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Sexual discourse and decision-making by urban youth in AIDS-afflicted Swaziland

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This article begins by considering the ethics and practicalities of researching sensitive issues with older children and young adults in the context of HIV/AIDS. As part of qualitative fieldwork in the municipality of Mbabane, Swaziland, family caregivers and learners at two secondary schools explained how and where sexual health knowledge is gained and what they consider to be the main influences on sexual decision-making. The findings show that despite one of the highest rates of HIV infection in the world, the information reaching youth in Swaziland is still often inaccurate and confusing. Young people wanted to be able to discuss sexual health issues with informed adults close to them in age and in a variety of settings. Peer pressure was an important influence on behaviour and led to high-risk behaviour for both genders. Alcohol and cannabis were readily available and often linked to high-risk behaviour. Low family incomes and the perceived need for luxury goods encouraged female learners to have transactional sex with older men. Cultural perceptions of the role of both genders militated against low-risk behaviour and left some adolescents feeling marginalised and lonely. Ways of approaching these issues at the community level are suggested.

Keywords: Africa, elderly caregivers, global childhoods, peer pressure, researching with children, social networks

Introduction

The paper seeks to explore the ways Swazi secondary school learners interact through social networks to gain knowledge about HIV/AIDS and how these networks influence their sexual behaviour: What choices are they making? What are the main influences that lead to these choices? What do young people think is needed to encourage safer, healthier sexual behaviour? How could these findings be used to help in HIV/AIDS prevention? These questions were explored during qualitative fieldwork with 25 families and 84 secondary school learners in the city of Mbabane, Swaziland, between September 2003 and January 2004. This work is part of a wider study of the impact of HIV/AIDS on children and their families in Swaziland and it draws on other data collected between 1999 and 2005.

Since the start of the AIDS epidemic prevention efforts aimed at bringing about changes in high-risk sexual behaviour have been difficult to realise. Many times, research has proven that giving correct information about HIV transmission and prevention does not necessarily lead to behaviour change in most individuals (UNAIDS, 1999). Furthermore, focus on the behaviour change of individuals using cognitive theories and models of health behaviour has been criticised for its narrow framework (Airhihenbuwa, Makinwa, Frith & Obregon, 1999) since sexual behaviour involves negotiations between two people who are each, in turn, influenced by social, cultural, and economic factors. This has led to more multi-dimensional behaviour-change models that consider not only decision-making at the individual level but also the influence of both localised social sub-cultures and the socio-economic conditions in the wider community. In addition, there is a need to study the specific influence of HIV/AIDS itself.

Varga (1997, p. 49) gives a comprehensive review of the literature on sexual decision-making and negotiation among adolescents and concludes that "few studies have addressed adolescent sexuality, self-perceived risk and sexual decision-making in the context of HIV/AIDS." In relation to research on adolescents in Africa in particular, Varga (1997) notes that the few African studies that exist tend not to include the male perspective or the socio-cultural context and interpersonal factors that determine adolescents' sexual behaviour.

By 2004, only limited progress had been made on achieving behaviour change among youth in areas where AIDS is endemic. Programmes targeting youth prior to sexual debut have shown the most promise. Gallant & Maticka-Tyndale (2004) reviewed 11 school-based HIV risk-reduction programmes for African youth, in several African countries. They found that the programmes were generally unable to affect a change in sexual behaviour of older youth, aged 17 to 18 years, although one programme did lead to an increased use of condoms. Programmes that targeted younger school children had greater success in influencing sexual behaviour. They concluded that "it is easier to establish low-risk behaviours than to change existing

behaviours" (Gallant & Maticka-Tyndale, 2004, p. 1349) and that "knowledge and attitudes are easiest to change, but behaviours are much more challenging" (p. 1337). It is clear that more research is needed into how young people make decisions about sexual behaviour in the context of HIV, how they are influenced by their sexual partners, and how they are influenced by economic, social and cultural factors in the communities in which they are embedded.

Constructions of childhood

The way childhood is socially constructed and the way children are perceived in society has a bearing on how they gain knowledge about HIV infection and sexual behaviour. In the literature, there has been increasing recognition of children as social actors in their own right. They are not merely 'adults in the making', going through a series of mental and physical developmental stages, but persons who actively help construct their own social world. Their interaction with the social and economic environment in which they are embedded leads to a wide variety of potential childhoods. There is, therefore, no single universal childhood that HIV risk-reduction programmes can target. There may be commonalities between childhoods in similar socio-economic and cultural settings, but a more nuanced understanding of the local context becomes of paramount importance. James & Prout (1997, p. 8) note that:

> Childhood,[1] as distinct from biological immaturity, is neither a natural nor universal feature of human groups but appears as a specific structural and cultural component of many societies. Childhood is a variable of social analysis. It can never be entirely divorced from other variables such as class, gender, or ethnicity. Comparative and cross-cultural analysis reveals a variety of childhoods rather than a single and universal phenomenon.

They argue that children are not just passive subjects of social processes but that they actively engage in constructing their own social lives, and that to understand these processes it is necessary to carry out research with children to understand the world through their eyes. This view of children as persons with agency developed throughout the 1990s and has led to increasing demands that the voice of children be heard in matters concerning their lives (Burr & Montgomery, 2003; Kirby & Woodhead, 2003; Østergaard & Samuelsen, 2004; Ansell & Van Blerk, 2005).

A further consideration is the binary division between adults and children as if they are entirely separate categories. But this division is rather artificial and neglects the relational aspects of children and adults (Kehily, 2003). In the context of HIV/AIDS, there is a marked blurring of this division as children comfort and nurse sick parents, care for younger siblings and assume responsibilities normally associated with adulthood. Therefore, while children clearly grow physically and mentally through development stages, there are wide global variations in the types of childhood experienced. Their lives are also socially constructed and they are social actors in their own right. Their voice therefore needs to be included in behaviour-change models and these models must reflect local context.

While the term 'children' is defined internationally as persons from birth to 18 years old, other terms such as youth or adolescents or teenagers are used in the AIDS literature (as well as in this article) to include both those under and over age 18 (Nnko & Pool, 1997; Varga, 1997; Gallant & Maticka-Tyndale, 2004). It is common in Africa to have learners aged 18 and over attending secondary school, and some of the respondents in this study are young adults. While not denying the relevance of the development transitions of childhood and their influence on sexual decision-making (such as the age of puberty and associated hormonal changes), this paper concentrates on gender relations and the social construction of the sexual behaviour of young people in urban Swaziland. It also investigates the agency each gender has in sexual relations and the influence of socio-economic factors on sexual behaviour. If these processes are better understood it would help in the design of more appropriate behaviour-change interventions.

For instance, in Swaziland, a 15-year-old girl 'choosing' to have unprotected sex with a much older man can be understood as a rational choice if the contextual detail of the girl's poverty is included. The girl's inability to negotiate the older man's use of a condom is unsurprising in a Swazi context. Swazi social and legal constructions of women and children accords them lower status than men, and children are expected to be submissive and respectful towards male adults. If the girl sees *lobola* paid when a woman marries and if she perceives that women are viewed as objects to be traded, rather than as people of equal status to men, it is more likely that she may consider her body as merely an asset for transactions. If she notices that female fecundity is highly regarded, the need for contraception may seem a contradiction. If a boy witnesses his father having multiple partners and is encouraged by adult males to think that it is a Swazi tradition and a mark of masculinity for men to have multiple partners, he has to consider whether abstinence from sex, or being faithful to one partner, will have repercussions on his male relationships and his social position among his peers. If the Swazi King has many wives and *lobola* is paid, this further cements the patriarchal mores of the society. In other words, changing young people's sexual behaviour depends partly on wider social relations and requires a holistic approach that extends far beyond the classroom in order to engage the social world beyond. The social inequalities that exist between genders, between generations, and between different socio-economic groups in the wider community, all impact on young people's lives, including their sexual decision-making.

The section below examines what can be gleaned from large-scale national surveys about sexual behaviour and HIV prevalence in Swaziland and this leads to an account of the qualitative fieldwork carried out by the author.

HIV prevalence and Swazi youth

Biological markers as indicators of sexual behaviour

Like any data set, data from antenatal clinics (ANCs) have come under scrutiny, and extrapolation to other population groups must be carried out with caution. However, national ANC surveys do suggest high levels of HIV prevalence among urban youth. Based on data about ANC attendees, The Kingdom of Swaziland, Ministry of Health and Social

Welfare, 8th HIV Sentinel Serosurveillance Report in 2002 shows that the number of young females aged 15 to 19 infected with HIV rose steadily nationally from 17.8% in 1994 to 32.5% in 2002. The levels of prevalence are slightly higher in urban areas where they reached 34.9% in 2002 for the 15–19 age-cohort, compared with 28.1% for the same group in rural areas. The increase in national prevalence levels at ANCs is even greater in the 20–24 age-cohort, having risen from 18.8% in 1994 to 45.4% in 2002.

The education data in the report is not disaggregated by age group for more specific analysis of younger age groups, but in the same 2002 survey the level of educational attainment of pregnant women aged 15 to 49 did not seem to protect against HIV infection. There was little difference in HIV prevalence levels between the older group who had attended school and those who had not attended school. For example, women aged 15 to 49 who had never attended school had the lowest prevalence level (37.1%), those who had attained secondary education had the next lowest prevalence level (38.3%), and those who had attained primary education had the highest level of HIV prevalence (40.1%). Age-cohort data is given for marital status and shows that being married does not appear to minimise the infection level among young Swazi women: in the age 15 to 19 group, HIV prevalence was higher for ANC attendees who were married, at 38.8%, as compared to 29.5% for those who were not married.

The 9th HIV Sentinel Serosurveillance Report in 2004 (not yet published in full) shows national HIV prevalence for attendees at ANCs apparently rose from 38.6% in 2002 to 42.6% in 2004. However, in the 15–19 age-cohort, HIV prevalence reportedly declined from 32.5% in 2002 to 29.3% in 2004, and fewer teenage pregnancies were reported. It is hoped that this reflects the beginning of general changes in sexual decision-making among youth, either through sexual abstinence or the use of condoms for safer sex. Another source of data for this paper was a behavioural surveillance survey (BSS) carried out in Swaziland in 2002 (FHI, 2002).

Behaviour surveys as indicators of sexual behaviour

In 2002, the Swaziland Ministry of Health in conjunction with the Family Life Association of Swaziland (FLAS) conducted a national BSS that included a survey of youth in and out of school (FHI, 2002.). In the survey, in-school youth respondents were aged 15 to 19 while out-of-school youth were aged 15 to 24; however, care is needed when comparing both data sets. When just the 15–19 age-cohort is compared for both groups, the mean age of sexual debut was 16.3 years for in-school youth, compared with a surprisingly, slightly higher, 17.4 years for out-of-school youth. However, 33.2% of out-of-school youth aged 15 to 19 reported being sexually active in the previous twelve months, compared with only 15.7% of in-school youth. Another key finding of the BSS (FHI, p. 4) was that "stigma and misconceptions about HIV/AIDS were observed across all surveyed populations." Only 20% of in-school youth aged 15–19 had *no* incorrect beliefs about AIDS, compared with 11% of out-of-school youth aged 15 to 24, and condom use at first sex was much lower for out-of-school youth (37% for out-of-school and 74% for in-school youth). Overall, this suggests that those in school do practice less risky behaviour even though there is limited sexual health education in the curriculum. The local context is again shown to be important as findings differ from country to country. Unreliable information on HIV/AIDS was found to be a problem in a West African study of urban youth (Østergaard & Samuelsen, 2004), which concurs with findings in Swaziland, whereas Kelly (2000) found youth had good access to accurate HIV/AIDS information, though not particularly through schools, in six survey sites in South Africa.

Other key findings of the Swazi BSS include "multiple partners were common among both the adults and youth populations surveyed" and "female youth both in and out of school tended to have sex with partners older than themselves" (FHI, p. 4). There are no other Swazi behaviour surveys at a national level, but data from a more limited survey in 2003, of randomly selected households in two rural areas, are encouraging: only 6% of girls aged 15 to 19 years were HIV-positive, according to evidence from blood tests, though this jumped to 40% in young female adults. It is difficult to judge whether or not this is an indication of more widespread behaviour change, including in urban areas.

Kelly (2000, p. 43) notes that in addition to large-scale descriptive surveys of youth responses to HIV/AIDS, there is a need for qualitative research: "Until further qualitative data is gathered we can but speculate about what lies behind some of the trends observed." Østergaard & Samuelsen (2004) discuss the difficulty of researching sensitive issues, such as sexual practices, and in their studies of urban youth in Burkina Faso and Senegal they used a range of qualitative methodologies. I faced similar dilemmas when delving into the reasoning behind sexual behaviours of urban youth in Mbabane and these are discussed below.

Multi-method qualitative research

The fieldwork took place over five months and consisted of in-depth conversations with 25 family caregivers, focus group discussions (FGD), one-to-one conversations, written accounts, key informant interviews, and participant observation. The field sites were in the municipality of Mbabane, the small administrative capital of Swaziland. Youths in two government secondary schools and some young community members participated.

Insights from family settings

In order to gain a better understanding of the influence of family background on sexual behaviour of youth, informal in-depth interviews were undertaken with 25 families who lived in the vicinity of the two schools selected as field sites. Other matters concerning child care were also discussed but are beyond the scope of this paper. Given that the learners from the two government secondary schools were drawn from several informal settlements within the urban boundary, as well as from some formal housing, these interviews were used to gain insights into adults' constructions of youth sexuality, in the context of HIV/AIDS, rather than as an attempt to comprehensively cover all socio-economic groupings or to match young respondents with

their respective homes. In any case, the family setting was not considered appropriate for interviews with either young people or their adult caregivers, due to lack of privacy and the need for respondents, both adults and children, to be assured of confidentiality. Valentine, Butler & Skelton (2001, p. 122) discuss the problems of finding private spaces for research of a sensitive nature with children: "The dangers of attempting to conduct a 'private' interview in most familial homes where space is at a premium and other household members may be tempted to eavesdrop are self-evident."

The in-depth interviews with adult caregivers took place during school hours when school attendees were not present. The 25 families, each of whom cared for children, were selected using a variety of entry points. They were caring for a total of 111 children less than 18 years old, 57 of whom were orphaned. Sixteen of the families had family members in the 15- to 19-year-old age group. Ten of the families had children attending secondary school. Ankrah (1993) refers to a variety of definitions of the African family; in this study a family is defined as a kin-based group who live in a dwelling/s occupying a single compound and who recognise a common household head. The physical environment, where the 25 families lived, broadly reflected the findings of the Mbabane Structure Plan (City Council of Mbabane, 1997) for informal settlements. Only seven homes were of block construction; the remainder were made of mud and stick.

The adult caregiver participants were assured of confidentiality and they gave informed verbal consent. Hunter (1990, p. 689) writes in relation to AIDS research: "A context-rich self-conscious research programme avoiding self- and other-alienation has some necessary and simple dimensions: stay awhile; teach, live, share; incorporate indigenous researchers in your projects; train them during the project execution; take the pain to transfer your skills; listen to their ideas, their conceptualisations, their pain."

The author had worked as a teacher[2] in Mbabane from 1999–2002, but to help overcome the limitations of the author's position as a white European outsider, two locally recruited Swazi female research assistants[3] advised on culturally sensitive issues and helped with family interviews and focus groups with children. Older adults preferred to speak in Siswati, whereas the school learners used both English and Siswati, depending on the activity. Teaching at both schools is conducted in English. The author was present at all caregiver interviews and an assistant acted as an interpreter. This part of the research took place over five months, between September 2003 and January 2004, with a short follow-up visit in November 2004.

The ethics of researching with children in the context of HIV/AIDS

The author was very aware of the stigma and denial that still surrounds HIV in Swaziland, especially its link with culturally inappropriate sexual behaviour. A further consideration was the possibility of some children reporting sexual abuse. Other research with children in the context of HIV/AIDS has led to distress, despite careful preparation by the researcher. Foster, Makufa, Drew, Mashumba & Kambeu (1997), in their research into children's perceptions of orphanhood in Zimbabwe, carried out focus group discussions with children aged 9 to 16. They took care to gain consent from both orphans and their caretakers, assured them of confidentiality, and had community visitors on hand "for children who became upset during focus group discussions" (Foster *et al.*, 1997, p. 393); however, they write: "During one focus group discussion, the facilitator asked about changes experienced following parental death. One boy stated his stepmother mistreated him whereon a 12-year-old boy started crying and continued sobbing throughout the rest of the discussion." It is difficult to see how the information about the behaviour of the stepmother would remain confidential in the presence of other children, and it seems inappropriate to leave a child, as it appears, "sobbing throughout the rest of the discussion", rather than allowing him to withdraw.

Nyamukapa & Gregson (2005) describe in-depth interviews with children and their primary caregivers, when they were seeking views on the care and education of orphaned children. Again, children aged 12 and 13 became upset during interviews. Such research, however beneficial the findings, highlights the ethical difficulties facing researchers. Eyber (2003) has researched adolescents' perception of war-related stress in Angola and suggests that general questions should be used with groups, while individual questions, requiring personal accounts, should be left for when the child is alone. She also suggests that researchers working with children should be trained in coping with emotion if the child becomes upset. Lewis (2003) describes the concept of 'fully informed consent', where child participants are given information at an appropriate level in advance of the research, they understand what their role will be, they know it is voluntary to take part and that they will not be identified, they may withdraw at any time, and they know what the research will be used for.

On the basis of these findings and the author's own experience working with bereaved young Swazi people, the qualitative methodology was designed to protect children from distress. While the results pertaining to sexual behaviour are discussed here, the research also included experiences of orphanhood. Preparatory work involved visiting the two schools prior to the research, discussions with teachers in each school, and guidance from the Swazi research assistants and older Swazi children known to the author. Focus group guides were piloted with children before the larger survey and amended where necessary. Individual letters, based on the principles outlined by Lewis (2003), were given to learners in standards 7 and 9 (a selection made by the school as neither grade faced external exams) with the aim of recruiting about 50 volunteers from each school. The median age of the 84 participants was 16 years for girls (range 14–24 years) and 17 years for boys (range 14–20 years). Any learner who had lost a close relative in recent months was advised both in the letter and on the days of the research, not to take part. The author also repeated that taking part in some or all of the activities was voluntary and learners could withdraw at anytime. Both research assistants were prepared with strategies to help any child who became upset. Teachers advised that the volunteers consisted of both orphaned and non-orphaned children. To avoid stigma-

tising orphaned children, no obvious attempt to single out such children was made, but during data collection and analysis their orphan status often emerged.

Creating an ambience for researching sensitive issues

Each school provided a private room and space away from other learners and staff. In order to use the research as a beneficial intervention, advice and information about HIV/AIDS was included in the introductory activities at both schools, and helped to create an informal rapport with learners. Harpham, Huong, Long & Tuan (2005), researching poor families and their children in Vietnam, describe the need to take time to establish a rapport with children so that they can relax with interviewers. The author sought to create an informal, participatory atmosphere. Learners were treated as 'authorities' as they were the first generation to have experienced the pressures of growing up in an AIDS epidemic. The researchers were situated as learners. During the 'warm-up' activities, discussions included some stimulus material compiled from dominant themes that had emerged during caregiver interviews. The themes included other issues besides sexual behaviour, but they are not covered here. At the point where learners seemed to be relaxed and speaking freely, a range of voluntary activities was introduced.

Sixty-four of the 84 learners in the two schools chose to write about their views on teenage sexual decision-making and sexual behaviour (38 females and 26 males). Some commented on the stimulus material discussed, others ignored it and wrote in a completely open-ended fashion. Privacy was assured during this process as the rooms used were large and some learners had left to take part in focus group discussions at another venue. The author remained with the writing group, while the two Swazi research assistants facilitated the focus group discussions. The discussions were tape recorded and one assistant made notes. Five focus groups (three with girls, two with boys) took place, differentiated according to gender and school year group. Some learners also engaged in one-to-one discussions, or informal small group conversations, with the author. Others read information booklets provided and asked questions on aspects of HIV and AIDS, either privately with a researcher, or in groups. The transcribed family interviews, transcripts of school focus groups, learner's written accounts, and researchers' notes on other conversations and observations with youth, teachers and community members were cross-examined and coded to gain a more nuanced understanding of sexual decision-making and the sexual behaviour of young people. The main themes that emerged are discussed here, supplemented with representative extracts from both young people and caregivers.

Caregivers' attitudes towards teenagers' sexual behaviour

Communicating the link between sexual behaviours and AIDS

In a study of gender-focused responses to HIV/AIDS in Swaziland, UNDP (2002, p. 26) found that "discussing sexuality issues with children is still considered a taboo by many people in Swazi society. The majority of the population was said to rather turn a blind eye and pretend that their children are not sexually active than discuss sex issues with them." Yet Marwick (1940) in his ethnographic study of the Swazi gives a more nuanced insight to traditional sexual education within the kin group. He describes the custom of *ukujuma* practiced by unmarried young people, which involved sexual arousal to the point of climax but without the act of penetration: "Among the Swazi it is part of normal education of children to have this custom explained to them" (Marwick, 1940, p. 87). Kuper (1986) stressed the role of grandmothers in child-rearing and this is likely to include the explanation of such customs.

Sexual discourse within the Swazi family may be less overt than in some cultures, but the research findings from the family interviews showed that many caregivers, including elderly grandmothers, did try to discuss sexual behaviour and the risk of HIV infection, although not always very effectively. Nhongo (2004, p. 9) refers to the important role older people play, in Africa, as advisors to their families and communities, but he notes that older people are often excluded from information and education about HIV prevention, and they may even perpetuate misconceptions and "contradict prevention messages targeted at youth in their care." Although lone grandmother carers were not a common feature in the Swazi families interviewed, grandmothers were often the head of a household of several generations and well respected in their households. Several grandmother respondents said they talked about HIV/AIDS and risky sexual behaviour with their teenagers, but later, in the school survey, it became clear that teenagers' exchanges with most adult caregivers, of whatever age, were limited in extent and rather vague in many cases.

Another difficulty for adult caregivers is the use of appropriate language. Giese, Meintjes, Croke & Chamberlain (2003, p. 38), in a study of life-skill programmes in South African schools, found that language was a barrier to speaking about sex: "Several teachers said it was particularly difficult to teach about sex using a language other than English, and that they would struggle to find words that are not vulgar in Sotho or Zulu." In an interview with the author, a Swazi director of an orphanage explained: *'We don't have the vocabulary about sex in Siswati. We have words but it would be an insult to use them. When my own children challenge me, I have to relate in English.'* It seems that children, in the presence of adults, also find it difficult to use words that specifically refer to sex or sexual behaviour. In this research, as in similar work in schools in Tanzania by Nnko & Pool (1997), when talking about their behaviour children often described sexual intercourse as 'doing this thing' and avoided the specific words sex or sexual intercourse.

Though the nature of the exchanges were not explicit and so suggest a need for further research, most of the caregivers in the vicinity of the two schools felt they did talk with teenagers about HIV/AIDS and risky sexual behaviours:

> *'I do talk to them about HIV and tell them to abstain or be loyal to one person'* (Grandmother caregiver).
>
> *'I do talk to them a lot about HIV/AIDS and our lives in general. I try to make sure they feel proud of where they come from and to resist pressure from their friends'* (Mother).

'I talk openly with them about everything. Drugs, sex, HIV, everything' (Grandmother caregiver).

Some caregivers felt that their attempts to communicate were ineffective:

'I talk to them about HIV/AIDS every day but they don't listen' (Great-grandmother caregiver).

'If the parents are not educated, the educated teenager assumes they know everything. We were brought up differently' (Mother).

'Kids know the information but they are choosing to ignore it and they continue to sleep around' (29-year-old mother, supporting teenage sisters).

Others were critical of some caregivers:

'Teenagers make decisions on their own. There is no communication between parents and children. I will try with mine when they are older' (Mother).

'I do see some parents are trying but children don't listen. Some of the parents are drinking, that is why there is no discipline' (Mother).

Key influences on teenage sexual behaviour according to caregivers

Caregivers described friends as the dominant influence on teenage sexual behaviour, particularly when acting as part of a group. Another important theme was the influence of older men on girls. Some felt teachers were respected and effective at communicating with teenagers and that schools could do more. Church leaders were not seen as particularly effective because many older teenagers did not attend church. In addition to the influence of different groups, the effects on young people of drugs, alcohol, poverty, and lack of opportunity were interlaced throughout conversations (alcohol is often home-brewed and the street value of Swazi-grown cannabis is low, so both are readily available even to poor youths). These themes are exemplified in respondents' views:

'The teenagers are listening to each other. When you do things as a group you tend not to remember what your parents and elders have told you. Drugs and alcohol are the number-one problem. They are having sex without using condoms [note condoms are available free of charge at health clinics and in several public buildings such as Mbabane library, but many factors besides availability affect usage]. Poverty is the cause of the spread of HIV. Girls do sex because men promise them things and they see it as a way out of poverty' (Mother, age 30, living with teenage siblings).

'I feel most teenagers listen to their friends, but they do listen to their teachers so teachers could be more involved. The boys are involved in drugs and alcohol and teenage girls are prone to falling pregnant. I really fear my daughter will get pregnant' (Mother).

'The main problem I am seeing with teenagers in this area is they are really into drugs and alcohol. They smoke all day. It impairs their judgement. They have no vision and they are dropping out of school' (Grandmother caregiver).

'There are no jobs when they finish school so they are getting into drugs, pick-pocketing and breaking into houses. With the girls, they are falling pregnant and don't even finish school. I don't think they understand AIDS or they wouldn't be sleeping around' (Father).

'Teenagers these days don't like to go to church. The youth in our church are not very active. There are not many men at church either. It's peer group pressure; most are involved with drugs and alcohol so can't achieve a better life. There are a lot of teenage pregnancies. Men drink a lot too' (Grandmother caregiver and church elder).

'I think there is enough knowledge but they don't think it will happen to them. Once they are intoxicated with drugs they forget about safe sex. There must be talk about the link between AIDS and drugs. They are influenced by their friends to get involved with drugs and then they get into sex and problems of HIV/AIDS' (Mother).

Caregivers frequently expressed concern that their girls would 'fall pregnant'; a fear of girls becoming infected with HIV was mentioned much less often. The main concerns with male children centred on alcohol and drug abuse and where this might lead. Again, becoming infected with HIV was not mentioned as the prime concern, despite the high HIV prevalence in the vicinity and the high number of deaths.

The 'voice' of young respondents on gaining sexual knowledge

Sexual discourse in the family setting

Swazis are predominantly Nguni in language and culture. In traditional Nguni culture, the responsibility of providing sex education is usually delegated to the grandmother or, in her absence, an aunt or uncle. As mentioned, there is a cultural emphasis on sexual abstinence, and, traditionally, virginity has been promoted by the practice of non-penetrative sex (UNAIDS, 2000). Even so, new social sexual mores are developing that lead to a confused message for these urban teenagers. The gap in communication between caregivers and their teenage children remains for many young people. Some teenagers in the study felt at ease gaining information from grandparents, aunts, uncles and parents, but the majority felt unable to talk openly about sex with adult family members. Both genders wanted their parents to discuss sex issues with them, especially in relation to HIV/AIDS, and to offer more guidance, as the following extracts show. These are some focus group comments with in-school males:

'It is difficult to talk about it. Some of us are ashamed to talk about changes in our bodies. Even our parents didn't talk about HIV/AIDS with us. They say — You are not man enough, just wait a little bit until you are older — *but that time never comes.'*

'We are scared to speak to our parents. They will think I have started having sex.'

'Parents must talk to us convincingly. [About] the advantages and disadvantages of this virus. How is it going to affect our lives and in what way? We need to know.'

'I talk to my aunt.'

'I talk to my brother.'

'I don't think it [the parent-child gap] can be bridged. We respect them [parents] too much; conversation consists only of greeting and asking for things.'

Focus group comments with in-school females echoed similar sentiments:

'At FLAS [Family Life Association of Swaziland] you can talk freely there, unlike at home. When you say — Hey mom, what do I do when it happens to me? — *she will just misjudge you, you see, so you are not free to express yourself at home. The parents must be taught first 'cos, seemingly, where there are ones who are taught and their parents are left behind, we feel scared to tell them the truth. Maybe they should have a club for the parents to talk about sex and stuff. Maybe tell them to be open to their kids and stuff.'*

'When your parents tell you — Hey, you are going to the shops, you'll get pregnant — *you get furious and then you want to do this thing without thinking, but when your parent comes down and tells you* — You know what, my child, this happens, this happens, and this happens — *you take your own decisions' [the facilitator asked the girl what 'thing' meant and she replied 'sex'].*

'At home there is no one that I talk to. My father came from a meeting where they were told about AIDS. He returned and just left the book on the table without talking about it.'

A few girls felt they could talk to female relatives:

'Mom and I talk about condoms. She tells me that when you sleep with someone, don't do it just like that, use a condom every time you do it. We talk about the consequences of unprotected sex without a condom, STDs.'

'My aunt does something, like every month, call the teenagers in our family, and she shows us a video about AIDS and says — If you do that and that, you will get STDs and stuff.*'*

These findings are in accord with findings in West Africa by Østergaard & Samuelsen (2004, p. 108): "In relation to sexual and reproductive health matters, it seemed parents rarely talked with children about sexuality or bodily functions and most of our female informants had not received any information at all about the menstrual cycle from parents or from other adults in their household." However, the importance of local context needs to be emphasised. In a larger quantitative survey at six sites in South Africa, Kelly (2000) found parents did talk about sexual health, as 27% of respondents aged 15 to 22 chose parents as one of their top-two sources of information about HIV/AIDS. Youth in South Africa are similar to Swazi youth in other respects though, as they both favour health sources of information above other sources such as teachers.

Sexual discourse with teachers

The report by the Global Campaign for Education (2004, p. 9) refers to evidence from 17 countries in Africa and four in Latin America: "…better-educated girls hold off longer on sexual activity, and are more likely to require their partners to use condoms." It is not just access to facts about HIV/AIDS but the empowering nature of education that places girls in a stronger negotiating position, according to the report. However, in Swaziland the effects of education have not yet been reflected in the HIV prevalence levels of educated women attending antenatal clinics, as mentioned above. The 7th HIV Sentinel Serosurveillance Report recommended that HIV/AIDS education should use "new learning techniques such as project work, discovery-based learning, child-to-child and youth-to-youth techniques" (Ministry of Health & Social Welfare, 2000, p. 61).

The support that schools need to effect such changes in the curriculum is large. The Deputy Head at one of the field-site secondary schools sums up the pressures facing teachers and learners and the desperate need for more resources:

'We have some learners who haven't paid fees for three years but we have kept them on to do their exams. Learners come to school without eating. Sometimes they haven't eaten for two days. Food is basic. Some are staying with Gogos [grandmothers]. The Gogos have no social welfare. Some can't even afford a school uniform. Most of the parents are not employed [in formal employment], so they go to shylocks [for loans for school fees]. We do have pregnancies too. The rural area is better than the urban area. I am from the rural areas and you have land and can grow food. There is the traditional social structure. In my family, I can't take all the [orphaned] children so we split them up. We concentrate on them going to school and staying with a relative. We face the problems at home and in school it's double. Swaziland is a religious country but you just don't know how to cope. There are kids with so many problems that sometimes you just don't want to hear more. We do encourage learners to tell us their problems but we encourage them to face their own problems. Being an orphan shouldn't be an excuse. When they moan about a stepmother, I talk about rights and responsibilities. They are affected a lot when their parents are sick. They have to leave class to take their parent to hospital. When I ask — Why you? — *they say* — There is no one else. *Their work does drop off, especially during their parents' sickness'* (Interview, November 2003).

To help such learners cope, the Deputy Head requested food donations from teachers and other learners and asked Form 5 leavers to donate their uniforms to the school.

The evidence from this fieldwork is that some engagement with HIV education occurs at both schools but it appears limited to formal learning approaches in science lessons. At one school a teacher remarked, *'We haven't done much on HIV/AIDS with Form 4 [Standard 9] but Form 2 [Standard 7] have.'* A Standard 9 learner told the author: *'We only do things on HIV/AIDS when we get to that bit in the book in the syllabus',* and she showed the relevant part of a biology book. Standard 7 learners said they had discussed HIV/AIDS and condom use in class and they knew condoms were not 100% safe. At the second school the deputy head said *'We encourage teachers to talk about it, especially in science [class]',* and, at that school, some learners mentioned teachers as a possible source of

information and advice. Most learners were embarrassed to discuss sex issues with teachers and preferred the FLAS organisation in town: *'Teachers talk to us but we can't ask questions in class because they [other learners] laugh'* (female, focus group). And, *'Sometimes teachers tell us more about HIV/AIDS, but we feel shy to approach them and ask more about the disease'* (female, written account). Teachers are important role models, but as this learner explained, *'The same people that teach us are those we see in town doing the things they say we shouldn't'* (male, focus group).

Research in other parts of Africa has also highlighted the barriers to providing sex education in schools (World Bank, 2002; Giese *et al*., 2003; Gallant & Tyndale, 2004; Global Campaign for Education, 2004). These barriers include: embarrassment on the part of learners and teachers, sexual abuse by some teachers, lack of training and support for life-skills educators, and lack of community approval for teachers to teach sex issues. Swaziland is therefore experiencing difficulties similar to some other countries in delivering effective HIV/AIDS education within schools. These findings partly support a survey by Buseh, Glass & McElmurry (2002) that found Swazi adolescents preferred information from healthcare workers.

Gender issues at health clinics

Learners mentioned two clinics that they used for advice on sexual issues and treatment of STDs. However, boys found it more difficult than girls to use the clinics due to a perceived negative attitude by nurses, disapproval from peers and fear about the way HIV/AIDS is portrayed, as these male focus group comments show:

> *'Most of us feel that when we go there, to FLAS, most of the people are girls so we feel shy.'*
>
> *'FLAS people shouldn't frighten us too much with the facts, talking about AIDS as if it's a completely different disease, unique. They should normalise it.'*
>
> *'I'm scared to go [to a clinic]. They'll tell you you've started having sex.'*
>
> *'If I go there my friends will think I'm no longer cool, you see.'*

Girls were much more confident about using the health clinics: *'They teach us about HIV/AIDS and we have discussions.'*

The influence of mass media

Buseh *et al*. (2002, p. 528) found, in their questionnaire survey of 941 Swazi secondary school learners that "the majority of participants reported the print and broadcast media as their primary source of HIV/AIDS information." The research findings here show that Swazi school learners are exposed to a range of conflicting messages on sexual issues. Thus, UNDP (2002, p. 26) describes one regular radio programme, which is hosted by Jim Gama, an authority on Swazi Law and custom: "The host of the radio programme believes neither in condom use nor the rights of women." Press reports in *The Times of Swaziland* have also questioned the reliability of condoms. Many learners in the survey had negative or inaccurate views on condoms:

> *'They [her friends] said that they don't want to condomise because this oil in the condom has AIDS, but they are not sure about that, they just think and talk. The problem is that they don't know about that oil so we have to get some people who will talk and describe this condom'* (Female, age 14, written account).
>
> *'They tell us that condoms are not protecting us from getting this disease HIV/AIDS'* (Female, age 15, written account).
>
> *'Nowadays we are told that even condoms carry the virus. It is better not to use them as we teenagers are not supposed to be having sex'* (Male, age 18, written account).
>
> *'I think you have to demolish the idea of condoms. The condoms now are useless. Because now they are saying that the condom is not 100%. So really, the 100% is to abstain, not to condomise. Because if you start to use the condom, sometimes you use the condom twice, which is not good'* (Male, focus group).

While homes may lack electricity, battery-powered televisions are used in some, and several learners, of both genders, referred to watching sexual behaviour on TV programmes, videos and what they described as porn movies. They noted that actors and actresses often had several sexual partners and that condoms were not used:

> *'Who I think influences teenagers is the adolescent stage and these romantic and nude movies. What they see on these movies they will try to do experiments, so that is why they don't abstain. They also see these actors changing partners now and then and they will want to do the same…in none of these movies and dramas do they show them using condoms, so they will want to know how it is like when you don't use a condom'* (Male, age 15, written account).

Meekers & Calves (1997), researching HIV high-risk behaviour among young people in Cameroon, suggest that exposure to Western values through television, movies, novels and magazines might be one reason why adolescents start having sexual intercourse, but that other context-specific factors were more important, such as gaining sexual experience, and financial or other economic factors. Ganguly-Scrase (2004, p. 54) also describes how media images and Hindi films may encourage Indian girls to contest popular notions of women's sexuality, including arranged marriages, but concludes, "In most cases their defiance is ultimately muted and their hopes of remaining unmarried are quickly dissipated." In both these examples, while global images of other sexual behaviours are now accessible in many poor countries, the influence of local social norms, values systems and economic circumstances still appear the dominant influence on sexual behaviour.

These young people in secondary school wanted to have more accurate knowledge of HIV/AIDS and sexual issues and most wanted more discussions and guidance from their families as well as other sources. They were not equipped with accurate information about the role of condoms in disease control and tended to hold negative views about condoms. Next, I consider how they made choices about their sexual behaviour, while emphasising the need for multi-dimensional behaviour-change models that take into

account the importance of gender in sexual negotiations, the influence of local social sub-cultures, and the socio-economic conditions of the wider community.

Making choices about sexual behaviour

The range of options

The data collected portray a range of decisions about sexual behaviour across genders and ages. There were those who had decided to abstain, those who were having sex with condoms, and those who were having multiple partners without protection. Those abstaining were frightened of becoming infected and sometimes associated HIV/AIDS with moral failure. Sometimes the male decided against sex: *'I told her I didn't want to catch up with HIV and did not want to go to hell'* (male, age 15, written account). Some implied they were using condoms: *'About the ABC ['abstain, be faithful, use a condom'] message, it is a fact that most teenagers do not take it seriously and to tell the truth, they really aren't even considering A and B'* (male, age 17, written account). Or, *'In the ABC message, like in A, girls are like* — Damn! Abstain? I've tasted it already. *Others are like* — Abstain? I also want to taste what it feels like having sex. *Some teenagers are faithful and condomise [when] they do it'* (female, age 16, written account).

Others implied that having multiple partners without using condoms was quite common and some were fatalistic about AIDS, sex and death:

> *'Teenagers now don't take ABC messages seriously because they think that if you abstain your chances of marriages are going to be limited. They say it is a must to have more than one boyfriend to avoid disappointment. There is this slogan, usually said by boys, which runs: you can't eat a sweet which is inside a paper, you won't have the taste, and they don't use condoms'* (Female, age 16, written account).
>
> *'We believe that, as young people, we have to enjoy ourselves. It's still our time. Yes. So as to enjoy ourselves we don't look at the generation. We don't look at these times, but there is this disease that is killing us. We apply the way where the developed countries are doing it. In America, my friend can have a boyfriend but she cannot get HIV. We still believe: I can do it, but we don't do it the way they do it'* (Female, focus group).
>
> *'You know what? You will die sooner or later so why waste your life? It's better doing it'* (Female, focus group).
>
> *'We are all going to die anyway'* (Male, focus group, in discussion about condom use).

The importance of gender in sexual negotiations

There is much literature on the subordinate position of women in many sub-Saharan African cultures. Swaziland is a patriarchal society where women are accorded the status of a minor in law. Marwick (1940, p. 60) wrote: "As among the other Bantu tribes the female occupies a characteristically humble position in most spheres of life." More recently, Kuper (1986, p. 28) wrote: "No equality is expected or desired between Swazi husband and wife. He is the male, superior in strength and law, entitled to beat her and to take other women." Despite the attempts of women activists to improve the rights of women and children, progress has been very slow and often meets with resistance (Aphane, Hlanze, Khumalo, Manzini & Mkhonta, 1998). A UNDP report on gender-focused responses to HIV/AIDS states, "Most cultural expectations and practices were found to contribute to women's vulnerability to HIV/AIDS. The Swazi society expects women to be subordinate and submissive; allows men to have multiple sexual partners; and polygamy, which exposes women to HIV infection, is legal in the country," and "condoms are generally available in the country, however, their usage is still very low, partly because of the myths surrounding them (UNDP, 2002, p. 2)."

The descriptions of sexual negotiations between school-attending young people in the study generally reflected low self-esteem and the subordinate position of females, but, sometimes, males felt pressurised by their girlfriends to have sex. The decision whether to use condoms or not was mainly taken by males. Both sexes noted that drugs or drink affected their decision-making:

> *'Sometimes it's not that we do not take it [HIV/AIDS] seriously, it's because of our boyfriends…they will be like* — Oh, you do not like me.*… Our boyfriends like flesh to flesh, they think it is more enjoyable without a condom'* (Female, age 16, written account).
>
> *'Others don't use condoms because they practice sex while they drink and everything happens automatically so they don't remember to use a condom'* (Male, age 18, written account).
>
> *'The lifestyle we lead now, exposed to parties where there is booze and drugs. We get exposed very young. We have a couple of drinks, and a guy comes along that you fancy, and you forget about condoms. It is not necessarily because the man forces you to have sex'* (Female, age 18, one-to-one conversation).

Some female focus group comments on whether boyfriends insist on sex were:

> *'No, he is not pressuring. I might be the one! I might be the one doing the dumping if he doesn't talk about it [sex].'*
>
> *'Sometimes you feel pressure to have sex, to keep that man. Sometimes I enjoy it. Not always.'*
>
> *'You know, some girls are not confident enough about their bodies, about themselves, they think — I'm a virgin, I don't want to do this. Then some man will convince you some way or another. Then you think — Oh what the hell! Let me just do it because everyone does it.'*

One orphaned girl mentioned loneliness as the driving influence to have sex:

> *'You know how it feels when you don't have parents to love you, to look after you. You turn to someone. Some of them will even, like, go to older men and look for love in their arms. It's just like that.'*

The place where sexual intercourse took place was varied, but quite often occurred within the home when parents were absent: *'You go home with the chick, with the condom in your pocket. Your parents go to work. At the weekend, maybe they go home [the homestead in the rural area] and you have the whole weekend'* (Male, focus group).

Social sub-culture and economic drivers of sexual behaviour

For both genders, peer pressure, from their own gender, was very important and usually encouraged young people to engage in sexual intercourse. However, some girls encouraged each other to resist peer pressure. Boys felt particular pressure to have sex with their girlfriends as a sign of their masculinity and feared being marginalised and ridiculed by their male peers if they did not. This resulted in some males feeling unhappy and lonely. Girls also feared being mocked or losing female friendships but a wider range of options were seen as acceptable. In addition, in the written accounts, the most frequently mentioned reason for girls having sex was the need for money. Sometimes, this money was for necessities such as food or school fees, but sexual transactions for goods such as mobile phones, jewellery and fashionable clothes were frequently mentioned. Transactional sex was normally with older men, but sometimes same-age male partners gave money. Boys were very aware of the role of older men and, as a consequence, were sometimes irritated by their inability to compete materially. The extracts below illustrate some of these points:

> *'Some teenagers feel that abstaining and being faithful to their boyfriends does not make them cool. They have many boyfriends so as to get recognition. They want to be the coolest kids at school and abstaining will make their boyfriends dump them. Teenagers should be encouraged to use condoms because they do not want to abstain. The condoms should be provided at school…. Sugar daddies have got cars and a lot of money so most girls are after these things. In return for these things the older men want to have sex with the girls without a condom. They do not have sex with only one girl. After they get what they want they dump you. Even if you are pregnant they do not accept the child. So in this way the virus is spread very quickly among teenagers'* (Female, age 17, written account).
>
> *'My own sister wanted to have a 18-carat necklace and her friend had to come and take her at night to go to some place where they were going to make cash'* (Male, age 17, written account).
>
> *'When you don't make love to your girlfriend your friends laugh at you saying that you are shy, your lover will run away from you and look for sex'* (Male, age 16, written account).
>
> *'As teenagers we listen to each other and we have a strong influence on each other compared to the influence our parents have on us. For example, if a boy comes to me and says* — Have you had sex? — *and I say no, he laughs his lungs out giving the idea that I am a fool and he is clever. I have to have sex too, which is very wrong'* (Male, age 20, written account).
>
> *'Parents, they do not give their children money. And these children look for people who can give them money and these people have sex with them and pay money for it…. Majority of us like cell phones and if someone who said that I must have sex with him will give me a cell phone I will simply have the sex and get the cell phone'* (Female, age 16, written account).
>
> *'Teenagers are also influenced by sugar daddies who would buy jewellery, have money, and do luxury things for the teenager, and by that way they would be influenced because they don't get those luxuries at their homes. Teenagers are also influenced by their parents who told them that nobody is going to have food on the table for them and no one is going to pay the bills. So in that way, teenagers think that the best way to have all this is to go to the streets at night, have sex with a lot of males and then they could have the cash to maintain the bills and put food on the table'* (Female, age 16, written account).
>
> *'Teenagers are influenced by their friends. When they see they're having money for lunch they tend to have relationships with old people who will give them money to be like their friends. Fashion also influences teenagers to love sugar daddies because they want money to buy those fashion clothes'* (Female, age 16, written account).

Young respondents' conclusions on what is needed to promote low-risk sexual behaviours

During the course of the fieldwork, young people made various comments on what they felt they needed to help them make wiser decisions about sexual behaviour. More accurate information about the virus and the protection afforded by condoms was often mentioned. They also wanted more help in decision-making and more opportunities to talk about sexual issues. Males in particular felt isolated and confused. While fearing HIV/AIDS on the one hand, male peer pressure to practice high-risk behaviour was intense. Both genders wanted their family caregivers to be more open with them about HIV/AIDS and sexual issues. They suggested peer education and links with youths in other schools and the use of well-informed educators who were close to them in age.

Conclusions: linking the findings to practical solutions

The findings and their limitations

This small-scale, qualitative study set out to give a more nuanced understanding of how young people in Swaziland make decisions about sexual behaviour in the context of high HIV prevalence. It draws on respondents from a relatively poor urban area, thus youth in other settings may have different experiences. Researching sexual decision-making and sexual behaviour with adolescents is obviously difficult given the desire to impress peers and the personal nature of the subject. While these limitations must be borne in mind, by using a variety of data collection methods and a variety of respondents, this fieldwork supports the evidence from the Swazi BSS (FHI, 2002) as well as findings in other parts of sub-Saharan Africa (e.g., Meekers & Calves, 1997; Varga, 1997; Kinghorn, 2002; Østergaard & Samuelsen 2004). There was inadequate knowledge about the condition, HIV transmission, and the efficacy of condoms. There were cultural and economic drivers of high-risk sexual behaviour superimposed on the development stage of adolescents, where peer pressure is of particular

importance. Drugs and drink were also strongly linked to high-risk behaviour. The perceived need for cash was a dominant cause of high-risk behaviours among school-attending females in the study. The negotiation between sexual partners was dominated by males in most cases and reflects Swazi attitudes towards gender. Some teenagers were choosing to abstain from sex and girls sometimes support each other in this decision. However, cultural constructions of masculinity were problematic for those male youths who wished to follow less-risky sexual behaviours.

Recognising the vulnerability of adolescents

The results show that Swazi young people have adolescent experiences similar in many respects to adolescents in other cultures, for example: anxiety over changes in their bodies, a desire to be liked and accepted by their peers, difficulty in communicating with their parents, and a desire to make their own decisions. Some were clearly lonely, confused and feeling vulnerable about sexual decision-making and sexual behaviour. Surrounded by unemployed relatives, death and illness, and unsure of their own future prospects, some adolescents seemed to be retreating into childhood as a form of denial rather than embracing the perceived uncertainty of adulthood. Choosing to ignore confusing safer-sex messages and deciding *'it is still our time'* and *'we are going to die sooner or later',* may partly reflect the development stage of adolescents and the need to break away from authority, but it may also reflect the deep fear, insecurity and uncertainty they are experiencing. Denial of the reality around them may be a coping mechanism for some. Young people wanted much more discussion and guidance from well-informed adults and a more positive vision of their future, where low-risk sexual behaviour could become part of the pathway to achieving that vision. The agency of children and the need to listen to their experiences and their coping strategies is being increasingly recognised. Cunningham (2003) refers to children as social actors entitled to involvement in the decisions that affect them. He argues that children have an important role to play in their own protection, though he cautions against giving them more responsibility than they can manage.

Youth and the elderly as part of a community-level solution

Parker (2004) stresses the need to move from top-down approaches to participatory approaches at the community level to achieve behaviour change. He sees people and communities as agents of change and calls for a move away from a focus on individual behaviour towards integrating communities in assessing issues of concern at a local level.

These findings in Swaziland, and the literature referred to above, suggest that young people, with adequate adult support and guidance, could be much more actively involved in promoting low-risk sexual behaviour. Agha (2001) evaluated a peer-led HIV prevention programme in a secondary school in Zambia and found that peer education provides information in a setting that adolescents are comfortable with and is effective. Given the present reality of young people's sexual behaviour, HIV prevention education must extend into empowering each gender to exercise choice over their sexual behaviour and a right to sexual health. This includes the right to choose abstinence if they wish. Abstinence and delaying sexual debut is too late for some in the 15–19 age group. It must become the norm for youth to take regular HIV tests in easily accessible, youth-friendly clinics. HIV-negative youth have an incentive to stay that way. It must be the norm for results to be shared with partners and not just taken on trust. Respect for each other's sexual health must extend to accurate practical knowledge of how female and male condoms work and how they can fail to protect if used carelessly.

There is much more that the older, unemployed youth in the communities could do. Resources for community centres, perhaps based in schools after-hours, not just for health education but to provide recreational opportunities and vocational advice for youth, would help break the cycle of boredom, lack of vision, and habits of drink, drugs, and unprotected sex. These centres could provide well-informed peer educators, who would also be able to reach marginalised out-of-school youth. Some salaried youth-development staff would be required, and, given the levels of poverty and perceptions of community work, assuming high levels of youth volunteerism is unwise. For example, the author interviewed the young male Mbabane Urban Youth Network Secretary. He felt that youth needed some incentive to be involved with community work; he was helping with a community soup kitchen but remarked: *'For many of my friends, community work doesn't look glamorous.'* He suggested the provision of education scholarships for those who showed commitment to community service over a period of time.

Peer education could be extended to include elderly peer educators so that grandparent caregivers may become well informed. The Islamic Medical Association of Uganda (1998, p. 14) found that while mass information campaigns help some people, many needed a more personal approach: "Overall, individuals are more likely to adopt safer-sex practices if they are perceived as the norm prevailing among their peers and community. It is crucial to work at the community level to personalise social norms, such as mutual fidelity and the moral responsibility not to endanger others."

The importance of schools

The difficulties of providing better HIV prevention education in under-resourced schools have been discussed, but there are ways that schools can help empower youth over sexual decision-making. The Global Campaign for Education (2004, p. 15) suggests that free primary education in Uganda, introduced in the mid-1990s, and the inclusion of HIV/AIDS education in the classroom, led to a 'sea change' in sexual behaviour: "In one school district in 1994, more than 60% of learners aged 13–16 reported that they were sexually active. In 2001, the figure was fewer than 5%." Schools need to be better resourced to include a wide range of life skills in a revised curriculum. Kinghorn (2003) refers to the low importance of life skills in the curriculum in other African countries and how even the best staff often do not teach it.

Østergaard & Samuelsen (2004, p. 111) elaborate on how sexual relations require negotiation among partners: "Young

people, particularly young girls who are disempowered and without strong communication skills, find themselves incapable of negotiating condom use." Creating open-ended learning styles in all subject areas, where girls are encouraged to analyse, discuss and form their own opinions, and where boys are encouraged to consider wider constructions of masculinity, are needed. The forum for such discussions needs to be non-threatening and participatory. Occasional provision for lessons split by gender may encourage more female engagement. It takes time for such initiatives to take effect, but the evidence that education protects against HIV infection is strong, especially if started before sexual debut (World Bank, 2002).

The role of the international community

Youth in Swaziland are an integral part of the larger society around them. Bray (2003) warns us of the dangers of labelling groups of children according to just one aspect of their lives, in this case children affected by HIV/AIDS, without considering the wider social and political setting. As Piot (2005) emphasises, HIV/AIDS is far more than a health issue and is driven by inequality of all kinds. While health issues and the roll-out of antiretroviral treatment are absolutely vital, the international community must also continue to help AIDS-afflicted countries in their fight to reduce the rate of new infections. Supporting education and community initiatives, as suggested in this paper, is part of the solution. Another part is to work towards reducing the poverty and the lack of opportunity experienced by youth in poor settings so that they have a positive vision of an achievable, disease-free future.

Notes

[1] Using the internationally agreed definition of childhood as the period from birth to age 18, as denoted in the Convention on the Rights of the Child (CRC) drawn up by the United Nations in 1989.

[2] The author had the responsibility of introducing a comprehensive AIDS policy, the first of its kind in Swaziland, to the school community. Apart from specifically education-based aspects, the initiative acted as a springboard for many other intertwined community activities. Relationships were formed with families caring for sick relatives and with children who became orphaned. Some of these families, with whom the author remains in contact, were invaluable in providing an entry point to making contact with some respondents in this study.

[3] Both research assistants were young black Swazi women. One research assistant was a graduate with counselling experience; the other was a medical student. Where possible, families and learners found to be experiencing considerable difficulties were given help.

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