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Using focus groups to develop HIV education among adolescent females in Zimbabwe

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SUMMARY

Seventy-eight adolescent females from Zimbabwe participated in focus groups to assess need for HIV/AIDS prevention and education. The interview guide dealt with HIV transmission, prevention and education. Results show a high level of awareness regarding HIV transmission, however, myths and misconceptions still persist. General AIDS information was perceived as widely available, but individual counseling was perceived as nonexistent. Although most of the young women still hold to traditional values regarding marriage, negative male sexual attitudes and economic hardships were perceived as major factors that make females of their age vulnerable to HIV infections. Participants recommended face-to-face, gender-specific HIV/AIDS prevention and education. Nurses, physicians, persons living with AIDS and church officials were identified as possible facilitators. Based on this focus group experience, future efforts in developing comprehensive AIDS prevention and education programs should target adolescent and adult males in order to assess salient issues regarding HIV/AIDS prevention and education.

Key words: adolescent females; focus groups; HIV/AIDS; Zimbabwe

BACKGROUND

The government of Zimbabwe adopted a primary health care (PHC) delivery system in 1982 to provide health care services to its rural populations. Health education was considered the cornerstone under PHC delivery services and community participation in program planning and implementation became a prerequisite to program success (Ministry of Health, 1986). About half of Zimbabwe's population of about 10 million is under the age of 15 years. Although Zimbabwe has made significant progress in providing primary health care services to its general population, specifically in the area of maternal and child health services, HIV infections and AIDS threaten to retard those gains.

In Zimbabwe, reported cases of HIV infections and AIDS show a distribution of cases by gender and age that is consistent with the literature on the rest of sub-Saharan Africa. According to the National AIDS Control Program (Ministry of Health, 1992), the male-to-female ratio is nearly 1:1 among adults; incidence is highest among the very young (0–4 years) and the sexually active young adults (20-39 years). This pattern highlights the heterosexual mode of transmission and points toward a need to identify factors which influence HIV transmission among a defined target population for the purpose of developing effective intervention. Youth and adolescents remain at a greater risk for contracting the AIDS

virus, especially females because of limited economic opportunities upon graduating from high school. The socio-economic inequality directly contributes to high risk practices among young females such as turning to prostitution (commercial sex workers) with rich adult men (Van de Walle, 1990). Youths and adolescents are under tremendous pressure to satisfy immediate needs such as food, clothing and shelter. These clearly more compelling needs seem to overshadow the adolescents' desire for preventing high risk practices that could expose them to contracting HIV.

In developing countries, lack of participation in the planning process by program participants is considered a major cause for program failure (Bryant, 1972; Airhihenbuwa, 1993). Because of strained financial and human resources, Zimbabwe has been slow in developing comprehensive health education for its youth and adolescent population. Baseline needs assessment data on health knowledge, attitudes and practices by age, gender, geographical location, marital status, educational level or income are not available at the national level. As the impact of HIV/AIDS begins to weight heavily on a health care system that has other health care needs competing for limited resources, these data are going to be critical for planning intervention programs.

PURPOSE OF THE STUDY

This study used a social marketing strategy, the focus group approach, to identify need for HIV/AIDS education and prevention among adolescent females participating in self-help groups organized by church groups and a mining company in Zimbabwe. Specific objectives for conducting focus groups among adolescent females in self-help groups were to:

(i) assess knowledge, attitudes and practices related to transmission and prevention of the AIDS virus;
(ii) identify salient issues among adolescent females related to HIV/AIDS prevention and education; and
(iii) identify factors perceived by adolescent females as enabling or reinforcing the adoption of HIV/AIDS prevention and education messages.

SIGNIFICANCE OF THE STUDY

The World Health Organization (WHO) Adolescent Health Program (1990) has called for studies on behavioral patterns, beliefs and cultural values in youths and adolescents prior to program implementation. Traditionally, data gathering methods to identify needs or wants of a target population that yield quantitative as opposed to qualitative data tend to dominate social science research. Focus groups are known to yield a great deal of information which would not be revealed if conventional quantitative methods were used. According to Kotler and Zaltman (1971) and Lefebvre and Flora (1988), the focus group interview approach demands that most effort be spent on discovering the wants of the target group and then creating the goods and services to satisfy them. Several studies (Smith, 1984; Glik *et al.*, 1987/1988; Airhihenbuwa, 1988; Clift, 1989; Egwu, 1991/1992) have demonstrated the utility of the focus group approach in behaviour analysis among specific target groups in developing countries. Furthermore, according to Green and Kreuter (1991), focus group interviews have the potential to reduce the gap between the target population and the planning team by permitting uninhibited discussion on both cultural and socio-economic issues.

The results of this study are likely to result in programmatic changes in the 'Fight-Against-AIDS Campaign' which is currently being implemented among employees and their dependants in the mining community of Hwange, Zimbabwe. At the time this project was conducted, there were no structured programs addressing HIV/AIDS among adolescents. Participants in this study were enrolled in self-help groups organized by churches or the mining company for the purpose of helping unemployed adolescent females learn skills such as dress-making or typing. Because one of the main goals of the Fight-Against-AIDS National Campaign is to reach young people in places where they make their daily decisions or where lifestyle behaviors are exhibited, these self-help groups were found to be ideal for assessing the need for HIV/AIDS prevention and education programs among adolescent females.

METHODS

The interview guide

Research questions and scenarios were used to develop the interview guide. The following are sources for in-depth detail on how to develop an interview guide: Agency for International Development Report PN-AAL-008 (1991); Stewart and Shamdasani (1991); Glasser and Strauss (1967). Three university professors in the United States with expertise in conducting focus group interviews validated the interview guide. After receiving feedback, the interview guide was refined and then sent to Zimbabwe where a trained health educator with expertise in HIV/AIDS and knowledge about the culture of the target group reviewed the interview guide for cultural sensitivity and cultural appropriateness. The health educator pretested the interview guide for clarity, sequencing and time required to complete the interview. About 55–65 min was needed to complete the interview. A complete copy of the proposal was then sent to the Research Council of Zimbabwe and to the University of Akron Institutional Review Board for authorization to conduct the study, which was granted. The interview guide contained an introduction, the purpose of the meeting and the rules guiding the interviews, including participants' anonymity and confidentiality. Identifying self, other people or location by name was not allowed. Although participants were encouraged to express themselves openly, each participant was free to remain silent and disclosure of sensitive personal information was discouraged. Consent to tape-record the discussion was obtained from each participant.

Subjects

Adolescent females from Wankie Colliery Company participating in self-help groups organized through the company and church organizations participated in this study. The self-help groups provide unemployed high-school graduates with skills in areas such as typing, farming, sewing, or playing amateur netball. To recruit participants, the Community Welfare and Recreation Division was contacted to identify existing organizations in the company offering self-help groups to adolescent females. Ten groups were identified; eight were church-sponsored and two were run by the company. All ten groups were contacted by telephone and followed up by a personal visit from a member of the research team. Except for two church-based groups which had scheduling problems, the rest agreed to participate in the study. Five of the church-based groups trained adolescent females in dressmaking (commonly referred to as sewing) and one church group was a youth club involved in Bible studies and vegetable gardening. The two self-help groups organized by the company sponsored an amateur netball team (similar to basketball) and a typing school. The amateur netball team represents the company in regional and national competitions while some of the students from the typing school are employed by the company in secretarial positions after successfully completing their training.

To qualify, an individual had to meet the following criteria: (i) they had to be between the ages of 15 and 22 years; (ii) must be a high-school graduate or a dropout; and (iii) be unmarried (single parent within the 15–22 years age range). After the screening process was completed, a total of 78 adolescent females qualified to participate in this study. Each of the six church-based groups had an average of seven participants (n = 42). However, the company sponsored self-help groups, i.e. netball and typing, each had 15 and 21 adolescent females respectively (n = 36). Because an average focus group was to consist of 6–12 participants, netball and typing teams were each divided into two groups making a total of ten focus groups.

Focus group interviews were conducted over a period of 3 days. Each interview session took between 55 and 65 min to complete. Audio tape recorders were pretested to determine any recording problems before the interviews started. Since all the facilities had electricity, audio taping was done using electrical power instead of batteries. All recorded audio types were clearly coded for identification.

Focus group moderator

Two local single females, ages 23 and 24 years, employed by the company were recruited to participate as focus group moderators. The two were interviewed separately by members of the research team. The purpose of the interview was to assess (a) fluency in English plus all three of the local languages commonly spoken in the area (Sindebele, Shona and Nambiya); and (b) level of comfort when talking to other females about AIDS and other sexual issues. Although focus group interviews were to be conducted in English, it was necessary that the moderators be fluent in the three major ethnic languages spoken in this part of Zimbabwe, because of the technical nature

of the subject. Both participants and moderators were allowed to use a local language if necessary. Moderators were trained for 2 days, each meeting lasting for 2 h. Training was intended to familiarize the moderators with the interview guide and the data collection process, especially with respect to interviewing skills including follow-up questions and nonverbal communication. Moderators held mock focus group interviews under the supervision of a member of the research team, paying special attention to back-translation using English and the three main local languages.

Data collection

At the beginning of each session, a female member of the research team, who acted as the project supervisor, introduced each moderator, spelled out the purpose of the project, explained the reasons for the audio recording of sessions, assured participants of anonymity and confidentiality, and invited any questions regarding the project. Because of the sensitivity of the topic and the apparent uneasiness among these young females, the project supervisor assured them that men were not going to be allowed to come to these discussions or even to listen from a distance, including the male member of the research team. Before the sessions started, demographic data on age, education level and type of self-help group were collected using a questionnaire. The interview format used semi-structured, open-ended questions with three to four follow-up/trigger questions. Before making a transition to the next major question, the moderator summarized the responses (see Appendix).

Incentives to participate in the project included refreshments before, during and after the interview session; entertainment, i.e. dancing to popular local music before and after the interview sessions; a group picture and an opportunity to have questions about HIV/AIDS answered by members of the research team. All members of the self-help groups including married women were invited to participate in the question-and-answer session. The question-and-answer session was intended to provide the research team with answers to specific questions about HIV/AIDS, some of which may have come up during focus group interviews. It also provided an opportunity for the research team to hear from married women. Refreshments and local music were intended to help the participants to relax.

Data analysis

The constant comparative method of analysis described by Glasser and Strauss (1967) was used to analyze the data from this study. The research team and two focus group moderators listened to each tape three times. The first time, tapes were checked for clarity, flow of discussion was compared with the interview guide and any portions where a local language was used were identified so that translations could be done. During the second review, each tape was transcribed, and relevant notes and observations from nonverbal communication were incorporated. During reviewing and transcribing of the recorded tapes, the two focus group moderators provided their input regarding observations on nonverbal communication during interviews. Open coding, grouping of concepts, interpretation and writing of the report was done by members of the research team only. Information gathered from the ten focus groups on each item used during the interviews was coded or labeled. The labels consisted of quotes or key words from the participants. The next step was to group the codes following interviews guide categories. The purpose of the grouping was uniquely to define each category. The last step was to name or describe responses in each category in order to determine if all data fitted or reflected the main sections of the interview guide. To validate this process, an independent reviewer was asked to examine the data codes and categories to determine any ambiguity.

RESULTS

Knowledge

In response to an item 'What do you think females of your age do not know about HIV/AIDS?' most repeated responses were: 'they do not believe there is no cure'; 'that AIDS can kill them' and 'denial that there is AIDS'. A common reason given by participants for this apathy was that many had never seen or heard of someone of their age group who was HIV positive or had died from AIDS. Also, some felt this was God's way of punishing people who have left His teachings. A follow-up question assessed participants' opinion regarding the effectiveness of current AIDS prevention and education in Zimbabwe. There was unanimous agreement that current efforts have not been very effective as demonstrated by the number of reported AIDS cases. However, a

target group perceived to be taking the AIDS message seriously were prostitutes. Several reasons were suggested to contribute to the increase in HIV/AIDS cases and these included a lack of moral values, ignorance and denial among the general public, conflicting educational messages, e.g. you should stick to one partner or you could also use a condom. Many of the participants felt this message was confusing because a partner is not in any position to know the HIV status of the other partner. Participants strongly recommended that everybody should just use a condom but the efficacy of condoms was questioned regarding: (i) manufacturing defects; (ii) breaking during or before application if correct steps are not followed; and (iii) availability.

Condoms

The response to the item 'have you heard about condoms', drew the most nonverbal communication (giggles and laughter). Unanimously, all participants had heard about condoms. However, two participants from one group indicated they had never seen a condom and the moderator produced one and sent it around. When asked to estimate the effectiveness of a condom on a scale of 0–100%, the response ranged from 25 to 100% with many settling for a 50–50 chance. Reasons cited for the ineffectiveness of condoms were (a) improper application; (b) poor storage and (c) can break. When asked if females of their age would use condoms, and why or why not?, those who expressed a willingness to use the condom did so to protect themselves from pregnancy and from contracting sexually transmitted diseases including HIV infections. Those willing to use condoms all the time were clearly in the minority. Those not willing to use a condom associated condoms with prostitution and suggested that they would remain celibate or stay with one faithful partner.

Sources of AIDS information

Participants discussed credible and non-credible sources of HIV/AIDS information in the community and identified accessible sources for HIV/AIDS information. Frequently cited as unreliable places to obtain HIV/AIDS information were buses, discos, liquor stores, night clubs, beer halls, peers and traditional healers. Sources cited as reliable were health clinics, hospitals (nurses and doctors), schools and churches. There was obvious implication that those places where people frequent to socialize were perceived as poor sources of helpful information and places associated with health care services were perceived as sources of good information. Many stated that they did not have anyone with whom to discuss personal issues or concerns related to HIV/AIDS. However, sisters or mothers were identified as accessible sources of information by a small number of participants. In those few cases, the mothers or sisters were nurses.

Future AIDS education

Responding to an item on how best to implement AIDS prevention and education targeting adolescent females, the general consensus was to target schools and youth clubs. Instructional techniques suggested included face-to-face small group discussion comprised of females only and facilitated by person(s) living with AIDS (PLWA), health educators, nurses, doctors, priests or nuns. In other words, they wanted someone with firsthand knowledge about HIV/AIDS. Many recommended abstinence education; however, condoms should also be promoted for the sake of those who decide to be sexually active. Locally produced AIDS education materials such as videos, pamphlets and posters were also recommended, in addition to having PLWA speak on the radio and on television.

Cultural norms and values

Adolescent females discussed the role of cultural norms and values regarding virginity, marriage and monogamy within the AIDS context. A follow-up question asked participants to discuss what they felt should be the appropriate reward for meeting those cultural norms and values. Participants in this study unanimously expressed a desire to adhere to cultural norms and values regarding virginity, marriage and monogamy. Frequently cited by adolescent females as major obstacles to achieving the above goal were unfaithful male partners, 'boyfriends' and economic hardships. Often-mentioned rewards for achieving these cultural norms and values were getting married, and having a big wedding, children and a faithful husband.

General information

Based on the response to the item 'How does one get AIDS?', adolescent females indicated that they were aware that sexual intercourse was the most common route by which HIV was transmitted. Only participants from two groups gave

the following complete correct answer: 'Unprotected sexual intercourse (no condom) with an infected person.' Transmission through 'blood transfusion' came up more often compared to 'pregnant mother to unborn child' and 'deep kissing'. Practices known to be 'no risk' relative to HIV transmission were identified as possible modes of transmission and these included 'contact with someone with AIDS', 'mosquito bites', 'shaking-hands' and 'toilet seats'.

A follow-up item participants discussed was 'Do you think someone of your age could get infected with the AIDS virus and why?' An overwhelming majority felt it was possible. The following were the most salient reasons why young females would be infected: (i) sex with many partners; (ii) attracted by marriage prospects, young females will not use condoms; (iii) economic hardships will lead young females to date married men or engage in prostitution; and (iv) young females want to experiment with sex. Adolescents have compelling needs which compete with a desire to postpone fulfilling such needs especially given the threat of AIDS. The following statement from one of the participants summarizes the dilemma which faces most of the young females: 'AIDS will kill you in about ten years but one can die from hunger within days.'

Most adolescent females wanted to know why casual contact or mosquito bites do not transmit the AIDS virus. Some adolescent females even expressed doubts about the existence of AIDS and challenged the government's decision to keep names of HIV infected individuals confidential. The question about the origin of the AIDS virus also came up. Adolescent females were eager to know about the origins of the AIDS virus and many felt it did not come from Africa but from the United States.

DISCUSSION

Although AIDS cases among adolescents comprise a small percentage of all reported cases, the predominance of cases in the 20–29 years age group suggests that some of these adults became infected during adolescence given the latency period of several years to as much as a decade between HIV infection and clinical symptoms. Adolescence is a period when individuals may experiment with sex, drugs and alcohol leading to possible acquisition of STD/HIV or unwanted pregnancy. Conversely, it is also a period when young people might learn life skills that could promote a positive lifestyle. In Zimbabwe, AIDS distribution among 15–19-year-olds shows a 2:1 ratio by gender with more cases being reported among females (Munodawafa and Gwede, 1995). Therefore, the first step in understanding the dynamics of HIV/AIDS would be to undertake age- and gender-specific needs assessment.

In this study, results from focus group interviews yielded vital information on predisposing, enabling and reinforcing factors related to HIV/AIDS prevention and education among adolescent females. Results suggest that adolescent females realize the gravity of HIV infections and AIDS, although some doubts about origin, transmission and individual level of risk still persist. Because of the apparent interest among participants regarding the origin of AIDS, educators must openly address this issue. During such discussions, the educators must challenge their audiences to consider whether knowing the geographic origin would have an impact on how they would protect themselves against HIV.

Although adolescent females indicated that they still hold to cultural norms and values regarding virginity, marriage and monogamy, two major factors were brought up which may expose young females to contracting HIV infections. Participants cited socio-economic hardships and negative sexual attitudes by male partners as factors which influence their sexual decision-making. It was the general belief among participants that lack of gainful employment leaves adolescent females vulnerable to 'sugar daddies'—older working men who provide gifts and money in exchange for sex. The pressure to satisfy immediate needs such as food, clothing and shelter makes adolescent females easy prey. In the study location, which is a mining community, job opportunities tend to be low-paying manual labor positions reserved for males and highly paying artisans positions, again reserved for males. Employment for females is largely as secretaries, receptionists or sales cashiers, jobs which are scarce and low paying.

Another barrier raised by the participants was the negative sexual attitudes by males towards marriage, monogamy and condoms. Participants felt that male partners are generally unfaithful and perceive women who use condoms to be prostitutes. Because many adolescent females aspire to get married, if a female suggested using a condom, she would be labeled a prostitute by the male partner. Furthermore, these young females face

not only the negative attitudes of their male partners regarding condom use, but also the limitations of the condom itself. Condoms do not provide 100% protection, they often break and can only be used once. In this community, condoms are not readily accessible to adolescents and often the cost is prohibitive. The barriers identified by the participants in this study support findings by Worth (1989) that men often determine the course of events in a sexual relationship. This finding points to a need to rethink current approaches to economic development and to address negative male sexual attitudes in order to seriously address transmission and prevention of HIV infection among adolescent females in developing countries.

Participants in this study recommended that future AIDS prevention and education programs be age- and gender-specific in order to allow for uninhibited discussions on sensitive issues. There is a need to develop an intervention to increase adolescent females' self-advocacy skills as a way of empowering them in determining the outcome of sexual interactions with their male partners. The empowerment process demands that target populations take the initiative to develop necessary skills that will make them independent as they grow to adulthood (Fleury, 1991; Brady *et al.*, 1992). Sexual decision-making skills, including negotiation and refusal skills, should be taught as a component of HIV/AIDS education and abstinence education to help support adolescent females in taking charge of their reproductive health. Also, HIV/AIDS prevention and education programs should deal with social, cultural, political and economic as well as epidemiologic factors in order fully to address the dynamics of HIV/AIDS transmission and prevention among this target group.

Participants indicated that they felt that sources providing one-to-one AIDS information were nonexistent. Participants further identified PLWA, nurses, priests, nuns and physicians as credible sources of information. These individuals were believed to be effective agents for communicating HIV/AIDS prevention messages to adolescent females. Participants also recommended female- or male-only face-to-face peer education, facilitated by someone of the same gender, for the purpose of having an open discussion. Much to our expectation, participants unanimously recommended the use of PLWA in these presentations. These recommendations by participants provide a basis for using available community human resources for implementing community-based AIDS prevention and education programs. The authors recommend that future efforts should target adolescent and adult males for the purpose of identifying salient issues related to HIV/AIDS prevention and education, since both males and females are integral parts of a comprehensive community-based HIV/AIDS prevention education program.

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APPENDIX—INTERVIEW GUIDE

General AIDS information (10–15 min)
(a) How does one get the virus that causes AIDS?
(b) How likely do you think females of your age could get the AIDS virus?
(c) Summary by moderator.

Knowledge (10–14 min)
(a) What are some of the things that you feel females of your age do not know about HIV/AIDS.
(b) How effective do you think is the current HIV/AIDS education targeting females of your age?
(c) Are there educational needs of young females like yourself that you feel AIDS educators do not know about?
(d) Summary by moderator.

Sources of information (10–15 min)
(a) What places can someone of your age group get good information about HIV/AIDS?
(b) What places can someone of your age get bad information about HIV/AIDS?
(c) Is there someone in your family who you feel has accurate information about HIV/AIDS?
(d) Where do you think this person gets the information from?
(e) Summary by moderator.

Condoms (10–15 min)
(a) Have you heard about condoms and what are they?
(b) Would you consider using them? Why or why not?
(c) How effective do you think they are?
(d) Summary by moderator.

Cultural norms and values (5–10 min)
(a) As a young female, what would you consider 'good behavior' and how would you like to be rewarded for such good behavior?
(b) Summary by moderator.

Future AIDS education (10–15 min)
(a) What would you tell health educators to do to enable females of your age to discuss openly about HIV/AIDS?
(b) If you were to receive educational information about HIV/AIDS, how would you like this information presented?
(c) Summary by moderator.

Other issues (5–10 min)
(a) Is there any other issue related to HIV/AIDS females of your age would like to discuss among yourselves?
(b) Summary by moderator.