"They know but do not take it to be real"

HIV/AIDS EDUCATION AND BEHAVIOUR CHANGE: Contextual factors that affect translation of knowledge into action among in-school adolescents in rural Uganda

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Abstract

The main goal of the present study was to investigate the factors that affect translation of HIV/AIDS knowledge into action. Using both qualitative and quantitative methods, data was obtained from students, teachers, parents, school administrators and the HIV/AIDS coordination department from the Ministry of Education and Sports. The Health Belief Model and Social Learning Theory that formed the basis of this study were used through discussion and analysis of research findings. The study identified interplay of individual, social and structural factors with the school and family as the main agents.

The findings suggest that the interplay of individual, social and structural factors hindered the translation of knowledge into action. Within the school context, although HIV/AIDS education is not treated as an independent subject in the formal school curriculum, students get information from various sources. HIV/AIDS knowledge among adolescents in this study was found to be high, but with inabilities to transfer it to their daily lives, which partly explains the low perceived risk. The social setting (family and school) that includes peers and friends, sex differences and gender roles, lack of skills related to HIV prevention, the socio-economic and structural environments as well as individuals' abilities to make healthy decisions and choices influence the way young people respond to the knowledge.

The study recommends the strengthening of school capacity by making HIV/AIDS education an integral part of school programs and providing school staff with training in life skills and HIV/AIDS prevention. Student-initiated School Anti-AIDS Clubs should be supported and established where they do not exist. Parents/guardians, young people and the community are key stakeholders and therefore, their input should be regarded in planning and delivery of in-school programs. Basing on the available evidence from this and other studies, the Ministry of Education and Sports should design a uniform strategic plan for HIV/AIDS activities in schools. Means of monitoring and evaluation of such activities should be put in place so as to monitor progress or setbacks as well as to identify emerging challenges such as children orphaned by HIV/AIDS, those already infected, etc and deal with them.

Key words: HIV/AIDS education, Behaviour change, adolescents

Dedication

Mama, you have been a mother and a father in my life and you will always be. I would be nothing without you and I owe all my work to you.

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Naturally, nobody missed me more than my family during my absence. Joel and Nolan were denied the opportunity of freely playing with me at their toddler ages. For Joel I missed to see his first step of walking! Nolan, I missed your first attempt to crawl. Julian, my wife, gave me all the practical and moral encouragement I needed so much despite the fact that she missed my company and my services for so long. Together, we have risen and fallen and to me, I am because Julian is and because she is, we are.

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Acronyms

ABC	Abstinence, Being Faithful and Consistent and Correct Condom use
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ARRM	AIDS Risk Reduction Model
ART	Anti-Retroviral Therapy
ASRH	Adolescent Sexual and Reproductive Health
BTVET	Business Technical and Vocational Education and Training
CHAI	Child Health AIDS Initiative
CSOs	Civil Society Organisations
EFA	Education for All
EI	Education International
FBOs	Faith Based Organisations
FGDs	Focus Group Discussions
HBM	Health Belief Model
HDI	Human Development Index
HDR	Human Development Report
IATT	Inter-Agency Task Team
JSI	John Snow, Inc.
MDG	Millennium Development Goals
MGLSD	Ministry of Gender, Labour and Social Development
MoES	Ministry of Education and Sports
MoFPED	Ministry of Finance, Planning and Economic Development
MTT	Mobile Task Team
NCDC	National Curriculum Development Centre
PLHAs	People Living with HIV/AIDS

PMTCT	Prevention of Mother-to-Child Transmission
PTA	Parents Teachers Association
SAC	Students' AIDS Club
SHEP	School Health Education Project
STF	Straight Talk Foundation
STIs	Sexually Transmitted Infections
UAC	Uganda AIDS Commission
UBOS	Uganda Bureau of Statistics
UHSBS	Uganda HIV/AIDS Sero-Behavioural Survey
UNDP	United Nations Development Program
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
UNAIDS	Joint United Nations Program on HIV/AIDS
UNESCO	United Nations Educational, Scientific and Cultural Organisation
UNICEF	United Nations Children's Fund
UPHOLD	Uganda Program for Human and Holistic Development
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing
YEAH	Young Empowered and Healthy

"I fall, I stand still...I trudge on. I gain a little...I get more eager and climb higher and begin to see the widening horizon. Every struggle is a victory".

1. Introduction

1.1 Chapter overview

This chapter presents the basis of the research by discussing the importance of adolescent sexual and reproductive health education in the context of HIV/AIDS. Before presenting the statement of the research problem and the research objectives as well as the questions posed by this research, I examine the justification of education in HIV/AIDS prevention. I also point out that although behaviour change is the core purpose of information provision for in-school adolescents, it has not been widely explored.

1.2 Rationale for the research

HIV/AIDS education refers to giving people correct and comprehensive information about HIV/AIDS, such as how the disease is transmitted, how people can be protected from infection, and the impact of the disease on wider society. It also involves giving people the knowledge of how to put this information to use and act on it practically (UNESCO, 2006). The Dakar Framework for action (2000) noted that HIV/AIDS poses an enormous challenge to education but at the same time, education systems world wide provide enormous potential to help reduce the incidence of HIV/AIDS and to alleviate its impact on society (Kelly, 2000). The UK based HIV/AIDS information website[1] highlights the rationale for HIV/AIDS education. It is argued that the main reasons for HIV/AIDS education are: prevention of occurrence of new infections, improvement of quality of life for People Living with HIV/AIDS (PLHAs) and to reduce stigma and discrimination among the people who are infected and/or affected by the disease.

[1] The portal www.avert.org/aidseducation.htm further argues that education needs to be an ongoing process, because each generation of young people need to be informed about how they can protect themselves from HIV as they grow up. Older generations, who have already hopefully received some AIDS education, may need the message reinforced, so that they continue to take precautions against HIV infection, and are able to inform younger people of the dangers.

Among adolescents[2], HIV/AIDS education is concerned with prevention of infection through the provision of information on their sexual and reproductive health, relationships and life skills and this has become a critical policy and programmatic issue in sub-Saharan Africa. This is because many adolescents are at a higher risk for HIV/AIDS transmission and unwanted pregnancy (Neema, *et al.,* 2004). According to a report published by The Guttmacher Institute (2005), adolescents are at high risk mainly because many who may not have previously engaged in sex experience sexual coercion and because they are not prepared for sex, they are not able to protect themselves. The same report further indicates that those who are already sexually active are also at high risk because many engage in multiple sexual partnerships. This situation calls for continued research in provision of information, the impact of such information on behaviours as well as the environments in which behaviour change is expected to be promoted and this research is part of the attempt.

The Ugandan government has adopted policies and programs such as: the 1996 Uganda National AIDS Control Policy that addresses adolescent sexual and reproductive health as well as access to Voluntary Testing and Counseling (VCT) services, the National Youth Policy that commits the government to fulfil youth development goals as spelled out at the 1994 International Conference on Population and Development in Cairo as well as the Education and Sports Sector HIV/AIDS Policy Guidelines among others. The projects include Program for Enhancing Adolescent Reproductive Life (PEARL) under the Ministry Gender, Labour and Social Development and the School Health Education Project (SHEP) under the Ministry of Education and Sports. These policies are said to be important in creating an environment supportive of adolescent sexual and reproductive health (Guttmacher, 2005). However, although most of them have played a significant role in provision of information, adolescents have remained vulnerable largely because knowledge alone does not prompt them to take action to protect themselves (Guttmacher, 2005). Further more, information provision and other sexual and reproductive health services are concentrated in urban areas leaving the rural adolescents largely under-served (Guttmacher

[2] Adolescence refers to the stage of development between childhood and adulthood around ages 12-20 (Sefert & Hoffnung, 1994). Although this term is commonly used interchangeably with 'youth', the definition of the latter varies from society to another since it is either culturally or socially constructed. Countries tend to define adolescence and youth by age categories such as *Uganda Youth Policy* (12-30 years), *Kenya Youth Policy* (15-30 years) and the United Nations (15-24 years). It is also synonymously used in this research and in many cases to refer to adolescents in school unless mentioned otherwise.

Institute, 2005). Hence, it was inevitable for this research to conduct the study from the rural area.

1.3 Justification of HIV/AIDS education

Various studies have been conducted in the field of HIV/AIDS education and most of them analyse and justify the role of education in promoting behaviour change and hence reduce the spread of the virus that causes AIDS. Education has been called a 'social vaccine' against HIV/AIDS because through provision of information about the epidemic, it empowers individuals with appropriate skills to receive and act on knowledge of protection against infection (Kelly, 2000a; Balikana *et al.*, 2005; Rispel *et al.*, 2006; World Bank, 2002). However, although there has been an inverse association between the disease burden and the level of education for most infectious diseases, Vandemoortele (2002) argues that because of its propagation channel, HIV/AIDS first affects those with more opportunities, including more educated, mobile and better-off people. However, this was only in the early 1990s when there was less information about the virus (de Walque *et al.*, 2005). Further cross-sectional studies conducted in Uganda in late 1990s and 2000 suggested that educated young adults were more likely to respond to HIV/AIDS information and prevention campaigns by effectively reducing their sexual risk behaviour .

According to the World Bank (2002), education equips optimistic and hopeful young people with morale and intellect to make sound and healthy decisions concerning their own lives, deal with pressure and keep themselves free of HIV infection. Michael Kelly, a prominent HIV/AIDS education researcher noted that 'the long, arduous and costly search for the HIV vaccine must continue, but in the meantime every one of our communities is equipped with a structure that can boost society's immune system, the structure of education' (Kelly, 2000b:7).

Apart from providing information on transmission and prevention, education prolongs the time young people can engage in risky sexual behaviours because schools give students hope and aspirations to become successful which in most cases discourage them from indulging in risky behaviour. In the long term, education is said to play a key role in establishing conditions that render the transmission of HIV/AIDS less likely through empowering individuals, reducing poverty and ensuring gender equity (Kelly, 2000a). Thus, in the absence of curative drugs for HIV/AIDS, the only option available is to develop appropriate

standards of behaviour with information being translated into action (Kelly, 2000). To this end, education is perceived to provide a multi-pronged approach to the fight against the epidemic (Bastien, 2005).

The majority of young people, who are at high risk, can be found at school and further than that, the school system brings together students, teachers, parents and the community. Thus if AIDS information and sex education is provided at school, it captures a bigger audience (MoES, 2006)[3]. In addition, it is argued that education equips and empowers people, especially young women, to understand and internalise relevant information and to translate knowledge into behavioural change (Vandemoortele, 2002). Education also helps to change the family and community environment and attitudes whereby it enables open and frank discussions about HIV transmission. Thus, if correct AIDS information is properly absorbed, the allies of silence, shame, stigma and superstition upon which AIDS thrives will be defeated.

Aside from the above preventive-focused reasons, HIV/AIDS education targeted at People Living with HIV/AIDS (PLHAs) and who urgently need information, enables and empowers them to improve their quality of life. With education, the great deal of fear and stigma accompanied by resentment and anger of people who are diagnosed HIV positive can only be dealt with through provision of information about positive living components of coping with positive results, nutrition and drug adherence[4]. Ignorance about such issues leads to hopelessness and emotional stress which are known to shorten the lives of PLHAs.

Education as a 'social vaccine' is contested by Hargreaves & Glynn (2002) as they argue that unless it incorporates health education programs, general schooling does not necessarily equip people with skills to avoid HIV/AIDS infection. Hence;

> It cannot be assumed that those with more schooling have received more HIV-related health education at school because the extent of integration of sex education into the school curriculum is insufficient in most African countries (Hargreaves & Glynn, 2002:496).

[3] The Uganda Education and Sports sector policy published by the ministry of Education mentions that the education sector provides a unique opportunity because of the established structures for learning and teaching at different levels.

[4] See www.avert.org/aidseducation.htm

Thus, it is important to mention what type of education really has an important role in protecting people against the HIV risk. Studies show that education may delay sexual debut and marriage and may facilitate changes in behaviour in response to health promotion (Hargreaves & Glynn, 2002). At the same time, the improved socio-economic status due to education, particularly among men, leads to greater disposable income, increased leisure time, increased ability to travel and increased opportunity to use commercial sex workers hence increased risk (Vandemoortele, 2002). Hence, the problem is that the socio-economic and lifestyle factors that accompany education and increase the risk of exposure to HIV have not been counterbalanced by changes in behaviour that would decrease HIV risk.

Therefore, from the above assessment, it may be inferred that by giving people information and equipping them with skills to prevent HIV/AIDS infection, education acts as a 'social vaccine'. However, it should be emphasised that education alone without behaviour change may not be sufficient in AIDS prevention. The gaps that exist between HIV/AIDS education and behaviour change need to be systematically investigated and addressed in policy, program as well as research such that education, exposure and behaviour are balanced. This research represents one attempt to explore factors that influence behaviour change in relation to HIV/AIDS knowledge.

1.4 Statement of the Research Problem

The education sector has over the years stepped up efforts to respond to the threat of the AIDS epidemic. These efforts include the development of the sector policy that guides all HIV/AIDS interventions that include workplace intervention and prevention education through schools and institutions. The primary efforts put emphasis on behaviour change communication and information provision. Various studies[5] have been done about these efforts in attempts to assess the implementation and the impact of the epidemic on the sector. Despite the evident effects of the epidemic on the education sector, there has been no systematic research to look at issues related to teaching of HIV/AIDS education or whether the Behaviour Change Communication strategy adopted by the Ministry of Education and

[5] Karin *et al.,* (2001); Mirembe (2002); Morisky *et al.,* (2006); Namusisi *et al.,* (2007) conducted studies specifically in Uganda's education sector and Bennell *et al.,* (2002) with focus on sub-Saharan Africa, Uganda included in the case studies.

Sports has an impact on the sexual behaviour among the in-school adolescents at the secondary school level. While it is true that young people receive messages about HIV/AIDS prevention and risk reduction, the question remains whether the knowledge they receive is acted upon. This study attempts to respond to this question by exploring the factors that affect translation of knowledge into action in efforts to prevent HIV/AIDS infection among the in-school adolescents.

1.4.1 Overall research goal

The study attempts to investigate the factors that affect the translation of HIV/AIDS education knowledge into behaviour change among secondary school adolescents in rural Uganda.

1.4.2 Research objectives

The overall research goal as mentioned above has been broken into specific objectives so as to generate research questions to be addressed by this research. Those objectives are;

- To determine the knowledge levels about HIV/AIDS among secondary school adolescents in rural Uganda;
- To identify prevailing HIV/AIDS programs for in-school adolescents in Uganda; and
- To identify factors that affect translation of HIV/AIDS knowledge into action as perceived by students and stakeholders.

1.4.3 Research questions

The study was guided by the following questions;

- What is the knowledge level about HIV/AIDS among the in-school adolescents in rural Uganda and what are their main sources?
- What are the prevailing HIV/AIDS education programs for in-school adolescents in Uganda?

- What are the contextual factors that determine negative or positive behaviour change in response to information about HIV/AIDS as identified by students and stakeholders?

1.4.4 Justification of the study

As pointed out earlier in the research problem statement, there is a gap in knowledge about whether HIV/AIDS knowledge that adolescents have is put into action and to what extent. This study is an attempt to fill this gap with findings from a rural area where there is less exposure compared to urban areas[6]. The findings may also contribute to the knowledge needed by policy makers in further education sector efforts to improve on service delivery by filling gaps identified by this research.

1.5 Structure of the thesis

The thesis is divided into six chapters. The first chapter starts with rationale for the research. It discusses the urgent need for addressing adolescent sexual and reproductive health problems through provision of information and how to act on it so as to induce sexual behaviour change. The chapter continues with the justification of using education to combat HIV/AIDS. It further provides the research objectives and questions of this study.

The second chapter introduces the background information to the study with a look at general information about Uganda, the education system and the national response to the threat of HIV/AIDS pandemic. The overall response is narrowed down to look at how both the private and public sectors have been involved in provision of HIV/AIDS education. The chapter concludes with the review of related literature about HIV/AIDS education provision for young people.

The third chapter introduces the theoretical framework of this study. It provides a brief overview of behavioural theories related to this study. The chapter then presents the main

[6] The Guttmacher Institute Report on *Adolescent and Sexual Reproductive Health in Uganda*, 2005 reports that young people in rural areas are under-served in terms of access to information and services compared to urban youths.

theory used in this study and later an analysis of the application and implications to HIV/AIDS education and behaviour change for in-school adolescents in a rural setting.

Chapter four presents the methodology and procedures used in this research. It explains the use of both qualitative and quantitative methodologies for the research and details the purpose and reasons for their use. After presenting the methods used in analysing data, it concludes with both the limitations to the study and ethical considerations.

The fifth chapter introduces part of the findings while responding to the first two questions posed by this research. It addresses the question of levels of knowledge and awareness about HIV/AIDS among the in-school adolescents and the main sources of information both within the school and the outside environment.

Chapter six is a continuation of the previous chapter but analyses the findings concerning contextual factors that affect behaviour in response to HIV/AIDS knowledge. Utilising behavioural theory, the chapter attempts to show how the interaction of the individual and the environment plays an important role in behavioural formation and modification. It also justifies the need for motivating efforts to effect behaviour change.

Finally, chapter seven presents the conclusions, implications of this research and the recommendations for both future research and what should be done to enhance program interventions aimed at behaviour change in response to HIV/AIDS prevention among the in-school adolescents in rural Uganda.

2. Background information

2.1 Chapter overview

This chapter provides the contextual analysis about Uganda, its geographical location and other socio-demographic characteristics. It also provides a background to Uganda's education system and policy and the attempts to incorporate HIV/AIDS education into the planning and the general curriculum. The analysis of HIV/AIDS response within the education sector is also given attention with reference to both government and private sector efforts.

2.1.1 Uganda: Socio-demographic characteristics

The Republic of Uganda is located in East Africa and lies astride the equator about 800kilometres inland from the Indian Ocean. It is a landlocked country bordering Kenya in the east, Tanzania in the south, Rwanda in the southwest, the Democratic Republic of Congo in the west, and Sudan in the north. Both eastern and western parts of the country are marked by mountains with Mount Ruwenzori and Mount Elgon in the west and east respectively.

The country has an area of 241,551sq.kms with total population estimated at 28.9 million (UNDP, HDR 2007/2008). The UNDP Human Development Report 2007/2008 puts Uganda at 154 in the Human Development Index (HDI) ranks. Uganda's life expectancy increased from 48.4 in 2006 to 49.7 in 2007/2008 but still the lowest in the traditional East Africa region [Kenya (52.1); Tanzania (51.0)]. The adult literacy rate (15 years and older) is 66.8% also lower than its neighbours in the region [Kenya (73.6%); Tanzania (69.4%)]. Historically, until it achieved its political independence in 1962, Uganda was ruled by the arm of British colonial power since 1894 declaration of protectorate rule. During this period, most of the home and all the foreign affairs were controlled by the British. As a result, education was managed by the missionaries who according to Tiberondwa (1998) were agents of colonialism and hence, they promoted character education as opposed to the traditional education that provided the learner with traditional values of culture, production and self-sustenance. Most subjects were taught according to the British syllabus until 1974, and British examinations measured a student's progress through primary and secondary school. In 1975 the government implemented a local curriculum, and for a short time most school materials were published in Uganda.

Figure 1: Map of Uganda

Source: United Nations, Department of Public Information, Cartographic Section, 2003.

School enrolments continued to climb throughout most of the 1970s and 1980s, but as the economy deteriorated and violence increased, local publishing almost ceased, and examination results deteriorated (CIA World Fact book, 2007). In the late 80s and early 90s,

the education system was reformed with the recommendations of the 1992 Uganda Government White Paper on Education.

2.1.2 Uganda's Education system

Uganda's formal education system starts with seven years of primary school[7] (ages 6-12), which is compulsory (supposedly) and free according to the current Universal Primary Education (UPE) policy. This is followed by lower secondary education (O' Level) and upper secondary (A' Level). This level is succeeded by two or three to five years of University or tertiary education depending on the profession selected by the individual as well as the affordability of a given course requirements.

Secondary school education is composed of 4 years leading to the award of the Uganda Certificate of Education (UCE) plus 2 years of Advanced Level Education leading to the award of a Uganda Advanced Certificate of Education (UACE). 53.6 % of the secondary schools are located in the rural areas. 32.5% are government owned schools, 61.6% are private schools and 5.9% are owned by the community (MoES, 2006). Tertiary education and University education provide highest qualifications of education in Uganda. There are various types of institutions including teacher training, vocational institutions, and Universities both government and private.

With regard to HIV/AIDS, this is still a big challenge to the sector and has adversely affected the quality of education. For example, the MDG Uganda's Progress Report, 2007 published by the UNDP indicates that many teachers are sick [although no clear figures are indicated], which leads to frequent absenteeism and there are many HIV/AIDS orphans in school, some of whom are HIV positive while others take care of sick family members. HIV/AIDS also contributes to rising dropout rates, absenteeism, repetition and poor academic performance, and overall poor quality education.

Yet there exists no specific curriculum regarding teaching HIV/AIDS in the country. The approach taken in tackling issues regarding the epidemic falls under the wider government

[7] This 'traditional' trend is rapidly changing where kindergarten education is gaining momentum especially in urban areas and the educated, working class where kids of 3 years and above are already in school. The kindergarten school takes approximately three years (Lower, Middle and Top class) for each year before a child joins formal primary schooling.

policy of integration and mainstreaming[8] and the scope of implementation of the Education and Sports sector national policy guidelines on HIV/AIDS. Both the government and private sector (NGOs) are involved in implementing HIV/AIDS awareness in schools at all levels through sensitisation and provision of Information, Education and Communication (IEC) materials (Morisky *et al.*, 2006). Most of the programs focus on behaviour change among the youths through life skills promotion.

The education sector takes 16.8% of the total national budget (*Background to the National Budget*, 2007/2008) but very unfortunate is that although efforts of mainstreaming and integrating HIV/AIDS are clearly mentioned in most ministry strategic plan documents, HIV/AIDS is not mentioned in the priority areas[9]. As will be seen later in the findings among the challenges, the education sector has many sub-sectors of primary, secondary, Business Technical Vocational Education and Training (BTVET) as well as tertiary. HIV/AIDS is incorporated in the budgets of each sub-sector but with insufficient resource allocation since it is not a priority issue.

2.1.3 Uganda national HIV/AIDS response

Uganda was one of the first African countries to recognise the presence of HIV/AIDS. According to the Uganda AIDS Commission, the first case was identified in 1982, one year, after the virus was first recognised by scientists in the United States of America. Since then, it is estimated that about 2 million people were infected by HIV during this period, of whom about 1 million have died and another 1 million are living with the infection today (UHSBS Report, 2006). The national efforts adopted a multi-sectoral approach[10] that saw the infection rates declining from over 30 percent to 6.4% in 2006. There are fears of stagnation and likely rising number of infections. It is projected for example that the number of HIV-positive individuals is likely to increase from 1.1 million in 2006 to about 1.3 million in 2012 (National HIV & AIDS Strategic Plan 2007/8 – 2011/12) and thereby calling for intensified

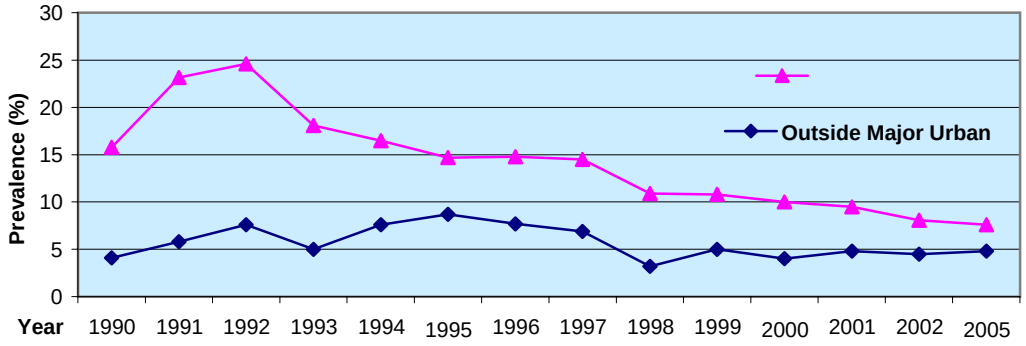
[8] Also mentioned in the interview with the commissioner for secondary education, MoES who is also the sector coordinator for HIV/AIDS activities in the ministry.

[9] According to the report of the Social Services committee in Parliament on ministerial statements and budget estimates 2007/2008, HIV/AIDS is not mentioned among priority areas.

[10] A multi-sectoral approach advocates for active involvement in AIDS control activities by all members of the society, individually and collectively and it seeks to address not only HIV/AIDS prevention but also management of all perceived consequences of the epidemic. Details see: www.aidsuganda.org/pdf/maca.pdf

collective efforts. The Uganda AIDS Commission, a national coordinating body for HIV/AIDS activities identifies and agrees on priority intervention and strategies for the management of the epidemic. Hence, the development of the current National Strategic Plan 2007/08-2011/12 is part of the efforts to expand and scale up interventions of prevention, care and treatment (Uganda AIDS Commission, 2007).

Figure 2: Median HIV prevalence of Antenatal Care (ANC) attendees 1990-2005



Source: National HIV & AIDS Strategic Plan 2007/8 – 2011/12

In the multi-sectoral approach, prevention is the mainstay of HIV/AIDS programming and a focus on sexual behaviours is the major priority in order to accelerate prevention of sexually HIV transmission. Since about 80% of new HIV infections are through heterosexual transmission (UHSBS Report, 2006), prevention of high-risk sex is the cornerstone of the prevention. This response targets the ultimate outcomes, at the individual level, of abstinence; mutual faithfulness to a partner of known HIV-status; reduction of multiple sexual partners; correct and consistent condom use with positives or any partner whose HIV status is unknown. Hence Uganda's HIV/AIDS intervention model has come to be termed ABC+ to include Voluntary Counselling and Testing (VCT), Prevention of Mother-to-Child Transmission (PMTCT), anti-retroviral Treatment (ART) and HIV/AIDS care and support services[11].

[11] This information was obtained from the Uganda AIDS Commission website; www.aidsuganda.org

2.2 HIV/AIDS education in Uganda

2.2.1 Introduction

This section presents some of the national HIV/AIDS programs that target youth in schools. It is important to note that some of these programs overlap and others target young people in general and not just adolescents or in-school. With the multi-sectoral approach that the government of Uganda adopted, both the government (public) and the NGOs (private sector) have been involved in HIV/AIDS education programs and therefore, both cases will be considered in this discussion.

2.2.2 Approaches to HIV/AIDS education

HIV/AIDS education has been categorised into two major approaches although they in most cases overlap such that it becomes difficult, for example, to know which specific approach is being used in Uganda. They are categorised as the curriculum approach and extra-curricular approach. The curriculum approach entails reforming the formal curricular to incorporate HIV/AIDS as a stand-alone subject and/or as integral part of others such as biology, health and hygiene, family life education, guidance and counselling, and social studies (UNICEF/UNAIDS, 2002). Coverage ranges from the biology of HIV, signs and symptoms of AIDS to prevention through teaching of life skills.

In the curriculum approach, the design and development of HIV/AIDS is done by curriculum experts within the ministry while teachers are tasked with the teaching of the new curriculum. An interview with a Ministry of Education official revealed that the National Curriculum Development Centre (NCDC) is responsible for this but added that services of consultants are also sought to provide a basis for the integration of HIV/AIDS in the secondary school curriculum. This study is concerned that teachers are not involved in this process and therefore, the new curriculum will be dumped on them without any knowledge of mechanisms of implementation. Mere sensitisation that the ministry gives to teachers is, according to the understanding of this study, useless otherwise any serving teacher would not undergo teacher training before starting to teach. A United Kingdom based AIDS charity – AVERT- notes;

> ‘Teachers also need to feel that they are entirely clear on the information that they will be passing on – they need to feel confident that they are able to answer any

questions that might be asked. This necessitates an adequate level of teacher-training – something that is sadly lacking in many parts of the world'[12].

Hence, the argument is that sensitisation gives knowledge but not skills of teaching a new curriculum, moreover on an issue like HIV/AIDS.

Secondly, the curriculum approach assumes young people who are not sexually active and aims at providing them with essential knowledge to alert them to the dangers and consequences of sexually transmitted diseases including HIV/AIDS. This has been possible at the primary level and it is said to have achieved some measure of success[13] (PIASCY Handbook, 2005). That this approach is used for secondary school is evident in PIASCY Handbook for lower and upper post-primary. Yet studies indicate that majority of secondary school adolescents are sexually active (Darabi *et al.*, 2007)[14]. Using the same approach used at the primary school level to teach secondary school adolescents therefore identifies where gaps exist in teaching HIV/AIDS education in schools. Even if it was to be taught in class, it leaves doubts whether the teacher chalk and talk approach would impart appropriate HIV/AIDS prevention skills.

HIV/AIDS education also takes a form of extra-curricular approach. In this case, extra-curricular activities related to HIV/AIDS complement the formal curriculum and its main advantage over the curriculum approach is that it provides avenues for student participation in teaching and learning process (UNICEF/UNAIDS, 2002). Extra-curricular activities are organised in forms of school health clubs or drama clubs and/or associations and they are led and/or implemented by peers. It provides opportunity for peer education approach which gives young people opportunity to talk to their peers at the same level. This approach requires careful planning especially in an education system characterised by overloaded timetable. Teachers would also require specialised training in extra-curricular activities, peer education approaches and life skills.

[12] See www.avert.org/school.htm accessed on March 20, 2008.

[13] Minister of Education Namirembe G. Bitamazire in the preface of PIASCY handbook for post-primary says that it has been very effective at primary school level and recommends it for O'Level and other post-primary institutions. (see Preface page 3, Lower Post Primary PIASCY handbook for students).

[14] In their report entitled *Protecting the Next Generation in Uganda*, Darabi *et al.*, note that 20% of women aged 20–24 and 10% of men that age have had sexual intercourse by age 15; by age 18, 64% of young women and 50% of young men have become sexually experienced. It adds that 23% of 15-19 aged females have ever been in a union.

2.2.3 Ministry of Education and Sports

The Ministry of Education and Sports (MoES) first introduced HIV/AIDS prevention campaigns on a national level in 1986 (Morisky *et al.,* 2006). The ministry activities included media messages targeting young people, HIV/AIDS in the primary school curriculum and school theatrical performances that depicted real-life scenarios facing the youth. Under a UNICEF funded project called School Health Education Program (SHEP), the ministry aimed at reaching the youth with AIDS information before they were sexually active. However, an evaluation of the project that was completed after more than 4 years since its implementation found that although education and awareness had increased, not much was reflected in behaviour change (*Interview with the HIV/AIDS coordinator, MoES*). Secondly, at the end of the project in 1994, the primary objective of integrating health education in the primary, secondary and tertiary curricula had not been achieved because the program had been poorly designed.

Many lessons were learnt from the SHEP evaluation notably, that life skills for Ugandan youth such as assertiveness, self esteem and the ability to resist peer pressure were essential in HIV/AIDS prevention and intervention strategies (Morisky *et al.,* 2006). A critical missing link was the ability of children to translate knowledge into positive health behaviours and the adoption of life skills education was expected to fill this gap. The major assumption underlying life skills education is that young people somehow lack skills such as assertiveness or abilities to say 'no' and for coping with social pressures. That if taught and learned, such skills would be applied in different situations thereby reducing the risk of HIV infection. Skills-based health education enables the development of interpersonal and other skills, such as critical and creative thinking, decision making and self-awareness (World Bank, 2002). It is probably based on this argument that Uganda embraced this approach.

While commenting on skills-based education, Mutonyi *et al.,* (2007) argues that this was aimed at providing young people with access to critical prevention interventions including services to develop the life-skills needed to reduce their vulnerability. Hence,

> It was believed that skills-based education using interactive teaching methods such as role-play would promote healthy lifestyles and reduce risky behaviour. The programs looked at self-awareness, self-esteem and empathy; private communication and interpersonal relationships; decision making and problem solving; creative and critical thinking; and coping with emotions and stress' (1365)

A life skills approach to HIV/AIDS education presents a number of questions regarding applicability, acceptability and cultural sensitivity in different situations. In the first instance, not everything that is learned is applied or acted upon unless important motivating conditions such as self-efficacy are in place (UNICEF/UNAIDS, 2002). Secondly, they are taught in a generalized way in disregard of gender, individual differences and heterogeneous socio-demographic and economic backgrounds of the learners (Mirembe & Lynn, 2001). There are also claims that life skills education has less impact on sexual behaviours in developing countries and that this is a donor-driven approach imposed on government ministries with no regard to local situations (Boler & Aggleton, 2005). All these concerns pose questions to future research in Life Skills and HIV/AIDS Education.

There is also a limiting factor in using life skills-oriented curricula in Uganda. In an exam-oriented curriculum where teaching strategies continue to be dominated by the traditional content and examination focus (Karin *et al.,* 2001; Morisky *et al.,* 2006) rather than a more holistic learner-centred curriculum, it leaves one with doubts of whether this approach which lacks not only a pedagogical base but also a clear methodology in relation to HIV/AIDS has the capacity to transform lives of Ugandan adolescents. In addition, as Asingwire *et al.,* (2006) note, limited support to implementing institutions and lack of a defined strategy for life skills training have hindered the effectiveness of the approach.

2.2.4 Presidential Initiative on AIDS Strategy for Communication to Youth (PIASCY)

Popularly known as PIASCY, this is an education program proposed by President Museveni whose aim was to disseminate HIV/AIDS prevention, treatment and mitigation information to students on a more sustained basis. It is the most recent education program spearheaded by the Ministry of Education and Sports in continued efforts to improve communication on HIV/AIDS to young people. Launched in 2003 starting at the primary school level, the program includes creation and distribution of manuals on HIV/AIDS prevention in schools. In the foreword to the Upper Post Primary Handbook, Y.K Museveni notes the increased awareness in responsible sexuality and reproductive health. In the same edition, the minister for education notes that PIASCY has been effective at the primary school level in empowering young people with information and life skills that are vital tools in staying safe from HIV/AIDS (MoES/PIASCY, 2005).

The PIASCY program was later extended to cover secondary school level and two handbooks were developed: for lower and upper post-primary levels together with teachers' guides. This initiative goes beyond targeting individuals because of the increasing number of children. PIACSY adopted 'the whole school approach' whereby its activities do not just target clubs or students' groups[15]. Like the primary level program, messages are passed on to students through assembly messages held per fortnight or once a week. In other cases, short dramas are acted out at assemblies by both girls and boys and these dramatise dangers of premarital sex and school drop out.

It is also aimed at building the capacity of teachers hence the development of Teachers' handbook. Unlike the primary school level, PIASCY messages are not just to be disseminated at the assemblies only. Through the earlier mentioned integrated approach, information is to be incorporated into the traditional classroom subjects such as Biology and Christian Religious Education and even English language[16]. From PIASCY handbooks, there are many verses from the Bible and the Qur'an that put much emphasis on development of religious morals to promote abstinence for in-school adolescents. The implementation of this design entirely depends on teachers' own initiative even though they indicated that they were not trained unlike primary school teachers who received basic HIV/AIDS training[17]. This points out one of the setbacks in implementing this program at the secondary school level which even still prevails at the primary school level where it started;

> 'While there is emphasis on pupil-centric activities, the programme still underlines the need to train additional teachers in the use of PIASCY materials, including the PIASCY Handbook…and guidance and counselling materials among others since the teachers are the main conduit for the behaviour change messages, as well as the key facilitators of the planned pupil-centric activities'. PIASCY II Quarterly Report October – December, 2005 p.4

Parents are reached through school drama shows and songs and this helps opening avenues for parents to talk 'with' and not 'talk to' their children as it used to be. PIASCY reaches the community through public rallies and gatherings as well as World AIDS Day exhibitions

[15] Interview with the MoES HIV/AIDS sector coordinator, who is also the Commissioner for secondary education.

[16] From a MoES official, purposely to promote confidence in communication and speech about HIV/AIDS.

[17] PIASCY II Quarterly Report, December 2005 MoES/UPHOLD/USAID p.4. UPHOLD project has been involved in training teacher trainees on HIV/AIDS in some districts of Uganda.

organised by the MoES in conjunction with other organisations. However, the participation of parents is quite limited, if any, in the design and implementation of PIASCY program yet it targets the population whom they are solely responsible for (the young people). Yet in its guide for use, the handbook for lower post primary (O' Level) concludes referring students to ask their teachers or parents for more information about the book. This is as if either of the teachers or parents have sufficient knowledge of what the book is about and thereby in position to respond to further questions regarding it.

It should be noted here that unlike other traditional school subjects which typically depend on the knowledge from books, reproductive health and sexual maturation depend mainly on the social environment where children grow up from and also whom they interact with. To further show the purpose of involving parents, AVERT notes;

> 'If possible, it is usually advantageous to involve the parents and guardians in the planning process, before an AIDS education curriculum is decided – parents who have already agreed the content that their children will study are unlikely to complain about it being unsuitable. Furthermore, parents who are involved in the education of their children will be able to give additional support, if it is needed, outside the classroom'[18].

This is among the reasons why the role of parents is regarded by this study as very paramount in HIV/AIDS prevention efforts for young people.

The other obstacle to the PIASCY program is cited in lack of learning aids or materials for demonstration and teaching activities (Human Rights Watch Vol.17, No.4) and this is much experienced at the secondary school level. At the primary school level, a number of NGOs have been involved in training and providing resources that are aimed at equipping teachers with necessary skills and knowledge to pass on information to pupils. The role of JSI/USAID-funded Uganda Program for Human and Holistic Development (UPHOLD) in partnering with the MoES and Primary Teacher Colleges in the preparation and implementation of PIASCY for primary school level cannot be underestimated[19]. According to the information from school authorities, PIASCY information is provided through

[18] See www.avert.org/school.htm accessed on March 20, 2008.

[19] See http://uphold.jsi.com/FeatureStories/piascysuccessstory.htm accessed on January 3, 2008

brochures and charts which are pinned up in the school library[20]. In other cases, the ministry simply gives circulars to schools that for every fortnight, the messages should be delivered at the school assemblies. It was also found out that although there are two handbooks for upper and lower secondary schools; messages are given collectively at one assembly for both levels, irrespective of age and abilities to understand the meaning. The mechanisms for monitoring and evaluation of the progress made using this approach, the loopholes and challenges faced could not be established by this research.

The principal strategy for PIASCY typically excludes children who are out of school. On one hand, messages are delivered at school assemblies, as noted above while on the other, it is English-based communication and this assumes that all children in school understand and discuss in this language at a sufficiently high level of comprehension to participate in effective discussion regarding the content (Morisky *et al.,* 2006). This principally limits participation of young people. This is even more of a challenge for the rural schools where the language of communication is vernacular[21]. Attempts to reach out-of school adolescents involve public rallies and health education promotion campaigns but these, apart from being occasional and hence offering piecemeal messages, they are not contextualised as evidenced from materials being printed in English language. It is also important to realise that not all out-of-school youth can read or write in English language.

The content and approach of PIASCY for post primary levels can also be criticised for offering limited choices for young people and trying to cover what adolescents already know. Whereas it is true that abstinence is the safest way to prevent HIV infection, this is not an easy goal to achieve. Thus, to assume that abstinence-only messages are helpful to the adolescents already exposed to the media (some of whom are sexually active) would render adolescent reproductive health communication programs less effective. The PIASCY handbook for upper post primary (in actual terms A' Level) notes;

[20] Most of the posters pinned up in the school library were actually designed for PIASCY at the primary school level. Students left the messages in the primary school and found the same messages in secondary even though their age, level of education and probably sexual life has changed.

[21] Note the difference between the 'language of instruction' and the 'language of communication'. The local language is widely spoken in the school. Even in classrooms, for easy understanding, teachers use vernacular. I had to translate some questions in the FGDs into the local language because I detected difficulty in interpreting English questions.

> 'Abstinence means one has chosen not to engage until marriage… Young people are in schools are not married and should therefore not indulge in sex. The use of condoms among unmarried young people therefore does not arise. Young people do not need condoms; they need skills for abstaining from premarital sex' pp70-71.

This statement dismisses the possibility of learning how to use condoms[22] for protection from HIV infection among some already sexually active young adults who are in need of correct information about proper use and storage of condoms. The President of Uganda himself is quoted condemning condom use describing it as dangerous and disastrous for young people. He threatened to open war on condom sellers reasoning that instead of saving life, they are promoting promiscuity among young people.

There is a traditional saying in the agricultural parts of western Uganda that says *'an exposed stone cannot damage/ hit a hoe'* literally meaning that while digging, you cannot damage your hoe by hitting the stone that you already see, it is the hidden stone that actually spoils. Therefore, it would be proper to provide appropriate information rather than assume that they do not know and hence should not know.

2.2.5 Straight Talk Foundation

Uganda's multi-sectoral response to HIV/AIDS involves not only government agencies but also the private sector such as the Non-Governmental Organisations (NGOs) and Faith-Based Organisations (FBOs) whose efforts have helped to sustain the response especially at the grassroots level. The efforts of the private sector and other Civil Society Organisations (CSOs) involve a wide variety of approaches including prevention through information provision and education, care support and mitigation interventions. These joint interventions gathered momentum as soon as the effects of the epidemic started to show.

Straight Talk Foundation (STF) is one of the leading health communication organisations in Uganda targeting young people in and out-of-school. It began its work in 1997 out of a UNICEF-funded news paper called '*Straight Talk'* that was first published in 1993 (Straight Talk, 2007). It produces Behaviour Change Communication materials which include Straight Talk Radio Show, Straight Talk and Young Talk Newspapers produced for secondary and primary school students respectively. Although it originally planned for the inclusion of

[22]This is compounded by the government position on condom use. See *The New Vision* article: '*Museveni condemns condom distribution to pupils'*. Online at http://www.newvision.co.ug/D/8/12/360669

parents, it later narrowed to focus on older adolescents primarily because of poor response on the part of parents. The establishment of Straight Talk Radio Show, which is aired in various local languages, was mainly to reach out-of-school adolescents who could not access newspapers and could not read English.

As noted earlier, the multi-sectoral response brought on board various players from both government and private organisations. However, when it comes to HIV/AIDS education, most organisations pay occasional visits to schools through informal arrangements. Secondly, most NGOs that respond to HIV/AIDS in the education sector have failed to integrate their work fully in national curriculum goals apart from not being institutionalized (EI, 2006). Also, apart from being restricted to local and individual organisation initiatives, different NGOs pay visits to individual schools to hold short seminars with students and teachers and their approaches are not coordinated. This raises concerns of not only the failure of HIV/AIDS education to have impact but also that such programs may serve to confuse young people about the reality of HIV/AIDS (UNAIDS/IATT, 2006). Even within the ministry itself, there have not been efforts to fully mobilise teachers and staff associations to play an active role in the implementation of HIV/AIDS activities (MoES, 2006). Hence, these uncoordinated efforts in HIV/AIDS response in the education sector pose many questions for future research on effectiveness without coordination.

To sum it up, I have discussed the general background information about Uganda and the response to the threat of HIV/AIDS epidemic. I analysed some of the efforts by both the government and the private sector to combat HIV/AIDS through awareness and information provision. In the next sub-chapter, I will take an analysis of some of the reports from independent researchers, government and other agencies involved in HIV/AIDS work to shed more light on what has been studied and written about HIV/AIDS in Uganda and particularly in the education sector.

2.3 Review of related literature

Uganda has attracted a lot of international attention as far as HIV/AIDS is concerned. This is attributed to the fact that the Ugandan Government has, since the advent of the epidemic, been relatively open about the scale of the problem and has allowed considerable indigenous and foreign research into HIV/AIDS (Green, 2004). As a result scholars from both developed and developing world have devoted time and resources to investigating various

aspects of the epidemic. Also, Uganda's ability to stop the trend of spread of HIV and reduce the infection rates in the 1990s from over 30% to the currently reported 6.4% (ORC Macro/MoH, UHSBS Report, 2006) attracted attention of world. Cohen (2003:01) notes that word of the "Uganda miracle" spread, journalists, researchers, policy makers and advocates all descended to try to ascertain how it was accomplished.

As a result, there is a large scientific body of literature about HIV/AIDS in Uganda. However, most of this literature has broadly centred on aspects of prevention success and the reduction of infection rates (Green, 2004; Low-Beer & Stoneburner, 2003; Allen, 2004) and the ABC model used by Uganda (Abstinence, Being Faithful and Condom Use) and which of these behaviours has been effective and why (Cohen, 2003; Green, 2004; Allen & Heald, 2004; Okware *et al.*, 2005; Kilian *et al*., 2007). In relation to HIV/AIDS education, some independent studies have been conducted especially in relation to access to information and services on adolescent sexual and reproductive health (Neema, 2006; Guttmacher Institute, 2007; Biddlecom, 2007) as well as the impact of HIV/AIDS on the education sector (Baldo et al, 2000; Karin et al, 2001; Morisky et al, 2006; Bennell *et al.,* 2002). In all these studies, the element of behaviour change is generally regarded to be a core component in HIV/AIDS prevention efforts.

All healthy behaviour maintenance and behaviour change interventions towards HIV prevention involve provision of information and awareness as well as how to put knowledge into action. This is what is generally referred to as HIV/AIDS education. However, according to Allen & Heald (2004), human behaviour rarely changes because of health education alone. Their assessment agrees with Baldo *et al.,* (2000) who point out the importance of skills[23] in health promotion campaigns. Hence,

> In sexual health and AIDS-related education, the most relevant skills are the ability to refuse undesired sex, to insist on protected sex, to use a condom correctly, to seek a trusted person for counselling and to resist pressure to take drugs.

Kelly (1995), points out that in addition to education, there are certain elements of importance in any HIV risk reduction behaviour change intervention. These elements include

[23] Baldo *et al.,* (2000) define skills as 'how to' of behavioural goals. Using correct and consistent condom use as an example, one should know how to get one, how to store it, how to use it, how to discard it as well as how to discuss condoms with a partner and how to insist on its use and how to react in case of refusal.

activities that: strengthen behaviour change intentions and self-efficacy in enacting change, help individuals to accurately judge their risk, provide normative support for avoiding high risk behaviour or making behaviour change, teach skills needed to communicate effectively with partners to decline sexual pressure or negotiate safer sex, and reinforce and support behaviour change efforts. These elements provide a good yardstick for designing HIV/AIDS interventions but then, it is important to identify the current behaviour and determine whether desired behaviours exist and hence should be reinforced or there is need to change from undesired to desired ones. Baldo *et al.,* (2000) suggests that program designers should work with adolescents to identify the desired behaviour and then determine the skills needed to put them into practice. The important issue raised here is that the target group should be the starting point because such a group knows better what challenges they face.

Baldo *et al.,* (2000) raise another important issue about behaviour change education and information for adolescents. The argument is whether the concept of behaviour change serves all young adolescents well. Many of young adolescents do not need to change any behaviours; they just need to maintain healthy behaviours that the already possess. This sounds similar to the concept of 'age appropriate' messages raised by the MoES[24] although it lacks detail of what and how. Although it is not easy to determine who is sexually active or not at secondary school level, programs need to be finely tuned to the age of beneficiaries and messages should cater for both. Abstinence only messages tend to confuse those who are already sexually active and likewise, being faithful and condom use tend to confuse the 12-year olds who are not yet engaged in sexual activities (Baldo *et al.,* 2000). In all however, skills for healthy behaviours are relevant to all whether they are to be applied now or later.

HIV/AIDS education programs for young people are focused towards reducing risks and vulnerabilities with the premise that multiple partners and unprotected sex increase the risk of contracting AIDS virus. The question raised by Jurich *et al.,* (1992) is whether such programs will have significant influence on behaviours of young people who perceive themselves to be at a low risk. In some cases, the adolescents think that HIV/AIDS is a disease for prostitutes who have sex with anyone willing to pay for the service (Woodcock *et al.,* 1992) while others think they are free from AIDS because they are poor and cannot

[24] The Education and Sports Sector National Policy Guidelines on HIV/AIDS points out that all learners shall be provided with age appropriate, current, accurate, complete, and scientifically factual information, education and communication on HIV/AIDS.

afford sex (Ntozi *et al.*, 2001). Hence, although many interventions assume the high risk nature of adolescents, not all of them see it that way and will less likely change their behaviour (Jurich *et al*., 2001). It is at this point that Kelly (1995) observes a missing link that has been understudied and this is preventing the initiation of high risk behaviours. Hence he notes,

> 'A broader and perhaps different question is whether preventive interventions offered earlier before people become sexually active can prevent the initiation of high-risk behaviour patterns. It is undoubtedly easier to prevent the initiation of risky behaviours than to change risky patterns that have already become established' p.98

An important issue raised here is whether HIV/AIDS education should be focused on those adolescents who are seen to be at high risk. But one could argue that prevention of initiation of high risk must begin with homes where children grow from before they reach school. This is likely to be more effective when initiated within the community norms or social context such that the schools continue to provide supportive environment for maintenance of behaviour.

Schools are seen to be an effective place to offer adolescents sexual and reproductive health-related information and skills (Biddlecom *et al.*, 2007). Apart from providing a forum for reaching a large number of adolescents in a structured setting, the classroom provides opportunity for students to practice skills, raise questions and concerns and get comprehensive education on sexual and reproductive health issues over an extended period of time. The *World Development Report 2007*[25] suggests that education gives young people an opportunity to imagine a better future in a way that has some immediate personal value. That education is an effective place has been asserted in many publications but with less consideration of the internal aspects of the school environment that support or impede effectiveness.

On the other hand, the school culture may also constitute a risky environment and increase the vulnerability of school adolescents. Mirembe & Lynn (2001) argue that gendered practices such as gendered discipline patterns, sexual harassment and other social and environmental factors constitute a risk in themselves in terms of sexual health such that some

[25] The *World Development Report 2007* is a publication of World Bank. Box 5.2, page 130 gives an overview of the role of education in behaviour change. However, it does not give the aspects of school environment that support behaviour change in reproductive health and HIV/AIDS prevention matters.

of them undermine student self-efficacy and reduce their likelihood of refusing sex. Females especially are rendered powerless in schools where hegemonic masculinity is supported and males always strategise to prove their sexual prowess on girls. Mirembe & Lynn (2001) conclude;

> '[...such an environment] is not always safe, especially of it involves sexual encounters with people who have been rendered powerless… Powerlessness limits effective responses to prevent infection. If females are followers, this is a position which makes them ill-equipped in making personal decisions'. p.412

Lloyd (2007) discusses aspects of schools quality that are important for adolescent sexual and reproductive health pointing out that elements such as time to learn, school resources, pedagogical practices that directly contribute to the acquisition of basic learning skills should be considered. Lloyd (2007) is also concerned about little research linking school quality and academic performance to other events occurring during adolescents such as sexual initiation, pregnancy and marriage. In making schools work better, Mutonyi *et al.,* (2007) suggests that there should be dialogue among students and this will enable students to challenge their beliefs while making connections between school and home knowledge. This is mainly because there has been a problem of students not being able to transfer classroom knowledge to their daily lives. Dialogue can be promoted through school debates and essay competitions about sexual and reproductive health issues including HIV/AIDS prevention. The UNAIDS Inter-Agency Task Team (IATT)[26] on education (2006) suggests that this is possible only if it involves working with communities to support learning as well as acknowledging what the learner brings from her/his own experience.

The above discussion points to the fact that while the school is seen as a proper institution in teaching HIV/AIDS education and other sexual and reproductive health issues, supportive mechanisms to achieve this goal may be lacking. Most schools focus on teaching for good academic grades and lack means of incorporating events of growth that adolescents get through at school. Like Lloyd (2007) suggests, longer term health benefits of schooling require not just the completion of grades but acquisition and retention of skills.

[26] The document entitled: *Quality Education and HIV/AIDS* provides a framework for quality education and HIV/AIDS. It points out that at the level of the learner, quality education should: seek out learners, acknowledge what the learner brings, consider the content of formal and non-formal teaching and enhance learning processes as well as provide a conducive learning environment.

In summary, this sub-chapter highlights some of the literature about HIV/AIDS education and behaviour change. It points out that while there is a lot of literature on HIV/AIDS in Uganda, this literature tends to focus on broad aspects of prevention, success and the reduction of infection rates. Literature about HIV/AIDS education is also emerging but still there is less coverage on aspects of behaviour change for adolescents. It is for this reason that much of the subsequent literature used here tried to discuss aspects of behaviour change and how the school environment can be improved to promote healthy behaviours for adolescents, which are important aspects of this research.

To further explore the aspect of behaviour change about how it occurs and its relation to HIV/AIDS prevention, next chapter will discuss the theories of behaviour change used in this study and the implications for HIV/AIDS information provision and education.

3. Theoretical Framework

3.1 Introduction

A theory, according to the Cambridge dictionary, refers to a formal statement of the rules on which a subject of study is based, or of ideas which are suggested to explain a fact or event. Looking at the function of a theory, the major advantage of behavioural prediction and behaviour change theories, Fishbein *et al.,* (2006), argues that they provide a framework to help identify the determinants of any given behaviour, an essential first step in the development of successful interventions to change that behaviour. Hence, the more one knows about the determinants of a given behaviour, the more likely it is that one can develop an effective intervention strategy to reinforce or change that behaviour. In the context of HIV/AIDS, theories provide important guidance to interventions in formulating design and evaluation in a diversity of settings. Elaborating further on the functions of theory, Fishbein *et al.,* (2006:S6) write;

> 'Those who design interventions to improve health behaviours are faced with a number of decision points when developing interventions. These decisions include the primary goal of the intervention, its target population, and the selection of messages for the intervention…behavioural theory provides an important tool to make informed decisions when dealing with such issues'.

Behavioural theories however do not go without criticism. For instance, although it has been argued that theories enhance the understanding of both the success and failure of interventions (Kinsman *et al.,* 2001), some of them have been criticised for focusing excessively on explanation and prediction, and that they have little application as far as design, implementation and evaluation of actual interventions are concerned (Leviton, 1989).

Many theories of behaviour change and behaviour prediction have been developed over the last 50 years (Fishbein *et al.,* 2006), and with the emergence of HIV/AIDS, some of these theories have provided the foundation for most HIV prevention efforts worldwide. As King (1999) points out, except for the AIDS Risk Reduction Model (ARRM) that was developed specifically for AIDS, other psychosocial models, though were developed previously and for other contexts, are widely used in HIV prevention. King (1999) categorises the models and theories of behavioural risk into those that focus on individuals and how they change their behaviours, those that focus on interactive relationship of behaviour in its social, cultural and

economic context and those that explain the structural and environmental influence on behaviour change. The emphasis made in these categories is that any intervention using any of the behaviour change theories should take context applicability and relevance as critical (Fishbein *et al.*, 2006; King, 1999). The local context, notes Bastien (2005), must be considered including the target population's characteristics, social pressures and constraints they face (economically, socially and politically) and the surrounding environment.

3.2 Contextualising behaviour change theories and HIV/AIDS education

Behaviour change theories have been largely used in HIV prevention efforts mainly because HIV transmission is propelled by behavioural factors (King, 1999). The main problem however, is that most of these theories were conceived in the developed world, yet they are commonly used in the developing world which is hardest hit by the AIDS epidemic. This has raised the question of whether this might be part of the reason why some interventions do not bring about meaningful impact on behaviours because of lacking context considerations.

This study takes a brief consideration of two of these theories: The Social Learning Theory (Bandura, 1977; 1986), and the Health Belief Model (Rosenstock *et al.*, 1974). The implications of these theories for the provision of HIV/AIDS education for in-school adolescents are also discussed.

3.2.1 The Social Learning Theory

This theory, which is also known as the Cognitive Social Learning model is largely based on the work of Albert Bandura (1977; 1986). According to the Social Learning theory, human behaviour is not simply determined by motivational forces in form of needs, drives and impulses that are within the individual. Instead, these inner forces can be induced, eliminated and reinstated by varying external influences. Thus, the determinants of behaviour reside not within the individual or organism but in the environmental forces.

The theory further states that individuals have self-regulatory capacities with the ability to exercise some measure of control over their own behaviour by arranging environmental inducements, generating cognitive support and producing consequences for their own actions.

To bring it to context, Bandura's research led him to conclude that children learn to behave through both instruction (i.e., how parents, teachers, and other authorities and role models tell them to behave) as well as observation (i.e., how they see adults and peers behaving). Their behaviour is reinforced, or modified, by the consequences of their actions and the responses of others to their behaviours. Children learn to behave, then, through observation and social interaction, rather than just through verbal instruction. Hence, children should be taught skills through a process of instruction, rehearsal, and feedback, rather than just verbal instruction. The concept of self-efficacy helps children to learn and maintain behaviors, especially in the face of social pressure to behave differently.

In HIV/AIDS context, Social Learning Theory notes that prevention of AIDS requires people to exercise influence over their own behaviour and their social environment through self-efficacy.[27] Information and awareness must be accompanied by self-directed efforts for behaviour change to occur.

Social Learning theory influenced this research in two main ways: the impetus to find out how HIV/AIDS education programs for adolescents help them in the development of skills necessary for coping with internal aspects of their social lives, including assertiveness, self-control, ability to withstand or resist pressure as well as decision-making. Secondly, the theory provided a ground for questioning whether teaching and learning about HIV/AIDS prevention utilises processes by which adolescents learn behaviour such as observation, role-play and peer education components or just plain instruction.

3.2.2 The Health Belief Model

The Health Belief Model (HBM) was developed in the1950s in the United States as a result of widespread failure of people to accept disease preventives although they were provided at low cost or sometimes for free. According to this theory, an individual exists in a life space composed of regions categorized as positively valued (positive valence), negatively valued (negative valence) and relatively neutral regions. Negative valence is undesirable thereby forcing people to move away from it while being pulled by positive forces. Taking the

[27] Self-efficacy according to Bandura (1986) refers to the ability of a person to have confidence in themselves and the belief that they can practice the recommended behaviour by arranging environmental inducements, generating cognitive support and producing consequences for their own actions.

disease as an example of a negative valence, in order for an individual to avoid the disease, one needs to believe that he/she is personally susceptible to it (perceived susceptibility), that the occurrence of the disease would have at least moderate severity or serious consequences on some components of his life (perceived severity) and that taking a particular action would in fact be beneficial by reducing his susceptibility to the condition or if the disease occurred, by reducing its severity (Rosenstock *et al.*, 1974). Also, the individual has to believe that taking such action would entail overcoming important psychological barriers such as costs, pain, convenience or embarrassment, etc. hence perceived benefits.

The theory further argues that a person's beliefs about the availability and effectiveness of an action determine what course he/she will take. Even then, the individual does not take action immediately according to this theory. The combined levels of susceptibility, severity and less barriers do not guarantee an overt action. An instigating event (*cue to action*) must occur to set the process in motion and such an event may be internal (like perception of bodily state) or external (like interpersonal interactions, the impact of media and communication, etc). Further than that, the theory further points out that these cues to action must be intense and the levels of susceptibility and the severity must be adequate.

In the Health Belief Model, promoting action to change behaviour must include changing individual personal beliefs. Individuals must get enough information from where to choose options. In the context of HIV/AIDS education, if one takes an example of *abstinence only* programs for young people who are already sexually active, information about abstinence only is not enough. It does not give the individuals the options to choose from because these are people who already practice sex. Hence, it is important to provide information about other options such as condom use such that the individual can choose from various possibilities (King, 1999). Providing enough information also enables an individual to weigh the benefits of taking this action and not the other. In the case of risk perception in HIV/AIDS interventions, beliefs in the severity or seriousness of the disease i.e *'AIDS has no cure'* enables an individual to adopt such options as correct and consistent condom use or abstinence.

The HBM points to perceived benefits of taking an action and its effectiveness. Still this involves provision of enough information on *what to do, why do it, how to do it* and *when to do it.* This is exactly what HIV/AIDS education should address and it is a component that was found lacking in the school efforts. The message always emphasised here is abstinence

till marriage (PIASCY, 2005) and some young people showed the willingness to abstain because they hope they will get good marriage partners when they wait and finish their education. However, they still insisted that it is goal that is not easy to achieve because of what characterises the society today. Hence, the benefits of abstinence are clear but the means of doing it and how to sustain it was seen to be an obstacle to its effectiveness. Practical issues of how to resist pressure, how to refuse undesired sex or seeking a trusted person for counselling are lacking. Yet if skills such as decision making and communication are given proper attention in AIDS education interventions, they would prove more empowering and effective.

Baldo *et al.,* (2000), who define skills as *'how to'* of behavioural goals provide a practical example of condom use saying that for one to use a condom consistently and correctly (behaviour), it is necessary to know how to get one, how to store it, how to use it, how to discard it as well as how to discuss condom use with a partner, how to insist on its use and how to react in case of refusal. By having all these skills, an individual is likely to adopt such behaviour. Hence, while sexually active young people who cannot abstain are encouraged to use condoms; the issues of '*how to'* are not properly addressed. This obstacle was evident from the group discussion with some students who reasoned that asking for condoms makes them feel embarrassed and that their storage conditions are difficult to follow in a situation where one carries a condom many times in the pocket before using it. This is why Baldo *et al.,* (2000:82) further point out that skills alone are not enough.

> 'Skills development by individuals is just one element of health promotion. Policies (on education, health and youth), healthy environment, community development and health services must also be in place… There is danger in promoting skills that cannot be applied'.

Hence, while information and skills are very important in AIDS prevention education, policy environment must be supportive. This study therefore calls for the practical resolution of condom debate in schools[28].

The Health Belief Model has relevance for this study and indeed, it provides an insight on the efforts to design HIV/AIDS education programs. It challenges program designers

[28] See, *The Daily Monitor* newspaper, September 8, 2005 under the heading: '*No Condoms in schools, says ministry'*.

towards the creation of means and mechanisms that are meant to prepare individuals for action which many behaviour change programs seem to be still lacking. It should however be pointed out that like most theories, it does not suggest practical alternatives for individuals who may not hold all the beliefs as it points out. Secondly, the model seems to ignore the fact that social environment in which an individual lives has a significant influence on the individual behaviour. Socially speaking, societal norms and the members of any given society that form the immediate surroundings of an individual, the peers that one identifies with and other factors contribute significantly to the shaping of one's behaviour.

3.2.3 Summary and application of theories

So far, the importance of theory in providing basis for research and designing health promotion interventions has been discussed. In HIV/AIDS education, the Social Learning Theory tells us that it is important for teachers to replicate the natural processes by which children learn behaviour such as observation and social interaction. Such process of instruction should induce the atmosphere for rehearsal and feedback. Reinforcing a positive or desired behaviour is very important in shaping growth and behaviour of young people. If anything as Baldo *et al.*, (2000) puts it, many young adolescents do not need to change any behaviour, they just need to maintain healthy behaviour that they possess. Hence, 12-year adolescents who are not sexually active do not need to change their sexual behaviour but should be helped to maintain it through reinforcement.

Teachers and other adults who are standard setters and sources of influence, just like parents, should be important role models for the growing adolescents. It is through this that young people will emulate the desired behaviour and reinforce it through extended interaction that takes place when they are in school.

The Health Belief Model views an individual's intention to perform certain behaviour as a combination of attitudes and beliefs towards performing that behaviour and what others think that individual should do. This process involves weighing up benefits of taking certain action and minimising constraints in a given context. The main implication here is that interventions to induce positive behaviours in HIV/AIDS education programs and other forms of interventions should focus on motivating individuals to develop strong beliefs and attitudes towards taking certain actions that will eventually influence behaviour.

A very important component missing in most behavioural theories is about monitoring of behaviour. In any behaviour change intervention, it is very important to identify peoples' beliefs, norms and self-efficacy as well as intentions about performing certain behaviour (Fishbein *et al.,* 2000). It is only after identifying such beliefs and attitudes that one can determine why a desired behaviour is not being performed. In HIV/AIDS education context, program designers should ask themselves such questions as; what are peoples' beliefs about this intervention or why have people not formed intentions or if intentions are formed, why are people unable to act on them? Getting answers to such questions especially identifying constraints helps to modify goals and strategies and provide a basis for the next steps for a given intervention.

In summary, this chapter has introduced the theoretical approaches to this study. The main theories that influenced the study have been discussed and their implication for behaviour change. The next chapter will discuss the methodology used in the study presenting and discussing the whole process of research including data collection and analysis.

4. Methodology

4.1 Introduction

This chapter will present and discuss the methodology used in this study. It includes the initiation and choice of the research project, the study design, data collection methods, tools and strategies, study participants as well as issues of validity and reliability. Due to the use of mixed methods in this study, various tools will also be used in analysis. The researcher background and the likely influence on the choice of study, the entry into the field and actual fieldwork, the qualitative and quantitative approaches will also be discussed. I will describe the choice and how each of the tools such as questionnaires, Focus Group Discussions (FGDs), interviews and document analysis were used as important data collection tools. Ethical concerns and researcher impact will also be discussed.

4.2 Initiation and Choice of the research project

The initiation of my interest to do research among young people stems from my previous studies in adolescent reproductive health. The choice of the research project was heavily influenced by personal research interest, the social and development issues that currently affect the globe and my country in particular and later enhanced by my choice of Education and Development as my specialisation at the Institute for Educational Research at the University. On a more specific level, to do a study on HIV/AIDS prevention was influenced by the previous practice in HIV/AIDS Counselling and Care. It is important however to note that although such a background could embed some personal biases so as to have any influence on objectivity and validity of the study (Silverman, 2001) it provides a basis for continuous inquiry in this area.

4.3 Study Design

Bryman (2004:27) defines a study design as “a structure that guides the execution of a research method and the analysis of the subsequent data”. In other words, it is the framework for data collection and analysis which enables the systematic conduct of the study. It can also refer to a procedural plan that is adopted by the researcher to answer questions validly, objectively, accurately and economically (Kumar, 2005). The overall goal of the study was

to investigate the factors that affect the translation of HIV/AIDS education knowledge into behaviour change among secondary school adolescents in rural Uganda, and to be able to meet this goal, both qualitative and quantitative approaches were used. It is improper to assume that either qualitative or quantitative methods are intrinsically superior of each other and so 'in choosing a method, everything depends upon what we are trying to find out. No method of research, quantitative or quantitative is intrinsically better than any other' (Silverman, 2005:6).

This mixed approach, similar to triangulation, was used mainly because it was realised that none of each isolated approach would provide sufficient answers for the research questions. As Bryman (2004:458) points out, 'this occurs when the researcher cannot rely on either quantitative or qualitative method alone and must buttress the findings with a method drawn from the other research strategy'. For instance, ethnographers may employ structured interviewing or self-completion questionnaire to get information about social characteristics of people in a particular setting because this is not accessible through participant observation. From this example, it was justified to use both methods to complement each other in collecting data from various settings of the study participants.

4.3.1 Qualitative methods

> 'Qualitative inquiry means going into the field – into the real world of programs, organisations, neighbourhoods, street corners – getting close enough to the people and circumstances there to capture what is happening'(Patton, 2002:48),

Among the most common features of qualitative research is the emphasis on words rather than quantification in the collection and analysis of data. These words aim at seeking answers to questions, collecting evidence and produce findings that were not determined in advance. It is for the above reasons that this study used in-depth interviews and Focus Group Discussions (FGDs) as key data collection methods. HIV/AIDS and sexuality being sensitive subjects, individual personal perspectives and experiences could only be explored through in-depth interviews. Individual structured interviews involved consented digital voice recording of the interview sessions. FGDs were also effective in eliciting data on cultural norms of groups, and in generating broad views of issues of concern on HIV/AIDS prevention among the adolescents. These were conducted separately for boys and girls (due to the sensitivity of the issue in question and the co-educational nature of the school) in groups of 6 to 8 among the 14-17 years age group. Other methods involved informal

conversations, which proved to be more revealing than expected, resource library visits and document analysis. Attending workshops also enabled collection of both quantitative and qualitative data and this was possible because of the flexibility that is characteristic of qualitative research methods (Bryman, 2004). In document reviews and analysis, it became obvious to collect quantitative data from national and local statistical reports.

Qualitative methods have earned criticisms from quantitative researchers that they are 'too impressionistic and subjective' arguing that their findings rely too much on the researcher's often unsystematic views about what is significant and important (Bryman, 2004:284). To further explain this argument, critics dwell on the researcher impact on the findings and responses due to the unstructured nature of qualitative data. The characteristics of the researcher are said to have a likely influence on the results since interpretation will be profoundly influenced by the subjective leanings of the researcher. In qualitative research, the fingure is also pointed to the problems of generalisation of data and lack of transparency. It is due to these multiple criticisms of qualitative research that this study adopted mixed methods but to a larger extent, the findings in this study were obtained through qualitative inquiry.

4.3.2 Quantitative Methods

Quantitative research emphasises quantification in the collection and analysis of data. The instruments used in quantitative research are in a more rigid style and they use highly structured methods in data collection such as questionnaires, surveys and structured observation. Among other important advantages, use of highly structured methods provides uniform information, which assures the comparability of data (Patton, 2002; Kumar, 2005). For this particular study, it was important to study the social characteristics of adolescents especially for purposes of age categories, level of education and residence status. These helped me to identify their level of interaction with people from various settings as well as their access to various kinds of information regarding HIV/AIDS education. This was possible through the use of self-administered questionnaires[29] categorised for in-school

[29] These questionnaires were selected from Behavioural Surveillance Surveys (BSS) guidelines from Family Health International (FHI) (FHI, 2000). All of them could not be used because some of them could not suit the social and environmental settings of the study area and group. However, these guidelines have been widely used in reproductive health research among the youth.

adolescents and teachers. However, it is important to note that data from both categories of questionnaires could not be sufficient enough in itself but instead, as noted earlier, they were meant to supplement on the information obtained through other methods.

4.4 Case Study Selection

Silverman (2005) justifies the case study approach that it helps to 'make a lot out of a little'. In other words, when compared to generalised studies, case studies provide an opportunity for intensive analysis of many specific details. In addition, they are helpful in investigating a general phenomenon. The case study approach has been criticised because it may not be representative (Bryman, 2004) since what takes place in this case may not necessarily be true to other cases. However, for reasons of time and financial constraints, this approach was used. Further more, it provided a suitable context for getting answers to questions this research poses.

Case studies usually demarcate a unit of analysis within a system and this study focuses on the school as a unit of analysis with the primary focus on students' viewpoints. This study also integrated other important actors such as teachers, parents and other education sector officials so as to provide a holistic picture of the way in which HIV/AIDS prevention efforts among the young generation are promoted.

The school chosen for the case study was randomly selected among the 15 secondary schools in Sheema County, in Bushenyi District. The choice of the selected school had various advantages for this research. In the first place, it had students from different social and economic backgrounds. While some of them were staying at school for the whole term (boarders), others used to travel from their homes every morning to school and back home in the evenings. The reason for this is that the majority of those who are not boarders cannot afford boarding fees, while others prefer to come from home daily and help their parents with domestic work in weekends. This enabled the possibility of getting information from students of various settings. Secondly, the school being a co-educational institution enabled free discussion and interaction from students of both sexes and during questionnaire administration it increased the possibility of getting gender balanced responses.

4.5 The Fieldwork

> "Qualitative inquiry designs cannot be completely specified in advance of fieldwork… A qualitative design unfolds as fieldwork unfolds" (Patton, 1990:61)

The fieldwork was conducted between mid-September and October 2007 in a rural secondary school in Bushenyi District, south western Uganda. The school is a mixed co-educational for both day and boarding students with ordinary (O' Level) and advanced (A' Level). It is a church founded school but funded by the government[30]. At the time of research, the term had just started 2 weeks before and everybody seemed busy. When I visited the office of the head of school, he was preparing for a meeting of board of governors, the highest governing body in the school. A number of opportunities and challenges occurred during the whole period of two months in the field but these will be discussed in detail in a different section.

An arrangement was made before through the ministry of education and the permission to conduct research in the school under the ministry was acquired as early as June 2007. The letter to the head of the school was written before the fieldwork but due to postage delays, the telephone had to be used. For two days, I did not get through on the head master's phone until the third day. We made an appointment for interview and the arrangements for meeting students and teachers. He was a very friendly administrator who managed to delay the meeting and accept an interview with him. There was a problem of time on the side of the researcher because the means of transport to be used got a technical and probably a human-made problem early in the morning.

The fieldwork involved use of self-administered questionnaires for teachers and students and Focus Group Discussions for students (*see Table 1*). It also involved both structured and unstructured interviews with the parents and the Commissioner for secondary education who is at the same time the coordinator HIV/AIDS activities in the Ministry of Education and Sports. A number of visits were made to the resource centres of the ministry, Uganda AIDS Commission, Uganda Program for Human and Holistic Development (UPHOLD) and Straight Talk Foundation. All of these had relevant literature for the study. During the fieldwork I was also privileged to attend two workshops: for launching HIV/AIDS

[30] Although it is government funded, parents pay fees to supplement on staff salaries and the general school budget. By the time this study was conducted, the Universal Secondary Education had not been implemented.

Mainstreaming guidelines at the district and national levels and Straight Talk Foundation National Dissemination workshop. Although this was not among my initial fieldwork plans I found both of these beneficial to my research. This flexibility in fieldwork is supported by Bryman (2004) who contends that during the process of fieldwork, alternative avenues of inquiry might arise which do not necessarily lead to superficial or unscientific data but instead may help to strengthen data.

Table 1: Sample Selection of Study Participants

Students		Teachers	Others
Questionnaire (n=60), actual 51	Focus Group Discussions (n=12)	Questionnaires (n=11)	Interviews (n=4)
Females = 27	Females = 6	Females = 2	MoES, Headmaster
Males = 24	Males = 6	Males = 9	2 Parents (1 male, 1female)

4.5.1 Quantitative method: the Questionnaire

Given the nature of the societal norms in discussing sexual related issues in public and the nature of the topic itself, it was decided that self-administered questionnaires be used. For adolescents, these questionnaires generally asked about their socio-economic characteristics, knowledge and attitudes towards Sexually Transmitted Infections (STIs) with emphasis on AIDS as well as their practices and beliefs. For teachers, apart from their social and professional background characteristics, they were asked about their attitudes towards HIV/AIDS education and the capacity of their profession and education sector in general to contribute to HIV/AIDS prevention efforts among their students.

With the help of the teacher given to me by the head teacher to help me identify the respondents, 60 students were randomly selected out of more than 100 who had voluntarily offered to take part in the study from form two, three and five in the age category 14 – 19 years. During this selection, it was explained that many females are encouraged to participate as males and hence in all the responses received, were from 27 females and 24 males. 60 questionnaires each with 46 questions were distributed and out of these, only 51 (85%) questionnaires received response. The questionnaire administration took form of three

sessions under trees in the school compound[31] for each class category. This was mainly to maintain close supervision and ensure that there was no close interaction during the exercise.

For teachers, 20 questions were prepared for proposed 20 respondents. Out of the prepared 20 pieces, it was possible to distribute only 15 because some teachers were not in school that day since some of them teach in other schools in what is popularly known as part-timing. Out of 15 sets distributed, only 11 were returned with responses.

Although questionnaires have such advantages as offering greater anonymity especially in sensitive topics like this one as well covering a large study in a short period especially under scarce resources, they also have their criticisms and their limitations too which cannot be ignored.

Validity for the questionnaire could have been perhaps affected by the fact that the questionnaire was in English. Further more, due to limited time, the questionnaire was not pilot tested. Although students from the upper level could have given more valid responses due to their better comprehension, this could not have been the case with class one and two. However, since I was present during the administration of the questionnaire, I was able to respond to some of the questions that were brought to me for translation in the local language. I believe this could have reduced the problem to a minimum. Other studies had used questionnaires in English for students in a secondary school and got valid results (Kinsman *et al.*, 2001) and I thought this would do the same for me.

4.5.2 Focus Group Discussions

Focus group discussions (FGDs) can be defined as the group interviews with several participants, with emphasis on questioning on a particular defined topic, and to observe interaction within the group (Bryman, 2004). It is essential that the selected participants have certain characteristics in common that relate to the topic of the focus group. Among the principal advantages of focus groups, apart from yielding a large amount of information over a relatively short period of time, they are effective for accessing a broad range of views on a specific topic, social norms and variety of views or opinions.

[31] The school has a spacious compound with grown trees that provide shade. There are benches under each tree and respondents were asked to keep a distance from one another to avoid bias and social influence in responses.

In this study, two FGDs, each consisting of 6 members were held with the age group 14-17 years selected randomly from any of the classes. Separate discussions were held for both males and females, although some members from the male group had requested a mixed discussion. The response was that such an arrangement was not made before in the study proposal and so it would not be possible to adopt it at that time. No participant who participated in responding to the questionnaire again did so in the focus groups. New participants were selected and the main reason for this was to avoid any influence that would emerge from the prior knowledge or responses from the questionnaire.

Although the group members had consented to the use of a voice recorder, discussion sessions were not voice-recorded because the environment was not so conducive. The only place that was available for the discussion was in the compound under a mango tree. In the vicinity of where the discussion took place, there was an electric generator that produced loud sound and it was feared that this could affect the voice recording quality. Thus, it was only possible to take notes while the discussion went on. The major limitation in this case was found to be with taking notes while at the same time listening and moderating the discussion, which actually made it difficult to record most direct quotes from the participants. This is one of the reasons why it is recommended for more than one researcher in cases where the tape or video recorder is not used (FHI, 2002) such that they play various roles. One researcher, who acts as a moderator leads the discussion while the other takes the notes on the discussion. For this particular study, resources could not allow employing a co-researcher and what I did was to take brief notes as I led the discussion and these were expanded on as soon as possible after the discussions. The expansion took a form of transforming shorthand into narrative and elaboration on observations made during the sessions.

The above does not mean that focus groups were not properly utilised in this study. It gave me the opportunity to probe issues of problems faced in accessing information on HIV/AIDS, as well as utilisation of protective measures such as the use of condoms. Through such probing for example, it was revealed particularly from the male group that condom use cannot be assured because apart from having *'enkara'* - a bad omen[32], one can

[32] Boys expressed a common view that when they carry condoms, the girls cannot allow even though there was a promise in advance. Hence they saw no reason of carrying them all the time. There was a belief that condoms do not protect because whenever one carries them, he cannot have sex, calling them 'shield from sex'.

never be sure that when you carry a condom, the girl will accept. Similarly, from the female group, it was revealed that it is difficult to promise sex on the next time of meeting although boys always ask. The common answer is 'we shall see' and with this the boy can never be sure what will happen the next time. During this probing, care was taken not ask for specifics owing to the cultural context of the group.

The topics/questions for the focus group discussions were similar for both males and females. They focused mainly on problems of accessing HIV/AIDS information and the role their teachers and parents played in talking to them about the disease. They also included the ability to act on information they receive from various sources and whether the socio-economic environment in which they lived favoured total proper protection from AIDS. When setting these questions, I took caution of avoiding 'leading questions' – those that could lead the participants along a particular line of thinking thereby influencing their responses. From the female group, various questions were raised towards the end of the discussion regarding relationships, Prevention of Mother to Child Transmission (PMTCT) as well as AIDS drugs. I had to be cautious in my responses to these questions because I had to remain within my boundaries of a researcher and not a counsellor or service provider.

Focus group discussions also have limitations. They are not the best method for acquiring information on highly personal or socially sensitive topics and one-on-one interviews are suggested in this case. However, owing to the limited resources and time, it was not possible in this study. There is also alleged dominancy of certain group members over others who may seem to be weak or not so experienced and vocal. But this is so common in mixed groups where due to gender differences, males tend to dominate females and this study was cautious of that hence use of separate group discussions for different gender groups. In terms of social status, age and education level, there was unnoticeable difference since O'level students were only selected. The other observed limitation was to do with confidentiality which seemed to have been partly compromised. Some group members seemed to have their stories told from experience or just revelation of their friends' secrets and most of them caused laughter. But since these stories were told to the same sex, there was lot of comfort and even, contributions from fellow participants came up on such issues that would have been impossible in mixed groups.

4.5.3 In-depth individual structured interviews

In-depth interviews with key informants are designed to elicit a vivid picture of the participant's perspective on the research topic. They are usually conducted face-to-face and involve one interviewer and one participant and during this process, the person being interviewed is considered the expert and the interviewer is considered the student. One of the reasons for their popular use is that they are very effective in giving a human face to research problems (FHI, 2002) whether the persons to be interviewed are in high profile positions, or of average or low level of social status.

In this study, the selection of the interview participants was based on professional experience and responsibility in relation to efforts to prevent the further spread of HIV/AIDS among the in-school adolescents. For the parents for instance, they have a lot of stake in determining the social and behavioural growth of the children with responsibilities of feeding them, paying fees and offering parental advice and guidance and for this reason, I argue that they should not be left out in any studies concerning young people. The choice of the headmaster for interview was based on the fact he, too, plays a significant role in the school system. Apart from being just an administrator, the headmaster acts as a link between all stakeholders in school whether in matters concerning curriculum, staff, students, parents and the community in general as well as the ministry responsible for education. Thus to gain a broader perspective and gain deeper insight into HIV/AIDS education programs in school and their implementation, the headmaster was also interviewed.

An official from the Ministry of Education and Sports (MoES) at the level of commissioner and at the same time the overall coordinator of HIV/AIDS programs in the ministry was also interviewed. It was important as part of the research questions to find out about the ministry programs for HIV/AIDS at the school level as well as the factors that determine negative or positive behaviour change as identified by students and stakeholders. It would not viable to find answers to some of those questions without interviewing those at the policy level. In addition, gaining access to his office enabled me to gain access to the ministry's library/resource centre since he granted me such permission. Indeed, the interview topics revolved around finding out the programs in the ministry that respond to HIV/AIDS for in-school adolescents, the support to schools and the challenges faced among others. His responses gave a policy level perspective of HIV/AIDS education programs in Uganda.

In all interviews, semi-structured questions were used and these were thematically developed from the overall research goal and the questions that the study poses. Except for parents, digital voice recorders were used in all other interviews, though in some cases, there were some interferences from other nearby businesses going on. For example, telephone calls, which had to be received, forced me to on hold the recording process and sometimes switch off the recorder. This was a big challenge because some interviewees were not bothered receiving the phones even when they knew that they were being interviewed. Other interferences were noisy construction machinery and the electric generators. In all however, these had limited impact on the process of interviewing.

4.5.4 Document Analysis and Secondary Data

> 'In contemporary society, all kinds of entities leave a trail of paper and artifacts, a kind of spoor that can be mined as part of fieldwork… Organisations of all kinds produce mountains of records, both public and private… These kinds of documents provide the [researcher] with information about many things that cannot be observed'. (Patton, 2002:293)

Although qualitative and quantitative methods provided primary data for this study, secondary data was also important to give it more strength. Secondary data was obtained from the key documents that included Presidential Initiative on AIDS Strategy for Communicating to Young People (PIASCY) handbooks I and II, the Ministry of Education and Sports Strategic Framework, the National HIV/AIDS Strategic Plans (previous 2000/1-2005/6 and current 2007/8-2011/12) and Monitoring and Evaluation (M&E) reports from various organisations involved in HIV/AIDS Education work. I also consulted official document reports from international bodies that include UNAIDS, World Bank, World Health Organisation, UNDP, UNESCO and others. I had access to most resource libraries of both the government and private stakeholders mentioned above. In this case, documents proved valuable not only because of what I learnt from them directly but also as a stimulus for further inquiry. These visits to the libraries and resource centres gave me the opportunity to have informal talks with various stakeholders and the information obtained helped in clarification of issues raised from documents and reports.

4.6 Data Analysis

Overall, just like various methods were used to collect data, various means have been used to analyse data. Data from quantitative tools (questionnaires) was analysed using Microsoft

Office Excel 2003 and SPSS 14.0 for Windows. These have been used to calculate simple descriptive statistics of frequency distributions, means and standard deviations. Raw data was entered in Ms Excel sheets and then exported to SPSS for analysis. The output was produced in form of tables, graphs and charts from which conclusions are made as will be seen in the subsequent chapters of findings and discussion.

Data from qualitative methods was analysed according to the themes that were developed along the research questions. During instrument preparation, each of the questions in Focus Group Discussions and interviews was developed falling under any category in the research questions. During data collection, it was very important to list any responses under each of the themes. Even in some cases where information was got from informal discussions, like for the case of teachers, important points were allocated a theme where they fell. This enables the writing of the findings and discussion in the next chapter where sub-headings are developed from the research questions.

4.7 Validity and Reliability

4.7.1 Validity

In common speech, a statement is said to be valid if it true or correct (Brock-Utne, 1996). In research, validity is concerned with the integrity of conclusions that are generated from a piece of Research (Bryman, 2004). In qualitative research, validity is addressed through the honesty, depth, richness and scope of the data achieved, the participants approached, and the extent of triangulation[33]. Bryman (2004) identified two components of validity: external validity, which refers to the degree to which the findings of the study can be generalized to similar cases or have relevance to the population from which participants were drawn. Internal validity, which means that there is a good match between the researchers, observations and the theoretical ideas they develop or the degree to which research findings can be influenced by extraneous variables. In relation to this research, external validity holds relevance since the findings may help to understand factors that influence behaviour change

[33] The use of more than one method or sources of data in the study of a social phenomenon so that findings may be cross-checked (Bryman, 2004).

among in-school adolescents elsewhere in rural Uganda because they share similar social, economic and cultural context.

Internal validity was enhanced by the use of various methods such as focus group discussion, questionnaires for both the students and teachers, and interviews with head of school, parents and the ministry of education official. The fact that all the questions in either of the above were developed according to the questions posed by this research helped to keep tracking the relationship between the two. Probing questions that emerged during the interviews were aimed at keeping the responses on track. Questions such as '*what to do you tell your children about HIV/AIDS'* were often followed by others like *'do they ask questions, if not why do you think so'* for parents. Responses were helpful in giving clarification and making sure that interviews were not diverted. I also followed up responses that needed further clarification with telephone calls to the head of school during data analysis and all this was aimed at ensuring that the match between questions and response was maintained.

4.7.2 Reliability

Biseth (2005) while quoting Silverman (2001) writes that unless methods are reliable, it is difficult to convince the audience that the conclusions are valid. Bryman (2004) defines reliability as the degree to which a measure of a concept is stable; hence the results must show a high degree of consistency. To ensure consistency, at the end of each field day, I compared notes that were taken during each session. This was particularly important in focus group discussions and interviews with parents where the use of a voice recorder was not possible. In cases where voice recording was possible like the head of the school and the ministry official, I listened to these interviews as often as possible.

Although I had perceptions of what certain issues were in HIV/AIDS education in Uganda because of my previous study and teaching experience, I was convinced within my mind that many things are changing. In HIV/AIDS education, many projects are going on and different stakeholders are implementing various interventions. Hence, my previous knowledge had somewhat limited influence on the findings. For example, the district support of School Anti-AIDS Clubs in the school was news to me because I previous knew only Straight Talk that supported these clubs and in any case, the form of support itself had changed. This is not to mean that there was complete objectivity in this study as this is impossible to achieve (Bryman, 2004). Hence, I followed Bryman's (2004) proposal of confirmability that;

> ‘While recognising that complete objectivity is impossible in social research, it should be apparent that the researcher has not allowed personal values or theoretical inclinations manifestly to sway the conduct of the research and findings deriving from it,’ p.276.

4.8 Limitations of the study

Due to the envisaged limitations, this study avoided where possible to make a lot of generalisations. The researcher previous knowledge about the subject could have hindered the reliability of some of the findings of the study and objectivity. To some extent, this is unavoidable and conclusions may not necessarily be the ‘truth’ (Bryman, 2004) because we are human beings and we give our own interpretations to what we see or hear. It is important however to note that although such a background could embed some personal biases so as to have any influence on objectivity and validity of the study (Silverman, 2001) it provided an insight for posing further questions for continuous inquiry in this area.

What is presumed to have limited the validity of this study is that small samples were selected and just a single rural-based school among many others. Hence, the conclusions made from this study may not necessarily be representative of what takes place else where in other schools or other different contexts, even with the same study group. However, this was mainly due to resource constraints and hence as the proverb in my part of the world goes, *‘the chicken picks only what it can afford to swallow’* literally interpreted here that I could only do what resources available could allow.

Biseth (2005) asserts that a researcher will always be an “outsider” or an “alien substance” in an every day life situation. Her/his presence will, in one way or the other, influence the people s/he is studying. Being a male, it was somehow challenging to conduct a Focus group discussion with female students. Did this therefore affect girls’ responses? On one hand, whereas I had reasoned that by holding separate discussions for females and males would provide a comfortable environment for either side, it turned out to be a challenge. Indeed, it took a lot more time building a rapport with girls than it did for boys. However, I indicated in my introduction that I am a teacher and my teaching skills experience could have helped me to bring students closer with some ease. Secondly, I assured them of confidentiality to be maintained for their responses and allowed them to use a language of their choice if they were not comfortable with English. Eventually, when they began to ask some questions, I

realised that they were at par with the discussion although this could not completely rule out the possibility of age, gender and hierarchy differences.

On the other hand being an 'insider' in the area could affect objectivity of the research. Narayan (1993) expresses how difficult it can be to obtain data despite being an "insider" in a culture. She argued that other than just cultural identity, factors such as education, gender, sexual orientation, class, race, or sheer duration of contacts may at different times outweigh the cultural identity we associate with insider or outsider status (Narayan, 1993). She suggests that in such circumstances, research should entail letting the people that we focus our attention towards, know that they are subjects with voices, views and dilemmas which are reflected in our text. Thus, while doing my work, I try to focus more on what people say rather than what I know.

4.9 Ethical considerations

Research ethics according to Family Health International (2002) deal with the interaction between the researcher and the people under the study or those who have any stake in the study. Interaction with people was guided by the principle of respect – honouring the individual autonomy and decision to participate in the study or not. This was based on the belief that individuals have the capacity to exercise free will. For example, although the use of voice recording device in the interviews with parents would ease the capturing of data for me, it could not be used when they indicated that they were not comfortable with it since it was important to seek consent before the use. Sacrificing research for the respect of the research participants is acceptable as noted by Family Health International (2002);

> 'Whenever we conduct research on people, the well-being of research participants must be our top priority. The research question is always of secondary importance. This means that if a choice must be made between doing harm to a participant and doing harm to the research, it is the research that is sacrificed'p.8

For students, the permission was sought from the school administration and this is difficult to assert whether such consent should be sought directly from students themselves. Even then for this case, all students who participated in this study volunteered to do so after a briefing from the researcher about the purpose of the study and the importance of their participation both to the researcher and the participants.

Marshal (2007) suggests that it is important to obtain consent with individuals representing the study population and that in other settings, it is important to seek advice or permission from a third person [or those who hold authority]. Therefore, it was important to seek permission from the ministry and the head of the school that provided the case study. Hence, prior permission was also sought from the Ministry of Education and Sports and was granted. Interviews were also done with prior requests in writing to the persons concerned and this was after explanation of the purpose of research was provided.

4.10 Conclusion

So far, this chapter has introduced methodology and procedures used in this research. It has given the explanation and justified the use of both qualitative and quantitative methodologies for this research. After showing the methods used in analysing data, I have attempted to discuss the issues of validity and reliability and how these were considered in this research. It ended with both the limitations to the study and ethical considerations and this takes me to the next chapter that presents the findings and the discussion of the factors that affect behaviour change.

5. HIV/AIDS education: Knowledge and Behaviour change

A central element of health promotion is providing health education to change youth behaviour and encourage adoption of healthy behaviours. However, behaviour change is one of the most difficult goals to achieve in health promotion. In recent years, experience with health education, particularly in the context of HIV prevention, shows changing knowledge alone may not change behaviour. *World Development Report, 2007* p.129

5.1 Introduction

This chapter presents the findings of the study conducted in a rural based secondary school in Uganda. The findings are presented according to themes of knowledge levels among in-school adolescents, HIV/AIDS education programs in Uganda that target in-school adolescents, and the contextual factors that influence behaviour change. These themes are developed from the research questions such that each of the sub-headings is addressing issues related to the question. The research questions that guided this study are;

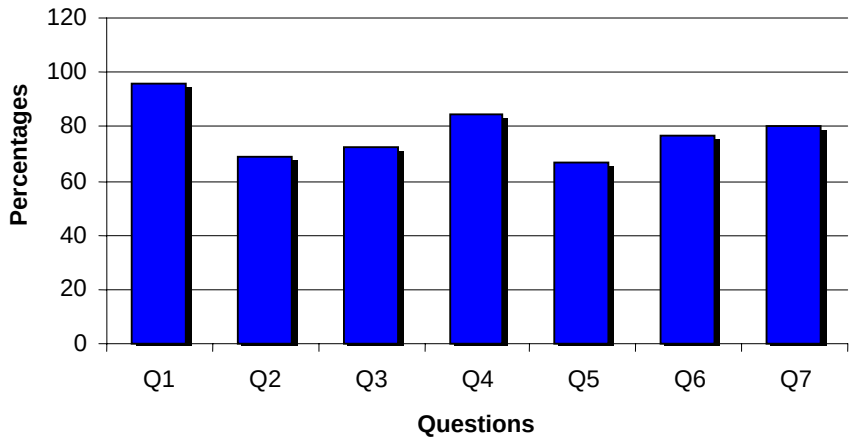
- *What is the knowledge level about HIV/AIDS among secondary school adolescents and what are their main sources?*
- *What are the HIV/AIDS education programs for in-school adolescents in Uganda?*
- *What are the contextual factors that determine negative or positive behaviour change in response to information about HIV/AIDS as identified by students and stake holders?*

Note that these research questions were generated from the overall research objective and narrowed down into specific research objectives which provided a guide to methods of data collection and analysis. Findings are presented in various forms such as statistical charts and graphs, diagrams, direct quotes from the informants and paraphrased texts since this study used mixed methods and tools to collect data. Discussion and analysis will simultaneously follow each of the findings presented and the conclusions will be made in the subsequent chapter with recommendations.

5.2 HIV/AIDS knowledge among in-school adolescents

Results from questionnaire responses indicate high rates of HIV/AIDS awareness among the in-school adolescents. To ascertain HIV/AIDS awareness levels, the tool included among others, questions that assess basic knowledge, attitudes, behaviour and practices (KABP). These questions included whether respondents had ever heard of HIV/AIDS (Q1), whether the virus can be transmitted through mosquito bite (Q2) or if one can get protection by having one faithful uninfected sexual partner (Q3). Other questions included whether a healthy looking person may have the virus (Q4), if a pregnant mother can transmit the virus to an unborn baby (Q5), whether one can eat food served by a person living with HIV/AIDS (Q6) as well as whether contraceptive pills can prevent HIV infection (Q7). The results indicate high levels of awareness (90.8% overall) as evidenced from the responses as illustrated in Figure 3 below.

Figure 3: HIV/AIDS knowledge among in-school adolescents (12-19) in rural Uganda



A number of observations can be further made from the above graph. It is clear that awareness among in-school adolescents is high in this particular rural area. However, although 96.1% indicated that they have ever heard about HIV – the virus that causes AIDS, only 68.6% were sure that the virus cannot be transmitted through a mosquito bite. What this means is that the knowledge they have is not comprehensive[34]. The Uganda National

[34] Comprehensive knowledge means agreeing, in response to prompted questions, that people can reduce their chances of getting the AIDS virus by having sex with only one faithful, uninfected partner and by using condoms consistently, and knowing that a healthy-looking person can have the AIDS virus and that HIV cannot be transmitted by mosquito bites or by sharing food with a person who has AIDS.

HIV/AIDS Sero-behavioural Survey report (2006) also noted this trend that among the 15-19 age group, only 29.0% females and 32.5% males have comprehensive knowledge about HIV/AIDS but with no explanation of neither the cause of these low percentages nor the reasons for this variation between males and females.

Responses from the group discussion with the adolescents of the same age category in the same school further indicated that the knowledge got about HIV/AIDS is basic knowledge and there is lack of proper channels where the emerging questions could be addressed. This was raised when the group was asked about the problems that they face during accessing information regarding HIV/AIDS. A female participant said;

> "Sometimes when I read a newsletter or listen to the radio when I am at home, I do not have anybody to ask when I have a question. Our parents and teachers are harsh and I cannot ask them."

Other participants from the same group indicated that there are opportunities to write to Straight Talk Newsletter[35] but they do not use it and no clear reasons were given for this. There are no opportunities for seeking confidential or private consultations at school regarding sexual issues. It was also revealed from the female group that some teachers start demanding for sex when confidential talks are sought and so it is useless to approach them since failure to give in to their demands usually breeds hatred.

> 'I cannot go to the male teacher to ask him about sexual issues. I will have given him the opportunity to demand for sex. When he gets such opportunity, he starts asking you when you will visit him and you know what this means', Female student.

The group also reasoned that many teachers are males and they do not trust the senior woman in confidential matters because she is not approachable and when asked, she will start asking about the sexual activities one is involved in that are leading them to ask such questions. It was further revealed that she believes just like their parents, that they are not mature enough to ask about sexual issues.

There were other issues raised in regard to HIV/AIDS awareness. When asked whether parents and teachers were doing enough to talk about HIV/AIDS to them, the responses were

[35] Straight Talk is a monthly newsletter for secondary school adolescents published by the Straight Talk Foundation. It provides information on reproductive health and behaviour change. It encourages youth with questions to send them and answers are provided in the subsequent issue.

mixed. While some agreed, others disagreed pointing out that parents expect teachers to do this on their behalf and teachers also think parents will talk about that 'sensitive issue'. The same issue was raised in an interview with the head of the school who said;

> 'Very few parents come up openly to talk to their children about sex and AIDS. The majority of the parents want that role to be played by other people on their behalf such as teachers who at times do not have time. And even if teachers were to teach about such, it would sound the usual things teachers say and students will say 'ah those are the usual things we hear from him/her' [students will not take the issues seriously].

It was also pointed out that the information both parents and teachers give is not frequent and is presented in warning tone only arguing that they are still young and if issues like condoms are mentioned, they will encourage promiscuity. Under such circumstances, adolescents find it difficult to seek for more information.

Available data indicates that the average age of sexual debut in Uganda is 16.6 years among women and 18.1 years for men (UDHS, 2007). This data predicts a slight trend towards later initiation of sexual activity in future and this is possible with increased information provision and awareness. Indeed, nationwide data indicate later initiation of sexual intercourse among the educated. Hence education and information provision provides a better opportunity for delaying sexual initiation and hence help to prevent HIV/AIDS infection among the in-school adolescents. It is the contention of this study that such education and information should be comprehensive for both the promoters and the intended beneficiaries.

5.2.1 Sources of information regarding HIV/AIDS and sexual issues

Adolescents named several places where they access information on HIV/AIDS and sexual-related issues. These included the school (teachers, fellow students), newsletters (straight talk), health centres, radio, roadside/street posters and billboards, television and parents. They were asked about their first source of information regarding HIV/AIDS, the current most common source of information and how often they learn/hear about HIV/AIDS at school.

Figure 4: The first source of information regarding HIV/AIDS

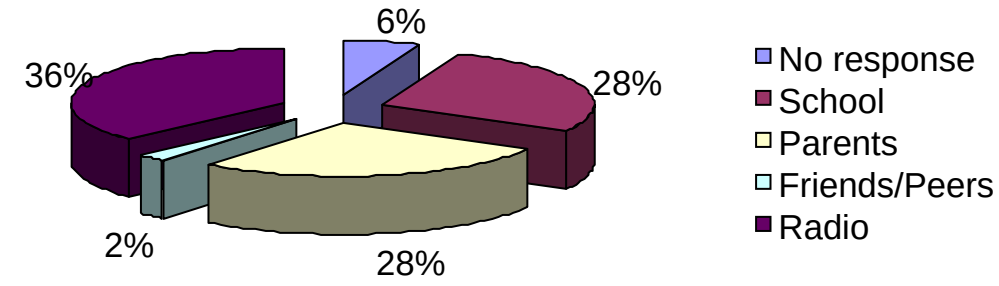
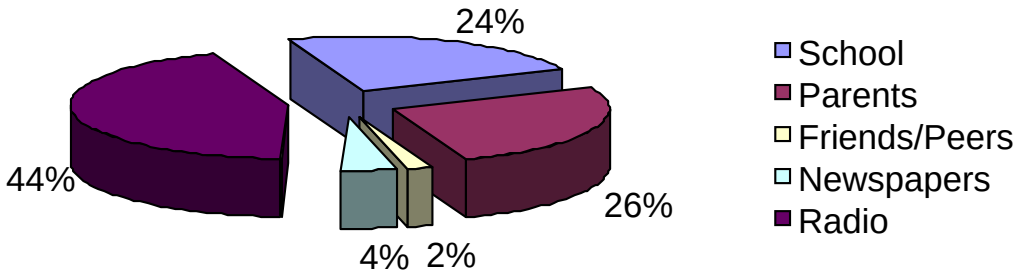


Figure 5: The current most common source of information regarding HIV/AIDS



Although television was included as an option in the questionnaire, it received no response and the reasons for this may be understandable considering the context. The research was conducted in a rural school where access to television is very limited. Secondly, from the interview with the head of school, although the school owns a TV, students prefer to watch soccer and then, movies and moreover, it is watched on weekends and when electricity is available.

Evidence of presence of Straight Talk materials was found in school during data collection. During interviews and focus group discussions, Straight Talk newspaper was mentioned to be the leading provider of sexual and reproductive health information. This paper that is posted to schools every month advocates for safer sex, including abstinence, non-penetrative

sex (setting sexual limits) and condom use. It is adolescent-driven and social values-based and also promotes life skills. The paper has a counselling page where a group of dedicated and adolescent-friendly counsellors and doctors advise readers on issues related to relationships, life skills, sex and reproductive health. Readers are encouraged to send their questions and they receive responses in the subsequent issues.

Figure 6: Straight Talk messages in the school library

Straight Talk Clubs have been formed in secondary schools and communities and these provide opportunities for open discussion about issues that affect adolescents. The Clubs are initiated by the adolescents themselves to discuss further the messages of safer sex with their peers. They are led by Straight Talk committees and patronised by any teacher who volunteers. In the school visited, there existed a similar club called School Anti-AIDS Club (SAC) that was formed with financial support from the district project called Child AIDS Health Initiative (CHAI). This club, according to the head of the school, was more vibrant than Straight Talk club because of financial support that helped in organising songs, plays and other drama activities that were held in school. However, the role of Straight Talk was still hailed because of the newspapers and other behaviour change communication materials as well as support visits by development and health workers through outreach programs.

The activities of Straight Talk Foundation providing adolescent reproductive health education and behaviour change communication have not been without criticism. As observed by the head of school, the school club activities are not vibrant. In other schools, the clubs are waning and according to one head of school where the club once existed but collapsed[36], this is partly due to lack of support from teachers and the school administration. The school budget does not include straight talk club expenditures and in addition, teachers do not have time for club activities. Secondly, the linguistic diversity that characterises Uganda limits the reception of information that is mainly published in English. This very problem was raised in students' focus group discussion among the challenges faced in accessing information regarding HIV/AIDS and other reproductive health issues.

Straight Talk also provides information mainly targeting the adolescents who are not yet infected with HIV/AIDS. There is at least circumstantial evidence to support the existence of adolescents living with HIV/AIDS. The fact that there is teenage pregnancy in schools means that young people have unprotected sex which is the easiest way to contract the virus. The prevalence rates for in-school or school going age adolescents are difficult to determine with only 8% going for Voluntary Counselling and Testing (VCT) service to know their status (Straight Talk, 2007). The problems of stigma and other related issues faced by those already infected are rarely addressed by Straight Talk and this is a serious emerging issue that needs to be addressed.

5.2.2 School provision of HIV/AIDS Information

Schools are an effective place to offer adolescents sexual and reproductive health-related information and skills for several reasons. The school provides an excellent forum for reaching a large number of adolescents in a structured setting. It is also argued that the daily ongoing format of classroom instruction provides an opportunity for adolescents to practice skills, raise questions and concerns and obtain comprehensive education on sexual and reproductive health issues over an extended period of time (Biddlecom, et al. 2007). However, in the context of this study, this is not necessarily true because students (especially girls) indicated fear and limited opportunities to raise questions and other concerns regarding

[36] This is from a different school (private) mixed, day and boarding with over 1200 students. The club once existed but its activities were not sustainable. The informant recalled of a Straight Logo that was on the wall of one of the school blocks in a place once termed 'Straight Talk Corner' which no longer exists in the school.

sexual related issues. In the long run, adolescents who may drop out of school will have already acquired basic information but questions can be raised on the ability to retain and sustain this knowledge soon after school due to the differences in both settings. For example, it is possible that what was taught at school may be forgotten, replaced by or conflict with the knowledge and experiences out of school where there is more freedom, a lot of exposure and quest for experimenting for example about issues related to abstinence and condom use[37]. Schools are said to be safer for adolescents than homes because according to the parents and some of the teachers, most problems occur when students are at home in the villages.

> 'We know these children misbehave when they go home in the holidays and many pregnancies that occur take place during this period. This is why many boarding schools check girls [for pregnancies] at the beginning of the term', Female teacher.

Although the fact that many sexual related problems occur when students are in the homes/village is generally accepted, the study also found out that schools are not completely safe either. For instance, the head of the school pointed out the need for separate campuses for boys and girls when asked how best to make the school environment safer in the HIV/AIDS prevention efforts.

> 'At the school level for boarding schools, there should be designed a way that separates campuses for girls and boys. This would minimise on the risky chances since most evils occur at night in dark corners', head teacher.

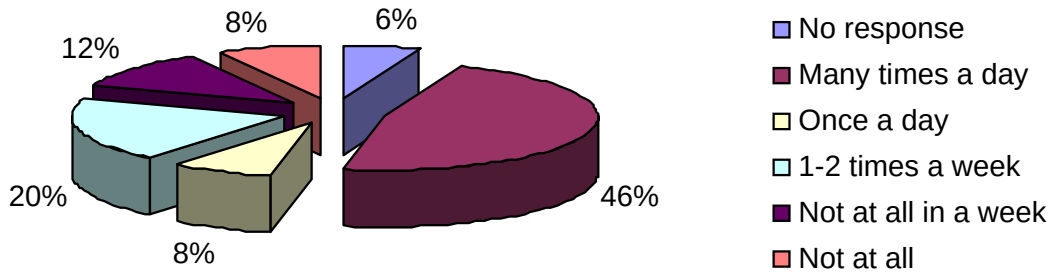
Hence, for prevention efforts for in-school adolescents to be more effective, they should not be limited to school settings only and there should be efforts to ensure continuity and sustainability of information during the period when children are not at school. Secondly, the school environment is not completely safe as mainly believed since there are chances of sexual risks too and limited supportive mechanisms as will be discussed later in this report.

In Uganda, provision of HIV/AIDS information has for long been incorporated in school health programs at the extra curricular level and it is not treated as an independent area for learning and practice. According to the HIV/AIDS coordinator in the MoES, HIV/AIDS issues were integrated in some syllabus subjects such as Biology, Religion and Health

[37] Abstinence may be taught at school but adherence to this is enhanced by the school environment where chances of having sex are limited due to school regulations and restrictions. In the villages (out of school) environment, possibilities of having sex are high because restrictions are not as high as in school.

Science and a teachers' hand book had been developed for secondary school level. However, other findings from this study indicate that instead, other means such as compound and assembly messages are used to provide information to school adolescents. What is important here is that adolescents hear about HIV/AIDS many times at school irrespective of whether in class or outside, from teachers or their fellow students. Although it was indicated that the majority of students (46%) hear about HIV/AIDS many times a day, 8% said that they do not hear about HIV/AIDS at school at all. The table below shows the responses about how often students heard about HIV/AIDS at school.

Figure 7: Frequency of learning/hearing about HIV/AIDS in school

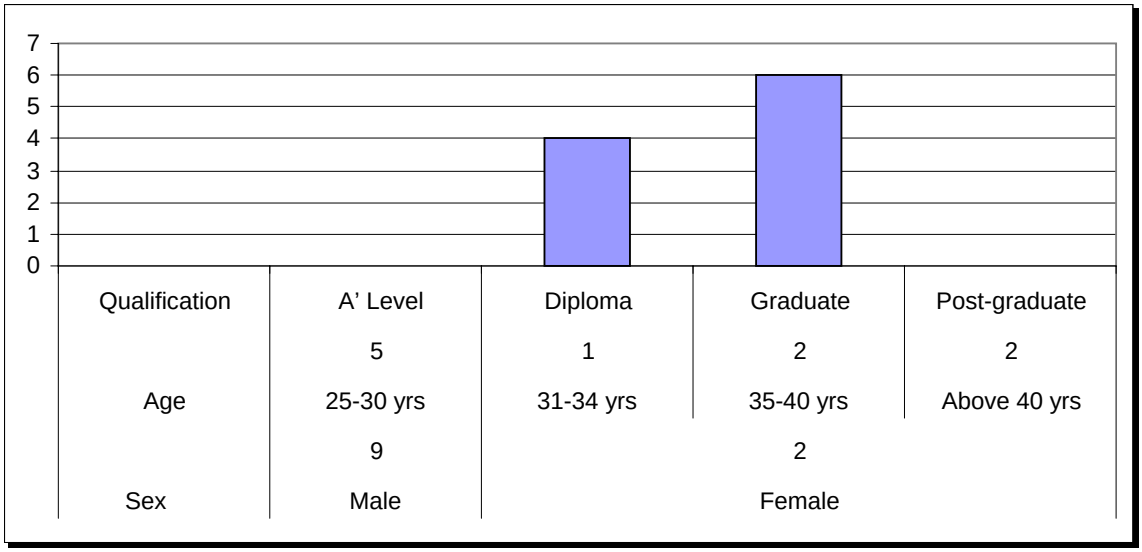


It is also important here to differentiate hearing about and learning about HIV/AIDS. In the first place, it possible that those who hear about it do not necessarily learn anything about it. This becomes worse for the categories of students who hear or learn about it less than two times a week or none at all. From the focus group discussions, it was found out that HIV/AIDS is not at all learnt about in the school and hence, it is possible that 46% who indicated hearing/learning about simply mean just hearing.

In this study, I facilitated self-administered questionnaires for teachers in addition to informal discussions that I held with them during lunch break in the staff room. The responses to questions regarding teaching about HIV/AIDS in school or simply mentioning it to students revealed that it is a neglected, yet important area. Nearly all of them contended that HIV/AIDS is a big threat to education and students' future in particular but were

sceptical about the school efforts in helping this situation mainly because it is less emphasised in curriculum learning and instruction.

Figure 8: Sex, Age and Qualification of teachers



To find out about the teachers views on HIV/AIDS provision of information and teaching at school, they were asked questions regarding whether they had ever heard about HIV/AIDS in school or whether as a subject, and if it is included on the regular school time table. Other questions were asked concerning their attitudes towards teaching HIV/AIDS and whether they think specialised training is necessary for teaching about HIV/AIDS.

Table 2: Teachers' attitudes towards HIV/AIDS education in school

Question	Response	Percentage
Have you ever heard about HIV/AIDS education in school?		
	Yes	80%
	No	20%
Is HIV/AIDS education is part of your school curriculum?		
	Yes	10%
	No	90%
Should HIV/AIDS education be included on the school time table?		
	Yes	80%
	No	20%
Is there a need for specialised training for teaching about sexuality and HIV/AIDS in school?		
	Yes	80%
	No	20%
Would you be comfortable teaching about sexuality and AIDS in class?		
	Yes	90%
	No	10%
Does the school provide a good environment to teach about sexuality and HIV/AIDS?		
	Yes	80%
	No	20%

Indeed, views from teachers about the presence of HIV/AIDS education in school do not differ much from those of the students. The majority indicated that they have heard about HIV/AIDS in school but when it came to teaching, almost none reported that it was taught in school. Teachers' realisation that AIDS is a big threat makes them feel that it is a challenge they should also confront. From the informal discussion, one teacher reasoned that just like teachers are at the forefront of fighting ignorance; it should be the same with HIV/AIDS. They indicated that they would be comfortable to teach about sexuality and AIDS since it is not necessarily true that discussing sex education with young people leads to increased sexual activity. This is only possible when it is part of the education curriculum and school time-table as it would be taught like other subjects. Being treated as an extra-curricular activity; HIV/AIDS education is denied careful attention and limits its teaching to those who volunteer to do so.

The commitment and patriotism that teachers demonstrate in raising an AIDS free educated group are confronted with a number of challenging issues. One concern is raised over their readiness. Findings of this study indicate that less than 30% of teachers have attended any short course related to HIV/AIDS. Even those who have attended a course said that they did not do it in the interest of integrating it into their teaching career but to enhance their personal knowledge. They argued that at the training colleges, they were trained to implement the curriculum and there is no time to teach what is not on the syllabus.

There are isolated efforts[38] by tertiary institutions to integrate relevant aspects of HIV/AIDS in teacher training programs. Various departments at Kyambogo University such as Psychology, Biological Sciences and Adult and Community Education as well as Special Needs have included aspects of HIV/AIDS in their training curriculum (Morisky et al., 2006). Graduates from these departments are posted to different schools across the country and are expected to guide and offer psychosocial support to the adolescents in addition to their care. However, these are not specialised HIV/AIDS teachers comparable to those that exist in other subjects. They find themselves with increased workloads to teach their own subjects and hence neglect to introduce HIV/AIDS in their classes. Even if they were to

[38] I refer to this as 'isolated efforts' because they are not following any government designed HIV/AIDS training policy. They depend greatly on initiatives of individuals or departments.

teach about it, teaching and learning about HIV/AIDS requires broad participation of young people and a highly interactive environment which are rare to find in Ugandan schools.

The curriculum and content of the subjects taught also poses serious challenge for effectiveness of HIV/AIDS education programs for in-school adolescents. An in-depth interview with the official from the ministry found that for a long time, the ministry has been using an integrated approach – where HIV/AIDS issues are introduced in other aspects of the core components of the curriculum and that recently there are efforts to mainstream HIV/AIDS in the ministry. A cursory observation in the syllabus textbooks used for teaching biology and health science indicates nothing related to HIV/AIDS. The total absence of HIV/AIDS aspects in the textbooks used[39] raises concerns of whether HIV/AIDS has ever been an integral part of secondary school syllabus or classroom teaching and this puts the approach at highly unattainable level.

Regarding whether or not the school environment is to teaching about HIV/AIDS, the majority (80%) of teachers agreed that the school provides a good environment to teach about AIDS. However, they were very sceptical about the knowledge that is offered at school and the ability of the students to apply it. There was a female teacher who mentioned about one incident that took place in a school (although she did not mention that it was that very school) that made her doubt adolescents' ability to put into practice what they learn or hear.

> 'I have a lot of doubts whether the efforts to teach young people about HIV/AIDS prevention will work. There is a male student who went to night preps with a condom on because the girl had promised to meet him after preps. How would you expect such a condom [that the boy put on for over three hours before using it] to protect him from AIDS?' - Female teacher.

Other teachers also expressed concerns about the sexually active students in school who cannot access any protection measures. Even if condom use is the alternative protective measure for those who cannot abstain, the schools do not allow carrying condoms to

[39] I asked a teacher who teaches Biology and Health Science and he told me the essential book for teaching his subjects was: *Introduction to Biology* by D.G Mackean. I perused through the pages of the book and HIV/AIDS does not appear. He told me it is a good book although it was published before HIV/AIDS became an issue.

school[40]. The head of the school reasoned that they come to school to study but not to have sex and hence, saw no reason why they should pack condoms.

> 'The school does not allow condoms in the school. We cannot allow them in the school canteen either because it would be like we are telling them to go and buy and use them. But sometimes they get out and get them from clinics and drug shops or even in bars. When they are being checked at the start of the term, some boys have them in their suitcases but these are not too many'. - School head teacher

Even if they go home during holidays, the home environment is not conducive either. If we take the argument that youth tend to engage in most risky behaviour in the context of homesteads and communities than in the tightly regulated schools (Asiimwe, 2006), we see that even those out of school are also at high risk. It becomes worse when by the time they leave school; the so called knowledge of protective measures is insufficient and does not help to protect them.

Figure 9: Compound messages (i)

Adolescents were also concerned about the storage conditions for condoms that made them doubt whether they are always effective at the time of use. When they go to disco dances, they carry them in their pockets but through a lot of warmth in their pockets, hard pressing

[40] The school has boarding section for both boys and girls although there are also those who walk from home to school daily.

and squeezing while dancing, and so by the time of use, some of them have already lost air in them. ‘I had no alternative, but to use it even if I found it had lost the air that was in it. I had carried it for several times without using it’, so one male revealed. Thus, it is not just the content and means to teach about HIV/AIDS prevention that affects the way adolescents respond but also the environment in which they live.

Figure 10: Compound messages (ii)

There are other efforts to promote HIV/AIDS prevention in the school. According to the findings from interviews, there are School Anti-AIDS Clubs (SACs) and these are joined by any willing member. For the school under study, such a club was mentioned and it has a teaching staff member who serves as its patron. However, this teacher does not have any specialised training in HIV/AIDS related work/issues, neither is he the counsellor and he was selected because he showed interest. This club does education through drama, songs and plays on school open days. Members also sometimes make presentations at the school assemblies to increase awareness of the whole school. This is very significant in enhancing youth participation in prevention efforts as well as making students talk openly about HIV/AIDS in public.

Observations in the school compound found posters with messages about abstinence and having healthy relationships, and discouraging young people from engaging in risky behaviours such as early sex. Such messages as ‘abstain’, ‘avoid sex until marriage’,

'virginity is health', and 'stay safe' are expected to keep in the minds of adolescents for all school days.

5.2.3 Media – print and electronic

> The monster HIV/Aids is still lurking in the backyard to pounce on us. So as you celebrate, beware of the dragon; don't become its prey as we say bye-bye to 2007. Avoid bad company that may lead you or lure you into dangerous temptation. *The Daily Monitor, editorial, December 25, 2007*

Apart from school compound messages and other sources earlier mentioned, the study found out that in-school adolescents get information from the media. Many media organisations are taking part in the fight against the epidemic and their main role is to increase awareness and educate readers, viewers and listeners about the facts of the epidemic and how to stop it. Quoting former UN Secretary General, Kofi Annan,

> 'When you are working to combat a disastrous and growing emergency, you should use every tool at your disposal. Broadcast media have tremendous reach and influence, particularly with young people, who represent the future and who are the key to any successful fight against HIV/AIDS' (UNAIDS, 2004).

The role of media in HIV/AIDS prevention has been emphasised as important to reach a wider audience. Indeed, Uganda's dramatic reduction of infection rates are said to be partly because of the openness and frank discussions fostered by the media (Green et al., 2006, UNAIDS, 2004). One of the most obvious roles pointed out is opening channels of communication and discussion about the disease. Mass media is also instrumental in breaking the silence that surrounds the disease and in creating an environment that encourages discussion of how individuals can protect themselves and change their behaviour, if necessary. HIV-related stigma and discrimination are major barriers to effective prevention and, in fact, have been identified as major risk factors for HIV transmission. Thus, media can play a vital role in efforts to overcome prejudice and encourage solidarity with people who are infected with, or affected by, the virus.

Adolescents mentioned Straight Talk radio talk show and Rock Point 256[41] where they hear young people of their age speaking openly about HIV/AIDS. The radio is also said to be the most important source of information regarding HIV/AIDS (UHSBS, 2006) mainly with messages of Abstinence, Being faithful and correct and consistent Condom use. However, although young people agreed to this fact, they reasoned that they miss many opportunities because they do not listen to radio at school since the school regulations do not allow. There is also a problem of gender differences in accessibility to the radios. It is reported that boys and girls have sharply different radio listener-ship patterns. Girls are three times more likely than boys to report that they do not listen to the radio at all (Straight Talk, 2007) and this poses a significant challenge to accessing information from the radio.

Table 3: Listener-ship patterns among the 10 – 19 year adolescents in Uganda

	Male		Female		Total	
	Number	%	Number	%	Number	%
Radio listening per week						
None	76	7.5	253	25.6	329	16.5
1–2 times	186	18.4	205	20.7	391	19.6
3–6 times	293	29.0	229	23.2	522	26.2
Daily	449	44.5	302	30.5	751	37.6
Total	1,004	100.0	989	100.0	1,993	100.0

Source: Straight Talk Report, 2007

The extent to which mass media is effective in transmitting HIV/AIDS information and hence contributing to enhancing prevention should also be examined. According to the head teacher of the school, the media is not properly utilised for the benefit of young people. This is one of the reasons why even parents themselves cannot support the idea of students taking radios to school. He argued that he had doubts whether they would listen to educational programs and not music that is played on the local FM radios. Even when the TV set is provided at school to be watched on week-ends, young people prefer either soccer channels or watching movies.

[41] Produced by the USAID funded Young Empowered and Healthy initiative (Y.E.A.H.), Rock Point 256 is a radio drama for young people that tells the story of the people living in a fishing and farming community called Rock Point. The central focus of the series is transactional sex, defined as exchanging sex for gifts or favours.

> ‘The media has done more harm than good especially to students who have not had a background exposure before. It has given them exposure that has come to them in ‘wholesale’. The global influence has exposed them to dstv[42], pornography, internet and what ever they come across, and then their immediate interest is to experiment or give it a trial. This has promoted the bad behaviour among the youth. For instance, drugs and alcohol are having a terrible effect. Once they have gone that far, they find it difficult to control. They want to practice what they see and this makes them more vulnerable’. Head of school

Apart from the radio programs, adolescents mentioned information from posters, magazines and newsletters. The Straight Talk newsletter is said to be the most common source of information in the print media category. The school receives copies monthly that are put in the library for students to read. When I toured in the school library, posters from Straight Talk, YEAH project and PEARL[43] project from the Ministry of Gender were pinned on the walls. These posters had messages such as ‘*be careful AIDS has no cure’ ‘wherever you are, stay safe’, have self control, value your body and respect yourself, etc.’* The main concern was that they are written in English while young people would prefer local languages. This was revealed in the focus groups, but was not a view of the majority. It was realised that such a concern was held by the lower secondary school students who have not mastered the use of the language and hence lower reading capacity.

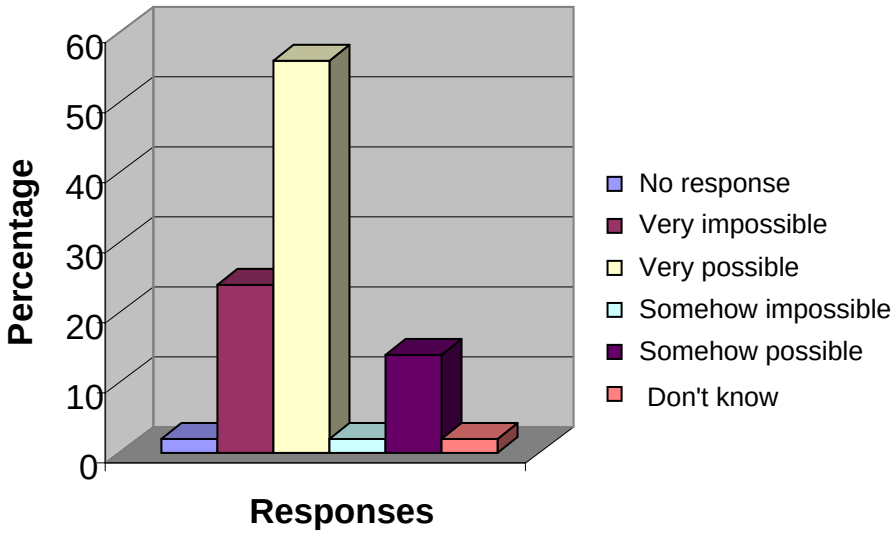
What do they learn from the media? Adolescents reported abstinence and delay of sex to avoid AIDS. Other issues learnt include how to prevent pregnancies (among the female group), communication with teachers and adults as well as how to avoid other sexually transmitted infections.

To know the extent to which action is taken on what is learnt, they were asked as an example, whether abstinence until marriage was possible, considering the socio-economic environment they lived in and the results are shown below;

[42] DSTV here refers to Digital Satellite Television , a local pay television provider that shows various types of music videos, sports as well as movies of drama, action and love stories among others.

[43] PEARL Project refers to Program for Enhancing Adolescent Reproductive Life, a project run by the Ministry of Gender, Labour and Social Development.

Figure 11: Possibility of abstinence till marriage



Respondents had a lot of scepticism with some of them doubtful arguing that apart from increasing promiscuity and lust that characterises the society today, there is increased need to 'enjoy what we see other people enjoying' in magazines and movies. Secondly, the economic conditions do not favour abstinence till marriage. Some members of both groups reasoned that some adolescents get involved in sexual activities to earn a living and survive because the pocket money from their parents is not sufficient to last for the term or buy them what they see their friends having.

The school administrators were also concerned about the material needs that lead young people especially girls into early sexual activities. Other issues raised were about what they read in newspapers about male youth advertising themselves seeking for *'sugar mummies'* [see appendix]. In an in-depth interview with the head of the school, he pointed out that unlike the days they went to school, students these days are so materialistic with the desire to be like others and this is so common in rural schools where they want to be like fellow students in urban areas.

> 'These days, students are very immoral and materialistic hence, you do not get surprised to find students pregnant and they impregnated by *boda boda* boys[44]. They

[44] *Boda boda* boys refer to the males who transport/carry people or items on motor-cycles. Most of these are semi-illiterate and they either dropped out of school or never went to school completely. They were said to be more interested in secondary school girls because they are not expensive and contacts are easy when they are being transported to and from the school.

> think they are getting fancy things but at the end of the day, they are the victims. In this case, you cannot be sure that they do not have AIDS'. Head teacher

The economic conditions and the threat of HIV/AIDS put young people at cross-roads and increase their vulnerability. The hopes of prevention are still alive because AIDS is still a big threat. Some adolescents argued that abstinence till marriage may be next to impossible, owing to the conditions they live in but the fear attached to AIDS helps them to postpone sex. In the focus group discussion, adolescents said that the increased fear of AIDS comes when you see somebody suffering from the disease or when somebody you know has died of it. Therefore, it can be said that although the information acquired is not acted upon in its full sense, it plays an important role in postponing risky sexual activities among the adolescents.

The media cannot be praised to the extent of downplaying other elements of HIV/AIDS prevention and motivating individual behaviour change such as interpersonal communication, such as interactive face-to-face educational support and counselling where messages are tailored to the specific needs of individuals. This is because when the information is heard from the radio or read in newspapers, it tends to sound so generalised and not fore them. Young people do not take the information from the media seriously and tend to feel that such information is for adults. This view is also held by the head of the school when mentioning some of the challenges of implementing HIV/AIDS education among the young adolescents.

> They have seen very few of their colleagues of their age dying of AIDS. They think AIDS is for older people. So, they know but do not take it to be real hence, they do not feel the threat. Boys are not aware that these young sisters of theirs go to 'sugar daddies' and girls likewise.

Therefore, individualised provision of information is important in such situations and is much emphasised in other HIV/AIDS counselling and care services because it provides the client with the support and opportunity to 'tell a story' from their own point of view. A study in Uganda that asked adolescents about their most preferred source of information found out that doctors and nurses were preferred because apart from being perceived to be well-trained to handle HIV/AIDS, they give individualised information and pay full attention to what young people ask (Neema *et al.,* 2007).These are some of the opportunities that adolescents miss when they get HIV/AIDS information from posters, at school, reading newspapers or listening to the radio.

Other media analysts point to issues concerning its focus on too broad an audience to cover and to this end have questioned its effectiveness in disseminating HIV/AIDS education messages such as Abstinence, Being faithful and correct and consistent Condom use properly (Zikusooka, 2006). For the message to be effective it should be specific to the target audience while cognisant of the audience's socio-cultural characteristics. However, most media messages in Uganda targeting the young people such as '*be responsible'*, '*say not to unsafe sex'* or '*abstain from sex'* are so generalised that they do not define clear boundaries for in-school or out of school, boys or girls, sexually active or those abstaining as well as adolescents and young adults. Young people also include Protestants, Catholics, Muslims, Adventists and other religious beliefs and all these react differently to these messages because of varying socio-cultural and religious beliefs. Hence, it leaves doubt whether issues like condom use will get a nod from for example the Catholic community even when the government's attitude towards condom use is negative.

5.3 Conclusion

This chapter has introduced the key findings of this study. In it, there is a discussion of some of the answers to the first and second questions posed by this research regarding the knowledge and the sources of information regarding HIV/AIDS at school. Among the main points noted, adolescents' knowledge about HIV/AIDS is high but not comprehensively understood. Secondly, there are various sources of information ranging from both print and electronic media to communication from peers and teachers. The school provision of information was also noted and its associated challenges. That said, the next chapter will continue the discussion of the answers to the last question of factors affecting putting knowledge into practice so as to effect behaviour change.

6. Factors that determine Behaviour change in response HIV/AIDS related knowledge

6.1 Introduction

Having explored HIV/AIDS awareness and information and knowledge provision to adolescents in school, I present the findings and subsequently discuss the contextual factors that determine negative or positive behaviour change in response to information about HIV/AIDS as identified by students and stake holders. The Social Learning Theory (Bandura, 1977; 1986) and the Health Belief Model (HBM) (Rosenstock *et al.*, 1974) are the theories that form the basis of this research and here, they guide the presentation and discussion of findings from the field and the related literature to examine the view that behaviour formation and change are determined by not only individual but also environmental and societal factors. The psychological and cognitive factors, the interpersonal interactions and the social setting/environment in which adolescents live are critical elements in determining desired (positive) or undesired (negative) behaviour change. I also examine whether the prevailing in-school behaviour change interventions for adolescents provide the supportive environment to motivate behaviour change.

6.1.1 The social setting – family and school

This study considered a case of a rural-based school where the family plays a very significant role in the growth and development of most, if not all, children as they grow into adolescence. The parents were purposively included in this study to discover what role both the family and school plays in shaping the behaviour of adolescents in the context of HIV/AIDS prevention. The family is the primary agent of socialisation, the context in which children begin to acquire the beliefs, attitudes and values, and behaviours considered appropriate in their society (Shaffer, 1999). The school not only takes over when the child reaches the school-going age, but also is expected to continue the process of promoting desired societal behaviours since this is the period when the child leaves the home sphere and spends more time with peers.

This study however found out that in the context of HIV/AIDS, the school is expected to do more than just that because today, young people need critical life skills that home environments sometimes do not promote and hence, they lack abilities to express their

opinions and decisions as well as asking critical questions of sexuality and HIV/AIDS. From the discussion with one of the parents, teachers are expected to provide a lot more in teaching about HIV/AIDS than parents. The parent, whose daughter was in the boarding section, said that since she interacted with her daughter during the holidays only, she expected much of the shaping of her daughter's future to be determined by the school.

> 'In this era, there is nothing much we as parents can do. We send the children to school and whatever happens, the school knows… Hmm about AIDS, what do I know? Let the school teach her about dangers of having sex'. Parent

This point indicates that parental and indeed familial roles have changed in the context of HIV/AIDS where children are expected to learn most of the things about their reproductive life, growth and socialisation at school. But it is not just this era that parents do not talk to their children about sexuality and adequate family life education in the context of HIV/AIDS since cultural norms also prevent parents and other adults from discussing sex with children and youth (Morisky, 2006). In addition, as Bastien (2005) observes, there is a lot of silence surrounding sexuality and HIV/AIDS at school and this is a significant barrier to school-based programs. Therefore, the knowledge that teachers provide is not reinforced and lacks parental input and hence will not likely bring about behaviour change.

Adolescents are more likely to act on the knowledge acquired from school and other sources if their parents value it and are interested as well as involved in school activities. Active parental involvement, which would create a difference, lacks in HIV/AIDS education for the adolescents whose life is much determined by the family values. The role of parents in shaping a child's life should therefore not be underestimated when designing HIV/AIDS education programs for young people who are still in school. Parents are less knowledgeable about the appropriate means of talking to their children about sex and HIV/AIDS prevention and as a result, give mainly authoritative and warning messages as students revealed in the focus group discussions. In addition, lack of parental participation likely makes students feel that family life education they get at school is not so important.

In the school environment itself, the study was unable to identify available supportive mechanisms to motivate behaviour change. Revelations from the female group discussions included the incidences in which some male teachers demand for sex if they get any chance

of talking to girls out of the classroom[45] and that hatred results if such demands are rejected. In the male group, it was also revealed that some teachers can be in conflict with male students because they think they need the same girl. Under these circumstances, students will rarely consult teachers and this is an environment where parents expect their children to get all the information they need. However, there is potential danger in such environment as noted by Shaffer (1999) who warns that lack of supportive relations with teachers makes many autonomy-seeking adolescents in impersonal secondary schools much more susceptible to peer values and influences most of which may be full of misinformation and misleading.

The above mentioned issues associated to school and family determination of how young people respond to HIV/AIDS education are not to mean that as agents of change, have not played significant role. Sexual health and other related knowledge in the face of HIV/AIDS has improved as reflected by high level of knowledge in this study. Both parents and teachers, for example together with other school programs have demystified sex and a number of youngsters have acquired skills that relate to sexual health (Mirembe & Davies, 2001). This study also found out that students depend on their parents for information regarding socialisation such as going to dance. They were asked; *do your parents talk to you about the good and bad of going to the dance?* The overwhelming majority (91%) responded affirmatively and this indicates how much they rely on their parents for information and guidance.

6.1.2 Peer influence

The Cambridge advanced dictionary defines the peer as a person who is the same age or has the same social position or the same social abilities as another person in a group. The behaviourists view peers as two or more persons who are operating at similar levels of behavioural complexity as long as they can adjust their behaviours to suit one another's capabilities as they pursue common interests or goals (Shaffer, 1999). How do peers influence the behaviour change of others?

[45] Carr-Hill *et al.,* (2002) mention also that teachers shy away from covering reproductive health issues for religious and cultural reasons as well as they themselves may be engaged in contradictory behaviour.

It is argued that because of their 'equal-status' contacts, the members of the group are freer to try out new roles, ideas and behaviours from each other since unlike with parents or older siblings, peers are less critical and directive. Hence in so doing, they are likely to learn a lot about themselves and others (Shaffer, 1999). Also, because of the shared interests and beliefs, compliance to group values is critically monitored and hence, once one becomes a member of a group, he/she undergoes a form of behaviour modification as one seeks interpersonal trust (Mangrulkar *et al.*, 2001). This argument seems to portray the fact that peer interactions may easily foster social and personal competencies that may not be acquired through interaction with older people.

In the school setting, students identify peers differently but what is true is that there are common interests that are shared before coming closer to one another. As the friendship strengthens, the information gathered through a web of social networks is shared (Shaffer, 1999). From the discussion groups, all members expressed that the best time for sharing this information for in-school peer adolescents is bed-time after night preps when they talk about their sexual experiences which they cannot tell to their elder brothers/sisters or parents and each of the members is expected to say something that happened to him/her during the holidays, at the party or dance attended or any community group gathering. This is the opportunity that day students (those that come from home daily for school) miss. If one does not tell anything for long, they either suspect he/she spies on them or he/she is not 'active' or *the sheep stepped on him/her*[46]. Accordingly, none would accept to be interpreted as behaving differently from others except on the risk of being isolated. Similarly, none would accept being nick-named or being jeered at.

Indeed, in the group discussion, boys expressed how peer influence can lure them into sex. One of the boys in a group amused others when he said;

> Whenever boys narrated stories of how they had wet dreams, I felt I was abnormal because I never experienced this. I was not sure that I could ejaculate and when I went to the village in the holidays, I decided to try it…' then the colleagues asked him if it worked and he said, 'yes it worked and now I know I will produce'

[46] This expression is commonly used to refer to an impotent person. When someone is 'inactive', they say the sheep stepped on him. It is a very degrading expression and puts someone on pressure to show that he/she is active. This is one of the ways how peer pressure can bring about risky sexual behaviours.

This is not to indicate that this boy would not have had sex at all if it was not because of this influence but it is very possible that on one hand, if he had enough information he would know that wet dreams are not a must for everybody and by his age it was not the time to conclude that he was abnormal. On the other hand, rather than seeking proper information, he would not have tried it on sex after he had gone for holidays.

The attitude of parents and teachers towards peer groups is not all that welcoming. From the interview with one of the parents, she never wants her son to be involved in those groups which she described as '*akakungu'*. She illustrated her hatred of these groups with two local proverbs that: '*akakungu/akariibi kariisa etaabe'* literally meaning that the peer group makes one chew Tobacco [or drugs] and '*ahari embuzi mbi totsibikaho yaawe'* meaning that where a poor species goat is tied, never tie yours next to it[47]. The head of the school also pointed out that these peer groups spoil children.

> 'In boarding schools, there is peer pressure and free talk during bed times. Students learn from their peers and hear of these things and are lured into doing them even when they do not know what the consequences are.' Head teacher.

However, even though this is the attitude of teachers and parents, there have been a number of programs targeting young people that aim at changing behaviour through peer education and influence and notably; School Health Education Program (SHEP) and Program for Enhancing Adolescent Reproductive Life (PEARL). These are mainly based on the belief that young people easily learn from each other because of shared interests and beliefs. Also where peer groups comprise People Living with HIV/AIDS (PLHAs), they offer support, counselling and friendship (Morisky *et al.,* 2006). It is highly doubtful though if such works in the school setting where teachers themselves lack essential knowledge, skills and resources to teach about HIV/AIDS. If students were to rely on information acquired from various sources without means of clarity there is a high possibility of distortion and confusion and this can be dangerous. Bastien (2005) notes the role of peer influence with caution when she notes;

> 'Peer influence is a compelling force in young people's lives and while it can be dangerous when levels of ignorance and confusion are high, the persuasive influence

[47] These two proverbs are moral proverbs used to discourage young people from joining negative or potentially harmful peer groups. Chewing tobacco is a sign of misbehaviour in the society and then to avoid influence from poor/bad specie, never come closer!

> of the peer group can also be harnessed to play a positive role in conveying accurate information about sex, condoms and HIV/AIDS' p.86

Thus, this study suggests that unless adolescents are equipped with proper knowledge and skills of talking about HIV/AIDS, comprehensive knowledge of prevention and management, their peer groups cannot be effective tools to influence positive behaviour change. Some of the findings from the questionnaire and viewpoints from the focus groups about abstinence illustrate this. Less than 60% of the respondents believed that abstinence is possible until marriage (see Figure 11) and close to the same number (59%) said that they had ever had sex. In the focus group discussions, students were asked why they thought it was impossible to abstain and they pointed out various obstacles to abstinence. Apart from increasing promiscuity and lust that they said characterises the society, they mentioned the need to try out what they hear from their colleagues and watch from films. They feel what 'they hear and see is enjoyable and cannot afford to miss this enjoyment' as one male student pointed out. They also pointed out the 'natural urge' to have sex though they agreed that abstinence was desirable and the best option to avoid HIV/AIDS. This poses a big challenge to use such peers in peer education approach to HIV/AIDS prevention efforts.

6.1.3 Personal/Individual choice

The issue of personal or individual choice in adopting certain behaviours or behaving in a certain way is discussed by developmental psychologists. Shaffer (1999) refers to this as a concept of *self* – the combination of physical and psychological attributes that are unique to each individual. It is common to hear of the expressions like *'have self-control'* in anti-AIDS campaigns for young people. Such expressions perhaps mean that while all people have had all the information they need, the choice of whether to comply or not remains personal, after all the disease is mainly spread through sex and this remains purely a secret of those involved. Teachers in one of our informal discussions were quick to subscribe to this view that all the choice lies with the individual on whether to have sex (protected or unprotected) and they seemed to categorise that there are loose people and others are not. One teacher expressed her view on the HIV/AIDS prevention programs;

> 'I am amused by people who always keep talking about AIDS prevention. Whatever they say and do, they should know that the decision lies with the individual'

The same view is shared by one of the parents who said that since they do not stay with their children, the decision on whether to have sex or not lies with them adding that as parents,

they give advice but cannot force what is to be done when their children are away. 'Unlike when the cultural practices were still strong, where control was possible, modernity has changed everything', he continued to say. They therefore seem to believe that today, behaviour formation and change is purely a personal issue, something that other people have little control over.

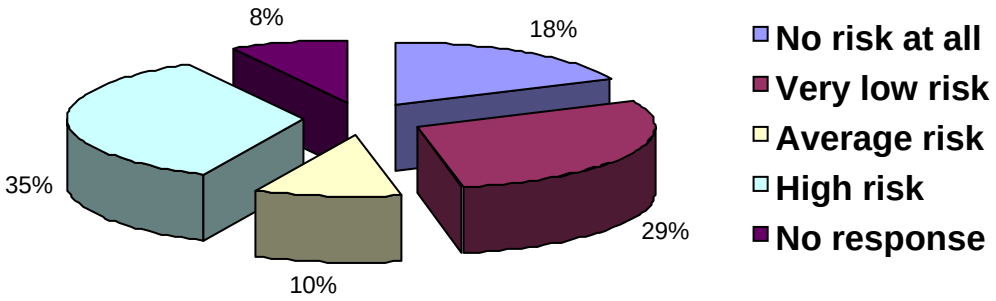
It is interesting also to learn how psychologists portray this *self* concept. The role of self-control – the ability to regulate one's conduct and inhibit actions that one might otherwise be inclined to perform is well recognised. Shaffer (1999) points out that self-control is unquestionably an important attribute adding that if we never learn to control our immediate impulses, we would constantly be at odds with other people and fail to display any patience to achieve long-range goals. This seems to disagree with the Social Learning theory (Bandura, 1977) which points out that human behaviour is not simply determined by motivational forces in form of needs, drives and impulses that are within the individual. Instead, these inner forces can be induced, eliminated and reinstated by varying external influences. Thus, the determinants of behaviour reside not only within the individual or organism, but in the environmental forces.

Whatever the viewpoint, it is important to note that human beings consist of public self – what others see on an individual and the private self – the inner character not available to others (Shaffer, 1999). That known, public campaigns about HIV/AIDS prevention seem to target the *public self* with a hope that it will have an effect on the *private self* since the latter cannot be reached directly. Hence, for this influence to occur the public self must feel it (and in this case, perceived susceptibility as pointed out in the Health Belief Model) and it should be severe enough to make the private self feel the potential benefits of taking it up. This is what behaviour change communication and HIV/AIDS prevention efforts should indeed target.

6.1.4 Perceived risk

Behaviour change among adolescents is also influenced by perceived risk. The findings from the field indicated that the majority of the respondents (35%) believe that they stand high risk of getting HIV/AIDS. They were asked how much they thought they were at risk of getting HIV and the distribution of responses is indicated below.

Figure 12: Risk Perception



After the questionnaire response, an additional question was added in the focus group discussion[48] asking why some of them felt that they were at risk. Responses varied from group to another but like the head of the school had alluded earlier; they thought that people of their age were safe. Some of them reasoned that they were not exposed to risky activities such as those of older people or those who lived in urban areas. Hence, one male adolescent reasoned;

> 'I do not drink or smoke *enjaga* (marijuana) or go to night club dances. I hear those are the things that youth in towns do and we are told that you cannot have self control when you take drugs or smoke. So I think I am not at risk'.

Another participant from the same male group said that they think if one has only one girl-friend, then they stand less risk. He reasoned that the girl he had sex with not long time ago was a virgin and he knew she was safe from AIDS. This made him feel that he was at low risk. From the female group, if one did not have sex, then the risk was low since they said they do not drink or take drugs. However, some of them felt that their friends who were involved in relationships with older men were at high risk.

From the above expressions from the adolescents, it becomes clear that those who felt that they were at low risk saw nothing to change in their behaviours. Even the male participant

[48] This question emerged after the interview with the head of the school. His expression that '*they know but do not take it to be real'* became very important in the study. He noted that since they have seen very few of their age-mates die of AIDS, they think they are safe. Hence, I had to take this question to adolescents themselves.

who said that he had sex with a virgin felt that he was safe. For such an individual, the messages of abstinence to avoid AIDS were not so meaningful to him. Jurich *et al.,* (1992) expresses similar sentiment on the feelings of less risk for school adolescents who were in a stable relationship.

> 'Those students who are currently romantically involved in a steady relationship may perceive themselves to be at less risk for contracting AIDS virus than those students having multiple sexual partners and consequently, would be less likely to change their behaviour', p.98.

When the head of school remarked that '*they know but do not take it to be real'* he was emphasising the point that many young people have not realised how much they are at risk of getting the virus that causes AIDS. Some of them still think that it is a disease of adults or prostitutes and people who live in urban areas. While the ministry of education and other health promotion agencies for young people are talking about avoiding HIV/AIDS, young people pay little attention because of low perceived risk. Zikusooka (2006) points to this issue related to messages that are not context-specific for age, level of education or social background as one of the setbacks in the use of the media in promoting the ABC HIV/AIDS model in Uganda. Hence, it is this study's contention that programs that promote HIV/AIDS prevention among the adolescents should put much emphasis on increased realisation of risk and susceptibility to this health problem. It is after they have realised how much they are at risk that they will think of taking measures such as condom use (for sexually active youth), Voluntary Counselling and testing to know the HIV status, being faithful to each other as well as delaying the onset of sexual relations among others to avoid infection as the Health Belief Model suggests.

Therefore, it can be concluded that although HIV/AIDS prevention messages are received by the adolescents, the feelings of susceptibility as expressed in the Health Belief Model (Rosenstock *et al*., 1974) are still low. Apart from the feelings that their age is safe, some of the sexually active adolescents think that they are safe with what they do and so there is need to change the behaviour as they have not seen the danger in it. But if one examines the head master's warning that young boys do not know that young girls have '*sugar daddies'* and vice versa, then the risk is high. This calls for more efforts in HIV/AIDS education to enable young people realise more of their susceptibility and therefore feel more compelled to alter their behaviours.

6.1.5 Skills related to HIV/AIDS prevention

While conducting this study, key stakeholders argued that adolescents have knowledge but they lack skills of how to put the knowledge into practice (personal interview with both the head of school and the MoES sector HIV/AIDS coordinator). Questions regarding what exactly these skills are, who imparts them and why they are said to be a better alternative emerged as a result. Taking Baldo et al (2000) definition of skills as the 'how to' of behavioural goals and World Health Organisation's definition that it refers to the abilities for adaptive behaviour that enable individuals to deal effectively with the demands and challenges of everyday life (WHO, 1993), this study could reveal that adequacy or inadequacy of skills determine a lot in behaviour change.

In sexual health and AIDS-related education, the most relevant skills are the ability to refuse undesired sex, to insist on protected sex or use a condom correctly, to seek a trusted person for counselling and to resist pressure. To be able to adopt such skills, one should have essential skills of critical thinking, assertiveness, self-awareness, friendship formation and ability to cope with stress (Baldo et al 2000). If we borrow a leaf from World Health Organisation assessment, skills-based health education is more effective when it is taught as part of a comprehensive approach to school health than in isolation (WHO Information Series on School Health, 2000). It should involve health and education personnel, teachers, parents and students as well as all the community members. Although the Education and Sports sector Policy on HIV/AIDS in the MoES is cognisant of this, this study found out that parents who are standard setters for the children are not involved in either planning or delivery of any related program.

Skills-related education in regard to health is not properly grounded in many Ugandan secondary schools and this case study was not exceptional. There is no clear methodology and materials to prepare for appropriate instruction are missing as evidenced by absence of Skills Education in the secondary school curriculum. The matter becomes worse when teacher training colleges also ignore it (Education International Report, 2006). The same observation was made by an official from the MoES when responding to the questions about the competence of teachers in teaching about HIV/AIDS in schools.

> 'Teachers have been sensitised and trained but studies have shown that they are not competent in teaching AIDS at school. Because Uganda developed a multi-sectoral

approach, other stakeholders like NGOs are involved in conducting sensitisation in schools'

Hence, teaching skills related to HIV/AIDS prevention such as those mentioned earlier is left to NGOs and other voluntary groups that make occasional visits to schools. The problem with these though, is that apart from being uncoordinated and hence creating a likelihood of confusing students, they are not sustainable. For instance, the head of the school mentioned of an initiative – Child Health AIDS Initiative (CHAI) that used to support the School Anti-AIDS Club with resources and training that phased out. He also mentioned of peer educators who once visited the school the previous but had never returned. Hence, even when the role of promoting skills related to HIV/AIDS among in-school adolescents is left to NGOs and other stakeholders, their activities are not sustainable.

6.1.6 Sex differences and gender roles

As a prologue to this sub-chapter, the place of one's gender gets recognition even before birth. In what women call 'kicking' when the infant actively turns during pregnancy, expectant mothers start differentiating between a baby boy or girl (this may not be scientifically true but people believe in it). At birth, it is very common that the first bit of information that people ask when the birth of a baby is announced is whether it is a girl or a boy.

In traditional Africa, when the first born is a boy, the response is '*omusika'* or the heir and such cannot be mentioned for a girl. In other instances, the parents say the continuity of the clan is enhanced still in the case of the boy. In the Western world, parents call the infant son things like '*bouncing baby boy'*, 'big guy' or 'tiger'. The infant daughter is more likely to be labelled 'sweetie', 'sugar' or 'adorable', (Shaffer, 1999). In naming, the name usually reflects one's gender. This gender indoctrination continues through growth as children receive gender appropriate clothing, toys and care. They are also expected to behave differently and to assume different roles. In a process termed 'gender typing', the child acquires a gender identity as well as motives, behaviours and values considered appropriate in his/her culture with females expected to be cooperative, nurturing, kind and sensitive to the needs of others and males to be assertive, dominant, independent and competitive (Shaffer, 1999). What does all this have to do with behaviour change and HIV/AIDS prevention? The foregoing discussion of reflections from the field and other literature attempts to explain the relationship.

In a group discussion with boys I asked them to explain who initiates the relationship and for that matter, sex. This same question was asked to girls and their responses were nearly similar to those of the boys that obviously, it is a boy[49]. A member from the male group, looking confident said;

> 'For me, even if I need that girl and she asks for 'things'…? No it can't be. I will think she is a prostitute and I will start fearing her. It is like finding a girl with a condom'

From the female group, although some insisted that things have changed and a girl can be the first to write a love letter to a boy, others vehemently rejected this. One of those who rejected the assertion said;

> 'I cannot do that even if I need the boy… it makes you cheap to ask a boy for love. Suppose he refuses, what kind of shame would that be… and he will go and tell other boys that you are cheap'.

These expressions indicate that even if the girls have feelings, they cannot express them[50]. Boys agreed that it is the reason a girl cannot go in a boy's family and ask for marriage and it is the boys who have the authority to do this. Although they believed that it is possible for the girl to refuse even to reply a letter, they said there are other ways including sending gifts, helping in exercises in class and trying to be close most of the time. This explains how the society and gender stereotyping offers the boys the opportunity and possibility to influence the behaviour of girls.

Participants were also asked whether they thought young people of their age were pressurised into having sex. As expected, the boys felt there was nothing like pressure only that there was influence from their friends during bed-time stories who brag about their girls and how apart from sex, they assist them with money when they are broke.[51] This feeling of greatness in those who have girlfriends has two implications for this study. In the first

[49] Bastien (2005) had similar findings but added that sometimes, girls send discreet signals that they are interested. Even then, a girl will not offer sex right away or she will risk being interpreted as loose and weak.

[50] Also noted by Bastien (2005), girls have as much interest in sexual pleasure as boys, though this is largely neglected.

[51] It was interesting to hear how boys who have girls in school feel great. They mentioned that they live like they are married because the girls keep books for them and when there is a school dance, they enjoy their company and those who do not have a girlfriend 'look small'.

instance, other boys are influenced and feel it so imperative to attain the same status. While all of them will not do so due to various reasons, a good number of them will certainly do so. Secondly, the boys will obviously turn to girls and use any means possible to win them. This partly explains why girls, while responding to the same question expressed that there was pressure from boys through letters, gifts and what they referred to as 'familiarity' from the boys.

Sex differences and gender roles also increase girls' vulnerability. Traditional cultures of male dominance and the socially accepted submissive position of women and girls make it difficult to be assertive. They are exposed to different situations of risk and pressure than for boys do. For example, while in the girls' group it was mentioned that some teachers demand for sex, this was not the case in the boys' group. Girls mentioned that some teachers promise good marks in what they termed '*sexually transmitted marks'* in exchange for sex. Therefore even if girls were to control themselves, their exposure to risky sexual pressures increases the chances of taking such risks and with male dominance and promises of favours and gifts, together with girls' perceived submissiveness, the chances of protection hence staying safe are significantly reduced[52].

In a similar assertion, the interview with the MoES official indicated that young people's vulnerability affects the way they are to put the knowledge into action. While mentioning that it is one thing to have knowledge and it is another to put it into practice, he reasoned that young people find themselves with knowledge but their vulnerability does not favour putting that into practice. He said;

> 'For instance, the girl is fully informed but is sent by the teacher to take books to the teacher's house and she is caught there and forced into sex by the teacher. Such vulnerability girls find themselves in does not favour putting knowledge into action'.

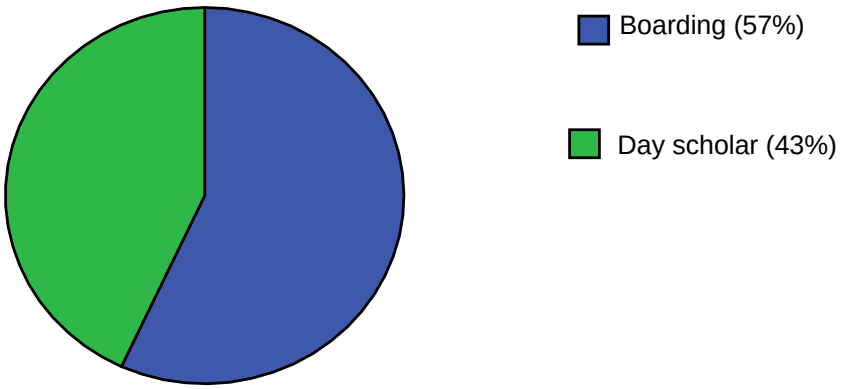
He pointed out that this is why the ministry had to change the strategy and adopt life skills education and other girl-child empowerment programs. Similar programs are going on, he said, in the work of Non-Governmental Organisations and other government sectors.

[52] UNESCO-MTT (2006) notes that such circumstances can make a woman unlikely to know how to protect herself from unwanted sex or afraid to demand condom use, (Module 3 p.22)

6.1.7 Socio-economic environment

Economic hardships faced by adolescents influence the way in which they respond to AIDS prevention messages. To put it into context, it is important to know why some students are in boarding section while others study from home every day and what determines this status quo.

Figure 13: School status of respondents



Although the percentage of boarding students (57%) is higher than that day scholars (43%), responses from parents indicated that if resources would allow, all students would be staying at school. The reasons given were that students would be more secure in the boarding section because they are under strict control of the school authorities. The indication was that students who walk to school everyday stand high risks of encountering obstacles along the way such as *boda boda* cyclists who want to offer 'lifts' in exchange of love for the case of girls. Others walk over 8 kilometres from home and they reach home when it is already dark. I had expected the parent to mention that they need the children to provide domestic labour but both parents insisted this is no longer the case since they want their children to pass with good grades. In fact, one of them added that he knows his son comes home late and tired but he encourages him to read before going to bed because he knows his counterparts are reading at school.

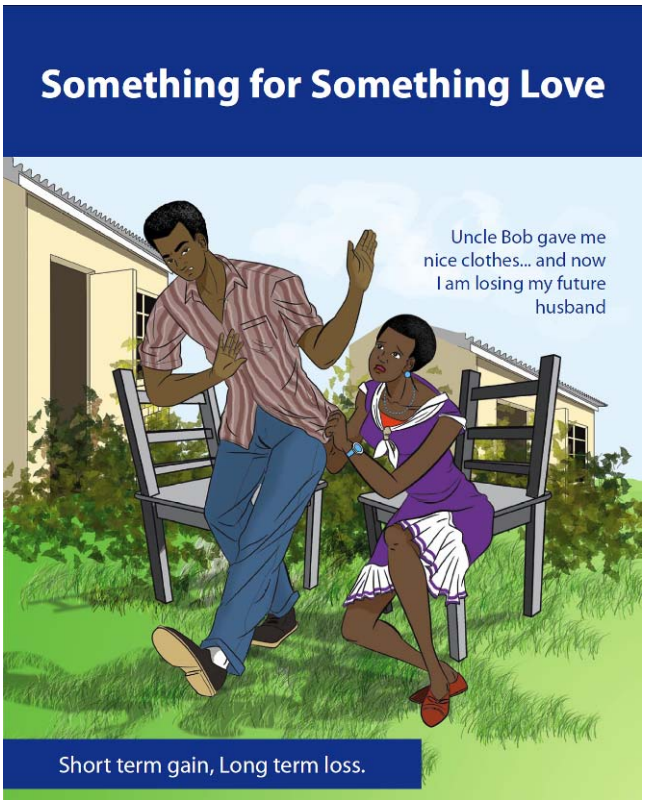
In the students' questionnaire responses, although over 75% indicated that they obtained money from their parents, the group discussions revealed more than just this. I asked the following question: *Considering the socio-economic environment we live in, why do you think young people engage in early sexual activity?* Among other responses, they reasoned that they do not have enough money to buy the items they need at school. One female

student, who however said that she had not obtained any money from boys but was sure some girls do, said;

> 'When my father pays school fees in the bank and buys books, he thinks everything is now finished. He does not realise that I need to buy 'eats' and other 'appetisers'. It is my mother who gives me little money and I buy pads'

Others added that pocket money is not enough to last for a term or until visitation days. Hence sometimes, they look for alternatives of getting money to buy the items needed. In the boys group, some of them said that they make their own money during holidays which they sometimes share with their girl friends. They reasoned that even if they did not work, their parents do not care much as they do for their sisters.

Figure 14: Anti-transactional sex messages



The implication from the above assertions is that poverty exposes young people especially girls to risky behaviours such as transactional sex. The gravity of this needs further research but however little it may be, it calls for provision of information to parents to provide as much as they can to protect their children from such risks. There are efforts to discourage transactional sex or '*something for something love'* but these efforts lack the analysis of context in which they take place. This study suggests that it is important to encourage parents to get involved and fend for their children before they go out to fend for themselves at their age.

6.1.8 Structural environment

This research included interviews with the stakeholders at the ministry level and the administrators of the school. The major purpose here was to find out if there are structural factors that impact on HIV/AIDS education and behaviour change programs for in-school

adolescents. For this particular issue, interviews with the head of school and the HIV/AIDS activities coordinator, who is also the commissioner for secondary education at the Ministry of Education and Sports (MoES) were interviewed. Access to the Sector Strategic Plan for HIV/AIDS activities 2001/01-2005/06 enabled me to analyse the objectives in relation to in-school adolescent behaviour change programs.

While advocacy and mobilisation for HIV/AIDS education in all education institutions has been intensified over the years (Morisky et al, 2006), the key aspects of incorporating HIV/AIDS and other reproductive health issues into the curriculum for all education institutions as well as promotion of specialised skills-based teacher training in HIV/AIDS and reproductive health education have remained largely on paper. To ascertain this, I asked the ministry official about programs that aim at enhancing and improving teachers' competence in teaching HIV/AIDS education. His response 'of training and sensitisation of teachers' was not reflected in the school-based findings about the existence of any teacher with specialised AIDS education skills when the head of the school said,

> 'The teacher in charge of HIV/AIDS activities or the one who patrons SAC does not have any special training in AIDS related work. The one who showed interest was picked from the rest'

The majority of the teachers (80%) also pointed out that although specialised training was necessary to teach HIV/AIDS education, none had ever received such. This gives reasonable ground to believe that what the ministry says[53] remains just in documents and is not implemented because it is not reflected on ground in terms of enhancing staff capacity. This questions the ability and effectiveness of the sector to implement its strategic plans to the ground and for the benefit of schools and the intended final beneficiaries of these programs (adolescents).

[53] Among the sector plan objectives 2000/01-2005/06, there was promotion of specialised skills-based teacher training in HIV/AIDS and reproductive health education and incorporation of HIV/AIDS and other reproductive health issues into the curriculum for all education institutions (see the MoES Sector HIV/AIDS Strategic Plan 2000/01-2005/06)

It was also found out that apart from ministry circulars and PIASCY handbooks, no other form of support specific for HIV/AIDS activities is received from the ministry by the schools. Both the ministry official and the head of the school pointed to this fact. The head of the school was asked about the support received from the ministry targeted at HIV/AIDS activities. He said;

> There is PIASCY delivered through the ministry of education that provides information through brochures, handouts and charts and they are hanged in the library for students to reflect on. The ministry also gave circulars that for every fortnight, the messages should be delivered at the assembly.

Although school activities such as club support for drama and plays require financial resources, the school budgets do not cater for these or if they do, they are squeezed as miscellaneous costs. The official from the ministry response was similar to that of the head of the school though he added the ministry's recognition of the work of NGOs.

> 'Some schools receive support from the government through information provision in circulars sent to schools. Also because Uganda developed a multi-sectoral approach, other stakeholders like NGOs are involved in conducting sensitisation in schools and these are encouraged to help schools', HIV/AIDS sector coordinator.

To this, the challenges that contribute to the ministry's inability to financially support HIV/AIDS education in schools were pointed out. According to the ministry official interviewed, the education sector is very wide and big serving close to more than half of the total population of the country and mobilising resources for complex issues like HIV/AIDS poses a paramount challenge. Inadequate resources were clearly pointed out as one of the major challenges facing the implementation of HIV/AIDS programs in the ministry.

> Although the ministry has structures in place that involve their officers, the challenge remains lack of adequate funds. And although HIV/AIDS is included in the ministry's budget every year, it does not receive adequate fund allocation because of budget ceiling' HIV/AIDS Coordinator, Ministry of Education and Sports.

Amone *et al.,* (2003); (MoES, 2006) also cited the same obstacle that there is no clear-cut budget line for addressing HIV/AIDS in the education sector[54]. The sector is expected to depend primarily on the individual institutions and departments within the ministry and to

[54] During the fieldwork exercise, I attended the workshop for '*Mainstreaming HIV/AIDS in Planning and Budgeting process at District and National levels*'. The workshop noted that although most line ministries, including Ministry of Education and Sports, have established HIV/AIDS Committees, they are generally present in name mainly due to limited funding.

plan accordingly. With these limited resources where HIV/AIDS is regarded as an additional responsibility rather than a policy issue (Morisky *et al.*, 2006), HIV/AIDS education may not receive priority attention among the institutional activities.

6.2 Conclusion

This chapter was a continuation of chapter five and continued to answer the questions posed by this research. In particular, I have provided an analysis of the findings concerning contextual factors that affect behaviour in response to HIV/AIDS knowledge. Utilising behavioural theory, the chapter has attempted to show how the individual factors and the interaction of the individual with the environment plays an important role in behavioural formation and modification. It also justifies the need for motivating efforts to effect behaviour change. The next chapter shows the summary of the findings and conclusions derived from them. It is from these that policy recommendations for action and further research are made.

7. Summary, recommendations and conclusion

7.1 Introduction

This last chapter considers the final analysis of this research. It gives a summary of findings according to the research objectives and questions. This is followed by recommendations for both policy and future research emerging from this study and ends with concluding remarks.

7.2 Summary

The study sought to investigate the contextual factors that influence behaviour change in the context of HIV/AIDS prevention among the in-school adolescents in rural Uganda. The study developed questions that guided the research and the answers to these questions are summarised in this chapter. More findings from the community, stakeholders, adolescents and previous research also revealed that it is not only individual but also the structural and environmental factors that influence the way young people respond to HIV/AIDS knowledge acquired from various sources.

7.2.1 Knowldege level and sources of information

The study found that HIV/AIDS knowledge is high among the in-school adolescents. This knowledge is received from various sources including the media (both print and electronic), parents, teachers and the general community. The role of the government and private sector, the school and parents in particular in educating children about sexuality and HIV/AIDS was discussed. These have significantly helped in demystifying sexuality and HIV/AIDS. At the same time, the study noted adolescents' inability to comprehend the knowledge and put it into action, mainly attributed to inadequate teaching and little attention given to HIV/AIDS as an important subject in the school curriculum and programs in general.

7.2.2 Factors that affect behaviour change

The study revealed that various factors, ranging from socio-cultural, environmental to structural influence the way adolescents in school respond to HIV/AIDS knowledge. Largely, adolescents have high knowledge regarding transmission and prevention of HIV/AIDS but the question that remained for this study was: *if they have enough knowledge*

of HIV/AIDS transmission and prevention, do they translate this knowledge into action? If yes what factors help in this and if not why? The study found out that both the school and the family are important change agents in children's growth and socialisation mainly because it is where they acquire the beliefs, attitudes and values, and behaviours considered appropriate in their society. However, these agents lack supportive mechanisms to encourage and promote behaviour change. The parents think the school/teachers will do the work of orienting young people on HIV/AIDS related issues and sexuality while at the same time; the school/teachers think parents should do the same. Hence, knowledge and information got from either the school or parents is not reinforced and lacks follow-up thereby making it difficult to tell which new behaviours are acquired.

The study also identified the peer influence as having a significant impact on behaviour change for adolescents. In their quest to try out new roles as they grow up, young people exert a lot of influence on others. At this stage of growth, they struggle to gain 'equal status' with others such that if a member of their peers engages certain behaviour, the colleagues are more likely to adopt it. It was interesting to learn how those who had not engaged in sexual intercourse before were determined to try it out given any chance so as to be like their colleagues, no matter the information received from the teachers, media or their parents. On the other hand, peers can also help to influence other peers positively, given appropriate means and if they are actively involved in the initiation and planning of the programs targeting them.

Although peer influence was identified among other factors, the issue of personal decision was raised by both the parents and teachers. Moreover, sex through which AIDS virus mainly spreads has remained a secret of those who do it and so whether to have protected or unprotected sex remains partly an individual decision. For that reason, parents can give guidance and teachers can teach, but the main obstacle remains that they cannot enforce what they teach. Hence, the elements of self-control and personal ability to make decisions remain paramount in behaviour change programs.

The Health Belief Model explains element of perceived susceptibility for individuals to consider changing from bad behaviour to desirable one. The researcher asked adolescents to tell how much they felt at risk considering the fact that the higher one feels at risk, the more the likelihood of avoiding actions leading to the risk. To put it in context, the more the adolescents felt at risk, the more they would adopt behaviours that expose them to the risk of

HIV/AIDS infection. Many young people were found to feel that they stand low risk of getting the virus. Having one sexual partner, not taking drugs and not seeing many people of their age die from AIDS made the adolescents feel that they are safe from the virus. It is for this reason that the head teacher had to say that 'they know but do not take it to be real'.

There was also evident lack of skills related to HIV/AIDS prevention. HIV/AIDS education being offered to adolescents does not promote the essential skills of critical thinking, assertiveness, self-awareness, friendship formation and ability to deal with pressure. Life skills education is expected to promote these elements but in practice, this is non-existent in schools. Teachers and parents who are standard setters for the adolescents do not possess these skills either and cannot promote them. In the end, they reject critical issues like safe sex practices such as condom use. As long as the standard setters are opposed to such issues, the adolescents will always look at them with suspicion because after all, their parents and teachers do not recommend them.

Sex differences and gendered practices also impact on behaviour change in relation to HIV/AIDS prevention. The cultural beliefs and gender stereo-typing that prevail in the society put the females not only in the inferior position but also at the receiving end. On the other hand, males feel that they will prove their manhood on girls by asking for sex or writing love letters and offering gifts. The inferiority that females are exposed to not only increases their vulnerability but also reduces their efficacy and assertiveness.

The prevailing socio-economic conditions also affect the way adolescents respond to HIV/AIDS education information. Students who are economically disadvantaged and are not able to pay boarding school fees are more vulnerable than those who stay at school all the term through. There are many obstacles encountered throughout the whole study period and this affects especially the girls. Even in the boarding section, it was found that students who do not get enough pocket money are likely to receive gifts from boys or older men who ask for sex in exchange.

HIV/AIDS education programs for schools are also inadequately resourced in terms of human capacity and funding. As a result, programs targeting the youth are not sustainable because they lack follow up. With inadequately trained staff, HIV/AIDS education is taught based on individual initiative and personal knowledge of teachers. With assembly messages

and no designed structure of teaching HIV/AIDS in schools, AIDS has remained a co-curricular activity in schools and this is attributed to weak structures supporting it.

7.3 Recommendations and orientation

From the findings of this study, a number of recommendations and orientation both for practice and further research have been generated. These recommendations are directed towards the improvement of service delivery of adolescent sexual and reproductive health programs especially for in-school adolescents.

7.3.1 Orientation for further research

This study has been a small scale one with a small sample. However, the results and the discussion therein have raised a number of issues that call for more inquiry in the area of HIV/AIDS education, information provision and behaviour change.

In further research, it is imperative to further investigate the role of parents who have been found to be the standard setters for the majority of adolescents in rural areas. Whereas it may be true that information is acquired from various sources, adolescents depend on their parents and guardians for clarity on issues related to reproductive health and other social issues. In this regard, the extent to which adolescents depend on their parents and the ability of parents to provide correct and appropriate information about HIV/AIDS prevention are some of the issues to investigate.

This research did not investigate the methods and means of monitoring behaviour change. If time and resources allowed, it was important to identify and monitor the current behaviour as a result of ongoing HIV/AIDS education programs for in-school adolescents in Uganda. This would be done again in future to find out what happens after some time. It would be from this assessment that appropriate supportive mechanisms of enhancing behaviour change would be identified and recommended.

7.3.2 Recommendations for practice

The results of this study also have implications for practice in HIV/AIDS education for preventing adolescents from HIV infection. These are a concern to all stakeholders from policy to implementation levels as shown below.

This study has demonstrated that having knowledge and putting it into practice are two different issues that demand equal and proper attention. Therefore, interventions should not just provide information but should also provide practical means of applying it. Life skills programs for adolescents could be helpful but the teachers need to be fully trained to enhance this. Those who are already in the field should receive support in form of skills-building workshops and further training. Parents should be sensitised on means of supporting their children to grow healthy and sensitive to adolescent and growth challenges.

It has also been found out that there are various players in providing information regarding HIV/AIDS prevention. However, these efforts are not coordinated a part from not following any designed structure. As a result, it becomes difficult to tell which program has certain impact and to what extent. In other cases, there is duplication of messages and information that is provided. It is with this analysis that this study recommends a designed structure for HIV/AIDS education delivery. The Ministry of Education and Sports should design a program to be followed by all agencies involved in providing HIV/AIDS education specifying among other things, what information is appropriate for which age and level of education, how this information is to be passed on and the parties responsible. The means of monitoring the progress and evaluation of successes or failures of these interventions should also be put in place.

Finally, HIV/AIDS education should be an integral part of the school programs. A part from being part of the education curriculum, the inclusion of the subject on the school agenda, in PTA meetings and school budget can lay a strong base for in school interventions. These are some of the supportive mechanisms that both Health Belief Model and Social Learning theory prescribe. Given the emerging challenges of AIDS orphaned children and those who are already infected yet receive no support, the school capacity need to be strengthened to respond to these challenges. This would involve adolescents themselves, both teaching and non-teaching staff, parents and care-takers or guardians of children, the school administrators and the community.

7.4 Conclusion

In this study, I have indicated how the interplay of individual and societal factors influence the way adolescents respond to HIV/AIDS knowledge. The theories used in this study helped to explain what is needed to effect desired behaviour formation and maintenance. It is

important that interventions to enhance HIV/AIDS prevention among young people should involve not only homes or schools but also the adolescents. The assertion that '*they know but do not take it to be real*' requires careful attention. It points to the fact that even with various efforts from various stakeholders, young people feel they are not at risk and this can be dealt with if those whom they depend on and the youth themselves are actively involved in every step of programs aimed at improving their plight.

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Appendices

Appendix A: Data collection tools

Part I: Questionnaire for Students

Dear respondent,
Thank you for your time and interest in responding to this questionnaire.

Note: *Do not write your name on this form. You do not have to respond to questions that you do not want to answer. However, your honest answers to these questions will help to understand young people's responses to HIV/AIDS messages. This will help service providers to plan for more friendly and appropriate services for adolescents to protect them for the risk of getting the AIDS virus. All answers will remain confidential.*

No	Question	Response category	Tick (✓) the appropriate	
1.	Gender	1. MALE		
		2. FEMALE		
2.	Age	1. BETWEEN 12-15		
		2. BETWEEN 16-19		
3.	Education Level	1. S.2 – S.3		
		2. S.5 – S.6		
4.	School status	1. BOARDER		
		2. DAY SCHOLAR		
5.	Who pays your school fees?	1. FATHER		
		2. MOTHER		
		3. RELATIVES		
		4. MYSELF		
		5. GOVERNMENT		
		6. DON'T KNOW		
6.	How often have you missed school because of fees, lunch or transport?	1. VERY OFTEN		
		2. OFTEN		
		3. SOMETIMES		
		4. NEVER		
		5. DON'T KNOW		
7.	Do you have money for yourself?	1. YES		
		2. NO		
No	**Question**	**Response category**	**Tick (✓) the**	

			appropriate	
8.	How do you obtain money?	1. FROM PARENTS		
		2. FROM FRIENDS		
		3. GIRL/BOYFRIEND		
		4. RELATIVES		
		5. OTHERS ……..		
9.	What religion are you?	1. MUSLIM		
		2. CATHOLIC		
		3. PROTESTANT		
		4. BORN AGAIN		
		5. TRADITIONAL		
10.	Where do you stay?	1. HOME		
		2. SCHOOL		
		3. OTHER……..		
11.	Whom do you stay with?	1. ALONE		
		2. PARENTS		
		3. PEERS/FRIENDS		
		4. RELATIVE		
12.	Some people have tried drinking alcohol. Do you drink it?	1. YES		
		2. NO		
13.	Other people enjoy themselves through dancing. Do you like going to dance?	1. YES		
		2. NO		
14.	If YES to (13) above, where do you like going most (whether in holidays or at school)?	1. SCHOOL DANCES		
		2. FRIENDS' HOUSES		
		3. DANCING CLUBS		
		4. PARTIES		
15.	Do your parents tell you about the good and bad of going to dances?	1. YES		
		2. NO		
16.	Boys and girls should be free to go dancing with their friends.	1. I AGREE		
		2. DISAGREE		
		3. I DON'T KNOW		
17.	Girls and boys should be free to have boyfriends and girlfriends while still in school	1. I AGREE		
		2. DISAGREE		
		3. I DON'T KNOW		

No	**Question**	**Response category**	**Tick (✓) the appropriate**	
18.	Have you ever heard of diseases that can be	1. YES		
		2. NO		

	transmitted through sexual intercourse?			
19.	Have you ever heard of a disease called AIDS?	1. YES		
		2. NO		
20.	Where did you first hear/learn about AIDS?	1. AT SCHOOL		
		2. PARENTS		
		3. FRIENDS		
		4. NEWSPAPERS		
		5. T.V		
		6. RADIO		
21.	Where do you most often hear/learn about AIDS?	1. AT SCHOOL		
		2. FROM PARENTS		
		3. FRIENDS/PEERS		
		4. NEWSPAPERS		
		5. T.V		
		6. RADIO		
		OTHER……		
22.	How often do you hear/learn about AIDS while at school?	1. MANY TIMES A DAY		
		2. ONCE IN A DAY		
		3. 1-2 TIMES A WEEK		
		4. NONE IN A WEEK		
		5. NOT AT ALL		
23.	Do you know anyone who is infected with HIV or who has died of AIDS?	1. YES		
		2. NO		
24.	Can a person get AIDS from a mosquito bite?	1. YES		
		2. NO		
		3. I DON'T KNOW		

25.	Can people protect themselves from HIV by having one uninfected faithful sexual partner?	1. YES		
		2. NO		
		3. I DON'T KNOW		
26.	Can people protect themselves from HIV by abstaining from sex?	1. YES		
		2. NO		
		3. I DON'T KNOW		
No	**Question**	**Response category**	**Tick (✓) the appropriate**	
27.	How possible or impossible is it for young people to abstain from sex till marriage?	1. VERY IMPOSSIBLE		
		2. VERY POSSIBLE		
		3. SOMEHOW IMPOSSIBLE		
		4. SOMEHOW POSSIBLE		

		5. I DON'T KNOW		
28.	Can a person get HIV by sharing a meal with someone who is infected?	1. YES		
		2. NO		
		3. I DON'T KNOW		
29.	Would you eat food served by somebody a person having AIDS?	1. YES		
		2. NO		
		3. I DON'T KNOW		
30.	Do you think a healthy-looking person can be infected with HIV?	1. YES		
		2. NO		
		3. I DON'T KNOW		
31.	Can a pregnant woman infected with HIV transmit the virus to the unborn child?	1. YES		
		2. NO		
		3. I DON'T KNOW		
32.	The pills can prevent HIV transmission.	1. YES		
		2. NO		
		3. I DON'T KNOW		
33.	Have you ever heard of a condom?	1. YES		
		2. NO		
34.	Do you know of any place where you can buy a condom?	1. YES		
		2. NO		
35.	In which places can you obtain a condom when you need it?	1. SHOP		
		2. CLINIC		
		3. FRIEND		
		4. BAR/DANCING CLUB		
		5. DON'T KNOW		

36.	Have you ever had sex?	1. YES		
		2. NO		
37.	Was it mutually agreed or forced?	1. MUTUALLY AGREED		
		2. FORCED		
		3. NOT SURE		
38.	How old were you when you first had sex (forced or mutually agreed)?	1. BELOW 10 YEARS		
		2. 10 – 12 YEARS		
		3. 13 – 15 YEARS		
		4. 16 – 18 YEARS		
39.	Have you ever used a condom while having sex?	1. YES		
		2. NO		
		3. NOT SURE		
40.	Did you use a condom the first time you had sex?	1. YES		
		2. NO		
41.	Did you use a condom the last time you had sex?	1. YES		
		2. NO		
42.	Would you suggest to your partner to use a condom when having sex?	1. YES		
		2. NO		
43.	Would you buy condoms yourself when going to have sex?	1. YES		
		2. NO		
44.	Do you think it is easy to ask for condoms in a clinic or shop?	1. YES		
		2. NO		
		3. NOT SURE		
45.	Would you advise your friend to use condoms every time they have sex?	1. YES		
		2. NO		
		3. NOT SURE		
46.	How much do you think you are at risk of getting HIV virus?	1. NO RISK AT ALL		
		2. VERY LOW RISK		
		3. AVERAGE RISK		
		4. HIGHER THAN AVERAGE RISK		

Thank you for your time and will to participate.

Part II: Questionnaire for teachers

Dear respondent,

Thank you for your time and interest in responding to this questionnaire.
Note: *This research is purely for academic purposes and not funded by any agency.*
Do not write your name on this form. You do not have to respond to questions that you do not want to answer. However, your honest answers to these questions will help to understand young people's responses to HIV/AIDS messages. This will help service providers to plan for more friendly and appropriate services for adolescents to protect them for the risk of getting the AIDS virus. All answers will remain confidential.

No	Question Category	Response category	(✓)	
1.	Gender	1. MALE		
		2. FEMALE		
2.	Age	1. 25 – 30 YEARS		
		2. 31 – 34 YEARS		
		3. 35 – 40 YEARS		
		4. ABOVE 40 YEARS		
3.	Level of Qualification	1. A' LEVEL		
		2. DIPLOMA		
		3. GRADUATE		
		4. POST-GRADUATE		
4.	How long have you been teaching?	1. LESS THAN 2 YEARS		
		2. 2 – 4 YEARS		
		3. 5 – 7 YEARS		
		4. MORE THAN 7 YEARS		
5.	Have you ever heard about HIV/AIDS education in your school?	1. YES		
		2. NO		
6.	Is HIV/AIDS education part of your school curriculum?	1. YES		
		2. NO		
7.	Have you ever attended any special course regarding HIV/AIDS education?	1. YES		
		2. NO		
8.	Do you think HIV/AIDS education should be included on the school time-table?	2. YES		
		2. NO		
9.	If you were to talk to your students about their sexual life, do you think you would need specialized training?	1. YES		
		2. NO		
		3. NOT SURE		
10.	Do you think the government is doing enough to promote AIDS education in schools?	1. YES		
		2. NO		
		3. NOT SURE		
11.	Do you think HIV/AIDS is a big threat to young people in schools?	1. YES		
		2. NO		
12.	Would you comfortably teach about sex to your students?	1. YES		
		2. NO		
13.	If NO above why?	1. IT IS EMBARASSING		

		2. STUDENTS REFUSE		
		3. STUDENTS ARE SHY		
		4. PARENTS' ATTITUDE		
		5. NOT SURE		

14.	Should parents be involved in teaching their children about sex?	1. YES		
		2. NO		
		3. NOT SURE		
15.	Do you think all young people should receive **abstinence only** messages in efforts to prevent AIDS?	1. YES		
		2. NO		
		3. TO SOME EXTENT		
16.	Do you think young people should be taught about use of condoms?	1. YES		
		2. NO		
17.	Do you think AIDS prevention messages for young people from radio, TV, newspaper and other media are effective?	1. YES		
		2. NO		
		3. TO SOME EXTENT		
18.	Would you support people who say that adolescents should be allowed to come with condoms to school?	1. YES		
		2. NO		
		3. TO SOME EXTENT		
19.	What age do you think young people should start learning about sex and AIDS?	1. BELOW 12 YEARS		
		2. 12 YEARS		
		3. 13 -15 YEARS		
		4. 16 – 18 YEARS		
		5. ABOVE 19 YEARS		
20.	Do you think a school provides a good environment to teach about sex and HIV/AIDS prevention?	1. YES		
		2. NO		

Thank you for taking your time to respond to this questionnaire.

Part III: Interview guide for the head of school

I am going to ask you a few questions regarding the HIV/AIDS prevention for young people in schools. You do not have to respond to questions that you do not want to answer. However, your honest answers to these questions will help to understand young people's responses to HIV/AIDS messages. This will help service providers to plan for more friendly and appropriate services for adolescents to protect them for the risk of getting the AIDS virus. All answers will remain confidential.

1. What programs exist in this school that address HIV/AIDS issues for your students?

2. What does it take to be a head of the school with many adolescents in the face of HIV/AIDS epidemic?

3. What kind of support do you receive from the Ministry of education concerning addressing HIV/AIDS in your school?

4. Do you think the government is doing enough to promote HIV/AIDS prevention in secondary schools? If yes or no, why?

5. What is your opinion on the current media and student behaviour in relation to prevention of HIV/AIDS?

6. What do you think should be done by the ministry to promote HIV/AIDS prevention efforts in the education sector?

7. What is your opinion on whether parents should talk to their children about AIDS prevention, including use of condoms?

8. What are the challenges faced in providing HIV/AIDS education for in-school adolescents in rural areas in Uganda?

Part IV: Interview guide for the HIV/AIDS Coordinator in the Ministry of Education and Sports

Questions in the interviews include, but not limited to:

- What programs/projects do exist in the ministry of education that tackle HIV/AIDS education for in-school adolescents at secondary school level?
- To what extent is HIV/AIDS Education part of Uganda secondary school curriculum?
- What kind of support do you offer to secondary schools in efforts to promote HIV/AIDS prevention among in-school adolescents?
- What are the programs that aim at enhancing and improving teachers' competence in teaching HIV/AIDS education?
- What would you consider as challenges, at the ministry level, in providing HIV/AIDS education for in-school adolescents in rural areas in Uganda?
- What are the ministry's plans to further improve HIV/AIDS prevention efforts for in-school adolescents especially at secondary school level in Uganda?

Part V:Interview guide for Parents

NB: These questions were translated to Runyankore (the local language) because it was preferred by the respondents. Caution was taken not to alter the meanings of responses and this was possible because I know both languages.

Dear parent,
I am requesting to talk to you. I am a student and my studies include talking to people who have their children in secondary school about issues regarding reproductive health and HIV/AIDS. I have been helped by the teacher of your daughter/son to know you. Can I ask you a few questions regarding your daughter/son about behaviour and AIDS? Please feel free to give me any time you want or if you feel uncomfortable to respond, it is also accepted.

Questions

1. Why did you choose to have a child in the boarding section/let your child study while staying at home?
2. How often do you talk to your daughter/son about sex and AIDS and what do you tell them? What do you tell them?
3. Comment about the behaviours of children these days in relation to prevention of HIV/AIDS. Do you think they are safe? Why or why not?
4. What is your opinion about the current prevention measures including the use of condoms?
5. How often do you attend school meetings and to what extent is HIV/AIDS discussed in parents' meetings?
6. What kind of support do you give to your child in terms of the essential materials to use a part from school requirements?

Appendix B: Media Reports/Articles

Part I: 7% use sex to get gifts

THE New Vision
UGANDA'S LEADING WEBSITE

7% use sex to get gifts

Publication date: Monday, 17th March, 2008
By Flavia Nakagwa and Fred Ouma

SEVEN per cent of Ugandans aged 15-49 have engaged in sex for gifts, referred to as transactional sex, according to a report released yesterday.

Most of them (93%) had sex for money, while 54% did it to get clothes. Other items exchanged for sex were jewelry and cosmetics (26%), food (10%), entertainment (4.3%), transport (3.1%) and school fees, alcohol and rent (2.5%).

The report, Transactional Sex in Uganda, is a compilation of various researches done from 1997 to 2007. It was conducted by the Young Empowered and Healthy (YEAH) programme in collaboration with Health Communication Partnership and the Uganda AIDS Commission (UAC).

According to the report, transactional sex, gender-based violence and alcohol remain major obstacles to the fight against HIV/AIDS, especially among the youth.

Rosemary Kindyomunda, the UAC information resource manager regretted that the youth were not involved in most HIV/AIDS programmes.

"There is complacency among young people; they have been left out and think they shouldn't be concerned about HIV/AIDS and that they are not in any danger," she said.

The director of YEAH, Anne Gamurorwa, said: "Most people are ignorant of the (Enguli) law, but we need to work together to prevent HIV/AIDS among young people. The Government should strengthen the laws against alcohol consumption."

Although there is no statistical association between adolescents engaging in transactional sex and household economic status, consultants concurred that most of the sex was not for survival or economic necessity.

"Both poor and rich adolescents are equally likely to engage in transactional relationships, against the general belief that the poor were most likely to engage in the practice out of economic needs," said Michaela Kerrissey, a consultant for the Health Communication Partnership.

This article can be found on-line at: http://www.newvision.co.ug/D/8/12/617178

Part II: Museveni condemns condom distribution to Pupils

THE New Vision
UGANDA'S LEADING WEBSITE

Museveni condemns condom distribution to pupils

Publication date: Monday, 17th May, 2004

BEST OF LUCK: President Museveni congratulates the newly-installed Kamuswaga of Kooki in Rakai on Saturday

By Eddie Ssejoba

PRESIDENT Yoweri Museveni has attacked the distribution of condoms to primary school pupils, describing it as dangerous and disastrous.

"I am going to review this issue. I will open war on the condom sellers. Instead of saving life they are promoting promiscuity among young people," Museveni said.

Museveni was on Saturday speaking at the installation of the hereditary ruler of Kooki, Kamuswaga Appollo Sansa II, at Rakai district headquarters.

The ceremony was performed by Katikkiro Joseph Mulwanyammuli Ssemwogerere on behalf of Kabaka Ronald Mutebi.

Kooki was an independent kingdom until 1896 when it merged with Buganda and the Kamuswaga became Kooki county head.

Museveni was responding to a report by Rakai district chairman Vincent Semakula on the HIV/AIDS prevalence in the district.

Museveni said the teaching of the Western countries on the use of condoms was inappropriate for Ugandans. "When I proposed the use and distribution of condoms, I wanted them to remain in town for the prostitutes to save their lives," Museveni said.

He said promiscuity was the major cause and spread of HIV/AIDS and that the solution lay in avoiding the habit.

"The best thing is to protect against promiscuity. Children in school should emphasise education after which one can look for a partner and start a life-time relationship," he said.

Museveni said that it was wrong to teach young children how to use condoms.

"I have heard your chairman (Semakula) saying that before we started educating people on how to avoid AIDS, the infection was at 48% and has reduced to 12%. In Uganda the rate is at 5%," Museveni said.

Semakula said in 1990 the rate of HIV infection in Rakai was 48% but it had fallen to 12%.

Museveni said the decline in infection rates was due to people's deliberate attempt to avoid HIV which they seemed to be abandoning now.

He said countries which emphasise condoms are instead recording higher infection rates.

Part III: HIV/Aids ignorance high among youths

TRUTH EVERY DAY
Daily MONITOR

HEALTH & LIVING | January 17, 2008

HIV/Aids ignorance high among youths

SUSAN K. MUYIYI

A 17-year-old mother tells a sad tale in the documentary: Abstaining from Reality by Population Action International and the International Planned Parenthood Federation.
"He used to sing to me this song: I am your Romeo would you be my Juliet," she narrated. Not able to resist his charm, she gave in. She sobs at the memory and consequences. Her first time sexual encounter resulted into an unwanted pregnancy and HIV infection.

Globally, young people are among the population that is more at risk and the most affected by the impact of the HIV/Aids epidemic. UNAIDS estimated that 40 percent of new infections in 2006 occurred in young people.

By the age of 17, half of the young people in Uganda are sexually active. Incidents of intergeneration sex are also high according to the book Health, HIV, Aids and Development, the commonwealth Youth forum 2007 version.

Among the key research findings on protecting the next generation by the Guttmacher research institute was that four in 10 adolescents either do not know or don't think that a woman can get pregnant the first time she has sex. Half or more don't know or don't think that a woman can get pregnant if she has sex standing up or if she washes herself thoroughly after having sex.

Dr Eliya Zulu, the president of the African Population and Health Research Centre while presenting the disturbing statistics of the research said that it is pointless for Africa to bury its head in the sand.

"The fact is that our young people are having sex, that is why they ought to be empowered through sex education for example by making condoms available to them in schools," Dr Zulu recommended at the fifth African population conference in Arusha, Tanzania recently. In Uganda, schoolgoing children engaged in sexual activities at beach bashes until the Ministry of Education and Sports banned them.

A portion of the young people in church is also sexually active. The message of abstinence is seemingly not practical based on these concerning statistics. The knowledge about their reproductive health, sex, sexually transmitted diseases and the risk of HIV/Aids varies among many of these young people. Fewer than one in five adolescents who have heard of Aids believe that the virus can be transmitted by sharing food or by witchcraft.

Some believe that it is through mosquito bites and yet the early age of the first sexual encounter ranks high as a key risk factor for HIV infection which is estimated at 18.8 percent and 16.7 percent for girls and boys respectively. However, few parents will face up to the fact that their young innocent looking children are sexually active.

One mother commented: "I can't imagine giving my daughter condoms to take to school. Is she going to have sex at break time or in the classroom?"
Dr Magdalena Ngaiza, a lecturer at the University of Dar'es Salaam said that supplying condoms to the young people as a method of protection against HIV and other undesirable consequences of sex isn't conclusive.

"How can you say that condoms alone will combat this scourge? Have you thought about including God? What about those who can abstain? Your approach should be comprehensive," Dr Ngaiza passionately echoed.

Besides, condom use alone isn't an effective method of protection because of the inconsistencies involved in using them. How many young people will demand for a condom before every sexual encounter?
Young girls especially should be taught what love is, which is definitely not having sex with a condom.

"When girls have a high self esteem, are productively occupied during the holidays and they know that their parents love them, sex will be the last thing on their minds," Dr Ngaiza said.

Rosemary Kidyomunda, the Information Resource Manager at the Uganda Aids Commission said that giving children as young as 12 years condoms in schools is rather extreme. Uganda has demonstrated that young people can adopt positive behaviours and reverse HIV incidence and prevalence rates, she said.

But in an age where parents can't or find it embarrassing to talk to their children about sex, the burden to provide sex education is weighing heavily on the schools. Like Dr Zulu argued, "We have to reach out to them before they start having sex."

Kidyomunda said the government after consulting with various stakeholders including religious leaders, came up with the presidential Initiative on Aids Strategy for Communicating to young people (PIASCY) in 2001.

"PIASCY involves three books for students, teachers and one for training about reproductive health. It is kind of a curriculum which was introduced in primary and secondary schools."Kidyomunda mentioned that the purpose of this initiative is to provide vital information about reproductive health.

Once every week during parade time, an HIV message is passed on. The other content focuses on body changes during adolescence and what they mean, also information about growing up and sexuality is provided depending on the age of the children involved.
"The books provide information about condoms but we are against having them distributed in schools," Kidyomunda added.

For the last 10 years, the Straight Talk foundation has published a monthly newsletter packed with informative articles on reproductive health issues which is distributed free of charge in a number of schools.

Naguru Teenage Centre and the family planning association clinics provide youth friendly services for the treatment of sexually transmitted infections (STI), information about HIV/Aids and how to avoid unwanted pregnancies.
Although many young people fill abstinence cards, the percentage that sticks to this commitment isn't known.

However, even with all these interventions, prevailing statistics are still worrying. The national HIV sero and Behavioural Survey 2004/5 puts the age of the first sex encounter at 15. Of the 117,000 unsafe abortions that occur in the country, 55 percent are among 17-20 year olds. About 2 percent result in death and 23 percent in serious complications.

The prevalence of (STIs) among the young people is also high. Uganda has been a success story in fighting the Aids epidemic but there is still need for a firm grasp on the existing campaigns and to improvise other practical ways of saving the lives of the young people of Uganda.