagramming sessions when discussing where they had acquired their knowledge about sexual behaviour from, the school or teachers were hardly mentioned (see 6.2.2.1). These results indicate that despite the government's efforts to educate children about these issues within schools as a way to prevent the spread of HIV/AIDS, and parents' reluctance to discuss sex with their children, children still choose family members as their preferred sex educators.

This finding has two main implications. Firstly, the failure of teachers as sex educators may be due to the methods used in teaching this topic. Schools need to make more of an effort to implement participatory and interactive ways of teaching these issues and to adapt them for the context that they are working in. The only way to do this is by conducting more research with children and getting them involved in developing methods of teaching that are appropriate for them such as the Auntie Stella project which was developed as a result of research and consultation with young people (Kaim & Ndlovu, 2000; see 3.6.1 for details).

Secondly, parents need to be encouraged to get more involved in talking to their children about sexuality and sexual behaviour. They need to be made aware that their children value their input on these topics and that they must step into the sex educator role that has been left by vacant by changes in the extended family system. Projects should be set up which help to train parents on how to address these issues and talk to their children. The earlier parents start learning to talk to children, the easier it will be for them to keep communication channels open when their children

are adolescents. There are cultural barriers that make this a challenging undertaking but under the crisis situation in Zimbabwe, it is not impossible. A review and evaluation of a Stepping Stones participatory education programme in a rural area near the study site, revealed that although parents who had been trained in this programme spoke to their children about the dangers of HIV/AIDS, the information was still relayed through moral and cultural filters e.g. 'abstain from sex until you are married', unidirectional, and parents were against recommending condom use to their children (Kesby *et al.*, 2002). These findings are compatible with the information relayed by the participants in this study about parent child communication about sex (see 6.2.2.1). Despite this challenging scenario, most parents want the best for their children and if they are made aware of what is at stake *i.e.* their children's future health and well-being, they may be more willing to get involved.

The children also displayed the potential and ability to be more progressive thinkers than adults particularly in their attitudes to condoms and HIV testing. This is a generation that was born into the era of AIDS; they have never known a world without it and as such there is no reason why they should remain ignorant now that there is so much known about the disease. The devastating effects of HIV/AIDS are clearly apparent but so are the methods through which infection can be avoided. Zimbabwean society is an arena full of contradictions: there is ample evidence of much good information and practice being transmitted country-wide, and yet rigid, moralistic and often destructive social controls still prevail. Adults fear that talking openly with children will make them lose control and do not understand that honest communication will foster even better relationships. Much of the reluctance on the part of adults is based more on their insecurities and fears, than on anything the children may or may not do; they do not realise that generally children respect and value their opinions and that to talk candidly to their children will only serve to strengthen this respect. Society has constructed adults as all knowing and they may also be reluctant to expose their own ignorance. Opening up to their children may help them to learn more about these issues from their children or from their efforts to obtain information to help inform their children. Lack of communication however only breeds suspicion and disrespect as children disobey parental rules in attempts to find out more information about sex and to experience this forbidden pleasure: this pleasure may be sweet, but in this context it also kills.

7.5. Limitations of the research process

While this study was thorough, various logistical practicalities placed limitations on the research. Zimbabwe was not an easy context to work in given the political climate and thus it was important to tread very carefully and behave in ways that did not alienate people or could potentially cause problems for those I was working with. This had an impact on my research and some of the decisions made because I relied heavily on gatekeepers to gain access to the children and for information.

Study site: I did not have the opportunity to visit all the primary schools in the area and therefore have some input into choosing the school where the research would take place. This issue was discussed in 4.4 but it is necessary to mention it again as this may have had an impact on the results obtained and their applicability to the rest of that context. The research did not try to achieve representation, but aimed to provide illustrative examples of the experiences and issues children face in Zimbabwe. However, as there was no access to other schools it was not possible to distinguish whether the experience of children in the sampled school illustrated a wide or narrow range of experiences. The gatekeepers had been fully informed of the need for a school that contained a mix of children from different backgrounds in the area, but without having visited the other schools I cannot be certain if this was achieved. Being able to provide descriptions of the other schools and make comparisons with the research school would have served to strengthen the results.

A second site related limitation was the exclusion of rural children. Although there is much movement between rural and urban areas, the rural experience may still be very different from the urban experience. Including a rural sample would have given further insights into the particular nature of rural children's experiences. The exclusion of rural children's voices, means that only those the voices of relatively privileged urban children (who have better access to information) were heard. Thus the view provided by this study of Zimbabwean children's childhoods, is partial.

Adults: This study was about children and talking to children, but their lives cannot be fully understood without examining adult attitudes towards children. The study involved informal discussions with teachers that gave limited indication as to

their views and opinions, however these discussions were not included as an explicit data source. It would have been more illuminating to talk to parents and family members as well. Parents are a major influence on children of this age and this was portrayed in the way they repeated messages from their parents. Interviews with parents and other family members would have provided a more holistic view of children's experiences and of their parents' influence on and interaction with them.

Sample: It would have been useful to include all the children from every class in the three grades that were covered in the study. This would have provided a larger quantitative sample that may have provided more information and better representation of the children in those grades. However, my decisions were constrained by the gatekeeper and I did not want to inconvenience the school further by taking up more classroom time. With hindsight children in grades one to four should also have been included, at least at the questionnaire stage. This would have given better indication of the variation of knowledge levels in primary school at different stages and what role spatial context plays in the acquisition of information. Comparisons could then have been made between those who are older and already receiving HIV/AIDS education and those who are younger and yet to receive it. This would have indicated how much information is acquired from school and how much from the outside environment.

7.6. The way forward

This research is a good starting point in illuminating the experiences and needs of primary school children in Zimbabwe in relation to HIV/AIDS and sexual behaviour. The section above has highlighted the major limitations of the study and this section will suggest ideas for further research by addressing some of these limitations. Reviewing literature in preparation for the research revealed that there was no HIV/AIDS prevention research that looked at the sexual behaviour of children in Zimbabwe, and regional data was limited. This study has gone some way to redress that imbalance but it only begins to address this research gap. More research needs to be done to build on this work before a clear picture of children's situation can emerge.

Wider research needs to be conducted which reaches a broader cross section of children from a variety of contexts. As mentioned above, my focus was on urban children from a small town; further research should include children from major cities and different socio-economic backgrounds within the cities, children from a variety of rural areas such as growth points, farming areas, villages, the emerging resettlement areas and other contexts. This will provide a more holistic picture not only of the geography of sex education but also of how space impacts on the way information is acquired.

This research focused on the experiences of *Shona*-speaking children, although not all the children would have been ethnic *Shonas*. Therefore, it is necessary to conduct research with children from other Zimbabwean ethnic groups, in particular those from minority groups that have distinctly different cultures and may often be excluded from research because of difficulties in accessing them, such as the Tonga people from the Kariba area. This will add more insight into how behaviour and knowledge are culturally constructed, how the different cultures interact with each other and how children negotiate cultural boundaries.

Interviews with parents, teachers and other adults who interact regularly with children should also be an important aspect of future research. To understand children, we do not only need to hear their voices but we also need to hear the voices of those who care for them and whose views and behaviours contribute to shaping children's lives. I would also advocate a region wide study including all southern African countries, similar to that conducted by UNICEF ESARO (2003) but focusing only on children. This will help to determine the trends and the experiences in the region and help to provide information on best practice and what works in similar contexts.

7.7. Summary

This final chapter has attempted to link the various elements of the study and discuss how they have addressed the original aims of the study. It begins by outlining the contributions the study's findings about Zimbabwean primary school children, HIV/AIDS and sexual behaviour have made to *Children's geographies*. The study

added to a growing body of research with children in the global South but also brought in a new dimension to this work by researching children's sexual behaviour, knowledge and attitudes in relation to HIV/AIDS. The chapter then examines the application of the epistemological and methodological frameworks used in the study and their influence in fulfilling the aims of the study and addressing the research questions. It also takes the main findings and applies them to a broader context by discussing how they can influence policy on HIV/AIDS and sex education with children in Zimbabwe. It acknowledges that this small research study was only the beginning of work in this field and that there is a need for future research that addresses the limitations of this study, and goes beyond what has been achieved in this thesis, both locally and regionally.

The thesis makes a significant contribution to *Children's geographies* by adding the voices of a group of Zimbabwean children to the growing collection of children's voices in this sub-discipline. It highlights issues that are not only relevant to children in Zimbabwe but may be relevant to children in other contexts as well, such as talking to children and young people about sex. It has the potential to inform HIV/AIDS prevention policy and practice in Zimbabwe because it provides new information on the situation of children and also contributes to the regional database of HIV/AIDS research. The research's originality is not only in its radical efforts to talk to children in this context about HIV/AIDS and sex but also in applying principles that encourage the respect of children's views and respects them as experts on their own lives. It provided a forum where the children could ask questions, receive honest answers, and gain more knowledge about HIV/AIDS related issues and it is hoped that participating in the study encouraged the children to gain more information and skills relating to HIV/AIDS and sexual behaviour.

Finally, by focusing on children's sexual behaviour and challenging the view of children as asexual, this thesis is not saying that children should be sexually active. The literature review clearly demonstrated why early sexual activity can be harmful, particularly to pre-adolescent girls with physically immature bodies. But it asserts that children living within contexts affected by the HIV/AIDS pandemic need to understand what is involved in the physical act of sexual intercourse as well as in sexual relationships; they need to know their bodies and how they work and through

this, gain a deeper understanding of how HIV can be transmitted and prevented. The attitude that talking to children about sex will encourage them to experiment is outmoded. Adults need to be made aware that there is ample evidence that young people who have access to good sexual and reproductive information, and who can communicate openly with their families about these issues are more likely to delay sexual debut and practice safe sex. Zimbabwe is a nation in crisis and if it is to preserve a future for generations to come, adults must realise that it is time for them to relinquish their conservative and moralistic views and talk to children and young people otherwise they will lose the next generation to HIV/AIDS and the country will have a very bleak future.

8. Bibliography

- Aitken, S. C. (2000). Play, rights and borders: gender-bound parents and the social construction of children. In S. L. Holloway & G. Valentine (Eds.), *Children's Geographies. Playing, living, learning*. Routledge, London.
- Aitken, S.C. (2001) Global crises of childhood: rights, justice and the unchildlike child. *Area* **33**(2), 119-127.
- Aggleton, P., Chase, E. and Rivers, K. (2004) HIV/AIDS Prevention and Care among Especially Vulnerable Young People. A Framework for Action. Thomas Coram Research Unit, Institute of Education, University of London
- Aarø, L-E. and Gwanzura-Ottemøller, F.P. (2000) Tidlig Intervensjon for å påvirke kreftrelatert atferd. En gjennomgang av relevante studier (Early intervention as a way to prevent cancer-related behaviour. A review of relevant studies). HEMIL- Rapport Nr 2, Universitet I Bergen, HEMIL Senteret.
- Aldinger, C., Whitman, C.V., Gillespie, A and Jones, J.T. (2003) Skills-based health education including life skills: An important component of a Child-Friendly/Health-Promoting School. *The World Health Organization's Information series on School Health*, Document 9.
<http://www.unicef.org/lifeskills/files/SkillsForHealth230503.pdf> accessed 21.08.2005
- Ansell, N. (2001) Producing knowledge about 'Third world women': the politics of fieldwork in a Zimbabwean secondary school. *Ethics, Place and Environment* **4**(2), 101-116.
- Ansell, N. (2001) 'Because its our culture!' (Re)negotiating the meaning of lobola in southern African schools. *Journal of Southern African Studies*, **27**(4), 697-716.
- Ansell, N. (2002a) 'Of course we must be equal, but...': imagining gendered futures in two rural southern African secondary schools. *Geoforum* **33**, 179-194.

- Ansell, N. (2002b) Secondary education reform in Lesotho and Zimbabwe and the needs of rural girls: pronouncements, policy and practice. *Comparative Education* **38**(1), 91-112.
- Aries, P (1962) *The Centuries of Childhood*. Cape, London.
- AVERT (2002) Quizzes. <http://www.avert.org/hivquiz.htm> accessed 15.04.06
- Bailey, A. (2005). *Making Population Geography*. Oxford University Press Inc., New York.
- Bantu (2005) <http://www.bantu-languages.com/en/> accessed 24.08.05
- Bassett, M.T. and Kaim, B. (2000) 'What they don't know can't hurt them': How school-based reproductive health programmes can help adolescents lead healthy reproductive lives. *Adolescent Reproductive Health Project (ARHEP)*. Training Research and Support Centre (TARSC).
- Baxter, J. and Eyles, J. (1997) Evaluating qualitative research in social geography: establishing rigour in interview analysis. *Transactions of the Institute of British Geographers* **22**, 505-525.
- Beazley, H. (2000) Home sweet home?: Street children's sites of belonging. In S.L. Holloway and G. Valentine (eds.) *Children's Geographies. Playing, Living, Learning*. London, Routledge.
- Bailey, A. (2005). *Making Population Geography*. Oxford University Press Inc., New York.
- Best, K. (2000) Many youth face grim STD risks. Adolescents need skills and self-confidence to abstain or reduce risks. *Network* **20**(3), 1-9.
- Birbili, M. (2000) Translating from one language to another. *Social Research Update*, **31** <http://www.soc.surrey.ac.uk/sru/SRU31.html> accessed 10.03.03
- Blaut, J.M. and Stea, D. (1971) Studies of geographic learning. *Annals of the Association of American Geographers* **61**, 387-393.
- Blaut, J.M. and Stea, D. (1974) Mapping at the age of three. *Journal of Geography* **73**, 5-9.

- Blaut, J.M., McCleary, G. and Blaut, A. (1970) Environmental mapping in young children. *Environment and Behaviour* **2**(3), 335-349.
- Bohmer, L. and Kirumira, E.K. (2000) Socio-economic context and the sexual behaviour of Ugandan out of school youth. *Culture, Health & Sexuality* **2**(3), 269-285.
- Browne, A.W. and Barrett, H.R. (2001) Moral boundaries: The geography of health education in the context of the HIV/AIDS pandemic in Southern Africa. *Geography* **86**(1), 23-36.
- Bunge, W.W. (1973) The geography. *Professional Geographer* **25**(4), 331-337.
- Bunge, W.W. and Bordessa, R. (1975) *The Canadian Alternative: Survival, Expeditions and Urban Change*. Geographical Monographs No. 2, Toronto, York University.
- Buseh, A.G., Glass, L.K., McElmurry, B.J., Mkhabela, M. and Sukati, N.A. (2002) Primary and preferred sources for HIV/AIDS and sexual risk behaviour information among adolescents in Swaziland, Southern Africa. *International Journal of Nursing Studies* **39**, 525-538.
- Cambridge (2006) Cambridge Advanced Learner's Dictionary. 2nd Ed, Cambridge University Press. <http://dictionary.cambridge.org/cald/book/> accessed 17.03.06
- Cameron, J. and Gibson, K. (2005) Participatory Action Research in a poststructuralist vein. *Geoforum*, **36**(3), 315-331.
- Campbell, B. and Mbizvo, M.T. (1994) Sexual behaviour and HIV knowledge among adolescent boys in Zimbabwe. *Central African Journal of Medicine*, **40**(9), 245-250.
- Campbell, R. and Wasco, S.M. (2000) Feminist approaches to social science: Epistemological and methodological tenets. *American Journal of Community Psychology* **28**(6), 773-791.

- Campbell, C. and Williams, B. (2001) Briefing: riding the tiger: contextualizing HIV prevention in South Africa. *African Affairs* **100**, 135-140.
- Carrier, J. & Bolton, R (1992) Anthropological perspectives on sexuality and HIV prevention. *Annual Review of Sex Research* **2**, 49-75.
- Christensen, P. and James, A. (2000) Introduction: Researching children and childhood: cultures of communication. In P.Christensen & A. James (eds.), *Research with Children. Perspectives and Practice*, Falmer Press, London.
- Collins, D. C. A., and Kearns, R.A. (2001). Under curfew and under siege? Legal geographies of young people. *Geoforum*, **32**, 389-403.
- Cornwall, A. (1992) Body mapping in health RRA/PRA. *RRA Notes* **16**, 69-76.
- Cornwall, A., and Jewkes, R. (1995). What is participatory research? *Social Science & Medicine* **41**(12-12), 1667-1676.
- Coyne, I. T. (1998). Researching children: some methodological and ethical considerations. *Journal of Clinical Nursing* **7**(5), 409-416.
- Curtis, S., Gesler, W., Smith, G., and Washburn, S. (2000) Approaches to sampling and case selection in qualitative research: examples in the geography of health. *Social Science & Medicine* **50**(7-8), 1001-1014.
- Djamba, Y.K. (1997) Financial capital and premarital sexual activity in Africa: The case of Zambia. *Population Research and Review* **16**, 243-257.
- Ekhaya (2003) Tsungirirai. <http://www.ekhaya.org/zimbabwe/tsungirirai.html>
- England, K.V.L. (1994) Getting personal: reflexivity, positionality, and feminist research. *Professional Geographer* **46**(1), 80-89.
- Feldman, D.A., O'Hara, P., Baboo, K.S., Chitalu, N.W., and Lu, Y. (1997) HIV prevention among Zambian adolescents: developing a value utilization/norm change model. *Social Science and Medicine* **44**(4), 455-468.
- Field, A. (2005). *Discovering Statistics using SPSS*, 2nd ed. Sage Publications, London.

- Fielding, S. (2000) Walk on the left!: Children's geographies and the primary school. In S.L. Holloway and G. Valentine (eds.) *Children's Geographies. Playing, Living, Learning*. London, Routledge.
- Foster, G. (1998) Today's children – challenges to child health promotion in countries with severe AIDS epidemics. *AIDS Care* **10**(suppl. 1), S17-S23.
- Foster, G., and Williamson, J. (2000) A review of current literature on the impact of HIV/AIDS on children in sub-Saharan Africa. *AIDS* **14** (suppl.3), S275-S284.
- Fuglesang, M. (1997) Lessons for life – past and present modes of sexuality education in Tanzanian society. *Social Science and Medicine* **44**(8), 1245-1254.
- Gagen, E.A. (2000) Playing the part: performing gender in America's playgrounds. In S.L. Holloway and G. Valentine (eds.) *Children's Geographies. Playing, Living, Learning*. London, Routledge.
- Gatenby, B. and Humphries, M. (2000) Feminist participatory action research: methodological and ethical issues. *Women's Studies International Forum*, **23**(1), 89-105.
- Gelfand, M. (1979) *Growing up in Shona Society. From Birth to Marriage*. Mambo Press, Gweru.
- Gilbert, M.R. (1994) The politics of location: doing feminist research at 'home'. *Professional Geographer* **46**(1), 90-96.
- Global Movement for Children (2006) Convention on the Rights of the Child. <http://gmc.freenet.uz/unicef/bg008.htm> accessed 18.03.06
- Goliber, T. (2004) Zimbabwe's political and economic problems hinder effective response to HIV/AIDS. Population Reference Bureau. <http://www.prb.org/Template.cfm?Section=PRB&template=/ContentManagement/ContentDisplay.cfm&ContentID=10184> accessed 22.09.05
- Gordon, R. (1998) 'Girls cannot think as boys do': socialising children through the Zimbabwean school system. *Gender and Development* **6**(2), 53-58.

- Graham, E. (1999) Breaking out: The opportunities and challenges of multi-method research in population geography. *Professional Geographer* **51**(1), 76-89.
- Graham, G. (2002). Behaviourism, *The Stanford Encyclopedia of Philosophy (Fall 2002 Edition)*, Edward N. Zalta (ed.),
<http://plato.stanford.edu/archives/fall2002/entries/behaviorism/> accessed 18.05.05
- Grinyer, A. (2002) The anonymity of research participants: assumptions, ethics and practicalities. *Social Research Update* **36**,
<http://www.soc.surrey.ac.uk/sru/SRU36.html> accessed 01.09.05
- Grunseit, A. (1997) Impact of HIV and sexual health education on the sexual behaviour of young people: a review update. UNAIDS Best Practice collection. UNAIDS.
<http://www.unesco.org/education/educprog/pead/GB/AIDSGB/AIDSGBtx/Impact/Intro.pdf>. Accessed 12.08.05
- Gwanzura-Ottmöller, F.P. and Kesby, M.G. (2005) 'Lets talk about sex baby...': conversing with Zimbabwean children about HIV/AIDS. *Children's Geographies* **3**(2), 201-218.
- Hansson, G. (1996) *Mwana ndi Mai. Toward an Understanding of Preparation for Motherhood and Childcare in the Transitional Mberengwa District, Zimbabwe*. Uppsala, Reprocentralen, HSC.
- Harden, J., Scott, S., Backett-Milburn, K. and Jackson, S. (2000). Can't talk, won't talk?: Methodological issues in researching children. *Sociological Research Online* **5**(2), 1-18.
- Hart, R. (1979) *Children's Experience of Place*. Irvington, New York.
- Hart, R. (1992) Children's participation: from tokenism to citizenship. *Innocenti Essays* **4**, UNICEF, New York.
- Heffner, C. L. (2001). Personality Development, Vol. 2005. AllPsych online.
<http://allpsych.com/psychology101/ego.html> accessed 20.05.05

- Heikes, D. K. (2004). The bias paradox: why it's not just for feminists anymore. *Synthese* **138**, 315-335.
- Hendrik, H. (2000) The child as a social actor in historical sources: problems of identification and interpretation. In P.Christensen & A. James (eds.), *Research with Children. Perspectives and Practice*, Falmer Press, London.
- Holloway, S.L., and Valentine, G. (2000a) *Children's Geographies. Playing, Living, Learning*. London, Routledge.
- Holloway, S.L., and Valentine, G. (2000b) Spatiality and the new social studies of childhood. *Sociology* **34**(4), 763-783.
- Holloway, S.L., Valentine, G., and Bingham, N. (2000) Transforming cyberspace: children's interventions in the new public sphere. In S.L. Holloway and G. Valentine (eds.) *Children's Geographies. Playing, Living, Learning*. London, Routledge.
- Holmes, R.M. (1998). *Fieldwork with Children*. Sage Publications, Thousand Oaks.
- Holt, L. (2004) The 'voices' of children: decentring empowering research relations. *Children's Geographies* **2**(1), 13-27.
- Huygens, P., Kajura, E., Seeley, J., and Barton, T. (1996). Rethinking methods for the study of sexual behaviour. *Social Science & Medicine* **42**(2), 221-231.
- Institute of Development Studies (2003) *Zimbabwe Human Development Report 2003. Redirecting our responses to HIV and AIDS*. (Harare, Graphtec Communications Zimbabwe).
- IRINnews.org (2004) ZIMBABWE: Plight of urban poor worsens, rural food stocks dwindle. <http://www.irinnews.org/report.asp?ReportID=44760> accessed 17.04.06
- Izugbara, C.O. (2004) Notions of sex. Sexuality and relationships among adolescent boys in rural south-eastern Nigeria. *Sex Education* **4**(1), 63-78.

- James, A., Jenks, C., and Prout, A. (1998) *Theorizing Childhood*. Cambridge, Polity Press.
- James, A., and Prout, A. (1997) A new paradigm for the sociology of childhood? Provenance, promise and problems. In A. James and A. Prout (eds.) *Constructing and Reconstructing Childhood*. London, Routledge Falmer.
- Jeater, D. (2000) No place for a woman: Gwelo town, Southern Rhodesia, 1894-1920. *Journal of Southern African Studies*, **26**(1), 29-42.
- Jenks, C. (2000) Zeitgeist research on childhood. In P. Christensen & A. James (eds.), *Research with Children. Perspectives and Practice*, Falmer Press, London.
- Jewkes, R., Vundule, C., Maforah, F. and Jordaan, E. (2001) Relationship dynamics and teenage pregnancy in South Africa. *Social Science and Medicine* **52**, 733-744.
- Jewkes, R., Levin, J. and Penn-Kekana, L. (2002) Risk factors for domestic violence: findings from a South African cross-sectional study. *Social Science and Medicine* **55**, 1603-1617.
- Johnston, R.J., Gregory, D., Pratt, G. and Watts, M. (2000) *The Dictionary of Human Geography* (4th Ed.), Blackwell Publishers Ltd., Malden.
- Jones, C (1995) The context of PRA. Edinburgh University training.
- Jones, O. (1999) Tomboy tales: the rural, nature and the gender of childhood. *Gender, Place and Culture* **6**(2), 117-136.
- Kaim, B., Chingwenya, P. and Gwata, S. (1997) Light on learning: using PRA to explore school-going adolescents' views on their sexual and reproductive health. *Training and Research Support Centre, Monograph 2*.
- Kaim, B. and Ndlovu, R. (2000) Lessons from 'Auntie Stella': using PRA to promote reproductive health education in Zimbabwe's secondary schools. *Participatory Learning and Action Notes: Sexual and Reproductive Health*, **37**, 45-49.

- Kaleeba, N., Kadowe, J., Kalinaki, D. and Williams, G. (2000) More talk, less sex: AIDS prevention through schools. *Participatory Learning and Action Notes: Sexual and Reproductive Health* **37**, 50-55.
- Kamp, K.A. (2001) Where have all the children gone?: The archaeology of childhood. *Journal of Archaeological Method and Theory* **8**(1), 1-34.
- Katz, C. (1993) Growing girls/closing circles: limits on the spaces of knowing in rural Sudan and US cities. In C. Katz (ed.) *Full Circles: Geographies of Women over the Life Course*. London, Routledge.
- Katz, C. (1994) Playing the field: Questions of fieldwork in geography. *Professional Geographer* **46**(1), 67-72.
- Kesby, M. (1994). *Geographies of Power: State and patriarchal spatial discourse and practice in Zimbabwe*. Unpublished PhD Thesis, University of Keele.
- Kesby, M. (1996) Arenas for control, terrains of gender contestation: guerrilla struggle and counter-insurgency warfare in Zimbabwe 1972-1980. *Journal of Southern African Studies* **22**(4), 561-584.
- Kesby, M. (1999) Locating and dislocating gender in rural Zimbabwe: the making of space and the texturing of bodies. *Gender, Place and Culture* **6**(1), 27-47.
- Kesby, M. (2000) Participatory diagramming as a means to improve communication about sex in rural Zimbabwe: a pilot study. *Social Science and Medicine* **50**(12), 23-41.
- Kesby, M., Maposhere, C., Moyo, I., Tavengwa, I., and Mhlanga, T. (2002). "A Review and Evaluation of the Stepping Stones Participatory HIV Education Project Run by Local NGO *Tsungirirai*, in Mhondoro North, Zimbabwe, March – July 2000. Fife, Scotland: School of Geography, University of St. Andrews. Available online at <http://www.st-andrews.ac.uk/gg/People/Staff/mgk/finalsststungiriraireport.pdf>

- Kesby, M., Gwanzura-Ottmoller, F. and Chizororo, M. (forthcoming) Theorising *other* 'other childhoods': Issues emerging from work on HIV in urban and rural Zimbabwe. *Children's Geographies*.
- Kesby M, Fenton K, Boyle P and Power R. (2003) An agenda for future research on HIV and sexual behaviour among African migrant communities in the UK. *Social Science and Medicine* **57**, 1573-1592.
- Kesby, M., Kindon, S. and Pain, R. (2005) Participatory approaches and diagramming techniques. In R. Flowerdew & D. Martin (eds), *Methods in Human Geography a guide for students doing a research project*. 2nd edn, Longman, London, pp.144-166.
- Kitchin, R. and Tate, N.J. (2000) *Conducting Research in Human Geography: Theory and Practice*. Prentice Hall, Harlow.
- Kobayashi, A. (1994) Coloring the field: Gender, 'race', and the politics of fieldwork. *Professional Geographer* **46**(1), 73-80.
- Kobayashi, A. (2001) Negotiating the personal and the political in critical qualitative research. In M. Limb & C. Dwyer (eds.) *Qualitative Methodologies for Geographers. Issues and Debates*, Arnold, London.
- Kong, L. (2000) Nature's dangers, nature's pleasures: urban children and the natural world. In S.L. Holloway and G. Valentine (eds.) *Children's Geographies. Playing, Living, Learning*. London, Routledge.
- Koskela, H. (1997) 'Bold walk and breakings': women's spatial confidence versus fear of violence. *Gender, Place and Culture* **4**(3), 301-319.
- Kim, Y.M., Marangwanda, C. and Kols, A. (1997) Quality of counselling of young clients in Zimbabwe. *East African Medical Journal*, **74**(8), 514-518.
- Lacey, A. and Luff, D. (2001) *Trent Focus for Research and Development in Primary Health Care: An Introduction to Qualitative Analysis*. Trent Focus.

- Lennard, H.L., and Lennard, S.H.C. (1992) Children in public places: some lessons from European cities. *Children's Environments* **9**(2), 37-47.
- Lennie, J. (1999) Deconstructing gendered power relations in participatory planning: towards an empowering feminist framework of participation and action. *Women's Studies International Forum* **22**(1), 97-112.
- Levy, S. (2002) N5 NUD*IST Workshop. University of St Andrews.
- Liben, L. S. a. D., R.M. (2003). Investigating and facilitating children's graphic, geographic, and spatial development: An illustration of Rodney R. Cocking's legacy. *Applied Developmental Psychology* **24**, 663-679.
- Lindegger, G. and Maxwell, J. (2004) A Gender Analysis of Targeted AIDS Interventions (TAI). A report for the Joint Oxfam HIV/AIDS Project (JOHAP).
http://www.preventgbvafrica.org/images/program_approaches/hiv/tai.hivprog_approach.pdf accessed 25.08.05
- MacPhail, C. and Campbell, C. (2001) 'I think condoms are good, but aai, I hate those things': condom use among adolescents and young people in a Southern African township. *Social Science and Medicine* **52**, 1613-1627.
- Magnani, R.J., Karim, A.M., Weiss, L.A., Bond, K.C., Lemba, M., and Morgan, G.T. (2002) Reproductive health risk and protective factors among youth in Lusaka, Zambia. *Journal of Adolescent Health* **30**, 76-86.
- Malungo, J.R.S. (1999) Challenges to sexual behavioural changes in the era of AIDS: Sexual cleansing and levirate marriage in Zambia. In J C. Caldwell, P. Caldwell, J. Anarfi, K. Awusabo-Asare, J. Ntozi, I.O. Orubuloye, J. Marck, W. Cosford, R. Colombo, and E. Hollings, (eds.) *Resistances to behavioural change to reduce HIV/AIDS infection in predominantly heterosexual epidemics in Third World countries*. Canberra, Australia: Australian National

- University, National Centre for Epidemiology and Population Health, Health Transition Centre, pp 41-57.
- Matasha, E., Ntembelea, T., Mayaud, P., Saidi, W., Todd, J., Mujaya, B. and Tendo-Wambuya, L. (1998) Sexual and reproductive health among primary and secondary school pupils in Mwanza, Tanzania: need for intervention. *AIDS Care* **10**(5), 571-582.
- Mathews, C., Everett, K., Binedell, J. and Steinberg, M. (1995) Learning to listen: formative research in the development of AIDS education for secondary school students. *Social Science and Medicine* **41**(12), 1715-1724.
- Mathews, C., Everett, K., Binedell, J. and Steinberg, M. (1995) Learning to listen: formative research in the development of AIDS education for secondary school students. *Social Science and Medicine* **41**(12), 1715-1724.
- Matthews, H. (1994) living on the edge: children as 'outsiders'. *Tijdschrift voor Economische en Sociale Geografie* **86**(5), 456-466.
- Matthews, H., and Limb, M. (1999) Defining an agenda for the geography of children: review and prospect. *Progress in Human Geography* **23**, 61-90.
- Matthews, H., Limb, M., and Taylor, M. (1999) Young people's participation and representation in society. *Geoforum*, **30**(2), 135-144.
- Matthews, H., Limb, M., and Taylor, M. (2000) The 'street as thirdspace'. In S.L. Holloway and G. Valentine (eds.) *Children's Geographies. Playing, Living, Learning*. London, Routledge.
- Mayall, B. (2000) Conversations with children: working with generational issues. In P.Christensen & A. James (eds.), *Research with Children. Perspectives and Practice*, Falmer Press, London.
- McKendrick, J.H., Bradford, M.G., and Fielder, A.V. (2000) Time for a party!: making sense of the commercialisation of leisure space for children. In S.L. Holloway and G. Valentine (eds.) *Children's Geographies. Playing, Living, Learning*. London, Routledge.

- Meursing, K., Vos, T., Coutinho, O., Moyo, M., Mpofu, S., Oneko, O., Mundy, V., Dube, S., Mahlangu, T. and Sibindi, F. (1995) Child sexual abuse in Matebeleland, Zimbabwe. *Social Science and Medicine* **41**(12), 1693-1704.
- Midwinter, E. (2005) How many people are there in the third age? *Ageing & Society* **25**(1), 9-18.
- Mohammad, R. (2001) 'Insiders' and 'outsiders': positionality, theory and praxis. In M. Limb & C. Dwyer (eds.) *Qualitative Methodologies for Geographers. Issues and Debates*, Arnold, London.
- Mullings, B. (1999). Insider or outsider, both or neither: some dilemmas of interviewing in a cross-cultural setting. *Geoforum* **30**(4), 337-350.
- Munodawafa, D., Gwede, C., and Mubayira, C. (1995) Using focus groups to develop HIV education among adolescent females in Zimbabwe. *Health Promotion International* **10**(2), 85-92.
- Munodawafa, D. and Gwede, C. (1996) Patterns of HIV/AIDS in Zimbabwe: Implications for health education. *AIDS Education and Prevention* **8**(1), 1-10.
- Murray, J. S. (2000). Conducting psychosocial research with children and adolescents: A developmental perspective. *Applied Nursing Research*, **13**(3), 151-156.
- Muyinda, H., Kengeya, J., Pool, R. and Whitworth, J. (2001) Traditional sex counselling and STI/HIV prevention among young women in rural Uganda. *Culture, Health and Sexuality* **3**(3), 353-361.
- Nayak, A. (2003). 'Through children's eyes': childhood, place and fear of crime. *Geoforum*, **34**, 303-315.
- Nast, H.J. (1994) Opening remarks on 'Women in the field'. *Professional Geographer* **46**(1), 54-66.
- NCH Swift Sound (2003) Express Scribe Transcription Playback Software. Australia. <http://www.nch.com.au/scribe/index.html> accessed 25.08.05

- Ndeki, S.S., Klepp, K-I. And Mliga, G.R.Z. (1994) Knowledge, perceived risk of AIDS and sexual behaviour among primary school children in two areas of Tanzania. *Health Education Research* **9**(1), 133-138.
- Ndeki, S.S., Klepp, K-I., Irema, M.N., Lyimo, B.A., and Msuya, M.H. (1995) Ngao: AIDS education for primary school children. In K-I. Klepp, P.M. Biswalo and A. Talle (eds.) *Young People at Risk. Fighting AIDS in Northern Tanzania*, Scandinavian University Press, Oslo, pp133-148.
- Ndlovu, R.J., and Sihlangu, R.H. (1992) Preferred sources of information on AIDS among high school students from selected schools in Zimbabwe. *Journal of Advanced Nursing* **17**, 507-513.
- Ndundu, T.J. and Shumba, A. (2001) The nature and frequency of reported cases of teacher perpetrated child sexual abuse in rural primary schools in Zimbabwe. *Child Abuse and Neglect* **25**, 1517-1534.
- Nnko, S. and Pool. R. (1997) Sexual discourse in the context of AIDS: dominant themes on adolescent sexuality among primary school pupils in Magu district, Tanzania. *Health Transition Review* **7**(Supplement 3), 85-90.
- Nyachuru-Sihlangu, R.H., and Ndlovu, J. (1992) Factual knowledge about AIDS and dating practices among high school students from selected schools. *Central African Journal of Medicine* **38**(6), 225-233.
- Nyanzi, S., Pool, R., and Kinsman, J. (2001) The negotiation of sexual relations among school pupils in south-western Uganda. *AIDS Care* **13**(1), 83-98.
- O’Kane, C. (2000) The development of participatory techniques: facilitating children’s views about decisions which affect them. In P.Christensen & A. James (eds.), *Research with Children. Perspectives and Practice*, Falmer Press, London.
- Pitts, M., Bowman, M., and McMaster, J. (1995) Reactions to repeated STD infections: psychosocial aspects and gender issues in Zimbabwe. *Social Science and Medicine* **40**(9), 1299-1304.

- Pitts, M., Burtney, E., and Dobraszczyc, U. (1996) 'There is no shame in it anymore': how providers of sexual health advice view young people's sexuality. *Health Education Research* **11**(1), 1-9.
- Plummer, M., Ross, D.A., Wight, D., Changalucha, J., Mshana, G., Wamoyi, J., Todd, J., Anemona, A., Mosha, F.F., Obasi, A.I.N., and Hayes, R. (2004) "A bit more truthful": The validity of adolescent sexual behaviour data collected in rural Tanzania using 5 methods. *Sexually Transmitted Infections*, **80**(suppl II), ii49-ii56.
- Pope, C., Ziebland, S and May, N. (2000) Qualitative research in health care. Analysing qualitative data. *British Medical Journal* **320**, 114-116.
- Power, R., Langhaug, L.F., Nyamurera, T., Wilson, D., Bassett, M.T. and Cowan, F.M. (2004) Developing complex interventions for rigorous evaluation-a case study from rural Zimbabwe. *Health Education Research* **19**, 570-575.
- Pridmore, P. (2003) Revisiting children's participation: a critical review of Child-to-Child experiences in Kenya and Vietnam. *Journal of Anthropology in Action*.
- Prout, A. (2000). Foreward. In P.Christensen & A. James (eds.), *Research with Children. Perspectives and Practice*, Falmer Press, London.
- Punch, S. (2000) Children's strategies for creating playspaces: negotiating independence in rural Bolivia. In S.L. Holloway and G. Valentine (eds.), *Children's Geographies. Playing, Living, Learning*. London, Routledge.
- Ray, S., Latif, A., Machekano, R., *et al.* (1998) Sexual behaviour and risk assessment of HIV seroconverters among urban male factory workers in Zimbabwe. *Social Science and Medicine* **47**(10), 1431-1443.
- Rivers, K. and Aggleton, P. (1999) Adolescent sexuality, gender and the HIV epidemic. *United Nations Development Programme*.
- Rivers, K. and Aggleton, P. (1999) Adolescent sexuality, gender and the HIV epidemic. *United Nations Development Programme*.
- Robson, C. (2002) *Real World Research*, 2nd ed., Blackwell, Oxford.

- Robson, E. and Ansell, N. (2000) Young carers in southern Africa: exploring stories from Zimbabwean secondary school students. In S.L. Holloway and G. Valentine (eds.), *Children's Geographies. Playing, Living, Learning*, Routledge, London.
- Robson, E. (2000a) Invisible carers: young people in Zimbabwe's home-based health care. *Area* **32**, 59-69.
- Robson, E. (2001) Interviews worth the tears? Exploring dilemmas of research with young carers in Zimbabwe. *Ethics, Place and Environment* **4**(2), 135-142.
- Robson, E. (2004) Hidden Child Workers: Young Carers in Zimbabwe. *Antipode* **36**(2), 227-248.
- Rose, G. (1997) Situating knowledges: positionality, reflexivities and other tactics. *Progress in Human Geography* **21**(3), 305-320.
- Runganga, A.O. & Kasule, J. (1995) The vaginal use of herbs/substances: an HIV transmission facilitatory factor. *AIDS Care* **7**(5), 639-645.
- Rusakaniko, S., Mbizvo, M.T., Kasule, J., Gupta, V., Kinoti, S.N., Mpanju-Shumushu, W., Sebina-Zziwa, J., Mwateba, R. and Padayachy, J. (1997) Trends in reproductive health knowledge following a health education intervention among adolescents in Zimbabwe. *Central African Journal of Medicine* **43**(1), 1-6.
- SAfAIDS (2003) <http://www.saf aids.org.zw>. Accessed 01.02.04.
- Schatz, P. and Dzvimbo, K.P. (2001) The adolescent sexual world and AIDS prevention: a democratic approach p programme design in Zimbabwe. *Health Promotion International* **16**(2), 127-36.
- Scott, S.J., and Mercer, M.A. (1994) Understanding cultural obstacles to HIV/AIDS prevention in Africa. *AIDS Education and Prevention* **6**(1), 81-89.
- Shah, M.K. and Nkhama, G. (1996) Listening to young voices: participatory appraisal on adolescents sexual and reproductive health in peri-urban Lusaka. CARE International in Zambia.

- Sherman, J.B., and Bassett, M.T. (1999) Adolescents and AIDS prevention: A school-based approach in Zimbabwe. *Applied Psychology: An International Review* **48**(2), 109-124.
- Shire, C. (1994). Language, space and masculinities in Zimbabwe. In A. Cornwall & N. Lindisfarne (eds.), *Dislocating Masculinity: Comparative Ethnographies*, pp. 147-158. Routledge, London.
- Sibley, D. (1991) Children's geographies: some problems of representation. *Area*, **23**, 269-270.
- Sibanda, A. (2000). A nation in pain: Why the HIV/AIDS is out of control in Zimbabwe. *International Journal of Health Services* **30**(4), 717-738.
- Silberschmidt, M. and Rasch, V. (2001) Adolescent girls, illegal abortions and "sugar daddies" in Dar es Salaam: vulnerable victims and active social agents. *Social Science and Medicine*, **52**, 1815-1826.
- Skelton, T. (2000) 'Nothing to do, nowhere to go?: teenage girls and 'public' space in the Rhondda valleys, South Wales. In S.L. Holloway and G. Valentine (eds.) *Children's Geographies. Playing, Living, Learning*. London, Routledge.
- Skelton, T. (2001) Cross-cultural research: issues of power, positionality and 'race'. In M. Limb & C. Dwyer (eds.) *Qualitative Methodologies for Geographers. Issues and Debates*, Arnold, London.
- Smith, F., and Barker J. (2000) 'Out of school', in school: a social geography of out of school childcare. In S.L. Holloway and G. Valentine (eds.) *Children's Geographies. Playing, Living, Learning*. London, Routledge.
- Smith, S. (2001) Doing qualitative research: from interpretation to action. In M. Limb & C. Dwyer (eds.) *Qualitative Methodologies for Geographers. Issues and Debates*, Arnold, London.
- Stewart, K.A. (2001) Towards a Historical Perspective on Sexuality in Uganda: The Reproductive Lifeline Technique for Grandmothers and their Daughters. *Africa Today* **47**(3/4), 122-148.

- Smith, M.K. (2002) Gender, poverty and intergenerational vulnerability to HIV/AIDS. *Gender and Development* **10**(3), 63-70.
- Talle, A. (1995) Desiring difference: risk behaviour among young Maasai men. In K-I. Klepp, P.M. Biswalo and A. Talle (eds.) *Young People at Risk. Fighting AIDS in Northern Tanzania*, Scandinavian University Press, Oslo, pp 69-85.
- Todd, J., Chagalucha, J., Ross, D.A., Mosha, F., Obasi, A.I.N., Plummer, M., Balira, R., Grosskurth, H., Mabey, D.C.W., and Hayes, R. (2004) The sexual health of pupils in years 4 to 6 of primary school in rural Tanzania. *Sexually Transmitted Infections*, **80**, 35-42.
- Tolman, D. (1994). Doing Desire. Adolescent girls' struggles for/with sexuality. *Gender and Society* **8**(3), 324-342.
- UNAIDS (1998) Mother to child transmission of HIV. UNAIDS Technical Update. www.unaids.org accessed 23.08.05
- UNAIDS (1999) Zimbabwe. Epidemiological fact sheet on HIV/AIDS and sexually transmitted diseases. <http://www.unaids.org> accessed 20.02.2002
- UNAIDS (1999) Africa's youth confront the epidemic. [Http://www.unaids.org/wac/1999/eng/africapaper-eng.doc](http://www.unaids.org/wac/1999/eng/africapaper-eng.doc)
- UNAIDS (2004) AIDS Epidemic Update. http://www.unaids.org/wad2004/EPI_1204_pdf_en/EpiUpdate04_en.pdf accessed 23.08.05
- UNAIDS (2004) Zimbabwe. Epidemiological fact sheet on HIV/AIDS and sexually transmitted diseases. <http://www.unaids.org> accessed 22.09.2005
- UNDP (2004) Human Development Report. http://hdr.undp.org/statistics/data/pdf/hdr04_table_1.pdf accessed 26.11.04
- UNDP (2005) Human Development Indicators. http://hdr.undp.org/reports/global/2005/pdf/HDR05_HDI.pdf accessed 22.09.05

- UNICEF (1999) The Progress of the Nations 1999-The AIDS Emergency.
[Http://www.unicef.org/pon99/aidsdat2.htm](http://www.unicef.org/pon99/aidsdat2.htm). accessed 22.08.03
- UNICEF (2000) Education and HIV/AIDS power point presentation with talking points <http://www.unicef.org/lifeskills/EducationandHIVAIDS.ppt>
- UNICEF (2004) The State of the World's Children.
http://www.unicef.org/lifeskills/index_statistics.html accessed 26.11.04
- UNICEF (2005) Zimbabwe. At a glance.
http://www.unicef.org/infobycountry/zimbabwe_statistics.html#5 accessed 21.03.05
- UNICEF ESARO (2003) Breaking silence: Gendered and Sexual Identities and HIV/AIDS in Education. Young Voices Series.
http://www.unicef.org/lifeskills/index_14927.html accessed 29.09.05
- Valentine, G. (1992) Images of danger: women's sources of information about the spatial distribution of male violence. *Area* **24**(1), 22-29.
- Valentine, G. (1997a) 'Oh yes I can'. 'Oh no you can't.': children and parents' understandings of kids' competence to negotiate public space safely. *Antipode* **29**(1), 65-89.
- Valentine, G. (1997b) 'My son's a bit dizzy.' 'My wife's a bit soft': gender, children and cultures of parenting. *Gender, Place and Culture* **4**(1), 37-62.
- Valentine, G. (2001) At the drawing board: developing a research design. In M. Limb & C. Dwyer (eds.) *Qualitative Methodologies for Geographers. Issues and Debates*, Arnold, London.
- Valentine, G. (2001) *Social Geographies. Space and Society*. Prentice Hall, Harlow.
- Van de Walle, E. and Franklin, N. (1996) Sexual initiation and the transmission of reproductive knowledge. *Health Transition Review* **6**(Suppl 6), 61-68.

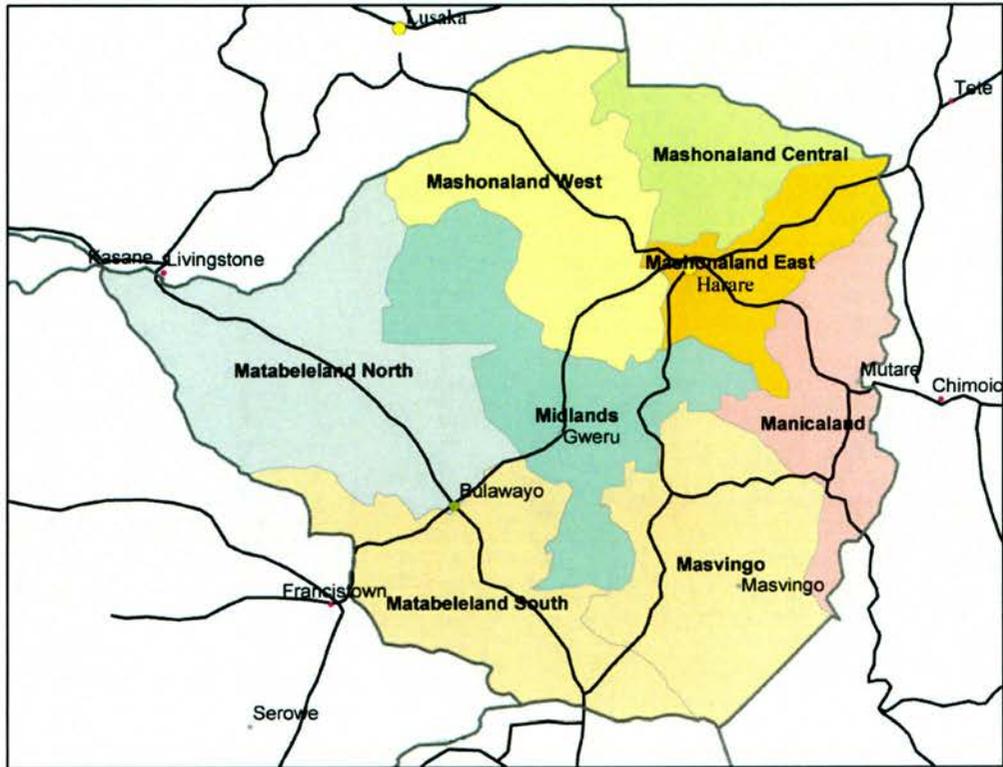
- Van de Wijgert, J.H.H.M., Khumalo-Sakutukwa, G.N., Coggins, C., *et al.* (1999) Men's attitudes towards vaginal microbicide trials in Zimbabwe. *International Family Planning Perspectives* **25**(1), 15-20.
- VERBI Software • Consult • Sozialforschung GmbH (2003) MAXqda – professional software for qualitative data analysis. Germany.
<http://www.maxqda.com/maxqda-eng/index.htm> accessed 25.08.05
- Verkuyl, D.A.A. (1996) Consequences, cultural factors, detection, and prevention of HIV/AIDS in sub-Saharan Africa. *Obstetrical and Gynecological Survey* **52**(1), 1-3.
- Vernier, J.L., Ross, M.W., and Akande, A. (1998) HIV/AIDS-related social anxieties in adolescents in three African countries. *Social Science and Medicine* **46**(3), 313-320.
- Vos, T. (1994) Attitudes to sex and sexual behaviour in rural Matabeleland, Zimbabwe. *AIDS Care* **6**(2), 193-203.
- Ware, V., and Cavanagh, S. (1992) Planning for children in public places. *Children's Environments* **9**(2), 48-62.
- Weiss, E., Whelan, D. and Rao Gupta, G. (2000) Gender, sexuality and HIV: making a difference in the lives of young women in developing countries. *Sexual and Relationship Therapy* **15**(3), 233-245.
- Weller, S. (2003) "Teach us something useful": Contested spaces of teenagers' citizenship. *Space and Polity* **7**(2), 153-171.
- Wikipedia (2005) Bantu. <http://en.wikipedia.org/wiki/Bantu> accessed 24.08.05
- Wikipedia (2006) Knowledge. <http://en.wikipedia.org/wiki/Knowledge> accessed 17.03.06
- Wikipedia (2006) Knowledge. Risk
http://en.wikipedia.org/wiki/Risk#Scientific_background accessed 17.03.06

- Wood, K., Maforah, F. and Jewkes, R. (1998) "He forced me to love him": putting violence on adolescent sexual health agendas. *Social Science and Medicine* 47(2), 233-242.
- Woodhead, M. and Faulkner, D. (2000) Subjects, objects or participants? Dilemmas of psychological research with children. In P.Christensen & A. James (eds.), *Research with Children. Perspectives and Practice*, Falmer Press, London.
- World Bank (2001) World development indicators CD-ROM.
- <http://devdata.worldbank.org/hnpstats/HnpAtaGlance.asp?sCtry=ZWE,Zimbabwe>
accessed 22.08.03
- Wilson, D.J., Lavelle, S., and Hood, R. (1990) Health knowledge and beliefs as predictors of intended condom use among Zimbabwean adolescents in probation/remand homes. *AIDS Care* 2(3), 267-274.
- World Bank (2004) World Development Indicators: Population dynamics.
<http://www.worldbank.org/data/databytopic/population.html> accessed 13.09.04
- World Bank (2005) World Development Indicators: Zimbabwe. http://ddp-ext.worldbank.org/ext/ddpreports/ViewSharedReport?REPORT_ID=1305&REQUEST_TYPE=VIEWADVANCED accessed 22.09.05
- World Health Organisation (2004) Adolescent health and Development. Overview of Child and Adolescent Health. http://www.who.int/child-adolescent-health/OVERVIEW/AHD/adh_over.htm accessed 23.08.05
- World Health Organisation (2004) WHO warns that HIV infections through marital sex are increasing. WHO Press Release, 1 December 2004 World AIDS Day. http://www.wpro.who.int/3by5/docs/World_AIDS_Day_2004.pdf accessed 23.08.05
- Wood, K., Maforah, F. and Jewkes, R. (1998) "He forced me to love him": putting violence on adolescent sexual health agendas. *Social Science and Medicine* 47(2), 233-242.

- Young, A. (1982). The anthropology of illness and sickness. *Annual review of Anthropology* **11**, 257-285.
- Young, L., and Barrett, H. (2001) Adapting visual methods: action research with Kampala street children. *Area* **33**(2), 141-152.
- Young, L. and Ansell, N. (2003) Fluid households, complex families: the impacts of children's migration as a response to HIV/AIDS in southern Africa. *The Professional Geographer* **55**(4) 464-479
- Young, L. (2004) Journeys to the street: the complex migration geographies of Ugandan street children. *Geoforum* **35**, 471-488.
- Zabin, L.S. and Kiragu, K. (1998) The health consequences of adolescent sexual and fertility behaviour in sub-Saharan Africa. *Studies in Family Planning* **29**(2), 210-232.
- Zimbabwe Ministry of Education and Culture and UNICEF (1993) Let's talk. An AIDS Action Programme for Schools, Grade 7, Pupils Book.
- Zimbabwe, Ministry of Health. (2005) The National AIDS Coordination Programme. <http://www.mohcw.gov.zw/mohcw/nacp.html>. Accessed 01.02.2005

Appendices

Appendix 1. Map of Zimbabwe



Appendix 2. HIV/AIDS questionnaire

1) Uri mugrade ani?

Which grade are you in?

2) Une makore mangani?.....

How old are you?

3) Uri musikana kanakuti mukomana?

Are you a girl or a boy?

- a) boy
- b) girl

4) Vabereki vako vapenyu here?

Are your parents still alive?

- a) Hongu / Yes
- b) Hongu, Baba voga ndivo vachiri vapenyu / yes, but only my father is alive
- c) Hongu, asi Amai voga ndivo vachiri vapenyu / yes, but only my mother is alive
- d) Kwete / no

5) Uno gara kupi? (kwete address)

Where do you live? (not address)

- a) Katanga
- b) Ngoni
- c) Flamingo
- d) Johannesburg
- e) Maridale
- f) Imwenzvimbo / Other.....

6) Unogara naani?

Who do you live with at this place?

- a) naAmai / Mother
- b) naBaba / father
- c) nevabereki vose / both parents
- d) neHanzvadzi / sister
- e) naMukoma / older brother
- f) naBabamukuru, babamudiki, sekuru / uncle
- g) naTete, amaiguru, amainini, ambuya / aunt
- h) naVasekuru, ambuya / grandfather, grandmother
- i) nevamwewo / other.....

7) Unogara muno muNorton nguva dzose here?

Do you live here in Norton all the time?

- a) Hongu / Yes
- b) Ndinogara muno kanachikoro chakavhurwa chete / I only live here during the school term

- c) Ndinogara muno mazuva ekuchikoro chete asi maweekends ndinenge ndisiri muno / I only live here during the week
- d) Zvimwewo / Other.....

8i) Kana uchimboenda kuimwe nzvimbo pazororo, ndekupi kwacho kwaunoenda?

If you stay somewhere else during the holidays, where is this place?

.....

ii) Uye unenge uchigara naani?

And with whom do you live with at this place?

- a) naAmai / Mother
- b) naBaba / father
- c) nevabereki vose / both parents
- d) naHanzvadzi / older sister
- e) naMukoma / older brother
- f) naBabamukuru, babamudiki, sekuru / uncle
- g) naVatete, amaiguru, amainini, ambuya / aunt
- h) naVasekuru, ambuya / grandfather, grandmother
- i) ne vamwewo / other.....

9) Murivana vangani mumhuri menyu?.....

How many children are in your family?

10) Pane umwe we mumhuri menyu here anoshanda achitambira mari? Kana arimo ndiani?

Does anyone in your family do any work to earn money? If yes, who?

11) Iwe, pane basa raunoita here kuti uwane mari?

Do you do any work to earn money?

12) If yes, what kind of work do you do?

Kana wati hongu, ibasa rakaita sei?

- a) Kutengesa maputi,masiwiti kana kuti mabisikiti / Selling snacks
- b) Kushandira vanhu mudzimba / Cleaning
- c) Kutengesa michero ne miriwo / Selling fruit and vegetables
- d) Zvimwewo / Other.....

13) Mari yaunowana unoshandisa chii?

What do you use the money you earn for?

- a) Kutengera vanhu vekumba chikafu / buying food for the family
- b) Kuzvitengera chikafu / to buy myself food
- c) Kuzvitengera mbatya / buying clothes for myself
- d) Kutenga zvinhu zvinenge zvichidiwa kuchikoro / buying school items
- e) Kubhadhara mari yechikoro / paying school fees
- f) Zvimwewo / other.....

14) Basa iri unowanzoriita kakawanda sei?

How often do you do this work?

- a) Mazuva ose ndisati ndaenda kuchikoro/ Every day before school

- b) Mazuva ose ndabva kuchikoro / Every day after school
- c) Kakawanda pasvondo / Several times a week
- d) Pamaweekends chete / Only on weekends
- e) Pazororo rechikoro chete / Only during the school holidays
- f) Zvimwewo / Other.....

15) Unofarira kuita basa iri here?

Do you enjoy doing this work?

- a) Hongu / yes
- b) Kwete / no
- c) Dzimwenguva / sometimes

16) Pane rubatsiro rwaunowana kubva kuTsongirirai here?

Do you receive any help from Tsongirirai?

- a) Hongu / yes
- b) Kwete / no
- c) Handizive / don't know

17) Kana wati hongu, unowana rubatsiro rwakaita sei?

If yes, what type of help do you receive from them?

- a) Vanondibhadharira chikoro / they pay my school fees
- b) Ndinoenda ikoko kunopiwa chikafu / I go there for food
- c) Rumwewo rubatsiro / Other.....

HIV/AIDS quiz – 22 questions

1) Chii chinonzi HIV?

What is HIV?

- a) Zvirwere zvakawanda-wanda / a collection of illnesses
- b) Ivirus / a virus
- c) Ibacteria / a bacteria
- d) Handizive / don't know

2) Chii chinonzi AIDS?

What is AIDS?

- a) Zvirwere zvakawanda-wanda / a collection of illnesses
- b) Ivirus / a virus
- c) Ibacteria / a bacteria
- d) Handizive / don't know

3) Munhu ane utachiona hweHIV anechirwere cheshuramatongo kana kuti AIDS here?

Does a person with HIV also have AIDS?

- a) Hongu / yes
- b) Kwete / no
- c) Dzimwenguva / sometimes
- d) Handizive / don't know

4) Munhu ane utano hwakanaka anogona kunge aine utachiona hweHIV here?

Can a healthy looking person be infected with HIV?

- e) Hongu / yes
- f) Kwete / no
- g) Dzimwenguva / sometimes
- h) Handizive / don't know

5) Munhu mukobvu haakwanise kuva neutachiona hweHIV.

A fat person cannot be infected with HIV.

- a) Ichokwadi / true
- b) Manyepo / false
- c) Handizive / don't know

6) Ukava nekuteseka kumunhu mumwechete haukwanise kuwana utachiona hweHIV

If you stick to one sexual partner you wont become infected with HIV?

- a) Ichokwadi / True
- b) Ichokwadi, ndokunge munhu wacho asina hwutachiona hweHIV / True, but only if that partner is not already infected with HIV
- c) Manyepo / False
- d) Handizive / Don't know

7) Munhu anowana utachiona hweHIV sei?

How can a person get HIV?

- a) Kubva kumosquito, nhata kanakuti tsikidzi/ From mosquitoes, fleas or bedbugs

- b) Kubva mukusangana pabonde / From having sex
- b) Kubva mukusangana pabonde nemhunu ane utachiona hweHIV / From having unprotected sex with a person infected with HIV
- c) Kubva pazvigarro zvechimbuzi / From a toilet seat
- d) Kubva kushandisa marheza, tsono ne majekiseni akashandiswa ne vamwe / From sharing razorblades, needles and injections
- e) Handizive / don't know

8) Vanhu vangazvidzivirire sei kubva kuutachiona hweAIDS ? (denderedza mhinduro dzese dzaunofunga kuti dzinechokwadi)

How can people protect themselves from getting AIDS? (circle all possible answers)

- a) Kusaita zvepabonde / avoid sexual intercourse (don't play sex)
- b) Kuva nemudiwa mumwechete / limit number of sexual partners
- c) Kushandisamacondom kana vave kusanga pabonde / use condoms during sex
- d) Kusasangana pabonde nepfambi / avoid sex with prostitutes
- e) Kunwa mapiritsi kana vave kuda kusangana pabonde / take antibiotics prior to sexual contact
- f) Kusangana pabonde nevanhu vane hutano hwakanaka chete / have sex only with healthy persons

9) Ndechipi pane zvinotevera chinochengetedza zvakanyanya kuti usabate HIV?

Which one of these protects you most effectively against HIV infection?

- a) Mapiritsi efamily planning / contraceptive pill
- b) Macondomu / condoms
- c) Kusatosangana pabonde nemumwe munhu zvachose / not having sex at all
- d) handizive / don't know

10) Munhu anokwanise kubata HIV/AIDS here paanotanga kusangana pabonde nemukumomana kanamusikana?

Can a person get HIV/AIDS the first time they have sex?

- a) Hongu / yes
- b) Hongu, asi kana umwe wake aineutachiona / Yes if their partner is infected
- c) Kwete / no
- d) Handizive / don't know

11) Vanhu vanowana hutachiona hweAIDS kana / People get AIDS if they:

- a) Vachienda kumabhawa / go to beerhalls
- b) Vachinwa mvura kana kudya chikafu chinetsvina / drink dirty water and eat dirty food
- c) Kanavakave neshamwari dzakawanda dzepabonde / have multiple sex partners
- d) Kana vakave nebarika / Are polygamous
- e) Kana vakadanana neMasugar daddy kana kuti masugar mummy / go out with sugar daddies or sugar mummies
- f) Kana vakatamba nevanhu verudzi rwakasiyana navo / play with the opposite sex
- g) Kana vakasangana pabonde nemunhu ane hutachiona hwe HIV / have unprotected sex with a person infected with HIV
- h) Handizive / Don't know

12) Pane mushonga here unorapa chirwere cheAIDS?

Is there a cure for AIDS?

- a) Hongu / yes
- b) Kwete / no
- c) Handizive / don't know

13) AIDS inorapika here nekusangana pabonde nemunhu achiri mhandara?

Can AIDS be cured by having sex with a virgin?

- a) Hongu / yes
- b) Kwete / no
- c) Handizive / don't know

14) Pane munhu waunoziva here akafa nechirwere cheAIDS?

Do you know of anyone who has died from AIDS?

- a) Hongu / yes
- b) Kwete / no
- c) Handizive / don't know
- d) Handina chokwadi chakakwana / I'm not sure

15) Vana vezera rako vanokwanisa here kubata chirwere cheAIDS?

Can children your age get HIV/AIDS?

- a) Hongu / yes
- b) Kwete / no
- c) Handizive / don't know

16) Wakanzwa nezveAIDS kubvakupi? (denderedza minduro dzese dzaunofunga kuti ndidzo chaidzo)

From which sources of information did you learn about HIV/AIDS? (circle as many as are relevant)

- a) kuradio
- b) kuTV
- c) kumaNewspaper/magazines
- d) kumaPoster/pamphlet
- e) Kubva kuvashandi vehurumende vanoita zveutano / Government health worker
- f) Kubvakumudzidzisi / School teacher
- g) Kubvakushamwari / Friends
- h) Kubvakumudiwa wako / Boyfriend/girlfriend
- i) Kubva kuvabereki, kanavachengeti kana hama dzako / Parent/guardian/relative
- j) Vamwewo vanhu (Nyora kuti ani) / Other (specify).....
- k) Handizive / Don't know

17) Ndokupi kana kuti ndokunaani kwawaka nyanyo dzidza nezve HIV ne AIDS?

Where or from whom have you learnt the most about HIV/AIDS?

- a) Kubva kumudzidzisi kuchikoro / teacher in school
- b) Kubva kvanhu vekumba / family
- c) Kubva kushamwari / friends
- d) Kubva kunemudiwa / Boyfriend/girlfriend
- e) Kubva kuna chiremba kana nesi / doctor/nurse

- f) Kubva kuclinic ye family planning / family planning clinic
- g) Kubva kuchikoro / school
- h) kuradio
- i) kutv
- j) kumanewspapers/magazines/books
- k) Handizive / Don't know
- l) Zvimwewo (nyora kuti kupi) / other (specify).....

18) Kana uine mubvunzo pamusoro pezveHIV/AIDS unobvunza ani?

If you had a question about HIV/AIDS who would you ask?

- a) Mudzidzisi / teacher in school
- b) Vabereki / parents
- c) Mukoma kana kuti hanzvadzi / sister or brother
- d) Shamwari / friends
- e) Mudikani wangu / Boyfriend, girlfriend
- f) Chiremba kana nesi/ doctor, nurse
- g) Nesi we family planning / family planning clinic nurse
- h) Handizive / Don't know
- i) Imwe minduro / other (nyora/specify).....

19) Unofunga kuti ndiani anofanira kutaurira vechidiki vezera rako nezve pabonde, zveHIV ne AIDS, nezvekubatwa kwepamuviri?

Who do you think should tell young people like yourself be told about sex, HIV/AIDS, and pregnancy?

- a) Vadzidzisi kuprimary / Teachers at primary school
- b) Vadzidzisi kusecondary / Teachers at secondary school
- c) Vanhuvakuru kumba / Adults at home
- d) Handizive / don't know
- e) Vamwewo / other

20) Chii chinonzi kusangana pabonde?

What is having sex ?

.....

21) Kufunga kwako, ndevapi vanoziwa zvakanyanya nezve pabonde?

Who knows more about sex?

- a) Vasikana / Girls
- b) Vakomana / Boys
- c) Handizive / Don't know

22) Chii panezvinotevera chaungaite neumwemunhu kuti uwane mari kana chipo?

Would you ever do the following with someone for money or a gift:

	Hongu/Yes	Kwete/No	Pamwe/maybe
Kubatana maoka / hold hands			
Kuenda kunoshanya / go for a walk			
Kutsvodana / kiss			
Kuenda kunoona firimu/go to see a film			
Kupinda mumota yemunhu wausingazive/ To get into a stranger's car			
Kubatwabatwa kwenhengo dzakavanzika / let them touch your private parts			
Kusangana pabonde navo / let them have sex with you			

Appendix 3. HIV/AIDS Quiz answer sheet

1) Chii chinonzi HIV?

What is HIV?

- b) Ivirus / a virus

2) Chii chinonzi AIDS?

What is AIDS?

- e) Zvirwere zvakawanda-wanda / a collection of illnesses

3) Munhu ane utachiona hweHIV anechirwere cheshuramatongo kana kuti AIDS here?

Does a person with HIV also have AIDS?

- c) Dzimwenguva / sometimes

4) Munhu ane utano hwakanaka anogona kunge aine utachiona hweHIV here?

Can a healthy looking person be infected with HIV?

- a) Hongu / yes

5) Munhu mukobvu haakwanise kuva neutachiona hweHIV.

A fat person cannot be infected with HIV.

- b) Manyepo / false

6) Ukava nekuteseka kumunhu mumwechete haukwanise kuwana utachiona hweHIV

If you stick to one sexual partner you wont become infected with HIV?

- b) Ichokwadi, ndokunge munhu wacho asina hutachiona hweHIV / True, but only if that partner is not already infected with HIV

7) Munhu anowana utachiona hweHIV sei? (denderedza mhinduro dzese dzaunofunga kuti dzinechokwadi)

How can a person get HIV? (circle all possible answers)

- d) Kubva mukusangana pabonde nemhunu ane utachiona hweHIV / From having unprotected sex with a person infected with HIV
- e) Kubva kushandisa marheza, tsono ne majekiseni akashandiswa ne vamwe / From sharing razorblades, needles and injections

9) Ndechipi pane zvinotevera chinochengetedza zvakanyanya kuti usabate HIV?

Which one of these protects you most effectively against HIV infection?

- c) Kusatosangana pabonde nemumwe munhu zvachose / not having sex at all

10) Munhu anokwanisa kubata HIV/AIDS here paanotanga kusangana pabonde nemukumomana kanamusikana?

Can a person get HIV/AIDS the first time they have sex?

- f) Hongu, asi kana umwe wake aineutachiona / Yes if their partner is infected

12) Pane mushonga here unorapa chirwere cheAIDS?

Is there a cure for AIDS?

- b) Kwete / no

15) Vana vezera rako vanokwanisa here kubata chirwere cheAIDS?

Can children your age get HIV/AIDS?

- d) Hongu / yes

Appendix 4. Semi-structured interview

The interviews will be used to get an understanding of the individual children's attitudes and behaviour. To see whether they are the same as those expressed in the group context.

In the introduction before the interview, stress confidentiality, this for research purposes so we can understand what they have experienced and what they think. We need to talk to them not only in the group but also as individuals its not always easy to find out what an individual thinks and feels in the group context.

Interview

As we talked about during the activities some young people of your age are having sex. Do you know any girls/boys of your age who have had sexual intercourse?

2) Who are they having sex with?

Probes: boys/girls in primary school, boys/girls in secondary school, boys/girls out of school, adults

3) Why do you think they are having sex?

(Probe if there is no answer, love, poverty, money, abuse) (If the issue of abuse comes up, find out details, who when why how)

4) Who do you think decided when the couple should have sex, the girl or the boy? Why? (Probes: mutual consent, pressure, coerced, forced)

5) Where do they go to have sex and who chooses the place? Why?

(Probes his house, your house, friend's house, at school, outside, in a car, in a hotel)

6) Do you think they use condoms? Why or why not?

7) Do you think they should use condoms? Why or why not?

8) Do you think it is easy for a girl/boy to say no to sex? Why?

7) Has anyone ever asked you to have sex with them? If yes, (who when what did you say)

If the respondent had sex then:

a) Who did you have sex with?

Probes: boy in primary school, boy in secondary school, boy out of school, adult male

b) Which one of you decided you were ready to have sex, your boyfriend or yourself?
Why?

c) Where did you have sex and who chose the place? (his house, your house, friend's house, at school, outside, in a car, in a hotel)

Why ?

d) Did you/your boyfriend use a condom? Why?

e) Do you think it would be easy for you to say no to sex? Why?

7) If no,

a) Why have you never had sex?

b) When do you think you will decide to have sex? (probe: when older, when married, when I've found the right man/) Why and what type?

c) When you do decide to have sex will you use protection? Why or why not?
(if yes what type and why)

Appendix 5. Feedback letter to the school head teacher

3 March 2003

Dear Head teacher,

This is short preliminary report of our observations during the research period. I have not yet looked at the data in depth, so this is just a short summary of some of the notes we made during the research period. I hope they will be useful and at least give you some indication of the kind of findings we made.

Questionnaire: HIV/AIDS quiz

Generally the children's knowledge of HIV, its transmission and how it can be prevented is not bad. They are however, unclear of the difference between HIV and AIDS. Many thought that both HIV and AIDS are viruses. Although we explained the difference between the two both after the completion of the AIDS Quiz, and during the activities with the smaller groups, most of the children still kept talking about a person with AIDS meaning a person with HIV. This may need further clarification and explanation from the teachers. The children knew that AIDS is not curable and had reasonably clear ideas on how to prevent themselves from catching HIV. The majority of children in all grades also knew that a healthy looking person may be infected with HIV. Most of the children, however, also thought that the most effective way of protecting oneself from catching HIV is through using condoms rather than abstention. Many children also knew of someone who had died from AIDS or said they were not sure, which could have meant they suspected that someone they knew had died from AIDS. This shows that HIV/AIDS is a reality in the children's lives and thus something they should learn to understand clearly. When asked who they think should tell them about sex, HIV/AIDS, pregnancy etc, the majority of children felt they should be told by their parents or guardians, and the next group of adults they felt should tell them about these things are teachers in primary school. The final question in the quiz asked the children whether they would ever let someone do certain things to them in exchange for money or a gift these things ranged from holding hands to having sex. Quite a large number said they would do various things for money or a gift for example kissing, getting into a stranger's car, letting someone touch their private parts and having sex with someone. This shows how vulnerable children are to being enticed into risky activities for money or material goods. This same issue came up again during the group activities, when we asked the children why girls and boys of their age get involved in sex. The overwhelming response to why girls have sex was for money or because of poverty. The reason for boys having sex was more for fun, peer pressure or being influenced by others. Again these responses underline the vulnerability of girls to being enticed by money and the need to empower them so they may be able to resist these pressures.

Group activities

Generally the children came up with similar things in the activities as they had in the questionnaire. There was a lot of curiosity especially among grades 5 and 6 as to how babies are born and many things to do with reproduction. The children's

understanding of their bodies is limited with the exception of grade 7s who had learnt about the body, but they still had some misconceptions about where the sexual organs are and how exactly they work.

The children were very curious and keen to learn about their bodies, about HIV/AIDS and about condoms. When asked whether they would be interested in learning more about reproductive health and how to cope with the challenges young people face, they were enthusiastic for more knowledge. We also learnt from talking to the children during our various activities that children in primary school are sexually active, either with boys of their own age, or with boys in secondary schools.

From these activities we recognize that there is still a lot of work to be done with children in primary school. They are at an age where they are getting curious about their bodies and about sex. They also pick up a lot of information from the media especially from HIV prevention programmes on TV. Some of this information is not clearly understood and may lead them to having misconceptions about HIV transmission. I feel that it is important for the school, as far as it can to clarify the basics about HIV prevention and transmission to the children, as well as to help them have a basic understanding of how their bodies work in order to prevent them from being misled by adults who want to take advantage of their ignorance to abuse them.

It is difficult to address issues like poverty because it is beyond the school's capability to deal with those issues, but it may help to talk about the temptations children (especially girls) may face and how to avoid situations where one may be tempted to use their body to get money.

These are a few of the early observations I have had during our research with the children. I hope they will be of some help to the school and the teachers in their approach to HIV/AIDS and life skills education. I will provide you with further information when the data has been fully analysed, through Tsungirirai.

I am sincerely grateful to you for welcoming us into your school and for all the help you have provided us with, your cooperation, and I thank your teachers and the rest of your staff for accommodating us. I hope we caused minimum disruption. Finally I would like to thank the children of Grades 5A, 6A and 7A for their cooperation, their enthusiasm, and their thirst for knowledge. They were a pleasure to work with and I wish them all the best in their school years and bright futures.

Yours sincerely,

Fungisai P. Gwanzura-Ottmoller

Appendix 6. Feedback report to Tsungirirai

3 March 2003

Preliminary report on research conducted at Chiedza Primary School in Norton, February 2003, on HIV related knowledge, attitudes and behaviour of young adolescents aged 9-14 years

This is short report of our observations during the research period. I have not yet looked at the data in depth, so this is just a short summary of some of the notes we made during the research period. I hope they will be useful and at least give you some indication of the kind of findings we made.

Questionnaire: HIV/AIDS quiz

Generally the children's knowledge of HIV, its transmission and how it can be prevented is not bad. They are however, unclear of the difference between HIV and AIDS. Many thought that both HIV and AIDS are viruses. Although we explained the difference between the two both after the completion of the AIDS Quiz, and during the activities with the smaller groups, most of the children still kept talking about a person with AIDS meaning a person with HIV. This may need further clarification and explanation from the teachers.

The children knew that AIDS is not curable and had reasonably clear ideas on how to prevent themselves from catching HIV. The majority of children in all grades also knew that a healthy looking person may be infected with HIV. Most of the children, however, also thought that the most effective way of protecting oneself from catching HIV is through using condoms rather than abstention. Later during the activities children in grade six were keen to see condoms and to learn how they were used. We asked the head for permission to show them condoms but this was denied, the reason being that the children are too young and they may go out and try to use them and also that the school policy is to teach them abstention.

Many children knew of someone who had died from AIDS or said they were not sure, which could have meant they suspected that someone they knew had died

from AIDS. This shows that HIV/AIDS is a reality in the children's lives and thus something they should learn about and understand clearly.

When asked who they think should tell them about sex, HIV/AIDS, pregnancy etc, the majority of children felt they should be told by their parents or guardians, and the next group of adults they felt should tell them about these things are teachers in primary school.

The final question in the quiz asked the children whether they would ever let someone do certain things to them in exchange for money or a gift these things ranged from holding hands to having sex. Quite a large number said they would do various things for money or a gift for example kissing, getting into a stranger's car, letting someone touch their private parts and having sex with someone. This shows how vulnerable children are to being enticed into risky activities for money or material goods.

This same issue came up again during the group activities, when we asked the children why girls and boys of their age get involved in sex. The overwhelming response to why girls have sex was for money or because of poverty. The reason for boys having sex was more for fun, peer pressure or being influenced by others. Again these responses underline the vulnerability of girls to being enticed by money and the need to empower them so they may be able to resist these pressures.

Participatory activities

Generally the children came up with similar things in the activities as they had in the questionnaire. There was a lot of curiosity especially among grades 5 and 6 as to how babies are born and many things to do with reproduction. The children's understanding of their bodies is limited with the exception of grade 7s who had learnt about the body, but they still had some misconceptions about where the sexual organs are and how exactly they work.

The children were very curious and keen to learn about their bodies, about HIV/AIDS and about condoms. When asked whether they would be interested in learning more about reproductive health and how to cope with the challenges young people face, they were enthusiastic for more knowledge. We also learnt from talking

to the children during our various activities and through the individual interviews that their peers in primary school are sexually active, either with boys of their own age, or with boys in secondary schools. The grade sevens were the most cited as being sexually active, but some grade sixes were also said to be sexually active.

From these activities we recognize that there is still a lot of work to be done with children in primary school. They are at an age where they are getting curious about their bodies and about sex. They also pick up a lot of information from the media especially from HIV prevention programmes on TV. Some of this information is not clearly understood and may lead them to having misconceptions about HIV transmission. I feel that it is important for the school, as far as it can to clarify the basics about HIV prevention and transmission to the children, as well as to help them have a basic understanding of how their bodies work in order to prevent them from being misled by adults who want to take advantage of their ignorance to abuse them.

It is difficult to address issues like poverty because it is beyond the school's capability to deal with those issues, but it may help to talk about the temptations children (especially girls) may face and how to avoid situations where one may be tempted to use their body to get money.

We found the grade six children in general to be the most curious about sex and condoms. They seem to be at a stage where they are on the brink of becoming sexually active or have just started to realize what sex is all about. We felt that this is an important target group because they are very eager to learn and also very open about what they think and know. Grade 5 girls were more mature than the boys, but they are still a young group and had some knowledge about HIV transmission and prevention, but did not know much about how their bodies work. Grade 7s were a mixed group, they tended to be more reserved. The boys were initially shy, but became more open as time went by, they were not the type of boys to boast about sexual conquests, but were keen to abstain and wait till later in life to have sex. The girls we felt were a bit more experienced but they were not very open about their experiences even though we picked up some things from their discussions on their own which indicated that they knew of people of their age who are sexually active. Unfortunately some of them were not forthcoming about this during the individual interviews.

The issue of abuse came up during the group activities, sugar daddies, sugar mummies as well as fathers abusing their daughters. When we asked them who they would report to if someone tried to abuse them they said relatives. None of them mentioned teachers.

I would recommend that Tsungirirai starts some kind of HIV prevention education programmes within the schools because from what we have observed and what the children told us there isn't much going on in the schools and they are really keen to learn more. The children said they would like to learn more of the type of thing we had been discussing. Some of the girls said they would like to learn skills of how to avoid kissing boys and how to say no to sex. They were very curious about reproduction and how babies are born, and childbirth complications etc.

It is important for us to be aware that children of these ages are sexually active or thinking about becoming sexually active. We need to be proactive and give them the chance to have a realistic idea of what this means instead of thinking that they are too young for us to be honest and candid with them. They have the right to have their questions answered honestly and I think Tsungirirai could provide that for them. I will provide you with more detailed results once I have them. But this is my initial report and my initial observations.

Appendix 7. Questionnaire: Socio-Demographic information codes

Question	Answer	Code
1) Which grade are you in?	a)5	1
	b)6	2
	c)7	3
2) How old are you?	a)9	1
	b)10	2
	c)11	3
	d)12	4
	e)13	5
	f)14+	6
3) Are you a girl or a boy?	a) boy	1
	b) girl	2
4) Are your parents still alive?	a) yes	1
	b) yes, but only my father is alive	2
	c) yes, but only my mother is alive	3
	d) no	4
5) Where do you live? (not address)	a)Katanga	1
	b)Ngoni	2
	c)Flamingo	3
	d)Johannesburg	4
	e)Maridale	4
	f) Other	5
6) Who do you live with at this place?	a) Mother	1
	b)father	2
	c)both parents	3
	d)sister	4
	d)older brother	5
	e) uncle	6
	f) aunt	7
	g)grandfather, grandmother	8
	h)other	9
8i) If you stay somewhere else during the holidays, where is this place?	a) not applicable	1
	b) Harare and its suburbs	2
	c) Rural home	3
	d) Chitungwiza	4
	e) Bulawayo	5
	f) Chipinge	6
	g) Chivhu	7
	h) Zvimba	8
	i) Mutare	9
	j) Chegutu	10
	k) Shamva	11
	l) Chinhoyi	12
	m) Chihota	13
	n) Mhondoro	14

	o) Seke	15
	p) Chiredzi	16
	q) Nyanga	17
	r) Gweru	18
	s) Masvingo	19
	t) Rusape	20
	u) Guruve	21
	v) Out of zimbabwe-regional	22
	w) Kwekwe	23
	x) Gutu	24
	y) other	25
ii) And with whom do you live with at this place?	a) Mother	1
	b) father	2
	c) both parents	3
	d) older sister	4
	e) older brother	5
	f) uncle	6
	g) aunt	7
	h) grandfather, grandmother	8
	i) other	9
9) Murivana vangani mumhuri menyu?	a) 1-2	1
	b) 3-4	2
	c) 5-6	3
	d) 7+	4
10i) Does anyone in your family do any work to earn money?	a) yes	1
	b) no	2
10ii) If yes, who?	a) not applicable	1
	b) mother	2
	c) father	3
	d) both parents	4
	e) older sister	5
	f) older brother	6
	g) uncle	7
	h) aunt	8
	h) grandparents	9
	i) other	10
11) Do you do any work to earn money?	a) yes	1
	b) no	2
12) If yes, what kind of work do you do?	a) Selling snacks	1
	b) Cleaning	2
	c) Selling fruit and vegetables	3
	d) Other	4
13) What do you use the money you earn for?	a) buying food for the family	1
	b) to buy myself food	2
	c) buying clothes for myself	3
	d) buying school items	4
	e) paying school fees	5
	f) other	6
14) How often do you do this work?	a) Every day before school	1
	b) Every day after school	2

	c) Several times a week	3
	d) Only on weekends	4
	e) Only during the school holidays	5
	f) Other	6
15) Do you enjoy doing this work?	a) yes	1
	b) no	2
	c) sometimes	3
16) Do you receive any help from Tsungirirai?	a) yes	1
	b) no	2
	c) don't know	3
17) If yes, what type of help do you receive from them? ...	a) they pay my school fees	1
	b) they give me food	2
	c) they buy me clothes	3
	d) they pay my fees, give me food, buy me clothes and many other things	4
	e)Other	5
		6

**Appendix 8. HIV/AIDS quiz - Attitude, information and behaviour
question codes**

Question	Answer	Code
11) People get AIDS if they... (circle all answers that you think are correct)	a) go to beerhalls	No= 0 Yes= 1
	b) drink dirty water and eat dirty food	No= 0 Yes= 1
	c) have multiple sex partners	No= 0 Yes= 1
	d) are polygamous	No= 0 Yes= 1
	e) go out with sugar daddies or sugar mummies	No= 0 Yes= 1
	f) play with the opposite sex	No= 0 Yes= 1
	g) have unprotected sex with a person infected with HIV	No= 0 Yes= 1
	h) Don't know	No= 0 Yes= 1
13) Can AIDS be cured by having sex with a virgin?	a) yes b) no c) don't know	1 2 3
14) Do you know of anyone who has died from AIDS?	a) yes b) no c) don't know d) I'm not sure	1 2 3 4
16) From which sources of information did you learn about HIV/AIDS? (circle as many as are relevant)	a)radio	No= 0 Yes= 1
	b)TV	No= 0 Yes= 1
	c) magazines	No= 0 Yes= 1
	d) Poster/pamphlet	No= 0 Yes=1

	e) Government health worker	No= 0 Yes= 1
	f) School teacher	No= 0 Yes=1
	g) Friends	No= 0 Yes=1
	h) Boyfriend/girlfriend	No= 0 Yes=1
	i) Parent/guardian/relative	No= 0 Yes=1
	j) Other	No= 0 Yes=1
	k) I haven't heard about AIDS	No= 0 Yes=1
17) Where / from whom have you learnt the <u>most</u> about HIV/AIDS? (circle only one answer)	a) teacher in school b) family c) friends d) Boyfriend/girlfriend e) doctor/nurse f) family planning clinic g) school h) radio i) tv j) magazines/books k) Don't know about AIDS l) other	1 2 3 4 5 6 7 8 9 10 11 12
18) If you had a question about HIV/AIDS who would you ask? (circle only one answer)	a) teacher in school b) parents c) older sister or brother d) friends e) boyfriend, girlfriend f) family planning clinic nurse g) Don't know h) other	1 2 3 4 5 6 7 8
19) Who do you think should tell young people like yourself be told about sex, HIV/AIDS, and pregnancy?	a) Teachers at primary school b) Teachers at secondary school c) Adults at home d) don't know e) other	1 2 3 4 5
20) What is having sex ?	a) Sleeping/lying with opposite sex b) Making a baby/causing pregnancy c) Doing rude/stupid things d) Associated with HIV/AIDS e) Sex/sexual intercourse f) Love/loving g) Meeting (polite) h) Touching, hugging, lying or climbing on each other	1 2 3 4 5 6 7 8 9 10

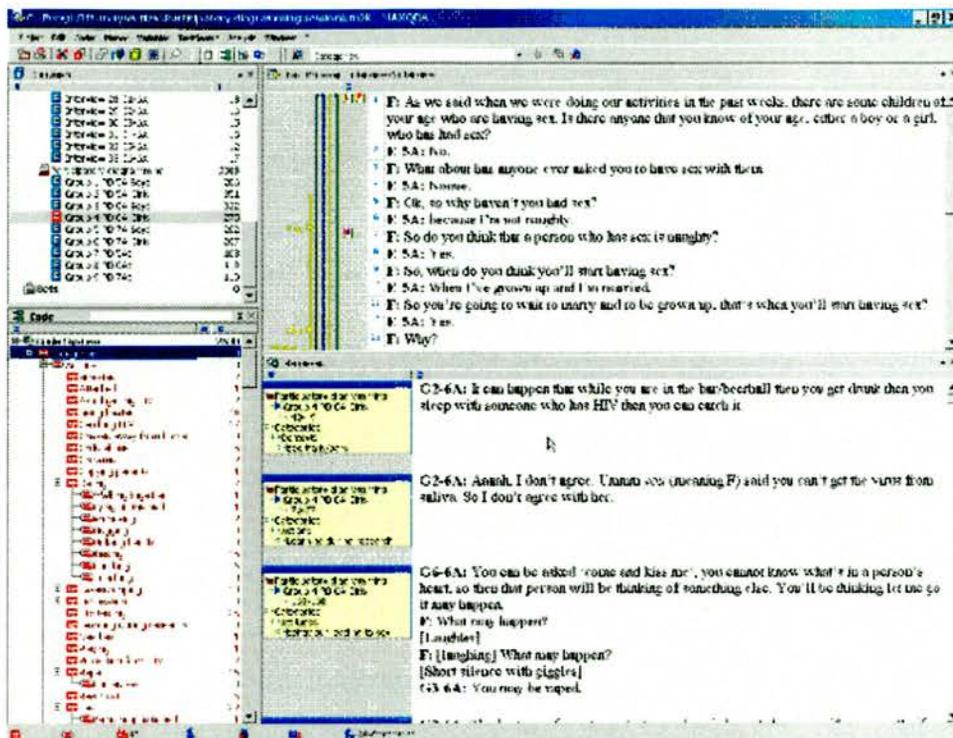
	i) Associated with use of condoms j) Having many partners k) Rape l) A job m) Male sperm meeting female egg n) to do razor and injection o) kuita upombwe p) Dont know	11 12 13 14 15 16 17
21) Who knows more about sex?	a) Girls b) Boys c) Don't know	1 2 3
22) Would you ever do the following with someone for money or a gift:	a) hold hands	Yes=1 No=2 Dontknow=3
	b) go for a walk	Yes=1 No=2 Dontknow=3
	c) kiss	Yes=1 No=2 Dontknow=3
	d)go to see a film	Yes=1 No=2 Dontknow=3
	e)To get into a stranger's car	Yes=1 No=2 Dontknow=3
	f) let them touch your private parts	Yes=1 No=2 Dontknow=3
	g)let them have sex with you	Yes=1 No=2 Dontknow=3

Appendix 9. Questionnaire HIV/AIDS quiz – knowledge question scores

Question	Answer	Score
1) What is HIV?	a) a collection of illnesses	2
	b) a virus	4
	c) a bacteria	-1
	d) don't know	-4
2) What is AIDS?	a) a collection of illnesses	4
	b) a virus	1
	c) a bacteria	-1
	d) don't know	-4
3) Does a person with HIV also have AIDS?	a) yes	1
	b) no	2
	c) sometimes	4
	d) don't know	-4
4) Can a healthy looking person be infected with HIV?	a) yes	4
	b) no	-1
	c) sometimes	3
	d) don't know	-4
5) A fat person cannot be infected with HIV.	a) true	-2
	b) false	4
	c) don't know	-4
6) If you stick to one sexual partner you wont become infected with HIV?	a) True	2
	b) True, but only if that partner is not already infected with HIV	4
	c) False	3
	d) Don't know	-4
7) How can a person get HIV?	a) From mosquitoes, fleas or bedbugs	-4
		2
	b) From having sex	-1
	c) From a toilet seat	4
	d) From having unprotected sex with a person infected with HIV	4
	e) From sharing razorblades, needles and injections	-4
f) don't know		
8) How can people protect themselves from getting AIDS? (circle all possible answers)	a) avoid sexual intercourse (don't play sex)	4
	b) limit number of sexual partners	2

	c) use condoms during sex d) avoid sex with prostitutes e) take antibiotics prior to sexual contact f) have sex only with healthy persons	4 2 -4 -4
9) Which one of these protects you most effectively against HIV infection? (circle one answer only)	a) contraceptive pill b) condoms c) not having sex at all d) don't know	-3 4 4 -4
10) Can a person get HIV/AIDS the first time they have sex?	a) yes b) Yes if their partner is infected c) no d) don't know	2 4 -1 -4
12) Is there a cure for AIDS?	a) yes b) no c) don't know	-4 4 -4
15) Can children your age get HIV/AIDS?	a) yes b) no c) don't know	4 -4 -4

Appendix 10. MAXqda screenshot



Appendix 11. Example of thematic chart

Actors	Media/Books	Media/ TV	Media/ Newspapers
	<p>Text: Participatory diagramming\Group 3 PD 6A Boys Position: 718 - 721 Code: Categories \Actors\Media</p> <p>B2-6A: He is saying that the sperms are coming from there have you ever seen it? B6-6A: They come from there sometimes you see it in diagrams. B4-6A: We are just saying what we think? We may see it in diagrams in books. B2-6A: Oh, ok.</p>	<p>Text: Interviews \Interview 29 G2-6A Position: 8 - 8 Code: Categories \Actors\Media \TV</p> <p>G2-6A: I've heard things on TV about children raped by their fathers.</p>	<p>Text: Participatory diagramming\Group 1 PD 5A Boys Position: 806 - 807 Code: Categories \Actors\Media\ Newspaper</p> <p>A-5A: I read it in the newspaper.</p>
	<p>Text: Participatory diagramming\Group 6 PD 7A Girls Position: 570 - 572 Code: Categories \Actors\Media</p> <p>G2-7A: Sometimes when you read a book it'll say something about sleeping with a boy. F: From books as well? G2-7A: Yes.</p>	<p>Text: Participatory diagramming\Group 1 PD 5A Boys Position: 539 - 541 Code: Categories\ Actors\Media\TV</p> <p>E-5A: I've seen it on TV. F: On TV. Yes it's seen on TV. What about you C? C-5A: I've seen it on TV and at weddings.</p>	