The adolescent sexual world and AIDS prevention: a democratic approach to programme design in Zimbabwe

PAULETTE SCHATZ and KUZVINETSA P. DZVIMBO
Canadian Society for International Health, Ottawa, Canada and 1Zimbabwe Open University, Harare, Zimbabwe

SUMMARY
The main aim of this study was to redress the under-representation of adolescent attitudes in AIDS prevention programme design and to discuss the implications of a democratic sexuality education approach within a health promotion context. The study surveyed the attitudes of adolescents (average age 16 years) on sex-related topics such as culture, marriage, sexual behaviour and sex education, identified similarities and differences in attitudes according to gender and socio-economic environments, and examined sources of students’ knowledge of selected sex-related topics. Questionnaires were completed by 3429 secondary school students from different backgrounds. Findings showed significant differences in attitude related to gender and socio-economic settings and also in sources of information. The study drew on a democratic sexuality education approach. Using this approach, adolescents review ideological perspectives and decide which are most appropriate for them as guides in making decisions about their own lives. This type of education is fully consistent with the principles of democratic living and gives guidance to teenagers who are trying to decide how to live a healthy life. Study results suggest that programmers would be well advised to collect information from the adolescents’ psycho-social-economic environment and link it with good governance and civil society strategies in developing AIDS prevention programmes that involve the adolescent in making lifestyle decisions. To achieve a more supportive environment for AIDS prevention, this approach can link adolescent attitudes and health promotion action to advocate for public policy reform, gender equality, multi-dimensional partnerships and social marketing.

Key words: adolescent; AIDS prevention; democratic sexuality programme; good governance; health promotion interventions; programme design; sexual attitudes; supportive environment; Zimbabwe

INTRODUCTION
About 1.1 million Zimbabweans are expected to die of AIDS in the decade up to 2005 (Kapata, 1998). A US Census Bureau report states that average life expectancy in Zimbabwe, the country ‘worst hit by AIDS,’ will be halved by 2010, plummeting from 61 to 39 years (Kaiser Family Foundation, 1998). According to The Economist (June 2000), the virus will claim the lives of half of all 15-year-olds in Zimbabwe, South Africa and Botswana.

Given that nearly 50% of Zimbabwe’s population is under the age of 18 years, directing prevention efforts at young people is crucial in minimizing the further spread of the epidemic (WHO, 1999).

Despite a variety of AIDS prevention programmes, today’s teenagers in this south African country continue to practise risky sexual behaviour, thereby exposing themselves to infection. A US$700 million education and condom programme has done little more than delay the inevitable (Watt, 1998). Studies show that most formal HIV/AIDS prevention messages are directed towards knowledge improvement and only superficially address cultural factors in the context of practice and not at all in the context of
attitude and beliefs (Nduat and Kiai, 1997). Sex education in schools has been unable to reach its full potential in helping young people protect and enhance their sexual health (Ehrhardt et al., 1991). All too frequently the culture (including school culture) has sought to issue commandments about sexuality to adolescents rather than assist them in developing the critical skills necessary to make considered decisions (McKay, 1998).

In this context, programme planners are being challenged to examine the fundamental issues relevant to AIDS prevention. Where once the focus was solely on personal risk behaviour, we know today that there are factors way beyond the control of the individual that encourage such behaviour and make it hard for people to protect themselves. These factors include poverty, discrimination, lack of education and opportunity, and, crucially, the subordination of women that puts young females at even greater risk than males (UNAIDS, 1999).

This study's main aim was to redress the under-representation of adolescent attitudes in AIDS prevention programme design and discuss the implications of a democratic sexuality education approach within a health promotion context. This approach helps students to identify prevailing ideological positions on sexuality and what it means to live a healthy life. Adolescents discover and clarify which ideological perspectives are most appropriate to guide them in making decisions about their own lives (McKay, 1998). This type of education is fully consistent with the principles of democratic living and what it means to have a healthy lifestyle.

The Ottawa Charter for Health Promotion (WHO, 1986) defines health promotion as the process of enabling people to increase control over and improve their health. Studies show that health promotion for young people aims at helping adolescents gain and increase control over the determinants of their health, influencing their lifestyles to be conducive to health and preventing infection among their peers and in their community (Franzkowiak, 1990; Nutbeam and Blakey, 1990; Erben, 1991). This study links adolescent attitudes to democratic health promotion action areas such as advocacy for public policy reform, gender equality, partnerships and social marketing, to provide a more supportive environment for AIDS prevention.

This study defines the adolescent sexual world as holistic, and this is elaborated further through a model of the human ecosystem as shown in Figure 1, 'The mandala of health' [from (Hancock, 1993)]. In the mandala, the individual is at the core of a set of environments including the family, the community, the human-made environment, culture and the biosphere. The model also shows four key factors that influence the health of both the individual and the family: human biology, personal behaviour, the psycho-social-economic environment and the physical environment. The term 'lifestyle' is used to connote 'personal behaviour as influenced and modified by, and constrained by, a lifelong socialization process, and by the psycho-social-economic environment, including cultural and community values and standards' (Hancock and Perkins, 1985). Using this model, it is obvious that the adolescent sexual world must also be partially defined by the psycho-social-economic environment.

The study’s main objectives were:

- to survey attitudes of 16-year-old students on sex-related topics in the areas of culture, marriage, sexual behaviour and sex education (these relate to the mandala’s psycho-social-economic environment);
- to identify similarities and differences in attitudes according to gender and socio-economic environments; and
- to identify the sources of students’ knowledge of selected sex-related topics.

Results were examined and discussed in terms of a democratic approach to programme design.

**METHODS**

The survey, conducted in 1992, focused on students aged 15–19 years, a crucial period for developing sexual attitudes. Questionnaires were completed by 3429 students attending 45 secondary schools, and the overall response rate was 95%. The mean age of the students was 16.08 years. The majority of the students were from the Shona (74.2%) or the Ndebele (19.2%) tribes.

The study examined the attitudes between genders; 49.1% of those surveyed were male and 50.9% female. It also examined attitudes among students in relation to the type of schools attended. Five types of schools—low-density, high-density, mission, growth-point and rural—were visited in Zimbabwe’s nine regions. They are described as follows:

- Low-density schools were originally intended for urban whites. These expensive schools
maintain a high academic standard for fee-paying students of all races from mainly upper and upper middle-class families. Today, >80% of the students in these schools come from Zimbabwe’s two main tribes, Shona or Ndebele.

- High-density schools attract students who can pay only low fees and are located on the city outskirts or in urban settings. There is much overcrowding with a high teacher:student ratio. Students come from poorer socio-economic backgrounds. They live with both parents, a single parent, relatives, friends, or possibly on their own.

- Mission schools cater for boarding and day students paying high fees in both urban and rural areas. They are run by various religious denominations including Anglican, Methodist, Catholic and Seventh Day Adventist. The majority of the students come from a middle-class or high socio-economic background.

- Rural schools attract students from a poor socio-economic background who pay only low fees. Many parents work as subsistence farmers, labourers or miners, and most students live with their families. However, a significant number of adolescents in more remote areas are left in charge of the family hut and their siblings while the parents work in urban areas.

- Growth-point schools are in a transitional situation. The students pay low fees, often live in huts, walk to a nearby school and have a business-oriented collection of stores, banks,
bars and discos within walking distance. The environment is torn between two worlds—rural and urban. Female students are exposed to direct sexual contact with truckers, male teenagers who have been with prostitutes or barmaids, or men who may be in sexual contact with truck-stop prostitutes (Nzyuko, 1991).

The study included a good cross-section of the secondary school population, with 27.9% of the students from high-density schools, 25.4% from schools near a growth point, 23.1% from mission schools, 15.3% from low-density schools and 8.3% from rural schools.

A random number-generating computer program selected 449 questionnaires from among the total of 3429 completed by students to represent an ~12% sample. The program used in data processing was the SPSS 4.1. \( \chi^2 \) tests were used to test statistical association of a factor with the proportion of responses to an item. Gender and type-of-school factors were tested separately. The criterion for statistical significance was that type 1 error be <0.05.

RESULTS

The findings of adolescent attitudes examined in areas related to the mandela’s psycho-social-economic environment (culture, marriage, sexual behaviour and sex education) are described below.

Culture

The study looked at issues such as the Age of Majority and traditional healers in relation to the adolescent sexual world.

The Age of Majority and decision making

The Age of Majority Law of 1982 states that ‘an 18-year-old person attains the full legal capacity to do such things as sign contracts or make wills without the assistance of a parent or guardian’ (Encyclopedia of Zimbabwe, 1987). This also includes being able to marry, move out of the house and make future decisions without parental consent. Adolescents were asked to comment on this law and although they agreed with it in general, male and female attitudes differed. Females (50.9%) wanted the Age of Majority increased, but males (52.3%) were not in favour (see Figure 2).

![Fig. 2: The legal Age of Majority at 18 years is too young and should be changed to an older age (\( p < 0.05 \)).](image)

Traditional healers and spirits

Traditional healers (n’anga) and local spirits play an important role in the Zimbabwean culture and are consulted about AIDS and HIV. Spirits (ngozi and mamhepo) often intervene in a Zimbabwean’s life and at times cause misfortune. Traditional healers are called to provide treatment and are so culturally embedded that the Zimbabwean Traditional Healers Association cooperates with the Ministry of Health and other groups involved in the health field. Students surveyed did not support the role of traditional healers (51.2%) and perceived them as being less effective than generally believed. Similarly, <15% of subjects in another (local) study believed that traditional healers could cure AIDS (Wilson et al., 1989). However, the students’ respect for spirits was significant. Students in high-density (39.5%), rural (50%) and growth-point (50.5%) schools agreed that the school population should be taught to respect certain spirits, while those in low-density and mission schools did not (see Figure 3). The three lower socio-economic schools may have stronger traditional respect for spirits because of spiritual intervention practices in their daily environments. Overall, 83% of students stated that they had a religious affiliation.

Marriage

In Zimbabwe, marriage is governed by two acts: the Marriage Act (1964) and the African Marriage Act (1917). The Marriage Act applies to those who solemnize their marriages before state-designated marriage officers, including recognized ministers of religion; these marriages are monogamous. The African Marriage Act applies to marriages solemnized by a state-designated African marriage officer, who must
be satisfied that the bride price has been agreed upon; these marriages may be polygamous. The study examined the role of the wife, extramarital relationships and virginity in terms of gender equality.

Role of the wife in marriage
Students (77.6%) acknowledged that an important role of wives was to bear children. This belief may have resulted from the fact that traditionally a wife’s status has depended on the quantity and quality of her offspring (Gelfand, 1979). At the same time, students (49.5%) agreed that marriage did involve love and affection and was not mainly an economic and social bond.

Role of extra-marital relationships
Of the students surveyed, 59.6% stated that in Zimbabwe a married man could have sex with other women but a married woman should not have sex with other men. Of these, 36.8% also noted that in ‘real’ life most men had a wife for having children, and a mistress. Most of those who thought it acceptable for married men to have girlfriends came from rural schools (52.6%).

Extra-marital relationships may be condoned because men are believed to be powerless when confronted with sexual temptation—they are responding to biological needs and cultural expectations (Mhalu, 1991). This may, in fact, explain why women are unable to prevent HIV infection, as their men are sexually intransigent (Panos Dossier, 1988). Interestingly, a high percentage (51.5%) of students did not believe that it is natural for men to have more than one sexual partner.

Role of virginity
Students agreed that both males and females wanted to marry a virgin. The majority (80.4%) believed that most boys wanted to marry virgins, while 44.4% believed that most girls wanted to marry virgins. The majority of the students who disagreed were from rural schools (39.5%) or growth-point schools (43.4%). Students strongly supported the values of virginity before marriage and many stated that marrying a virgin would prevent AIDS.

Sexual behaviour
The study explored how males and females differ in understanding female and male behaviour and decision-making with respect to sexual intercourse.

How males and females differ in ways of understanding
Male and female understanding of each other’s behaviour revealed differing expectations. For example, males (49.1%) strongly agreed that shy and quiet girls were sexually active while females (47.1%) strongly disagreed (see Figure 4). Males may consider shyness an indication of submission, while females link shyness to their silent role in a patriarchal society.

Similarly, the majority of males (42.1%) thought that schoolgirls often have sex because of the material gains, while females disagreed (39.5%). Since gifts can result from several motives, the role of gift-giving should not be assumed. Finally, students (81.1%) overwhelmingly agreed that boys will tell lies to convince a girl to have sex with them. Most of those who

Fig. 3: Students should be taught to respect ngozi ($p < 0.05$).

Fig. 4: Most school girls who are quiet and shy are having sexual intercourse ($p < 0.05$).
agreed were female (54.2%); of the 10% who disagreed, 63.6% were males.

Female behaviour
Students overall agreed (76%) that if girls behaved properly, then boys would be able to control their sexual urges; 60% agreed that most girls do not know how to say ‘no’ to sex. Many students agreed (36.1%) that girls tease the boys/men and arouse them and then refuse to have sex with them.

Male behaviour
Students (57.8%) agreed there is a significant amount of male adolescent peer pressure to have sex.

Females (62.9%) agreed that most girls were often forced to have sexual intercourse by threats of beatings, while males (59.3%) disagreed (see Figure 5). The number of physically and sexually abused women in Zimbabwe is high (this fact was established through personal communication with Women’s Action Group representatives) and the denial by the males is an added obstacle in developing relationships to share equal responsibility for avoiding AIDS.

Decision-making on sexual intercourse
Most students (47.2%) agreed that the girl makes the final decision about having sexual intercourse, not the boy; interestingly, of the 37.6% who disagreed, 63.6% were female (see Figure 6). This supports and encourages male irresponsibility. To compound the problem, the majority of students (60%), as mentioned earlier, agreed that most girls did not know how to say ‘no’ to sex. This may be because women have been taught never to refuse their sexual partners. Only students (42.1%) from rural schools did not expect the girl to make the final decision, perhaps because traditionally a female has been taught to be submissive in a relationship and is not allowed to make any decisions without the male’s intervention.

Sex education
The study drew on a list of sex education topics from the Education for Living syllabus (1991) to help identify adolescent sources of information.

Talking about sex
Overall, Zimbabwean society believes youths who talk about sex are sexually active, and when youths talk about sex they become aroused. The majority of students (73%) disagreed, but the study showed that males (62%) did associate talking about sex with being sexually active and they (60.7%) strongly agreed that being taught about sex aroused them.

Sources of information
The survey identified sources of information for 16 sex-related topics covered in the Zimbabwe Education for Living syllabus. Overall, students showed a lack of understanding of basic sex education terms, either because they were not informed about them or did not want to reveal that they knew what they meant. Most students received information from peers and books and not from the schools. Biological, factual topics such as menstruation, sexual intercourse and STDs were learned from teachers and books. Pregnancy and marriage were discussed by the family. Zimbabwean students learned about sexual abuse from the radio (22.6%) and books.
(23.1%), the condom from the radio (36%), menstruation from teachers (24.6%), sexual intercourse from books (29.6%), STDs from books (31.6%), pregnancy from mothers (24.6%), and marriage from aunts and uncles (51.7%).

There were source differences between Zimbabwean males and females on menstruation, sexual intercourse, homosexuality/lesbianism and pregnancy. Males learned about menstruation from teachers (37.2%) and books (27%). Females learned about menstruation from their mothers (36.6%) and aunts (23.7%). Most males learned about sexual intercourse from peers (24.4%), pregnancy from uncles (22.5%) and marriage from uncles (51.2%). Females learned about pregnancy from mothers (37.2%) and about marriage from aunts (52.3%). Those males who understood masturbation learned about it from their peers (20.6%). Those females who understood masturbation learned about it from books (17.9%).

School role
Students (76.8%) believed that schools should talk about how to avoid sexual intercourse to discourage teenage pregnancies. They also agreed (58.7%) that schools should promote family planning.

Perceptions of family planning
Students showed that they differed in what they believed family planning to represent, and the degree of support for family planning varied according to the socio-economic setting. The more ‘modern’ the lifestyle of the students, the more inclined they were to support family planning. The strongest support for family planning came from students (63.1%) attending low-density schools, perhaps because they learned through television, books and the media. Students from other schools were cautious—perhaps because of the negative associations of family planning (long-term effects) or, more likely, its connection to promiscuity (Worth, 1989) and the belief that people who use condoms are ‘loose’ (Wilson et al., 1990). Almost half (47.6%) of the students agreed that most people believe that an unmarried girl who uses family planning is immoral, yet 58.3% agreed that a schoolboy who uses a condom is sexually responsible. The majority of students (67.3%) did not agree that a schoolgirl should be allowed to have an abortion if she got pregnant.

DISCUSSION—IMPLICATIONS OF A DEMOCRATIC APPROACH TO PROGRAMME DESIGN

The following discussion looks at the implications of a democratic philosophy of sexuality education in classroom practice. It shows how this study’s findings can be used to make AIDS prevention health promotion practices more effective in areas such as public policy reform, gender equality, multi-dimensional partnerships and social marketing. Though applying specifically to Zimbabwe, the democratic approach could easily be adapted to other countries and cultures.

The following are examples of health promotion strategies drawn from the study’s findings:

- developing healthy public policy that looks at modern and traditional values of a community;
- using gender and socio-economic differences as tools to stimulate discussion and mobilize community groups regarding local AIDS prevention concerns; and
- enhancing professional and personal skills of educators, adolescents, parents and community leaders to use multi-level, multi-faceted, multi-disciplinary approaches to prevent AIDS.

Public policy reform
Priority actions, response analysis and feedback from youth organizations must include promoting young people’s genuine participation in expanding national responses to HIV/AIDS (UNAIDS, 1999). In Zimbabwe, the Age of Majority law provides an opportunity for multifaceted discussion shifting from the more common focus on individual behaviour to include the political and economic aspects of AIDS (Kapata, 1998). Youths could review the impact of the Age of Majority law on gender and traditional and modern values. Networks and education groups could advocate for national and local laws/policies that contribute to a supportive AIDS prevention environment.

Although the adolescent was the main participant in our study, AIDS prevention applies to many other groups and age ranges. In fact, all people who must make decisions with regard to sexual behaviour should be programme participants. If there is no concerted multi-sectoral approach by society to force a drastic behavioural change in sexually active people, the death toll caused by AIDS in Zimbabwe will escalate (Kapata, 1998).
Gender equality

Gender and AIDS need to become mainstream concerns in the programmes of governments and non-governmental organizations in all countries (UNAIDS, 1999). Unfortunately, neither the theories advanced by the proponents of sex education, nor the most-used teaching materials on which these courses are based, have addressed the fundamental issues of sex differences in socialization and the repression of women’s sexuality (Szirom, 1988). We still are no further ahead as we start the new century.

This study provides key gender-related topics for adolescents to critique, to help them discover more about their sexual world, their personal values and assumptions. The study found that males in Zimbabwe assume that shy females submit easily to sex. Thus, quiet females are at a special disadvantage with regard to their ability or willingness to make healthy sexual decisions to reduce their own risk of HIV infection (Bassett and Mhoyi, 1991). Studies show that shy people have lower self-esteem than less shy people and that a relatively higher percentage of shyness occurs among adolescents of lower socio-economic classes (Lawrence and Bennett, 1992). Similarly, there was a general belief that if girls were more assertive, they would make healthy sexual decisions and would be able to behave properly and say ‘no’ to sex.

Single sex and co-ed focus groups could be used in Zimbabwe to enhance self-esteem in girls and personal interrelationship communication skills in both sexes. Finally, women’s inability to prevent HIV infection because of the belief that ‘men are powerless when confronted with sexual temptation’ needs to be explored so both males and females can enhance their partnering skills in a social transformation.

Multi-dimensional partnerships

A participatory approach to targeting the adolescent sexual world should involve a mix of adolescents, teachers, parents and other community members. Interventions such as multi-sectoral, multi-level approaches contribute to the empowerment of persons, emphasizing the advantages of a long-term perspective and influencing social norms regarding acceptable risk behaviour (Franzkowiak and Wenzel, 1994). For example, AIDS prevention messages and approaches based on traditional and Christian morality have been developed in partnership with schools and community members in Zambia (Wilson et al., 1989), and are proving to be effective.

A multi-level, multi-sectoral presentation of information sources is needed for AIDS prevention among adolescents in Zimbabwe. It is worth noting that although very few school-based sexuality education programmes of any kind have been shown to modify adolescent sexual behaviour, those that have been successful provided information and skills relevant both to students who are sexually active and to those who are not (Kirby, 1994). Overall, studies have found that adolescents pay more attention to information provided by professionals (Abraham et al., 1991). Trained teachers can help design/coordinate/facilitate/nurture the required learning atmosphere. Of course, the role of the family (nuclear and extended) in Zimbabwe should not be undermined. Pregnancy and marriage are deeply rooted aspects of the physical and spiritual life of Zimbabweans (Mahmoud et al., 1990; Mutambirwa, 1989), and family should be included in the teaching teams.

Social marketing

Social marketing, a concept developed several decades ago, uses the private sector and its advertising and distribution networks to promote public health (UNAIDS, 1998). AIDS prevention programmers can make use of the mass media to target adolescents with information and skills enhancement. Radio can provide a public forum to discuss physical issues (ejaculation, masturbation, conception), relationships (dating, homosexuality, lesbianism, sexism) and controversial topics (contraceptives, abortion, abstinence). Media can also be used to lobby against negative peer pressure, which is synonymous with the tradition of male sexual freedom in low socio-economic settings (Panos Dossier, 1987). It is common to hear that ‘a bull’s strength is recognized by his scars’; similarly, a man’s virility is related to the number of times he has been treated for STDs.

The prevention of pregnancy can be taught by providing factual information about condom use, safe sex and contraceptives, but education should also enhance critical decision-making skills related to abstinence from sex, mutual consideration, individual responsibility and gender differences.
Adolescents should be given the opportunity to review the various ideologies related to pregnancy and AIDS prevention. Habib, on the Teen Sexuality website, states that discovering and forming one's sexual identity is a focal point of adolescence and that today's teens are coming of age in a culture of confusion (Habib, 1999). Words such as ‘postponement’ and ‘safer sex’ compete with the ‘pop’ culture—a culture that pummels us with images of immediate gratification and unsafe, violent sexual behaviour. Habib concludes that teenage decisions about sexuality are influenced by complex, intertwined factors such as love, substance abuse, poverty, family, sexual abuse, racism and religion. The International Teen Star Federation (1998), of which Zimbabwe is a member, identifies its core components as self-discovery of the body together with the values of fertility, leading to norms governing the responsible use of fertility (Klaus, 1998). The Zimbabwe Family Planning Association is already active in association with schools and could be included in the teaching team.

Finally, although talking about sex is not supported in Zimbabwean society, there are times when people need to talk to each other and address issues vital to all. As philosopher John Dewey said on his ninetieth birthday, ‘democracy begins in conversation’. Deborah Tannen suggests that instead of asking ‘what is the other side?’, we might ask ‘what are the other sides?’ (Tannen, 1999). Instead of insisting on hearing ‘both sides’, we might insist on hearing ‘all sides’.

CONCLUSION

Since 1993, schools in Zimbabwe have provided their youth with an AIDS action programme that includes relationships, life skills, gender roles, peer pressure with role-playing, and community involvement. This is similar to many of the existing AIDS prevention programmes in the world and there is little evidence of their success. This study suggests that a democratic approach using health promotion interventions might be more effective.

Unfortunately, given the political and social climate in Zimbabwe over the past decade, this study’s recommendations have never been put into practice. We hope that, through publication of this paper, the benefits of the democratic approach will be recognized and applied by programmers in other countries and cultures.

ACKNOWLEDGEMENTS

This extensive study grew from research requested by the University of Zimbabwe to assist the Ministry of Education and the Ministry of Health in developing an AIDS prevention programme for Zimbabwean schools in 1992. It was made possible through financial assistance from the Canadian International Development Agency’s Awards for Canadians programme. Results and recommendations are attributable to the authors and do not represent any official viewpoint of the funding agency or participating institutions/organizations. The authors wish to express special appreciation to Dr Steven Shaw at Concordia University, Montreal, for his expertise in data analysis, and Maureen Johnson for her support. It is our honour to be able to draw on the expertise of Alexander McKay, Trevor Hancock, Fran Perkins and Irv Rootman.

Address for correspondence:
Paulette Schatz
707 Merkley Drive
Orleans
Ontario K4A 2T7
Canada

REFERENCES


