Knowledge of HIV transmission and sexual behavior among Zimbabwean adolescent females in Atlanta, Georgia: the role of culture and dual socialization

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ABSTRACT

AFRICAN-AMERICAN/AFRICANA WOMEN’S STUDIES/HISTORY

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KNOWLEDGE OF HIV TRANSMISSION AND SEXUAL BEHAVIOR AMONG
ZIMBABWEAN ADOLESCENT FEMALES IN ATLANTA, GEORGIA: THE
ROLE OF CULTURE AND DUAL SOCIALIZATION

Committee Chair: Dr. Josephine Bradley, Ph.D.

Dissertation dated December 2012

This study conducted in Atlanta, Georgia examines the knowledge of HIV transmission and sexual behavior among Zimbabwean adolescent females. A total of 30 adolescents were interviewed using qualitative techniques. This study utilized the Social Cognitive Theory as the theoretical framework in that it maintains that behavior is largely regulated antecedently through cognitive processes. This study also employed Self-efficacy Theory, which is concerned with people’s beliefs in their capabilities to perform courses of action to attain a desired outcome. Awareness of risk perceptions helps young people to learn to see actions as causes of events and believe in the changeability of heath risks and risky habits. The researcher found that a majority of the adolescents had a high level of knowledge of HIV transmission. Although adolescents’ knowledge of condom use is relatively high, their usage lags far behind. The conclusions drawn from the findings suggest that adolescents are aware of HIV transmission, but are not applying their
knowledge in practice. There is a gap between knowledge and action. Therefore, there is need to promote healthy sexual behavior. Effective educational programs that promote critical thinking, decision-making and skills that support the adoption of healthy behaviors and the reduction of high-risk behaviors are necessary.
KNOWLEDGE OF HIV TRANSMISSION AND SEXUAL BEHAVIOR AMONG ZIMBABWEAN ADOLESCENT FEMALES IN ATLANTA, GEORGIA: THE ROLE OF CULTURE AND DUAL SOCIALIZATION

A DISSERTATION
SUBMITTED TO THE FACULTY OF CLARK ATLANTA UNIVERSITY
IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR DOCTOR OF ARTS IN HUMANITIES

BY
LOVENESS MABHUNU

DEPARTMENT OF AFRICAN AMERICAN STUDIES, AFRICANA
WOMEN'S STUDIES AND HISTORY

ATLANTA, GEORGIA
DECEMBER 2012
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<td>Abstinence, Be faithful and Condom use</td>
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<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<td>CDC</td>
<td>Centers for Disease Control and Prevention</td>
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<td>ESAP</td>
<td>Economic Structural Adjustment Policy</td>
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<td>HIV</td>
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<td>UNDP</td>
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<td>United Nations Population Fund</td>
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<td>USA</td>
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WHO  World Health Organization
ZWAN  Zimbabwe Women AIDS Network
CHAPTER 1
INTRODUCTION

The purpose of this research was to examine the level of knowledge of HIV/AIDS transmission and sexual behavior among Zimbabwean female adolescents aged 13 to 22 years who reside in metropolitan Atlanta, Georgia. The research also explored the adolescents' experiences related to different socializations regarding sexuality and gender outside their traditional socialization. The primary motivation for this study was based on the realization that the reproductive health of black female adolescents is not well represented. In Zimbabwe, the Acquired Immune Deficiency Syndrome (AIDS) and its twin infection, the Human Immunodeficiency Virus (HIV), have been spreading at astonishing speed for approximately twenty-five years, and it is now one of the world’s greatest health challenges. Throughout Zimbabwe, the AIDS pandemic is affecting large numbers of adolescents, leading to serious psychological, social, economic and educational problems. The disease has a significant effect on women, children and their families. One in four people in the southern region of Africa, including Zimbabwe in the productive age group (15-49 years) is living with HIV.\(^1\) This means that fewer adults must support more people and the burden of care is shifted to societies’ weakest and most marginalized, women and girls. Desperate people adopt damaging and high-risk “survival strategies,” such as exchanging sex for food or cash. Children are especially at risk for HIV infection. According to recent UNICEF figures, there are currently 160,000

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Zimbabwean children infected with HIV/AIDS. Today 3 million children live with AIDS and over 13 million have been orphaned by AIDS, most of them in Sub-Saharan Africa. Children under 14 years of age offer a “window of hope” to stop the spread of HIV/AIDS. If given proper awareness about preventing disease and behavior change, they have a significantly improved chance of protecting their own lives and the lives of other people.

In the United States of America, HIV/AIDS hits African Americans the hardest. HIV/AIDS has become a silent, yet deadly epidemic for African Americans. Even though African Americans account for about 12% of the United States population, they account for about half (49%) of the people who are HIV-infected. The adolescent population represents the majority of new infections. Among young people infected with HIV, African Americans comprise the largest group, accounting for 55% of all HIV infections among 13 to 24 year olds. In the United States, women of color are overrepresented among female HIV/AIDS cases. Women of color accounted for 80% of all women living with HIV/AIDS in 2004; the overwhelming majority 64% of this total is African-American women. In particular, Georgia has the highest AIDS case rate and highest teenage pregnancy rate in the United States. Of particular note are statistics from

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the metropolitan Atlanta area which show some of the highest rates of STDs and HIV/AIDS in the state. Most of the Zimbabwean adolescents live in this city with highest rates of infection.

Despite advances in biomedical research, there is still no preventive vaccine or medical cure for this deadly disease. Consequently, efforts to change high-risk behaviors remain the only viable means to prevent HIV infection. The target group for this study is Zimbabwean female adolescents who reside in metropolitan Atlanta aged 13-22. These adolescents in the United States face a dual socialization challenge (that is African versus Western cultural beliefs and values). The focus on adolescent females is based on trends of prevalence of HIV/AIDS among females. Women have become the fastest-growing subgroup of AIDS cases worldwide. Adolescent females who are sexually active are at an increased risk of contracting HIV. Educational efforts about safe sex practices must be tailored to teenage girls. Adolescents need to be equipped with adequate information. Without proper education about sex, adolescent females will continue to engage in risky behavior.

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Statement of the Problem

It is universally agreed that HIV/AIDS constitutes one of the most serious threats to human life in our era, and represents one of the greatest problems for the socio-economic development of many countries. HIV/AIDS has become one of the leading causes of death. The epidemic has a serious impact on women worldwide. Globally, some of the highest rates of new infections are occurring among black women in both the developed and the developing world. High school and college students are at high risk of HIV infection due to unsafe sexual behaviors, experimentation with alcohol and drugs and failure to see themselves at risk for infection. Spira and Bajos in their findings conclude that female adolescents and young women under the age of 24 are at increased risk for contracting HIV because they are more likely to have multiple sex partners and are less able to negotiate safer sex practices. The poor economic conditions in Zimbabwe exert great pressure on young girls to engage in unsafe sexual activities. Many girls have turned to commercial sex work increasingly; they are involved in sexual networks to earn a living. In many cases, wealthy and elder men, referred to as “sugar daddies” entice these young women with money to have unprotected sex. Such circumstances may contribute to HIV/AIDS infection among youth. In urban Zimbabwe, the general HIV prevalence rate is 18% among adolescent girls aged 15 to 19 years. This statistic clearly shows that adolescents are at an increased risk of HIV infection.

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The impact of political unrest to the socio-economic status of the country of Zimbabwe led to the immigration of Zimbabwean people to the Diaspora. The majority of Zimbabwean people who migrated to the Diaspora live in Atlanta, Georgia. Job opportunities, weather conditions and a large black population attract Zimbabweans to Atlanta. However, the HIV infection rate is alarmingly high among African Americans. African-American adolescents in Atlanta account for more HIV and AIDS infections than any other group. 50% of new HIV infections are occurring in youth 16-24 years old. Adolescents are now identified as one of the fastest growing groups in the state of Georgia to be infected with HIV, accounting for 23% of all the AIDS cases. Recent trends indicate that the disease is now affecting many women in Atlanta at growing rates. Zimbabwean adolescents interact more with African-American adolescents because they are of the same race. As a result, Zimbabwean female adolescents who reside in Atlanta face a higher risk of being exposed to HIV infection because more people are living with HIV in black communities, and most blacks have partners who are of the same race/ethnicity.

The immigration of Zimbabwean people into America plays a major role in the socialization of Zimbabwean female adolescents. Socialization is how culture is transmitted from one generation to another. Culture pertains to traditions, beliefs, values, religious practices, dress, relationships, gender issues and sexual behavior. There is a general consensus that the migration of people constitutes culture shock. This involves

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where you live, what you eat, how you dress, your language, and so forth. Culture shock plays a major role in socialization. Culture assumes a significant role in the socialization process by shaping the specific beliefs and values held by parents. Zimbabwean adolescents in Atlanta face dual socialization challenges. As Espin has noted, immigrant and ethnic minority groups may preserve aspects of their traditional culture related to sexuality long after they have adopted other aspects of the host culture. Loss of identity, values needed to survive and traditions they are expected to keep in a new environment affect the behavior of adolescents. Zimbabwean parents face a dual socialization challenge of not only transmitting their own traditions, beliefs and values, but also those of the American society. Zimbabwean adolescents are exposed to the Western culture of sexual socialization which is different from the African culture. Zimbabwean youth often find it very difficult, if not challenging, to always be judged through a European social construct or cultural lens. They have separate needs when assimilating into the American culture.

In traditional Zimbabwean communities, sex education is the job of aunts, uncles, elders in the community, and grandparents. Initiation ceremonies marked the transition of boys and girls from adolescence to adulthood. However, these cultural practices are subjugated and suppressed by westernization; these practices are deemed backward. Furthermore, for those in the Diaspora, the children are living with their parents. They left their aunts, uncles and grandparents back home in Zimbabwe. The aunts and grandparents were traditionally important in the education of girls. In contrast, in

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America sex education is passed from parents, grandparents, church, schools, friends, media, and internet. Media and internet are becoming popular for sex knowledge among young people. The social bonds and traditions that used to shape Zimbabwean young people’s behavior and help them make the transition to adulthood have weakened in the face of migrating to western countries. The main problem is the transition and loss of cultural identity that affect Zimbabwean adolescents’ knowledge of HIV/AIDS transmission and sexual behavior.

Young girls need a clear understanding, along with precise information, about techniques and methods to safeguard themselves against this disease. Although there have been massive funding efforts toward global prevention, HIV infection rates continue to grow. This is especially the case with black people, both in the United States and Sub-Saharan Africa, where HIV prevention programs are having limited success and infection rates continue to grow.

A draft report for the United Nations’ (UN) AIDS agency found that even if people use condoms consistently, the failure rate for protection against HIV is an estimated 10%, constituting a larger risk than portrayed by many advocate groups.\textsuperscript{12} Green states that “the data on condom effectiveness should help set policy and that people in developing countries should know about that risk. One in ten of condom failure is not good enough for fatal disease.”\textsuperscript{13} Following this proposition, abstinence might be


the best method for HIV prevention. Hankins maintains that we need a combination of prevention, postponing sexual activities, reducing partners and using condoms. Incorporating the ABC (Abstinence, Be faithful and Condom use) strategy might prevent the sporadic spread of HIV/AIDS.

**Significance of Research**

This research is important because it adds to the knowledge base of disciplines such as African Studies, African American Studies, Africana Women Studies, Sociology, Psychology and Religion. The ways in which African cultural transitions and changes with breakdown in societal structures make the research significant to these studies. Research on HIV/AIDS infection among women in Zimbabwe has been insufficient and poorly targeted. There is a need for more epidemiological and clinical research in HIV progression among girls. Many researchers have focused on adults and not adolescents because HIV/AIDS originated among adults. Adolescents were not considered to be at risk until recently. Moreover, according to Brown and Waite, the programs that do exist in the United States (especially Georgia) often do not focus on the needs of African and African-American adolescents, perhaps contributing to the increasing spread of HIV in this population and highlighting the importance of creating an appropriate peer-led educational outreach program for African and African-American adolescents.

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This research attempts to add to the continuum surrounding HIV prevention. The study surveys primarily Zimbabwean adolescent females who face a dual socialization (African and Western) challenge and are at a greater risk of HIV infection in Atlanta. HIV/AIDS is a dreaded disease that has the potential for destroying humankind worldwide. Female adolescent health is part of reproductive health which is a component of maternal and child welfare practice.

The findings of this research can assist adolescents to have access to information, education (including peer education and youth-specific HIV education) and services necessary to develop the life skills required to reduce their vulnerability to HIV infection. It also adds to the existing body of knowledge. The study may also help the researcher in motivating or further alerting the adolescents in the reduction of HIV prevalence among female adolescents in Zimbabwe so as to improve the life expectancy, which has been reduced to approximately 39.

The information obtained from this research enables health professionals and educators to identify and assess the educational needs of adolescents concerning HIV/AIDS. It allows them to assess the adequacy of the current HIV/AIDS educational programs and to implement necessary changes to improve knowledge and prevent the spread of HIV/AIDS among the female adolescent population. Young people need information to make sound health choices and to protect themselves from the devastating effects of HIV/AIDS.

**Theoretical Framework**

The conceptual framework for this study is adapted from the works of Bandura. The theory applied to this study is Social Cognitive Theory (SCT). Social cognitive
theory provides the investigator with a useful system for describing the behaviors that female adolescents do and do not use in specific concepts. SCT stemmed from Social Learning Theory (SLT). According to Bandura’s social learning theory:

Children learn primarily through imitation and observation of others. Children learn how to behave in specific contexts by observing how others behave in that context. By imitating that behavior, children tend to imitate those with whom they identify. The learning process is the process of acquiring and gaining growth, knowledge, and understanding, or skill. An even broader definition of learning is described as any permanent change in behavior that occurs as a result of a practice or an experience.16

The learning process makes what we teach our children even more important. It has the potential to have a lasting effect on youths’ perceptions and behaviors. Youth years or maturation years are an important growth and developmental period.

Adolescence is a period when youth begin to care more about what others think, particularly about them. They want to be accepted and liked by others. They often begin to separate from parents and identify more with friends, entertainers and public figures. Generally youth tend to seek out their own identity and acceptance through various forms and experiences. Some of those identified forms are organized activity groups and social cliques, sexuality and sexual curiosity, hobbies and interests, and independent alone time.17 Zimbabwean children in the United States, for example, face double socialization, that is African socialization and American socialization. American or European culture has an impact on the traditions and identity of Zimbabwean

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adolescents. Adolescents imitate their American peers' behavior and find it challenging to cope with their African culture.

Social cognitive theory predicts that individuals will imitate the behavior of others when those models are rewarded or not punished, especially when viewers perceive them as attractive and similar to themselves. Bandura asserts that individuals model their behavior on vicarious experiences such as the media because their real life experiences are usually more limited. This may be particularly true for adolescents who may not have much first-hand experience with sexuality yet are starting to enter into dating relationships and thus are eager to learn about issues such as how to behave with a romantic partner or how to perform various sexual behaviors.

Adolescence is a period when children develop their skills and learning into adulthood. This is a period which is dangerous because they tend to identify with the socialization processes and influence one another to take risky behaviors. During this period adolescents experience changes and transformations in development through self-examination and through experimenting with different behaviors which contribute to the development of a personal, independent identity. There are several areas of development that affect Zimbabwean youth particularly during their teen years. Blos maintains that changes during this developmental period take place in four central areas: physical, cognitive, emotional and social. The emotional, physical, and social changes during the beginning stages of adolescence are often pressuring and problematic. They affect

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self-image and interpersonal relationships, especially among vulnerable girls who are prone to depression, eating disorders, or other behavioral problems. Adolescence, therefore, is a developmental stage associated with risky and health compromising behavior. Understanding the learning and development processes of Zimbabwean youth is an important component in assisting them to achieve productivity and success.

Social Cognitive Theory contends that behavior is largely regulated antecedently through cognitive processes. Moral behavior can be developed through competencies that include what children are capable of doing, what they know their skills are, their awareness of moral rules and regulations and their cognitive ability to construct behaviors. Therefore, response consequences of a behavior are used to form expectations of behavioral outcomes. It is the ability to form these expectations that give humans the capability to predict the outcomes of their behavior, before the behavior is performed. Having adequate knowledge of HIV transmission should influence adolescents to avoid risk behaviors so as not to acquire HIV/AIDS. Drug use, drinking and sexual risks are salient examples of detrimental behaviors that can impair health. Many adolescents drink, experiment with drugs and practice unsafe sex, perhaps because they are not aware of the risks they are taking. However, many young people do understand the risks they are taking but choose to ignore them because they weigh other values more heavily. The SCT’s strong emphasis on one’s cognitions suggests that the mind is an active force that constructs one’s reality, selectively encodes information, and

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20 Bandura, 30.

performs behavior on the basis of values and expectations.\textsuperscript{22} Through feedback and reciprocity, a person’s own reality is formed by the interaction of the environment and one’s cognitions. Interactive stage affects behavior. As one behaves, one is creating cognitive structures in his/her own mind. And they allow him/her to evaluate the actions of others and to change his/her own behavior consciously.\textsuperscript{23} It is through an understanding of the processes that enables human behavior to be understood, predicted and changed. A girl child’s expectations, beliefs, self-perceptions, goals and intentions give shape and direction to behavior. Knowing consequences of high-risk behaviors will determine behavior change among female adolescents.

SCT maintains that a bi-directional interaction occurs between the environment and personal characteristics. In this process, human expectation, beliefs and cognitive competencies are developed by social influence and physical structures within the environment. The social influence can convey the information and activate emotional reactions through such factors as modeling instruction and social persuasion. The researcher purports that Zimbabwean traditional ways are socialized. Traditionally, in Zimbabwe, adolescents learn cultural mores through their grandparents, aunts and uncles.

Socialization plays an important role in the life of female adolescents. The researcher argues that socialization in America has affected the Zimbabwean traditional sexualization. The American environment has a great impact on the behavior of


Zimbabwean adolescents in America. Many parents feel uncomfortable discussing sex education with their adolescent children; some parents prefer to stay silent and assume their children will learn what they want to know from school and the media. Some people believe that telling children about sex will encourage sexual experimentation. However, teenagers' perception of sex and sexuality can be skewed by incorrect or misleading information from interaction through various sources such as magazines, television, radio and peer pressure from other teenagers. The information adolescents receive in relation to sexual maturation is essential for their health development, and comes mainly from the various communication media. Recent studies show that adolescents who receive a thorough and comprehensive sexual education at an early age start having sexual relations at a later, more responsible stage of development and are more likely to use contraceptives.24 Today's adolescents are tomorrow's adults. Accordingly, to build a stronger and healthier society, we must pay close attention to educating the next generation. Zimbabweans in the Diaspora left most of their elders, grandparents, aunts and uncles in Zimbabwe which leaves parents to be educators to their children. Parents should be influential role models for adolescent children. By keeping silent, they allow their teenagers to interact and act on unreliable information and this can put them at high risk.

According to SCT, people have the ability to influence their behavior and destiny. Within the SCT perspective, humans are characterized in terms of five basic and unique

capabilities: symbolizing, vicarious experience, forethought, self-regulation, and self-reflection. It is these capabilities that provide humans with cognitive means by which to determine behavior. Vicarious learning refers to human ability to learn not only from direct experience but also from the observation of others. It enables humans to form patterns of behavior quickly, avoiding time-consuming trial and error as well as avoiding fatal mistakes. Adolescents should learn from the experiences of their peers who drop out of school due to pregnancy, HIV infection and STDs.

Self-efficacy is crucial to self-regulation of health behavior. It represents the belief that one has the ability to change risky health behaviors by personal action. Efficacy beliefs affect the intention to change risky behavior, the amount of effort expended to attain this goal, and the persistence to continue striving in spite of barriers and setbacks that may undermine motivation. A likelihood that people may adopt a valued health behavior or give up a detrimental habit may depend on three sets of cognitions:

1) The expectancy that one is at risk ("I have a high risk of getting HIV from premarital sex with multiple partners").

2) The expectancy that behavioral change would reduce the threat ("If I quit having sex, I will reduce my risk").

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25 Ibid.


27 A. Bandura, *Self-efficacy in Changing Societies*, 262.

28 Ibid.
3) The expectancy that one is sufficiently capable of exercising control over the risky habit ("I am capable of quitting sexual intercourse before marriage permanently").

Social Cognitive Theory (SCT) suggests that knowledge, though necessary, may not be sufficient to motivate people to adopt HIV preventive behaviors; at best, knowledge is a prerequisite for behavior change.\textsuperscript{29} SCT suggests that self-efficacy is also necessary when reducing risky sexual behavior and increasing safer sexual practices, such as condom use. Previous studies by DiClemente (et al) show that adolescents who feel confident in their ability to correctly use condoms, to negotiate condom use with their partners, to say “no” to unprotected intercourse, and to discuss their partner’s sexual history are likely to use condoms more often and have lower rates of STIs than are those adolescents who are relatively less confident or self-efficacious.\textsuperscript{30} This positive association between self-efficacy and safer sexual practices is important in understanding an adolescent girl’s risk of HIV infection, particularly when attempting to negotiate condom use.

Self-efficacy in adolescents affects the way they perceive their own abilities and competencies in dealing with problems or challenges.\textsuperscript{31} Young girls exposed to economic injustices, gender inequality, discrimination and violence may quickly develop the


\textsuperscript{31} Bandura, 265.
perception that they are incapable of positively impacting their life circumstances. Many feel helpless and succumb to unhealthy behaviors, which eventually expose them to high risk of HIV infection. Many young females are exposed to peer relations. As a result of social pressure and a desire to gain acceptance they begin to experiment with psychoactive substances which lead to high risk sexual behaviors. Therefore, knowledge of HIV transmission and adopting self-efficacy should positively influence the sexual behavior among Zimbabwean female adolescents.

Influencing health behaviors that contribute to the prevention of AIDS has become an urgent matter. Self-efficacy plays a role in such behaviors. Convincing a partner to abstain from sex or to comply with safer sex practices calls for a high sense of efficacy to exercise control over sexual activities. Programs should be launched in schools in Zimbabwe to enhance self-efficacy and to build self-protective skills among adolescents to prevent the spread of the HIV virus. Health cognitions regulate adoption of health-promoting behaviors and elimination of health-impairing behaviors.
Figure 1. *The Health Action Process Approach.*

There is evidence that perceived self-efficacy is closely associated with behavioral intentions and health behavior change. Figure 1 above gives a brief outline of the health action process approach. Three groups of cognitions are influential in establishing a behavioral goal or intention: Risk perceptions, outcome expectancies and perceived self-efficacy.\(^{32}\) Perceived self-efficacy is concerned with people's beliefs in

\(^{32}\) Bandura, 1995.
their capabilities to perform courses of action to attain a desired outcome. Outcome expectancies, in which consequences are produced by environmental events independent of personal action, represent specific contingency knowledge. A girl’s decision to participate in sexual behavior is influenced by what she considers as her perceived consequences, social/cultural norms, economic status, attitudes, and self-perceptions. Furthermore, it is important to note that the act of participating in sexual behavior is the observable result of the cognitive process that has taken place prior to any decision. Awareness of risk perceptions helps young people to learn to see actions as causes of events and believe in the changeability of health risks and risky habits. Through action control, in which outcomes flow from personal action, adolescents can avoid risk behavior. Focus is on cognitions that instigate and control the action that is a self-regulative process that is subdivided into action plans and action control.

Performing an intended health behavior is a health action. Abstinence and the use of condoms are examples of good behavior. The control of health-detrimental actions also requires effort and persistence, and therefore, is also guided by a volitional process that includes action plans and action control. This would curb the spread of HIV infection. However, Zimbabwean adolescents in the U.S. struggle with following their own traditional beliefs as well as European beliefs. Furthermore, they experience the external barriers such as sociocultural and socioeconomic barriers and as immigrants do not have access to a lot of resources. It is important for social workers and HIV/AIDS educators to reach out to immigrant communities.
**Research Questions**

The research answers the following questions:

1. What do Zimbabwean female adolescents in Atlanta know about HIV/AIDS transmission?
2. What are the sexual behaviors of Zimbabwean female adolescents?
3. How do Zimbabwean female adolescents in Atlanta learn about HIV/AIDS prevention?
4. What is the role of culture in Zimbabwean adolescents’ sexual behavior?

**METHODOLOGY**

A number of methods were used to research, document and recommend ways and means of overcoming the spread of HIV/AIDS. The research design that was employed in this study to gather information on Zimbabwean female adolescents’ knowledge of HIV/AIDS and sexual behavior was qualitative method. The research study was conducted in Atlanta, Georgia. Metropolitan Atlanta is the largest, and one of the fastest growing, urban areas in the state of Georgia.

**Qualitative Method**

A qualitative exploratory research design was used. A qualitative research method is useful because it has the capacity, primarily, to produce descriptive and vivid data about the adolescents’ written and spoken words. Through the application of this research method, the researcher extrapolated the meaning and common sense understandings of Zimbabwean adolescents’ sexual socialization. The researcher was positioned to document the sexual knowledge, aims, plans, beliefs, values, thoughts, feelings, content and experiences of Zimbabwean adolescents.
A qualitative research design, namely interviews and survey, was used to collect and analyze research data. This qualitative primary data-gathering technique was essential in providing the context and understanding of Zimbabwean adolescents’ knowledge, attitudes, and behaviors regarding sex. Researchers that advocate for feminist research strategies argue that qualitative methods allow for “individual women’s understandings, emotions and actions in the world which must be explored in those women’s own terms.”\(^{33}\) In addition, it is generally accepted that an interview-based method can give a rapid feel for the sex ethos.

The advantages of using a qualitative research method in this research are numerous. This method has the desired merit of containing parameters that allow for the discovery as well as verification of research data.\(^{34}\) It allowed the researcher to capture the “forces” that move human sexual behavior such as ideas, feelings and motives, as contained in Zimbabwe’s sex culture. Qualitative in-depth interviewing is a data collection technique that is often described as “a conversation with a purpose.”\(^{35}\) The purpose of which was to obtain valid and reliable information pertaining to the study. The researcher explored a few general topics to help uncover the participant’s meaning perspective, but otherwise respected how the participant frames and structures the responses. This, in fact, was an assumption fundamental to qualitative research that the


\(^{34}\) Ibid.

participant’s perspective on the social phenomenon of interest should unfold as the participant views it, not as a researcher views it.\textsuperscript{36} This style of research was beneficial because it allowed for the voices of Zimbabwean adolescents to be heard. The interviewees’ own written and spoken words were successfully documented through this method. Listening to the experiences of this population could improve the services provided to immigrant people.

\textbf{Study Sample}

Sampling is the process of selecting a portion of the population to be studied in a research project.\textsuperscript{37} When the population to be studied is large it would both be impossible and highly inefficient to attempt interviewing, surveying or observing all individuals. Rather the researcher needed to select a convenient sample of this full population. The main objective of drawing a sample is to make inferences about a larger population from the smaller sample. Inferential statistics are based on the assumption that the sample from which data will be derived will be obtained randomly. In this study, the sample required was 30 Zimbabwean female adolescents from 13 to 22 years old who are settled in metropolitan Atlanta. Parental permission was sought for underage participants. The investigator intended to use a convenience sample. The reason for choosing this age group was because the adolescents are of reproductive age and are at risk of contracting HIV.

\textsuperscript{36} \textit{Ibid.}

Instruments

An instrument is a written device that an investigator uses to collect data, such as questionnaires, tests or interview schedule. The researcher should take into consideration whether the instrument captures the conceptual definition of the variables being studied. The instrument should be valid and reliable to the sample being studied. According to Polit and Hunger, “reliability is the degree of consistency or dependability with which an instrument measures the attribute that it is designed to measure. Validity is the degree to which an instrument measures what it is intended to measure.” The instrument was designed to align with the previously stated research questions:

1. What do Zimbabwean female adolescents in Atlanta know about HIV/AIDS transmission?
2. What are the sexual behaviors of Zimbabwean female adolescents?
3. How do Zimbabwean female adolescents in Atlanta learn about HIV/AIDS prevention?
4. What is the role of culture in Zimbabwean adolescents’ sexual behavior?

The instrument designed in this study was a self-administered questionnaire, and interviews were administered in a face-to-face interview format. Questions were asked on the demographic data, awareness and knowledge of HIV transmission, and sexual behavior. The questions were designed to be short and easy to understand. The researcher gave a brief introduction and explanation of the nature of the study. After that a participant was given a survey to complete. All participants filled out a 30-question

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38 Ibid.
39 Ibid.
survey instrument. In using questionnaires, the researcher relied on the honesty and accuracy of participants’ responses. The nature of the questionnaire instrument was closed-ended but also included an open-ended schedule. The inclusion of an open-ended questionnaire allowed interviewees to more fully express themselves on any given question. A cover letter describing the research and inviting the subject to participate was accompanied by the questionnaire. The cover letter stated that there are no right or wrong answers to any questions and that all answers will remain anonymous and confidential.

Data collection procedures involved 20 interview questions. Data were collected via individual in-depth interviews. This was a useful way to get large amounts of data quickly. Each interview was audio-taped with the consent of the participant and their parents where necessary. The girls selected the time, location, and format for the interview. In an effort to ensure an ethical research study, an informed consent was initially obtained. Both the survey instrument and interview consent form were approved by Clark Atlanta University’s Institutional Review Board (IRB). This agreement documents:

• That the adolescents have agreed to participate in the research study;
• The purpose of the research;
• The procedures of the research:
• The risks and benefits of the research;
• The voluntary nature of their participation and that their real names will be confidential; and
• The participant’s right to withdraw from the research at anytime.
Ethical Considerations

Human rights are claims and demands that have to be justified through the eyes of the individual and have to be protected in research. When permission for underage participants is granted by the parents the researcher should take into consideration the principle of respect for human dignity, which includes the right to self-determination. The right to self-determination means the prospective participants have the right to decide voluntarily whether to participate in a study, without the risk of incurring penalties. Therefore, the researcher informed the participants that they had the right to withdraw at any time during the study without being penalized. The participants were promised confidentiality that any information they provided would not be publicly reported in a manner that identifies the participants.

Limitations of the Research

The scope of the study was Zimbabwean female adolescents in Atlanta, Georgia. There are some limitations to this study. The research cannot be based on collecting all the data from all the adolescent population in Georgia. It is only limited to a sample population of adolescents who reside in Atlanta, Georgia. Consequently, there is a limitation in generalizing the findings to a larger population due to the use of a convenience sample of the target population. Another limitation may be the comfort level of the participants in speaking freely about their knowledge of HIV and risky sexual behavior. There is a concern that participants may not be forthright or could possibly

\[40\] Ibid.
present inaccurate information as a result of speaking with the researcher in a face-to-face interview. Hence, social desirability presents a threat.

Another limitation of this study is that the focus is on exploring a sample of Zimbabwean adolescents' experiences of sexual behavior and socialization in the United States. As previously stated, the findings of this study cannot be generalized to other populations such as African American and Caucasian women who were born and raised in the United States who do not share the same lived experiences as immigrants.

**Chapter Organization**

This research is contained in four chapters. This includes chapter 1: Introduction, which establishes the problem to be examined. Chapter 2 presents the review of literature and examines previous research on the problem under investigation. This chapter is divided into the following categories: HIV/AIDS in Africa, HIV/AIDS in Zimbabwe, HIV/AIDS in the United States, HIV/AIDS in Atlanta, Knowledge of HIV transmission, sexual behavior and factors that influence adolescents’ sexual decisions and socialization. In chapter 3 the historical context explores the socio-economic history of Zimbabwe, its impact on the migration of Zimbabwean people to the Diaspora and also the impact of HIV/AIDS. The African indigenous’ perspectives on sexual socialization is also discussed in this chapter. Chapter 4: Analysis and Findings is related to data collection, which consists of interviews from Zimbabwean female adolescents who reside in Atlanta, Georgia. Chapter 5: Research conclusions and future research recommendations complete this research.
Summary

The present chapter introduced the qualitative research design for this study which addresses the socialization of Zimbabwean adolescents in Atlanta, Georgia and its impact on their knowledge of HIV/AIDS and sexual behavior. The expected contributions to the body of literature along with the research questions were outlined in this chapter. The next chapter is a review of relevant literature that addresses female adolescents, knowledge of HIV transmission, sexual behavior, and the risk for HIV and AIDS infection.
DEFINITION OF TERMS

Adolescence- Refers to the development period between the ages of 13-22 years. It is a period of physical and deep emotional changes.

Afrocentricism – The dominance of African cultural patterns.

AIDS- Acquired Immune Deficiency Syndrome. It includes all HIV- infected people who have fewer than 200 CD4+ T cells per cubic millimeter of blood (CDC, 2005).

African-American/Black- A person having origins/ancestors in Africa.

Cognitive- Thought process whereby individual participants perceive the need to change behavior.

Culture- The language, beliefs, values, norms, behaviors and material objects (ex. clothing, hairstyle and jewelry) that are passed from one generation to the next.

Gross Domestic Product (GDP) - Measures how a country is performing on the global market.

Human Immunodeficiency Virus (HIV) - Is the virus that causes acquired immune deficiency syndrome; it replicates in blood and kills the T cells.

Knowledge of HIV Transmission- Comprehensive correct knowledge of HIV that men and women share to correctly identify major ways of preventing transmission of HIV (like using condoms and abstinence).

Metropolitan Atlanta - a wide area outside the city limits.

Sexual Behavior- Is a form of physical intimacy that may be directed to reproduction and to enjoyment.
Sex Lock – The traditional method of preventing sexual intercourse from happening, especially penetration.

Sexually Transmitted Diseases- Refers to infections and/or viruses that are transmitted through sexual activity. This includes HIV infection.

Socialization – A process by which people learn the ways of society or of particular groups.

Social Learning Theory - The process of acquiring and gaining growth, knowledge, and understanding, or skill.

T- cell- A type of white blood cell essential to the body’s immune system; helps regulate the immune system. The level of T- cells in an HIV-positive person serves as an indicator of the progression of HIV infection.

Zimbabwean- Persons born in Zimbabwe with naturalized parents.
CHAPTER 2
LITERATURE REVIEW

Many systematic studies have been conducted since the late 1980s measuring adolescents’ level of knowledge, attitudes and high-risk behaviors concerning HIV/AIDS. This section reviews literature on knowledge of transmission, sexual behavior, and HIV/AIDS in an attempt to identify common threads and define the boundaries of what is known. This review incorporated HIV/AIDS statistical data from Zimbabwe and Atlanta, Georgia. Information is drawn from World Health Organization (WHO), UNAIDS, United Nations Children's Fund (UNICEF), Center for Disease Control and Prevention (CDC), Georgia Department of Public Health, textbooks and journals. The information presented here on knowledge and behavior can be used when researchers and policymakers seek to evaluate the impact of HIV prevention programs.

What is AIDS?

The Center for Disease Control and Prevention’s (CDC) definition of AIDS includes all “HIV-infected people who have fewer than 200 CD4t T cells per cubic millimeter of blood. In people with AIDS, these infections are often severe and sometimes fatal because the immune system is so ravaged by HIV that the body cannot fight off certain bacteria, viruses, fungi, parasites and other microbicides.”¹

HIV is the virus that causes AIDS; AIDS is a result of HIV infection. HIV affects the immune system which is a collection of cells and substances that act as the body's defense against anything foreign. When the system works as it should, the white body cells patrol the body and attack any organisms that should not be there. When an individual contracts HIV, the virus damages t-cells and white blood cells. People are said to have AIDS when certain signs or symptoms are present as specified in guidelines formulated by the Center for Disease Control. These include:

- coughing and shortness of breath
- seizures and lack of coordination
- difficult or painful swallowing
- mental symptoms such as confusion and forgetfulness
- severe and persistent diarrhea
- fever
- vision loss
- nausea
- abdominal cramps and vomiting
- weight loss and extreme fatigue.
- severe headaches
- coma

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According to Pantaleo “AIDS is characterized by a progressive failure of the immune system that renders the body vulnerable to opportunistic infections and cancers; it is the end stage of HIV, a retrovirus that affects the lymphocytes responsible for regulating the immune system. The typical course of HIV involves periods of primary infection, clinical, latency, constitutional symptoms, opportunistic infections and death.”

People with AIDS are also particularly prone to developing various cancers, especially those caused by viruses such as Kaposi’s sarcoma and cervical cancer, or cancers of the immune system known as lymphomas. These cancers are usually more aggressive and difficult to treat in people with AIDS. Signs of Kaposi’s sarcoma in light-skinned people are round brown, reddish, or purple spots that develop in the skin or in the mouth. In dark-skinned individuals, the spots are more pigmented.

There are three ways in which HIV enters the body: 1) Sexual transmission, 2) Intravenous transmission through HIV-infected blood transfusion and drug use; and 3) HIV-infected pregnant mother to child transmission.

**HIV/AIDS in Zimbabwe**

No one is yet sure how HIV/AIDS started in Africa. It was first detected in Uganda in 1985. Some scholars such as Ham believed that the HIV-virus was first transmitted to humans from monkeys in Central Africa, by eating the meat or being bitten

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by one.\textsuperscript{5} When the test became available in Kampala, Uganda, in 1985, the number of women found to be HIV-positive in the anti-natal clinics had already reached 11 percent.

Sub-Saharan Africa remains the epicenter of the epidemic, with 60 percent of the people in the region that makes up about 10 percent of the world’s population, living with HIV. The UNAIDS Epidemic Update stated that in 2005 an estimated 3.2 million people in the region were newly infected, while 2.4 million adults and children died of AIDS.\textsuperscript{6} An estimated 70 percent of the global total HIV positive people, 26 million out of 37.1 million, live in Sub-Saharan Africa. Furthermore, 9 percent of all adults in Africa are HIV positive compared to 0.6 percent of adults in the United States.\textsuperscript{7} Moreover, HIV prevalence is increasing among young people. According to UNAIDS of the four million people infected with HIV in 2006, 40 percent were aged 15-24.\textsuperscript{8} Young women are disproportionately affected. Of the six million HIV-positive young people in sub-Saharan Africa, 76 percent are female.\textsuperscript{9} Many young people continue to lack basic information and skills to protect themselves. To further complicate matters, young girls in Africa are poorly informed about reproductive health and HIV/AIDS in particular. Many young people do not consider AIDS to be a serious concern, further decreasing the likelihood of abstaining or using prevention methods consistently. Lack of immunological and medical

\textsuperscript{5} F. Ham, \textit{Aids in Africa} (Malawi: Kachere Series, 2004), 49.


\textsuperscript{7} Ibid.


intervention especially in Africa emphasizes the need for behavior intervention. UNAIDS expects that "this proportion will continue to rise in countries where poverty, poor health systems, and limited resources for prevention and care fuel the spread of the virus." It is generally known that sexual debut is reported as early as nine years in Zimbabwe. In urban Zimbabwe, the general HIV prevalence rate is 18% among adolescent girls aged 15 to 19 years. The adolescent respondents' last partners were at least five years or more years older than themselves, and HIV prevalence was high. Recent research conducted by the department of Gynecology and the Center for Applied Psychology of the University of Zimbabwe in conjunction with the United Nations Family Planning (UNFP) state that "As such having multiple partners, engaging in sex without a condom, sexual abuse of women, including rape, are merely expressions of the internalized male psyche that is driven by the pursuit of the sexual gratification from the women in a variety of situations." Therefore, women and girls are at significant risk of HIV infection.

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12 Ibid.
The Zimbabwe Young Adult Survey 2005 reports that an HIV prevalence rate for the ages 15 to 49 years was 24.6 percent. About 68 percent of women and 97 percent of the men interviewed indicate that their first sexual experience was prior to marriage.\textsuperscript{14} Women’s experiences are a barometer of how far people are in combating the disease. The increasing feminization of the pandemic, which continues to worsen the situation of women, calls for a comprehensive review of how far the region has come in ensuring practical, gender neutral and culturally sensitive HIV/AIDS treatment and prevention initiatives in resource-constrained communities across Southern Africa.\textsuperscript{15} The executive director of the United Nations Population Fund (UNPF), Thoraya Obaid, commenting at the recent United Nations General Assembly Special Session (UNGASS), expressed her concern at the increasing prevalence of HIV/AIDS in women compared to men. She noted that “the prevalence among women has jumped from 30 percent as of twenty years ago to nearly 50 percent today. The economic, social, cultural and political status of women determines the degree of pressure exerted towards responses in the areas of prevention, care, support, treatment and impact mitigation.”\textsuperscript{16} The impact of the escalating global HIV/AIDS crisis is having a harrowing effect on childhood. A number of issues are affecting children in Zimbabwe. The United Nations Children’s Fund (UNICEF) reports that a quarter of the Zimbabwean population is HIV positive; more than half of all new infections are among young people, primarily girls.


\textsuperscript{15} Ibid.

According to recent UNICEF figures, there are currently 160,000 Zimbabwean children infected with HIV/AIDS. There is a high probability that a significant number of the infections have resulted from having sex with multiple partners or prostitution. Most of the girls drop out of school due to financial problems. Education relating to sex is suffering. The future of Zimbabwe’s girl child remains bleak. Helen Jackson, director of SAFAIDS (Southern African HIV/AIDS Information Dissemination Service) predicts that “by 2010, the epidemic will have reached an infection ratio of one in every three children. Therefore, it is imperative that when addressing the issue of HIV/AIDS, we remember to look at the more vulnerable sectors of society, the children. Let us help them regain their childhood innocence. We must listen to their cries and give them a voice.”

The actress Elizabeth Lawrence contends that “ideally, childhood should be an effervescent carefree time of their lives, a time of awe, discovery and learning. There is a garden in every childhood, an enchanted place where colors are brighter, the air softer and the morning more fragrant than ever again.” Children are at an increasing risk of HIV infection.

AIDS has affected all aspects of society in Zimbabwe. As Fineberg further states, “Its reach extends to every social institution from families, schools and communities, to businesses, courts of law, the military and federal state and governments. It also has a

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18 Ibid.
profound impact on the way science; medicine and public health are practiced in Africa." 19 AIDS is a life-threatening disease and a major public health issue. Its impact on our society is and will continue to be devastating. 20 Therefore, something needs to be done to prevent it.

Despite notable advances such as the decrease in costs of treatment and the emergency of simpler regimes, access to these treatments has remained out of reach of the large number of people who need antiretroviral therapy. This has led some experts to conclude that prevention strategies are more cost effective in poor countries and should, therefore, be prioritized over treatment. 21 According to the WHO/AFRO press release, the launch of the conference on April 11, 2006 in Addis Ababa, Ethiopia was prompted by the fact that despite all efforts to combat the epidemic, 3.2 million new infections were recorded in 2005. It went on to say that from the UNAIDS and WHO’s point of view, “Comprehensive and interlinked prevention activities could avert 63 percent of new infections expected to occur by 2010." 22 At the Zimbabwean country-launch of the same initiative, the minister of Health and Child Welfare, Dr. Samuel Parirenyatwa reiterated

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that his three strategies against HIV/AIDS were “Prevention, prevention, prevention.”

Prevention therefore, becomes the key strategy to HIV infection.

**HIV/AIDS in the United States**

Early in 1980, physicians and public health officials began to notice inexplicable medical symptoms of HIV/AIDS primarily in gay and Haitian men. It was discovered in the gay communities of New York and San Francisco. By the end of 1981, both the CDC and the United States Surgeon General labeled these symptoms Acquired Immunodeficiency Syndrome (AIDS). Since then, more than one million people in the United States have been diagnosed with the dreaded malady and more than 750,000 have died from the disease. The populations first diagnosed and subsequently impacted by AIDS was gay men (59%), intravenous drug users and heterosexual men and women (41%).

Initially, AIDS was known as the gay men’s disease.

The epidemic is spreading rapidly among minority populations. According to CDC, AIDS affects nearly seven times more African Americans and three times more Hispanics than Whites. In recent years, an increasing number of African-American women and children are being affected by HIV/AIDS.

In the United States, black women represent the highest percentage of all reported AIDS cases among women nationally. According to the CDC report, most alarming is

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25 Ibid.
that HIV infection rates have climbed in the African-American community while infection rates are leveling off or declining around the nation.\textsuperscript{26} When HIV/AIDS emerged in the United States as the “Great Plague” of the twentieth century, women were rarely counted among the victims, as the spotlight was primarily on men cohabiting with men.\textsuperscript{27} Recently, the public understanding of HIV/AIDS has changed and its transmission among women, in general, and the African-American women in particular has created a new and potent threat to the security of family systems.\textsuperscript{28} Unfortunately, the social and economic effects of the HIV/AIDS epidemic have given rise to “the feminization of poverty.”\textsuperscript{29} The Center for Disease Control reports that 64 percent of women living with HIV/AIDS are African American. It is estimated that half of the new HIV infections occur among teenagers and young adults under the age of 25, which suggests that the young people represent the majority of new infections.

There is rising concern about the effects of HIV/AIDS among adolescents and young adults between the ages of 13 to 24 in the United States. The CDC reported that “there were 40,049 cumulative cases of AIDS among people ages 13 to 24 through 2004. The proportion of young adults with an AIDS diagnosis has increased from 3.9 percent in 1999 to 4.2 percent in 2004. Between the ages 13 to 19, African Americans and

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\textsuperscript{28} Ibid.

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Hispanics accounted for 66 percent and 21 percent, respectively, of the reported AIDS cases in 2003.³⁰ Because the average duration from HIV infection to the development of AIDS is ten years, most adults with AIDS were likely infected as adolescents or young adults.

Like women throughout the world, African-American women acquiesce to their partner’s demands for risky sex in order to avoid abandonment, abuse, and deleterious economic consequences.³¹ Therefore, females are at high risk for HIV acquisition.

**HIV/AIDS in Atlanta, Georgia**

HIV/AIDS have increased among adolescents and young adults in Atlanta. Infection rates have increased so much that public health scientists have identified adolescents as one of the fastest growing groups infected with HIV.

HIV/AIDS remains an important public health problem in Georgia. According to the Centers for Disease Control and Prevention (CDC), Georgia had the 6th highest number of AIDS cases in the United States and the 9th highest rate of AIDS cases per 100,000 persons in 2009.³² Based on data from the Georgia Department of Human Resources’ Epidemiology Branch of the Division of Public Health, “estimates for metro Atlanta show more than 26,000 people living with HIV/AIDS, and more than 9,500 of these (37%) have diagnosed AIDS cases. The region accounts for 66 percent of the total

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AIDS cases in Georgia." The health districts with the highest number of new
HIV/AIDS cases in 2009 were in the Atlanta metropolitan area: DeKalb had 473; Fulton
had 469; and Clayton (Morrow) had 160. The North (Gainesville) health district had the
lowest number of new HIV/AIDS cases with 21; South Central (Dublin) was the second
lowest with 25; Northwest (Rome) was the third lowest with 27. The Atlanta
Metropolitan Statistical Area (MSA) comprised over 50% of the state population in 2009
and had the highest number of people living with HIV/AIDS. The Georgia Department
of Health reports that in 2009, 67% of Georgians living with HIV/AIDS resided in the
Atlanta Metropolitan Statistical Area (MSA).

While African Americans make up 29% of Georgia’s population, they represent
77% of new AIDS cases in Georgia and 63% of all existing AIDS cases in Atlanta were
among this group. The epidemic in Atlanta, Georgia is primarily driven by sexual
exposure, especially among men who have sex with men and heterosexuals at risk.
Injecting drug use is also a high risk category, but less proportionate than through sexual
contact. Men who have sex with men still represent the largest group of people living
with AIDS in Atlanta at 51%. However, recent trends indicate that the disease is now


36 Ibid.

37 The Community Foundation for Greater Atlanta, “HIV/AIDS in Atlanta,”
affecting many women at growing rates. In Georgia, the AIDS epidemic among African Americans mirrors the epidemic throughout the United States. The Georgia Department reports: “From 2000 to 2009, Black non-Hispanic females had higher rates of newly diagnosed HIV/AIDS when compared to other races. Hispanic/Latino females had the second highest rate; White non-Hispanic females had the lowest rate.”

The Kaiser Family Foundation reports that “African-American women account for the largest share of new HIV infections among women and the incident rate among women is nearly 15 times the rate among white women. Moreover, African-American women also account for the majority of new AIDS diagnoses among women (64% in 2010); white and Latina women account for 15% and 17% of new AIDS diagnoses, respectively.”

A study conducted by Emory University released on March 8, 2012 indicates that HIV rates for black adolescent and adult women in parts of the U.S., including Atlanta, are much higher than previously estimated. African-American women account for 87% of all women with AIDS in Atlanta. Women are most likely to be infected through heterosexual sex, as well as injection drug use. Many women are sex partners of men who have used drugs or men who have sex with other men. The lack of condom use in this population presents the risk of HIV infection.


Among African-American adolescents, the HIV infection rate is alarmingly high. The CDC reports that although African-American adolescents (ages 13-19) represented only about 17% of United States teenagers in 2009, they accounted for 70% of new AIDS diagnoses among teens in 2010. This also mirrors the rates in Atlanta. African-American adolescents in Atlanta account for more HIV and AIDS infections. 50% of new HIV infections are occurring in youth 16-24 years old. Adolescents are now identified as one of the fastest growing groups in the state of Georgia to be infected with HIV, accounting for 23% of all the AIDS cases. The rate of new AIDS diagnoses per 100,000 among African-American adults/adolescents was about 10 times that of whites in 2010. Georgia leads the nation in the highest rate of unintended pregnancy among adolescents, with the metropolitan Atlanta area reporting the highest rates in the state. Becoming pregnant indicates unprotected sexual intercourse, a behavior that places them at greater risk of HIV infection. This is particularly significant among African-American adolescent females because HIV in this population is increasing at an alarming rate. But, AIDS activists are hoping to change that. In March, Sister Love, an Atlanta-based reproductive-health organization that focuses on HIV/AIDS, launched a mini


documentary series called "Everyone Has a Story," which features interviews with Black women who have HIV sharing the realities of life with the disease.

The inequality currently reflected in the healthcare industry is cause for concern. African Americans face greater barriers to accessing care than their white counterparts. African Americans in Atlanta experience disparities at a greater level due to historical socialization. This socialization created an environment that developed along with a system of discrimination. Historically, the voices of women of African descent have been silenced, especially in reference to reproductive rights. Reed asserts: "women are often neglected in the healthcare system. They are less likely to seek medical services, even if they are seriously ill." African Americans as a community are in need of adequate healthcare. When examining the difficult circumstances ascribed to African-American women surrounding reproductive and HIV/AIDS healthcare, it appears that African-American women are a third world populace within a first world nation. African-American women are allowed to frequent the same institutions for care as Euro-American women, but the type of service they receive is irrationally dissimilar. The manifestation of racist ideologies into oppressive practices and policies has, over the course of time, resulted in internalized oppression for African-American women.

Knowledge of HIV Transmission

Knowledge of HIV transmission is comprehensive knowledge of HIV to correctly identify major ways of preventing transmission of HIV.

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The principal mode of HIV transmission in Zimbabwe is heterosexual contact. In western countries the mode of HIV transmission is both heterosexual and homosexual contact among gay men. HIV is spread commonly by having sex with an infected partner. The virus can enter the body through the lining of the vagina, vulva, penis, rectum or mouth during sex. HIV can infect anyone who practices risky behaviors such as:

- Having sexual contact with an infected person without using a condom
- Sharing drug needles or syringes
- Having sex with someone whose HIV status is not known
- Infected blood
- Contaminated needles

Victoria Cargill of the office of AIDS Research at the National Institute of Health (NIH) asserts, “No matter who you are or where you live, there are three things you should know about AIDS. Know how it is spread, know when and how to get help and know that your life can go on productively even if you test positive.”\(^{49}\) Despite the success and availability of drug therapies that have cut the death rate from AIDS in the United States, the epidemic continues to gain strength in some groups such as women and minorities. African-American women and adolescents continue to account for the increase in rates of HIV infections. There are several reasons why these groups are hardest hit. According to

Cardill, "There continue to be knowledge gaps in racial and ethnic communities about how HIV, the virus that causes AIDS, is spread." Poverty, drug abuse, and unequal access to health care are studied as possible reasons for the growing burden of HIV/AIDS among minorities, particularly in inner cities.

In the United States, most women are infected with HIV during sex with an HIV-infected man or while using HIV contaminated syringes for the injection of drugs such as heroin, cocaine, and amphetamines. This is also the same with women in Africa, who are mainly infected by HIV positive men. Of the new HIV infections diagnosed among women in the United States in 2004, CDC estimated 70 percent were attributed to heterosexual contact and 28 percent to injection drug use.

Studies in Atlanta have demonstrated that STIs, particularly infections that cause ulcerations of the vagina (e.g. genital herpes, syphilis, and chancroid) greatly increase a woman's risk of becoming infected with HIV. In fact, incidences of rates of STIs including HIV and AIDS have increased among adolescents and young adults in Atlanta. African-American adolescents in Atlanta account for more HIV and AIDS infections.

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51 Ibid.


53 Ibid.
50% of new HIV infections are occurring in youth 16-24 years old. Adolescents are now identified as one of the fastest growing group in the city of Atlanta to be infected with HIV/AIDS cases. National Institute of Allergy and Infectious Diseases' (NIAID) sponsored studies in the United States have also found a number of other factors to be associated with an increased risk of heterosexual HIV transmission in Atlanta, including alcohol use, history of childhood sexual abuse, current domestic abuse, and use of crack or cocaine. These factors also apply to most other parts of the world.

There is some debate on how well-informed the adolescent population is about HIV/AIDS. Some studies among adolescents show them to be quite knowledgeable while some studies of the overall population finds widespread misconceptions. Harnock conducted research in the United States to assess the level of knowledge concerning HIV/AIDS among high school freshmen and seniors. The findings revealed that both freshmen and seniors had several misconceptions about HIV/AIDS, including the modes of transmission and the way of preventing the sexual transmission. However, the study performed by DiClemente demonstrated that the overall knowledge of HIV transmission among teenagers in the United States was high. But despite the high level of knowledge, teenagers continue engaging in risk behaviors. Why would they continue to take risk measures? Despite high levels of knowledge and awareness about HIV and how

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it is transmitted, adolescents do not think that they are personally at risk of contracting HIV. Mostly they think “it can’t happen to me.”

To date, information on perceptions of HIV/AIDS among young people in Zimbabwe is generally lacking. Knowledge about preventive techniques and behaviors remain superficial. According to the Zimbabwe Young Adult Survey (2002), approximately 93 percent of the women have heard about HIV/AIDS, while 83 percent knew of HIV; approximately 97 percent of the men have heard about AIDS and 92 percent knew of HIV. In 2005, the Zimbabwe Young Adult Survey concluded that the level of knowledge about HIV and AIDS is high with 75.7 percent of women (15-49 years) and 81.3 percent of men (15-54 years) knowing that condoms can be used to reduce the risk of getting HIV. Most adolescents surveyed were aware that sexual contact is a major mode of HIV transmission. However, it is mostly those exposed to education about AIDS who know; most of those who are not exposed to the information are ignorant. Therefore, adolescents should continuously be educated on HIV/AIDS issues to lower the infection rate.

In a study performed in Tanga, Tanzania, Ikamba and Ouedraogo found that 86 percent of adolescents knew that HIV/AIDS can be spread through sharing of skin piercing instruments while 9 percent cannot identify a single transmission mode. According to Manzini, her study on violence found that “forced sex can increase the risk

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of transmitting HIV because forced vaginal penetration commonly causes abrasions and cuts that allow the virus to cross the vaginal wall easily. About 25 percent of the 15 to 24 year old girls in Kwazulu Natal, South Africa said they had been “tricked” or “persuaded” into the first sexual experience.”

Despite high levels of knowledge and awareness about HIV and how it is transmitted, adolescents do not think they are personally at risk of contracting HIV.

Sexual activity is the major mode of HIV transmission in Zimbabwe and accounts for approximately 80 percent of infections in adolescents. In Zimbabwe, transitory sexual relationships and insufficient use of condoms among adolescents harbor misinformation about HIV/AIDS, further increasing their risk of infection.

Aniekwu in a study of adolescents in Nigeria reported that 88% of the adolescent migrant population knew that HIV could be transmitted through sexual intercourse. Although respondents of both sexes had high levels of knowledge about HIV/AIDS, their responses suggested some misconception about the native and the risk of acquiring the infection and many adolescents associated transmission with what they perceive as immoral sexual behaviors. Aniekwu’s study found that more than 35 percent of the respondents in Kano and 43 percent in Aba mentioned either promiscuity or immoral sex (or both) as the cause of HIV transmission. Furthermore, 29 percent respondents in Kano

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and 21 percent in Aba identified having sex with prostitutes as a mode of transmission.\(^{63}\)

It shows, therefore, that many adolescents do not think they are at risk. With these kinds of inaccurate perceptions, they tend to think that only prostitutes are prone to HIV/AIDS.

According to UNICEF, adolescents lack information about HIV. In African countries such as Cameroon, Central African Republic of Equatorial Guinea, Lesotho and Sierra Leone, adolescents do not have sufficient knowledge about HIV transmission.\(^{64}\) This indicates that lack of knowledge about HIV transmission is the main problem for adolescents in different parts of the world.

Even though AIDS turns into a chronic disease, prevention of HIV infection remains at the heart of the fight against AIDS, and improving knowledge about HIV/AIDS and stimulating condom use are the main weapons in this battle.\(^ {65}\) Although adequate knowledge of HIV transmission is shown in most countries worldwide, in particular the Western countries’ adolescents’ knowledge does not translate into protective behavior. Why do adolescents continue to engage in risky behavior?

**Sexual Behavior**

Sexual behavior is probably the most important determinant factor for the spread of HIV. It is not uniform among countries, age groups, men and women, or different social classes, and this diversity undoubtedly plays a major role in the epidemiologic

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\(^{63}\) Ibid.


heterogeneity of the HIV epidemic in Africa.\textsuperscript{66} High rates of partner change increase the risk for HIV infection.

Behavioral risk factors for HIV transmission among heterosexuals include number of sex partners, frequency of unprotected intercourse, commercial sex, a history of or concurrent infection with STD, and anal intercourse.\textsuperscript{67} Many women are at risk only because they have unprotected intercourse with a regular partner who is infected. The importance of STDs as a co-factor for HIV transmission among heterosexuals has been emphasized in a number of studies. It is generally accepted that homosexual contact between men is a minor route of HIV transmission in Sub-Saharan Africa, given that such behavior is reported only rarely in the region.\textsuperscript{68} Although homosexual transmission is presumed to be rare, underreporting of such behavior may be common because homosexuality is highly stigmatized in most African societies.

Cohen outlined sex-related risk factors associated with HIV/AIDS among Africans, such as a high number of partners/commercial sex, perceived risk, age, education, marital status, residence, migration, STDs, circumcision and traditional practices and alcohol. Milhausen, Crosby and DiClemente reported that risk factors for HIV transmission among African-American Youth include lack of knowledge and awareness, poverty, substance use that may increase the likelihood of engaging in unprotected sex, and high risk sexual behaviors such as lack of condom use and multiple

\textsuperscript{66} Ibid.
sexual partners.\footnote{R. R. Milhausen, R. Crosby, W. L. Yarber, R. J. DiClemente et al., “Rural and nonrural African American High School Students and STD/HIV Sexual-risk Behaviors,” \textit{American Journal of Health Behavior} 27 (4):373-79.} WHO (World Health Organization) reported that risk behavior is itself positively correlated with AIDS awareness and knowledge of its lethality and sexual transmission routes. Risk behavior is associated with age. In many African societies, over half of all those aged 14 to 19 are sexually experienced. Most young people in Zimbabwe are aware of HIV/AIDS but still engage in unprotected sex. Peer pressure and stereotyped sexual norms encourage young males to prove their manhood and enhance their social status by having sex. In a study performed by Rivers among Zimbabwean adolescents, 20 percent of the 15 year old females had already been sexually active and the mean age of sexual intercourse was found to be 14.6 years.\footnote{Kim Rivers and P. Aggleton, “Adolescent Sexuality, Gender and the HIV Epidemic,” \textit{Thomas Coram Research Unit} 5(2000): 7.} Based on culture, young women are socialized to be submissive, which leaves them unable to refuse or insist on condom use. Women’s economic dependence on men leads young females to exchange sex for the opportunity of marriage or for girls, sometimes with older “sugar daddies,” who may be HIV infected.

The evidence of multiple sex partners among young adolescents worldwide is increasing. A study conducted by Zimbabwe Young Adult Survey shows that among sexually experienced women ages 15 to 24 “only 71 percent reported four or more life sexual partners, 25 percent reported two to three partners and 4 percent reported one life partner. Adolescents that had sex at age 15 or younger reported more sexual partners.”\footnote{Zimbabwe Young and Adult Survey Report (Harare: Zimbabwe central Statistical Office, 2002), 3.}
Because of sexual behaviors, Zimbabwean youth between the ages of 15 to 24 years are the most affected age group. Research conducted by Eaton shows that in South Africa about 10 to 25 percent of the males’ behavior have more than four partners per year and between 50 to 60 percent of sexually active youth reported never using condoms.\(^2\) Malawi AIDS Council observed that 50 percent of the HIV infection is found among both boys and girls because they have their first sexual experience at 15 years.\(^3\) Ikamba and Ouedraogo in Tanzania stated that 86 percent of the youth know that HIV is spread through unsafe sex, and 31 percent know that it can be transmitted through sharing skin piercing instruments.\(^4\) Although the level of awareness has been heightened, adolescents engage in sexual activity without consistent use of condoms.

In contrast, researchers report that HIV/AIDS among African-American adolescents in Atlanta has remained high in recent years even though there has been increased attention to the problem.\(^5\) CDC states that many adolescents reported that they had multiple sex partners without using a condom.\(^6\) This clearly shows that adolescents are at a high risk of HIV infection. A study conducted by Georgia Department of Human Resources found that 66 percent of Georgia (including Atlanta) teenagers surveyed


reported being sexually active and 45 percent had not used a condom the last time they had sex.\(^7^7\) This behavior poses a problem to the health of adolescents because it may transmit HIV. Diallo, the Founder/President of Sister Love, an Atlanta-based organization contends that:

> Among HIV positive youth in Atlanta between the ages of 15-29, nearly 70% are Black. This is AIDS in America. Our people still act as if the AIDS epidemic belongs to someone else. Just as the Black struggle for social justice and human rights has always been a parallel struggle with Africans seeking independence and plurality, so is our fight to end the disproportionate and unchecked impact of AIDS in Africa and in Black America. Today, we have the potential to end this epidemic through continued behavior interventions, biomedical treatment and prevention technology, and changes in our healthcare system.\(^7^8\)

Sexual behavior placed women at risk for HIV infection due to the lack of condom use. A research conducted by Hobfoll, Jackson and Lavin found that “most women, although knowledgeable about heterosexual risk, believed themselves at low or moderate risk as a result of their own behavior. Women appeared to believe that their risk was low because they had one or few partners. These women were not adopting safer sex behavior, although a significant group reported altering their behavior because of AIDS.”\(^7^9\) This fact, coupled with findings that female adolescents do not regularly use condoms consistently, result in increased rates of HIV infection.

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\(^7^7\) Georgia Department of Human Resources, Epidemiology and Prevention Branch, “Teenagers, AIDS and STDs in Georgia: Fact Sheet,” (Atlanta: Georgia Human Resources, 1995), 1.


Adolescence perceptions about and patterns of condom use are essentially similar to those in the adult population. In Southern Africa, more than half of the school populations surveyed said they had seen or heard about condoms through posters, radio, television and newspapers.\textsuperscript{80} Despite the fact that they heard about condoms, adolescents continue to engage in risky sexual behavior. In the Limpopo province of Zimbabwe, at a rural high school, 34.7 percent of students responded that condoms did not offer protection against HIV/AIDS, and 27 percent reported that they had sex in exchange for gifts. Some girls reported engaging in early sex with truck drivers for money, which put them at a greater risk of getting HIV/AIDS.

The adolescents surveyed by the Zimbabwe AIDS Council gave a range of reasons for not using condoms. Among the most frequently cited was the perceived unavailability of funds to buy condoms, with girls in particular concerned that condoms could malfunction during sexual intercourse.\textsuperscript{81} Another frequently expressed concern among girls is that condoms may encourage promiscuity and boys appear to be the ones, if any, who are more likely to initiate their use. In general, most of the girls and boys disapprove of condoms, some citing religion as a reason. Many religions such as Islam, African Traditional Religion and some Christian churches condemn the use of condoms.

Young girls and women need to be empowered to make right choices. One of the best methods for empowering girls and women to make these choices is to ensure they receive an education. However, research into whether education helps to empower girls

\textsuperscript{80} Ham, 15.

and women to reduce HIV infection among them has had mixed results. A study conducted by ActionAid reviewed all the evidence from research published between 1990 and 2006 on the impact of girls’ education on sexual behavior and HIV. The research found that:

- Prior to 1995, educated women were more vulnerable to HIV infection, probably as they had better economic prospects, influencing their mobility and number of sexual partners.

- After 1995, highly educated girls and women were more likely to negotiate safer sex, thereby reducing their HIV infection risk.

- Girls who had completed secondary school had a lower risk of HIV infection and practiced safer sex than those who had completed primary school only.

- More educated adults had a positive influence on young women’s use of condoms, while more education also empowered boys and men to practice safer sex, reducing HIV infection.

- However, many children, especially girls, were excluded from education as most children in Africa had to pay primary school fees.  

The education of girls and women would be a large step towards turning around the HIV/AIDS in Africa. It is essential to work towards achieving gender equality and quality education by developing a flexible approach that aims to increase the number of girls who go to school and stay in school.

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FACTORS AFFECTING ADOLESCENTS’ SEXUAL BEHAVIOR

Gender Inequality

Until very recently, researchers paid little attention to sex or gender issues in HIV/AIDS. When differences between females and males on health matters were considered at all, the focus was clearly on women’s reproductive lives and not on factors affecting the spread of the disease. Gender inequality becomes a major problem among women and female adolescents. This is related to non-consensual relations in which women are coerced to engage in high risk sexual behaviors. Studies have shown that both African-American women and women in Africa are denied the opportunity to negotiate condom usage and to initiate or suggest safe sexual practices. Gender inequalities are reinforced by cultural pressures. Culturally, sex continues to be defined primarily in terms of male desire with women being the relatively passive recipients of male passions.\footnote{N. Aniekwu, “Gender and Human Rights Dimensions of HIV/AIDS in Nigeria,” \textit{African Journal of Reproductive Health} 6, no.3 (2002): 35.} Under these circumstances women often do not articulate their own needs and desires and their own pleasure may be of little concern. Matshalaga conducted a series of studies in Zimbabwe in which 97 percent of the respondents were females. These STD study participants named their husbands as the source of their infection. On the basis of their findings, the researchers noted that women, who raised the issue of safe sexual practices, or suggested condom usage, exposed themselves to loss of financial support and even more violence, so they remained as “silent sufferers.”\footnote{N. Matshalaga, “Gender Issues in STIs/HIV/AIDS Prevention and Control in Zimbabwe,” \textit{African Journal of Reproductive Health} 3, no.2 (1999): 87-96.} Many women
are unable to insist on condom use and negotiate the timing of sex and the conditions under which it occurs. Even when women know that their husbands are at high risk of HIV, many do not raise the issue of condoms as they might be perceived as accusing their husbands of infidelity or depriving them of sexual pleasure. As a matter of fact, women who do suggest condom use may be at increased risk of physical violence and/or economic abandonment. A study conducted by UNIFEM found that even when Zimbabwean women were educated about HIV/AIDS; their economic dependence on men left them feeling "helpless" to negotiate safer sex.\textsuperscript{85} Economic dependence becomes one of the causes of women’s risk of HIV infection. Gender inequality and economic dependence affect African-American women in Atlanta as well. Recently, in conjunction with an HIV/AIDS Atlanta-based organization called Sister Love, William Parker, an AIDS activist led a workshop entitled “What’s Next and What’s Needed with HIV Research with Women?” Parker said: “Nine out of ten Black women are contracting HIV through heterosexual contact. So to understand Black women and the epidemic, we also must address their partners. And for Black women, socially and historically, it’s going to be Black men. We are not comfortable discussing sex and sexuality in the Black community. “In order to de-stigmatize HIV/AIDS, we have to de-stigmatize sex and learn to discuss it in a healthy manner.”\textsuperscript{86} AIDS activists such as Sister Love are hoping to


change this perspective through working with African Americans in the black community.

**Poverty**

Poverty is regarded as the underlying factor in HIV-infection among African-American women and women in Africa and other parts of the world. President Mbeki of South Africa asserts that HIV is not the cause of AIDS in Africa, but poverty. Women's subordinate socioeconomic status affects their vulnerability to acquiring HIV.

According to UNDP:

> Zimbabwean women are the hardest hit by poverty and their situation is especially difficult in rural areas. Women constitute the majority of communal farmers and yet they have no land rights in accordance with customary law. Women in rural areas have lower education levels than men, which often mean that they have more limited capacity to access new technology and market/farming knowledge that could enhance their productivity. It is quite rare for women to participate in community development decision-making, and there are few women in positions of influence at the local and central levels. This means that women have little opportunity to establish development priorities that meet their needs. Gender inequalities are apparent in all social, political and economic spheres.

All people feel the economical burden, but the burden is doubled on girls and women. The reason is that the society has placed women at the lowest step of the human ladder. Omoigui observed, and rightly so, that women in Africa are characterized by poverty,

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oppression and violation of their rights.\textsuperscript{89} Complicated by poverty, girls and women have to suffer.

The poverty of Africa’s health services cannot be underestimated. The health needs of Africans are no different from those of the West. While wages and salaries in Africa are less, they have to pay Western prices in foreign currency for all the equipment and drugs they need, because very few of them are made in Africa. Because of poor health care people in Africa are vulnerable to AIDS-related diseases such as tuberculosis, typhoid or diarrhea, etc. Certainly the problems of poverty in relation to HIV/AIDS among African Americans resemble those in Africa.\textsuperscript{90} Demographics of HIV-positive African-American women indicate that a disproportionate number are poor and from urban environments. They are usually sole supporters of themselves and their children.\textsuperscript{91} The intersection of racial inequality, gender inequality, and sexuality help to explain the high rates of HIV-infection among African-American women. These women are usually faced with tragedies associated with impoverished living: inadequate housing, poor health, violence, isolation, discrimination and substance abuse that predated their HIV-infection. Some women started having sex at very young ages, almost always with older men, and they found that they had little ability to persuade their partners to use condoms. Some of the women end up resorting to drug use which puts them at more risk to HIV-

\textsuperscript{89} M.I. Omoigui, “Tradition, Poverty and The Church,” in D. Akintunde, ed. \textit{African Culture and the Quest for Women's Rights} (Ibadan: Oluseyi, 2002), 113-123.


infection. Implementing HIV/AIDS prevention programs for dependent women can be extremely challenging because of the complexity of their high-risk situations.

Violence

Violence is an important aspect of risky behavior among women. It is a problem of all women worldwide. A major study by the World Health Organization found that in most countries, between 30 percent and 60 percent of women had experienced physical or sexual violence by a husband or boyfriend. “Violence against women by an intimate partner is a major contributor to the ill health of women,” according to the former director general of WHO, Lee Jong-wook. Many women are helpless and voiceless. In studies cited by the World Bank, 10 percent of Zimbabwean girls reported that their first sexual intercourse was forced. In urban Zimbabwe, half of all reported rape cases involved girls younger than 15, who were most likely to have been abused by male relatives, neighbors, or schoolteachers.92 The reason these girls are facing this is because they are female and get minimal attention compared to men. Sexual violence among women in Zimbabwe is increasing. Women organizations such as the Musasa Project have been formed to help abused women in Zimbabwe.

The Musasa Project is a Harare-based NGO established in 1988 and affiliated with women's advocacy groups such as the Women's Action Group (WAG), Women and AIDS Support Network (WASN), and Zimbabwe Women's Resource Center and Network (ZWRCN). It offers counseling and shelter to women experiencing domestic violence. Most of the women also receive free legal advice and representation from members of the Women Lawyers Association. A report from the Musasa Project based on its findings from 1995-97 indicated the extent and type of violence experienced by wives at the hands of their husbands. Forced sex was most likely to occur among women who were formally married, had their

own income, knew that their partner, had a girlfriend, and whose partner used alcohol or drugs. Withdrawn sex was associated with important changes in a relationship, such as impending separation, or with an effort by men to protect their wives from STIs, including HIV. The report notes that there are mixed feelings in Zimbabwe about the acceptability of either form of sexual coercion.\textsuperscript{93}

Violence among women is also common in the United States. Emily Richie studied battered African-American women and incarcerated women and found that domestic violence was linked to a woman’s involvement in illegal activity, drug use, and unsafe sex.\textsuperscript{94} Dazon Diallo emphasizes the importance of ending violence in black communities especially against women, and children/youth. She asserts that “by ending violence in our communities, we can make even bigger strides to stop HIV and AIDS in our communities. We could practically end AIDS by creating greater quality and equality in our access to and achievements in healthcare, education and economic growth.”\textsuperscript{95} A woman’s history of childhood sexual abuse and involvement with an abusive partner have both been linked to a range of behaviors that leads to increased risk of HIV-infection. For example, abused women are more likely to experience early sexual initiation or teen pregnancy, dropping out of school and unstable living situations. These women need help because they are traumatized by the abusers. Girls particularly are at


risk of HIV infection in relationships with older partners because of a lack of power to negotiate safe sex and the threat of violence.

**Drug and Alcohol Use**

Developmentally, adolescents are considered to be a high-risk group for contracting HIV. It is generally known that the teenage years are characterized by the performance of high-risk behavior, increasing sexual activity and experimentation with illicit drugs. Among adolescents, especially in America, use of drugs, particularly crack cocaine, is significantly related to HIV-risk associated behavior. It is hypothesized that alcohol and drug use are part of the cluster of problem behaviors occurring during adolescence, and therefore substance use is likely to be related to sexual risk behaviors. Substance use is linked to HIV seropositivity for two reasons: 1) Sharing needles or syringes or other paraphernalia in injection-drug use is a direct transmission route for HIV infection; 2) substance use, like use of alcohol and other noninjectable drugs, can disinhibit sexual behavior, leading to HIV infection as a result of failing to use condoms during sexual intercourse.96 Drinking is often thought to be associated with lower self-control and greater risk-taking behavior with regard to sex. Research conducted by the University of Zimbabwe's Medical School found that in rural areas, alcohol consumption plays an important part in community life as it is associated with ceremonies and rituals. It is also seen as an essential recreational activity, especially for some men. For many, the purpose of drinking is to get drunk, and there is a high frequency of drunkenness among

those who indicate they drink. Drinking is associated with casual and transactional sex.\textsuperscript{97} According to Garbus and Mataure, researchers from the Southern Africa AIDS Information Dissemination Service (SAfAIDS), University of California San Francisco, San Francisco Department of Public Health, and University of Zimbabwe conducted a quantitative and qualitative study of alcohol use and high-risk sexual behavior among adolescents and young adults ages 15 to 21 in Harare. They found that “women tend to become infected with HIV at a younger age than men, most likely by having older male partners upon whom they are often financially dependent. Exchanging sex for money was reported by 63 percent of women. These relationships may be initiated at drinking establishments, especially nightclubs located in more affluent areas, which attract young women from poor areas.”\textsuperscript{98} If these behaviors continue to occur, the incidence of HIV infection in adolescence will continue to rise in light of the fact that young people have problems with decision-making skills.

**Condom Use**

Condom promotion becomes an essential element of AIDS prevention initiatives. Although female adolescents initiate sexual activity somewhat later than male adolescents, their partners are likely to be older, at higher risk for HIV, and more powerful within the relationship. These circumstances often translate into less control over condom use on the part of female adolescents. Promoting condom use has been a


problem in many African cultures and traditional societies where marital norms are influenced by a strong patriarchal system that confers decision-making power on men and older family members.\footnote{D. Wilson and S. Lavelle, "Psychosocial Predictors of Intended Condom use among Zimbabwean Adolescents," \textit{Health Education Research} 7 (1992): 55-68.} Men play the dominant role in decisions concerning the number of children a woman will bear and her use of family planning methods. As a consequence, it is difficult for women to refuse sex or demand protective measures such as male or female condom use even if they suspect their partners of infidelity. A study in Zimbabwe by Mhloyi found that the majority of women do not have assertive powers to make decisions on the use of condoms with their partners.\footnote{M. Mhloyi, \textit{Women's Participation in Development, The Role of Family Planning} (Harare: Friedrich Ebert Stiftung, 1998), 15.} In this study, men argued that they paid lobola (bride price), thus they should get maximum satisfaction from sexual intercourse. The problems have been exacerbated by the fact that the use of male condoms is dependent on the willingness of the men. In another study by Matshaka and Wekwete, women reiterated that as they are economically dependent on their husbands/partners, they cannot make decisions that are contrary to their wishes.\footnote{M. Francis-Chizororo, M. Wekwete and M. Matshaka, "Family Planning; Women's Participation in Development: The Mediating Effects of Gender," in Mhloyi, M. (ed). \textit{Women's Participation in Development, The Role of Family Planning} (Harare: Friedrich Ebert Stiftung, 1998), 71-89.} Therefore, women are forced to risk "biological deaths" from HIV/AIDS to avoid the "social death" and poverty due to divorce and abandonment.\footnote{M. T. Basset and M. M. Mhloyi, "Women and AIDS in Zimbabwe: The Making of an Epidemic," \textit{J Health Services} 21, no 1 (1991): 143-156.}

The fact that condoms have rarely if ever constituted a dominant part of African health or social welfare programs in the past means that extra care will now need to be
taken in designing programs to promote their use. However, the traditionalists and some scholars argue that condom use cannot work in Africa based on cultural differences. There are cultural differences between Africa and the West. Green asserts that “traditional sex values, not the promotion and distribution of condoms, are the only way to end the crisis in Africa. Westerners think that the promotion of abstinence and fidelity constitute unwarranted infringement in people’s personal lives.”103 Most Africans are still largely influenced by tradition and religion.

The Western model of AIDS prevention is to reduce risk by promoting condoms and treating the curable STDs. How has the Western risk-reduction model fared in Africa? In fact, countries with the highest levels of condom availability (Zimbabwe, Botswana, South Africa and Kenya) have some of the highest HIV prevalence rates in the world. Moreover, most of the condoms on sale in Africa are white or pink rubber, ideal for a white European, which is exactly how they are seen as “European and unnatural” and on top of that they are regarded as the world’s rejects, out of date, and having lost much of their elasticity, when stored in Africa’s heat.104 A 2003 report from the Population Council in Zimbabwe states that “clearly, a conflict is apparent in how condom use and abstinence are promoted in government and civic environments in Zimbabwe. These opposing strategies are part of an ideological battle in which morality, religion, cultural identity, and Western influences all play a role.”105


104 Ham, Aids in Africa, 60.

However, balanced programs promoting changes in sexual behavior combined with the use of safe sex techniques will be more successful at reducing the spread of AIDS in Africa, as compared to the safe sex programs used in developed nations. HIV-risk reduction interventions must teach adolescents how to use condoms. It is not enough to simply tell them they should use condoms. In a study conducted by Voisin and Bird, the majority of respondents (57 percent) believed that African-American youths were engaging in sexual risk behaviors that were placing them at heightened risk of becoming HIV positive, with one participant indicating that HIV risk was higher because “black youth have more sex than white youth.”\textsuperscript{106} In addition having an early sexual debut and having sex without condoms were identified as specific high-risk sexual behaviors. An example of these themes is illustrated here: “Black teens are less likely to engage in safer sex. Out of the people that I know who are pregnant, none of them say they got pregnant because a condom broke, it was because they were having unprotected sex” (Antwan, 17 years old).\textsuperscript{107} Perceived risk of HIV infection is one of the individual characteristics that may influence sexual behavior and condom use among adolescents.

**Marriage**

Marriage has long been considered a prerequisite for the onset of sexual activity. In the African society, an increase in premarital sex is often believed to be synonymous with the amoralizing influence of modernization. In pre-modern times, marriage for most

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African women took place around puberty. Now, changes associated with modernization, such as increasing urbanization and greater emphasis of formal education for women, have led to an increase in the age at first marriage for women. Young females engage in premarital sex and are prone to high risk for HIV infection. A question that is raised is whether sexual activity outside of marriage is the best choice for an individual or society? Intensive African-centered education is required to teach these females to postpone sexual intercourse.

Both African and African-American adolescents need to be taught that marriage is more than just falling in love, safe sex without condoms, and the bringing up of children. The message cannot be the simple one of always using a condom because that would suggest that if condoms are around, everything is alright and that has shown to have failed. It is more complicated. When condoms are not available in most of Southern Africa, the risk is no longer a risk but a certainty. Vanessa Warner argues that “even in America, research clearly indicates that America is not suffering from a lack of knowledge about sex, but from an absence of values. Traditional values for African Americans like love, commitment, responsibility, integrity and self-control are still relevant today and must be taught.” In agreement, Collins raises important questions:

Without developing moral and ethical communities that fully accept and support each African American, how can African Americans meet the challenge of HIV/AIDS? Why should non-Black American citizens care about African Americans if Black people do not value and care for one another? Divorce and single parenthood is very high in Western countries as compared to Africa. However, the message of sex outside a stable relationship has got to be “Don’t but

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if you do, then you must do it safely, and if you can’t do it safely, then you don’t do it at all.¹⁰⁹

Scholars such as Gilbert, Wright and Collins argue that a large part of why AIDS prevention messages have failed in the African-American community is the lack of knowledge about Black sexuality. African-American women tend to suffer the most extreme images of sexualized, deviant exotic and dehumanized behavior in the media, which is both perpetrated by Black males and supported by the larger media culture.¹¹⁰ In this context, women suffer from the problems of sexism, racism and classism. African women, on the other hand, experience the problem of sexism and classism. Collins argues that many African Americans fail to question dominant black gender ideology. For example, black men who confuse masculinity with dominance and take these beliefs into their romantic relationships, therefore are placing their partners at risk. Black women who confuse femininity with submission and weakness fare no better.¹¹¹ Male domination and female submissiveness is also common in Africa. Therefore:

Individual African-American and African men and women can construct their own sexuality and that of their partners as sites of control and domination. When heterosexual men, for example, demand sex without a condom, they become part of the HIV problem, whether or not they are infected with the virus. When heterosexual women trade sexual favors without practicing safe sex, they too are part of the problem. On the other hand, when black men and women strive to develop honest bodies and to reclaim the erotic as site of freedom, and love as a source of affirmation and others, they challenge the spread of HIV/AIDS.¹¹²


¹¹¹ Collins, 281.

¹¹² Collins, 290.
It is a challenge, therefore, for men and women to weigh their honesty in terms of gender and sexuality as a way of preventing the spread of HIV/AIDS.

**Cultural Influence**

The literature indicates that cultural norms regarding sexuality and gender roles exert powerful influences on the decision-making process. Cultural practices in Sub-Saharan Africa may increase the risk of STD transmission among adolescents. In Zimbabwe, the popular view that AIDS is a conspiracy aimed at reducing the African population may lead teenagers to underestimate their vulnerability to HIV infection. In Zimbabwe and most African societies, there is a belief that sex with a virgin could cure venereal diseases. Many young girls are victims of a widely held belief that if a man with HIV or AIDS rapes a virgin he will be cured of his disease. In Zimbabwe, female traditional healers reported that their male counterparts sometimes encourage men to have sex with young women to cleanse themselves of HIV. This so-called virgin myth, perpetuated by Zimbabwean traditional healers, has led to the rape of hundreds of girls, according to UNICEF.113 Further, there are some cultural practices that enhance women’s risk of HIV. There are cultural notions for women. Nicolson claims:

AIDS has spread in Sub-Saharan Africa because of cultural beliefs, and in particular the belief that men need, and are entitled to, frequent sex with a variety of partners. Even if we can immunize against AIDS, even if we find a cure for AIDS, issues such as the commercialization of sex, the expectation among men that women have a duty to provide them with casual sexual gratification, the belief among young women that their worth is determined primarily by satisfying the demands of their partners, remain.114

Beliefs promoting male dominance, female sexual submissiveness, and violence contribute to the likelihood that an adolescent female will agree to unsafe sexual practices. Gage points to the cultural factors of male dominance, female sexual submissiveness, and limited economic opportunity for women as contributing to women’s lack of agency in prevention of HIV/AIDS. Socialization patterns often prepare young women to accept male domination in sexual encounters.

In most parts of Africa, there is a belief that men prefer dry sex. Dry sex practices have been reported in many countries, including Nigeria, Zaire, Zambia, Malawi, Zimbabwe and South Africa. Dry sex practices intended to decrease vaginal secretions might be associated with an increased probability of HIV transmission. The insertion of crushed leaves, powders, or mineral infusions into the vagina can lead to tearing, lesions, or inflammation in the vagina, increasing the likelihood of transmission of STD and HIV. Dry sex could interfere with condom effectiveness. In a study conducted in Zimbabwe by van de Wijgert, school children of both sexes said that they preferred the vagina dry and tight and most could describe drying agents. The same was also true for older women in focus groups in Zimbabwe. The findings have shown that Zimbabwean women regularly insert a wide array of herbal and nonherbal preparations inside their vaginas. Zimbabwean women believe that intravaginal practices promote cleanliness,

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fertility, and good health. However, the most important reason for intravaginal practices is to provide sexual satisfaction for a man to maintain his fidelity. Moreover, the opinions of men about dry sex indicate that friction and warmth in the vagina increases their sexual pleasure and that they dislike vaginal secretions for an array of reasons. Some studies have suggested that intravaginal practices may increase heterosexual transmission of HIV and other STIs. The dryness of the vagina increases small tearing around the entrance; it also removes the natural protection of the walls thereby opening the space for the virus to enter the woman’s blood stream. The focus on pleasing the man continues to put women at risk of HIV/AIDS.

The practice of female circumcision in Zimbabwe makes women vulnerable to HIV. Female circumcision is considered a risk factor because the cutting and/or sewing of women’s sexual organs expose them to HIV through the sharing of the instruments. However, some people dispute this claim. Female circumcision continues to be widely practiced among some groups in Africa. The practice may put girls at risk if unsterile instruments are used and increase the risk of HIV transmission. However, Zimbabweans in Atlanta discontinue the practice of female circumcision because this is considered a human right violation in the United States.

There are numerous reasons for the need to focus on gender and cultural issues in HIV/AIDS prevention and control programs. Women constitute a high risk sub-group of the population. The combination of women’s sexuality and gender disadvantage in terms of cultural, economic and social factors place them more at risk for infection than men. The risk of HIV infection during unprotected vaginal intercourse is two to four times

\[118\] Ibid.
higher for women than men. This is because semen contains a higher concentration of HIV than vaginal secretions and can remain in the vagina for many hours after intercourse.\textsuperscript{119} A review of existing literature shows that women are more vulnerable to HIV/AIDS because of certain cultural beliefs and their lower socio-economic status. Due to gender power relations in sexual unions, women generally have limited say in the use of protective measures against STIs/HIV/AIDS. Knowledge of STIs/HIV/AIDS prevention and control is crucial for everybody regardless of social, economic or cultural status.

\textbf{Adolescents and the Media}

Communication about AIDS is the key channel and has been found to be a strong predictor of AIDS knowledge. Among the sociocultural factors found to influence young people’s sexuality, the media have received significant attention, especially television, as it continues to be the medium used most by youth.\textsuperscript{120} During adolescence, most teens become involved in dating relationships, and media portrayals of sexual issues may play a key role in their sexual socialization through the social norms.\textsuperscript{121} Exposure to sexual content in mass media is reported to lead to an increase in sexual activity and a stronger intention to engage in sexual intercourse. Pardun asserts that the media frequently portrays sex, love, and relationships, but tends to provide little information on possible


negative consequences of sexual behaviors such as STDs or on safe sexual behavior.\textsuperscript{122}

This suggests that the mass media might not be the best channel for HIV/AIDS prevention. According to Kallen, as many as one in five teens reports that entertainment is their most important source of sexual information.\textsuperscript{123} Television and the other media represent one of the most important and under-recognized influences on children and adolescents' health and behavior.

Researchers at Children's Hospital Boston found that early teen sex may be linked to viewing adult content on television as children. The study tracked children from ages 6 to 18 and found that the sooner children began to view adult content on television programs and movies, the earlier they became sexually active during adolescence.\textsuperscript{124} Television and movies are among the leading sources of information about sex and relationships for adolescents, according to Hernan Delgado, a specialist in adolescent and young adult medicine at Children's Hospital Boston. “Our research shows that their sexual attitudes and expectations are influenced much earlier in life.”\textsuperscript{125} Dwayne Hastings agrees, “It is a proven fact that the unchecked, prurient content on television and in movie theatres is a primary factor in the coarsening of the culture. Advertisers are willing to shell out millions of dollars for television commercials because they are confident they


\textsuperscript{125} Ibid.
can sway our behavior. We should not be surprised then to discover that what we watch on television shapes attitudes toward sexuality."\(^{126}\) Researchers have done studies demonstrating the connection between media with high sexual content and changes in teenagers' sexual behavior or attitudes. In a study of 75 adolescent girls by Colder-Bolz, half pregnant and half nonpregnant, the pregnant girls watched more soap operas before becoming pregnant and were less likely to think that their favorite soap characters would use birth control.\(^{127}\) A study of 391 junior high-school students in United States found that those who selectively viewed more sexual content on television were more likely to have begun having sexual intercourse in the preceding year. An example of these themes is illustrated here:

For those black youth at more risk, it's because of TV now sex is in everything, like in commercials, in movies, it's just shown, no editing......it's just out there. We are being exposed to it, especially in like music videos and we have been exposed to it......like may be more than a white teen.\(^{128}\) (Jimmy, 17 years old).

The United States continues to have the highest teenage pregnancy rate in the Western world. This is an important finding that points to the absence of a societal expectation that even with early sexual initiation, birth control is a necessity. If, as data suggest, the media represent an important and effective source of sexual information for teenagers, the United States pregnancy rate could be the result of several interrelated factors: a lack

\(^{126}\) Ibid


of easy access to birth control, a lack of information about birth control in sex education classes, a glut of inappropriate sexual messages in the media, and an absence of appropriate messages in the media about abstinence and the use of birth control.\textsuperscript{129} It is clear from the available evidence that television does influence children.

According to Bandura, individuals model their behavior on vicarious experiences such as media because their real life experiences are usually more limited.\textsuperscript{130} This may be particularly true for adolescents who may not have much first-hand experience with sexuality, yet are starting to enter into dating relationships and thus are eager to learn issues such as how to behave with a romantic partner or how to perform various sexual behaviors.\textsuperscript{131} A closely related concept is that sexual scenarios portrayed by the media provide scripts that may be used by youth to fill in gaps in their understanding of sexual situations.\textsuperscript{132} E. Gruber and H. Thau argue that although heavy viewers of all ages may be influenced by their exposure to television, teenagers may be particularly vulnerable to media messages regarding sex because of developmental limitations in their critical thinking skills.\textsuperscript{133} Thus, adolescence represents a sensitive period when interest in sexual

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matters is heightened and gender roles and sexual attitudes are being shaped. As a result, it is valuable to understand the messages about sex on television, especially among youth-oriented shows. Parents may now have a more urgent reason to monitor what their children watch on television.

**Peer Influence**

Adolescents’ decision-making around sexuality issues is an interaction of individuals, social, family, peer and sociocultural factors. In adolescence, parents and peers are the most important sources of information. Peers become increasingly important during this period. 134 This is supported by studies that found that peers have a stronger effect on changes in health risk behavior than parents. P.C.Giordano found that adolescents perceive information from friends as more useful than that from parents and those adolescents feel more comfortable talking about sexual issues with friends. 135 Direct pressure from peers and the adolescents’ perceptions of peer group norms influence youths’ decisions about whether, when, how, and with whom to engage in sexual behavior. What young people learn about sexuality from their peers generally does not promote the development of responsible sexual behavior. Stone and Ingham argue that the most crucial peer within a sexual relationship is the adolescent’s sexual partner, and talking about AIDS and condom use with one’s sexual partner is associated with

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According to UNICEF it has been repeatedly demonstrated that sex education does not lead to early sexual behavior; on the contrary, it serves to delay sexual activity. Appropriate messages from adults must therefore be communicated to children at an early age. Establishing such behavior patterns in children is easier than changing high-risk behavior later. Among youth who mainly rely on unreliable sources, information seeking may be quite ineffective and may result in little or no effect of sexual behavior on knowledge. As adolescents attempt to define themselves as sexual beings, the degree to which they take on the prescribed roles of their gender or peer group may play a significant part in defining their risk.

**Parental Involvement**

Parents can help prevent HIV/AIDS among young people. In Zimbabwe, parents, especially mothers, are key socializing agents in the lives of female adolescents; that is, parents can greatly influence their children's health behavior. In United States, talking about AIDS and condom use with parents is also linked with safer sex behavior. Parent education can stress the importance of parents being physically and psychologically available to their children, especially as they approach the teen years. According to Whitaker and Miller, parent communication is often more effective than

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peer communication because it is more accurate. \(^{139}\) Lack of communication may cause adolescents to turn to peers and that peers may then influence their behavior. As primary agents of socialization, families play a major role in shaping developmental experiences during childhood and adolescence. Studies done by Whitaker and Miller show that young people with a stable, positive, and supportive family environment that includes parental monitoring engage in less risk taking. However, for some, communication between parents and their children about sex is often difficult. Although there is literature showing the importance of parents in the socialization process, one aspect of socialization that has received less attention is sexual socialization. Historically, in Zimbabwean society, young people were educated about sex and their future adult roles by designated relatives (often the maternal uncle or grandfather, for boys and paternal aunt, for girls). However, Sherman purports that urban migration and changing family relationships have contributed to the demise of traditional instruction. In general, adolescent sexuality has been viewed as a natural process in the growth toward adulthood. HIV/AIDS is a sensitive topic that many parents avoid. In Zimbabwe, young people reported that communication with parents about sex was one-sided, with the parents mainly warning about the dangers of sex such as pregnancy and STDs. Judith Sherman and Mary Bassett contend that while young people are often given factual information about sex and reproduction, they are left to cope with their own nascent values, uncertain decision-

making skills, and acute social pressure. Lack of adequate parental monitoring is an important contributing factor to high rates of HIV infection among their peers. In a US study 90 percent of mothers said they had spoken to their children about sex, but only two-thirds of the children agreed. A certain level of despair and “living in the now” was identified by one participant as a significant factor leading to an increased HIV infection rate among peers:

They don’t really care......they just want to live in the now......They are just ready to have sex with a girl but they don’t think about what if I get this girl pregnant or what if I catch something......what could happen.....Black youth end up joining gangs and not thinking about the future when their lives don’t work out as planned and because they have no opportunities, no education, no job, joining a gang is the last hope.

Research findings suggest that parent-child communication about HIV/AIDS and sexuality should begin early so that it can evolve comfortably as the child matures. Lack of communication may cause adolescents to turn to peers and that peers may then influence their behavior. It is worth noting that all these studies assume that communication leads to knowledge, and that knowledge leads to behavior, rather than the other way round.

Human development theory has identified adolescence as one of the most difficult periods for emotional growth. The transition from childhood to adulthood can cause


many adolescents to experiment in risky activities. Many adolescents use this period to experiment in sexual activity. Early sexual activity can place these youth at risk for contracting HIV and other STDs. According to Kim, early initiation of sex has been linked to multiple sexual partners. Having unprotected sex with multiple sexual partners increases the risk of contracting and spreading STDs. The spread of STDs can be reduced if proper sex practices are encouraged and taught to sexually active teens. The increase in sexual activity among children in this age group suggests a need for more empirical research to better educate adolescents regarding safe sexual behavior.

The goal of sex education is to enable adolescents to become knowledgeable of healthy sexual behavior. Young people can be persuaded to change. The young are still learning, both in and out of school. Studies show that there is a lack of parental sex education among the adolescents. Adolescents learn about sex from their peers, books, magazines, radio, television and internet. Some argue that it is the parent’s job to teach their children the rights and wrongs of sex education but parents gave the job to the schools. Prevention is better than cure. We need to provide girls with relevant adequate knowledge, educating and empowering them. Further, increasing supervision for adolescents will reduce the opportunities for all young people to engage in high-risk behaviors. Therefore, strong parental-child relationships can be a young person’s best prevention from participating in high risk sexual behaviors. The best way to stop HIV from entering the body sexually is abstinence. Abstinence from sex may be difficult but in the absence of a vaccine or cure, it is something that one must consider seriously. It is
important to engage young people in issues and programs that are empowering to
affirming their destiny.

Summary

This chapter contained a discussion of the relevant literature related to
Zimbabwean female adolescents, knowledge of HIV transmission, sexual behavior and
socialization, and the risk for HIV and AIDS infection as a result of selected gender
issues. The literature, however, did not identify research that has addressed HIV/AIDS
among Zimbabwean female adolescents in Atlanta, Georgia. This void points to the
importance of this research. This chapter also included a discussion on the socialization
of adolescents in the United States and Zimbabwe. The next chapter presents an historical
text for this study. It includes a brief geography and socio-political history of the
Zimbabwean people as a necessary context to understand the culture, beliefs, and
perspectives of the respective immigrant population that is the target of this study. This
chapter also analyzes the socio-economic and political history of Zimbabwe and the
impact on the migration of people of Zimbabwe into parts of the Diaspora. It
demonstrates the impact of HIV/AIDS on the economic development via reduced
productivity and migration. Finally, the chapter examines more intensely the
Zimbabwean indigenous practitioners' sexual socialization within the cultural context.
CHAPTER 3

HISTORICAL CONTEXT

In this section, a brief geography and socio-political history of the Zimbabwean people is provided as a necessary context in order to understand the culture, beliefs, and perspectives of the Zimbabwean immigrant population that is the focus of this study. The study also presents the indigenous African sexual socialization in the HIV discourse.

Geography

Zimbabwe is a landlocked country in Southern Africa, lying wholly within the tropics. It is slightly smaller than California. As shown in Fig. 2 it is bordered by Botswana on the West, Zambia on the north, Mozambique on the east and South Africa on the south. The climate is tropical, although markedly moderated by altitude. There is a dry season, including a short cool season during the period May to September when the whole country has very little rain. The rainy season is typically a time of heavy rainfall from November to March. The whole country is influenced by the intertropical convergence zone during January. In years when it is poorly defined, there is below average rainfall and a likelihood of serious drought in the country.

Zimbabwe has a population of 11,651,858. The majority of the population in Zimbabwe lives in rural areas and engages in agricultural production. Many of these people live on the edge of poverty, and to them a square meal is a luxury. Cash, which is
needed for salt, oil and bread, is scarce. Black ethnic groups make up 98% of the population. The majority people, the Shona, comprise 80 to 84%. The Ndebele are the second most populous with 10 to 15% of the population.¹

The Ndebele descended from Zulu migrations in the 19th century and the other tribes with which they intermarried. Up to one million Ndebele may have left the country over the last five years, mainly from South Africa. Other Bantu ethnic groups make up the third largest with 2 to 5%. These are Venda, Tonga, Shangaan, Kalanga, Sotho, Ndu and Nambya. Minority ethnic groups include white Zimbabweans, who make up less than 1% of the total population. White Zimbabweans are mostly of British origin, but there are also Afrikaners. Afrikaners are Afrikaans-speaking South Africans of European ancestry, especially those who descended from 17-century Dutch settlers. Mixed-race citizens form 0.5% of the population and various Asian ethnic groups, mostly of Indian and Chinese origin, are also 0.5%. Zimbabwe has three official languages: English, Shona and Ndebele.

Figure 2. The Map of Zimbabwe

Origins

Historical evidence suggests that the ancestors of the Shona-speaking Karanga tribe were among the earliest permanent inhabitants of what is now Zimbabwe, followed by the VaZezuru. Both groups became dominated by the VaRozvi clan after the 14th century. The VaRozvi were the builders of Great Zimbabwe, headquarters of the Monomotapa Empire.\(^2\) During the 15th century the Portuguese were the only European active in the region of Southern Africa. The first documented Portuguese expedition to reach Munhumutapa territory was made in 1513, and it established a network of markets up the Zambezi; gold and ivory were purchased from suppliers and transported back to Sofala.\(^3\) This shows that during this period Shona people were involved in mining economy. The richest minerals in Zimbabwe attracted Cecil Rhodes and the British settlers to colonize the country. Zimbabwe became independent on April 1980.

HIV/AIDS in Zimbabwe

In colonial Zimbabwe, there were major disparities in the distribution of health care personnel, access to resources and disease patterns. Black people did not have equal access to healthcare and resources. At independence, April 1980, the government inherited an economy and health system characterized by racial inequalities and disparities between urban and rural areas. Since then, the Zimbabwe government has prioritized addressing equity in health and primary health care. The main focus of the new government was to redress the health inequalities that it inherited from the colonial


government. Attacking these major inequalities and addressing the link between the major health problems and poverty were the major concerns of the government’s first health policy of “planning for equity in health.” Scholars such as Meldrum and Chikanda agree that the 1980s were a period where positive gains in health were achieved by the government. There was improvement in the health sector.

Impressive developments in the education and health sectors illustrate the government’s welfare achievements in the first decade of independence. Since 1980, health care has been provided free of charge to those earning less than Z$150 per month, which constitutes about 90% of the population. Furthermore, the government allocated more resources to the health sector.

By 1987, 274 rural health centers had been completed; provincial, district hospitals and many rural clinics were upgraded. During this period, health expenditures increased by more than 200%, immunization increased from 25 to 86% of the population, infant mortality declined, life expectancy increased from 55 years to 59 years, and the number of village health workers increased by more than 200%. Also there was a steady rise in the share of the ministry’s budget allocated to salaries and allowances from 28.6% in 1980/1 to 44.7% in 1985/6.

These statistics clearly show the commitment of the government to implement strategies for improving health and access to health services for the poor.

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6 Ibid.

During this decade, HIV/AIDS was not one of the foremost health challenges within the country. The first HIV infection case in Zimbabwe was detected in 1985. During this period the HIV prevalence rate was very low. When AIDS first emerged in Zimbabwe, the government was slow to acknowledge the problem and take appropriate action. Although the National AIDS Co-ordination Programme (NACP) was established in 1987 and several short term and medium term AIDS plans were carried out over the following years, it was not until 1999 that the country’s first HIV and AIDS policy was announced. This policy was implemented in the following year by the newly formed National AIDS Council (NAC), which took over from the NACP. At the same time, the government introduced a 3% AIDS levy on all taxpayers to fund the work of the NAC.\footnote{UNGASS, \textit{UNITED NATIONS GENERAL ASSEMBLY (UNGASS) REPORT on HIV/AIDS}; "Zimbabwe Country Report," January 2006- December 2007, \url{http://www.unaids.org} (accessed December 2008).}

While these measures have had a positive impact, the government’s response to HIV and AIDS has ultimately been compromised by numerous other political and social crises that have dominated political attention and overshadowed the implementation of the national AIDS policy. Political conflicts emerged between the ruling government and the opposition party. The parties emphasized politics more than health issues.

Nevertheless, as the decade ended, it was clear that the situation was economically unsustainable. Mhone contends that during the first decade of independence, real per capita gross domestic product had been stagnant or declining, new jobs were created at a rate of only 20,000 to 30,000 per year, debt service had risen to 3.45% of exports, the government debt had risen to 71% of GDP, the fiscal debt was
above 10% GDP, and the real interest rates were negative. In addition, foreign exchange rationing had reduced private investment. The problem of large budget deficit persisted and long-term problems of insufficient replacement of outmoded capital stock and rapidly rising unemployment were unlikely to be inadequately dealt with in the absence of a more radical shift in policies. According to Stonemen, while the World Bank acknowledged that Zimbabwean economic performance was superior to that of most other African countries during the decade, the government failed to properly exploit the economic advantages it had inherited. In particular, it had pursued policies favoring stabilization rather than growth. Thus the government was increasingly placed in a tight situation. It was driven into adopting the structural adjustment policies of International Monetary Fund (IMF) and World Bank.

The Zimbabwe government introduced its own structural adjustment program in 1990. The economic reforms in Zimbabwe began with the enunciation of the “Economic Policy Statement” entailing aggressive management of exchange rate, a modest reduction in the fiscal deficit, new investment guidelines, more flexibility in price and wage setting, a foreign exchange retention system and a modest expansion of OGIL provisions.

The government of Zimbabwe adopted these IMF and World Bank policies with the hope that by 1995 the country would attain a 5 percent annual growth rate in GDP.

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9 Mhone, 107.


Since the implementation of these measures, Zimbabwe’s conditions have deteriorated drastically. Writing of this adjustment, political economist Antonia Juhasz states:

In order to radically reduce government spending, the government fired tens of thousands of workers, gutted the pay of those who remained and drastically reduced spending on social programs. At the same time, taxes were reduced, and the country was opened to foreign competition-hitting manufacturing sector. Both employment and real wages declined sharply. During 1991-96, manufacturing employment fell by 9% and wages dropped by 26%. Public sector employment fell by 23%, with wages dropping by 40%.13

The decrease in real income arising from inflation affects all vulnerable groups in the economy. According to the Central Statistical Office Report, the GDP which had been increasing toward the end of the 1980s plummeted by 8% to 11% in 1992, while the rate of inflation, which had been 20% prior to (Economic Structural Adjustment Policy) ESAP in 1990, sky-rocketed in 1992 to 47% and 36% for low and high income groups respectively.14 Higher unemployment leads to declining nutrition, health and education standards.

Zimbabwe’s 1991 economic SAP liberalized the economy but failed to control the budget deficit, which together contributed to strains on the health sector and on the poor. Inflation contributed to decline in real health spending and real wages for health workers. The World Bank persuaded the Ministry of Health to increase user fees in the early 1990s.15 The implementation of ESAP between 1990 and 1995 had a marked

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impact on health which negatively affected the poor or vulnerable groups. Jazdowska and Kanji purported that “real per capita on health had risen from (Zimbabwean Dollar) ZWD 10.76 in 1980-81 to a peak of ZWD 16.50 in the 1990-91 fiscal years, despite the relatively low average annual GDP growth rate of 3.1% over that period. In the three years since the introduction of the SAP, it has fallen by a total of 33.8% to a mere ZWD 10.92 in the 1993-94 fiscal years.” The implications of the cut-backs are now apparent.

It is generally agreed among scholars such as Kanji and Jazdowska that the SAP had a negative impact on health. Due to cost recovery and user pay schemes, the cost of health care has risen dramatically, especially for the urban poor who have watched accessible quality health services become unattainable. As such, people tend to drop out of treatment due to cost. Decreases in public spending have resulted in reduced maintenance of health facilities, shortages of essential drugs, and a high rate of staff attrition to the health sector. The health sector resulted in shortages of drugs and equipment, funding cuts, and overwhelming demands as a result of the HIV/AIDS epidemic. The Minister of Health, Timothy Stamps, commented as follows on the impact of SAP on health:

The structural adjustment policies have a bad effect on our health care system. In the rush to make our economy more efficient and market oriented, we are losing the gains made in health since independence. I do not claim to be an economist. What I do know, is that due to higher charges for health services we have seen an unacceptable rise in maternal death in child birth and a dramatic rise in death from preventive diseases from diarrhea.

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17 Ibid.

This clearly shows that the introduction of user fees resulted in the decline in the use of health facilities by low income populations. Introduction of cost recovery has made access to medical services much more difficult, especially for the poor, and has affected men and women differently. Women have been affected more than men because, as mothers, they are particularly dependent on adequate and accessible health facilities. Increased cost recovery measures in public health care place a greater work load on women who must make up for declines in public facilities.

SAP-driven health care cuts have come at a time when the HIV/AIDS pandemic has worsened both the economy and the government’s ability to react to the AIDS crisis. Since HIV/AIDS tends to affect the economically active cohort, household savings and assets decline as they try to pay for medicine, treatment and funeral costs. The rapid spread of HIV/AIDS differs from most health issues in that it strikes people in the prime of life, who otherwise should have decades left in which to build the economic and social capital of their families and communities.19 While HIV/AIDS transcends all socio-economic groups, the impact on the poorest households has been catastrophic as economic decline and overall vulnerability has been magnified. By the early 1990s, the adult HIV prevalence rate had already reached 10% in Zimbabwe.20 Economically, AIDS is likely to affect growth through the loss of young adults in their most productive years and through reduced public and private savings. In many ways, AIDS has a significant impact on economic development.


Development is often a major determinant of the spread of HIV. In the same way, HIV impinges on economic growth, both slowing it and distorting the allocation of resources because of the demands it places on health and the health care system. A Canadian expert in health promotion, Ronald Labante has written that “most of what creates health lies beyond organized health care sectors. Poverty, income inequalities, social inequalities, environmental pollutants/degradations, violence, and other complex social phenomena are far more important health determinants than access to health care services.” Labante aired out his argument in relation to HIV/AIDS by claiming that development is a major determinant of HIV. Poor economic development impinges on lack of resources for HIV/AIDS prevention. Resources available for HIV/AIDS prevention and treatment will reflect larger economic and political realities.

The AIDS epidemic is the most serious problem facing the health care system and along with the deficit, the economy as a whole. Because HIV/AIDS infects mainly adults during sexually active years, the socio-economic implications of HIV/AIDS for development are immense. These adults infected with HIV/AIDS are the working class group. Their sickness or death paves way to low labor. Moreover, the impact of AIDS is greater when the affected household is low-income. HIV/AIDS not only increases mortality, it also plunges the poor into destitution and widens the income inequality


22 Ibid.
between the ‘haves and have-nots.’ Poor economic development leads to the migration of people to seek greater opportunities.

Migration is another factor that contributes to the spread of HIV. The impact of SAP to the socio-economic status of the country led to the migration of people to the other countries. The early literature on migration and HIV/AIDS highlighted the danger that the predominant male migration to urban areas and across national boundaries posed in accelerating the spread of the epidemic. The role of migration in the spread of HIV has been primarily as a result of men becoming infected while they are away from home, and infecting their wives when they return. Hence, the rapid spread of AIDS is related to the forces of development and to global population movements.

There is a general consensus in the discourse on economic development that the migration of skilled workers constitutes a drain on the sending country’s human resources, as it benefits the recipient country. Low salaries and poor working conditions have fuelled the brain drain. The country’s health delivery sector is the worst affected by the phenomenon as the health workers are emigrating in search of greener pastures in other countries. The HIV/AIDS pandemic has increased; ECA/IDRC/IOM 2000 has shown that:

Africa is losing its “best and brightest” to the industrialized world. These “brains” constitute a significant, proportion of human capital necessary for establishing a solid foundation, for economic growth. Since it is usually the best and brightest professionals who are most likely to emigrate leaving behind the “weak and less

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23 Ibid.

24 Robin Cohen, Migration and Health in Southern Africa (South Africa: Van Schaik Content Solutions, 2003), 63.
imaginative," the brain drain represents socio-economic challenges for developing countries such as Zimbabwe.25

The decline of skilled health professionals in the public sector has resulted in significant changes in the quality of care provided. It has led to understaffing of health institutions in that patients have to wait longer before receiving medical attention. As a result, HIV/AIDS has increased the workload of a remaining health staff.

During the SAP period, Zimbabwe had one of the highest HIV prevalence rates in the world, which threatens to reverse the health progress made in the 1980s. Even though HIV/AIDS is best addressed through prevention and behavior change, declining per capita health spending and growing demands for curative care have weakened the preventive focus of the Ministry of Health.26 Although prevention and behavior change are the most cost effective means to fight AIDS, the government during this period has failed to spearhead a behavior change movement, and has devoted limited resources to fighting AIDS. The challenges of HIV/AIDS led to the development of international responses to AIDS. WHO established the Global Program on AIDS (GPA) based in the Geneva headquarters. UNDP and UNICEF also extended their help to Zimbabwe.

These agencies were offering technical support in terms of policy and program areas. Moreover, the privatization of health care has had disastrous consequences for AIDS treatment in Zimbabwe. The health sector has become dysfunctional to such an extent that people no longer visit the hospitals. Although the traditional medical


practitioners in contemporary society have been diminished with the introduction of the modern allopathic medicine, however, in recent years, traditional healers have begun to play an increasingly important role in the health care system due to the collapse of the formal health care system. Thus, the poor are finding themselves without formal health care service and are going to the informal sector where they are attended to by the traditional healers who charge affordable rates.

Today, HIV is increasingly devastating on women and girls. More than 50% of women are HIV positive. Gilbert and Walker assert that:

In Zimbabwe, there is a higher percentage of HIV positive women than men, and women have a younger age of onset of infection. They note the strong link between low income, high unemployment, poor education and rates of HIV infection. They attribute the higher rates of infection of poor younger women to several components; the general low status of women in society, their subordinate role in the family and limited personal resources, and sexual cultural norms and values which accept and encourage high numbers of sexual partners, especially among men.

This affects the development and health status of women. Women rely on adequate and accessible health care facilities. The effects of increased charges appear to be jeopardizing the health status of women in the poorest groups in Zimbabwe. Moreover, females are responsible for the care of sick family members. Once infected, the access to effective treatments is increasingly a matter of economic resources and access to expensive and sophisticated pharmaceuticals. A report from the World Bank about HIV/AIDS has warned that antiretroviral therapies are both expensive and uncertain,

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27 Altman, 70.

claiming that even if the costs were reduced to “one-hundredth of current costs there would still be several times the total annual per capita expenditure on health in many low-income countries.”

Oneshould notethat most women with HIV do not have access to even common drugs used to treat opportunistic diseases or to terminal care.

Today, there is increased involvement of other UN agencies especially the United Nations Development Program (UNDP) and recently the World Bank. UNAIDS began its operation in 1996. As its mission states, UNAIDS is meant to act as “The main advocate for global action on HIV/AIDS.”

Small-community based organizations or international development NGOs were established in Zimbabwe, for example, the Zimbabwe Women AIDS Network (ZWAN), Musasaproject, Zimbabwe Women’s National Resource Center (ZWNRC), CARE International Zimbabwe and the Girl Child Network. These organizations were established to implement prevention strategies for women and girls.

The dominance of Western discourse around HIV/AIDS meant the introduction of human rights as a major issue, often linked to the so-called new public health based on ideas of empowerment and community control. In general, most observers have seen this as a positive step, although the American anthropologist Nancy Scheper-Hughes has criticized the dominance of this particular paradigm as “founded on a phallocentric sexual universe that ignores the vulnerable position of women, children and other sexual passives vis-à-vis the dominant, aggressive, and active conquistador male sexuality.”

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29 Altman, 67.


31 Altman, 68.
mostly at risk for HIV infection due to gender inequality and poverty. The high prevalence rate among women deters women’s development.

While campaigns to prevent and treat HIV in other African nations benefit from International aid, the political situation in Zimbabwe has caused most foreign donors either to decrease aid for the country or halt it together. The United States, Australia and the European Union have also imposed economic sanctions on Zimbabwe. The neighboring nation of Zambia, which has a similar HIV prevalence rate, receives around US$187 per HIV-positive person from foreign donors; in Zimbabwe, the figure is estimated to be just $4.28. The government blames the West for the economic crisis and political instability in the country. However, the government is also to blame for chasing away NGOs and other agencies because the government believed that they were supporting the opposition party.

Altman asserts that “while the rest of Southern Africa is experiencing economic growth, Zimbabwe is the only country experiencing a negative economic growth rate. During the period 2000 to 2006, real GDP declined by 33.5% in cumulative terms. Zimbabwe’s economic growth rate fell from -2% in 2000 to -4.6% in 2006 as a result of unstable macro-economic environment.” The consecutive drought seasons have also compounded the economic challenges for Zimbabwe. While the national budget allocation increased in nominal and real terms in the period 2002 to 2007, the increase

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33 Ibid.
was not sufficient to match the demands on the health sector as a result of the impact of HIV and AIDS pandemic. Zimbabwe relied mainly on fiscal funding and support from mainly the UN. This has adversely affected the provision of antiretroviral drugs to those in need. The low donor funding has affected the coverage of most HIV and AIDS preventive services. The inflationary pressures arising from the drought, low economic growth, high fuel prices on the international market and high HIV and AIDS disease burden have negatively affected the effective response to HIV and AIDS in Zimbabwe.

These economic challenges have resulted in rising poverty levels, high unemployment and high international migration. Zimbabwe’s economic crisis has seen millions flee the country in search of jobs abroad and in neighboring countries. Several thousands were resettled in Europe and the United States. Some of the Zimbabweans who came to the USA settled in Atlanta, Georgia and were part of the target population of this study. This population shares different cultural, beliefs, and perspectives from the European cosmology. The following section highlights African perspective in the HIV discourse.

Indigenous African Sexual Socialization in the HIV Discourse

It is said, every three minutes, one young African gets infected with HIV, the virus that causes AIDS. This means by the end of the day, 1728 000 Africans – or two million new infections, will have occurred in Africa. The magnitude of the havoc this pandemic is wreaking on largely poor communities in Zimbabwe, most of which survive

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34 Ibid.
on less than US$1 a day, becomes horrific.\textsuperscript{36} Currently, there is no culture based HIV/AIDS prevention/intervention strategy that has been approved for worldwide use except the use of condom. The culture-based prevention involves the use of African traditional methods of preventing HIV/AIDS such as sex lock (the traditional method of preventing sexual intercourse from happening, especially penetration).

The exclusive application of this strategy, without taking away anything from it, has proved to be insensitive to the cultures of African people. The African sexual ethos should be taken into consideration in order to effectively deal with HIV particularly in Zimbabwe in particular.

The first case of AIDS in Zimbabwe occurred in 1985. By the end of the 1980s, approximately 10\% of the adult population was thought to be infected with HIV. The figure rose dramatically in the first half of the 1990s, peaking and stabilizing at 29\% between 1995 and 1997.\textsuperscript{37} But since this point, the HIV prevalence is thought to have declined. Some strides have been made in HIV prevention in Zimbabwe. Projections show a “miraculous” drop in HIV infection rate from about 32\% to 18, 1\% as from 1994/5 to 2006. According to government figures, the adult prevalence was 24.6\% in 2003, and fell to 15.3\% in 2007.\textsuperscript{38} The drop has been necessitated by the impact of the ABC (Abstinence, Be Faithful and Use condom) strategy employed to reduce HIV


infections. However, the inclusion of the traditional methods into the ABC strategy would help to drop the HIV prevalence rate.

The Government of Zimbabwe has continued to scale up the multi-sectoral response to HIV and AIDS based on the Zimbabwe National and HIV AIDS Strategic Plan (ZNASP) (2006-2010) that was launched in July 2006. This plan builds on lessons adopted in implementation of the National AIDS Policy of 1999 and the National HIV and AIDS Framework (2000-2004). According to the UNGASS: “The strategic plan continues to highlight HIV and AIDS as an emergency that requires Government and all stakeholders urgently mobilize the required resources in order to fight the epidemic. Within the context of the Zimbabwe National HIV and AIDS Strategic Policy 2006-2010, one of the guiding principles is that the needs of vulnerable populations including mobile and migrant populations should be prioritized and addressed.”39 Recognizing the need to move from awareness to action, Zimbabwe has put in place a National Behavior Change Strategy (NBCS) covering the period, 2006-2010. This plan provides guidance to all stakeholders on their contributions to behavior change promotion using key prevention elements such as condom use, reducing multiple partners and promoting faithfulness as a way of addressing root causes of risk behaviors.40 The NBC strategy also encompasses strategies to reduce the incidence of HIV infection especially among youth 15-24 years. However, to defy complacency and maintain the miracle making pace in behavioral


40 Ibid.
change, more needs to be done to bring, as is generally hoped, the prevalence rate to a single digit or zero which is the priority for every country the world over.

Despite the international recognition of the need for education and communication to prevent HIV/AIDS, young people today still have only limited opportunities to learn about the disease. At the same time, Zimbabwean traditional ways of educating the young about sex have diminished or disappeared altogether. Westernization discouraged initiation rites that defined the passage from youth to adulthood. As a result, the social bonds and traditions that used to shape young people's behavior and help them make the transition to adulthood have weakened in the face of westernization. There is need to address the suspicion of the indigenous. They perceive the condom strategy as a hallmark of savagery designed to weaken African parenting and reproductive technologies. As such, they believe, condom advocacy is being undertaken for both pure and impure ulterior motives of imperialistic and colonialist nature. This suspicion is one breeding ground that propels HIV infections among Africans. The need to incorporate African solutions to pandemic prevention, control and treatment is a dire one.

This study argues that according to the indigenous, one viable way to complement the ABC strategy is by including African value systems and norms, which involves African parenting and reproductive technologies. This will strengthen and transform the depth of the ABC strategy. At present, the condom is to the indigenous what the indigenous’ traditional parenting and reproductive technological heritage are to ABC

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advocates. As such, there is a negative regard of indigenous prevention values in the way the ABC strategy is being implemented. Scientists’ failure to acknowledge and invest in merging the polemical values between Africa’s traditional parenting and reproductive technologies and the ABC prevention tenants is costing Africa lots of lives. In short, if HIV education is to be genuine and relevant to Africa, it should articulate and respond to the existing beliefs and needs of the indigenous population by co-opting African cultural innovations into the ABC strategy. In line with this general observation, researchers such as Kalichman, and Goddard, as well as agencies such as WHO and UNESCO, have argued for the need to develop culture based HIV/AIDS prevention methods. All have agreed on the need to research and document indigenous sex culture as the starting point to the development of culture based HIV/AIDS prevention strategies.

The indigenous people are finding it hard, if not impossible, to accept the condom as the only prevention apparatus because it has no bearing on their traditional parenting and reproductive technologies. Against a background that conspires against the indigenous’ parenting methods and reproductive technologies, the indigenous end up ignoring the condom despite the danger posed by such an omission in implementing a sustainable public health itinerary. This way, attempts to directly or indirectly coerce the indigenes into accepting the condom, without accommodating African parenting methods and reproductive technologies in HIV prevention, is proving costly in terms of human life. Therefore, there is a need to suggest an amicable way, the golden mean in Thomistic terms, of consummating the contrasting values of the condom neo culture and the
indigenes’ ageless venereal prevention strategies that are still being imparted at every stage of development during parenting.

This study pursues the argument that promoting the use of condoms for the purpose of preventing the spread of HIV is mutually exclusive to the promotion of indigenous parenting and reproductive technologies that are potential partners in the crusade against HIV infections. The study explains that rites of passage and purity rites define parenting in African societies. Every rite of passage or purity rite has defined reproductive technologies, with the potential of averting sexual violence, abuses and stop sex-related infections, that have eluded epidemiologists’ attempts to usher an AIDS free generation in Africa.42 It presents aspects of traditional Zimbabwean parenting systems and some of her traditional reproductive technologies that are still being practiced in contemporary African societies in a similar manner. This study argues that the observed parenting methods make it difficult, if not impossible, for the condom culture to exert its values on modern Africans resulting, thereby in HIV infections.

The indigenous criticize the western’s preference of the condom as the universally approved method which discredits the indigenous cultural prevention strategies in the fight against HIV. The study questions the wisdom behind the little criticism being directed to electronic-culture and HIV-suspected bio terrorism activities that are believed to be sophisticated attempts to deal with the African HIV epidemiological belts. The study argues that the sophistry introduced by bio terrorism and electronic-culture can be diminished if traditional prevention methods advocated by

indigenous parenting and reproductive technologies, are embraced in the fight against the HIV pandemic.

This study advances the contention that merging condom use with the African parenting methods and reproductive technologies will reinforce the indigenous’ appreciation of the condoms’ effectiveness in HIV prevention. The study explains the inclusion of purity rites as a way of complementing the condom to African parenting methods and reproductive technologies. Furthermore, the study explains the reasons why the indigenous are self-defensive, in support of their parenting and reproductive technological heritage, in the face of a condom propelled sexual globalization.

**Axiological Challenges: Complementing the Condom with African Sexual Ethos**

Abstinence and faithfulness have been, and will always be, the cardinal points to the ideal culture of the indigenous people. They constitute the essence of African parental “modules” (written in their minds and hearts and not books) and perpetuate the values to be pursued in their reproductive technologies. Abstinence is one sexual value the indigenes have sought to entrench in their sexuality from time immemorial. Faithfulness, in sexual relationships, has always been central in African societies. The theory and practice of abstinence and faithfulness remain confined to family or community traditions. These family or community traditions assumed a ritual form where sages preside over. These rituals are enacted to enable the subject to sustain and maintain abstinence and faithfulness within any given station in life. The reasons for ritualizing abstinence and faithfulness are informed by the indigenous’ ethno-medical background whose dictating ethno philosophy is notoriously religious and exclusively other
centered. As such, the values that inform traditional African parenting and reproductive technologies are largely intolerant towards the latex technology that is making inroads in human sexuality.

Given the aforementioned Afrocentric assumption, the ABC strategy per se is not naïve to the indigenous. The indigenous’ bone of contention is with the “C” (use of condom) in ABC advocacy. African men, giving women no chance to negotiate for safe sex, attach little value to the condom. The condom is many times ignored, selectively used, frequently improperly, or misused as an expression of cultural indignation to the use of the condoms in any of their sex related pedagogies and practices. As Zimbabwe continues to struggle to lower the HIV infection rate, there is a need to promote the development of culturally sensitive innovations in the propagation and use of the condom, and to suggest the best way the condom can be complemented by the ideals of the indigenous’ parenting systems and reproductive technologies.

The condom’s axiology, as understood by the indigenous, is related to the individual’s sexual whims and fancies. The condom is outside of the ideals of the community and the spirits that are part and parcel of the indigenes’ existence. The omission of the community’s value system is, in part, what antagonizes the indigenes to the extent of ignoring condoms when indulging in promiscuous behavior. The spiritual and communal aspects in the indigenous’ sexuality are directly opposed to the self-centeredness espoused in the Cartesian convention, cogito ego sum: “I think therefore I exist” that seems to inform the condom neo culture. Partly, this is the source of the contradiction that exists between western and African HIV prevention methods. It is

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against the dictates of the outlined African ethno epistemology that the ABC strategy needs to incorporate religious and other centered values in its quest to be more relevant to the Africans.

Against this worldview, the indigenous prefer sex locks, which are their reproductive technologies, than condoms. Given this contrast, the best prevention strategy for the indigenous would see the merging of the contrasting values that inform the condom and sex locks. Once the contrast in the two prevention methods are made to complement each other, a realistic prevention strategy will result. Suggesting sex locks, as a complement to the ABC strategy, will be a likely strategy in protecting the indigenous against the HIV pandemic.

**Appropriating Indigenous Parenting and Reproductive Technologies in the HIV Discourse**

Most African governments, HIV researchers and educators give lip service to championing the indigenous’ intellectual property rights regarding their parenting methods and reproductive technologies. Strides must be made to vilify and dispose of the indigenous’ purity rites. Attempts to acknowledge Africa’s diverse settings in sexuality have only managed to have them labeled as gap knowledge systems that deserve no regular funding save for reviewing them and their underlying ethno philosophies as crisis response itineraries. The indigenous contends that such an omission is a way of globalizing the condom in HIV prevention. To this end, the indigenous’ axiomatic knowledge on traditional parenting and reproductive technologies is either mythified or reduced to “conjectures.”
Few institutions, governments included, are keen on funding the transformation of the HIV pandemic ignoring the African cultural aspect into the discourse. A recent research conducted by the Population Communications International (PCI) by Everett Rogers, a professor at New Mexico University and Arvind Singhal of the University of Ohio have observed:

"... most HIV/AIDS communication interventions are culturally rudderless and fly blind just because many HIV/AIDS intervention programmes are led by medical doctors, who certainly know all about the virus and its effects on the human body, but are often ill-prepared for developing and evaluating communication strategies that combat the spread of the virus."  

The report further observes that HIV/AIDS researchers avoid indigenous or traditional healers who are the most knowledgeable about cultural methods of prevention. To this end, the indigenous’ venereal prevention strategies used for centuries before the invention of the condom to fight catastrophic pandemics are refuted as scientifically debunk in HIV epidemiological prevention and control. Few Africans argue against the efficacy of the condom in preventing STIs, HIV and unplanned pregnancies. Condom use, to the indigenous, promotes promiscuous behavior however safe it may be. Purity rites are life cycle rites in the history of African sexuality. They have unparalleled efficacy in maintaining sexual dignity. Their role is to preserve physical and spiritual virginity, sustain and reinforce abstinence among the unmarried, maintain countenance in and outside marriage, transform sexual knowledge into behavioral change, conserve sexual morality and perpetuate an African sexual dignity in a changing world.

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Many single persons are, because of the latex technology, coerced to have sex or indulge in promiscuous behaviors more than the married. In a complementary manner, schools promote as opposed to traditional African parenting values the seduction of youth into becoming “clever and loose” adults. Young adults in school, in terms of African sexual ethos, have no business with condoms as the Kenyan First Lady Madam Kibaki\textsuperscript{45} was once quoted. The indigenous believe that condoms are meant for adult life. Accordingly, condoms minimize HIV infection while simultaneously inducing nostalgias for sex. Indigenous reproductive technologies like sex lockers, when complemented by condoms, have the potential to stop HIV infection and nostalgias for sex. Therefore, the condom strategy, in terms of the worldview of most indigenous Africans, is a dishonesty and irresponsible response to the HIV pandemic if the postulates of purity rites do not complement it.

Furthermore, HIV infections related to bioterrorism, induced e-HIV transmission behaviors expressed in pornography, e-dating, seductive music and e-dances are replete on the electronic media and the superhighway.\textsuperscript{46} All these facilitate in spreading e-HIV behaviors and weaken African parenting didactics in a cyber world. Little has been done to combat electronic devises that promote e-HIV behavioral modes of transmission. Measures being taken to protect clients in electronic banking (e-banking) and e-commerce have no match in e-HIV transmission behaviors. What is stopping investments in eavesdropping SMS messages, emails, SMS and IT surveillance units if the war

\textsuperscript{45} The Sunday Mail, Harare, Zimbabwe, 21 April 2006.

against HIV has no racial or political overtones? Obviously such units will act against other neo colonial agendas or strengthen the role of indigenous reproductive technologies. Hence, the suggestion may not be sound because they act against the latent agendas attached to the HIV/condom industry and other countless neo colonial agendas.

The African parenting song toward the epidemiological prevention of HIV/AIDS (abstinence...Faithfulness... abstinence...Faithfulness!) has no genuine supporters due to motives to sustain the HIV/condom and ARVs industries. As such, war has been declared on indigenous sexual practices like virginity rites that are an obvious obstruction to the advancement and dominance of industries in the HIV business. The majority of existing indigenous STD prevention strategies are depicted as substandard in the crusade against HIV and even criminalized. Enacting purity rites is condemned as violating human rights. Human rights in this case are indirectly manipulated and HIV infections, subsequently, rise. There has been much focus on sex whenever HIV is discussed rather than a focus on other fundamental issues related to HIV. The early sentiment of the missionaries and colonialists sentiment against the indigenes' sexuality comes out clearly. They falsely promoted the idea that Africans have untamed desires for sex. This same colonial and early missionary sentiment paints the contemporary African sexuality in form of the HIV regalia.

Young Africans, especially Zimbabwean youth, should be afforded the opportunity to understand the purpose of purity rites. African researchers, authors and broadcasters can help via a perspective that has an African face on the epidemic. It is
against this discriminatory medical background that clinicians and other professions degrade indigenous parenting and reproductive technologies.

Virginity tests, that clinicians take from the practice of rites of passage are nowhere in the indigenes’ vocabulary. What exist in the indigenes’ linguistic repertoire are virginity rites. Any test is supposed to be specific about the exercise being undertaken, achieve a measurable goal whenever employed, be accurate in its procedures, and be repeatable; thus a test is stringently imperial. Virginity checks are based on conventional observations of the anatomy of the body. Beliefs and social assumptions constitute the process of checking. Checks, as in virginity rites, do not need marks or scores to correlate with observed anatomical structures. General consensus, which satisfies those presiding over the rituals, is what is needed. This way, the virginity checks conducted are, if not misunderstood from a naïve perspective that is non-African, different from the virginity tests that medical practitioners ascribe to purity rites. The rites are enacted to protect young adults from potential abuses and correct sexual deformities. Virginity checks are a constituent of purity rites; mistaking virginity tests for purity rites is as deceptive as mistaking the wood for the forest.

Purity rites are enacted at birth, childhood, adulthood, marriage, post sexual life, death and thereafter. These rites are not enacted in all the tribes of Zimbabwe, however the theories that explain the purity rites are known nationwide. There is need to outline the way purity rites are enacted and rationalize their relevance in this HIV era. Noteworthy is the need for the western to realize the relevance of complementing the values of purity rites and those inculcated in the condom culture.
Epidemiological prevention has been the primary agenda in indigenous medical practices. The indigenous have always anticipated sex-related pandemics. Hence, they had inculcated precautions at every stage of the indigenes’ sexual development. As such, there are reasons to justify HIV advocates that argue for compulsory HIV testing at every stage of human development. However the indigenous should not throw caution to the wind since modernity has caused contemporary Africans to ignore most of their traditional parenting and reproductive technologies. Rather they should take precaution against human rights violation when trying to instill their sexual heritage on young adults.

The issue at hand is not about the denial of the reliability of the condom. It is about the way so much has been and is still being invested in a non-African culture at the expense of the indigenous’ traditional prevention strategies. The only way forward is to complement the condom with African innovations that have served indigenous Africans for centuries before the invention of the condom. This study has argued that it is the failure to merge traditional African parenting methods and reproductive technologies with the medical guidelines for preventing HIV/AIDS, and a focus on profits in the HIV/condom and ARV industries, that is propels HIV infections in Africa. Therefore, there is a need to move towards the suggested Afrocentric goal in the HIV discourse by blending the ideals of the condom culture with the values entrenched in indigenous parenting and reproductive technologies. This way, an African face can be given to the fight against HIV in Africa. It is therefore fundamentally necessary for HIV/AIDS researchers and educators to be knowledgeable about the cultures of the indigenous people to effectively reduce the widespread incidents of HIV/AIDS infections. Any
successful HIV/AIDS prevention strategy should be informed by the cultural traits of the indigenous peoples’ sexual socialization. Hence, any HIV/AIDS prevention strategy should be complemented by traditional prevention strategies.

Despite being in the Diaspora, Zimbabwean adolescents are expected to live by the standards of African parenting and culture. It is also important to examine at the impact of HIV/AIDS among African Americans in Atlanta, which is part of the black community. Zimbabwean adolescents mostly mingle with this population because they are also a black community.

**HIV/AIDS in Atlanta, Georgia**

For several years after the discovery of HIV disease in America, the impact on women was in no way similar to their sub-Saharan counterparts, where women had been infected at similar rates as men. That pattern has dramatically changed, and the proportion of cases among women has increased steadily during the past decade. According to the CDC in their June 2007 report, *Heightened National Response to the Crisis of HIV/AIDS among African Americans*, HIV/AIDS continues to threaten the health and well-being of many communities in the United States but for African Americans, HIV/AIDS is a major health crisis. In the United States, African-American adolescents are at a significant risk for HIV infection. For instance, African-American female adolescents between the ages of 14 and 24 years account for more than 55 percent of all new adolescent HIV infections. CDC identifies three interrelated factors as the prevention challenges that face the African-American community: “the continued health disparities between economic classes, the challenges related to controlling substance
abuse and the intersection of substance abuse with the epidemic of HIV and other sexually transmitted diseases. The lack of resources and attention can result in an increase in poverty and AIDS. Cohen claims that the broader context of HIV/AIDS in the African-American community, however, includes the lack of health care and education, homelessness, poverty, racism and sexism. The CDC concurred that:

There is growing evidence that the HIV/AIDS epidemic is increasingly concentrated in low-income communities in which people of color are often disproportionately represented. . . and are generally faced with multiple health and social issues including access to high quality health care and prevention education.

The combination of these sociopolitical influences strengthens the increase of HIV/AIDS among the black community. However, these efforts have been limited at best in decreasing the persistently high rates of HIV infection among African Americans. A heightened national response, one that ignites focused, collaborative action among public health partners and community leaders, is vital at this time to reduce the impact of HIV/AIDS on rural and urban African-American communities. We need to develop a culturally relevant approach to curtail the spread of HIV infection among African-American female adolescents. Instead of an intelligent broadening of dialogue to understand the interactive mix between, cultural, social and economic conditions that

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create circumstances conducive to the spread of HIV infection, the debate and research has been constrained by biomedical preoccupation and over simplification. HIV/AIDS thus poses a unique challenge. We need to find ways of enabling African-American people to assert control over the pandemic through culturally-sensitive humanitarian responses that empower and educate.

African-American culture and beliefs deter lifestyle changes. Conspiracy theories in relation to health have long been present among some segments of the African-American populace. According to Victor Turner's classic study, *I heard it through the Grapevine: Rumor in African-American Culture*, there is a distinction between malicious intent theories and benign neglect theories. Malicious intent theories refer to deliberate attempts by the government to "undermine" the African-American population. An example would be the belief that AIDS was created by white America to eliminate the African-American population. As evidence, the believers point to the disease's rapid spread in their community and the government's nonresponsiveness to African-American health care needs. Benign neglect theories involve a government that does little to solve the problems in the African-American community because the well-being of African Americans is a low priority.51 It is the government's responsibility to provide the resources as well as decrease the denial and silence surrounding the disease in order to help open the door for improvements. It is believed that conspiracy beliefs stem from

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chronic experiences of discrimination. However, only recently have studies examined the role of conspiracy theories about the origin of HIV and its relationship to sexual risk behaviors among African Americans. A study using a community-based sample of 1,494 men and women (ages 18 to 50 and over) from four racial or ethnic groups (African American, Latino, non-Hispanic white, and Asian) found that the highest levels of belief in conspiracy theories (for example, AIDS being an agent of genocide created by the U.S government to kill the minority populations) were reported among women, African Americans, and Latinos. In addition, for African-American men only, higher levels of belief in conspiracy theories were associated with lower rates of condom use. Many conspiracy beliefs may stem from a general mistrust of the health care system or the government.

David Kirp in his 1995 article, *Blood, Sweat, and Tears: The Tuskegee Experiment and the Era of AIDS*, describes AIDS as a metaphor for pervasive racism: “HIV and AIDS are not exclusively health issues. AIDS is a personal disease that has been politicized. Access to health, insurance, employment, housing, and education are just some of the social systems that intersect with a person’s personal response to HIV.” In agreement, Frances Cress Welsing, an African-American woman, clearly explains that

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the AIDS epidemic is a premeditated chemical-biological warfare activity undertaken by
the white supremacist power structure for the sole purpose of assuring white genetic
survival through the population reduction of nonwhite people, especially
African/African-American people. According to Dr. Welsing, AIDS was presented to the
world as an African disease caused by the African Green Monkey.\textsuperscript{55} However, this is
highly debatable. Quoting from \textit{A Survey of Chemical and Biological Warfare}, by John
Cookson and Judith Nottingham:

The question of whether new diseases could be used is of considerable interest. Vervet monkey disease (African Green Monkey Disease) may well be an example of a whole new class of disease-causing organisms. Handling of blood and tissue without precaution causes infection. It is unaffected by any antibiotic substance so far tried and is unrelated to any other organism. It causes fatality in some cases and can be venereally transmitted in man. It has possible potential as an infectious disease of man. It presumably is also of BW (biological warfare) interest. New diseases are continually appearing. In addition to these there are the possibilities of virus and bacteria being genetically manipulated to produce ‘new’ organisms.\textsuperscript{56}

The theory of the origin of HIV points back to Africa. However, there is no green
monkey in Africa running around biting people and giving them AIDS. The racist
stereotype of most Westerners, which said that Africans could not control their sexuality,
was revived and corresponding conclusions were reached as to why there were so many
HIV/AIDS infections among people of African descent. The origin of HIV/AIDS is
debatable. It is believed by some to have originated from gay men. Early in 1980,
physicians and public health officials began to notice inexplicable medical symptoms of
HIV/AIDS primarily in gay and Haitian men. It was discovered in the gay communities


\textsuperscript{56} J. Cookson, and J. Nottingham, \textit{A Survey of Chemical and Biological Warfare}, 1969.
of New York and San Francisco. By the end of 1981, both the CDC and the United States Surgeon General labeled these symptoms Acquired Immunodeficiency Syndrome (AIDS). Since then, more than one million people in the United States have been diagnosed with the dreaded malady and more than 750,000 have died from the disease.\(^{57}\) The population first diagnosed and subsequently impacted by AIDS was gay men and intravenous drug users. In 2004, Georgia ranked eighth in the United States with 30,405 cumulative AIDS cases, according to the CDC’s March 2007 \textit{HIV/AIDS Surveillance Report}. Of this cumulative number of cases, an estimated 27,000 people were reported to be living with HIV (non-AIDS). An additional 16,181 residents of the state were reported to be living with AIDS. Newly diagnosed persons with HIV accounted for 1,246 reported cases, while 1,268 newly diagnosed AIDS cases comprised the remainder of reported cases. Of these figures, African Americans accounted for 77% of all reported cases. The AIDS rate for African Americans is nine times higher than the rate for their white counterparts. The most common modes of transmission continue to be men having sex with men (59%), as well as heterosexual exposure (20%). Approximately two-thirds of all persons newly diagnosed with AIDS in Georgia live in the 20-county Atlanta metro area. Persons residing in the Fulton and DeKalb Health Districts combine to make up 51% of reported HIV/AIDS cases in 2005.

African-American women in Atlanta are the fastest growing population of newly diagnosed HIV infections. According to the CDC HIV AIDS Fact Sheet: “Today, women

account for more than one quarter of all new HIV/AIDS diagnoses. Women of color are especially affected by HIV infection and AIDS. In 2004 HIV infection was:

- The leading cause of death for black women (including African-American women) aged 25-34.
- The 3rd leading cause of death for black women aged 35-44 years.
- The 4th leading cause of death for black women 45-54 years.

The CDC 2008 report states:

Most women are infected with HIV through high-risk heterosexual contact. Lack of knowledge, lower perception of risk, extra drug or alcohol use, and different interpretations of safer sex may contribute to this disproportion. Relationship dynamics also play a role. For example, some women may not insist on condom use because they fear that their partner will physically abuse them or leave them.

Such sexual inequality is a major issue in relationships between young women and older men. Young women do not possess the power to demand safer sex. AIDS is, therefore, a threat to the health and welfare of the African-American women, and the African-American community. Michael Porter in his book *The Conspiracy to Destroy Black Women* argues:

African/African-American women must look the monster in its eyes. African people the world over are being used as worthless guinea pigs while simultaneously being destroyed in huge numbers. The African/African American woman’s quest to reduce the spread of AIDS is directly related to the necessity of stopping patriarchal White supremacy. So, while it is necessary to get all African people to practice abstinence, safe sex, and to stop drug usage, a major thrust

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59 Ibid.
must be the undoing of the White supremacist value/behavior system that is simply hell-bent on getting rid of all African people.\textsuperscript{60}

The conspiracy theories are based on historical events revealing the existence of discrimination in health care, such as the Tuskegee Experiment. Therefore, as purported by Bogart and Thornburn, interventions that encourage candid discussions of conspiracy beliefs within the context of societal and structural discrimination in relation to health may have the greatest chance of promoting HIV awareness and prevention among African-American Youths.\textsuperscript{61} Misinformation and conspiracy theories about HIV among African-American Youths is a very real phenomenon. This misinformation is likely to result in a poor understanding of HIV risk, denials of the prevalence of HIV infection within the African-American population, and increased HIV transmission. Despite increasing efforts of awareness and contraception usage, HIV and AIDS remain highly stigmatized in African-American community. The longevity of stigmatization prolongs the acceptance, acknowledgment and behavior change that is necessary to help decrease transmission. People living with HIV are often perceived as having done something wrong, and discrimination is frequently directed at them and their families. As a result, most people are afraid to get tested or make their status publicly known for fear of being alienated.

\textbf{Summary}

This chapter analyzes the socio-economic and political history of Zimbabwe and the impact this had on the migration of people of Zimbabwe into the Diaspora.

\textsuperscript{60} Michael Porter, \textit{The Conspiracy to Destroy Black Women} (New York: Plenum Press, 2001), 30.

HIV/AIDS also had an impact on economic development via reduced productivity and generating the capital for its prevention. The chapter also examined the history of HIV/AIDS and its impact among the African-American community in the United States. It is important to understand the historical context and the bigger picture of these contexts for this study to be relevant. The problem of HIV/AIDS has to be understood contextually. In order to understand the sexual behavior of Zimbabwean adolescents in the U.S., researchers must examine more closely sexual socialization within the cultural context. This study suggests that aspects of traditional culture influence sexual socialization among Zimbabwean adolescents in America. The next chapter, Chapter 4, presents the analysis and findings of the research.
CHAPTER 4
ANALYSIS AND FINDINGS

Method

The purpose of this research was to investigate the knowledge of HIV transmission and sexual behavior among Zimbabwean female adolescents. The study used a qualitative exploratory design. This method allowed for a more in-depth study of the research problem as participants freely discussed the issues from their perspectives. Approval for the study was obtained from the Clark Atlanta University Committee for the Protection of Human Subjects. The study was conducted among the Zimbabwean female adolescents who reside in Atlanta, Georgia. Metro Atlanta is the largest, and one of the fastest growing, urban cities in the state of Georgia.

Selection Procedure

Recruitment criteria for study participation included being a Zimbabwean adolescent female, residing in Atlanta, Georgia. Research participants (N=30) were recruited using purposive convenience sampling through formal and informal networks. All study participants were self-selected volunteers who met the study inclusion criteria.

Participants

The final sample consisted of 30 Zimbabwean adolescent females aged 13 to 22 years. The participants were characterized as follows: Their mean age was 17 years; most of the respondents indicated that they were in high school (63%) or college (37%).
Data Collection

Data sources utilized for this study constituted primary data from survey and interviews and secondary data from literature reviews and library research. Primary data such as demographic, sociocultural, sexual behavior and educational data pertaining to HIV/AIDS knowledge and prevention among Zimbabwean female adolescents were collected through face-to-face interviews. Secondary data such as published studies, research findings, and manuals on HIV/AIDS education and prevention among Zimbabwean adolescents and groups from similar countries and U.S were reviewed and collected. Studies on the target population in the USA were reviewed with the intention of exploring the sexual, cultural, and social dimensions underlying this group.

Data were collected via survey and individual in-depth interviews. This included a questionnaire with 30 questions and 20 interview questions. Questions on the survey and interview ranged from demographic, knowledge, behavior, socialization, perceptions about HIV/AIDS education and prevention in their community. Interviews were primarily conducted in English. Each interview was audio taped with the consent of the participant. For those under the age of consent, permission was granted by their parents. The adolescents selected the time, location, and format for the interview. Semi-selected, close-ended questions elicited the adolescents’ experiences. They were encouraged to speak candidly about their past and current relationships.
RESULTS/FINDINGS

Table 4.1. Respondents’ demographic characteristics (N=30)

<table>
<thead>
<tr>
<th>Variable</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13-15 years</td>
<td>9</td>
<td>30%</td>
</tr>
<tr>
<td>16-19 years</td>
<td>13</td>
<td>43%</td>
</tr>
<tr>
<td>20-22 years</td>
<td>8</td>
<td>27%</td>
</tr>
<tr>
<td>Nationality</td>
<td>30</td>
<td>100%</td>
</tr>
<tr>
<td>Educational Level</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High school</td>
<td>19</td>
<td>63%</td>
</tr>
<tr>
<td>College</td>
<td>11</td>
<td>37%</td>
</tr>
</tbody>
</table>

Demographic data are presented in this section in order to ascertain the background of the respondent. The participants in this study (N=30) were female and Zimbabweans. Their ages ranged from 13 to 22 years with a mean range of 17. The educational level of the respondents varied from high school to college. The sample included 63% who were in high school and 37% in college.
Table 4.2. Knowledge of HIV Transmission (N=30)

<table>
<thead>
<tr>
<th>Question</th>
<th>Positive</th>
<th>Negative</th>
<th>Don’t Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Have you ever heard about HIV/AIDS?</td>
<td>30 (100)</td>
<td>0 (0)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>5. You can become infected with HIV if you have oral or anal sex.</td>
<td>27 (90)</td>
<td>0 (0)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>6. You can get HIV through casual contact with an infected person.</td>
<td>4 (13)</td>
<td>25 (83)</td>
<td>1 (3)</td>
</tr>
<tr>
<td>7. You can tell by looking at someone if they have HIV/AIDS.</td>
<td>4 (13)</td>
<td>23 (77)</td>
<td>3 (10)</td>
</tr>
<tr>
<td>8. You can get HIV from the mosquito bite.</td>
<td>3 (10)</td>
<td>18 (60)</td>
<td>9 (30)</td>
</tr>
<tr>
<td>9. You can get HIV by sharing utensils or cups with an HIV infected person.</td>
<td>1 (3)</td>
<td>26 (87)</td>
<td>3 (10)</td>
</tr>
<tr>
<td>10. You can get HIV through sharing a bathroom with an infected person.</td>
<td>0 (0)</td>
<td>25 (83)</td>
<td>5 (17)</td>
</tr>
<tr>
<td>11. You can get HIV by sharing clothes with an infected person.</td>
<td>0 (0)</td>
<td>29 (97)</td>
<td>1 (3)</td>
</tr>
<tr>
<td>12. Condom use reduces chances of contracting HIV.</td>
<td>27 (90)</td>
<td>3 (10)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>13. It is possible to have the virus that causes AIDS without being sick from AIDS.</td>
<td>23 (77)</td>
<td>1 (3)</td>
<td>6 (20)</td>
</tr>
<tr>
<td>14. Is there a vaccine to protect you from HIV?</td>
<td>5 (17)</td>
<td>21 (70)</td>
<td>4 (13)</td>
</tr>
<tr>
<td>15. Is there a cure for HIV?</td>
<td>6 (20)</td>
<td>22 (73)</td>
<td>2 (7)</td>
</tr>
<tr>
<td>16. Having HIV means the person is promiscuous.</td>
<td>0 (0)</td>
<td>28 (93)</td>
<td>2 (7)</td>
</tr>
</tbody>
</table>

Percentages (%) are in parentheses. Positive represents the participants’ response to the questions as yes. Negative represents the participants’ response as no.
Table 4.2 displays the respondents' knowledge level of HIV/AIDS transmission. In general, most of the young girls had a high level of knowledge. 90% of respondents were aware that using a condom can prevent HIV transmission. 90% of adolescents knew that HIV could be transmitted by anal sex. Almost 73% of the participants knew that there was no cure for AIDS, 20% thought there is a cure and 7% did not know. Almost all of the participants (93%) knew that it was not an “immoral” disease. 10% of the respondents agreed that they had shared needles and syringes. Despite the high awareness of HIV, the myths around how HIV is spread still pervade. The proportion with correct knowledge about common transmission myths was 83% for transmission by casual contact, 87% for sharing utensils, 97% for sharing clothes, 83% for sharing a bathroom. The largest discrepancy with regards to knowledge was found when respondents were asked if a person can get HIV from the bite of the mosquito or insect. Only 60% answered correctly, 10% answered incorrectly, and 30% indicated that they did not know. Asked if you can tell by looking at someone if they have HIV/AIDS, 77% answered correctly, 13% answered incorrectly and 10% did not know.
Table 4.3. *Sexual Behavior (N=30)*

<table>
<thead>
<tr>
<th>Question</th>
<th>Positive</th>
<th>Negative</th>
<th>Don’t Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>17. Have you ever had sex in your lifetime?</td>
<td>21 (70)</td>
<td>9 (30)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>18. Have you ever had sex with more than one partner in the past 12 months?</td>
<td>14 (47)</td>
<td>16 (53)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>21. Did you use a condom at last sex?</td>
<td>6 (20)</td>
<td>15 (50)</td>
<td>12 (30)</td>
</tr>
<tr>
<td>22. Have you used needles that were used by someone?</td>
<td>3 (10)</td>
<td>26 (87)</td>
<td>1 (3)</td>
</tr>
<tr>
<td>23. Have you ever had sex for gifts or money?</td>
<td>2 (7)</td>
<td>28 (93)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>24. Do you think alcohol or drugs influence your sexual behavior?</td>
<td>21 (70)</td>
<td>7 (23)</td>
<td>2 (7)</td>
</tr>
<tr>
<td>25. Are most girls at your school having sex?</td>
<td>21 (70)</td>
<td>1 (3)</td>
<td>8 (27)</td>
</tr>
<tr>
<td>26. Have you ever been encouraged by friends to have sex?</td>
<td>16 (53)</td>
<td>13 (44)</td>
<td>1 (3)</td>
</tr>
<tr>
<td>27. Can you tell your boyfriend that you don’t want to have sex?</td>
<td>29 (97)</td>
<td>1 (3)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>28. Can you tell your boyfriend that you want to use condoms?</td>
<td>29 (97)</td>
<td>0 (0)</td>
<td>1 (3)</td>
</tr>
<tr>
<td>30. Abstinence from sex would protect me against HIV?</td>
<td>29 (97)</td>
<td>1 (3)</td>
<td>0 (0)</td>
</tr>
</tbody>
</table>

Due to the fact that heterosexual transmission accounts for the majority of HIV infection incidents, obtaining information about sexual behavior was necessary. The data for this sensitive subject matter should be considered cautiously since the data were obtained through self-report. Adolescents in this study were asked whether or not they
had sex in their life time. 70% reported that they had sex in their lifetime, and 47% had sex with more than one partner for the last 12 months. Even though 90% of the adolescents knew that the use of condoms reduce the chance of contracting HIV, other responses indicated barriers to wider condom use. 50% reported inconsistent condom use the last time they had sexual intercourse. Gender differences were also noted when adolescents were asked about condom interactions and general assertiveness when dealing with male partners. Most of the respondents (97%) indicated that they could tell their boyfriend to use a condom. 7% of girls admitted they had sex for gifts or money. 70% think alcohol or drugs influence their sexual behavior. 53% has been encouraged to have sex by their peers. Almost 97% of the participants were knowledgeable that abstinence from sex would protect them from HIV infection.

**DISCUSSION**

Sexual exploration is part of the normal lifecycle experience. The majority of adolescents in Aspy and Vesely's research findings experience sexual intercourse.\(^1\) However, Plummer, Ingall and Wamoyi found when using survey methods to measure sexual behavior in young people, that there was considerable inconsistency in reporting.\(^2\) While young girls were more consistent in their reporting, they were also more likely to under-report the extent of their sexual experience. Nonetheless, understanding behaviors and their determinants is important in designing and implementing appropriate and effective


reproductive health interventions and finding methods to improve the validity of these data is critical. The combination of correct knowledge and misconceptions of HIV transmission among Zimbabwean adolescents in Atlanta was typical of adolescents in Zimbabwe.

Research findings strongly suggest that sexual activity at young ages is more problematic than sexual activity initiated in later adolescence. Adolescents who initiated intercourse early were more likely to engage in unprotected sex and to have multiple partners, risk-markers for exposure to STDs. The responses from the young women in this study tend to corroborate these findings. The data in this study indicate that a substantial number of the Zimbabwean young women examined (50%) have had unprotected sex. Furthermore, many studies illuminate the role of an important contextual factor: fear of abuse because of negotiating condom use in risky sexual behavior among young women. Adolescents who engaged in safe sex worried about HIV/AIDS more than those who engaged in unsafe sex. Teenagers of color face additional developmental challenges in this adolescent period because they are developing their own cultural identity while confronting the culture and values of the majority and coping with its barriers and prejudices.\(^3\) Culture assumes a significant role in the socialization process by shaping the specific beliefs and values held by parents. Zimbabwean adolescents face dual socialization challenges. As Espin has noted, immigrant and ethnic minority groups may preserve aspects of their traditional culture related to sexuality long after they have

adopted other aspects of the host culture.⁴ Zimbabwean parents face a dual socialization challenge of not only transmitting their own beliefs and values, but also those of the American society. Zimbabwean adolescents are exposed to the Western culture of sexual socialization which is different from the African culture. The American culture appears to be too sexually charged to get by with parental hints. Most Zimbabwean parents bring up daughters in this environment where sex is ‘whatever’ and the pleasure is usually his. Misinformation about female sexuality is prevalent. However, some parents are often reluctant to give their daughters information regarding sexuality. Even the late feminist leader Betty Friedan, never at a loss for words on women’s reproductive freedom, fumbled when it came to having “The Talk.” As her daughter Emily, remembers:

“I was in high school when she tried to find out if I was having sex by awkwardly saying something like ‘I know I have fought long and hard for a woman’s right to have an abortion. But, um, I wouldn’t want you to be in a position to need one’. I just told her, ‘Don’t worry, I’m not having sex’ (I wasn’t yet) ‘and I know everything I need to’ (I didn’t). And she said, ‘Okay, good.’ Conversation over.”⁵

Many adolescents are at risk because parents have not taught them about HIV/AIDS or about how to protect themselves. The findings show that having parents who are disengaged from their children and cannot offer support and guidance through the challenging adolescent period has been linked to early sexual activity. Girls who

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engaged in safe sex were more likely to report that their parents were there when they needed them. Adolescents who talk to their parents before their first time are less likely to have regrets and risky sex. Most of the girls in the study (83%) reported that they had learned about sex from friends, books, magazines, media, and internet. Parents were virtually absent in the sex education of their children. Communicating a positive attitude toward sex helps girls to make wise choices. Communicating less about sexual topics leads adolescents to be less knowledgeable about their own sexual anatomy. In general, adolescents in this case are less likely to display the developmental readiness to engage in sensible sexual decision making.

Gage’s studies focused on components of adolescents’ decision-making surrounding sexual activity, contraceptive use, and condom use. She noted that the decision-making process is an interaction of individual, social, family, peer and sociocultural factors. Gage reported that in sub-Saharan Africa, the role of family members, particularly grandmothers, in providing information and advice on appropriate sexual and marital behaviors is declining. In traditional African communities, sex education was the job of aunts, uncles, elders in the community, and grandparents. Initiation ceremonies were held to mark the transition of boys and girls from adolescence to adulthood. Aunts and grandparents were traditionally important in the education and socialization of adolescents. Westernization suppressed the traditional cultural practices. They were deemed and are still subjugated as backward and barbaric. Since most people

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in the Diaspora left the aunts and grandparents in Zimbabwe, it is the duty of the parents to socialize and educate their children.

The gender differences apparent in the results raise several issues for intervention. The results confirmed the need identified in the literature review concerning gender issues. As Adih and Alexander and Gregson et al point out, perceived risk of HIV infection is one of the individual characteristics that may influence sexual behavior and condom use. A number of common fears, false expectations and misinformation seem to prevent many Zimbabwean adolescents from realizing their full sexual potential. Gage, Zabin and Kiragu, and Caldwell all point to the cultural factors of male dominance, female sexual submissiveness, and limited economic opportunity for as contributing to women’s lack of agency in prevention of HIV/AIDS. In this scenario, adolescents are unlikely to negotiate condom use. Viewed within this context, findings from the present study suggest that teaching medically correct information about human reproduction, HIV/AIDS, other STDs, and methods of prevention to Zimbabwean adolescents, although important, is not sufficient. Young people, particularly girls, need to be given permission to take control of their sexuality. Educational efforts should focus on helping young people change gender stereotypes as well as behavior.

Zimbabwean adolescents find themselves in an American society where seemingly “everyone is doing it.” However, in situations of overwhelming peer pressure, not all adolescents are engaging in risky behavior; about 30% of the adolescents in this study were not having sex. This finding has important implications for programs that

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promote safety and protect these adolescents from risky behaviors and HIV infection. It is important as well to promote safe sex for sexually active teenagers. Familiarity with the environment of adolescents, for example, their media input, their peers and their ethnic and cultural background is a key component in effective programming. Support networks based on enhancing cultural identity are necessary for young Zimbabweans in the Diaspora. Furthermore, efforts should be devoted to helping parents to become effective sex educators because parents are major socializing agents for children. It is therefore, fundamentally necessary for HIV/AIDS researchers and educators to be knowledgeable of the sexual terrain of the African people to effectively reduce the skyrocketing incidents of HIV/AIDS infections. Any successful HIV/AIDS prevention strategy should be informed by the cultural traits of the African peoples' sexual socialization. Hence any watertight HIV/AIDS prevention strategy among African immigrants in the Diaspora should therefore be complemented by traditional prevention strategies.

INTERVIEW FINDINGS

This section describes the findings from the interviews held with Zimbabwean female adolescents in Atlanta, Georgia. This study was conducted to assess the knowledge of HIV/AIDS and sexual behavior among Zimbabwean adolescents. The research also explored the adolescents’ experiences related to different socializations regarding sexuality and gender outside their traditional socialization. Information gathered through interviews and transcriptions were utilized to answer the following research questions:

1. What do Zimbabwean female adolescents in Atlanta know about HIV/AIDS transmission?
2. What are the sexual behaviors of Zimbabwean female adolescents?
3. How do Zimbabwean female adolescents in Atlanta learn about HIV/AIDS prevention?
4. What is the role of culture in Zimbabwean adolescents' sexual behavior?

Interviews were conducted to capture the knowledge and experiences of these adolescents in “their own words.” All the respondents described what they knew about HIV and AIDS. Interviews were conducted at several sites including restaurants, churches, and personal homes. The participants authenticated the research by agreeing to assist in this study. All of the interviews were conducted in Atlanta, Georgia. Adolescents were encouraged to select a place where they would be most relaxed and comfortable. A scheduled time to conduct interviews with each participant was established. Prior to each session, the researcher explained the purpose of the research. Time was allotted to answer any questions that the participant identified. The length of the interview averaged about 20 minutes. Informed consent was obtained from each participant and from parents for those who were underage. Consent forms were read, explained, and signed. A signature was required before any questions connected to the research were asked. Each respondent was informed of her individual right to withdraw from the study any time during or after the session. Interviews were recorded. The recordings were transcribed and statements were analyzed by the researcher.

This section begins with an overview of the twelve participants who comprised the sample. Motifs from the interview data are then presented. The names of participants presented in this research are not real names. Pseudonyms are used to protect the identity of the participants.
Description of Participants

Participants’ demographic information is highlighted. This data set comprised twelve participants. The participants were all female and from Zimbabwe. The age range of the participants was 13 to 22 years. The length of stay in the United States ranged from 2 to 18 years. The majority of the participants had come to the United States with their parents, and two of the participants came to the United States to study. Table 4.4 below shows the sample’s demography.

Table 4.4. Participants’ Name, Age and Reason for Coming to the U.S

<table>
<thead>
<tr>
<th>Pseudonym</th>
<th>Age (Yrs)</th>
<th>Reason for coming to the U.S</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maria</td>
<td>15</td>
<td>Parents</td>
</tr>
<tr>
<td>Tafadzwa</td>
<td>16</td>
<td>Parents</td>
</tr>
<tr>
<td>Tinotenda</td>
<td>16</td>
<td>Parents</td>
</tr>
<tr>
<td>Mary</td>
<td>17</td>
<td>Parents</td>
</tr>
<tr>
<td>Pamela</td>
<td>18</td>
<td>Parents</td>
</tr>
<tr>
<td>Farisai</td>
<td>18</td>
<td>Parents</td>
</tr>
<tr>
<td>Gloria</td>
<td>19</td>
<td>Parents</td>
</tr>
<tr>
<td>Vanessa</td>
<td>20</td>
<td>Parents</td>
</tr>
<tr>
<td>Prudence</td>
<td>21</td>
<td>Studies</td>
</tr>
<tr>
<td>LoveJoy</td>
<td>22</td>
<td>Parents</td>
</tr>
<tr>
<td>Melissa</td>
<td>22</td>
<td>Studies</td>
</tr>
</tbody>
</table>

Findings

The first research question of this study is: What do Zimbabwean female adolescents in Atlanta know about HIV/AIDS transmission? Adolescents revealed different explanations; for example, when asked about general knowledge of what they knew about HIV/AIDS, respondents made comments such as, “It is a killing disease all
around the world.” One participant stated, “It’s a disease that has no cure, transmitted through sexual contact.” Another said, “A virus that attacks the cells of the body,” and “There is no cure and it is sexually transmitted.” Participants understood that HIV/AIDS was sexually transmitted. However, one participant was confused on how one protects herself from contracting HIV/AIDS. She indicated, “You can protect yourself through birth control and condoms.” It is generally known that birth control like the use of contraceptives such as pills cannot protect one from STDs and HIV/AIDS.

The second research question looks at the sexual behavior of adolescents: What are the sexual behaviors of Zimbabwean female adolescents? Most respondents agreed that abstinence and the use of condoms are the best precautions for HIV/AIDS prevention. Statements such as, “Use condom or do not have sex,” “Have protected sex,” “Abstinence, monogamous relationships, and protection,” indicated this. This suggests that there is some level of prevention knowledge. One respondent stated: “Condom use is a method not to get pregnant, or HIV but sometimes the condom break and that’s a misfortune if you are not planning to have a baby or someone is positive.”

Although adolescents’ knowledge of condom use is increasing, their usage lags far behind. Among the sexually active adolescents under study, 20% use such methods. This clearly indicates that there is a gap between knowledge and behaviors. It is evident that adolescents are aware of modes of HIV transmission, but do not apply their knowledge in practice.
Moise confirmed that informing adolescents about their sexual and reproductive rights helps them develop responsible sexual behavior. Eighty three percent (83%) of adolescents disagreed that it is solely a man’s decision to use a condom. Gloria has the following to say about men:

“Boys think about sex every second. I have the right and power to say to a guy, no sex without a condom, because it’s my body and at the end of the day if am sick I have to take care of myself, so prevention is better. People say, if you say no to a guy he will desert you. Fine. I will find someone else who will respect me” (Gloria).

On the contrary, Vanessa agreed that women have the right to say no to sex and to insist on the use of condoms but she said this is difficult:

“In my situation, women do not have the power to actually say no even though you have the right. As women we are not strong enough, we are lonely and we go out to look for a man to fill that gap of loneliness in our life.”

Asked if a guy/boyfriend tells you anything to get you in bed, does it mean he likes you or he will be faithful to you? The respondents answered:

Maria: It depends, not always.

Lovejoy: No, it means he wants to get in my pants.

Melissa: No, he just wants sex.

Do you have to be in a serious relationship before having sex? Respondents had mixed feelings. Some said it is necessary to be in a serious relationship before engaging in sex and some said “no.”

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Vanessa: No, but it would be smart to use protection if sex was involved.

Mary: No.

Farisai: It's the best option.

Nokhutula: Yes.

Melissa: Yes.

Vanessa: Yes.

Gloria: Sex before marriage is not good.

Gender inequality is mentioned as a deterrent to the use of condoms among female adolescents. Ultimately, there is an intrinsic need for including the impact of gender inequities into HIV Prevention programs due to the increased rates of HIV infection and risk behaviors among young women.

**Parental Involvement**

Asked about whether their parents talk to them about sex, one respondent answered:

"The truth is my parents do not and have never talked to me about sex. They feel embarrassed to talk about it. Where I come from, they say you do not have to have sex before marriage, so it’s hard to discuss such things with your parents. So I learn a lot from my friends, TV and internet" (Farisai, 16).

Gloria said talking to her parents does not affect her decisions about sexual behavior: "If parents say you do not have to have sex, when you are a teenager you do not listen and then you actually do it because you are experimenting" (Gloria).
Maria reported more than two male sex partners at her age and claimed that if only her parents talked to her about postponing sex, her behavior could have been different (15 years). Her friends were telling her that sexual availability is a way of expressing your femininity. So for fear of appearing unfeminine she had to indulge in sex with boys. Parents need to teach their children that having sex does not equal being a real woman.

The media has confused children that having sex is equal to making love. True love is not made out of sexual intercourse. The general lack of knowledge among adolescents about sexuality stems from the idea that sexuality is a topic largely ignored by most parents. Thus adolescents find themselves seeking help from friends or peers/wrong places.

Nokhutula said: “I learned quickly at home that I shouldn’t ask questions about sex to my parents. If I ask about sex the embarrassment evidenced by my parents quickly convinced me not to ask again. Out of curiosity, I had only two avenues for my ignorance-internet, books or information from friends.”

For today’s youth technology is the food of the day. Between smartphones, iPods, video games and the internet, being wired is a way of life. Sexting is now common. Teenagers have hundreds of online friends they have never met. This connectivity is affecting children’s intellectual development. It is also changing the nature of children’s relationships to their families. Parents need to get involved in their children’s digital lives. On the other hand some adolescents admit that their communication with their parents helps them to make informed decisions about sex. The following illustrates this: “Talking to my mom help me to make smarter decisions and listened also to use a condom” (Vanessa).
“It influence how I respond and make decisions and been more careful.” (Melissa).

“I have not yet indulged into sexual intercourse” (Gloria).

Mary stated that communication with her mother helps her to make informed decisions:

“My mom spent a lot of time saying to me, ‘Don’t sleep around and you’d better not get pregnant.’ I was afraid to do anything because she always threatens to send me away if I do it. She would tell me that our culture allow us to serve sex for marriage. You don’t have sex before you are married. This would make the family proud and not shameful. To some extent talking to my mother affect my decisions about having sex. Even if I try to engage in sex, I always feel and hear my mother’s voice and constantly stop it” (Mary, 17).

Mary admitted that talking to her mother made her commit to abstinence before marriage.

The third research question highlights the source of information for the adolescents: How do Zimbabwean female adolescents in Atlanta learn about HIV/AIDS prevention? Most respondents stated that they learn a lot from friends, school, internet, media, books and magazines. Few of them mentioned parents as the source of their information:

“School and friends” (Nokhutula).

“School and parents” (Mary).

“Health department, media, friends and internet” (Tinotenda).

“Parents, friends, books and magazines” (Melissa).

“Television, internet and friends” (LoveJoy).
Friends/Peers

Peer pressure is definitely a force to be reckoned with. The most frequent source of information came from peers who rarely knew any more than we did (their colleagues). Looking at the socialization process, another respondent remarked:

“When my mom first talked to me about sex, I was like, “I know all this, Mom, because I learnt a lot from my friends” (Pamela, 18).

Most young people feel comfortable and open to talk to their friends than their parents. Most young people have the impression that virginity is rare in high school, so they just have to have sex to get rid of their virginity. Tafadzwa confirmed that:

“Most girls at my school are having sex. Some of them receive money, clothes and gifts for sex. They laugh/mock you if you are still a virgin. At the beginning my friends were having sex and they encouraged me to have sex. They said it’s not a big deal; you do not have to be afraid. I wanted to fit in, so I had it as well.”

As Prudence stated:

“Some girls think that the boy’s status that is being handsome, smart, a footballer, or an athlete will become theirs, through having sex with the boy” (Prudence).

Zimbabwean adolescents face challenges growing up in America due to different socializations. Vanessa indicated:

“I was nine years when we came to America. There is a lot of peer pressure in America. When you go to school everyone is against you basically if you do not have sex. They say, you do not have sex and if you say no, they laugh at you. So you end up having sex
to please your boyfriend and friends. I had sex at fifteen because of peer pressure. I did not want to do it. Honestly, there is a lot of peer pressure here in America” (Vanessa).

Coping up with identity as Zimbabweans is a challenge for adolescents. One respondent emphasized that some of their classmates think they are backward when they respect their culture that says no sex before marriage. Young women need to be taught about self-deception, about self-esteem and self-efficacy. It is important to talk to young women about having a sense of control and pride over their bodies. They have to be able to make right decisions and choices about themselves.

**Culture and Socialization**

The fourth research question looks at the role of culture in the socialization and sexual behavior of adolescents: What is the role of culture in Zimbabwean adolescents’ sexual behavior? Culture becomes the lens through which we perceive and evaluate what is going on around us. Society as well is shaping us. Society tells us how to think, feel, and act. Interaction is the way that we learn about who we are as individuals and whom we are in relation to others in society. Every group develops expectations concerning the right way to reflect its values. Gender roles are socialized; they are learned at a very early age. In fact, children begin to understand what it means to be masculine and feminine as early as the age of three.

Gender often times serves as a basis for social inequality providing more freedom for one group over another. For instance, one of the erroneous expectation or belief shared by many women based on the African culture is that the man should be the authority in sex, that the man is responsible for condom use. Expecting this to be the case
can lead to fear among young girls to negotiate safer sex. This is best described in the words of Gloria: “Our fear to tell your boyfriend to use a condom stem from the belief that the man should know all there is to know about sex. After all, isn’t a woman trained to be innocent until married, when her husband is then supposed to teach her the things she needs to know about sex? Most of us have never been given much accurate and specific information about sex, but rather have been led to believe that sex is a man’s area of expertise.”

Many women have been trained into passivity. They have been taught to hold back, or hide their strength and desires. Hence feelings of powerlessness can result from not asserting oneself.

“Our culture does not allow women to have control over their body, making it difficult for us to demand safe sex” (Vanessa, 20).

Women’s lives are not considered important by many societies, hence denied respect and their human rights. It is essential to transform that culture of female docility and submissiveness, so that women become more assertive and stand up for themselves. As a basic human right, women should be able to control their bodies and with good respect.

Asked if there are differences in terms of socialization between American and Zimbabwean culture, respondents concurred that there is a huge difference. Zimbabwean adolescents find it difficult to cope up with the environment. Respondents mentioned that they have challenges in socializing with American friends because American children have the perception that African kids are not equal or smart like American kids. Lovejoy who came to the United States when she was thirteen years reiterated:
“There is a big difference between Zimbabwean culture and American culture because there are so many things that we are allowed to do here than in Zimbabwe. For example, in America it’s okay to have sex at a young age and in the Zimbabwean culture it’s unacceptable at any age before marriage” (Lovejoy).

Farisai concurred with this notion:

“As we grow up as kids there is a certain level of maturity. My American friends say at sixteen you are mature enough to be indulging in sex. Once you have sex that a big step, so you have to face the consequences and Americans do not take it seriously like Zimbabweans do. It is very hard to cope up with our identity and culture here in America and do as we were brought up. I’m proud of my culture and I would say for the most part, I emphasize that I’m not American, of course they pick up the accent, and I even tell them that I do not tolerate their way of life.”

Prudence explored that she experienced culture shock interacting with the Americans.

“At first, I found these unfamiliar behaviors upsetting, like approaching a guy and tell him you like him, because they violated my expectations of how people ought to behave based on my culture. I experienced a culture shock when I discovered that cultural ideas and expectations were different” (Prudence).

Tafadzwa indicated:

“In America you can go out to a club. It’s okay to have sex with a man you are attracted to. It’s okay to be gay, it’s accepted. In my culture, it’s unacceptable to go out and have sex with anyone just because you are attracted to him; you must be in a serious relationship or be married before having sex” (Tafadzwa).
American youth in general are over exposed to sex, substance abuse, and violence. Zimbabwean youth living in urban areas such as Atlanta often experience increased over exposure of sex, substance abuse, and violence and this often turns into self-destructive behaviors due to lack of appropriate initiatives.

Melissa stated:

“Because you are an African, you may have AIDS because they believe AIDS came from Africa” (Melissa).

Coming into contact with a radically different culture challenges our basic assumptions of life. Most respondents agreed that they experienced culture shock when they came to the USA. Some of their beliefs, norms and value systems were different. Zimbabwean youth often find it very difficult, if not challenging, to always be judged through a European social construct or structural lens. They have separate needs when assimilating into the American culture. They are not fairly judged or equally compared. Zimbabweans operate within an Afrocentric cosmology. The Afrocentric paradigm is based on the conscious knowledge and respect for the diverse African culture.

**Programs**

The researcher posed this question: Are there any support systems in America for immigrants? To examine if there are services geared towards immigrants/foreigners in the U.S. The majority of adolescents were not aware of programmes being implemented for adolescents or immigrants. In addition, those who were aware of such programmes could not access or use the services due to racial and sociocultural barriers. Furthermore, lack of insurance for most immigrants permeates the inability to navigate the mainstream
health care system. Asked about intervention programs for immigrants, a respondent answered:

“No, we have heard of programs on HIV/AIDS but we have not participated in those programs. If we are exposed to such programs, it would be good, because we would be educated about AIDS and gain more knowledge on prevention” (Tinotenda, 16). If these voices of young women are implemented, this will empower adolescents to be aware of, knowledgeable about and exercise their sexual rights. One respondent who is in college queried that:

“Our culture teaches us that abstinence is the preferable option but HIV interventions should not insist on a single strategy; they must take into account the reality of young people’s lives, in which sexual activity plays a role. Young people are having sex, they are not abstaining, that is the reality” (Melissa, 22).

Lovejoy believed that education is the key for overcoming HIV/AIDS:

“If people are educated, then women will not be abused, raped or ill-treated. That is why many societies are afraid of educating women because they know once educated they can stand up for themselves” (Lovejoy).

Participant willingness to contribute towards HIV/AIDS intervention programs and community service was a positive highlight of the study. Most participants were willing to contribute at different levels towards such efforts.

Many programs for young people are implemented by adults. Young people must be involved in intervention programs. Prevention programs should instruct young girls about sexuality and reproductive health. Adolescents must develop an awareness of their
risk. It is clear that services for immigrants/foreigners are required to meet adolescents' health needs, yet adolescents throughout the world face limited access to such services.

The majority of the respondents were knowledgeable regarding HIV transmission and prevention. However, based on the findings, most adolescents are not practicing the behaviors of safer sex that are effective in preventing HIV transmission.
CHAPTER 5
CONCLUSION AND RECOMMENDATIONS

This study outlines the need to focus on young Zimbabwean sexually active adolescents as a distinctive risk group. Sexual activity is common among adolescents and is likely to have serious consequences in their life course. Although girls and boys need medically correct sexuality education, including education on HIV/AIDS, sexually transmitted diseases (STDs) and behavior, the findings suggest that such education is not enough. This finding tallies with other studies such as Rosenthal, Ryan, and Khaliq that found a need for increased education about HIV/AIDS among immigrant communities. This study showed that most participants had knowledge of the HIV/AIDS disease. However, the results have positively indicated the shortcoming related to adolescent’s sexual behavior. Information, education and communication are essential in the fight against AIDS. If our young girls become more educated they can protest and speak up for themselves. As Martin Luther King Jr. put it during the American civil rights struggle: “We must straighten our backs and work for our freedom. A man can’t ride you unless your back is bent.” It is important to help young girls find their voices. Education and empowerment training can show girls that femininity does not entail docility, and can nurture assertiveness so that girls and women stand up for themselves. Education and empowerment is what is truly needed for girls and women to be more assertive and fight back. However, empowering women begins with education. An African proverb says,
"You educate a girl, and you are educating an entire village." Investing in educating female adolescents will result in women having more economic value and more influence in society, and that would help curb the spread of HIV/AIDS.

Understanding the learning and development processes of Zimbabwean adolescents is an important factor in assisting them to achieve productivity and success. Child and youth development includes social, physical, educational, and emotional. There are several areas of development that affect Zimbabwean adolescents particularly during their teen years. Adolescents are at a point in their lives where they are facing many decisions regarding sexual behavior, and risky sexual behaviors are one of the most common ways to become infected with HIV/AIDS. HIV is a special problem for women, in part because of biology. Women are about twice as likely to be infected during heterosexual sex with an HIV-positive partner as men are. That is because semen has a higher viral load than vaginal secretions do, and because women have more mucous membranes exposed during sex than men. Although the findings show that a majority of Zimbabwean adolescents have heard of HIV/AIDS, many do not believe that they personally run any risk of becoming infected. Despite having a higher level of knowledge they do not protect themselves against infection because they lack the necessary skills, support and resources to behave appropriately. Knowledge alone is insufficient. There is need to promote healthy sexual behavior. Effective educational programs promote critical thinking, decision-making and skills which support the adoption of healthy behaviors and the reduction of high-risk behaviors. Furthermore, programs for adolescents must apply social learning principles to behavior change. The learning
process is the process of acquiring and gaining growth, knowledge, and understanding, or skill. The learning process makes what we teach our children even more important. It has the potential to have a lasting effect on adolescents’ perceptions and behaviors.

Adolescent years or maturation years are an important growth and developmental period. If we can reach youth before they become sexually active, we may be able to reduce the number of new infections. Because early sexual activity is interwoven with many developmental issues and contexts, no single intervention model or strategy is likely to be effective. This suggests a compelling need for all agencies or social workers involved with the health and well-being of adolescents to consider their role in intervention and address the various aspects issue cross-culturally. The objective of sex and HIV/AIDS education is to lead young people to engage in responsible sexual behavior.

Fewer studies focused on condom use among female adolescents only. In addition, all of the participants, in their own individual and private interviews, stated that HIV prevention education should be geared towards and tailored to Zimbabwean adolescents. The participants felt that many young girls are engaging in risky sexual behaviors and not using condoms which ultimately place them at greater risk. They also acknowledged that, in their opinion, men do not like to use condoms and some Zimbabwean young women are not empowered to enforce condom negotiation within a sexual interaction, thereby placing them at increased risk for HIV and AIDS infection. Additionally, beliefs promoting male dominance, female sexual submissiveness, and violence contribute to the likelihood that an adolescent female will agree to unsafe sexual
practices. The reality is that HIV/AIDS is a disease of gender inequality. Particularly in many parts of Africa, because of culture female adolescents do not have the power to say no to unprotected sex and so HIV spreads relentlessly. Therefore, gender inequality, as Stephen Lewis, the former UN ambassador for AIDS has said, “Gender inequality is driving the pandemic.”

Women are suffering and dying because societies have yet to make the decision that their lives are worth saving. The Lancet noted that the neglect of women’s reproductive health issues does reflect some level of unconscious bias against women at every level, from the community to high-level decision makers. Programs to protect young women from sexual exploitation and HIV infection must also address men. Men are key to reducing HIV transmission and have the power to change the course of the AIDS epidemic. Focusing on women’s empowerment is critical, but it has to be complemented by involving and empowering men and changing male attitudes, stereotypes and behaviors that further the spread of HIV. If men could respect and pay attention to the problem of HIV/AIDS it can make a real difference in the lives of women. HIV infection can be greatly reduced in large numbers. The solution lay in improving gender equality.

Familiarity with the ethnic and cultural backgrounds of adolescents is a key component in effective programming. In traditional Zimbabwean communities, sex education is the job of aunts, uncles, elders in the community, and grandparents. Initiation ceremonies marked the transition of boys and girls from adolescence to

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adulthood. However, these cultural practices are subjugated and suppressed by westernization; these practices are deemed backward. Furthermore, for those in the Diaspora, the children are living with their parents. They left their aunts, uncles and grandparents back home in Zimbabwe. The aunts and grandparents were traditionally important in the education of adolescents. The social bonds and traditions that used to shape young people’s behavior and help them make the transition to adulthood have weakened in the face of migrating to western countries. This has resulted in the breakdown of the extended family. Young people adopt new western attitudes toward sexuality. Although some of the adolescents still hold to traditional values regarding marriage, negative male sexual attitudes and western socialization were perceived as major factors that make females of their age vulnerable to HIV infections. Zimbabwean adolescents in the Diaspora are faced with a double jeopardy of the western culture versus the African culture. The western culture of individualism is at liberty for adolescence to have sex. American adolescents in general are over exposed to sex, substance abuse, and violence. Zimbabwean youth living in urban areas such as Atlanta often experience increased exposure of sex, substance abuse, and violence, and this often turns into self-destructive behaviors due to lack of appropriate initiatives. Many Zimbabwean adolescents today, especially in the Diaspora, lack the accountability that used to be offered by the aunts or grandparents, in keeping the girls pure until they marry. Experimentation, peer pressure, and the media filled with western culture have become the sources for adolescents’ sex education and socialization. It is through experimentation that some of these adolescents may be exposed to the HIV infection. It is the duty of
parents who are in the Diaspora to educate their children, since the aunts and 
grandparents are not with them in the Diaspora. Some parents are embarrassed to talk to 
their children about sex but then complain when what the media teaches is against their 
values. Most of the adolescents already know about this material from school, friends or 
from the media; however, what they need from their parents is the right application of the 
information. It is important for parents to teach their children about sexual responsibility. 

Zimbabwean adolescents often find it very difficult, if not challenging, to always 
be judged through a European social construct or cultural lens. They have separate needs 
when assimilating into the American culture. They are not fairly judged or equally 
compared. Zimbabweans operate within an Afrocentric cosmology. The Afrocentric 
paradigm is based on the conscious knowledge and respect for the diverse African 
culture. The difference between the Western and African cultures is that the Western 
culture is individualistic whereas the African culture is communal. The western world 
seems to emphasize “each person is for himself or herself, and God for us all.” Most 
African communities believe that the roots of an individual’s personal identity are rooted 
in the community to which one belongs, thus the common saying, “I am because we are; 
since we are, therefore, I am.” ³ Interdependence is very crucial for African people. 
Africans see themselves in light of either the community to which they belong or their 
communal relationships. The saying, “It takes a village to raise a child,” also points to the 
involvement of community in giving individuals an identity. It is imperative for the 
Zimbabwean community in Atlanta to work together and come up with programs that 
educate or socialize in giving their children an identity. An anonymous elder purported:

"If you can capture the youth and change the way they think, then you can change the future." Most of the adolescents I interviewed agreed that it would be a good idea to have such kind of programs in place for them. The battle against HIV/AIDS involves a global village.

Considering these aspects, current programs and policies that target immigrant population need to be modified. The following actions are recommended:

1. Explore additional HIV education and culture for the young women in this study in addressing individual and collective risk for HIV and AIDS infection. Zimbabwean adolescents need to recognize the urgency of condom use. By being able to negotiate condom use, the negotiator is empowered and gains control over her body.

2. Conduct other studies on Zimbabwean adult women regarding their perceptions of risk for HIV and AIDS infection.

3. Conduct a study with Zimbabwean adolescent boys in the Diaspora and other African men for understanding their perceptions of condom usage and safe sex practices.

4. In traditional Zimbabwean communities, sex education is the job of aunts, uncles, elders in the community, and grandparents. However, for those who migrated to the Diaspora, the children are living with their parents. They left their aunts, uncles and grandparents back home in Zimbabwe. Therefore, it is important to develop parent-child communication programs where issues such as contraceptive
use, sexuality and socialization can be discussed in a non-threatening environment.

5. There is a need to develop culturally sensitive and culturally competent interventions among immigrant communities and also involve adolescents in the process of developing these interventions so as to gain their confidence and trust.

6. Health services should be “user friendly” that is accessible and non-judgmental to immigrants or foreigners.

In conclusion, this study explored the effects of gender issues, culture and socialization on Zimbabwean female adolescents at risk of HIV infection and gave participants the opportunity to discuss their lived experiences in the United States from their perspective and in their own words. The focus of this study was ultimately on the knowledge of HIV transmission, sexual behavior and socialization among Zimbabwean female adolescents in Atlanta, Georgia.

This study utilized the Social Cognitive Theory as the theoretical framework in that it maintains that behavior is largely regulated antecedently through cognitive processes. It teaches empowering a person to engage in understanding risk behaviors, and to adopt health behaviors. This study also employed Self-efficacy Theory, which is concerned with people’s beliefs in their capabilities to perform courses of action to attain a desired outcome. Awareness of risk perceptions helps young people to learn to see actions as causes of events and believe in the changeability of heath risks and risky habits. By educating adolescents on their level of risk of unhealthy behaviors, they can be empowered to change and lead a healthier life with the newly acquired understanding.
Because the participants of this study detailed their lived experiences as foreigners in their own words and gave insight into factors that contributed to their risky sexual behaviors, the findings from this study provide important information to facilitators, educators and health professionals to consider gender specific and culturally relevant programming.

This study suggests that to understand the sexual behavior of Zimbabwean adolescents in the United States, researchers must examine more closely sexual socialization within the African cultural context and take African culturally-influenced beliefs and practices into account. Communication strategies to confront AIDS must view culture as an ally. Effectiveness in any environment demands that one be familiar with the cultural context in which one finds oneself working. Attributes of a Zimbabwean culture that are helpful for confronting AIDS should be identified and harnessed.
APPENDIX A

CLARK ATLANTA UNIVERSITY
Institutional Review Board
Office of Sponsored Programs

February 14, 2011

Ms. Loveness Mabhunu <Lmabhunu@yahoo.com>
Dept of African-American Studies
Clark Atlanta University
Atlanta, GA 30314

RE: Knowledge of HIV transmission and sexual Behavior among Zimbabwean
Adolescent Females in Metropolitan Atlanta, Georgia.

Principal Investigator(s): Loveness Mabhunu
Human Subjects Code Number: HR2011-1-375-1

Dear Ms. Mabhunu:

The Human Subjects Committee of the Institutional Review Board (IRB) has reviewed
your protocol and approved of it as exempt in accordance with 45 CFR 46.101(b)(2).

Your Protocol Approval Code is HR2011-1-375-1/A

This permit will expire on February 13, 2012. Thereafter, continued approval is
contingent upon the annual submission of a renewal form to this office.

The CAU IRB acknowledges your timely completion of the CITI IRB Training in Protection
of Human Subjects – “Social and Behavioral Sciences Track”. Your certification is valid
for two years (10/2012).

If you have any questions, please contact Dr. Georgianna Bolden at the Office of
Sponsored Programs (404) 880-6979 or Dr. Paul I. Musey, (404) 880-6829.

Sincerely:

Paul I. Musey, Ph.D.
Chair
IRB: Human Subjects Committee

cc. Office of Sponsored Programs, "Dr. Georgianna Bolden" <gbolden@cau.edu>
   "Dr. Josephine Bradley <jbradley@cau.edu>

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Formed in 1948 by consolidation of Atlanta University, 1865 and Clark College, 1868
APPENDIX B

CLARK ATLANTA UNIVERSITY
AFRICANA WOMEN’S STUDIES DEPARTMENT

KNOWLEDGE OF HIV TRANSMISSION AND SEXUAL BEHAVIOR AMONG ZIMBABWEAN ADOLESCENT FEMALES IN ATLANTA, GEORGIA

CONSENT FORM

I am a graduate student from Clark Atlanta University. I invite you to participate in a research study entitled “Knowledge of HIV Transmission and Sexual behavior among Zimbabwean Adolescent Females in Atlanta, Georgia.” You were selected as a possible participant because you are a female adolescent from Zimbabwe. We ask that you read this form and ask any questions you may have before agreeing to be in the study. This study is being conducted by Clark Atlanta University. The purpose of this study is to find out the knowledge of HIV transmission you have and sexual behavior in relation to HIV/AIDS. If you volunteer to participate in this study, you will be asked to complete the survey and return it in the provided envelope and participate in an interview. Completing the survey will take approximately 20 to 30 minutes. Your involvement in the study is voluntary, and you may choose not to participate or to stop at any time without penalty or loss of benefits to which you are otherwise entitled. You can ask to have all of your identifiable information returned to you, removed from the research records, or destroyed. No risks or discomforts are expected. You can skip any questions that you are uncomfortable responding to. No incentives will be given for participating in this study.

So that I can make certain that I get all of the information during our interview, I will make a tape recording of the discussion. The recordings and the survey will be kept strictly confidential and will not be made available to anyone else. The results of the research study may be published, but your name will not be used. Your identity will not be associated with your responses in any published format. The information gathered will be kept private for at least 3 years in a locked file; only the researcher will have access to the records. Federal regulations require that data and all other records connected to the research be kept for this time period (3 years). Contact information will be removed from the data and destroyed by January 31, 2014.

If you have any questions about this research project, please feel free to contact me at 857-383-1832 or send an e-mail to lmabhunu@yahoo.com. If you have any questions now, or later, related to the integrity of the research, you are encouraged to contact Dr. Georgianna Bolden at the office of Institutional Review Board (404 880-6979) or Dr. Paul Musey, (404 880-6829) at Clark Atlanta University.

You will be given a copy of this form to keep for your records.
Statement of Consent: I have read the above information. I have asked questions and have received answers. I consent to participate in the study.
Signature______________________________________________ Date:______________
Signature of Investigator_________________________________ Date:_____________
APPENDIX C

QUESTIONNAIRE
Please answer the questions by placing a "X" in the box. Choose only one answer for each question. If you do not feel comfortable answering a question, you do not have to answer it, just go on to the next one.

DEMOGRAPHY
1. Age:
2. Educational Level:

KNOWLEDGE OF HIV TRANSMISSION
3. Have you ever heard about HIV/AIDS? Yes ___ No ___ Don't Know ___
4. Where do you get most of the information about HIV/AIDS? Circle all that applies: a) parents b) media c) school d) Internet e) friends
5. Can you become infected with HIV if you have oral or anal sex, but not vaginal sex? Yes ___ No ___ Don't Know ___
6. Can you get HIV through casual contact with infected people? Yes ___ No ___ Don't Know ___
7. Can you tell by looking at someone if they have HIV/AIDS? Yes ___ No ___ Don’t Know ___
8. Can you get HIV from the bite of the mosquito or other type of insect? Yes ___ No ___ Don’t Know ___
9. You can get HIV through sharing a drinking glass with an HIV infected person? Yes ___ No ___ Don’t Know ___
10. You can get HIV through sharing a toilet seat/bathroom with an infected person? Yes ___ No ___ Don’t Know ___
11. Can you get HIV by wearing clothes that were worn by someone who has HIV? Yes ___ No ___ Don’t Know ___
12. The use of condoms reduces my chances of contracting HIV? Yes ___ No ___ Don’t Know ___
13. Is it possible to have the virus that causes AIDS without being sick from AIDS? Yes ___ No ___ Don’t Know ___
14. Is there a vaccine that can protect me from HIV? Yes ___ No ___ Don’t Know ___
15. Is there a cure for HIV? Yes ___ No ___ Don’t Know ___
16. Having HIV means the person is promiscuous and immoral?
   Yes____        No____        Don’t Know____

**SEXUAL BEHAVIOR**
17. Have you ever had sex in your lifetime?   Yes____   No____
18. Have you ever had sex with two or more partners in the past 12 months?
   Yes____        No____
19. How old were you when you had sex for the first time?
   _______________
20. It is natural for me to have more than one sexual partner.
   Agree____    Disagree____  Strongly agree____ Strongly disagree____
21. Did you use a condom at last sex?   Yes____   No____
22. Have you used needles or syringes that were used by anyone other than you?
   Yes____        No____
23. Have you ever given or received sex for gifts or money?   Yes____   No____
24. Do you think alcohol and drugs influence your sexual behavior?
   Yes ____       No ____       Don’t Know____
25. Are most girls at your school having sex?   Yes____   No____   Don’t Know____
26. Have you ever been encouraged by friends to have sex? Yes____ No____ Don’t Know
27. Can you tell your boyfriend who wants to have sex that you don’t want to have sex at present?  Yes ____       No ____
28. Can you tell your boyfriend that you want to use condoms?  Yes____  No____
29. How much do you worry about contracting HIV/AIDS?
   Not at all______    A little______    A lot______
30. Abstinence from sex would protect me against HIV.  Yes____ No____ Don’t Know____
APPENDIX D

INTERVIEW QUESTIONS

1. Age:
2. Educational Level:
3. How old were you when you came to America?
4. What do you know about HIV and AIDS?
5. How do people protect themselves from contracting HIV?
6. How do you feel about having sex with a condom?
7. If you have to use a condom, what would be the main reason for using it?
8. Where do you get the information about sex?
9. Had your mother/father ever talked to you about having sex?
10. How has talking to your mother/father affected your decisions about sex?
11. Do you think women need a man in their lives to be whole/complete?
12. Is it okay for a boy to be forceful in getting his girlfriend to have sex?
13. If a guy/boyfriend tells you anything to get you in bed, does it mean he likes you or he will be faithful to you?
14. Do you have to be in a serious relationship before having sex?
15. Does a woman have the right to say “No” to sex?
16. Can you tell your boyfriend who wants to have sex that you don’t want to have sex at present?
17. Does your culture and identity affect your decisions about sexual behavior?
18. How do you describe your growing up in America? Are there any support systems for immigrants?
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