

Attitudes, Beliefs and Knowledge About HIV Prevention for Children

Findings from Uganda and Zambia

In many communities, the extended family system and other traditional safety nets responsible for orphans and vulnerable children (OVC) are being severely strained by the multiple, mutually reinforcing impacts of HIV and AIDS. Building on proven strategies, World Vision continues to seek cost effective ways to help communities provide care for the unprecedented number of children and families made vulnerable by the pandemic. Through the Models of Learning programme, World Vision has developed a strategy that interlinks three core programming models to address the needs of children and others affected by HIV and AIDS.

The pilot phase of this strategy was implemented in Uganda and Zambia from 2002-2004. Assessments revealed that the three models are feasible, acceptable, and effective, although the level of impact is difficult to quantify. In order to enhance its understanding about the costs, effectiveness and impact of these programming models, World Vision designed an Operations Research (OR) project to be conducted in two Area Development Programmes (ADPs) where these models had not been previously implemented.

Addressing the needs of children affected by HIV and AIDS World Vision's three core programming models

1. **HIV Prevention for Children:** Equipping girls and boys with values-based life skills for HIV prevention
2. **Community Care Coalitions (CCCs):** Facilitating community-led care for orphans and vulnerable children through the mobilisation and strengthening of community care coalitions
3. **Channels of Hope (CoH):** Sensitising churches and other faith communities to the needs of people affected by HIV and AIDS, and mobilizing them to respond positively and constructively.

This document focuses on the first of the three core models: HIV prevention for children. This model aims to equip children aged 5–15 years to make healthy life choices and avoid acquiring HIV. The first step in the research process, prior to initiating the intervention, was to conduct a baseline assessment exploring gender and other key sociocultural factors in the community facilitating or hindering effective HIV prevention strategies.

Methodology – How was this Assessment Conducted?

In the two rural areas assessed – one in Zambia and the other in Uganda – *baseline data* was collected to gauge attitudes, beliefs and knowledge *before* WV began implementation. Both qualitative and quantitative data were collected from:

- ❖ Men and women in the communities who are considered to be opinion leaders;
- ❖ Boys and girls aged 10 – 17 years;
- ❖ Primary caregivers of children in the households;
- ❖ Adult household members; and
- ❖ Leaders and representatives of all the churches and other FBO congregations, relevant government ministries, NGOs and CBOs working in the area.

The research team initially conducted focus group discussions, in-depth and key informant interviews with 180 respondents in Zambia and 222 respondents in Uganda in order to identify the core practices, issues and beliefs around HIV and AIDS, with primary focus on children. This process was followed by the development and implementation of a quantitative survey informed and shaped by the qualitative findings.

The first *post-intervention* qualitative data will be collected in April 2006, after six months of implementation, and the quantitative surveys will be conducted in November 2006, and thereafter in November 2007 and July 2009. The findings described in this document are based on the baseline data collected between July and August 2005 from the two study ADPs.

	Uganda ADP	Zambia ADP
FBO, NGO & CBO leaders and representatives interviewed	270	246
Adults interviewed (aged 18-59)	838	650
Children interviewed (aged 10-17)	656	380

What did the Baseline Survey Show?

The data served to illuminate important points about the attitudes, beliefs and knowledge of both adults and children regarding HIV transmission and prevention, including condom use and abstain/be faithful/use condoms (ABC) information, abstaining from sex until marriage, sexual coercion and perpetration of sexual abuse.

Attitudes towards Condom Use and Provision of ABC Information

Qualitative data showed some groups, especially religious leaders, displayed disparaging attitudes towards condoms and strongly opposed their use.

Results from the quantitative surveys, however, demonstrate that although the number of interviewees who chose ‘use condoms’ in prevention messaging is lower than for ‘abstinence’ and ‘being faithful,’ some parents and religious leaders approve of the provision of condom information to children aged 5-17 and youth aged 18-24 years.

Approval for provision of ABC HIV prevention information	
Abstinence for children aged 5-17 years	51% - 87%
Abstinence for youth 18-24 years	61% - 97%
Be faithful for children aged 5-17	42%-70%
Be faithful for youth aged 18-24	62% - 94%
Condom use for children aged 5-17	39% - 57%
Condom use for youth aged 18 – 24	64% - 91%
Children ever received ABC prevention information	
Abstinence from parents	22% Zambia 38% Uganda
Abstinence from religious meetings	23% Zambia 25% Uganda
Be faithful from parents	16% Zambia 27% Uganda
Be faithful from religious meetings	16% Zambia 21% Uganda
Condom use from parents	08% Zambia 23% Uganda
Condom use from religious meetings	09% Zambia 13% Uganda

Attitudes towards condoms

R1 “We as Muslims preach against condom use. They just have increased the rate of infection since they are not used consistently. People use them at the beginning and abandon them when they get used to each other” R2 “ ... the condoms are not reliable”. R3 “Condoms promote promiscuity. Therefore, as Muslims we don’t agree to their use” R4 “ ... we advocate for abstinence”
FBO/ Muslim focus group participants, Uganda

“I am a pastor, we advise the youth to conduct themselves in a God fearing way, not to think of condoms, abstain until marriage”
Male Community Leaders focus group participant, Uganda

Apart from condom use in Uganda, where the FBOs had the lowest approval, children expressed the lowest approval for provision of ABC compared to adults and FBO respondents. Parents report that they provide ABC information to their children, and religious leaders do the same in religious meetings. Responses from children confirm this to be the case. In Uganda, children were more likely to receive ABC information from parents than from religious meetings.

HIV Awareness and Knowledge about Transmission and Prevention

Basic HIV awareness was almost universal among adults in both countries (between 95 and 100% among adults and FBO/NGO/CBO respondents), but not among child respondents (63% in Zambia & 93% in Uganda).

Sources of HIV information mentioned most frequently		
ZAMBIA		
Children	Adults	FBO/NGO/CBO
1. Radio 47	1. Radio 71	1. Radio 79
2. Schools 42	2. Friends 36	2. Religious 43
3. Friends 40	3. Religious 27	3. TV 35
4. Religious 20	4. Public meet 26	4. Friends 32
		4. Leaders 32
		6. Print media 24
UGANDA		
Children	Adults	FBO/NGO/CBO
1. Radio 73	1. Radio 86	1. Radio 91
2. Schools 52	2. Friends 31	2. Public meet 49
3. Friends 28	2. Public meet 31	3. Friends 32
4. Leaders 15	4. Religious 18	3. Leaders 32
	5. Religious 23	
	6. Print media 22	
	7. WV staff 21	

The majority of all respondents (between 79% and 95% in Zambia and 87% and 99% in Uganda) had been exposed to HIV information in the 12 months prior to the date of the interview. For those exposed, radio was the highest single source of HIV information for all the groups in both countries. While other sources of information varied, a significant number of respondents mentioned schools, friends/peers, religious meetings, public meetings and community leaders.

Although exposure to HIV knowledge was high, knowledge of methods of HIV transmission and prevention was low, particularly among the children. The FBO/NGO/CBO respondents had the highest level of exposure to information and knowledge of HIV in both countries. Infection through 'sexual intercourse,' 'injection with non-sterile needles' and 'contact with infected blood' were mentioned by more than 20 percent of respondents in each group. The various methods of mother-to-child transmission (MTCT) were virtually unknown.

A significant number of respondents had misconceptions and incorrect knowledge of HIV transmission such as the belief that one can contract HIV through casual contact with an infected person, or through insect bites. Respondents in Zambia had lower HIV knowledge and more misconceptions than their Ugandan counterparts.

Knowledge of HIV Prevention and Transmission Methods

	Zambia			Uganda		
	Child N=380	Adults N=650	FBO/NGO/ CBO N=246	Child N=656	Adult N=838	FBO/NGO/CBO N=270
Transmission: No knowledge of HIV transmission method (<i>could not name a single correct method of transmission</i>)	42	6	2	12	1	0
Transmission: Incorrect transmission method mentioned (<i>named myths and misconceptions as forms of transmission</i>)	51	71	60	62	36	33
Prevention: No knowledge of HIV prevention method (<i>could not name a single correct method of prevention</i>)	64	18	7	22	6	0
Combined: No knowledge of HIV transmission and prevention method (<i>those who could not name a single correct method for prevention or transmission</i>)	41	5	2	10	1	0

Abstaining from Sex until Marriage

Attitudes in support children abstaining from sex until marriage was high particularly in Uganda, and among FBO/NGO/CBO representatives in Zambia (both over 90%). Slightly above 70% of the children and 81% of adults in Zambia expressed the view that male and female children should abstain from sex until marriage.

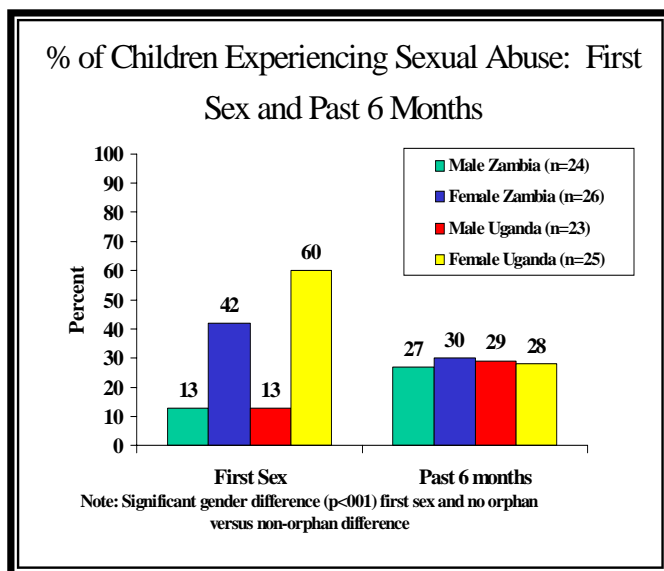
Seventy nine percent of the children in Zambia and 94% in Uganda reported that they could abstain from sex until marriage. A significantly higher proportion of girls (89%) than boys (71%) in Zambia reported that they could abstain from sex until marriage.

Despite the fact that a high proportion of children reported that they could wait until marriage, significant numbers reported that they had already had sex. In Zambia, more than a third of the girls (38%) and a quarter of the boys (26%) aged between 15 and 17 years 'had ever had sex'. In Uganda, slightly lower proportions of girls (23%) and boys (21%) of the same age group were already sexually active. According to the survey results in both countries, boys start having sex earlier than girls. But by age 13, the gender differentiation disappears and by age 15, more girls are having sex than boys.

Sexual Coercion

Sexual coercion is a prominent factor in children’s initiation of sexual intercourse. Although girls were significantly more likely to report their first sexual encounter as ‘coerced’, significant proportions of boys in both countries reported experience of sexual abuse¹. There was no significant difference in reported experience of sexual abuse between orphan and non-orphan children.

In addition to stratifications based on poverty and modern cash economy values, gender-based cultural practices also play a significant role in increasing children’s vulnerability to sexual abuse. These include:



- The culture of girls’ abduction among the pastoralist groups in Katwe ADP in Uganda – leads to forced early marriage and sexual initiation.
- Separate accommodation for girl children in Keembe ADP in Zambia --by moving out of her parents’ house into her own hut at age 13, a girl experiences increased vulnerability to sexual abuse.
- Institutionalized sexual abuse of boys through the practice of ‘sexual cleansing’ of a widow by the boy to cleanse the widow of her husband’s ghost. In response to the AIDS pandemic, some individuals are adopting ‘symbolic’ sexual cleansing practices such as having the naked boy slide through the thighs of the widow, instead of engaging in penetration.

¹ Defined as having sex because s/he was (i) persuaded with money, gifts and other favours (ii) tricked (iii) feared the implications of refusal to have sex with the person (iv) forced through threats (v) raped

Perpetrating Sexual Abuse

The study found legal and community responses to sexual abuse in both countries to be inadequate. Reasons for the inadequacy include ignorance about sexual rights under the law; prevailing cultural beliefs which fail to recognize various practices as ‘sexual abuse’; under-reporting of the abuse due to a culture of silence; and a tendency to blame the victim of the sexual assault instead of the perpetrator.

Blaming the Victim

R1 “You find the boys who smoke marijuana, when they call you and you refuse, they chase you”
Chorus “Yes they run after you and take you to the bush and rape you....”
R5 “They cover your mouth, if they don’t, you raise an alarm and then they run away.”
Moderator: And when they run away and people come, what happens?
R1 “They check if he raped you and if he did, they arrest him.”
R2 “If he does not use force but threats and starts slapping you, even if you tell people at home, nothing will be done to him....”
Chorus “They keep quiet and say ‘those are your issues’”
R3 “ Yes they say you had planned...”
 (Female OVC age 15 FGD Participants - Uganda)

Perpetration of sexual abuse begins early, particularly among males, and continues into adulthood. Five percent of male children (aged 10-14) in Zambia, and 2% in Uganda, reported that *they* had been the perpetrators of sexual abuse.

For children of ages 15-17, 16% had perpetrated sexual abuse in Zambia and 7% in Uganda. More than one-third of adult male household members in both countries had perpetrated sexual abuse; and 25% and 17% (for Zambia and Uganda respectively) of FBO/NGO/CBO leaders reported ‘ever having perpetrated sexual abuse’.

Females also are perpetrators of sexual abuse but the proportions were significantly lower than those of their male counterparts.

Other Cultural Beliefs and Practices

The study also revealed various other sociocultural factors and practices (many of which are gender-based) that increase HIV risk and vulnerability.

- The practice of infertility treatment in Uganda results in the traditional healer having unprotected sex with his female clients
- The practice of securing the baby boy’s manhood, and opening the baby girl’s reproductive passage by ‘inserting’ mother’s breast-milk in the genitals in Zambia
- Sharing of wives with kin among pastoralist groups in Uganda
- Sexual cleansing after death of spouse in both countries
- Widows are inherited by the dead husband’s family (e.g. one of his relatives takes her as his wife) in both countries, and widowers inheritance also exists in Zambia
- Belief in witchcraft in Zambia influences some community members to seek treatment from traditional healers first
- Some religious groups in Uganda rely on faith healing only

Among adult respondents, reports of practicing ‘risky behaviour’ were significantly higher in Zambia than in Uganda.

Percentage of Adult Household Members and FBO/NGO/CBO Representatives Practicing Risky Sexual Behaviour				
Zambia	Adults		FBO/NGO/CBO	
	M	F	M	F
Never used a condom	53	70	51	62
More than 1 sex partner past 6 months	24	03	19	05
Had sex with non-regular past 6 months	19	02	08	05
Didn't used condom with non-regular partner	60	67	58	60
No consistent condom use with non-regular partner	91	100	83	75
Uganda	Adults		FBO/NGO/CBO	
	M	F	M	F
Never used a condom	49	75	57	69
More than 1 sex partner past 6 months	17	04	10	00
Had sex with non-regular past 6 months	13	04	05	00
Didn't used condom with non-regular partner	48	47	13	N/A
No consistent condom use with non-regular partner	74	85	33	N/A

Conclusions and Implications for Programming

The findings from the baseline surveys in Zambia and Uganda confirm that some of the factors that increase HIV risks and vulnerability among children and adults are context specific. While some issues can be addressed by increasing HIV awareness, knowledge and prevention skills, others are due to gender-based, sociocultural factors. Thus it's clear that a supportive environment is required to facilitate behaviour change. Both community mobilisation strategies and individually-focused behaviour change strategies will be necessary if the program is to address this range of issues effectively.

- ❖ In addition to targeting teachers for provision of life-skills training to pupils, HIV prevention programs should also seek to increase the participation of parents and religious leaders. This will require capacity building for these groups in order to increase their HIV -related knowledge and skills.
- ❖ Baseline survey findings related to cultural beliefs and practices should be shared by the programmes with local leaders to facilitate change among FBOs and communities.
- ❖ Sensitising communities, including children, on what constitutes 'sexual abuse', mobilizing communities to take action against sexual abuse, and increasing their knowledge of sexual offense laws and the gender-specific rights enshrined in the country's constitution should be an integral component of HIV prevention programs.

How Will the Research be Used?

A two-day workshop held in Nairobi in October 2005 brought together Africa regional office (RO) and national office (NO) staff teams from Uganda and Zambia to analyse and interpret the baseline data. Using these findings, they identified areas of the project requiring modification and improvement.

Ongoing research findings and lessons learned will be disseminated to local stakeholders in the communities where the project is implemented; World Vision national office (NO) staff in Uganda and Zambia; and the Africa Hope Regional Office (RO) team to inform implementation of the project and adjust project design where necessary.

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