

**DETERMINANTS OF NON-ADHERENCE TO RECOMMENDED
PREVENTATIVE METHODS FOR SEXUAL TRANSMISSION OF HIV AMONG
15 - 24 YEAR OLDS IN LIVINGSTONE (ZAMBIA).**

BY

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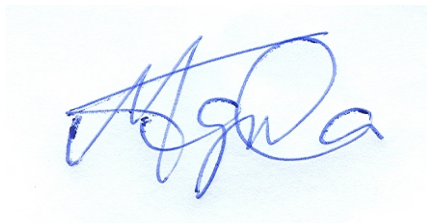
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April 2006

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I declare that

**DETERMINANTS OF NON-ADHERENCE TO RECOMMENDED
PREVENTATIVE METHODS FOR SEXUAL TRANSMISSION OF HIV AMONG
15-24 YEAR OLDS IN LIVINGSTONE (ZAMBIA), is my own work and that all
the sources that I have used or quoted have been indicated and acknowledged by
means of complete references.**

A handwritten signature in blue ink, appearing to read 'Sitwala Mungunda', is written on a light blue rectangular background.

Signed: Sitwala Mungunda

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Date

SUMMARY

This qualitative study was done in Livingstone, Zambia, and used focus group discussions to investigate the reasons that youths aged 15 to 24 years see as justifying, or compelling, their non-use of recommended methods for prevention of sexual transmission of HIV. It focused on four methods, namely abstinence, condom use, voluntary counseling and testing, and mutual faithfulness.

The study found that non-adherence to HIV preventative methods is linked to variables in the process of adolescent growth and development, to contextual variables in society, to characteristics of products and services associated with these HIV preventative methods, and to disease characteristics of HIV itself. A key conclusion of this study is that to improve the effectiveness of HIV prevention programs among the youths it is essential that factors that hinder adherence to preventative methods are recognized and addressed.

Key words: Adherence, Adolescent, HIV, Sex, prevention, youths, Abstinence, Condoms, HIV testing, Faithfulness.

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CHAPTER ONE: AN INTRODUCTION TO THE RESEARCH SUBJECT

In this chapter the researcher will give an overview of the professional interest of social workers in the HIV/AIDS pandemic, a statement of the problem, and a description of the study objectives and the research questions. An explanation of the major concepts used in the study as well as their operational definition will also be given. The chapter will end with a description of the location of the study.

1.1 Social work and the HIV/AIDS pandemic

The social work profession is a helping profession dedicated to promoting human well being. One distinguishing feature of social work's mission of promoting wellness, of alleviating and preventing suffering and hardship, is that it is anchored on a set of core values which are explicitly stated in professional codes of ethics which are adhered to by social work associations around the world. Some of these values are service, social justice, dignity and worth of the person, importance of human relationship, integrity and competence.¹ Another distinguishing aspect of social work is its focus on assisting clients to function optimally within their environment. This perspective is called the person-in-environment approach.² According to the National Association of Social Workers (NASW),

“A historic and defining feature of social work is the profession's focus on individual well-being in a social context and the well-being of society.

¹ National Association of Social Workers, Code of ethics
<http://www.socialworkers.org/pubs/code/code.asp>

² University of Missouri-Columbia, School of Social Work, The social work profession,
<http://ssw.missouri.edu/profession.shtml>

Fundamental to social work is attention to the environmental forces that create, contribute to, and address problems of living.”³

The advent of the HIV/AIDS pandemic in the 1980s and its effects over the last two and a half decades has posed a direct challenge to the social work profession. HIV undermines wellness and creates hardship and suffering at all levels of society on a large scale. It destabilizes the socio-economic structure, organization, and functioning of society. It threatens the viability of individuals and their families and heavily taxes the societal capacity to cope.⁴ Social workers have found that the well-being of their clients, however defined, whether as individuals, groups, families, organizations, communities, or nations, has been negatively affected, or are under imminent threat, from the pandemic. It is a credit to the social work profession that social workers came to a realization early in the epidemic that no scheme of interventions to promote well being can be complete, or can be implemented competently, without taking the HIV epidemic into account. The Canadian Association of Schools of Social work, for example, in examining the subject of AIDS and the responsibility of social work education in 1988 reached the following conclusion:

“If we are dealing with the ethics of social work, individual versus public rights and questions of confidentiality, poverty issues, issues related to women, the understanding of human sexuality and sexual expression, the meaning of family, social work and health care, dying, death and bereavement, minority and disenfranchised groups, issues of discrimination or human rights and legal

³ National Association of Social Workers, Code of ethics
<http://www.socialworkers.org/pubs/code/code.asp>

⁴ UNAIDS, 2006 report on the global AIDS epidemic, The impact of AIDS on people and societies, http://data.unaids.org/pub/GlobalReport/2006/2006_GR_CH04_en.pdf

responsibility, it is no longer possible to teach or study these topics adequately without involving the AIDS phenomenon as a key reference point.”⁵

National and international professional associations of social workers have endeavored to establish consensus among their members on their responsibilities in the context of HIV/AIDS. A number of concrete perspectives and guideline have emerged over the years. A few of the notable ones are discussed below.

In 1990 the International Federation of Social Workers developed an **International Policy on HIV/AIDS** to guide social workers. The document recognized that:

“Social Workers, by virtue of their training, their particular perspective of the individual within the family and community constellation, together with the wide range of Social Work employment in health and welfare settings, are uniquely well placed to play a very effective role in the global effort to deal with the HIV-epidemic and the empowerment of those affected.”⁶

This policy document further outlined three strategies for social workers in dealing with HIV/AIDS, namely:

- To work towards the prevention of HIV.
- To confront and deal with fears, attitudes and prejudices towards AIDS, both amongst social workers and the general public, and

⁵ Canadian Association of Schools of Social Work (1988) AIDS Social Work Training in Canada, AIDS and the Responsibility of Social Work Education, <http://www.mun.ca/sweaids/doc1part1.html>

⁶ International Federation of Social Workers, International policy on HIV/AIDS, <http://www.ifsw.org/en/p38000082.html>

- To provide a counseling and support service to persons with HIV, their families, partners and significant others, which maintains confidentiality.

In May 1993 the New York Chapter of the National Association of Social Workers (NASW) in the United States issued recommendations to guide its members in a document called **Social Work practice for people affected by HIV infection**. In this document the chapter stated that:

“It is clear that the efforts and skills of all professional social workers, in all settings, must be readied to respond to the continuing pandemic.”⁷

The document then listed eleven guidelines for social workers, two of which stated as follows:

- Social Workers in all practice settings and different levels of authority are obligated to become knowledgeable about transmission of HIV and the disease process and be prepared to educate and counsel peers, other professionals and clients.
- All Social Workers are obligated to update continually both their scientific knowledge about HIV disease and their skills in effectively working with people with HIV infection, their family members, friends and others.

On July 29, 2000 the Canadian association of social workers (CASW), in conjunction with the Joint Conference of the International Federation of Social Workers (IFSW) and the International Association of Schools of Social Work (IASSW), sponsored a one day symposium on HIV/AIDS in Montreal, Canada. The symposium involved social workers from 32 countries and its purpose was to create a call to action for social workers and

⁷ New York National Association of Social Workers, Social work practice for people affected by HIV infection-NASW recommendations (May 1993), <http://www.naswnyc.org/c10.html>

social work educators around the world regarding HIV/AIDS. The symposium produced a document called the **Social Work Manifesto on HIV/AIDS** which declared in its pre-
amble that:⁸

“The HIV/AIDS pandemic and its psycho-social, medical, legal, and economic ramifications are a priority for all social workers and social work educators throughout the world”.

Under five subject headings of human rights, social and health policy, social work education, partnership, and social research, the manifesto provided detailed guidelines on the practical goals and tasks of the social work profession with regard to the study, prevention and mitigation of the impact of HIV/AIDS all over the world. Notably, under the subject of social work education, two of the goals set by the manifesto are:

- To teach all students, practitioners and academicians of social work about HIV/AIDS and apprise them of the medical, physical, psychosocial, cultural, legal and economic issues involved in the pandemic.
- To develop an understanding of the determinants of health and the principles of the prevention-to-care continuum of care as they apply to individuals and community well-being, emphasizing health promotion, prevention of infection, social and psychological care, medical treatment and counseling support.

The present researcher considers that the present work on “Determinants of non-adherence to recommended preventative methods for sexual transmission of HIV among 15 to 24 year olds in Livingstone (Zambia)” is in accord with the values and guidelines of the social work profession as outlined above.

⁸ International Federation of Social workers, [Social Work Manifesto on HIV/AIDS](http://www.ifsw.org/en/p38000241.html), <http://www.ifsw.org/en/p38000241.html>

1.2 statement of the problem

Over the more than 18 years of his working career, the researcher has worked for several non-governmental organizations. Most of his work has been in the area of HIV/AIDS prevention and mitigation. He came to understand that HIV could be transmitted in several ways but that the predominant mode of transmission in Zambia is through unprotected sexual intercourse among heterosexuals. He also came to know that even though AIDS has no cure, it can be prevented by the use of a handful of methods which are not complicated to understand: namely abstinence, correct and consistent condom use, use of voluntary counseling and testing in partner selection, and mutual faithfulness in a monogamous relationship. In his work he has however been intrigued by the apparent persistence of the non-use of these methods in the population.

His main area of interest has been in the young people of Zambia. The 5 to 14 year olds have been referred to as the “window of hope” because the HIV prevalence rates in this age group are very low.⁹ Controlling or reducing the HIV prevalence rates in the general population seemed, to the researcher, to imply that the 5 to 14 year age group must be protected from HIV and have their HIV negative status preserved into adulthood. In other words they have to grow up while accepting and using the recommended HIV prevention strategies; thereby with time becoming a new HIV free adult population. Unfortunately, available data suggests that as the young people grow out of the 5 to 14 year age group into the 15 to 24 year age group, they become sexually active and are getting infected by HIV, meaning that they are either not getting the message or they are unwilling or unable to use the recommended preventative strategies.

The UNICEF report “Progress of Nations 2000” reported that a study conducted in Zambia found that 52% of the girls aged 15 to 19 years who were sexually active believed that they faced no risk of contracting HIV. The report also indicated that these

⁹ BESSIP 2000, HIV prevention and the Ministry of Education: A review of on-going HIV/AIDS activities in schools and among youths, December 2000, Ministry of Education, Lusaka, Zambia. P.9

girls had information on HIV/AIDS but that the information did not seem to translate into a sense of personal awareness of risk.¹⁰

The World Health Organization report “HIV/AIDS Epidemiological surveillance update for WHO Africa region 2002 Country profile” also gave some worrying statistics.¹¹ The report gave the median age for first sex for young women as 16.9, 16.3 and 17.0 years in 1996, 1998, and 2000 respectively. For young men the median age for first sex was 16.2, 17.2 and 17.0 over the same period. This means that by age 17 the majority of young people have abandoned abstinence as an HIV prevention strategy. What is the reason for this?

The same report also quotes figures from the 2000 Sentinel Based survey (SBS) and the Zambia Demographic and Health Survey (ZDHS) on premarital sex. In the 2000 SBS, 31% of young women and 36% of young men reported having had premarital sex in the last year. The figures from the ZDHS are 35% for young women and 53% for young men.

Most of this premarital sex does not appear to be protected sex. The proportion of young unmarried women who reported having had premarital sex and who used a condom at the last premarital sex in the last year was 21% in 1996, 36% in 2000 and 34% in 2001/2002. The implication is that as much as 66% of the premarital sex among young people is unprotected. This is happening in a context where knowledge about HIV/AIDS has been said by the ZDHS to be universal.¹²

The HIV prevalence figures do appear to confirm what is going on among the young people. Among the 15 to 19 year olds attending antenatal care clinics, HIV prevalence

¹⁰ UNICEF.org, UNICEF, *Progress of nations 2000*, <http://www.unicef.org/pon00/datas1.htm> (access gained 01 June 2004) P.1

¹¹ WHO.int, WHO, *HIV/AIDS epidemiological surveillance update for WHO Africa region 2002 country profile*. <http://www.who.int/hiv/pub/epidemiological/pubafro2003/en/>, (access gained 01 June 2004)P.56

¹² Measuredhs.com, MEASURE, *Zambia demographic health surveys 1992 and 2000: HIV/AIDS indicators data base*. <http://www.measuredhs.com/hivdata/surveys/start.cfm> (Access gained 10 June 2004)

increased from 10.8% in 1998 to 12.6% in 2001/2002, portraying a different picture to that observed between 1994 and 1998 when there seemed to be a declining trend in HIV prevalence in this age group. In 1994 HIV prevalence was 14.8%.¹³

The question is why is there this persistence of non-use of recommended methods for prevention of sexual transmission of HIV among the 15 to 24 year olds? How do the 15 to 24 year olds themselves understand and explain their non-use of recommended methods for prevention of sexual transmission of HIV?

In most studies that have been done on the sexual practices of young people in Zambia a lot of attention has been paid to describing the behavior of the young people but not enough attention has been paid to explaining the rationale of that behavior. The focus of this study will be on trying to understand the “logic” of non-use of recommended methods for prevention of sexual transmission of HIV among the 15 to 24 year olds as seen by the 15 to 24 year olds themselves.

1.3 Objective and research question of study

The objective of this study is to understand the reasons as well as the factors and circumstances that the 15 to 24 year olds perceive to compel or justify their non-use of recommended methods for prevention of sexual transmission of HIV.

The study focused on the following research questions:

What are the determinants of their non-adherence to the recommendation of abstinence?

What are the determinants of their non-adherence to the recommendation of condom use?

¹³ WHO.int, WHO, HIV/AIDS epidemiological surveillance update for WHO Africa region 2002 country profile. <http://www.who.int/hiv/pub/epidemiological/pubafro2003/en/>, (access gained 01 June 2004)P.59

What are the determinants of their non-adherence to the recommendation of voluntary counseling and testing?

What are the determinants of their non-adherence to the recommendation of mutual faithfulness?

1.4 Explanation of concepts

In his approach to the study problem and study objectives the researcher has made use of two main concepts, namely:

- i. Adherence, and
- ii. Recommended methods for prevention of sexual transmission of HIV/AIDS.

1.4.1 Adherence

In 2003, the World Health Organization (WHO) held a landmark conference on Adherence to Long-term Treatments. The conference examined the determinants to patient adherence to long-term therapies to chronic conditions such as asthma, cancer, depression, diabetes, epilepsy, hypertension, tobacco smoking cessation, tuberculosis and HIV/AIDS. The conference was concerned that many patients with chronic illnesses have difficulty adhering to their recommended remedial regimen. The conference report noted the following:

“ ... in China, the Gambia and the Seychelles, only 43%, 27% and 26%, respectively of patients with hyper tension, adhere to their anti-hypertensive medication regime. In developed countries such as the United States, only 51% of patients treated for hypertension adhere to the prescribed treatment. Data on patients with depression reveal that between 40% and 70% adhere to anti-depressant therapies. In Australia, only 43% of

patients with asthma take their medications as prescribed and all the time and only 28% use prescribed preventive medications. In the treatment of HIV and AIDS, adherence to anti-retroviral agents varies between 37% and 83% depending on the drug under study.”¹⁴

Non-adherence to treatment regimens was said to be a major and world wide problem that resulted in less than optimal management and control of illness, sub-optimal clinical benefits, and impairment of the ability of health care systems around the world to achieve population health goals¹⁵. Adherence was defined as:

“ The extent to which a person’s behavior- taking medication, following a diet, and or executing lifestyle changes - corresponds with agreed recommendations from a health care provider.” ¹⁶

Adherence is differentiated from **compliance** in that compliance arises from obedience to expert instructions. It is largely based on respect and trust and does not require agreement or understanding by the person complying. Adherence, on the other hand, arises from agreement, based on mutual understanding on required action, between the person and the expert as partners. ¹⁷ Although adherence has been researched mainly in the medical field in relation to the question of behavior management to facilitate a treatment regimen, the concept is treated in this study as being equally applicable to HIV/AIDS where the issue is slightly different in the sense that the focus is on behavior management for infection prevention.

The conference on adherence to long-term therapies identified three types of non-adherence¹⁸:

¹⁴ WHO (2003) Adherence to long term therapies: Evidence for action, WHO, Geneva. P.7

¹⁵ WHO (2003) Adherence to long term therapies: Evidence for action, WHO, Geneva. P.11

¹⁶ WHO (2003) Adherence to long term therapies: Evidence for action, WHO, Geneva. P.3

¹⁷ WHO (2003) Adherence to long term therapies: Evidence for action, WHO, Geneva. P.4

¹⁸ WHO (2003) Adherence to long term therapies: Evidence for action, WHO, Geneva. P.50

Unwitting non-adherence: occurs when people fail to understand fully either the specifics of the regimen or the necessity for adherence.

Erratic non-adherence: occurs when people who know both the specifics of the regimen and the necessity of adherence and who want to adhere fail to adhere because of circumstantial factors outside their control.

Intelligent non-adherence: occurs when people who know both the specifics of the regimen and the necessity of adherence make a reasoned choice, though not necessarily a wise one, not to adhere partly or in full.

These three types of non-adherence were recognized as being determined by sets of factors that could be classified into five dimensions¹⁹:

Socio-economic related factors: These are related to social, economic, and other environmental circumstances.

Health care team/ health care system related factors: These are related to the competence, availability and user friendliness of the services.

Condition/ disease related factors: These are related to disease properties, immediate and long term effects of the disease.

Therapy/ treatment related factors: These are related to the convenience, ease of use, and side effects of the recommended regimen.

Patient/ intra-personal related factors: these are related to the mental state, beliefs and attitudes, knowledge and skills of the patient.

Even though the above types and categories of determinants of non-adherence have been postulated across different human problems and illnesses, the relative importance of each type and or category of determinants of non-adherence are not identical across the various social or medical problems and those associated with non-adherence to HIV preventive methods have to be investigated and identified independently.

¹⁹ WHO (2003) Adherence to long term therapies: Evidence for action, WHO, Geneva. Pp.27-30

In this study the researcher has adopted the concept of adherence and is treating the term as being equivalent and interchangeable with the term “non-use” contained in the problem statement. Further more, in using the concept of adherence the researcher has taken that the term recommended regimen can be substituted with “recommended methods for prevention of sexual transmission of HIV” in order to move the concept of adherence from the realm of medical prescriptions to the realm of behavior change interventions.

1.4.2 Recommended methods for prevention of sexual transmission of HIV/AIDS

The Zambian government has made specific recommendations on what people should do to avoid sexual transmission of HIV. The Zambia Ministry of Health, in its publication **HIV/AIDS in Zambia: background projections, impacts, and interventions**, has listed what it calls “Interventions to limit transmission through heterosexual contact”.²⁰ In this publication four interventions are listed:

Promoting abstinence before marriage and mutual faithfulness to one partner.

This intervention is explained as “...encouraging people to abstain from sex before marriage and remain faithful to a single partner. This could be done through a combination of mass media, counseling and educational programmes.”

Promoting the use and availability of condoms, including female condoms.

This is explained as “...(promoting) condom use through mass media, counseling and education and to increase the availability of condoms through expanded distribution, social marketing programmes and programmes in the work place.”

²⁰ Ministry of Health/ Central Board of Health, HIV/AIDS in Zambia: Back ground, projections, impacts, and interventions, September 1999. P56

Encouraging voluntary counseling and testing (VCT) and ensuring availability of services.

The publication indicates that, “It is important to encourage VCT but also to ensure the availability of services in all communities.”

These same recommended methods of prevention of sexual transmission of HIV are also outlined in the National HIV/AIDS/STI/TB intervention strategic plan 2002-2005, published by the National HIV/AIDS/STI/TB Council²¹.

These recommendations have been disseminated to the public through the programme activities undertaken by government, Non-governmental organisations, churches, and other stakeholders involved in the national fight against HIV/AIDS.

In this study the researcher has taken these recommendations as THE recommended methods for prevention of sexual transmission of HIV.

1.4.3 Operational definition of concepts

The following operational definitions of the key concepts used in this study were used in communication with respondents:

Abstinence: Avoiding sex before marriage.

Condom use: Using a condom every time you have sex.

Voluntary Counseling and Testing: Using medical tests to find out whether you or your partner have contracted or have not contracted HIV, in order to

²¹ National HIV/AIDS/STI/TB Council, National HIV/AIDS/STI/TB Intervention Strategic plan 2002-2005, 2003. pp.11-12

decide whether it is safe or not safe to have unprotected sex.

Faithfulness: Having a love relationship with only one person and having sex only with that one person.

Adherence: Doing what you are advised to do.

Non-adherence: Not doing, failing to do, or refusing to do what you are advised to do.

1.5. Geographic location of the research

The research was done in Livingstone town in the Republic of Zambia. The town has a population of 97,000 people²². It is the district capital for the district of the same name that has a population of 103,288 people in 2000, consisting of 51,828 males and 51,460 females, with an annual growth rate of 2.1%.²³

Livingstone is a border town as it shares an international boundary with the Zimbabwe town called Victoria Falls town. Livingstone is also a transit route for people going to and from Kazungula, another border town some 65km away, which provides entry into two other neighboring countries of Botswana and Namibia.

Livingstone is the tourist capital of Zambia, as it hosts the Victoria Falls, which is one of the natural wonders of the world. Apart from the Victoria Falls the town also has the Zambezi River and the Mosi oa tunya game park, all of which have attracted tourist related investment that employs a lot of people in the town. Other people earn their living through petty trading, beer brewing, cross border trading, selling traditional hand crafts, working in the transport and service sectors and for various government departments.

²² Zambia Census of population and housing 2000, Migration and urbanization, p. 62

²³ Zambia Census of population and housing 2000, Summary report, p.17

The population lives in three general types of housing areas. There are 3 low-density areas, 5 middle-density areas, and 8 high-density peri-urban areas. These areas correspond generally to the three income groups of high, medium, and low respectively.

The population is cosmopolitan in the sense that ethnic groups from all parts of Zambia are represented in Livingstone. This is reflective of the town's past as a transit point for African migrant laborers going to Southern Rhodesia (now Zimbabwe) and South Africa to look for work or returning home. Zambia has 73 ethnic groups. Even though geographically Livingstone is in a *Chitonga* speaking province, the main medium of communication on the street is Chinyanja from eastern province, followed by Silozi from Western province. Chitonga is third. In official communication English, which is the official language and the medium of instruction in school, is used.

Livingstone was especially suited for this study because according to the district estimates of 1999 by the Central Board of Health of the Ministry of Health, Livingstone district had an HIV prevalence of 31%, which was not only higher than the national average of 19.6% but also the highest among all the districts in the whole of Zambia.²⁴

Apart from this factor, Livingstone was also convenient for conducting the study because this is the town where the researcher lived and worked at the time of the study.

²⁴ Ministry of Health/ Central Board of Health, HIV/AIDS in Zambia: Back ground, projections, impacts, and interventions, September 1999, pp71-73

CHAPTER 2: RESEARCH METHODOLOGY

In this chapter the researcher will describe the sampling method and criteria used in the study, the characteristics of the sample, the data collection process, and the data analysis procedure. This chapter is closed by a look at issues of reliability and validity as they relate to the study.

2.1 Sampling method and criteria

Livingstone has about 16 main urban settlements. Out of these, the researcher selected 8 compounds in order to end up with a number of respondents that could allow for manageable size of focus groups. The selected compounds are Namatama, Malota compound, Dambwa North compound, Dambwa Site and Service compound, Dambwa central Compound, Linda compound, Nottie Broadie compound, Ngwenya compound, and Elleine Brittel compound. The selection was based on the researchers knowledge as a resident of Livingstone town about which settlements consisted mostly of the relatively rich, which ones the middle class and which ones the relatively poor.

Table 1: Selected residential compounds

No.	Compound	Population Density	Income class
1	Namatama	High	Low
2	Malota	High	Low
3	Dambwa north	Medium	Medium
4	Dambwa site & service	Medium	Medium
5	Dambwa Central	Medium	Medium

6	Nottie Broadie	Low	High
7	Ngwenya	High	Low
8	Elleine Brittel	Low	High

Each of these compounds has a Residents Development Committee (RDC). These RDCs were used as reference groups that were requested to help in identifying the respondents. The RDCs are legally constituted bodies, by act of parliament, administered by local authorities but which are composed of volunteer community members. They have a mandate on developmental and non-partisan issues that require community participation, such as security, water and sanitation, and education for orphans and vulnerable children. They also represent and articulate the interests of the communities to other organisations that have a bearing on development issues in the community. The researcher used the RDCs as reference groups in identifying the possible respondents because they are organized and elected entities that have legitimacy in their respective communities and they were convenient groups to assist in the identification of respondents. The researcher also used them because their mandate is promotion of community development and they understood public health as a key element of community development.

The criteria for identifying possible respondents that was given to the RDCs were as follows:

- Young people, identified as those aged between 15 to 24 years.
- Unmarried people, since marriage has social and cultural implications for adherence that can complicate the analysis.
- The researcher had also requested that all respondents should have children, so that having children could be used as a proxy indicator for exposure to unprotected sex.

Consent was sought from parents and guardians for all respondents participating in the study by way of signed consent form, which is attached as appendix 4.

2.2 Characteristics of the sample

The sample consisted of two separate groups of respondents designed to be identical in respect of meeting the respondent selection criteria. The first group was used in the initial focus group discussions to bring out factors that determine non-adherence to recommended methods of HIV prevention. The second group was used to validate and triangulate the findings that had emerged from analysis of the data provided by the first group. The two groups were constituted almost 5 months apart.

To form each group, each community RDC was asked to identify one boy and one girl aged 15 to 19, and another boy and girl aged 20 to 24 years. Thus four respondents were requested from each of the eight compounds, creating a total sample of 32 respondents to allow for 4 focus groups, two for boys and two for girls, of 8 people each.

2.2.1 First group of respondents.

In the first group of respondents, even though all respondents had confirmed that they would report at the venue of the focus group discussions on assigned days and at the assigned time for their gender and age group, only 22 respondents turned up for the focus group discussions. The rest either did not turn up or turned up on the wrong date or at the wrong time and consequently did not participate in the focus group discussions.

The respondents who participated in the discussions were 11 girls and 11 boys. All the respondents were within the target age range of 15 to 24 years.

Among the girls average age at first sex was 16. The youngest age at first sex was 14 years and the oldest age at first sex was 17 years. All eleven female respondents had children. Four of the female respondents were students, 3 were in gainful occupation, and 4 were neither in school nor in gainful occupation.

Among the boys average age at first sex was also 16. Youngest age at first sex was 8 years and oldest age at first sex was 20. All eleven male respondents had children. Five of the respondents were in gainful occupation, 2 were students, and 4 were neither in school nor in gainful occupation.

The school system in Zambia has three levels, namely primary school (grade 1-7), junior secondary school (grade 8-10), and senior secondary school (grade 11-12). Transition from one level to another is conditional on passing exams.

The highest educational attainment for girls was: primary school one, junior secondary school five and senior secondary school five.

For boys, the highest educational attainment was primary school two, junior secondary school seven, and senior secondary school two.

The representation of respondents from the settlements was for girls 2 from low density areas, 4 from medium income areas, and 5 from high density areas. For boys representation was 2 from low density areas, 3 from medium income areas, and 6 high density areas.

The detailed descriptive data for these respondents is shown in Appendix 2

2.2.2 Second group of respondents

Five months after the first group, after initial analysis of the data from the first group had been done and some preliminary reasons for non-adherence had been identified, the Residence Development Committees in the various settlements were asked again to invite respondents for a second round of focus group discussions. The purpose of the second round of focus group discussions was to accord the respondents an opportunity to verify the validity and to rank the reasons for non-adherence that had come out of the qualitative analysis of the data from the initial focus groups. If the original individuals were not

available than other individuals who met the criteria of being in the 15 to 20 age group and who had a child would be invited in their place. All individuals in the second group of respondents were new people who did not participate in the phase one focus group discussions.

The respondents who participated in the second round of focus group discussions were 17 girls and 16 boys. All the respondents were within the target age range of 15 to 24 years.

Among the girls average age at first sex was 17. The youngest age at first sex was 14 years and the oldest age at first sex was 22 years. All 17 female respondents had children. Four of the female respondents were students, 2 were in gainful employment, 11 were self employed.

Among the boys average age at first sex was 15. Youngest age at first sex was 13 years and oldest age at first sex was 20. All 16 male respondents had children. One respondent was in gainful employment, 5 were students, and 10 were self employed.

The school system in Zambia has three levels, namely primary school (grade 1-7), junior secondary school (grade 8-10), and senior secondary school (grade 11-12). Transition from one level to another is conditional on passing exams.

The highest educational attainment for girls was: primary school 4, junior secondary school 6, and senior secondary school 7, college 0.

For boys, the highest educational attainment was primary school 1, junior secondary school 6, and senior secondary school 8, and college 1.

The representation of respondents from the settlements was for girls 4 from low density areas, 4 from medium density areas, and 9 from high density areas. For boys, representation was 2 from low density areas, 7 from medium income areas, and 7 high density areas.

The detailed descriptive data for these respondents is shown in Appendix 3.

2.3 Data collection

This study is qualitative and based on primary data obtained via registration questionnaire and focus group discussions. The registration questionnaire is shown in Appendix 5 and the interview guide for focus group discussions is shown in Appendices 9 and 10.

The questionnaire was directly administered on respondents who came to participate in the focus group discussions on the agreed day. The questionnaire was used to collect data that is descriptive of the group of respondents in order to provide context for data that would be obtained from the focus groups. Each individual respondent was interviewed alone in private by a research assistant of the same sex. The questions were open ended. Each interview lasted approximately 4 minutes.

The focus group discussions were the main source of data for this study. This method was chosen because it is able to collect a lot of detailed data in a short time. This method is like an in-depth interview except that it is conducted on several people at the same time. The planning and facilitation of the focus group was done in accordance with the outline and guidelines set by Carter McNamara which is attached as Appendix 1.²⁵

2.3.1 First group of respondents

In the first group of respondents 4 focus group discussions were held, one for 15 to 19 year old boys, one for 20 to 24 year old boys, one for 15 to 19 year old girls, and one for 20 to 24 year old girls. This approach was intended to ensure homogeneity of the

²⁵ MAPNP.org, McNamara C. Guidelines for conducting focus groups: Basics of conducting focus groups. <http://www.mapnp.org/library/evaluatn/focusgrp.htm> (Access gained 06 June 2004)

respondents in each focus group. Each focus group was intended to consist of 8 people each.

Four research assistants, 2 male, to conduct the focus groups for boys, and 2 female, to conduct the focus groups for girls, were recruited and trained to assist in this study. The research assistants were aged between 25 and 30 years old. This was done in order to minimize age and gender barriers in discussing sensitive issues with respondents.

Each focus group discussion lasted approximately one and a half hours. Proceedings of the focus groups were recorded by tape recorder for subsequent analysis. The focus group agenda, schedule, ground rules, and discussion guide are attached as appendices 6 -9.

Consent was sought from parents and guardians for all respondents participating in the study by way of signed consent form (appendix 4).

2.3.2 Second group of respondents

In the second group of respondents two focus group discussions were held, one for boys, one for girls. Since the purpose of this second group of respondents was to validate the data that the first group had already provided, it was considered that two focus groups broken down by gender were adequate to prevent communication barriers in the focus group discussions. Each focus group was intended to consist of 16 people each.

The same four research assistants, 2 male, to conduct the focus groups for boys, and 2 female, to conduct discussions with the girls, who were used in discussions with the first group of respondents were again used to facilitate discussions in this group.

Each respondent was given a printed list of the determinants of non-adherence to abstinence, condom use, HIV testing, and faithfulness that had come out of the analysis of the data from the first group of respondents. Each item on the list was explained and

the respondents were given an opportunity to ask questions. Each respondent was asked to provide a ranking of the various determinants of non-adherence to abstinence. They were asked to rank the determinants on a scale of 1 to 5. A ranking of 1 being considered by respondents as the most dominant influence while a ranking of 5 being the least dominant. They were asked to rank the main categories of factors and also to rank the sub-categories within each category. The mode rank which each category or sub-category got was taken as the rank of that category or sub-category of factors. Each focus group discussion including the ranking lasted approximately one hour.

The focus group agenda, schedule, ground rules, and consent form used were the same as for group 1, except for the discussion guide which is different and is shown in appendix 10.

2.4 Data analysis

The following methods of qualitative data analysis were used:

i. *Familiarization with the data:*

This was done through reviewing and reading interview notes and questionnaires, and listening to the audio tape recordings of the focus group discussions.

ii. *Transcription of tape recorded materials*

The focus group discussions were recorded on six 90 minute audio tapes. These were transcribed verbatim into hand written text and later the hand written text were typed into computer as Microsoft Word documents.

iii. *Organization and indexing of data for easy retrieval and identification:*

The data sets from the different focus groups were kept separate and within each data set headings were inserted to mark where the discussions on abstinence, condom use, HIV testing , and faithfulness started and ended.

iv. Anonimising of sensitive data

In the focus group discussion data sets, any references to people's names were removed. Also the dialogue of many respondents with two facilitators was recorded in the text as a two-person dialogue between a facilitator and a respondent.

v. Coding/indexing of data

The four focus group discussion data sets were examined for dialogue that answered the research questions. All text containing reasons for non-adherence were copied and pasted into a new combined data set document under the appropriate heading of abstinence, condom use, HIV testing, or faithfulness. Each piece of text was appropriately marked with identifiers as to focus group source; that is, age group and gender.

vi. Identification of themes

The reasons for non-adherence under each heading were then examined for themes. Several themes were identified under each heading. These themes were identified from the data itself and not created before hand. Each theme was chosen on the basis that it best describes, at an abstract level, the reasons given by the respondents which are classified together under that theme.

vii. Refinement of themes and categories and exploration of relationships between categories

The reasons under each theme were not identical. Rather they fell into categories and sub-categories. Part of the analysis involved exploring the relationship between themes, categories, and sub-categories. Occasionally, themes were redefined and items that had been classified in one category were moved to another category where they were considered, on second thoughts, to be more appropriate.

viii. Development of theory and incorporation of pre-existing knowledge

The reasons for non-adherence, as analysed by the themes, categories and sub-categories are then consolidated into a theoretical construct that attempts to explain the phenomenon of no-adherence among the 15 to 24 year olds. This construct is then compared with pre-existing theory on adherence.

ix. *Report writing including excerpts from the original data*

The dissertation was written based on the analysis of the data, theoretical constructs, and a comparison of the findings with existing theory. Excerpts from the original data in the form of verbatim quotes of what respondents actually said have been included.

2.5 Reliability and validity

The findings of this study are expected to be valid and reliable in relation to the youths in Livingstone in the age group 15 to 24 years. The rigor of the findings was achieved through the following strategies:

- Asking the same questions to four different focus groups and triangulating the results.
- Respondent validation of the key themes by summarizing them to the participants at the end of each focus group discussion and asking them to confirm each theme.
- Allowing for free and open discussion of issues through participant homogeneity and using young facilitators of the same gender as the respondents.
- Ensuring inter-rater reliability by training all facilitators on the procedures and concepts used in the study.
- Convening two additional focus groups (one for boys and one for girls) five months later and summarizing the key findings to them and asking them to validate and rank the key themes.

The findings however might not necessarily be generalizable to youths in every part of Zambia because the life circumstances in different parts of the country might be different. Replication of this study in different towns across the country and triangulating the

results could provide information on which findings, and to what extent, they can be generalized.

CHAPTER 3: FINDINGS

In this chapter the researcher will present the findings of the study. He will discuss the factors that inhibit adherence to the recommended methods for prevention of sexual transmission of HIV among the 15 to 24 years old. The chapter is divided into four sections corresponding to the four recommended preventive methods, namely a section on abstinence, a section on condom use, a section on HIV testing, and a section on faithfulness. Each section describes in detail the factors presented by the respondents. Each section also has a subsection on rankings of the factors by respondents and a subsection summarizing the findings in that section.

3.1 DETERMINANTS OF NON-ADHERENCE TO ABSTINANCE

Adherence to abstinence as a way of preventing HIV is undermined by the following factors which youths see as compelling, allowing or justifying their non-use of abstinence as a method for prevention of sexual transmission of HIV:

- Natural development of sexual drive
- Peer pressure
- Exposure to pornographic materials and acts
- Deliberate enticement by members of the opposite sex
- Force of habit and sexual addiction
- Intimidation and threat of violence from members of the opposite sex
- Power of love and perception of sex as proof of love

These factors are described in detail below.

3.1.1 Natural development of sexual drive

Respondents reported that abstinence becomes difficult because of the physiological changes that occur as they grow from childhood to adulthood. They said hormonal changes result in an increase of sexual feelings which then creates pressure for sexual curiosity and experimentation which are hard to resist. They also said they succumb to these pressures because the feeling of admiration of sex is high among young people:

“When you graduate from childhood, you start having feelings in the body, then at the end you just find you have a boy friend.” (20-24 girls)

“When you are young, sex is admired.” (20-24 girls)

We are not taught how to start sex. Each individual learns sex on their own. There is a stage when sex finds you.” (20-24 girls)

“People say sex is painful in the beginning of the act but later becomes sweet. So we want to experience it.” (15-19 Girls)

“Change of hormones in the body.” (15-19 Girls)

“Feelings for sex. Feelings have power too much, they convince us.” (20-24 Boys)

“Boys and girls want to experiment.” (20-24 Boys)

3.1.2 Peer Pressure

Respondents reported social pressure to start sex from sexually experienced peers to boys and girls that are abstaining. This was said to occur in the form of negative and positive pressure. Positive pressure was said to be exerted on those abstaining through telling them stories about how nice sex is and inducting them into social contacts with possible sex partners in order to encourage them to experiment. Negative pressure took the form of abstaining boys and girls being laughed at and called names. These pressures are especially effective because of a lack of full understanding of the possible consequences of sex.

“When you are in a group of friends, they would start telling stories about sex and things you have never seen or heard. So you would just say... aah. When they say that things happen this way (when they describe their sexual experiences), and you would be forced to do it, to experiment, without knowing the consequences behind it.” (20-24 girls)

“Then you just want to try so that you taste or experience sex.” (20-24 girls)

“What causes most of us not to abstain is group influence, it is the most causer. When I sit I think ... aah... my mother (I remember my mother’s prohibition of pre-marital sex), but once you are in a group of friends who have experienced sex or who have boy friends you are tempted. For example you will see that today your friend bring buns, the other day she brings something else, you will be forced to bring something also, and in the end you will also have a boy friend to give you something so from that you start.” (20-24 girls)

“When you meet friends who have boy friends and you do not have a boy friend, your friend will take you to her boy friend and he will buy drinks, and her boy friend has friends and you will be co-opted into the group of his friends. This friend will come and take you out and you will think you are playing, yet that is how it starts without you realizing, thinking it is life but you start destroying slowly.” (20-24 girls)

“Peer pressure. Fear to be laughed at for being a virgin.” (15-19 Girls)

“If your best friends have sex relationships with girls you will be encouraged by them to also start a sex relationship and that is nice when you put it into practice.” (15-19 Boys)

“Friends will tell you that you are missing on something good.” (15-19 Boys)

“As a boy if you don’t have sex the other boys will start laughing at you, saying that you are a boyar.” (A boyar is slang for someone unintelligent, lacking in self confidence, and unfamiliar with sophisticated ways of town life, especially someone coming into the urban area from a village in some deep rural area.) (15-19 Boys)

“Being laughed at and ridiculed is very painful, so out of fear of that you follow what your friends are doing.” (15-19 Boys)

“Fear of being laughed at is greater than fear of HIV.” (15-19 Boys)

“As boys we join groups, and our friends in those groups have girl friends and my self I don’t have. So they will start telling me that you don’t like girls or maybe you are a chilima (slang for impotent person, literally a castrated bull used for plowing). When I hear that, I would want to show my friends that I want a girl. So I go ahead and con a girl, not even knowing that she maybe HIV positive. After coning her then I have to fuck her to cement the relationship. Then you don’t know even that the girl has a virus, you just have direct sex without a condom.” (15-19 Boys)

3.1.3 Exposure to pornographic materials and acts

Respondents reported that exposure and access to pornographic material was a factor in stimulating sexual arousal and making abstinence difficult. They described pornographic materials as films on national television and satellite television, books, magazines, and video shows. Glimpses during early childhood of sexual activity by parents or other people, as well as traditional initiation ceremonies for girls coming of age, where they are taught different “dances” (body movements) performed during sex, were also identified as factors contributing to early sexual activity by youths.

“What causes first sex is some type of movies that we watch where they show someone having sex with a girl, you know. You have that feeling that ooh, it is nice, let me go and try it They are a catalyst for making a decision to go and have sex with that girl.” (15-19 Boys)

“Movies like blue movies and really pornographic magazines with different sex styles.” (15-19 Boys)

“These magazines you just find them by chance. They are very few. You may just get a glimpse of the magazine when the other boys bring them to school. You will just notice a group of boys at school then you know that they are watching a porno magazine and you would want to go and see and right there you become carried away. They may hide the porno magazine inside an innocent looking book and you think they are studying but it will be a pornographic book.” (15-19 Boys)

“After watching a pornographic magazine, you have ideas; you want to find out, to experiment.” (15-19 Boys)

“On ZNBC (Zambia National Broadcasting Corporation) you know what; you will find that in movies about love they will show Americans kissing their girl friends. Also on Mnet Movie Magic (channel on satellite television) at night around 23.00hrs to 02:00 they show blue movies.” (15-19 Boys)

“Blue movies say no one under 18 should watch, but these young ones watch people having sex. (After watching such movies) Young ones try to find out what it is like to have sex (and) they try to put into practice what they saw.” (20-24 Boys)

“In the peri-urban compounds where we come from children are disturbed because of these films.” (20-24 Boys)

“Apart from films, also parents sleep in one room with their children who are busy watching what the parents are doing. Parents sleep with as many as 6 to 8 children who are on the floor while the parents are on the bed. In the morning these children start playing mother and father (with their friend) and even start imitating sex.” (20-24 Boys)

“Initiation ceremonies teach about how to dance in bed (recommended sexual body movements) with your partner and when you come out (of initiation) you would want to experiment.” (15-19 Girls)

“Before initiation ceremonies we do not know that there are some dances (recommended body movements) to perform during sexual intercourse.” (15-19 Girls)

“During initiation ceremonies they do not talk about HIV prevention measures. They are preparing a girl for marriage and they do not talk about condom use in homes, it is a taboo.” (15-19 Girls)

3.1.4 Deliberate enticement by the opposite sex

Respondents explained that members of both sexes who want sex set up various traps and ruses to lure members of the opposite sex into sexual activity, which those targeted find hard to resist. Girls were reported to use tricks such as sexually provocative dressing and seating postures designed to accentuate their sexual appeal through outlining or exposing parts of their bodies to sexually arouse males. They also used methods such as going to boys and pretending to need help and asking for assistance. Boys used tricks such as counting money in the presence of girls and posing as being financially well resourced. They also trapped girls using such methods as by inviting them to secluded places and arousing them sexually by exposing them to pornographic videos or caressing them as a way to weaken their resolve for abstinence.

“The difficulty we face is the dressing styles of nowadays, when you go out on the streets you might want to abstain but when you go out there you will find girls wearing short mini-skirts, you know.” (15-19 Boys)

“When you see a girl wearing a mini skirt, if you have had sex before you will have feelings and you will think about having sex.” (15-19 Boys)

“Abstinence is difficult because girls sometimes come to us themselves, and as a result even if I want to abstain I can’t because girls bring themselves to me.” (15-19 Boys)

“They don’t come to tell me that lets have sex, but they give me signs. They touch us, they ask us to give them money. As boys those things make us think too much right there and we feel like proposing love to them simply because she asks me some money. Sometimes just by touching you your heart gives in.” (15-19 Boys)

“Women are found in bars drinking beer, as you buy yourself one beer also girls come to you, what does she want, all she wants is money. She entices you by coming for a chat and seating carelessly, which makes you to lose control and propose her and she can’t refuse.” (15-19 Boys)

“Girls sometimes look at you as someone who has money, maybe you are a taxi driver. A school girl can come and ask you to take her to school for free, enticing you because you drive a car and have money. Because she is nice and fresh you agree and in that process you get tempted from a transport arrangement to a love arrangement which results in sex.” (15-19 Boys)

“If you have a video (player) at home then maybe there is a girl whom you like and you fail to tell her, you invite her over to your house and when she comes you let her in and start wanting(making sexual advances to) her. If she refuses you take the blue movie and start watching and you close the door. As you watch she will feel sexy. When you now try she won’t refuse.” (15-19 Boys)

“Things happen like when you are watching a video and you like a girl and you are not telling her and for her to know that you want her, the video show will make her sexy. In the mean time, you will pretend to be doing something else and locked the door. You start asking her how she found the movie. Girls sometimes fail to say no, you just take her and they fail to refuse.” (15-19 Boys)

“Even the way they sit girls must learn to sit properly.” (15-19 Boys)

“When a girl touches you it is hard to leave. When you see a nice girl provoking you by showing you parts of her body it is hard to look away or to tell her my friend you are not seated properly, put on a chitenge (piece of cloth used by women for wrapping around the lower body).” (15-19 Boys)

“Girls dressing is provocative, slits in dresses and skirts, tight cloths and hipsters, tight t-shirts which outline their breasts, tight jeans with low waist lines which reveal their under pants.” (15-19 Boys)

“When the eyes see, they want to see more. All of us when you find money on the street you cannot leave it there. So even a girl when undressed already, you can’t tell her to go away because you also want.” (15-19 Boys)

“When girls wear provocative dressing and if you have had sex before, you will remember your sexual experiences and your mouth won’t have problems telling her that you want sex with her. For her to dress like that it means she wants men to propose her. Once you just tell her she will just say yes. They even have a name for such dressing with the underwear elastic showing.” (15-19 Boys)

“Girls use tricks such as exposing their thighs in order to attract men. Girls want men but they can’t tell a man straight, so they know for you to propose them they dress indecently so that when you see you will have feelings and when you do you will propose her no matter what. She won’t tell you she wants you but she will greet you ask for water and tell you irrelevant stories and when you see her dressing you stop listening to her stories and start looking at her dressing and in the end you tell her you have liked her and you have sex with her.” (15-19 Boys)

“I have asked girls why do you dress like this? She told me that if you are selling sweets, can you put them where people can’t see? That’s why we dress like this so that men can see what we have.” (15-19 Boys)

“But sometimes even us guys, it is us who provoke the girls. If I have money, I will start counting it in her presence.” (15-19 Boys)

“I once had a girl friend and she started demanding for sex. She even hated me after I refused to have sex with her. She said that I was opwalala (a person who fails to recognize and seize opportunities).” (15-19 Boys)

3.1.5 Exchange of sex for goods and services

Respondents reported the role of a sometimes implicit at other times explicit exchange of sex for goods in undermining abstinence. Girls reportedly deliberately enticed men into sexual relationships in order to receive gifts, money and entertainment to meet real needs or to keep up with the lifestyles of peers. Sometimes experienced girls maneuver unsuspecting and inexperienced girls into relationships involving receipt of gifts from men without disclosing to them that the relationship in the final analysis confers obligation to agree to sex. Males were also reported to entrap girls with gifts and favors to create a sense of indebtedness in the minds of the girls and then they can recoup their expenses through acquiring sexual gratification.

“Our parents can not provide all that we may require so we look for boy friends to supplement.” (15-19 Girls)

“He will insist on payment and it is sex. He can not give you things for nothing. It is an exchange.” (20-24 girls)

“The exchange of goods for sex is not obvious and straight forward. I can give an example, when one starts giving me things with my friends without knowing that that man is after me until my friends tell me after I have eaten his things, someone will tell me that those things you have eaten the owner wants to see you. When I go to see him, he will start feeling me and I will start having the feelings and in the end we have sex.”

(20-24 girls)

“Through accepting gifts you find you have accepted a relationship. You have sex with him and you get used to sex.” (20-24 girls)

“We have sex with girls because they cannot just eat our money for free.” (15-19 Boys)

“You can’t just look for a girl to throw your money to. You will want to have sex with her so that the money spent is worth while.” (15-19 Boys)

“Sometimes girls older than you can take you because they have liked you. They ask you to go to their homes with them and they promise you K500 and you become excited with the amount and when at their place the woman starts seducing you and ends up undressing and you will end up staying and sleeping with her.” (15-19 Boys)

3.1.6 Force of habit and sexual addiction

Respondents reported that having experienced the bliss of sex at an early age before the message of abstinence as a method of HIV prevention reached them, they now find it hard to abstain because they find it intolerable to stay away from sex. Early sexual experience also makes them more susceptible to succumbing to sexual provocations by girls. Abstinence is only considered after an adverse sexual experience such as contracting a sexually transmitted infection.

“Most of us youths start having girl friends and boy friends and sex early when we are still at school. When a baby is given a sweet and it tastes the sweet, next time you tell him/her that don’t eat that sweet, he/she won’t agree because he/she has tasted a sweet before.” (20-24 Boys)

“The first time I had sex it felt nice, then someone comes and tells me to abstain, I will look at him not to be fair.” (20-24 Boys)

“Most of us start having sex at an early age or stage and for us to stop it is hard and its too late, so it is very difficult to stop but others start abstaining after an STI (sexually transmitted infection) saying oh I have stopped I will never do it again until I marry. But then us guys who have never had an STI it is hard to abstain.” (20-24 Boys)

3.1.7 Intimidation, violence and threats of violence

The use of violence and threats of violence by boys and girls when they refuse sex was mentioned by respondents as a factor which makes girls succumb to male sexual demands. This is probably linked to gifts which usually precedes a demand for sex.

“For us as boys if I find a girl that is abstaining, if as a boy I really want to have sex with that girl, I will tell her that if she refuses I will beat her up. Even if she doesn’t want I will have what I want.” (15-19 Boys)

3.1.8 Love, proof of love and fear of rejection

Respondents reported that both boys and girls believe that a love relationship has to be consummated by sex, if not then that love is unproven. The party demanding such consummation usually threatens to opt out of the relationship if the other party is unwilling to prove their love through sex. The one who was resisting sex usually succumbs to the demands when faced with this threat for fear of the relationship ending.

“If you propose to a girl it means you like her, and you may even end up marrying her. But again you wouldn’t want your money to be wasted or gone for free. You will want sex with her (for you) to prove that she really loves you. Guys think that sex is proof of loving someone and with this the girls agree.” (15-19 Boys)

“Love for partner. Fear to be ditched by a partner if you refuse them sex.” (15-19 Girls)

3.1.9 Ranking of determinants and exploration of implications

Respondents provided a ranking of the various determinants of non-adherence to abstinence. A ranking of 1 being considered by respondents as the most dominant

influence while a ranking greater than one being considered progressively less dominant, but non-the-less present influence. The rankings are shown in Table 2 below:

Table 2: Ranking of determinants of non-adherence to abstinence

	CATEGORIES AND SUB-CATEGORIES OF DETERMINANTS	Votes per rank				Mode	Rank
		1	2	3	4		
A	SOCIAL CULTURAL	8	20	4	0	2	2
	Encouragement and influence from peers	12	11	7	2	1	2
	Demands and threats from love partner	4	7	15	6	3	3
	Exposure to sexually explicit information & training	13	8	7	4	1	1
	Forced sex	2	6	3	21	4	4
B	ECONOMIC FACTORS	16	4	12	0	1	1
	Lack of basic necessities	9	14	6	3	2	2
	Financial inducement by opposite sex	8	7	10	7	3	3
	Comparative need/ wanting to have what others have	12	9	6	5	1	1
C	INDIVIDUAL FACTORS	8	8	16	0	3	3
	Natural development of sexual desire	12	10	6	3	1	1
	Vulnerability to sexual enticement by opposite sex	12	8	8	4	1	2
	Sex as a habit/ routine	4	7	7	14	4	3

From Table 2 it can be seen that according to respondents, the order of rank in categories of factors determining non-adherence to abstinence is economic factors as number 1, socio-cultural factors as 2, and personal factors as 3.

The sub-categories identified under the economic category were ranked as follows: Wanting to have what peers have (comparative need) was ranked 1, real lack of basic needs was ranked 2, and financial and material inducement by opposite sex was ranked 3. The economic category was described as a determinant of non-adherence to abstinence mainly for girls, even though incidents of girls luring younger boys to sex using money were also cited.

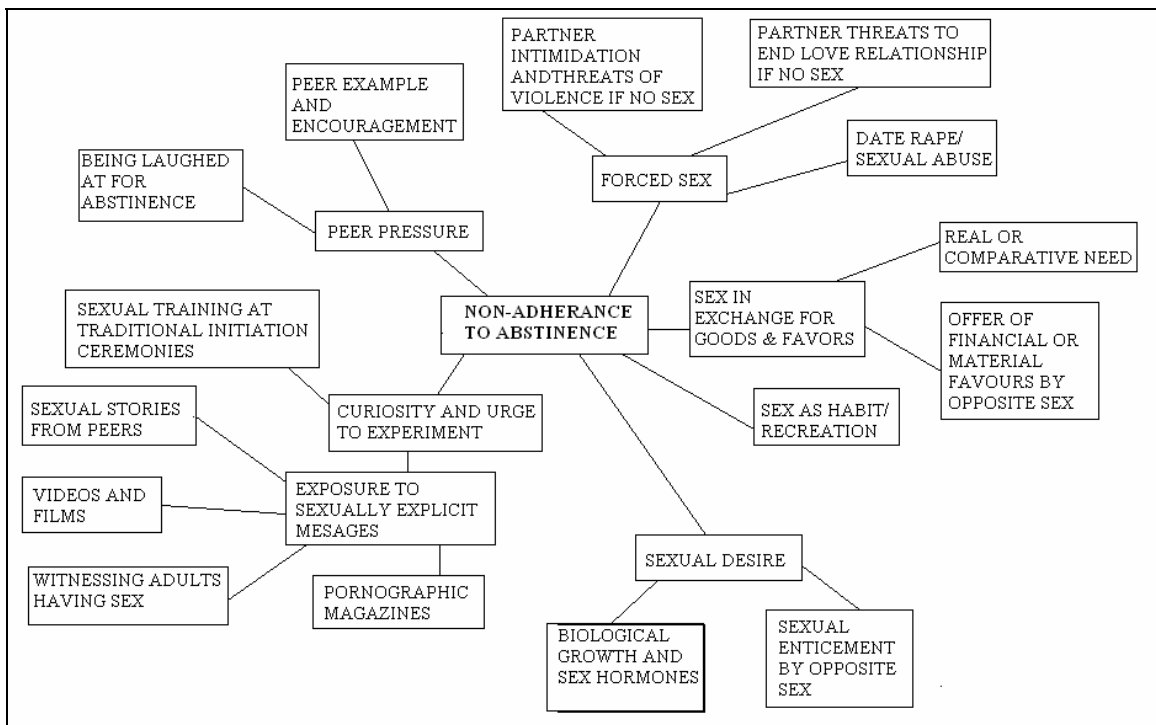
The sub-categories under socio-cultural category were ranked as follows: exposure to sexually explicit information and training was ranked 1, encouragement and influence of peers was ranked 2, demands and threats from a love partner was ranked 3, and forced sex from a love partner was ranked 4.

The sub-categories under personal category were ranked as follows: Natural development of sexual desire was ranked 1, vulnerability to sexual enticement by opposite sex was ranked 2, and sex as a habit was ranked 3.

3.1.10 Summary

The message to the youths to abstain from sex is a key HIV prevention message. On the face of it the choice before the youths seems to be a simple one: abstain and avoid HIV and live a healthy life, or don't abstain and risk catching HIV and ending up with AIDS. It would seem that self interest and rationality would make abstinence the obvious choice, but data from this study shows that the choice is not so simple and is sometimes non-existent, and that self interest is not as clear cut as it would at first seem. The factors that drive youths towards non-compliance to abstinence are summarized in the diagram below:

Diagram 1: Determinants of non-adherence to abstinence



The data shows that the youths are passing through a stage of dramatic physiological and hormonal changes. The hormonal changes subject them to intense sexual desire which is in direct conflict with the message of abstinence by virtue of the amount of self denial which adherence to abstinence implies. At the same time the physical maturation creates a situation whereby for the first time in their lives the youths find themselves the subject of overtures from members of the opposite sex who want a sexual relationship with them. From this circumstance alone it can be seen that the message of abstinence though objectively sensible is emotionally and physically counter intuitive. Promotion of

abstinence for HIV prevention has therefore to examine the experience of sexuality and physical maturation as experienced by the adolescents.

The data also shows that adherence to abstinence is also faced by other countervailing forces.

It has been seen that sometimes initiation of sex is forced on the youths by members of the opposite sex. Sometimes youths who are in a love relationship are put under pressure by their partners who want sex. The pressure takes the form of threats that the love partner will opt out of the relationship if the love is not sexually “proven”. Sometimes the pressure takes the form of bullying, threats of violence and actual violence. Non-adherence to abstinence in these circumstances then occurs because of fear to lose the love relationship, fear of violence, or due to an act of actual rape. It would seem that for the promotion of abstinence to be effective it has to address the social and emotional meaning of affectionate relationships among the youths, and the power relationship between partners in such a relationship, as well as the phenomenon of date rape and child sexual abuse.

The influence of non-abstinent friends was indicated as a strong determinant of non-abstinence. The data shows that youths are susceptible to forces of conformity with the behavior, beliefs and norms of peers. Youths who abstain but whose friends are non-abstinent are subjected to pressure to also stop abstaining. They are laughed at, ridiculed, and called names, or they are encouraged, tutored, and influenced by force of example to stop abstaining. For the promotion of abstinence to be effective there is need to deal with issues of the management of peer relationships and influence among the youths.

The content of the electronic and written information and entertainment media does not help matters as the information available to youths through these media is often contradictory to the HIV prevention message of abstinence. The content of films, novels, magazines, and songs consists of messages that suggest that sex is good and that sex appeal is a desirable attribute. They show the joys of sex and rarely contain messages that

promote abstinence or that show the dangers of sex. This is to be expected because the mass media as profit making entities carry messages that appeal to youths as entertainment but rarely respond to the public health agenda of the nation. The mass media is an important source of information on norms and models for youths, and if the messages they carry runs counter to the message of public health then that is bound to be reflected in the behavior of the youths. The portrayal of sex as desirable, risk free and common practice among successful people is bound to not only arouse a sense of curiosity among youths to find out, for them selves, how sex feels like but also legitimize non-abstinence as an alternative life style.

The curiosity is further enforced when adolescents come of age and are taken through traditional initiation where they are taught sexual techniques by elderly mentors through lessons and simulated sexual exercises. The initiation is a cultural practice from olden days when adolescents used to be married off soon after puberty and was meant to be a preparation for married life but now is done to adolescents who still have many years of education and single life ahead of them. The data suggests that the traditional practice of initiation makes the youths susceptible to pre-marital sex. Traditional initiation confers a sense of sexual competence and heightens curiosity for practical experience. After experiencing sex there is then the danger of sex becoming a habit or source of entertainment.

The use of sex as a means of exchange to obtain goods and favors also came out from the data. Some youths, especially among the girls, perceive themselves as being in real material need or in comparative need when compared with their peers. They report a life of inadequate support from their parents or guardians, which is a source of feelings of deprivation and embarrassment to them. This circumstance makes them susceptible to succumbing to members of the opposite sex who offer them goods and other favors in exchange for sex, or they might take the initiative themselves to start selling sex in imitation of peers in similar circumstances who are using a similar method to alleviate their problems. For promotion of abstinence to have long term effect, there is need for the

message to be supplemented by programs which deal with issues of family disadvantage, poverty, and limited economic opportunity.

From the foregoing it seems evident that non-abstinence is determined by several factors which in their operation are sometimes under the complete or partial control of the youths while at times they are not under their control. For the promotion of abstinence to be effective among the youths there is need for intervention models which recognize and address these countervailing factors.

3.2 DETERMINANTS OF NON-ADHERENCE TO CONDOM USE

Adherence to condom use as a way of preventing HIV is undermined by the following factors which youths see as compelling or justifying their non-use of condoms as a method for prevention of sexual transmission of HIV:

- Power of sexual desire and need for sexual spontaneity
- Failure to buy condoms due to embarrassment
- Mistrust of condoms
- Need for trust based relationship
- Indifference to the risk of HIV
- Lack of availability of condoms
- Stigmatization of condoms
- Need for sexual authenticity
- Ulterior motives

These factors are described in detail below.

3.2.1 Power of sexual desire and sexual spontaneity

Respondents reported that a threshold exists during romancing between a boy and girl when sexual arousal cannot be stopped or interrupted or subjected to rational

considerations. When that threshold is reached, sex will occur whether the couple has a condom or not. Respondents reported failing to wear a condom even when it was there in the room. It was said that stopping foreplay to wear a condom would have wasted time.

“Sometimes you have a boy friend who insists that you have sex with him. When you do not have a condom and there is no place where to buy it, you just have sex without it.” (20-24 Girls)

“When you reach a climax in romancing you can not stop to go and look for a condom.” (20-24 Girls)

“We don’t think of AIDS when we see thighs, it is so. We only think about HIV after having sex. Sex is difficult to resist, after sex that’s when we think of maybe I am sick. That is the way it is.” (15-19 Boys)

“When the penis has erected it is difficult to control yourself, you just go in straight with no doubts that there is disease.” (15-19 Boys)

“When you like a girl, when the time comes for you to put on a condom, you will fail (to wear a condom), after all you will be feeling sexy. Even the girl will be feeling the same so you will both think wearing a condom will be a waste of time, at last you will just go in live (without a condom).” (15-19 Boys)

“Why things (not wearing a condom) happen like that is because the condom is a waste of time, also delaying. Even if it is there in the room we fail to tear it and wear it. It is difficult once you have seen a girl’s nakedness and you are horny (aroused). That is what happens.” (15-19 Boys)

“Preparing a condom and wearing one feels like wasting time.” (20-24 Boys)

“Sometimes we just look at the girl, the beauty, we sacrifice our lives even saying even if I die its okay because I want to feel how it(sex) feels to the fullest.” (20-24 Boys)

When it comes to sex we lose our mind.” (20-24 Boys)

“Laziness and stupidity.” (20-24 Girls)

“Sometimes we spend the night with a girl but its not (possible) that you will use condoms the whole night.” (20-24 Boys)

3.2.2 Failure to buy condoms due to embarrassment

Condoms are said to be generally available in shops in town and in makeshift roadside stalls and are sold at an affordable price. However, girls find it hard to buy them because of embarrassment. They are concerned about what the person selling and other customers who are there to buy different goods will think of them. Condoms are also available free at government clinics but girls don't go to collect them there for fear of being seen by someone they know given that clinics are public places. They fear that being seen collecting condoms could damage their reputation.

“It is embarrassing to buy condoms.” (15-19 Girls)

“Sometimes as a girl you know where to buy condoms and have money, but you feel shy. Shy because you think people will think you are promiscuous.” (20-24 Girls)

“Some are shy to buy condoms. The person selling them could start thinking about what you are going to do.” (15-19 Girls)

“Shy at the thought of other customers thinking you are going straight to have sex.” (20-24 Girls)

“Its like a girl is a prostitute when she buys condoms.” (15-19 Girls)

“We don’t get condoms from the clinic because you can find someone you know, who might spread the rumor (that you use condoms) and your mother will get to know it.” (15-19 Girls)

3.2.3 Mistrust of condoms

Respondents reported that condoms are not used because their efficiency is in doubt and the safety of using them is suspect. It is thought that they have pores which can allow HIV and sperms to pass through, that they are expired and prone to bursting, and that the oil in them is suspected of causing abdominal pains in girls and a genital rash in males. Particles from a burst condom are feared to be likely to remain in the vagina and cause some harm. The usability of the female condom is also suspect because of a fear that it can come loose and get stuck in the vagina.

“People say condoms cause problems like abdominal pains towards monthly periods.” (20-24 Girls)

“Some suspect that the oil in the condoms is the cause of the abdominal pains. That’s why some people refuse to use condom.” (20-24 Girls)

“Some say condoms are not 100% effective because three quarters of condoms sold at Tuntamba (roadside makeshift stalls) are damaged, because of poor storage and exposure to the hot sun on the street. You can buy it but when a man wears it, just after wearing it will be torn off immediately he wears it, it will be damaged in front. We do not know if it is its nature or what. So many people do not trust condoms.” (20-24 Girls)

“The fluid that is found on the condom has an effect”. (15-19 Girls)

“Some people say constant use of condoms causes illness, but we do not know what kind of effect.” (15-19 Girls)

“Some people say when the condom bursts, the particles will remain in the vagina. Those particles will cause problems but I don’t know what kind of problems.” (15-19 Girls)

“Those who have seen the female condom are scared that it can remain in the vagina.” (15-19 Girls)

“People prefer male condoms to female condoms because the female condom has a lot of lubricating oil which does not feel ok to the touch.” (15-19 Girls)

“What we know is that condoms are not 100% safe. You can use them but it’s the same as skin to skin.” (15-19 Boys)

“Like me with the condom I experienced something. I used them twice and after both times I experienced a rash on the head of my penis. I finally concluded that maybe the rash was caused by the condoms.” (20-24 Boys)

“Many people believe that most condoms on the market are expired. Hence when you use something which is expired you are bringing diseases to your self.” (20-24 Boys)

“On my side I last used a condom two years ago. So far I have never suffered from STIs, but for HIV I would say I don’t know.” (20-24 Boys)

“To make matters worse a condom is not 100% safe because sometimes people who used a condom get pregnant, which means condoms have holes and because the AIDS virus is more tiny than a sperm it is very easy to get HIV.” (20-24 Boys)

“Sometimes you go and buy a condom (and while using it) it bursts. After experiencing four bursts, it looks useless to wear a condom any more. Even if I use a condom it will burst, and one decides to be having unprotected sex”. (20-24 Boys)

3.2.4 Need for trust based love relationship

Respondents reported that the use of condoms in a love relationship is said to imply lack of trust about the health status or character of a partner. Mistrust in turn implies lack of genuine love. Partners in a love relationship resist condoms because they want unconditional trust, which is considered to be proof of unconditional love.

“I can not use a condom with a man I trust. Like for example a Kalubale (a person from the Luvale tribe), even if they say he is a womanizer so long he is clean I cannot use a condom. He is clean because he is circumcised.” (20-24 Girls)

“But me I look at the behavior of someone not at the beauty, and know if she has respect and she is always at home and doesn't move about too much. There it is unprotected sex. If the girl looks fine not sick you have unprotected sex. But then even if she is beautiful but cant respect herself its better just looking at her and never having sex with her. ” (20-24 Boys)

“But like me I have an experience, I went to see one girl but she was older than me. She was thirty years old with three children. I went to see her, I went inside, I became high and the love I have for her we made love and she did anything that I told her. We had unprotected sex because I thought with a condom there is

nothing I was going to feel, but I had a condom in my pocket. But the other girl I had I used a condom because I had heard that she once had an STI and I was afraid.” (20-24 Boys)

“Some girls will say that you don’t trust them when you suggest that you use condoms. She will say she knows she is HIV negative and that she wants skin to skin. To show her that you love and trust her, you know a man where love is concerned, right there you throw the condom aside.” (15-19 Boys)

Some girls refuse condoms, and when you ask them or tell them about HIV they ask you whether you want them or not. They say if you want me you must not use a condom. You must not be scared of me. When I hear that I just throw the condom away because if I insist on using a condom the girl will refuse and so I go direct.” (15-19 Boys)

“When you don’t use a condom girls feel loved and trusted.” (15-19 Boys)

“When a girl refuses to use condoms then you know that if you insist then you won’t have sex that day. She will go. She will say that if you don’t remove the condom then she won’t agree. She will say if you insist on condoms it means you don’t trust her. They will tell you that if you want to use condoms then go to the prostitutes, me I am not a prostitute for you to use a condom.” (15-19 Boys).

“Sometimes we get blinded by love so we don’t think of using a condom.” (15-19 Girls)

3.2.5 Indifference to the risk of HIV

Respondents said people seem to have a capacity to ignore risk even though they are aware of it. They see HIV as one of the many inescapable factors which can bring man’s mortal existence on earth to an end. They see no need to make strenuous efforts to avoid

death when death is inevitable anyway. They see dying from AIDS as no different from dying by any other cause.

“Humans are just problematic. We know that a condom needs to be used; there can not be justification for feeling shy to buy a condom. We ignore when we know that a man will have sex with you without a condom and might have HIV. We know but we ignore as if we don’t know. This ignoring of risk is what is killing us.” (20-24 Girls)

“Sometimes girls say they want skin to skin (unprotected sex), they say that AIDS came for people not for wild animals, but human beings. (AIDS has to happen to some people because it’s a disease for humans hence unavoidable in society) ” (15-19 Boys)

“Some say death is one and the same thing. People die in different ways, others in (automobile) accidents and others in water.” (15-19 Boys)

3.2.6 Lack of availability of female condoms

Male condoms were reported as being widely available and easily accessible. The female condoms however were said to be rare. Many of the female respondents had never seen or used one. All the adverts they had seen were about the male condoms.

“Condoms are for men. The female condom is not available in our communities.” (20-24 Girls)

“Male condoms are available and can easily be bought and there are no problems in buying them.” (15-19 Girls)

“We don’t know about the female condom or how to use it.” (15-19 Girls)

“A female condom is rarely seen or not seen at all. Most adverts or posters and on TV are about the male condom.” (15-19 Girls)

3.2.7 Stigmatization of condoms

The reports by the respondents appear to suggest that use of condoms is stigmatized. It was thought that people using condoms in a love relationship are suspected of being promiscuous, being unfaithful, being HIV positive, having STIs, or being people who for some reason are unable to use standard family planning methods.

“For girls we can buy a condom but using it is a problem because your partner would say you are not faithful.” (15-19 Girls)

“Sometimes if you want to wear a condom the girl will feel like you have, an STI or you don’t trust her.” (15-19 Boys)

“Usually when a girl tells you to put on a condom you can never beat her up. She is most probably trying to protect you from a disease she has. More especially prostitutes they really like condoms; they will even physically inspect to ensure you have worn a condom. Those girls who seem to be ok (who are free of any disease) don’t insist on condoms, we just sleep with them without protecting ourselves knowing that they are ok. Those that like using condoms they have experience (of disease), its better not to have sex with them. Better tell her it’s ok, see you (bye).” (20-24 Boys)

“Some times girls refuse condoms and say you think I am a bitch who will leave you with a disease. To avoid quarrelling you don’t use a condom.” (20-24 Boys)

“Women who know they are HIV positive or who are having periods but their partners want sex or who for some reason can not put themselves on family planning pills can go to a shop without feeling shy to go and buy condoms.” (20-24 Girls)

3.2.8 Need for sexual authenticity

Respondents indicated a belief that sex with a condom is not authentic sex. They say using a condom feels like masturbating or having sex with a paper or plastic and not with the person one is purporting to be having sex with. They said in fact such a sex partner can plausibly deny that you ever had sex with them. Respondents also said that sex with a condom is qualitatively different and less enjoyable, for both males and females, than unprotected sex.

“The first time we had sex the vast majority of us had it without a condom because we wanted to find out the real taste. It is difficult because you want to experience (real sex), you have that high temperature to the point where the dick feels like it will explode.” (20-24 Boys)

“Also wearing a condom feels like masturbating, that’s what people think. Its like fucking yourself. With a condom a girl can deny that you ever had sex with her.” (15-19 Boys)

“Some men do not like using condoms, they say that when they use a condom they feel like they are using paper or having sex with a paper. So they want direct sex, that is when they feel they are having sex and satisfaction.” (20-24 Girls)

“There is a difference between live sex and sex using a condom. A condom is tasteless. When you go live at least you get something because you know all the sperms will go in, you won’t have to walk away with them again to go and throw

them. When you have to carry away your sperms after sex, then you haven't slept (had sex) with her but with a condom.” (20-24 Boys)

“It is difficult to use condoms because there is no one who can eat a sweet that is in a plastic, so direct sex is better.” (15-19 Boys)

“Some girls say you cannot buy a sweet in a plastic and put it in your mouth. You won't enjoy the sweet, so that's how they refuse to wear condoms.” (15-19 Boys)

“Some girls refuse to have sex if you insist on using condoms. They say they won't feel nice, only you will feel nice.” (15-19 Boys)

“I feel as though a condom is just a plastic disturbing me from fully experiencing sex. It is like being put inside a 90kg bag and you can't breath nicely.” (20-24 Boys)

“Three quarters of women have no problem with using condoms but the problem comes from men. Men refuse to have sex with a condom. Three quarters of men say it takes time to ejaculate when they are wearing a condom.” (20-24 Girls)

“The way the woman's body looks like, the beauty and the nice breasts. She might want to use a condom but we boys we are carried away, we lose our thinking. We pretend as though we are putting on a condom and then go in without one.” (20-24 Boys)

3.2.9 Ulterior Motives

Respondents reported that sometimes condoms are resisted by partners for undeclared ulterior motives. Girls were said to resist use of condoms when they wanted to get pregnant as a way of stopping school, for trapping a rich man into marrying them, or for accelerating a slow moving courtship into marriage. It was said that sometimes girls

refuse to use condoms in order to create a prima facie case for framing an innocent man with responsibility for a pregnancy that is not his.

“Some girls don’t want condoms because they want to get pregnant so that they stop school. They want to stop school early so that you marry them. When wanting a girl you don’t say I like you, you say I love you and I want to marry you. To speed up the marriage she will refuse to use condoms so that she gets pregnant so that you marry her early.” (15-19 Boys)

“There are girls who when they know that they are pregnant from another man they will want to still sleep with you, so that they accuses you of making them pregnant. She will refuse to use condoms so that she claims that it is you who made her pregnant because she may not like something about the real guy who made her pregnant.” (15-19 Boys)

“Some girls from poor families if you once propose her, they will want to be married to you because you come from a rich family and can look after her. So she will start refusing sex with you if you wear a condom so that you make her pregnant, and when you do, you marry her and she will be leading a good life with you. This happens because of the poverty in our country.” (15-19 Boys)

3.2.10 Ranking of determinants and exploration of implications

Respondents provided a ranking of the various determinants of non-adherence to condom use. A ranking of 1 being considered by respondents as the most dominant influence while a ranking greater than one being considered progressively less dominant, but non-the-less present influence. The rankings are as shown in the table 3 below:

Table 3: Ranking of determinants of non-adherence to condom use

	CATEGORIES OF DETERMINANTS	Votes per rank							Mode	Rank
		1	2	3	4	5	6	7		
A	MISTRUST OF CONDOMS	13	8	1	4	5	0	1	1	1
	Belief that condoms cause health problems	6	11	15	0	0	0	0	3	3
	Belief that condoms are not effective	17	10	5	0	0	0	0	1	1
	Social stigmatization of condoms	10	10	12	0	0	0	0	3	2
B	NEED FOR SEXUAL AUTHENTICITY	5	4	13	3	6	1	0	3	3
	Belief that sex without condom feels better	23	9	0	0	0	0	0	1	1
	Belief that sex with condoms is fake sex	9	23	0	0	0	0	0	2	2
	Need for sexual spontaneity	8	11	13	0	0	0	0	3	3
C	FAILURE TO OBTAIN CONDOMS	1	3	3	12	3	10	0	4	4
	Condoms not available	7	13	12	0	0	0	0	2	3
	Lack of information on female condoms	12	14	4	2	0	0	0	2	2
	Too embarrassed to buy condoms	13	4	15	0	0	0	0	3	1
D	TRUST FOR SEX PARTNER	8	10	6	2	5	1	0	2	2
	Good partner behavior	15	7	8	2	0	0	0	1	1
	Circumcised partner	2	3	7	20	0	0	0	4	4
	Good partner reputation	9	11	8	4	0	0	0	2	2
	Healthy looking partner	6	11	9	6	0	0	0	2	3
E	INDIFFERENCE TO RISK OF HIV	2	2	7	7	4	10	0	6	6
	Foolhardy: "let it happen as It may"	13	8	11	0	0	0	0	1	1
	Fatalism: "there is nothing we can do"	10	14	8	0	0	0	0	2	2
F	ULTERIOR MOTIVES	3	6	3	3	9	7	1	5	5
	Need for a child	10	9	13	0	0	0	0	3	3
	To entrap partner into marriage via pregnancy	17	9	6	0	0	0	0	1	1
	To transfer paternity to a better man	5	14	12	0	0	0	0	2	2

From table 2 it can be seen that according to the respondents, the order of rank in categories of factors determining non-adherence to condom use were as follows: mistrust of condoms is ranked 1, trust for sex partner is ranked 2, need for sexual authenticity is ranked 3, failure to obtain condoms is ranked 4, ulterior motives is ranked 5, and indifference to risk of HIV is ranked 6.

The sub-categories identified under mistrust of condom use were ranked as follows: Belief that condoms are not effective was ranked 1, Social stigmatization of condoms was ranked 2, and belief that condoms cause health problems was ranked 3.

The sub-categories identified under trust for sex partner were ranked as follows: Good partner behavior was ranked 1, good partner reputation was ranked 2, healthy looking partner was ranked 3, and circumcised partner was ranked 4.

The sub-categories identified under need for sexual authenticity use were ranked as follows: Belief that sex without condoms feels better than sex with condoms ranked 1, belief that sex with condoms is fake sex was ranked 2, and need for sexual spontaneity was ranked 3.

The sub-categories identified under failure to obtain condoms were ranked as follows: Too embarrassed to buy condoms was ranked 1, lack of information on female condoms was ranked 2, and condoms not available was ranked 3.

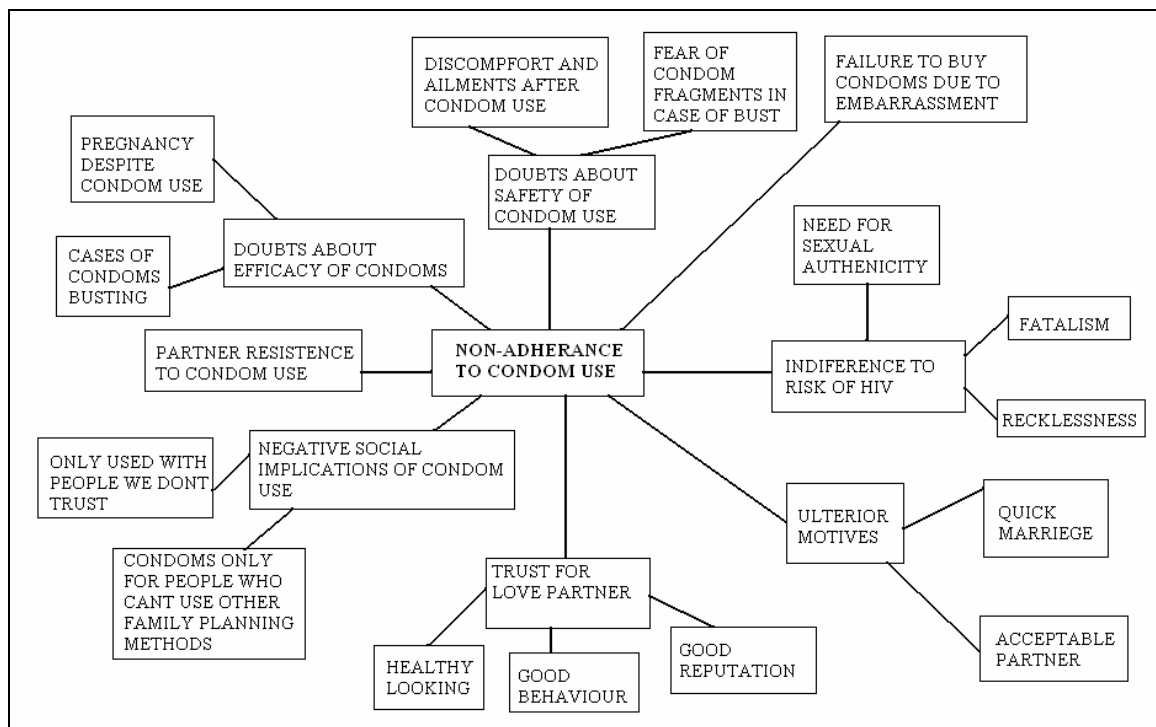
The sub-categories identified under ulterior motives were ranked as follows: To entrap partner into marriage by using pregnancy was ranked 1, to transfer paternity to a better man was ranked 2, need for a child was ranked 3.

The sub-categories identified under indifference to risk of HIV were ranked as follows: Foolhardy was ranked 1, Fatalism was ranked 2.

3.2.11 Summary

The determinants of non-adherence to condom use are summarized in the diagram below:

Diagram 2: Non-adherence to condom use



From the data it would appear that though the youths receive public health messages urging them to adhere to condom use, the sexual behavior of the youths is a function of a complex cost benefit analysis of this message in comparison with some local knowledge and other messages, present in the community, about the value of using condoms.

From the data it would appear that youths have doubt about the suitability of condoms as a product. Firstly, the youths have doubts regarding the efficacy of condoms in preventing HIV. They give case studies of persons who have become pregnant despite

using condoms as a family planning method, and of experiences of condoms busting during sex. Some cite what they consider as technical data that condoms have pores which are bigger than the HIV virus and hence the virus should be able to pass through. They conclude that given this apparent circumstantial evidence of the unreliability of condoms then there is no point in using condoms.

Youths also have doubts about the safety of using condoms. They say condoms could be physically harmful to the user. They cite experiences of rashes and period pains after using condoms and the supposed harm that fragments of a bust condom could do to a woman's reproductive system.

Apart from questions about the quality of condoms as a product, they also have other concerns as well.

The data shows that youths believe condoms interfere with the integrity and authenticity of the sex act. They believe that unprotected sex is sensually better than sex with condoms, and that sex with condoms is counterfeit sex. They also believe that using condoms interferes with the natural spontaneity of sex. For these reasons respondents reported that the vast majority of first time sex experiences are unprotected because the youths want to experience the real thing. They also reported cases of failure to use condoms even when a condom was in the room or in the pocket.

The data also shows that use of condoms appears to have negative connotations. There is a perception among youths that condoms imply mistrust of the partner, and that condom use makes sense when dealing with people suspected of having sexually transmitted infections or HIV such as prostitutes and not with a trusted and loved partner. The only exception to this rule is when a couple is for some reason unable to use other family planning methods. The youths find the mistrust inherent in condom use intolerable, and therefore unsustainable, in a love relationship. If the partner looks healthy, has good behavior, and a good moral reputation then the perception of personal risk of unprotected sex is reduced and with it the necessity of using condoms is diminished accordingly.

The two factors given above are closely related to cases indicated by the data of one partner wanting to use condoms but facing resistance from the partner. In this situation the partner who wanted to use condoms sometimes gives up in order not to lose the relationship. Sometimes however one partner resists condoms because they want a child, or because they want to use a pregnancy to trap the other partner into a marriage, or for other reasons. In these cases the risk of HIV is seen as being of lesser concern in comparison with these objectives.

The data also revealed other factors at play in hindering adherence to condom use. Among them is the case of failure to buy condoms due to lack of privacy at the condom selling point and the associated fear of public opinion when youths are seen buying condoms. Another factor mentioned is the existence of a sense of futility of trying to avoid HIV. Some youths see HIV as an unavoidable human fate and do not use condoms out of a sense of helplessness or lack of sense of personal efficacy in HIV prevention. Other youths do not use condoms out of a sense of shire indifference to the consequences of HIV.

It is evident that for public health interventions to motivate higher levels of adherence to condom use over the long term there is a need for these interventions to address the factors that foster non-adherence to condom use. The doubts about the safety and efficacy of condoms, the need for sexual authenticity, the role of love and trust, the negative social implications of condom use, and the phenomena of fatalism and ulterior motives need to be addressed.

3.3 DETERMINANTS OF NON-ADHERENCE TO HIV TESTING

Adherence to HIV testing as a method for preventing HIV is undermined by the following factors which youths see as compelling or justifying their non-use of HIV counseling and testing as a method for preventing sexual transmission of HIV:

- Fear of the psychological impact of an HIV positive test result
- The stealth nature of HIV
- Fear of stigma and discrimination
- Partner's resistance
- Lack of confidence in VCT staff and ignorance of VCT procedures

These factors are described in detail below.

3.3.1 Fear of psychological impact of a positive HIV test result

Respondents see HIV testing as a double edged sword or a kind of Russian roulette. They would like to know the HIV status of their partners but they fear discovering that they themselves are HIV positive. They see the HIV testing centre as a needless possible source of bad news that would lead to many negative thoughts, loss of life purpose, depression and an early death. They say depression kills faster than HIV/AIDS. They prefer to let sleeping dogs lie. They also fear the same consequences for their partner and would feel responsible for any adverse consequences that could occur to their partner in the event that their partner is HIV positive and they are not.

“What leads us not to go for HIV testing is fear. When I learn that I am HIV positive..... Ok at the VCT centre I can be strong but when I go home I will be depressed. To know that I am HIV positive it scares us so much.” (20-24 Girls)

“Sometimes we say that its better I stay without going for testing because when I know my status I will die faster than the day I was supposed to die because it would make me think all the time and anywhere where I sit, I would be thinking that I will die any time especially when I feel sick, even with a simple illness, that I will die.” (20-24 Girls)

“When they tell you that you are HIV positive, you would appear to be strong but when you leave the clinic, you start thinking that you will die. You will accept

fakely but deep down your heart you will not accept that you are HIV positive.”
(20-24 Girls)

“Going for VCT is scaring, you will never be free.” (15-19 Girls)

“If you are HIV positive, you will soon die. We know we will die eventually with or without HIV, but for now it is ok because we are not going to go thin and later die.” (15-19 Girls)

“For us who are still in school, when you discover you are HIV positive you will stop concentrating on studies. You will start thinking you may die before you complete your education.” (15-19 Girls)

“You will start feeling guilty when you are with friends.” (15-19 Girls)

“When you go for VTC and you test positive, you start thinking a lot, even if they taught you how to live positively, you will always be thinking about your HIV status being positive. What kind of life will that be? Thinking only of the negative? You wont be thinking of positive things that will make your life progress forward, that will be able to work. You will think there will be nothing for you to do on the earth because you have HIV.” (15-19 Boys)

“You may even say, it is better for me not to suffer from HIV, its better I kill my self than suffer HIV. That is what we are scared of, thoughts of living with HIV and in the end you die.” (15-19 Boys)

“We only think of finding bad news at the VCT, because you realize that you have been with a lot of girls, because there are lots of beautiful girls in the world. You are in love with one today and tomorrow you see another girl. Maybe the girl you trusted has left town on transfer, you will see another beautiful one and you will want her. So you will find that controlling yourself becomes difficult and when

you go for VCT they can tell you that you are HIV positive and what kind of life will I lead, because my mind will be full of negative thoughts. Even if you stop school, and your friends finish school, you start thinking of the money you wasted. You start thinking only of bad thoughts and what you are going to do. ” (15-19 Boys)

“We don’t want to go for HIV testing because should you be found to be positive then you will start having a lot of thoughts and that life has no purpose any more since I have the HIV virus. We think that we will die immediately after contracting the virus.” (15-19 Boys)

“You start thinking about people who have AIDS and how they suffer when sick, and get thin. At last those thoughts can get you depressed and you can die from depression. So we don’t want to bring thoughts which will lead us into depression. Why should I go for VTC and bring depression into my life when I can just sit not knowing whether I am positive or not? It is better I don’t go for HIV testing to avoid thoughts which might lead to depression.” (15-19 Boys)

“When going for HIV testing you may think that you don’t have and you want to see if the girl you have chosen has HIV. You may think that if she has HIV then I won’t go out with her, and when you get there you may find that she is negative and you are positive because you can’t know maybe you may have been born with it. All you know is that you are HIV negative and yet you were born with it. And when you go for testing you will be found with HIV and start having bad thoughts.” (15-19 Boys)

You may be thinking that let me see if she is HIV positive and if she is I wont go out with her and if she is negative then she will become my girl friend. But then when you get there you will find that it is you with the virus and regret going there.” (15-19 Boys)

“It is scary to go for VCT because if I am found with it then money would have just been wasted on my education and I won’t benefit anything.” (15-19 Boys)

“If found to be positive others think that they should infect others so that they don’t die alone. A lot tell me that if found to be positive then I will die alone so I have to infect others because it is not right for me to die alone. HIV came for people and it is better we die a lot of us.” (15-19 Boys)

“Its better you stay not knowing your status and wait until you suffer from TB, than going for an HIV test. At least you don’t know that you have HIV, you can live longer, but when you know, depression is what will kill you. You will start thinking that you have HIV and you will die. Depression will set in and that’s how you will die.” (15-19 Boys)

“When having sex it is nice and that is like our profit but when going for VCT it is like suicide. That is how we feel, sex is nice and VCT brings depression. For some of us we just hear of VCT where your blood is checked for HIV and AIDS to know whether we are positive or not, now we are just scared.” (15-19 Boys)

“When you know that you are HIV positive everyday you will see as though 06hrs to 22hrs it is just the same because you are not sleeping, just thinking, so I am dying, it’s the fear of dying.” (20-24 Boys)

“We fear taking girls to VCT, we think maybe if this person is positive she can kill her self.” (20-24 Boys)

3.3.2 The stealth nature of HIV

Respondents reported that they still use the age old methods for detecting disease and health, based on sensory detection, which are useless with HIV. They do not appear to appreciate the stealth properties of HIV. Because HIV infection causes no immediate pain

or sensuously detectable signs and because a person can remain healthy for many years even after infection, people do not have a sense of danger. If a partner appears to be of good character and looks healthy, they trust that that partner does not have HIV. Also respondents associate going to hospital with being sick and seeking treatment, they have not appreciated the concept of a healthy person going to a hospital for a medical checkup.

“When you love your partner so much, you can be saying there is no need for a test because no one is feeling any pain anywhere. When you are sick you feel pain so you go to the clinic fast.” (20-24 Girls)

“When you trust your partner so much you don’t even think of going for a test because you trust him and (you believe that) nothing (bad) will happen. The way a person would look you can think that he can not have the virus.” (20-24 Girls)

“When you think of the place (HIV testing centre) and when you look at yourself and see how healthy you look you would think that you do not have the virus, yet you have it. You would have this doubt that even if I don’t go for a test I do not have the virus yet you have it.” (20-24 Girls)

“When we are getting infected we do not feel any pain.” (20-24 Girls)

“We are not scared (of HIV when having unprotected sex) because when you are in that position of wanting a girl you cant even think of the disease, you just concentrate on the programme of having sex with that girl. Nothing comes to our minds about HIV.” (15-19 Boys)

3.3.3 Fear of stigma and discrimination

Respondents reported being afraid to go for HIV testing because of the fear that they might be stigmatized and discriminated against in the event of an HIV positive test result. They fear that if found positive this information will become public and that when that

happens people will gossip about them behind their back. They fear being labeled or blamed as having been promiscuous and irresponsible. They also fear that people will avoid associating with them because of misconceptions about the transmissibility of HIV in normal social contact and the fear of associating with a dying person. They also fear the embarrassment and humiliation of the love partner they go with for an HIV test dumping them and avoiding them from there onward.

“Many fear that when they go for HIV testing, the news will spread because there is no confidentiality. They think that when they go for HIV testing everyone will know that they are positive.” (20-24 Girls)

“What I can say makes us to fear HIV testing is that when a person is found with HIV he/she is condemned even if he/she dresses nicely or go to different places, he/she will be condemned by people.” (20-24 Girls)

“Because people will hear that he went for HIV test and was found positive, so when you are walking, you will think it is a secret yet people have already known your status. So even if you are walking people have already condemned you.” (20-24 Girls)

“They will condemn that you were having sex with different men no wonder you are HIV positive.” (20-24 Girls)

“They know that HIV will develop into AIDS or it has already developed into AIDS and any time you will die.” (20-24 Girls)

“If you have a baby the baby will be accepted by society and they won’t trouble the baby. They will say its ok she gave birth to a baby and the baby will be accepted because a baby has only one father not many. But HIV is a shame and that is why three quarters of the people do not want to go for VCT testing because they fear to be discriminated against.” (20-24 Girls)

*“HIV testing is scaring because if you are found positive it is an embarrassment.”
(15-19 Girls)*

“We may want to go for VCT but we are scared of people at home, they will say why do you want to go for VCT it means you have boy friends.” (15-19 Girls)

“If found positive it is difficult for me to keep it to myself. I will tell a friend who will also tell some one else, rumor will spread and people will start running away from me.” (15-19 Girls)

“Even the boy friend, immediately he realizes that you are positive, he runs away from you or avoids you.” (15-19 Girls)

“When you know you are positive to keep it to yourself is hard. You will tell a friend and through that people will learn about that you are HIV positive. Some say you can even get infected by touching someone who is HIV positive. So they will start avoiding you.” (15-19 Girls)

“HIV and a child are both signs that we have been having sex, but we feel less embarrassed about a baby because it will grow unlike HIV which is a disease and you will later die.” (15-19 Girls)

“When you have the HIV Virus people will take you as a prostitute who has had sex with many men, but for a pregnancy its ok because a child will always have one father.” (15-19 Girls)

“When going to the VCT centre you might find people you know and that will bring doubts. They will go to your girl friends and tell them you were seen at the VCT centre and girls will start rejecting you. They won't trust you, they will be asking why you went for a test and want to know the results. That isn't good. Even

if you want to marry the girl she won't trust you because you had gone for VCT and that you must have AIDS, otherwise why did you go for VCT? They think that it is only people who have HIV that go for VCT. You see when the girls see you there they start talking about you having AIDS.” (15-19 Boys)

“Some times we are embarrassed to go to the VCT centre because the people you find there you know them and they know you. I can go to another VCT centre but I am scared of the Idea of VCT.” (15-19 Boys)

“The issue of going with your partner brings thoughts like what if I am the one who is HIV positive and she is ok and she leaves me. That will be the end of the relationship, even in the streets she will run away from me like she has seen a snake. That's what scares people, a girl refusing you.” (15-19 Boys)

“I find it ok to go for VCT with a girl and only test her for HIV. At least just knowing she is HIV positive or not and not me going for actual test. The problem is when you decide to go for VCT, you may find that you the initiator are the one who has got the virus and you end up with a lot of thoughts. So it is better you just take the girl to see if she has the virus.” (15-19 Boys)

“When you go for VCT and you are told that you are positive stigma develops. People no longer want to be next to you even in church; hence it gives one a lot of thinking too much that it (life) is over.” (20-24 Boys)

3.3.4 Partner resistance

Respondents reported that sometimes they are willing and ready to go with their partners for HIV testing but their partners refuse to go. For fear of losing the partnership they decide not to go and end up having sexual relations with a partner whose status they don't know. They said they comply with their partner because of love for the partner.

“Men refuse to go for VCT. It is difficult because I can tell him to go but he will refuse. If you really want to go and he is refusing you will stop and have him or if you love him you will accept what he wants.” (20-24 Girls)

“Fear of losing the man on account of non-compromise on HIV testing.” (20-24 Girls)

“When you tell a boy friend to go for VTC they don’t just agree immediately, they refuse first and say they are scared.” (15-19 Girls)

“The counselor might want you to go with your partner but then you will find that the girl becomes difficult, she doesn’t want to go or maybe you only meet at night. The mother cannot allow you to take her for VCT, and the girl will also be scared to go for VCT, even refuse to go for fear of her mother hearing about it.” (15-19 Boys)

“If you are really committed to each other a girl can’t refuse to go with you for VCT. You will discuss it and promise to marry so she can’t refuse.” (15-19 Boys)

“As guys when you want a girl to marry, the parents of a girl should know that you want their daughter, and your parents should know the girl you want to marry. If the girl’s parents have been officially informed of your relationship with their daughter they can’t stop you going for VCT. However if the relationship is a kind of dark corner relationship (secret love affair) the parents can refuse you to go with her for VCT because they don’t know your intentions. Even the girl when you tell her now lets go for VCT she can refuse.” (15-19 Boys)

“We pretend to be mere friends in the day and in the night when we meet nobody knows because it is in the dark corners.” (15-19 Boys)

“When parents don’t know of the relationship or your intention, they cannot agree for you to go for VCT with their daughter because you are just stealing (not a recognized fiancée for the girl).” (15-19 Boys)

“If you want to marry a girl, even if you approach the mother of the girl, if she realizes you are poor she wont let her daughter with a rich back ground to go with a poor guy for a check up for AIDS. She will tell you that if you don’t love my daughter just go away.” (15-19 Boys)

“Taking a girl for VTC is difficult. You can ask her as a friend to go with you for VCT but she will refuse and when you continue forcing her to go for VCT she ends up asking you to decide if you want to continue your relationship with her or not. But then for fear of losing her we decide to forget the VCT idea.” (20-24 Boys)

3.3.5 Lack of confidence in VCT staff and ignorance of VTC procedures

Respondents reported lack of trust and confidence in the competence and professionalism of the personnel at the HIV testing centres. Mistrust was less towards the older staff but more towards the younger staff. There were concerns that the testing centre may not maintain professional confidentiality and might leak the personal test results into the public domain through gossip or publications.

Many respondents said they had never been inside a testing centre before. Some said they don’t go there because they expect most of the clients to be grown-ups and fear that they as youths would look out of place. Some believe that testing services are paid for when they are actually free in Zambia.

“Us people we fear that when I am tested, the counselors will start telling other people.” (20-24 Girls)

“We are more comfortable with elderly counselors than young ones, but we do not know who is there because we mostly don’t go there.” (15-19 Girls)

“Some times we think that the same people who do the HIV testing will reveal the results to everyone. That’s the main issue.” (15-19 Boys)

“At the clinic where VCT is done there are too many young nurses. There are just young nurses nowadays, without wisdom; you know how young women are, without wisdom. She can tell other people (about your HIV status) like she is joking and yet she will be destroying your reputation because she tells one person, and that person will obviously tell the next and so on and it becomes a life circle. You might cross into Zimbabwe to go and have some fun only to discover that the rumor has reached there that you are HIV positive.” (15-19 Boys)

“Some of the young nurses have no experience. Some are students who are there for field practicals, and she might even be training on you and tell you that you are HIV positive.” (15-19 Boys)

“Me I saw a newspaper were they just photographed someone suffering from TB and the statement they wrote was that that person was suffering from HIV, you see. So that’s why we are scared of going there because if they find you are HIV positive they can entice you for them to take a picture of you with money and later produce a magazine saying that you have the virus. The magazine may not be found here but in other distant countries.” (15-19 Boys)

“People do not know the conditions of HIV testing.” (20-24 Girls)

“We may want to go for VCT testing but we don’t have the money. Your boy friend might agree but he will tell you he has no money.” (15-19 Girls)

“If we look at our age group we think or say that it’s only for adults who are supposed to go for VCT not us because they will think evil of us.” (15-19 Boys)

“You will find that in the line of people wanting to be tested, you will find people with pot bellies, adult men and women and you will think that you are in the wrong place, this line is for old men and women and you should go and look for young people, for youths. Its not just me thinking like this, a lot do in the compounds that if you see a line for adults then it is only for adults and they forget and leave it at that.” (15-19 Boys)

“Like us drivers you might meet this girl in another town. You will have no time of going for VTC before sex.” (20-24 Boys)

3.3.6 Ranking of determinants and exploration of implications

Respondents provided a ranking of the various determinants of non-adherence to HIV testing. A ranking of 1 being considered by respondents as the most dominant influence while a ranking greater than one being considered progressively less dominant, but non-the-less present influence. The rankings are as shown in Table 4 below:

Table 4: Rankings of determinants of non-adherence to HIV testing

		Votes per rank							Mode	Ranking
		1	2	3	4	5	6	7		
	Categories of Determinants of non-adherence									
A	FEAR OF PSYCHOLOGICAL TRAUMA	17	4	4	2	2	2	1	1	1
B	LACK OF CONFIDENCE IN VCT SERVICES	4	8	6	3	5	2	4	2	3
C	FEAR OF STIGMA AND DISCRIMINATION	3	10	4	3	5	4	3	2	2
D	BELIEF IN LOW LIKELYHOOD OF POSITIVE RESULT	4	1	6	8	5	3	5	4	5
E	BELIEF IN HIGH LIKELYHOOD OF POSITIVE RESULT	0	1	5	12	4	7	3	4	4
F	PARTNER RESISTANCE TO HIV TESTING	2	1	5	3	7	7	7	5	6
G	UNCERTAINTY ABOUT THE BENEFITS OF VCT	2	7	1	2	5	7	8	7	7

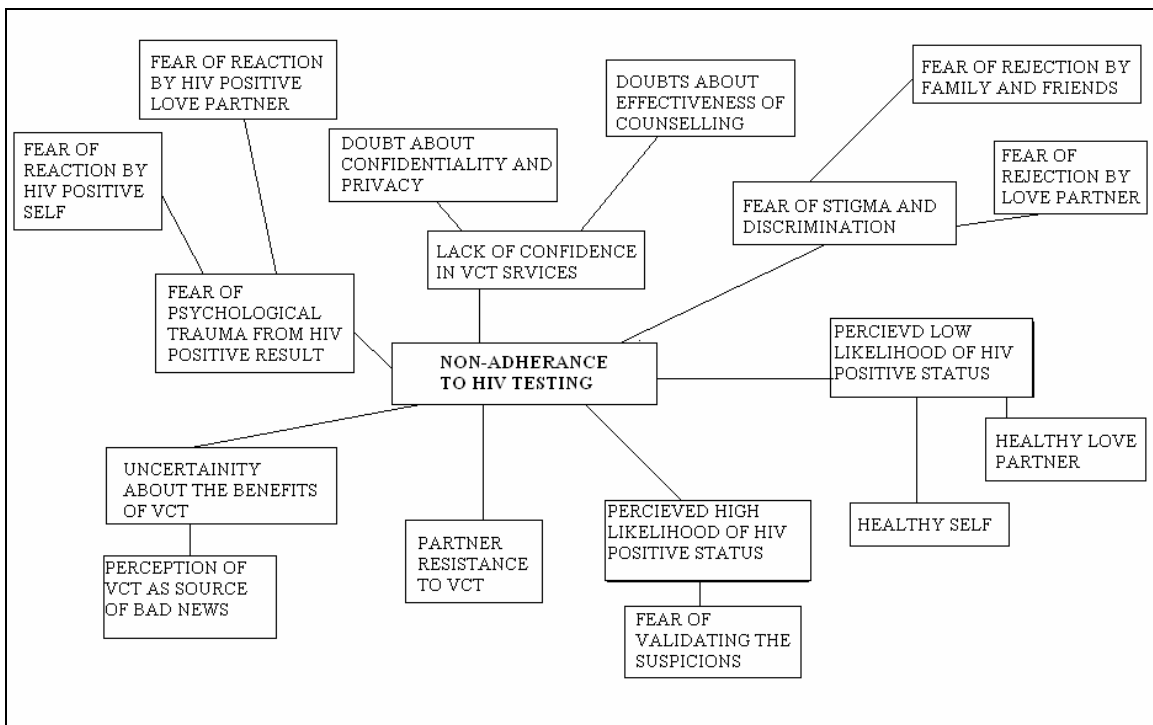
From Table 3 it can be seen that according to the respondents the order of rank in categories of factors determining non-adherence to HIV testing is as follows: Fear of psychological trauma is ranked 1, fear of stigma and discrimination is ranked 2, lack of confidence in professionalism of VCT services is ranked 3, Refusal to test due to self diagnosis as HIV negative is ranked as 3, Refusal to test due to self diagnosis as HIV positive is ranked as 5, Partner resistance to HIV testing is ranked 6, and skepticism and uncertainty about the benefits of HIV testing is ranked 7.

3.3.7 Summary

The public health message on HIV testing appears to be clear and simple. The message is that HIV is a serious infection to be avoided. It is sexually transmitted but one can not tell whether a sex partner is infected or not by just looking. The only way to tell is through using HIV counseling and testing services. This is recommended rather than partner selection by trial and error.

The data from this study however reveals factors under whose influence non-adherence to this message appears to be a viable choice. The determinants to non-adherence to VCT are summarized in diagram 3 below.

Diagram 3: Non-adherence to HIV testing



The data reveals that one of the reasons why youths do not use the VCT services is because of the fear of the psychological trauma that is associated with learning that one is HIV positive. The fear arises because youths are not sure they would be strong enough to cope with the stress, lose of life purpose, depression, and anticipation of death which they believe is usually invoked when one receives an HIV positive result. They also fear for

their love partner in the event that they are HIV negative but their partner has a positive result.

Another reason that came out is the fear of stigma and discrimination. They fear that if they learn that they are HIV positive then this confidential information will be the subject of rumor and gossip in the public domain, having got there through they themselves revealing to their family, their love partner revealing to other people or through other social networks. They fear that when this happens then they might suffer discrimination and rejection from their families, love partner, and friends.

There is also an apparent lack of confidence in the VCT services on account of belief that they lack confidentiality and privacy, that some of the medical staff are too young, inexperienced and do not adhere to professional ethics. There are also doubts that the counseling offered can not be adequate to deal with the anticipated magnitude of the emotional trauma. In general VCT services are seen as a source of bad news and youths are uncertain about whether the benefits of knowing ones HIV status are adequate to offset the costs of receiving an HIV positive test result.

Given these factors, it is no wonder that the data reveals that even when youths want to go for VCT they sometimes face a lot of resistance from their love partners. It also came out from the data that when youths believe that the likelihood of them being positive is low on account of them being healthy and having a healthy love partner the motivation to take an HIV test is low as testing is deemed unnecessary. On the other hand even when youths judge that the likelihood of being HIV positive is high on account of past unprotected sex, the motivation to take an HIV test is still low as they fear to validate their suspicions and they choose to let sleeping dogs lie.

3.4 DETERMINANTS OF NON-ADHERENCE TO FAITHFULNESS

Adherence to faithfulness as a way of preventing transmission of HIV is undermined by the following factors which youths see as compelling or justifying their non-use of faithfulness as a method for prevention of sexual transmission of HIV:

- Retaliatory unfaithfulness
- Imitation of unfaithful role models
- Need for variety of sexual experiences
- Unfulfilled monetary and sexual expectations in present relationship
- General disillusionment with faithfulness of members of the opposite sex
- Need for access to sex whenever needed
- Unfaithfulness as transitional step to ending a relationship

These factors are described in detail below.

3.4.1 Retaliatory unfaithfulness

Respondents reported that some of the unfaithfulness is done for revenge against unfaithful partners. Unfaithfulness by one partner leads to the other partner, especially the women, to become unfaithful as well as a way of equalizing the scores. Unfaithfulness by ones partner is usually discovered through rumors from people, suspicious periods of absence, and discovery of sexually transmitted diseases.

“As a girl you would want to have one boy friend, but the problem is with the boys. They will always have someone else so when you hear that as a girl you would also want to fight back. You also decide to have another boy friend.” (15-19 Girls)

“Sometimes a man will start to double cross you and you will also join in double crossing him by competing so that it can be equal rights. When he has sex with a woman I will also go and have sex with a man.” (20-24 Girls)

“Misunderstandings in a relationship cause lose of faithfulness, especially when you listen too much to what people are saying about your partner. Our tempers also contribute. A friend can come and tell me that I have seen your partner at such and such a place. There and then I will lose my temper and start a quarrel with my partner and lose trust. The man will try to explain but because I have lost my temper I won’t listen and I will lose trust in him.” (20-24 Girls)

“You will hear reports that your partner was with a lady and another day you will hear that your partner was with another lady. Mean while you are faithful to him and at the end of the day he will bring disease to you. As a result, it will make you lose faith in your partner. You will be forced to look for another man so that it pains him as it pains you.” (20-24 Girls)

“You will discover that he will bring diseases and through diseases you will note that your man is a womanizer.” (20-24 Girls)

“Breast feeding also causes to lose faithfulness because some men do not like women who are breast feeding and when you start to breast feed they will go and look for another woman and find that problems begin in the home. Two days he will be with you two days away, in the end you know what he does and you lose faithfulness.” (20-24 Girls)

3.4.2 Imitation of unfaithful role models

Female respondents reported being prone to imitate examples of unfaithfulness. They reported doing it to imitate film stars, doing it to prove independence from regular sexual partners, and doing it under direct encouragement of friends. They also do it for fun.

When you see that your friend has more than one boy friend even you you try having more than one boy friend.” (15-19 Girls)

“It is fun.” (15-19 Girls)

“I think it is modern life, you can even see how girls change boy friends in films like Isidingo (a program shown on Zambia National Broadcasting Corporation television).” (15-19 Girls)

“Boys usually have pride, so we would want to show them that we can do without them.” (15-19 Girls)

“Even group influence where your friend would tell you to accept a love proposal from another man (even though you already have another boy friend) so that you double cross them.” (20-24 Girls)

3.4.3 Need for variety of sexual experiences

Male respondents reported unfaithfulness to their partners based on an urge to explore an assumed difference in sexual pleasure derived from different girls arising from differences in complexion, size, shape, height and other physiological differences among women. Males stressed a need to have variety in sexual partners and experiences in order to identify the most pleasurable one or to avoid the boredom and monotony of sex with only one partner.

“Some people say you can not have Kapenta (type of finger sized fish usually sold dry) for relish everyday, you need to change relish. It’s the same with sex.” (15-19 Boys)

“Some of the girls, they are all the same with vagina, but you want to have sex with them so that you feel and compare.” (15-19 Boys)

“You just also need to test other girls not just having one sexual partner. If you sleep with the same girl continuously for a week, at last you will get fed-up with

her. There has to be a change in the diet so that you know how other different girls taste like.” (15-19 Boys)

“Some girls have watery vaginas and others have dry vaginas.” (15-19 Boys)

“Women have different shapes and sizes, others have wide hips others not, others are fat others slim, others are dark in complexion others light’ So people usually compare their girl friends with other girls, so you end up with two girl friends, maybe one who is light and another one who is dark in complexion.” (15-19 Boys)

3.4.4 Unfulfilled monetary and sexual expectations in relationship

Female respondents reported becoming unfaithful when their partners fail to meet their material, financial or sexual needs to the expected level. They become unfaithful in order to have other males who can supplement or completely meet their requirements.

“Some would want to get money from both men so that by combining the money they can buy something which money from one man can not buy.” (15-19 Girls)

“You can love your boy friend but if he does not give you the money you need you get a second boy friend who will give you money.” (15-19 Girls)

“When you have a boy friend that can not support you financially during break at school, you will feel shy to tell him that you are ditching him. You will find another friend who will support you financially but you will keep both to yourself.” (15-19 Girls)

“Sometimes it is because of money, because when you have only one man he will give money when he gets paid and it will be little, so you want different men to sleep with you so that they give you money just like that.” (20-24 Girls)

“They fail to give us the full support we need that is the reason why we are not faithful to them because when he is giving you the support you need you can be faithful to him. Not only money but to also satisfy you sexually.” (20-24 Girls)

“When you look at most women, they just like money. Once your money finishes even faithfulness finishes.” (15-19 Boys)

3.4.5 Disillusionment with opposite sex

Respondents reported that disillusionment with a relationship or with the opposite sex in general sometimes leads to unfaithfulness by the disillusioned party.

This could happen when one’s spouse is absent for long periods, when courtship goes on for a long time without materializing into marriage, and when one has experienced several disappointments and does not trust any member of the opposite sex.

“A lot of relationships have ended because either the man or the woman work as business persons. Long periods of absence by your partner (when partner is away on business) will make you sense danger, and trust and faithfulness breaks dawn.” (20-24 Girls)

“Sometimes if you court for a long time and the man is not marrying you, you lose faith in him and become unfaithful to him.” (20-24 Girls)

“Even faithfulness usually is not enough. Even if you tell a woman that you will marry her, she won’t believe you and she will go for more guys, even three, So that who ever will be faster to marry her wins the race. You may find that you trust your girl friend and when you come back from business you will find that your girl was impregnated by someone else or married to someone else. It means that faithfulness is not there. You will now want to have at least three girl friends

yourself so that when you come from a business trip and find that some of them have been married off you will just get the remaining woman and she becomes yours. That's how faithfulness becomes less through disappointments.” (15-19 Boys)

3.4.6 Need for access to sex when ever needed

Male respondents reported becoming unfaithful when they can not get sex from their regular love partners when sexual need arises. It was reported that when a partner declines sex on account of abstaining, sickness, or other reasons boys seek out second girl friends to relieve the sexual urge. The use of traditional aphrodisiac medication was said to be a factor contributing to boys having unmanageable sexual urges.

“When I have two girl friends and one is sick or not available when I want to have sex I just go to the other one. You cant just have one girl friend because when you need sex she may refuse and you start regretting that you should just have a lot of them around so that when one refuses (to have sex with you) you go to the next one.” (15-19 Boys)

“When you have a girl friend you love who denies you sex, you just look for another girl on the side because of this situation.” (15-19 Boys)

“Some guys may want to have one girl but may not be sexually satisfied by one girl. Some guys even take traditional medicine to increase their sexual powers. The guy will start sleeping around with different girls because of the traditional medicine he took.” (15-19 Boys)

“These guys who go for Mukanda (traditional initiation for boys from the Luvale tribe where they are circumcised and initiated to be men) they are encouraged to sleep with girls. When they are circumcised they will take advantage because they are given traditional potency medicine there. You can have faith with your only

girl friend and when that Mukanda guy proposes to her, your girl friend wont refuse.” (15-19 Boys)

“Guys are allowed to have more (than one girl), but we don’t allow our girl friends to have a lot of boy friends. If a girl is caught having more than one boy friend everyone will shout at her for being a prostitute. But for a man, he will never be called a prostitute. It’s OK for men to have more than one girl friend than a girl having more boy friends. A man can even marry three wives if he wants, as long as he is able to look after them.” (15-19 Boys)

“It becomes difficult especially when your girl friend refuses when you try asking for sex. You lose trust in her that maybe she has another boy friend and think that maybe she is from having sex that’s why she is refusing.” (20-24 Boys)

3.4.7 Unfaithfulness as transitional step to end current relationship

Respondents reported that sometimes unfaithfulness was a transitional step to end a relationship. Unfaithfulness was said to occur when one wants to replace a partner who has indicated intention to leave town for good, when there is too much quarrelling in a relationship, and when one wants to look for a new relationship but wants to retain the old one in the meantime.

“You may have a girl friend and find out that she will be leaving town. What will happen is that you will look for another one because the first one is leaving you and you need a replacement.” (15-19 Boys)

“We look for other girls on the side because of what happens, sometimes you quarrel too often and that will lead you to look for another girl.” (15-19 Boys)

“Lack of faithfulness, because if you have faith in your girl friend you can not look for another girl on the side.” (15-19 Boys)

“A man will come and say he wants to marry you. In the course of the relationship he makes you pregnant and you have a child with him. After that he stops providing for you with support and you hear stories about what he is doing. In the end you start following and you see for yourself what he is doing. When other men propose love to you, you accept and the new partner starts providing for you.” (20-24 Girls)

“There are other situations whereby, you can have one girl friend, if you really trust her. The girl is the one who will disappoint you, you go for the next girl just like that. That’s the way it goes.” (15-19 Boys)

“For women who are married to men who work in the night, they will want other men and bring them at home. The husband will report for work and the wife will bring men at home. That’s how it happens that faithfulness just fades away; you even stop trusting each other.” (15-19 Boys)

3.4.8 Ranking of determinants and exploration of implications

Respondents provided a ranking of the various determinants of non-adherence to faithfulness. A ranking of 1 being considered by respondents as the most dominant influence while a ranking greater than one being considered progressively less dominant, but non-the-less present influence. The rankings are as shown in Table 4 below:

Table 5: Ranking of determinants of non-adherence to faithfulness.

		Rankings							Mode	Ranking
		1	2	3	4	5	6	7		
CATEGORIES OF DETERMINANTS										
A	DISSATISFACTION WITH PRESENT LOVE RELATIONSHIP	13	7	5	7	0	0	0	1	1
B	DISILLUSIONMENT WITH PRACTICABILITY OF FIDELITY IN SOCIETY	10	10	6	5	1	0	0	1	2
C	SEX AS A HOBBY OR ADDICTION	9	11	5	7	0	0	0	2	3

From table 4 it can be seen that according to the respondents the order of rank in categories of factors determining non-adherence to faithfulness is as follows:

Dissatisfaction with present love relationship is ranked 1, disillusionment with practicability of fidelity in society ranked 2, sex as a hobby or addiction ranked 3.

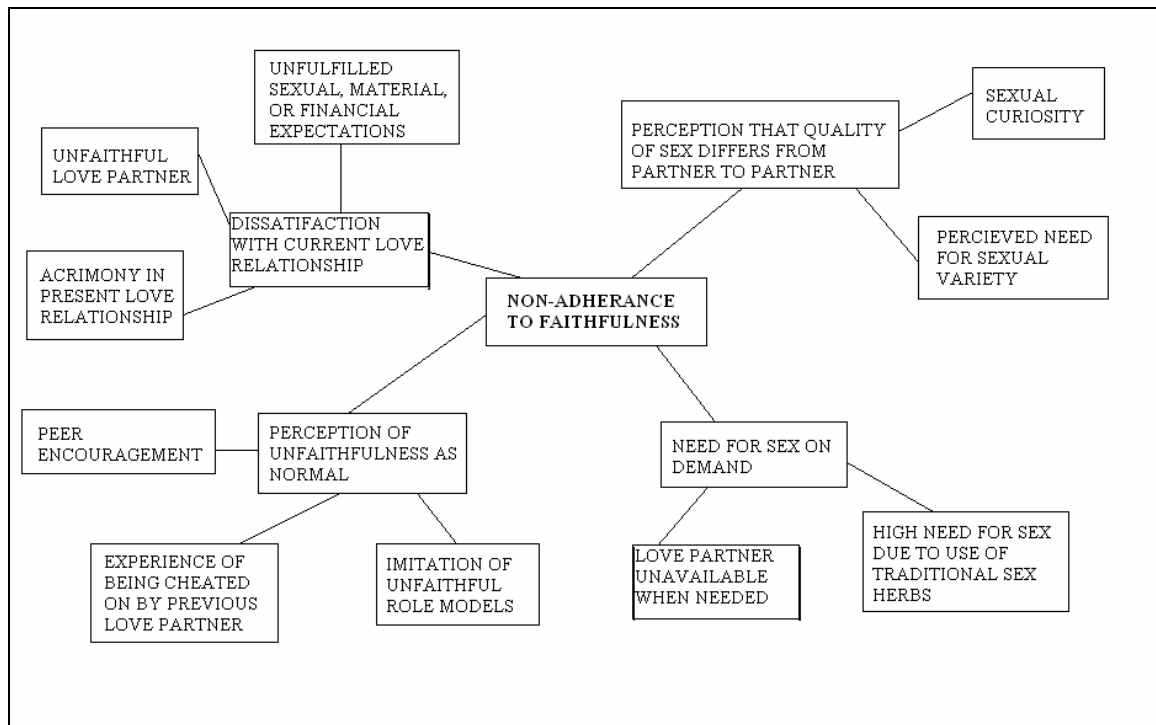
3.4.9 Summary

The message that people should refrain from having multiple partners is another key public health message in the fight against HIV/AIDS. In a society where HIV prevalence among the sexually active population is one HIV positive person in every five, it is apparent that the more sexual partners one has the greater the chance of catching HIV.

The data from this study reveals that there are factors within whose context the youths believe having multiple sexual partners makes sense.

The diagram below summarizes the factors that determine non-adherence to the message of abstinence:

Diagram 4: Non-adherence to faithfulness



One of the factors identified as a determinant of non-adherence to faithfulness is dissatisfaction with the existing love relationship. One of the contributory factors to dissatisfaction is when the current partner has been found to be unfaithful. In this case the aggrieved party also becomes unfaithful as a way of settling scores. Acrimony in the relationship for various reasons is another factor identified. Unfaithfulness then becomes a transitional strategy to end the existing relationship and move to a new one with no break in between. Unfulfilled expectations in a love relationship, in matters such as sexual satisfaction, and financial and material support or success, were identified as another factor that contributes to non-adherence to faithfulness. Unfaithfulness is then a strategy to acquire from another love relationship what is lacking in the existing love relationship.

Another factor identified from the data is the perception that quality of sexual experience differs from partner to partner. It is believed that some partners are more satisfying as sexual partners than others. Non-adherence to faithfulness then becomes justified on the basis of curiosity to compare different sexual partners and identify the best. In this case it

is seen as a necessary screening process in the search for the best marital partner. Unfaithfulness is also justified on the ground that there is a need to occasionally sample other sexual partners as away to avoid sexual monotony with the existing partner.

There is also a perception that unfaithfulness by people in a relationship is part of human nature and is therefore normal. This perception is founded on personal experiences of being cheated on or of observing other people of either sex being cheated on. Peer encouragement to cheat on one's partner and influence of unfaithful role models were identified as circumstances which tended to normalize non-adherence to faithfulness.

Non-availability of regular sex partner when needed was identified as another factor which tended to encourage non-adherence to faithfulness. The urge for sex was said to be strong and sometimes made so by the consumption of traditional sex drive boosting herbs. If then the normal sex partner is for what ever reason unavailable when needed, or as often as needed, then unfaithfulness appears to be a rational alternative.

CHAPTER 4: ANALYSIS OF RESEARCH FINDINGS

In this chapter the researcher intend to first analyze the findings within the context of existing literature on adolescent sexuality. He will analyze the findings as they relate to each recommended preventive method separately; first to be looked at will be abstinence, then condom use, then HIV testing and finally Faithfulness. Secondly the researcher will also analyze the findings in relation to the adherence model described earlier in the introductory section of this report. He will look at how the model fits with the determinants of non-adherence identified in the study.

4.1 Analysis of non-adherence to Abstinence

From the findings of this study it is evident that adolescence is a time of physical maturation and growth, and of transition from childhood to adulthood.

The changes that occur have been well documented in the literature. Angela Hueber describes three categories of physical development:

- Rapid gains in height and weight: youths undergo a spurt in the rate of growth characterized by gains in height of as much as 4.1 inches for boys and 3.5 inches for girls. There is an increase in weight from increased muscle development in boys and body fat in girls. These changes occur two or so years earlier for girls than for boys.
- Development of secondary characteristics: These include (1) growth of pubic hair; (2) menarche (first menstrual period for girls) or penis growth (for boys); (3) voice changes (for boys); (4) growth of underarm hair; (5) facial hair growth (for boys); and increased production of oil, increased sweat gland activity, and the beginning of acne.

- Continued brain development: improved connection of emotional, physical and mental abilities.²⁶

These are visible signs of physical maturation and transition into adulthood. As a result of these changes youths find that, even before they think of sex, they are the object of amorous overtures from members of the opposite sex who want sexual relationships. They are offered financial, material, and other inducement. At times they are victims of non-voluntary sex through intimidation, emotional blackmail and force. Often youths find themselves under these pressures at a time when they are ill equipped to deal with them. According to Chapin the social development of youths tends to lag behind the physical development. He explains that "... Adolescent bodies mature before cognitive development and emotional maturity are far along"²⁷. This creates vulnerability due to lack of life skills for managing these pressures.

Adolescence also appears from the data to be a sexually volatile time. It is a time of sexual maturation and of strong sexual feelings among both boys and girls. This does not appear to be a circumstance localized among Livingstone youths alone. According to Renshaw, "Sudden normal reflex erections are common in male teens. This sometimes can be embarrassing. Reflex arousal can also occur normally in girls (clitoral throbbing and vaginal lubrication). Only rarely will an adolescent ask a grown up about these reactions"²⁸ This is contrary to the dominant social perception that adolescence is a sexually passive stage. Kim Rivers and Peter Aggleton have noted that "Many adults also have difficulty acknowledging adolescents as sexual beings, and therefore adolescent sexuality is viewed as something which must be controlled and restrained. These

²⁶,Hubner Angela, (2000) Adolescent growth and development, , Family and Child Development, publication 350-850 Virginia Cooperative Extension, Virginia state Polytechnic Institute and State University. P.1

²⁷ Findarticles.com, Chapin, John R (2000) Adolescent sex and mass media: A developmental Approach. http://www.findarticles.com/p/articles/mi_m2248/is_140_35/ai_70777841/print p2

²⁸ Findarticles.com, Renshaw, Domeena C (1999) Adolescent Sex and AIDS, Adolescent Psychiatry, http://www.findarticles.com/p/articles/mi_qa3882/is_199901/ai_n8842943/print p.1

stereotypes have also informed much HIV related research and practice with young people.”²⁹

The influence of peers also comes out in the data. According to the theory of life tasks, the influence of peers is part of the process of growing up; specifically it is related to processes of psycho-social development. John R Chapin describes a life task as “a task which arises at or about a certain period in the life of an individual, successful achievement of which leads to happiness and to success with later tasks, while failure leads to unhappiness in the individual, disapproval from society, and difficulty with later tasks”.³⁰ Angela Huebner describes five psychosocial issues that teens deal with during their adolescent years:

- Establishing an identity: Finding answers to the question of “who am I?” This involves collecting and organizing the opinions of influential others (e.g. parents, other caring adults, peers etc) into one’s own likes and dislikes. The eventual outcome is a person who has a clear sense of their values and beliefs, occupational goals, and relationship expectations, and knowledge of where one fits or doesn’t want to fit in this world.
- Establishing autonomy: Becoming an independent and self-governing person within relationships. It involves acquiring the ability to make and follow through with one’s own decisions, live by one’s own set of principles of right and wrong, and become less emotionally dependent on parents.
- Establishing intimacy: Intimacy refers to close relationships in which people are open, honest, caring and trusting. Establishing intimacy involves learning how to begin, maintain and terminate relationships and practice social skills.
- Becoming comfortable with one’s sexuality: understanding and expressing ones sexual potential.

²⁹ UNDP.org, Rivers, Kim and Aggleton, Peter, Adolescent Sexuality, Gender and the HIV Epidemic, [http:// WWW.undp.org/hiv/publications/gender/adolesce.htm](http://WWW.undp.org/hiv/publications/gender/adolesce.htm) p.3

³⁰ Findarticles.com, Chapin, John R (2000) Adolescent sex and mass media: A developmental Approach. http://www.findarticles.com/p/articles/mi_m2248/is_140_35/ai_70777841/print p2

- Achievement: Seeing the relationship between one's current abilities and plans and one's future vocational aspirations. It involves figuring out what one is good at and what one is willing to strive to achieve.³¹

In dealing with these tasks, youths are exploring their identity and developing a sense of autonomy from their parents and family. They bond with their peers who are in a similar process of exploration. Through interaction with their peers, some of whom are non-abstinent, they are sometimes influenced to initiate sex. This influence comes in the form of transfer of erroneous information, encouragement, ridicule, and example.

This finding about peers having influence on the sexual behavior of youths is consistent with data from other parts of the world. A publication by the National Association of Social Workers (NASW) in the USA indicated that “teenagers are most likely to seek sexual information from their friends (61 percent).”³² Rivers and Angleton report a similar pattern: “there is evidence from elsewhere in Africa to suggest that peers have become a more important source of knowledge, advice and support. In Malawi, for example, sixty percent of girls recently interviewed reported having learned about menstruation from friends, not from grand mothers or advisors as traditionally occurred.”³³

According to Rivers and Angleton the increased influence of peer groups can be attributed to the weakening of traditional family expectations and structures in shaping sexual beliefs. This could be attributed to population movements and urbanization and the effect of working parents delegating parenting to other people, such as house maids, and traditional multi-generational extended families being replaced by nuclear families, lone

³¹ Hubner Angela, Adolescent growth and development, 2000, Family and Child Development, publication 350-850, Virginia Cooperative Extension, Virginia State Polytechnic Institute and State University. P.3

³² NASWDC.org, National Association of Social Workers (2001) Parents, peers, and pressures: Identifying the influences on responsible sexual decision-making. http://www.naswdc.org/practice/adolescent_health/ah0202.asp, p2

³³ UNDP.org, Rivers, Kim and Aggleton, Peter, Adolescent Sexuality, Gender and the HIV Epidemic, <http://WWW.undp.org/hiv/publications/gender/adolesce.htm> p.9

parent families, and child headed families.³⁴ Another contributing factor which they identify is the apparent reluctance of adults to talk to youths about sex, to an extent where the communication that exists may be infrequent, of poor quality, and carried out by adults who are less sure of their roles than in the past. This is no less true for teachers in schools as it is for adult kin and family members. In many countries teachers have reported being embarrassed to talk about the topic of sex, and being ill prepared for teaching about sexual matters.³⁵

There is still however an important role for parents in the sexual socialization of youths. Data from the National Association of Social Workers (NASW) indicates that:

- Although they are least likely to seek information from their parents (32 percent), a significant number of teenagers (43 percent) express a strong desire to have more information on how to talk to their parents about sex and relationship.
- Nearly 80 percent of teenagers indicate that what their parents have told them and what their parents might think influences their decisions about sex and relationship.³⁶

The mass media is one of the major influences that are available to adolescents in their process of identity exploration and formation. The media takes the form of books, magazines, films, and music. Adolescents see the media as a credible source of role models, information, and values. But the media is a plural medium containing both valuable and dangerous content. The media products have been shown in various studies around the world to be high in sexual content and low on content that show the hazards of sex. The National Association of Social Workers in the USA noted that images that pervade the media (television, music videos, the internet etc) are increasingly more explicit in sexual content. They observe that “more than half (56 percent) of all television

³⁴ UNDP.org, Rivers, Kim and Aggleton, Peter, Adolescent Sexuality, Gender and the HIV Epidemic, <http://WWW.undp.org/hiv/publications/gender/adolesce.htm> p.2

³⁵ UNDP.org, Rivers, Kim and Aggleton, Peter, Adolescent Sexuality, Gender and the HIV Epidemic, <http://WWW.undp.org/hiv/publications/gender/adolesce.htm> p.10

³⁶ NASWDC.org, National Association of Social Workers (2001) Parents, peers, and pressures: Identifying the influences on responsible sexual decision-making, http://www.naswdc.org/practice/adolescent_health/ah0202.asp, p.2

shows contain sexual content-averaging more than three scenes with sex per hour. For shows with sexual content, just 9 percent includes any mention of the possible risks of sexual activity, or any reference to contraception, protection, or safer sex.”³⁷ The situation is likely to be the same in Zambia because the vast majority of media programs are imported. Collins et al conducted a national longitudinal survey of 1,792 adolescents to measure the relationship between viewing sexual content on television and initiation of intercourse and advancement in non-coital sexual activity, during a one year period. Their finding was that there was “... substantial association between the amount of sexual content viewed by adolescents and advances in their sexual behavior during the subsequent year. Youths who viewed 1 SD more sexual content than average behaved sexually like youths who were 9 to 17 months older but watched average amounts of sex on TV.”³⁸ This finding is in agreement with the prediction of social learning theory that novel behaviors are modeled by others, and then observed and reproduced by observers. If the model is observed as being rewarded and re-enforced then imitation will be reinforced in the observer through vicarious reinforcement. Through this process, children exposed to sexual content in the media will (1) learn amorous techniques (2) have reduced sexual inhibitions, (3) have altered sexual attitudes about which behaviors are acceptable and which ones are not, and (4) develop new sexual practices.³⁹

At the same time the youths don't have the skills, experience and sophistication to filter what they get from the media so as to distinguish the useful content from the dangerous content. The media is therefore an important influence on the decision of youths to adhere or not to adhere to recommended methods for HIV prevention.

Traditional initiation was also identified as contributing to non-abstinence. At puberty, girls, and boys in some ethnic groups, pass through a stage of confinement where adult mentors teach them what they need to know about marriage, including matters of sex.

³⁷ NASWDC.org, National Association of Social Workers (2001) Parents, peers, and pressures: Identifying the influences on responsible sexual decision-making.

http://www.naswdc.org/practice/adolescent_health/ah0202.asp. p.3

³⁸ Pediatrics.aappublics.org, Collins Rebecca L et al Watching sex on television predicts Adolescent initiation of Sexual Behavior, <http://pediatrics.aappublications.org/cgi/content/full/114/3/e280> p13

³⁹ Findarticles.com, Chapin, John R (2000) Adolescent sex and mass media: A developmental Approach. http://www.findarticles.com/p/articles/mi_m2248/is_140_35/ai_70777841/print p.4

Rivers and Aggleton have observed that traditional initiation has its origins at a time when the transition from childhood to adulthood was sharper and less protracted and did not constitute “adolescence” as contemporarily understood.⁴⁰ In traditional societies initiates would have been available for marriage immediately after traditional initiation. In modern times many youths go through this training when they still have several years of schooling and professional training ahead of them before they get married. Youths leave this training feeling sexually competent but lacking practical experience. This disjunction between the content of traditional initiation and the circumstances of modern society is a source of pressure on the youths to experiment with pre-marital sex to satisfy their curiosity. Traditional initiation worsens the sexual problems of youths because even in a country like the United States the prolonged period of adolescence is a problem on its own even without traditional initiation. More et al have found that “... on average, there are seven years for women and ten years for men between first intercourse and first marriage. This creates a substantial interval of risk for non-marital pregnancy.”⁴¹

Poverty as a countervailing force against abstinence was another factor that came out in the data. This also has been observed in the literature. More et al have observed that family disadvantage, poverty, low educational aspirations, and limited economic opportunities are related to earlier unprotected sexual intercourse, unintended pregnancy, and unmarried adolescent parenthood. They explain that these factors reflect limited future opportunities or life options. Adolescents engage in risky sexual behavior because they believe that they have little to lose. Inversely adolescents who experience educational and job success and perceived positive future opportunities for themselves should have stronger motivation for avoiding early pregnancy and parenthood.⁴² Rivers and Aggleton however have explained a further aspect to the association between poverty and non-abstinence, which is that young people living in stressful situations may engage in “survival sex” in order to meet their need for shelter, food and adult protection. Young

⁴⁰ UNDP.org, Rivers, Kim and Aggleton, Peter, Adolescent Sexuality, Gender and the HIV Epidemic, <http://WWW.undp.org/hiv/publications/gender/adolesce.htm> p.8

⁴¹ ASPE.HHS.gov, More Kristin A et al, Beginning too soon: Adolescent sexual behavior, pregnancy and parent hood: A review of research and interventions. <http://aspe.hhs.gov/hsp/cyp/xsteesex.htm>. p.2

⁴² ASPE.HHS.gov More Kristin A et al, Beginning too soon: Adolescent sexual behavior, pregnancy and parent hood: A review of research and interventions. <http://aspe.hhs.gov/hsp/cyp/xsteesex.htm>. p.7

people in such situations are unable to make rational decisions on the basis of new information or practice newly acquired skills because they are constrained by the circumstances they find themselves in.⁴³

4.2 Analysis of non-adherence to Condom use

Having initiated sex, youths have the option to use condoms as protection or not to use condoms. The findings of this study have shown that youths are confronted by another array of factors that hinder them from using condoms.

The findings of this study show that the challenge of promoting condom use is not merely to inform youths about the protective value of condoms but to identify confront and change social knowledge circulating among the youths which indicate to the youths that condom use is of little value.

The data suggests that youths have doubts about the efficacy of condoms as an HIV prevention method. They believe that condoms have pores which are bigger than the HIV virus through which the virus is assumed to be able to pass.

At a technical level, the subject of the permeability of condoms to the human Immunodeficiency Virus (HIV) has had mixed results. For example, Drew WL et al conducted experiments using HIV contaminated female condoms fitted to an artificial intercourse model to see if the virus would be able to pass through. They did not detect viral leakage in three trials.⁴⁴ Their conclusion was that female condoms were a viable option for prevention of sexual transmission of HIV. In contrast, Lytle, C. David et al did an experiment to determine the proportion of male condoms that allow virus penetration and the amount of virus that penetrates. Their finding was that under test conditions, 2.6% (12 of 470) of the latex condoms allowed some virus penetration. Lubricated

⁴³ UNDP.org, Rivers, Kim and Aggleton, Peter, Adolescent Sexuality, Gender and the HIV Epidemic, <http://WWW.undp.org/hiv/publications/gender/adolesce.htm> p.11

⁴⁴ Pubmed.gov, Drew WL, Blair M, Miner RC, Conant M,(1990) Evaluation of the virus permeability of a new condom for women, <http://www.pubmed.gov>.

condoms performed similarly to non-lubricated ones. Polyurethane condoms yielded results higher than but not statistically different from those for latex condoms. Their conclusion was that a small proportion of new condoms do allow virus penetration but that, even for the few condoms that do allow virus penetration, the typical level of exposure to semen would be several orders of magnitude lower than for no condom at all⁴⁵. It has been reported that the church which is in favor of abstinence and is uncomfortable with the promotion of condoms has picked this ambiguity in permeability experiments to argue that condoms can not be trusted. Cardinal Alphonso Lopez Trujillo, President of the Vatican's Pontifical Council for the Family provoked condemnation from the World Health Organization when he said on a BBC program that condoms were permeable to HIV. His position was that "The AIDS virus is roughly 450 times smaller than the spermatozoon. The spermatozoon can easily pass through the "net" that is formed by the condom. These margins of uncertainty ... should represent an obligation on the part of the health ministries and all these campaigns to act in the same way as they do with regard to cigarettes which they state to be danger."⁴⁶ These beliefs about the permeability of condoms to HIV have been found to be repeated by Catholics as far apart as Asia and Latin America.⁴⁷ It seems likely that youths in Zambia could have received these countervailing messages on condom use, especially that the Catholic Church is the biggest Christian denomination in Zambia.

Youths also believe that condoms break often during use. The literature indicates that condom breakage during sex has been proven to occur. Health Presses Limited, at their web site called Embarrassingproblems.com, have quoted several researches that have been done on condom breakage. According to the web site:

⁴⁵ Stdjournal.com, Journal of the American Sexually Transmitted Diseases Association, Lytle, C. David, Routson, Licia B, Seaborn, Gerald B., Dixon, Lurlene G., Bushar, Harry F., Cyr, Howard W., (1997) An in vitro evaluation of condoms as barriers to a small virus, <http://www.stdjournal.com>

⁴⁶ Kaisernetwork.org, Daily HIV/AIDS report, Global challenges, Vatican Cardinal 'surprised' by reaction to statements about condoms, HIV prevention, http://www.kaisernetwork.org/daily_reports/rep_index.cfm?dr_id=20353

⁴⁷ Guardian.co.uk, Guardian Unlimited, Vatican: condoms don't stop AIDS, <http://www.gourdian.co.uk/aids/tory/0,7369,1059068,00.html>

- The University of Sydney, Australia, ran a study of condom breakage in three brothels. They supplied the fresh condoms, together with forms to fill in if there was an accident and little plastic bags to put the torn condoms in so the researchers could analyze in the laboratory how and why they tore. Of the 1,269 condoms the sex workers used, only 6 were broken. Next, they did a survey of ordinary men, and found that their breakage rates were far higher – about 7%, including breakages while putting the condoms on (Lancet 1989: 1487-88).
- A USA study asked 92 couples to keep a sex diary, totaling 4,637 condom usages. Six condoms split while being put on, and 13 split during sex – a total breakage rate of 0.41% (Contraception 1997; 56:3-12).
- French researchers did a telephone survey of 20,000 people, asking about condom breakage. The breakage rate seemed to be 3.4% (Am J Public Health 1997; 87:421-4).⁴⁸

Why do condoms break? Marjorie Greenfield explains that condom breakage happens most commonly among people who are unfamiliar with their use. Knowing how to properly put on the condom decreases its chances of breaking.⁴⁹ Health Press Limited, at their web site called Embarrassingproblems.com say damage caused to condoms during the process of removing the condom from its packaging could account for some of the breakage. They name damage caused by nails, teeth, scissors, knives and pencils.⁵⁰ Dr Myrtle on the A woman's Touch website gives three other reasons why condoms break:

- Using expired condoms
- Insufficient lubrication. She says “most condom breakages happen because the people using them have not used enough lubricant. Condoms, even if they come packaged ‘with lubricant’, need additional water based lubrication applied to them so that they will not develop small or large tears in them.”

⁴⁸ Embarrassingproblems.com, (2005) Health press Limited, Common problems with condoms, http://www.embarrassingproblems.com/condoms_b.htm p.2

⁴⁹ DRSPOCK.com, Greenfield M(2001) Barriers and spermicides for birth control, <http://www.drspock.com/article/0,1510,5421,00.html>. P.1

⁵⁰ A-womans-touch, How to avoid condom breakage, http://www.a-womans-touch.com/article/4/33/how_to_avoid_condom_breakage.html p1

- Using oil based products such as Vaseline, massage oil, cooking oil and so on. She says “Oil literally dissolves the latex structure, and leads to condom breakage in as little as 30 seconds.”⁵¹

It would appear that youths are correctly aware of the possibility of condoms breaking. It would appear also that youths would be prone to breakages because of inexperience in using condoms. Given that condoms are marketed as effective protection against HIV infection, the phenomenon of condom breakages, in the absence of adequate explanation of the causes, prevention, and probability of breakage, would tend to create doubts about their protective efficacy. Consequently youths believe that not using condoms during sex poses no more risk than is present when a condom is used.

The data also indicates that youths have doubts about the safety of using condoms; doubts which are unrelated to matters of HIV. Youths complain of uncomfortable body reactions, such as skin rashes and abdominal pains, which they experience after using condoms. Health press limited, at their web site called [Embarrassingproblems.com](http://www.embarrassingproblems.com) identify three possible sources of condom related sources of skin irritation:

- (1) Allergy to latex: this is said to be unusual but has been known to occur.
- (2) Reaction to nonoxynol 9 or nonoxynol 11, which are spermicides used as ingredients in some lubricated condoms.
- (3) Too much friction due to insufficient lubrication on the condom.

It would be understandable that youths would interpret these reactions as signs that condoms might be harmful if such reactions are not explained and a remedy suggested. Female youths also expressed fears that when condoms break during sex the fragments can cause internal health problems. This might be related to a fear of having foreign particles lodged in ones sensitive parts, especially if this is accompanied by irritation.

⁵¹ Embarrassingproblems.com, (2005)Health press Limited, Common problems with condoms, http://www.embarrassingproblems.com/condoms_b.htm p.1-2

Use of condoms was also found to be associated with implied mistrust and doubts about the health status and moral rectitude of a love partner. It was also found that youths seem to find this mistrust inappropriate in a steady relationship. Condom use is only seen as being justified when sex is done with prostitutes, as a one night stand, or with sexual partners who are suspected of having HIV or other sexually transmitted infections. For this reason youths resist condom use in a regular love relationship. Some youths do not use condoms because they think condom use is not necessary. They rely on an examination of their own sexual history and what they know of the sexual history of their partner to make an estimate of risk. If the partner has a good moral reputation, looks healthy, and is of good behavior they develop a sense of trust and conclude that the possibility of them having HIV is low and hence the use of condoms is unnecessary. This apparent need for trust among people in love might seem strange in the era of HIV, but recent studies show that love, sex and trust seem to be inbuilt in the human biological system. Research published by the Society for Neuroscience found that a chemical called dopamine, which is responsible for producing feelings of satisfaction and pleasure, and which plays a key role in attracting people back to sources of pleasure, such as food, and in keeping drug addicts hooked on heroin or cocaine is also active in people who are madly in love.⁵² They found that among most women in the study dopamine showed more activity in parts of the brain associated with reward, emotion, and attention, while for most men in the study dopamine activity was in regions of the brain associated with visual processing and sexual arousal. After studying this finding the researchers reached the following conclusion: “We believe romantic love is a developed form of one of three primary brain networks that evolved to direct mammalian reproduction. The sex drive evolved to motivate individuals to seek sex with any appropriate partner. Attraction, the mammalian precursor of romantic love, evolved to enable individuals to pursue preferred mating partners, thereby conserving courtship time and energy. The brain circuitry for male-female attachment evolved to enable individuals to remain with a mate long enough to complete species specific parenting duties.”⁵³ The implication of this finding is that

⁵² News.bbc.co.uk, BBC News (2005) Love like a drug, scientists say, <http://news.bbc.co.uk/2/hi/health/4498764.stm>. p.1

⁵³ Innovations-report.com, Society for Neuroscience (2003) Scientists uncover neurobiological basis for romantic love, trust, and self, <http://www.innovations-report.com/html/studies/report-23211.html> p.1

romantic love is inherently designed for sex and reproduction as the default function, and using condoms requires effort to override this biological programming. Such effort requires motivation and rationalization. It would explain why youths find it harder to use condoms in a steady relationship with a potential marriage partner who looks healthy.

In another study whose results were announced by the Society for neuroscience researchers monitored a hormone called oxytocin in an experiment to investigate trust which was described as “something that pervades nearly every aspect of our daily lives.” In animal studies oxytocin had been found to play a role in social recognition and social bonding, such as between mother and offspring and, among some monogamous species, between males and females in a family unit. In this study on humans, it was found that when someone observes that another person trusts them, levels of oxytocin in the blood rise, and that the stronger the signal of trust the higher the level of oxytocin. It was also found that the higher the levels of oxytocin the more trustworthy the subjects were, which was interpreted as meaning that people who felt they were trusted paid back by becoming even more trustworthy. From this study the researchers made the following observation: “Interestingly, participants in this experiment were unable to articulate why they behaved the way they did, but nonetheless, their brains guided them to behave in ‘socially desirable ways’, that is, to be trust worthy. This tells us that human beings are exquisitely attuned to interpreting and responding to social signals.”⁵⁴ If trust is an important part of our social interaction as human beings, and if trust is reciprocated by trust through a biologically driven subconscious process, it can be explained why there appears to be a demand for mutual and reciprocal trust in a romantic love relationship. It can be explained also why condoms are resisted, because they place mistrust where biological programming normally places trust to anchor intimate human relationships.

It was also established from the data that youths resist condom use because they perceive sex with condoms as fake sex. They initiate sex in order to satisfy their curiosity about how sex feels like and they want to experience the real thing. The condom as a barrier

⁵⁴ Innovations-report.com, Society for Neuroscience (2003) Scientists uncover neurobiological basis for romantic love, trust, and self, <http://www.innovations-report.com/html/studies/report-23211.html> p.2

method is seen as defeating this objective. There is also a belief that unprotected sex feels sensually better than sex with condoms. The study also found that some youths don't use condoms out of sheer indifference to the risk of HIV. Some are indifferent because they want children or they want to use pregnancy as a means to entrap a partner into marriage. There were also others who were indifferent because they felt that avoiding HIV was unsustainable or they had accepted the risk of HIV as an unavoidable reality of human existence.

This resistance to condoms on account of wanting "real" sex has been observed elsewhere. The most debated has been among the gay community in the USA. The gay community was the first to be affected by HIV and they were the first to initiate HIV prevention programs, including awareness programs and promotion of condom use, which were very effective. Later it was observed that some gay men had gone back to unprotected sex not as temporary lapses but as part of a conscious and organized sub-culture called barebacking. Michael Scarce describes this as follows: "Whereas some gay men have continued to engage in unprotected anal sex since the beginning of the AIDS epidemic, only lately has there emerged a heightened eroticization, premeditation, and form of structured organizing devoted to the practice of unsafe sex. An abundance of internet web sites, online chat rooms, e-mail listservs, personal ads, private parties, jargon and slang terminology, and even amateur and professional videos dedicated solely to barebacking, have been created in the past two years. A few of these venues extol the pleasures of intentional infection with HIV as well as the open exchanges of bodily fluids."⁵⁵ The reasons why gay men resist condoms seem to be the same as those given by the youths when they deliberately reject safety from HIV in favor of sexual pleasure. Michael Scarce identifies these reasons as need for increased physical sensation, a sense of greater connectedness or intimacy with their sex partner, excitement in transgressing the paternal proscriptions of many AIDS prevention campaigns, and sharing semen as a symbolic act of bonding.⁵⁶ It would appear that condom use seems to be attempting to

⁵⁵ [Managingdesire.org](http://www.managingdesire.org), Scarce, M (1998) [Back to barebacking](http://www.managingdesire.org/scarcebtb.html), <http://www.managingdesire.org/scarcebtb.html>p.1

⁵⁶ [Managingdesire.org](http://www.managingdesire.org), Scarce, M (1998) [Back to barebacking](http://www.managingdesire.org/scarcebtb.html), <http://www.managingdesire.org/scarcebtb.html>p.1

reconcile two strong human needs which in most contexts are both desirable, but in the context of HIV appear to be in opposition, namely happiness and safety. The issue of adherence to condom use is complex in that it has at one level a simple choice between life and death and at another level a more difficult choice between happiness and longevity. From this, it can be seen that different estimations of what constitutes rational self interest can arise depending on the frame of reference used, making it possible for actions which contradict public health goals to arise.

When youths do decide to use condoms they still find it difficult to buy condoms because of embarrassment. Condoms are sold in public retail outlets that do not provide for the privacy and confidentiality that youths need. Adolescence is a time of heightened self consciousness where youths believe that everyone is as concerned about their thoughts and behavior as they are. It is also a time when adolescents have not fully worked out issues of identity, autonomy, and sexuality.⁵⁷ Further more adolescent sex and pre-marital sex are not looked on with approval by mainstream society. Youths therefore find it difficult to buy condoms in a public place where they could be identified as being sexually active.

The data has also found that even when they have condoms in the pocket or in the room youths fail to use them. Youths appear to have an intense sexual urge which does not allow for a reasoned interruption of foreplay to wear a condom. They fail to use condoms because doing so contradicts the spontaneity which is dictated by the sexual urge. Anton Mischewski has explored this phenomenon where subjects who are knowledgeable about HIV find it difficult to explain or account for sessions or episodes of unsafe sex; where they say one thing led to another and sex just happened in the heat of the moment. He suggested that the role of desire in human sexual decision making is a neglected subject that looks promising in understanding some of the irrational behavior observed in the area of sex. He argues that "... The range of factors that mediate between knowledge and practice of safe sex and sexual practice could fruitfully be explored through the excluded

⁵⁷ Hubner Angela,(2000) Adolescent growth and development, Family and Child Development, publication 350-850,,Virginia Cooperative Extension, Virginia state Polytechnic Institute and State University. P.2-3

and marginalized notion of desire. I suggest that what is at stake here firstly, is the problematic place of reason and rationality in sexual conduct and secondly, the way we researchers and educators construct interpretations about those arenas of sexual conduct (especially unsafe sex) with recourse to reason.”⁵⁸

4.3 Analysis of non-adherence to HIV testing

Prior to initiating sex, or shortly afterwards, youths have the option of going for VCT to learn whether one of them has the HIV virus or not. The study found that youths do not do this for a number of reasons.

The study established that there is uncertainty among the youths about the benefits of VCT services as opposed to remaining ignorant of one’s HIV status. Youths tend to see VCT as a potential source of bad news with immediate and direct personal negative consequences while the benefits are seen as indirect, long term, speculative and theoretical. Ignorance of ones status is seen as offering stability and continuity in the present life circumstances while knowledge of an HIV positive result appeared to imply a negative change and uncertainty in life circumstances.

The study found that youths fear the psychological trauma that could result in the event that the test yields an HIV positive result. They fear that they could experience stress, depression, and lose of life purpose. They fear the life altering effect of knowing that they are HIV positive and they avoid taking the test because they are not sure they can handle the consequences. Depression is a human reaction related to the process of mourning when one suffers a serious loss such as when one loses a loved one or is told that one has a terminal illness. It has been identified that mourning has 5 stages, namely denial, anger, bargaining, depression, and acceptance.⁵⁹ Acceptance is the desirable condition, but before reaching that stage one passes through the other stages which are unpleasant, and

⁵⁸ Managingdesire.org, Mischewski, A, Does desire displace knowledge?, <http://www.managingdesire.org/Mischewski.html>

⁵⁹ GreaterSwiss.com, Five stages of mourning, <http://www.greaterswiss.com/mourning.htm> p1

depression is the most unpleasant of them all. It has been documented that depression does occur in HIV positive people as a reaction to knowledge of their HIV status. It is a serious medical condition that affects thoughts, feelings, and the ability to function in daily life and if untreated it has been known to result in suicide, murder, and acceleration of HIV's progression to AIDS. Recovery from depression takes time, and medications for depression take several weeks to work and may need to be combined with ongoing psychotherapy.⁶⁰ It would appear that youths have observed or heard about these potential effects of an HIV test and want to retain the security of ignorance.

It was also found that youths fear the stigma and discrimination that sometimes occurs when love partners, family members, and community members learn that someone is HIV positive. Youths fear that they will be blamed, rejected, and isolated by their social associates. They fear the emotional, social, and economic effects of stigma and discrimination. The issue of stigma and discrimination is broader than just the youths. The UNAIDS/WHO policy statement on HIV testing states as follows: "The current reach of HIV testing services remains poor: in low and middle income countries only 10 percent of those who need voluntary counseling and testing, because they may have been exposed to HIV infection, have access to it. Even in settings in which voluntary counseling and testing is routinely offered, such as programmes for prevention of mother to child transmission, the number of people who avail themselves of these services remains low in many countries. The reality is that stigma and discrimination continues to stop people from having an HIV test."⁶¹

Youths also appear to have doubts about the professionalism and effectiveness of the VCT services. They have doubts about the confidentiality of the VCT service both in terms of staff adhering to professional ethics and in terms of the heterogeneity of the clientele at the VCT centre which increases the likelihood of information reaching the wider community that a youth has sought VCT services. Youths also have doubts about

⁶⁰ 4therapy.com, [Depression and HIV](http://www.4therapy.com/consumer/conditions/item.php?uniqueid=7064&categoryid=41), <http://www.4therapy.com/consumer/conditions/item.php?uniqueid=7064&categoryid=41> p.1-5

⁶¹ WHO.INT, UNAIDS/WHO policy statement on HIV testing, <http://www.who.int/hiv/pub/vct/statement/en/index.html> p.1

whether the counseling service provided is adequate to assist them cope with the life changing effects of an HIV positive test result. The UNAIDS/WHO policy statement on HIV testing states that HIV testing services must provide “...assured access to integrated prevention, treatment and care services. The conditions under which people undergo HIV testing must be anchored in a human rights approach which protects their rights and pays due respect to ethical principles. Young people require special attention to their needs through provision of confidential youth friendly health services. Public health strategies and human rights promotion are mutually reinforcing.”⁶² It would appear from the data that the needs of youths for confidential youth friendly HIV testing services are not yet observed as being present by the youths, which contributes to their reluctance to go for HIV testing.

4.4 Analysis of non-adherence to Faithfulness

Having initiated sex, whether they are using condoms or not and whether they have been for an HIV test or not, youths can minimize the risk of HIV by remaining faithful to one sexual partner. They however do not do this for a number of reasons.

The study found that one of the reasons for unfaithfulness is sexual curiosity. Youths want to find out how a sexual partner who is darker, lighter, fatter, slimmer, shorter, taller than the current partner they have taste like sexually. Youths believe that different sexual partners differ in the quality of sexual satisfaction they provide and that some are more sexually satisfying than others. Unfaithfulness is then justified as an exploratory process to sample different partners in order to identifying the best sexual partner, possibly for marriage. Sometimes unfaithfulness is done for sexual variety to avoid monotony with one partner or as a fun hobby. All these factors are sometimes exacerbated by the use of traditional sexual potency herbs. This sexual curiosity has been observed even among adults. One woman who had been unfaithful is documented as saying “Looking back, I don’t regret any of it. I think I needed to see firsthand that the grass isn’t greener on the

⁶² WHO.INT, UNAIDS/WHO policy statement on HIV testing, <http://www.who.int/hiv/pub/vct/statement/en/index.html> p.1

other side. I no longer feel any guilty over my other guy! It was a blessing in disguise. He made me realize that I needed to change not my marriage but myself.”⁶³

The American Association of Marriage and Family Therapy distinguishes between sexual addicts and philanderers. They write that multiple affairs may indicate an addiction to sex, love or romance. Such addicts are driven by the passion of a new relationship and are compulsively attracted to the high and the anxiety release of sexual orgasm which however usually ends in feelings of shame and worthlessness. Philanderers on the other hand perceive infidelity as an entitlement of gender or status and take advantage of opportunities without guilt or withdrawal symptoms.⁶⁴ It is not known at what stage of life these propensities for unfaithfulness are developed; it might well be during the adolescent years.

Dissatisfaction with current love relationship was another factor identified as a cause of unfaithfulness. Unfaithfulness is sometimes used as a step towards ending the current relationship and starting a new one. The need to move on might be caused by too much acrimony in a relationship, or due to unmet sexual, financial, material or other expectation. Sometimes unfaithfulness is done as a revenge act to settle scores with an unfaithful partner. The same reasons for unfaithfulness have also been identified in studies on adult infidelity. Dattani Meera writes that “Studies suggest that one in three married British women has had, or is having an affair. And why? Well, unhappy marriages, craving a better sex life or having a husband who’s cheated are cited as the main reasons for straying.”⁶⁵

It was also found that some youths see unfaithfulness as a normal aspect of human relationships. Some had been cheated on by previous partners or they had observed other

⁶³ Ivillage.co.uk, the website for women, Meera Dattani, Why women stray, http://www.ivillage.co.uk/relationships/community/couples/articles/0,,598857_682622,00.html

⁶⁴ AAMFT.org, American Association for Marriage and Family Therapy, Infidelity, http://www.aamft.org/families/consumer_updates/infidelity.asp

⁶⁵ Ivillage.co.uk, the website for women, Meera Dattani, Why women stray, http://www.ivillage.co.uk/relationships/community/couples/articles/0,,598857_682622,00.html

people of either sex being cheated on by their partners. They have then developed a pessimistic attitude towards faithfulness in love relationships and they believe that attempting to uphold faithfulness as a standard or principle in a relationship is a form of self delusion. On this premise they themselves then become unfaithful to their partners.

4.5 Revisiting the adherence model

The model of adherence posited by the adherence conference classifies determinants of adherence by their primary originating sources: These are socio-economic related, health care team/ health care system related, condition/ disease related, therapy/ Treatment related, and patient/ intra-personal related. These classifications have been found to be applicable to the determinants of non-adherence to preventive methods for sexual transmission of HIV among the youths. It was also found to be possible to identify which categories of factors were predominantly responsible for non-adherence to each of the recommended methods for prevention of sexual transmission of HIV. This relationship is summarized in the table below:

Table 6: determinants of non-adherence and the adherence model

	Factor Category	Factors promoting non-adherence to recommended HIV preventive method	Preventive method affected
1.	Socio-economic related factors.	<ul style="list-style-type: none"> Economic: the influence of family disadvantage, and the use of sex to acquire monetary, material and other services. 	Abstinence, Faithfulness
		<ul style="list-style-type: none"> Social: The role of cultural beliefs and practices, the mass media and other socialization processes in motivating sexual need and directing sexual practice. 	Abstinence, faithfulness
		<ul style="list-style-type: none"> Relational: the role of inter personal influences, and of the power relationship between the persons involved, in directing sexual practice. 	Abstinence
2.	Health care team/ Health care system related factors.	<ul style="list-style-type: none"> Accessibility of health care services to different user groups such as girls, youths and rural people 	Condom , VCT
		<ul style="list-style-type: none"> Competence and professionalism of service staff 	VCT
3.	Condition/ disease related factors.	<ul style="list-style-type: none"> The stealth characteristics of HIV whereby sensory methods for disease detection such as sight or pain are unreliable or useless. 	Abstinence, condom use, VCT, Condom use, Faithfulness.
		<ul style="list-style-type: none"> The chronic nature of HIV whereby sickness and death from infection occurs in the long term rather than immediately. 	Abstinence, condom use, VCT, Condom use, Faithfulness.
4.	Therapy/ treatment related factors.	<ul style="list-style-type: none"> Product/ service effectiveness: doubts about the efficacy of condoms or counseling 	Condom use, VCT
		<ul style="list-style-type: none"> Product/ service availability: Unavailability of product. 	(Female)Condom use,
		<ul style="list-style-type: none"> Product/ service safety: Fears about the safety of using product. 	Condom use, VCT
		<ul style="list-style-type: none"> Product/ service usability: fears about confidentiality and privacy 	Condom sale points, VCT
5.	Patient/ intra-personal factors.	<ul style="list-style-type: none"> Psychological: emotions such as love, fear, and trust. 	Abstinence, condom use, VCT
		<ul style="list-style-type: none"> Biological: Hormones and physical growth; desire and sexual arousal 	Abstinence, condom use, faithfulness
		<ul style="list-style-type: none"> Cognitive: Awareness, semi-awareness, and non-awareness of recommendations or the need for their implementation. 	VCT
		<ul style="list-style-type: none"> Volitional: Willingness or unwillingness to implement recommendations based on considerations of risks and benefits of implementation. 	Abstinence, condom use, VCT, Faithfulness.

From the above table, the following patterns can be identified.

Adherence to abstinence is undermined by factors that fall in the two categories of socio-economic related and patient/ intra-personal related. Health care team/ health care system related factors, condition/ disease related factors, and therapy related factors appear to have very little role in impeding adherence to abstinence.

Adherence to Condom use is impeded by factors spread over all categories: socio-economic related, health care team/ health care system related, condition/ disease related, therapy/ Treatment related, and patient/ intra-personal related. However, factors under patient/ intra personal related had a dominant role over the others in impeding adherence.

Adherence to HIV testing is mainly impeded by patient/ intra-personal related factors, but socio-economic related, health care team/health care system related, and condition\ disease related factors also have a moderate impact in discouraging adherence. Therapy/ treatment related factors appear to have no role.

Adherence to Faithfulness is impeded by factors in the two categories of socio-economic related and patient/ intra-personal related factors. Health care team/ health care system related factors, condition/ disease related factors, and therapy related factors appear to have no role in impeding adherence to faithfulness.

From this analysis it is evident that non-adherence to recommended methods for prevention of sexual transmission of HIV among 15 to 24 year olds is determined by a complex of multi-faceted and interlinked factors.

Some of these factors are related to the social and economic circumstances and environment in which the youths live, the intra-personal dynamics within individuals, the perceived efficacy and credibility of the Health care team/ health care service delivery system that support the recommended methods, the unique condition/ disease

characteristics of HIV, and the quality and usability of the products associated with the recommended preventive methods.

These factors exist as reality to the youths, affecting their decisions and influencing their behavior. Adherence cannot be improved and HIV transmission cannot be reduced among the 15 to 24 year olds unless the workings of these determinants of non-adherence are understood and addressed.

The adherence model also posits that non-adherent behavior fall into three types, namely unwitting non-adherence, erratic non-adherence, and intelligent non-adherence.

Unwitting non-adherence is said to occur when people fail to understand fully either the specifics of the recommendation or the necessity for adherence to it.

Erratic non-adherence occurs when people who know both the specifics of the recommendation, and the necessity of adherence to it, and who want to adhere fail to adhere because of circumstantial factors outside their control.

Intelligent non-adherence occurs when people who know both the specifics of the recommendation and the necessity of adherence make a reasoned choice, though not necessarily a wise one, not to adhere partly or in full.

This typology proved difficult to use in classifying the types of non-adherence revealed by this study.

A possible example is the case of peer pressure which is a socially generated circumstance outside the individual and which could therefore be classified as a case of involuntary non-adherence, i.e. erratic non-adherence. On the other hand, succumbing to peer pressure is not an automatic occurrence. The people subjected to peer pressure go through a process of cost benefit analysis, and given the option of sex or abstinence they have the potential to choose either and different individuals do choose one or other of

these options. Succumbing to peer pressure can then also appear to be a case of voluntary non-adherence i.e. of intelligent non-adherence.

The typology appears to rely on the following conceptually distinct criteria:

- Choice versus circumstances
- Knowledge versus ignorance

The data available from this study however suggests that in real life it is not always possible to differentiate these criteria and determine in every case which one has been responsible for a particular behavior.

Knowledge can fall on a continuum ranging from full knowledge to partial knowledge to ignorance and the cutting points may not always be obvious as there is an inverse gradation and blending between the two extremes. The same continuum exists for the knowledge versus circumstances dichotomy where the influence of one category of factors can be stronger or weaker depending on the blending and interplay of the various factors. Further more the choice/circumstances paradigm interacts with the knowledge/ignorance paradigm to further complicate the interpretation and classification of people's behavior.

CHAPTER 5: CONCLUSIONS AND RECOMMENDATIONS

Youths are a precious resource as they present a window of hope for the future in the era of HIV. This study has revealed that that hope is under threat due to a number of factors that prevent the youths from adhering to the recommended methods for prevention of HIV transmission. The study has identified these factors and also shown that adherence is a complex variable determined by an array of factors that cut across several knowledge disciplines, such as biological, psychological, social, economic, political, and cultural. Further more, these factors interact within themselves and with each other in the domain of social reality.

It seems evident from the findings of this study that programming for HIV prevention among the youths requires equally sophisticated intervention models based on theoretical paradigms that cut across several knowledge disciplines. It would appear from the literature that not enough attention has been paid to the development of such models.

Many have observed that interventions to influence adolescent sexual risk behavior have tended to focus on the individual and have neglected the role of contextual factors and exposures in influencing sexual behavior (Di Clemente).⁶⁶ These interventions have been criticized on the basis that they a) assume a linear relationship between individual knowledge and individual behavior independent of the context in which the individual is located and, b) assume that decisions about HIV prevention are based on rational, volitional thinking with no regard to emotional responses that play a part in sexual behavior (Panos).⁶⁷ Other criticisms have been that sometimes the reasoning behind the design of the interventions has been fragmented and atheoretical, focusing exclusively on single variables or classes of variables (Werner-Wilson).⁶⁸ These criticisms appear justified in light of the determinants of non-adherence which have been revealed in this study.

These weaknesses might account for the relative modesty of the impact of HIV prevention programs as compared to the heavy investment that has been made, and the growing frustration over this circumstance. There is a growing body of opinion that current intervention strategies are necessary and show some results in the short term but are not sufficient to promote the adoption and maintenance of HIV prevention behaviors for prolonged periods due to the effect of pervasive counter veiling factors, such as those

⁶⁶ Di Clemente, Ralph. J, Wingood, Gina. M. (April 2003) Human immunodeficiency virus prevention for adolescents: Windows of opportunity for optimizing intervention effectiveness, Archives of Pediatrics and Adolescent Medicine, vol 157, No. 4, Atlanta GA. Pp. 319-320.

⁶⁷ The panos institute (2003) Missing the message? 20 years of learning from HIV/AIDS, London; The Panos Institute. Pp. 19-20.

⁶⁸ Findarticles.com, Werner-Wilson , Ronald, J. (Fall 1998) Gender differences in adolescent sexual attitudes: The influence of individual and family factors, http://findarticles.com/p/articles/mi_m2248/is_131_33/ai_53368567/print, (access gained 01 February 2006). P.1

documented in this study, that encourage risky behaviors, and due to sheer lack of sufficient depth and scope to address the complexity of these factors. The PANOS report entitled **Missing the message? 20 years of learning from HIV/AIDS** summarizes the feeling thus: “There has never been a time when fighting AIDS has been such a global policy concern. Determined, courageous, insistent advocacy by people from the highest level of government right through to those at the frontline of civil society has succeeded in making the response to this pandemic a top priority within international development. (...) There has also never been a time when so much energy has been translated into so little hope: so little hope that the pandemic will be contained in the medium term, and so much concern that the strategies being pursued are not those which will have the greatest effect in the long term.”⁶⁹

The researcher would suggest from his examination of the findings of this study that a possible solution to this problem might be to develop an integrating model such as the adherence model developed by the adherence conference within which classes of determinants of non-adherence such as biological, psychological, social, economic, political, cultural and so on can be located. Based on research, such as this one, which identifies the specific determinants of non-adherence to each specific recommended HIV prevention method, a process of identifying theoretical frameworks from any discipline which best explain the observed factors can be initiated. The next step would be to identify theoretically logical remedies for each observed factor within the context of the relevant theoretical framework. The final step would be to test out these solutions through pilot studies and, if successful, followed-up with fully fledged interventions.

This approach would have several advantages:

- It would produce theoretically well grounded intervention models that are focused on the real factors and circumstances confronting the youths in relation to adherence to HIV preventive recommendations.

⁶⁹ The panos institute (2003) Missing the message? 20 years of learning from HIV/AIDS, London; The Panos Institute. P. 3.

- It would produce interventions that have the scope and depth to capture the wide range of determinants of non-adherence and make an impact on them in the long term.
- It would avoid the generality of trying to premise interventions on general prerequisites for human behavior change and instead premise them on the specific determinants of non-adherence to specific recommended preventive methods for HIV prevention.

It is the contention of the researcher that this cocktail of theoretically well grounded intervention models focused on specific determinants of non-adherence to specific recommended HIV preventive methods might contribute to improved efficacy and long term impact of HIV prevention programs among the youths.

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APPENDICES

Appendix 1: Basics of conducting focus groups

Basics of Conducting Focus Groups

Written by Carter McNamara, PhD | Applies to nonprofits and for-profits unless noted
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This document contains the following sections:

[Preparing for Session](#)

[Developing Questions](#)

[Planning the Session](#)

[Facilitating Session](#)

[Immediately After Session](#)

Also see

[Related Library Links](#)

[On-Line Discussion Groups](#)

Focus groups are a powerful means to evaluate services or test new ideas. Basically, focus groups are interviews, but of 6-10 people at the same time in the same group. One can get a great deal of information during a focus group session.

Preparing for Session

1. *Identify the major objective of the meeting.*
2. *Carefully develop five to six questions (see below).*
3. *Plan your session (see below).*
4. *Call potential members to invite them to the meeting.* Send them a follow-up invitation with a proposed agenda, session time and list of questions the group will discuss. Plan to provide a copy of the report from the session to each member and let them know you will do this.
5. *About three days before the session, call each member to remind them to attend.*

Developing Questions

1. *Develop five to six questions* - Session should last one to 1.5 hours -- in this time, one can ask at most five or six questions.
2. *Always first ask yourself what problem or need will be addressed by the information* gathered during the session, e.g., examine if a new service or idea will work, further understand how a program is failing, etc.
3. *Focus groups are basically multiple interviews.* Therefore, many of the same guidelines for conducting focus groups are similar to conducting interviews (see the [Basics of Conducting Interviews](#)).

Planning the Session

1. **Scheduling** - Plan meetings to be one to 1.5 hours long. Over lunch seems to be a very good time for other to find time to attend.
2. **Setting and Refreshments** - Hold sessions in a conference room, or other setting with adequate air flow and lighting. Configure chairs so that all members can see each other. Provide name tags for members, as well. Provide refreshments, especially box lunches if the session is held over lunch.
3. **Ground Rules** - It's critical that all members participate as much as possible, yet the session move along while generating useful information. Because the session is often a one-time occurrence, it's useful to have a few, short ground rules that sustain participation, yet do so with focus. Consider the following three ground rules: a) keep focused, b) maintain momentum and c) get closure on questions.
4. **Agenda** - Consider the following agenda: welcome, review of agenda, review of goal of the meeting, review of ground rules, introductions, questions and answers, wrap up.
5. **Membership** - Focus groups are usually conducted with 6-10 members who have some similar nature, e.g., similar age group, status in a program, etc. Select members who are likely to be participative and reflective. Attempt to select members who don't know each other.
6. **Plan to record the session with either an audio or audio-video recorder.** Don't count on your memory. If this isn't practical, involve a co-facilitator who is there to take notes.

Facilitating the Session

1. **Major goal of facilitation is collecting useful information to meet goal of meeting.**
2. **Introduce yourself and the co-facilitator, if used.**
3. **Explain the means to record the session.**
4. **Carry out the agenda** - (See "agenda" above).
5. **Carefully word each question** before that question is addressed by the group. Allow the group a few minutes for each member to carefully record their answers. Then, facilitate discussion around the answers to each question, one at a time.
6. **After each question is answered, carefully reflect back a summary of what you heard (the note taker may do this).**
7. **Ensure even participation.** If one or two people are dominating the meeting, then call on others. Consider using a round- table approach, including going in one direction around the table, giving each person a minute to answer the question. If the domination persists, note it to the group and ask for ideas about how the participation can be increased.
8. **Closing the session** - Tell members that they will receive a copy of the report generated from their answers, thank them for coming, and adjourn the meeting.

Immediately After Session

1. **Verify if the tape recorder, if used, worked throughout the session.**
2. **Make any notes on your written notes**, e.g., to clarify any scratching, ensure pages are numbered, fill out any notes that don't make senses, etc.
3. **Write down any observations made during the session.** For example, where did the session occur and when, what was the nature of participation in the group? Were there any surprises during the session? Did the tape recorder break?

Appendix 2: Descriptive data for group one respondents

No.	Income Strata	Gender	Age Category	Occupation	Age	Age at 1 st sex	Age of 1 st child	No. of children	Highest education attained
1	High	Girl	20-24	Business	23	17	5	1	Grade 9
2	Medium	Girl	20-24	Business	24	16	5	1	Grade 12
3	Medium	Girl	20-24	Business	23	15	5	1	Grade 12
4	High	Girl	15-19	Student	18	17	0.7	1	Grade 11
5	Medium	Girl	15-19	Nil	18	15	1+	1	Grade 8
6	Medium	Girl	15-19	Nil	19	17	1+	1	Grade 12
7	Low	Girl	15-19	Student	17	14	1+	1	Grade 12
8	Low	Girl	15-19	Student	16	13	0.2	1	Grade 8
9	Low	Girl	15-19	Nil	19	17	1	1	Grade 7
10	Low	Girl	15-19	Student	19	16	1+	1	Grade 8
11	Low	Girl	15-19	Nil	18	16	2	1	Grade 8
12	Medium	Boys	15-19	Nil	18	10	0.3	1	Grade 9
13	Low	Boys	15-19	Nil	18	8	0.1	1	Grade 7
14	Low	Boys	15-19	Nil	17	14	1	1	Grade 10
15	High	Boys	15-19	Nil	19	19	0.8	1	Grade 9
16	High	Boys	15-19	Student	19	19	2	1	Grade 9
17	Medium	Boys	15-19	Nil	19	15	1	1	Grade 9
18	Low	Boys	20-24	Business	22	18	2	1	Grade 12
19	Low	Boys	20-24	Driver	21	19	1	1	Grade 8
20	Low	Boys	20-24	Business	23	15	8	4	Grade 7
21	Low	Boys	20-24	Business	24	15	6	2	Grade 12
22	Medium	Boys	20-24	Nil	22	20	0.4	1	Grade 12

Appendix 3: Descriptive data for group two respondents

No.	Income Strata	Sex	Age	Occupation	Age at 1 st sex	Age of 1st child	No. of children	Highest education attained
1	High	Male	20	student	18	0	0	12
2	High	Male	22	student	13	0.1	1	college
3	High	Female	23	business	19	1.9	1	12
4	High	Female	22	Business	17	2.4	1	12
5	High	Female	24	Business	19	5	2	11
6	High	Female	20	student	15	3	2	12
	Low	Male	24	Business	16	3	2	9
7	Low	Male	23	Business	18	4	2	12
8	Low	Male	23	Business	15	3	1	9
9	Low	Male	17	student	15	2	1	8
10	Low	male	21	Business	15	0.2	1	9
11	Low	male	24	business	14	3	1	12
12	Low	male	24	business	20	3	1	12
13	Low	female	24	Business	22	1.1	1	11
14	Low	Female	24	Business	16	4	1	8
15	Low	female	22	business	14	3	1	4
16	Low	female	20	business	16	3	1	7
17	Low	female	22	Business	15	8	2	7
18	Low	female	23	Business	16	3.5	1	7
19	Low	female	20	student	14	2	1	8
20	Low	female	22	business	17	0.6	1	9
21	Low	female	22	business	20	2	1	9
22	Medium	male	23	Business	12	2	1	11
23	Medium	male	23	Business	15	2	1	9
24	Medium	male	23	business	12	5	1	12
25	Medium	male	24	Business	16	4	1	11
26	Medium	male	24	student	15	3	1	12
27	Medium	male	24	student	16	3	1	9
28	Medium	male	22	bar man	16	0.9	1	7
29	Medium	female	23	Maid	18	9	1	9
30	Medium	Female	21	student	18	3	1	12
32	Medium	female	22	student	17	1.9	1	12
33	Medium	female	22	Maid	16	6	1	9

:

Appendix 4: Consent form

Title of project: Determinants of non-adherence to recommended preventive methods for sexual transmission of HIV among 15 to 24 year olds in Livingstone

Name of researcher: Sitwala Mungunda

1. I confirm that I have read and understood the attached information sheet for the above study and have had the opportunity to ask questions.
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my legal rights being affected.
3. I agree to take part in the study.

_____	_____	_____
Name of participant	Date	Signature

_____	_____	_____
Name of parent/ guardian giving consent	Date	Signature

_____	_____	_____
Researcher	Date	Signature

Sitwala Mungunda,
CHANGES PROGRAMME
Ministry of Education
P.O.Box 61223
Livingstone.

Tel: 03-320821
Cell: 095-838434

17th August 2004

To Whom It may concern.

RE: Research on why youths do not use the recommended methods for preventing sexual transmission of HIV.

I am a *Zambian* working for the CHANGES Programme under the Ministry of Education.

I am studying for a Masters Degree in Social Work with the University of South Africa by distance education. One of the requirements in my studies is that I should conduct a research on an important social problem and write a book on my findings. To fulfill this requirement, I have chosen to research on the following question:

What reasons do the young people aged 15 to 24 year olds have for not using the recommended methods for preventing sexual transmission of HIV, such as abstinence, use of condom, going for HIV testing, or remain faithful to one partner?

To answer this question I am looking for young people to interview:

- I am looking for young men aged 15 to 24 years old. These people must have at least one child and must be single (not married).
- These people will be interviewed in groups of 8 people at a time. There will be 4 separate groups.
- Boys will be interviewed separately from girls, and 15 to 19 year olds will be interviewed separately from the 20 to 24 year olds.
- Each group interview will last approximately two (2) hours.

- When the research findings are published actual names of participants will NOT be used. Confidentiality will be completely respected. We are interested in the REASONS that young people have for their behavior, not in their names.

Drinks and snacks will be provided to all the participants and a transport allowance of K10, 000 will be provided to each participant.

The group interviews will be conducted at the Ministry of Education CHANGES office, located at plot 150/1 Kuta way, next to Society for family Health. Dates for these group interviews will be communicated to all once all those participating have been identified.

I will be very grateful if you can assist me in this assignment.

Yours Sincerely,

Sitwala Mungunda

Appendix 5: Registration questionnaire

CODE NUMBER:	
NAME:	
PHYSICAL ADDRESS:	
SEX (Male Female):	
PRESENT AGE:	
AGE AT FIRST SEX:	
NO. OF CHILDREN:	
AGE OF FIRST CHILD:	
HIGHEST EDUCATION ATTAINED:	
OCCUPATION:	

Appendix 6: Focus group agenda

1. Registration
2. Welcome and introductions
3. Review of purpose of the focus group discussion
4. Review of agenda
5. Review of ground rules
6. Questions and answers
7. Summary of issues
8. Wrap-up

Appendix 7: Focus group ground rules

1. Keep focused
2. Maintain momentum
3. Get closure on questions

Appendix 8: Programme

Saturday		
15-19yrs Boys	Morning	09:00-11:00hrs
20-24yrs Boys	Afternoon	14:00-16:00hrs
Sunday		
15-19yrs Girls	Morning	09:00-11:00hrs
20-24yrs Girls	Afternoon	14:00-16:00hrs

Appendix 9: Focus group discussion guide: group 1

1. INTRODUCTORY QUESTIONS

Do you know HIV and AIDS?

Do you know that HIV can be contracted through penetrative sex?

Do you know that you can prevent sexual transmission of HIV by using the following methods? (See definitions)

- i. Abstinence
- ii. Condom use
- iii. HIV testing
- iv. Mutual faithfulness.

2. DISCUSSION QUESTIONS

Abstinence

- What caused you to stop abstinence?
Or
- What are the difficulties in using abstinence as a method for HIV prevention?

Condom use

- What caused you not to use condoms?
Or
- What are the difficulties in using condoms as a method for HIV prevention?

HIV testing

- What caused you not to use HIV testing services?
Or
- What are the difficulties in using HIV testing as a method for HIV prevention?

Mutual faithfulness.

- What caused you not to be faithful to one partner?
Or
- What are the difficulties in using faithfulness as a method for HIV prevention?

Appendix 10: Focus group discussion guide: group 2

1. INTRODUCTORY QUESTIONS

Do you know HIV and AIDS?

Do you know that HIV can be contracted through penetrative sex?

Do you know that you can prevent sexual transmission of HIV by using the following methods? (See definitions)

- v. Abstinence
- vi. Condom use
- vii. HIV testing
- viii. Mutual faithfulness.

2. DISCUSSION QUESTIONS

Five months ago we met with youths from your residential areas and asked them the following questions:

Abstinence

- What caused you to stop abstinence?
Or
- What are the difficulties in using abstinence as a method for HIV prevention?

Condom use

- What caused you not to use condoms?
Or
- What are the difficulties in using condoms as a method for HIV prevention?

HIV testing

- What caused you not to use HIV testing services?
Or
- What are the difficulties in using HIV testing as a method for HIV prevention?

Mutual faithfulness.

- What caused you not to be faithful to one partner?
Or
- What are the difficulties in using faithfulness as a method for HIV prevention?

From their answers, it appears their reasons are as follows:

Abstinence

- Natural development of sexual drive
- Peer pressure
- Exposure to pornographic materials and acts
- Deliberate enticement by members of the opposite sex
- Force of habit and sexual addiction
- Intimidation and threat of violence from members of the opposite sex
- Power of love and perception of sex as proof of love

Condom use

- Power of desire and need for sexual spontaneity
- Failure to buy condoms due to embarrassment
- Mistrust of condoms
- Need for trust based relationship
- Indifference to the risk of HIV
- Lack of availability of condoms
- Stigmatization of condoms
- Need for sexual authenticity
- Ulterior motives

HIV testing

- Fear of the psychological impact of an HIV positive test result
- The stealth nature of HIV
- Fear of stigma and discrimination
- Partners resistance
- Lack of confidence in VCT staff and ignorance of VCT procedures

Faithfulness

- Retaliatory unfaithfulness
- Imitation of unfaithful role models
- Need for variety of sexual experiences
- Unfulfilled monetary and sexual expectations in relationship
- General disillusionment with faithfulness of members of the opposite sex
- Need for access to sex whenever needed
- Unfaithfulness as transitional step to ending a relationship

TASK FOR THE GROUP

You are required to do the following:

1. Discuss each of these reasons and confirm if you agree or not. You are free to add or subtract any item but you have to give reasons.
2. Rank these items in terms of which one is the strongest reason, second strongest. Third strongest and so on.