



**Children's Access to Information on
Behaviour Change, Sexuality and Reproductive
Rights: A MYTH OR REALITY**

December 2009



Save the Children
Swaziland

Save the Children Swaziland is a member of the International Save the Children Alliance.

Our Vision is a world in which every child attains the right to survival, protection, development and participation.

Our Mission is to inspire breakthroughs in the way the world treats children, and to achieve immediate and lasting change in their lives.

Our Values:

- 1. Accountability:** We take personal responsibility for using our resources efficiently, achieving measurable results, and being accountable to supporters, partners and, most of all, children.
- 2. Ambition:** We are demanding of ourselves and our colleagues, set high goals and are committed to improving the quality of everything we do for children.
- 3. Collaboration:** We respect and value each other, thrive on our diversity, and work with partners to leverage our global strength in making a difference for children.
- 4. Creativity:** We are open to new ideas, embrace change, and take disciplined risks to develop sustainable solutions for and with children.
- 5. Integrity:** We aspire to live to the highest standards of personal honesty and behaviour; we never compromise our reputation and always act in the best interest of children.

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ACRONYMS

ACRWC	African Charter on the Rights and Welfare of the Child
AIDS	Acquired Immunodeficiency Syndrome
BCC	Behaviour Change Communication
CANGO	Coordinating Assembly of NGOs
GOS	Government of Swaziland
HIV	Human Immunodeficiency Virus
IEC	Information Education Communication
ICPD	International Conference on Population and Development
MDG	Millennium Development Goals
NSF	National Multisectoral Strategic Framework for HIV AND AIDS 2009-2014
REO	Regional Education Office
SC	Save the Children
SCS	Save the Children Sweden
SC-SWD	Save the Children Swaziland
SDHS	Swaziland Demographic and Health Survey
SHAPE	Schools Health and Population Education
SPSS	Statistical Package for Social Scientists
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
UNAIDS	Joint United Nations Programme on HIV& AIDS
UN-CRC	United Nations Convention on the Rights of the Child
UNESCO	United Nations Education, Scientific and Cultural Organization

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GLOSSARY¹

Adolescence: Adolescence is a transitional stage of physical and mental human development that occurs between childhood and adulthood. It comprises of biological, social, and psychological changes.

Behaviour Change

Communication: Behaviour Change Communication is an interactive process that engages an individual to make informed choices to change attitudes and opinions and to carry out a desired positive behaviour or lifestyle.

Child: A child refers to any human being below the age of eighteen years.

Child Protection: A broad term to describe philosophies, policies, standards, guidelines and procedures to protect children from both intentional and unintentional harm.

Peer Education: Peer education is the use of a select group to effect change among a defined population with similar characteristics as the select group by attempting to modify a person's knowledge, attitudes, beliefs, norms and stimulating collective action in programme and policies.

Puberty: Puberty refers to the physical and psychological changes that lead to sexual maturity and ultimately to sexual activity. It is the stage at which one is capable of reproducing sexually.

Reproductive Health: Reproductive health is a state of complete physical, mental and social well-being (and not merely the absence of disease or infirmity) in all matters relating to the reproductive system and its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to

¹ Sources: FANRAPAN 2006, UNESCO 2009, UNAIDS 2004, WORLD BANK 2009, SCS 2007, ICPD 1994, www.childhopeuk.org, www.wikipedia.org

reproduce and the freedom to decide if, when and how often to do so.

Reproductive Rights: "Reproductive rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence" (International Conference on Population and Development, 1994).

Respondents: The term refers to the number of research subjects in the sample that have answered a particular question.

Risk Behaviour: Risk behaviour refers to actions that increase a person's chances of acquiring HIV infection.

Sexuality: Sexuality is a central aspect of being human and it encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships.

Sexual Abuse: Sexual abuse is any form of non-consensual physical contact. It includes rape, molestation or any sexual conduct.

Sexuality Education: Sexuality education is an age-appropriate, culturally sensitive and comprehensive approach to sexuality education that includes programmes providing scientifically accurate, realistic, non-judgmental information. Comprehensive sexuality education provides opportunities to explore one's own values and attitudes and to build decision-making, commu-

nication and risk reduction skills about all aspects of sexuality.

Sexual Development: The sexual development of a person is a process that comprises physical, psychological, emotional, social and cultural dimensions. It is also inextricably linked to the development of one's gender identity and it unfolds within specific socio-economic and cultural contexts (UNESCO, 2009:5)

Sexual Health: Sexual health is a state of physical, emotional, mental and social well-being in relation to sexuality.

Sexual Rights: Sexual rights refer to the entitlement of all persons, free of coercion, discrimination and violence, to:

- the highest attainable standard of sexual health;
- access to sexual and reproductive health care services;
- seek, receive and impart information related to sexuality;
- sexuality education;
- respect for bodily integrity;
- choose their partner;
- decide to be sexually active or not;
- consensual sexual relations;
- consensual marriage;
- decide whether or not, and when, to have children; and
- Pursue a satisfying, safe and pleasurable sexual life.

Vulnerability: "Vulnerability is a forward looking concept relating to exposure and sensitivity to shocks and stresses and the ability to recover from them. It can be used to describe the general characteristics of complex systems (thus an economy, ecology or system can be said to be vulnerable) but it is also often used to describe the individuals or groups that depend on these systems" (FANRAPAN, 2006)

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CHAPTER ONE

INTRODUCTION

1.0 Background

According to the Joint United Nations Programme on HIV and AIDS (UNAIDS, 2008), more than ten million young people globally are living with HIV, two-thirds of whom live in sub-Saharan Africa. New HIV infections are concentrated among young people, with roughly 45% of all new infections occurring among those aged 15 to 24 years. In 2007 UNAIDS reported that at least half of students around the world did not receive any school-based HIV education. Furthermore, five of fifteen countries reporting to UNAIDS in 2006 indicated that the coverage of HIV prevention in schools was less than 15 % (UNESCO, 2009:6)

'In many countries, young people have their first sexual experiences while they are still attending school making the setting even more important as an opportunity to provide education about sexual and reproductive health' (UNESCO, 2009:7)

Data from Swaziland's 11th National HIV Sero-surveillance Survey which measures HIV infection rates among pregnant women indicates that HIV prevalence has increased from 39 to 42% from 2006 to 2008. The annual rate of infections is estimated at 3% and 26% of the population aged 15-49 years of age. HIV prevalence is 5% among children aged 2-4; 4% for children aged 5-9; and declines to 3% for children aged 10-14 years (SDHS 2007: 243). It was projected that 2711 children would die of AIDS in 2008 (Nercha, 2009). The estimated number of orphaned children has also increased from 32 000 in 2001 to about 117 000 in 2008 and children are reportedly still dropping out of school in large numbers in communities affected by HIV and AIDS, despite policies and programs that are designed to support their continued attendance (Nercha, 2009:20, GOS, 2006).

In line with Article 14 (f) of the ACRWC regarding preventive health care, Save the Children Swaziland (SC-SWD) has been implementing small scale projects aimed at mitigating the effects of the AIDS pandemic. The HIV and AIDS component of SC-SWD's country



strategy also gives special focus to reducing HIV infection rates particularly amongst children. However in response to the persistence of the epidemic, SC-SWD was increasingly concerned at the extent to which children have access to information on behaviour change as well as the impact of behaviour change communication on children. These concerns were further compounded by the apparent lack of evidence demonstrating that school-going children have tangible access to Behaviour Change Communication (BCC) materials meant for the general public.

Access to BCC and the Imperative to Protect Children's Rights

According to the Committee on the Rights of the Child, which is responsible for monitoring the 1989 United Nations Convention on the Rights of the Child (UN-CRC), "the rights to health and information require states to provide children with adequate, appropriate and timely HIV and AIDS, and sexual health information, and state parties must ensure that children have the ability to acquire the knowledge and skills to protect themselves and others as they begin to express their sexuality."

Article 17 of the UN-CRC convention also prescribes that:

States Parties recognize the important function performed by the mass media and shall ensure that the child has access to information and material from a diversity of national and international sources, especially those aimed at the promotion of his or her social, spiritual and moral well-being and physical and mental health (UN, 1989).

EDUCAIDS, a UNAIDS initiative for a comprehensive education sector response to HIV and AIDS that is led by UNESCO, recommends that HIV and AIDS curricula in schools "begin early, before the onset of sexual activity", "build knowledge and skills to adopt protective behaviours and reduce vulnerability", and "address stigma and discrimination, gender

inequality and other structural drivers of the epidemic" (UNESCO, 2009:64). Guidelines for promoting young people's sexual and reproductive health, including the provision of sexuality education in schools were also identified as a key strategy towards achieving the Millennium Development Goals (MDGs), especially MDG 3: Achieving gender parity; MDG 5: Reducing maternal mortality; and MDG 6: Combating HIV and AIDS (UNESCO, 2009:5).

Evidence of an Empowerment Deficit

Several studies have recently been conducted aimed at determining children's access to Information, Education and Communication (IEC) on HIV and AIDS. In 2004 a study was carried out by the Coordinating Assembly of Non-governmental Organizations to determine the availability of IEC to children. However this survey did not consider key variables such as sexuality and reproductive rights. The survey comprised of a random sample of 488 children across the country including both in-school and out-of school children. The study found that most organizations did not have specific programmes addressing issues that affect children. Only about a third of the organizations had IEC materials specifically developed for and targeting children and only for ages 10 and above. Thus it found that there were absolutely no materials developed for children below age 10. The study also found discrepancies in the information provided by rural and urban schools thus demonstrating that there was no national curriculum for HIV and AIDS education in schools. In terms of critical gaps the study concluded that children specifically needed information on:

- How to protect themselves from infection;
- Basic facts about the virus, including its mode of transmission, care and support.

In 2005, the Schools Health Population and Education organization (SHAPE) carried out an outcome evaluation of the Swaziland In-School Youth HIV and AIDS Prevention and Education Programme. This was a three year programme designed to bring about positive

behaviour change among in-school youth between the ages 10-19 using an HIV and AIDS Crisis Communication Strategy. The study was based on a sample of 32 schools which were derived from a population of 300 schools that participated in the programme.

- The study found that only 73 percent of girls and 81 percent of boys had ever heard of HIV and AIDS;
- Only about 61 percent of the pupil respondents acknowledged that the programme had given them correct information on HIV and AIDS;
- Only 50 percent agreed that the programme materials used were easy to understand (2005:9);
- The leading sources of information on HIV and AIDS were reported to be radio, television and teachers respectively;
- Information offered by NGOs (including SHAPE) as well as by teachers only helped to inform 12 percent of the respondents.

The study recommended special BCC interventions aimed at boys because they were less likely to be targeted for discussion on HIV and AIDS.

Results from the Swaziland National Demographic and Health Survey 2007 (DHS) revealed that just over 50 percent of young people had a comprehensive knowledge of the facts about HIV and AIDS and its management. With respect to the effectiveness of IEC, 47 percent of children aged 12-14 reported that there was too much focus on condoms in the HIV and AIDS information they had received; and 42 percent argued that the information was either not enough for them or was confusing (2007:286).

The National Strategic Framework for HIV and AIDS 2009-2014 (NSF) concluded that Swaziland's HIV prevention interventions were frequently generic in nature and they failed to address challenges within key populations (2009:29). It further concluded that BCC programmes focusing on individuals only had not been successful in changing the course of the HIV pandemic (NSF, 2009).



1.1 Study Objectives

The extent of the HIV and AIDS epidemic coupled with the empowerment deficit in respect of current BCC interventions impelled SC-SWD to carry out this baseline survey to help determine access to information on 1) HIV and AIDS prevention, 2) sexuality and 3) reproductive rights for in-school children.

1.1.1 Specific Objectives

The objectives of the study were:

1. To document existing Behaviour Change Communication (BCC) materials, initiatives and programs for children;
2. To document the BCC methods to children including the packaging of information and dissemination;
3. To establish the relevance of BCC materials to children;
4. To compile empirical evidence on the impact of BCC materials on children in Swaziland.

1.2 Study Outcome

The ultimate aim of the study is to promote behaviour change through access to communication initiatives leading to reduced HIV infection rates amongst children. Save the Children Swaziland is also cognizant of its role as a lead agent in transforming and improving the wellbeing of children. Therefore through this study it generally seeks to influence the current design of BCC programmes for children; and to influence and support both government and civil society initiatives aimed at improving children's access to information on sexual and reproductive health.

CHAPTER TWO

METHODOLOGY

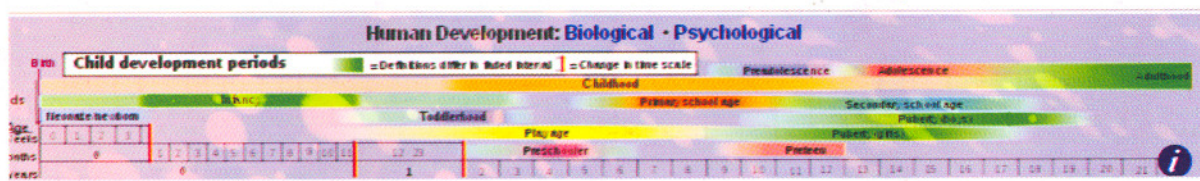
2.1 Research Approach

The survey was a case study designed to investigate children's access to BCC, information on sexuality and sexual rights for in-school children. Therefore the approach encompassed age groups that represent students in all school grades. The average admission age at primary school is 6 years and therefore the research covered children from age 6-18.

However in view of the different stages of development among children as well as sensitivity to their different cognitive abilities, the sample was divided into two main categories. The first category comprised of young children aged 6-9 and the second comprised of pre-adolescents (10-12) and adolescents (13-18).

The average onset of puberty is estimated at 10 years for girls and age 12 for boys. The average age of full puberty is estimated at 16 years for girls and 18 years for boys. Therefore this fluidity of the pubertal stage across the ages 10-18 (see figure 1) persuaded the researchers on the efficacy of using one interview guide for both Pre-Adolescents and Adolescents. They are therefore also treated as one research category in the discussion of research results.

Fig.1: Child Development Periods



Source: <http://en.wikipedia.org/wiki/Adolescence>

2.1.2 Justification for In-School Focus

The focus on in-school children was found useful for testing assumptions suggesting that HIV prevention interventions that are implemented in learning environments are relatively more effective than those in non-learning environments.

The education sector plays a critical role in preventing HIV among young men and women and in mitigating the effects of HIV and AIDS on individuals, their families and communities (UNAIDS 2004). According to Kirby (et al), school-based HIV and AIDS education can reach many children and young people with HIV information and equip them with the skills they need to protect themselves before they become sexually active (2006).

Sex and HIV education programmes that are based on a written curriculum and that are implemented among groups of youth in schools, clinics, or other community settings are a promising type of intervention for reducing adolescent sexual risk-taking behaviours (Kirby et al, 2005).

2.1.3 Introduction of Variables and Research Instruments

The survey comprised of two interview guides instruments for young children aged 6-8 and for children aged 10-18 (Appendix A). Both instruments sought to determine children's access to information, quality of information, knowledge, responsibility, attitudes, empowerment, norms, values, behaviour and relationships relating to behaviour change, sexuality and sexual rights. HIV and AIDS related issues were cross-cutting for all three thematic factors. There were also questions

that sought to establish interrelationships between different variables. Both instruments had identical questions for information on the demographic characteristics of respondents (i.e. age, education, gender). Other important variables included access to child protection services and the role and effectiveness of teachers in Behaviour Change.

2.2 Methodology

The study was qualitative in nature whereby the researchers investigated children's experiences in their natural settings on the problem of HIV and AIDS and behavioral change. It looked at the meanings that children in the study attach to their experiences. It also looked at multiple contexts within which these experiences occur. The contexts include schools, home and community settings. The researchers used a Case Study method whereby, it is a type of qualitative research in which in-depth data are gathered relative to a single individual, programme, or event, for the purpose of learning more about an unknown or poorly understood situation (Leedy and Ormrod, 2005).

2.3 Research design

The study focused on primary and secondary schools in the four regions of the country. These are Manzini, Shiselweni, Lubombo and Hhohho. Primary data was collected through personal interviews with children by trained research assistants. Since this was a case study, a representation of approximately 5% of the

whole number of schools in Swaziland was sampled. The sample therefore comprised of a total of 40 schools. Interview guides were used to direct the study and they were structured to capture all the relevant information needed from the children.

2.4 Study Population and Sampling

Different questions were designed for the different age groups, namely: 6-9 years and 10-18 years and the sample size were 600 children in the 40 schools (24 primary and 16 Secondary/High). An up-to date list of schools obtained from the Ministry of Education (Regional Education Offices) was used to facilitate the sampling. A purposive sampling procedure was followed where the sample units were randomly sampled based on the region in which the school is located.

Children from the different age groups were also randomly selected with assistance from the class teacher or the school principal. Children who were selected for the interviews were informed of the nature and purpose of the study and their consent was sought before the interview was conducted. The data collection team did not encounter any refusals from students but some respondents expressed the principle that they do not ordinarily speak to strangers, however the researchers were accepted only because they had been given permission by the teachers.

2.5 Data Collection Process

A two day workshop was held for training the data collection team. Study tools were first pre-tested to familiarize data collectors with the tools as well as establish a standard procedure. The tools were pre-tested using a similar population before data was collected from the target population. During the actual study Interviews were conducted by trained research assistants over a period of 10 days. To ensure quality control, supervisors were assigned to the research team to closely monitor the data collection process.

Permission to carry out interviews was sought prior from both the REO and from school principals. On arrival at the research site, data collectors would first meet both the school principal and the respective class teachers.

2.6 Data Processing and Analysis

Apart from the demographic information, the data from the interviews was entered according to the different age groups according to a specially designed coding system. Data was entered into the Statistical Package for Social Scientists (SPSS) programme to facilitate the data analysis process.

2.7 Consultation with Stakeholders

On 9th October 2009 a stakeholder consultation meeting was held to solicit stakeholder inputs into the study design as well as the research variables. A report validation and dissemination meeting was also held on 21st January 2010 for stakeholders to discuss and review the findings of the study (Appendix B and C).



CHAPTER THREE

DISCUSSION OF FINDINGS

3.0 Introduction

This chapter presents the results of the study and it is made up of three main sections. Section 3.1 explains the demographic characteristics of respondents and the main variables are physical location, age, gender, education and family situation. Section 3.2 explains the findings on young children aged 6-9 and section 3.3 outlines the survey results for children aged 10-18. The interrelationships between the different variables are also discussed in this chapter.

3.1 Demographic Characteristics of Respondents

The study sample comprised of 600 respondents from 40 schools. There were 12 urban and 28 rural schools respectively. 12, 28 and 59 percent of the total number of respondents represented the age groups 6-9, 10-12 and 13-18 respectively as shown in table 1a.

Table 1a: Age Range of Respondents

Age Range			
6 to 9 yrs	10 to 12 yrs	13 to 18 yrs	Total
74 (12.3%)	168 (28%)	358 (59.7%)	600 (100%)

Regional Dynamics

The sample was evenly spread across the regions as indicated in table 1b. Shiselweni region recorded the highest number of respondents and Manzini had the lowest number. Respondents from the Shiselweni region also demonstrated more knowledge of the HIV and AIDS epidemic than respondents from all the other regions (see table 1c). This higher knowledge positively correlates with the region's low level of HIV infection. According to the SDHS, the national prevalence rate in the population aged 2 and older ranged from 16% in Shiselweni to 21% in Hhohho region (SDHS, 2007).

Table 1b: Region Distribution of Respondents

Regions			
Manzini	Hhohho	Lubombo	Shiselweni
150 (25.0%)	135 (22.5%)	150 (25.0%)	150 (25.0%)

Table 1c: Knowledge about HIV and AIDS

Region	Well informed	Informed	Partial knowledge	Un-informed	Total
Manzini	25.45%	21.48%	20.75%	37.5%	24%
Hhohho	19.70%	27.40%	34.0%	12.50%	23%
Lubombo	21.18%	30.37%	18.90%	25.0%	24%
Shiselweni	33.0%	20.74%	26.42%	25.0%	29%
Total	62.27%	25.70%	10.1%	1.52%	100%

Knowledge of Behaviour Change among Males and Females

The respondents comprised of 44 % males and 56 % females thus giving a ratio of 0.8 male to female (see figure 2). More females than males were generally more knowledgeable about HIV and AIDS. Similarly in the 6-9 cohort, more females than males demonstrated knowledge of their rights to bodily integrity (See figures 3 and 4).

Figure 2: Knowledge of Behaviour change by sex

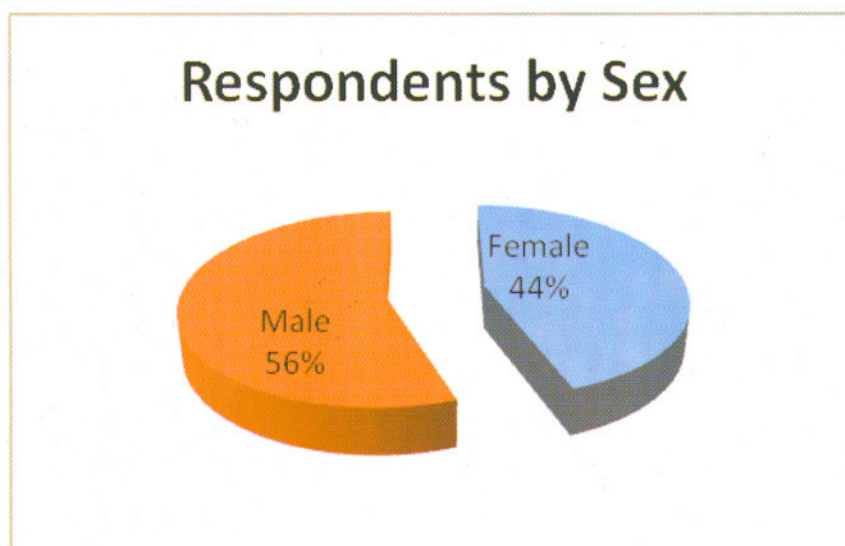


Fig.3: HIV and AIDS Knowledge among sexes

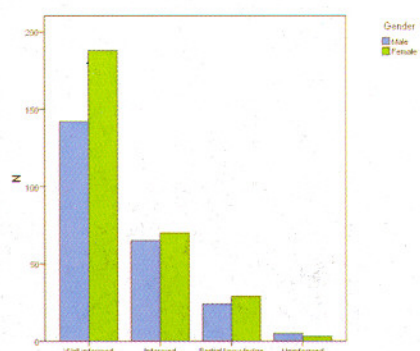
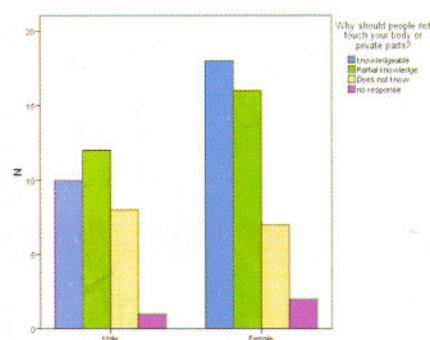


Fig. 4: Awareness of Right to Bodily integrity





Level of Education and BCC Knowledge

There was no positive correlation between level of education and BCC knowledge. Most respondents across all school grades placed a greater emphasis on abstinence over faithfulness and this is the expected prevention best practice among persons who are non adults (fig 6). On comparison of education level and sex education received, the majority (443)84% understood the importance of abstinence (fig 5).

Fig. 5: Education and Abstinence

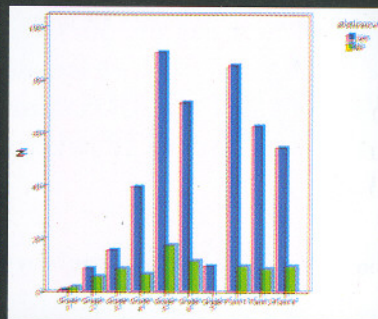
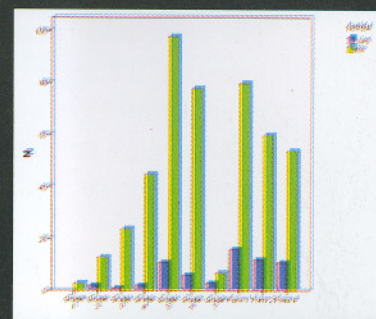


Fig. 6: Education and Faithfulness



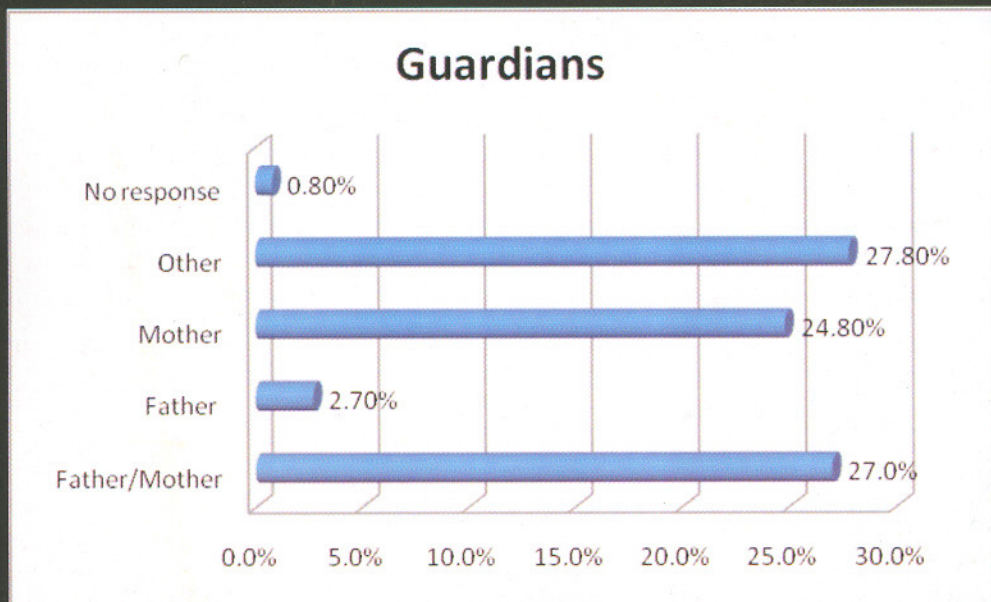
Family Situation

The UN-CRC accords fundamental importance to the family, as the fundamental group of society and the natural environment for the growth and well-being of all its members and particularly children. It prescribes that children should grow up in a family environment, in an atmosphere of happiness, love and understanding (1989).

In the survey, the majority of children were found to live with a guardian other than their mother or father. Thus most children are under the custodianship of a grandparent, aunt or siblings. The second largest group was those that still live with both parents. Most boys were found to be living with an 'other' guardian whereas girls were mostly under the care of their biological parents.

Only 31 percent of the children in the age group 10 -18 were found to live with both parents and this suggests that 69 percent either live in single, broken, improvised and vulnerable family settings. It further implies that the majority of children live under the care of secondary guardians whose guardianship is occasioned by unplanned and unforeseen circumstances such as death of biological parents, sickness, family breakdown, conflict etc. As a result, it is highly unlikely that these children can grow up in the kind of environment envisaged by the UN-CRC.

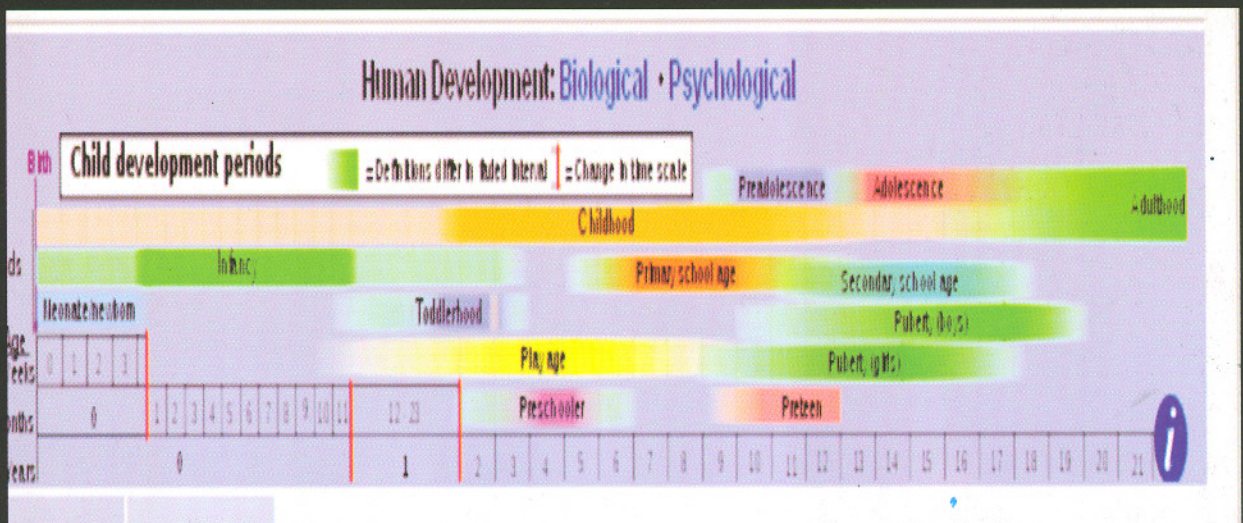
Fig. 7: Family Situation of Respondents



OTHER GUARDIANS

A number of 'other' guardians were mentioned by the respondents. The list was quite wide as it included many other individuals, family members, community members, government and organizations as seen on fig 8 below. Grandmothers had the highest number (59)35% followed by grandparents combined (37) 22% of the 167 respondents who said they had other guardians other than father/mother or mother or father combinations. Those who mentioned 'aunt' as guardian were 23(14%), sister (10)6% and uncle (8)5% respectively. The rest of the respondents had smaller numbers.

Fig. 8: Other Guardians



3.2 Young Children 6-9 Years

Introduction

Section 3.2 outlines the research findings pertaining to young children aged 6-9. This cohort had a specific set of questions that were developed in line with their cognitive abilities. The research



variables for this age group comprised of two broad categories, namely BCC knowledge and sexuality. The total sample population for this group was 74.

3.2.1 Behaviour Change Communication

Knowledge of HIV and AIDS and Risk Behaviour

Only 20% of young children were well informed about HIV and AIDS, 28% were informed, another 28% had partial knowledge and 19% were not informed. This is in spite of the fact that respondents had been exposed to the same information within the classroom setting. 34 percent of respondents believed that AIDS was the mostly likely outcome of risk behaviour followed by STIs.

HIV and AIDS Prevention Knowledge

More than 40% of respondents cited abstinence as the most effective measure against sexual disease. Therefore abstinence constitutes the leading HIV and AIDS prevention method for this age group followed by other measures such as not kissing, not sharing razor blades and needles, not touching blood. The use of condoms was cited as the third most important preventive measure against HIV and AIDS.

Knowledge of HIV and AIDS

Fig. 9a: Knowledge on HIV and AIDS
(From teachers)

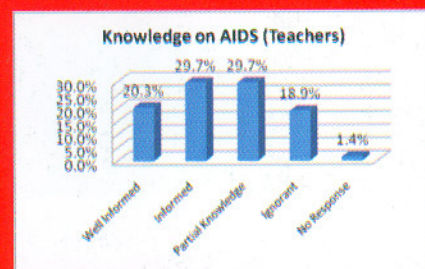
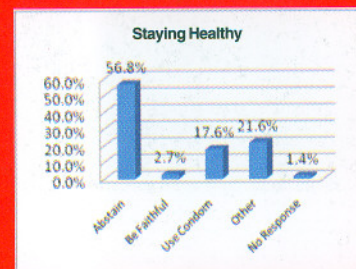


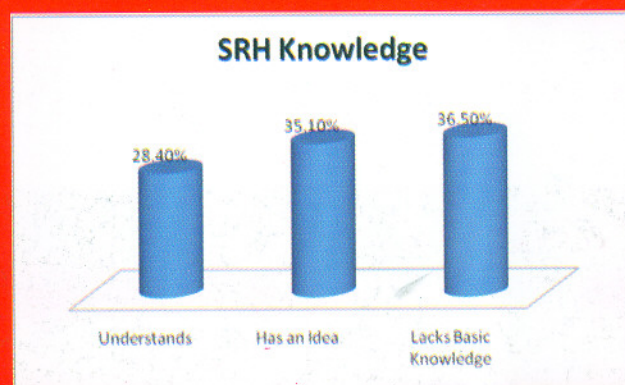
Fig. 9b: Staying Healthy



Knowledge of Sexual and Reproductive Health (SRH)

36 percent of respondents were not informed and lacked basic knowledge of SRH. Only 28% understood and 35% seemed to have a slight idea (figure 10).

Figure 10: SRH Knowledge



Access to Information on Sexuality

The majority of children prefer to discuss sex related subjects with persons other than their guardians. Parents are second in priority for children who want to discuss sexuality issues and a significant proportion of children do not discuss with anyone at all. These findings are consistent with NSF data which showed that only 39% of young people aged 10-24 relied on a family member for acquiring information on HIV and AIDS (2009:31). Notably, teachers are not among the most relevant 'others' for discussing sexuality.

Only less than 25% of respondents discussed sex with their friends. However among those that had ever discussed sex with someone, the majority cited friends as the most significant others. This therefore suggests that a large number of young children do not discuss sex with anyone and this veil of silence is indicative of the stigma and taboo that still pervades young children and communities regarding sexual matters.

Figure 11: Talking about Sex

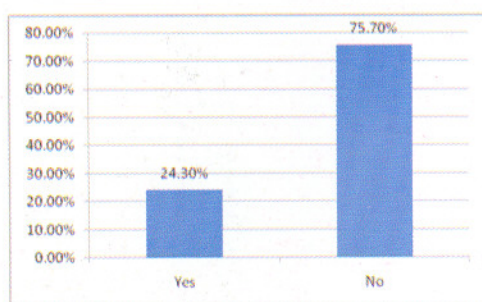
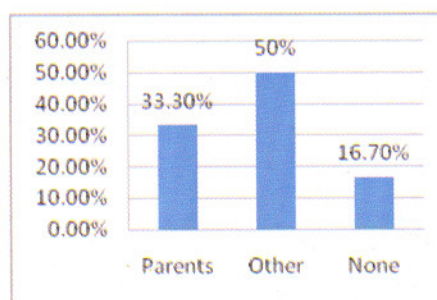


Fig. 12: Most frequently asked people about sex



Sources of Information on Child Protection

Teachers were the leading source of information on child protection. The home and the media were the second and third most important sources of information respectively.

3.2.2 Sexuality

Awareness of Sexuality

51 percent of respondents were knowledgeable while 38% had partial knowledge of the body parts and their functions. This question was primarily testing knowledge of body parts that related to sex and reproduction and the interviewer had been trained to elicit responses that encompassed this aspect. Only 11% were well informed, whilst 28% were informed, 23% had partial knowledge and 35% were uninformed of the stages of development (i.e. pubertal growth) of a child and the implications thereof (Figs 13 and 14). Lack of knowledge in this area easily exposes children to the risks of sexual abuse, manipulation and sexual risk behaviours.

Fig. 13: Knowledge of Body parts and their functions

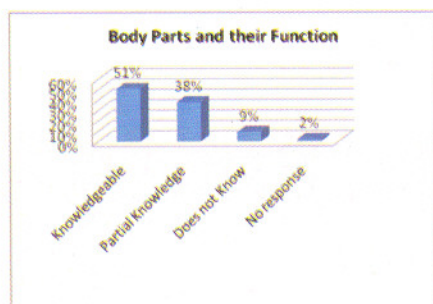
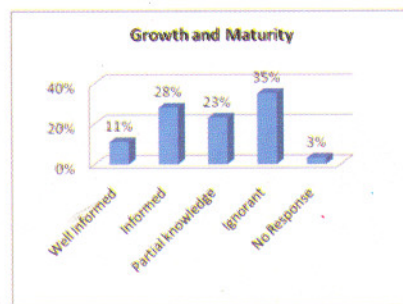


Fig. 14: Understanding maturity (puberty)



Sexual Rights

38 percent of young children were knowledgeable and also another 38% had partial knowledge of their rights to bodily integrity. However a significant number was found to lack basic knowledge regarding their basic sexual rights (See Fig 15a).

Access to Information on Child Protection

Teachers and the home are the leading sources of information on child protection for young children. 18 and 13 percent of children reported that they accessed child protection information from teachers and the home respectively and only a meager 2% reported accessing information from the media. Cumulatively the total number of children that access information on child protection is quite low (less than 35%) thus showing that most children actually do not have access to information on child protection.

Access to Child Protection

51 percent of the respondents had basic knowledge; 28% had partial knowledge and 16% of respondents were not aware of what to do in circumstances relating to sexual abuse (See fig 15b.) Slightly more females than males had basic knowledge of how to react to sexual abuse.

Fig. 15a: Awareness of Child Protection

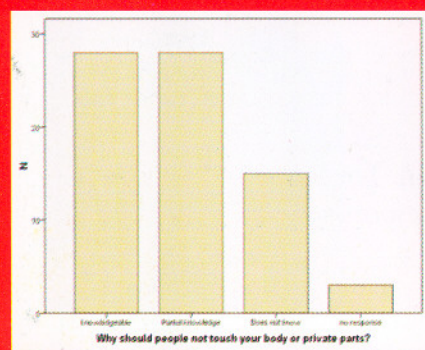


Fig. 15b: Awareness of Child Protection



3.3 Pre-Adolescents and Adolescents 10-18 Years

Introduction

Section 3.3 discusses the research results for children aged 10-18. This age comprises of pre-adolescents and adolescents. The research variables were classified into three sub-sections namely, BCC, sexuality and sexual rights respectively. The total sample population for this cohort was 526.

3.3.1 Behaviour Change Communication

BCC Knowledge

Respondents cited primary risk behaviour as having sex without protection and having sex with many partners respectively. 63 percent of respondents were well informed about HIV and AIDS (Figure 16) and only less than 3% of respondents were either not informed or believed a myth about how HIV spreads from one person to another. 87% of respondents understood the information that they received on HIV and AIDS (Figure 17).



Fig.16: Knowledge of AIDS pandemic

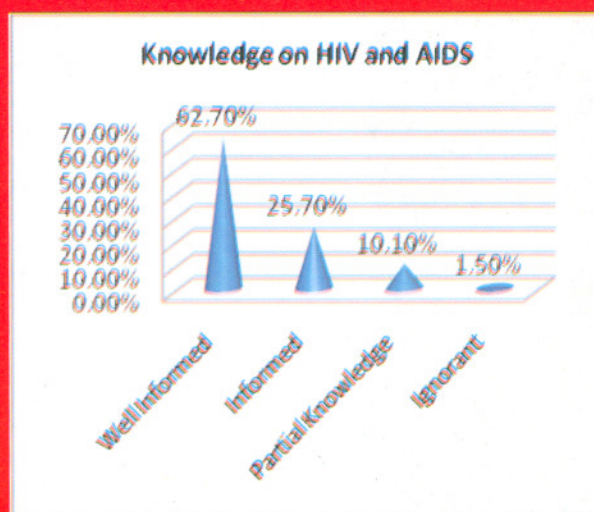
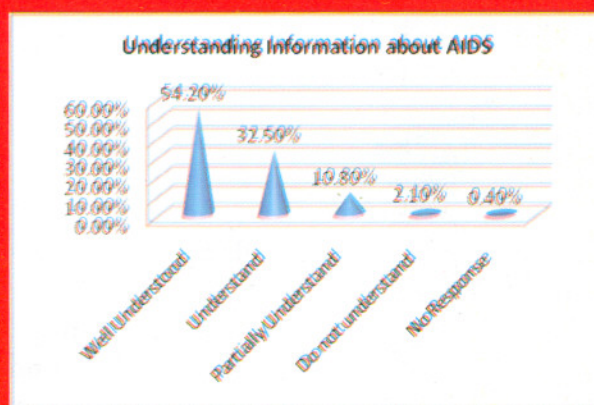


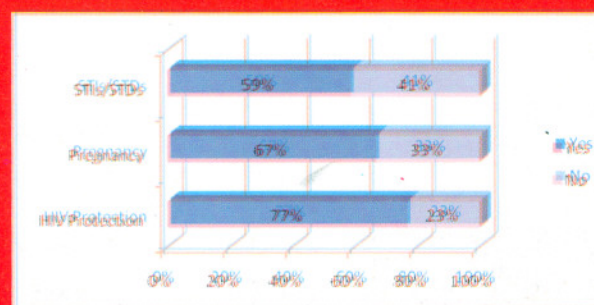
Fig.17: Understanding information about AIDS



Efficacy of Condoms

The majority of respondents identified abstinence, the use of condoms, faithfulness and responsibility respectively, as the most effective preventive measures against HIV infection. However respondents did not mention male circumcision at all though the NSF has designated it as one of the key prevention strategies for young men (15-24) in Swaziland. When asked about their knowledge of the efficacy of condoms most respondents 406 (77%) said they protect against HIV; 351 (67%) said condoms prevent pregnancy 311 (59%) said condoms prevent STIs/STDs (figure 18).

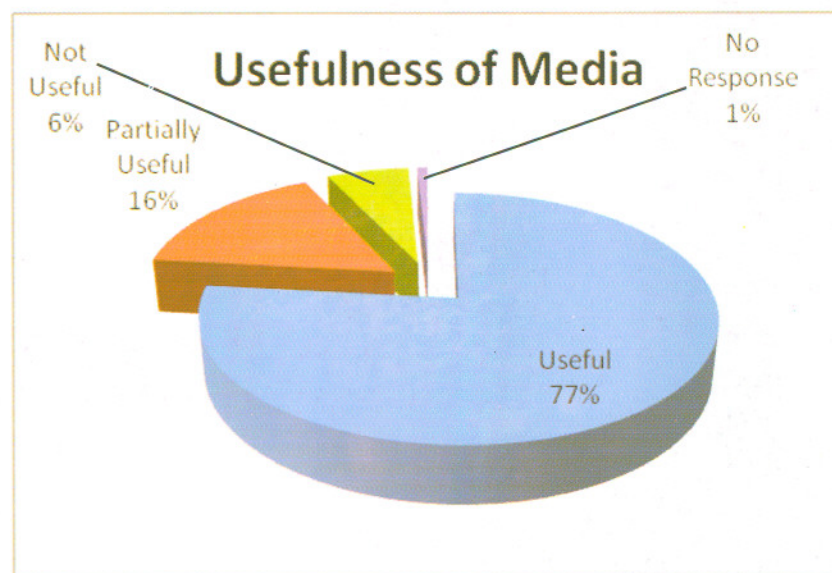
Fig.18: Knowledge on Efficacy of Condoms



IEC Effectiveness

The majority of children acknowledged that the material/information displayed in the school setting was useful.

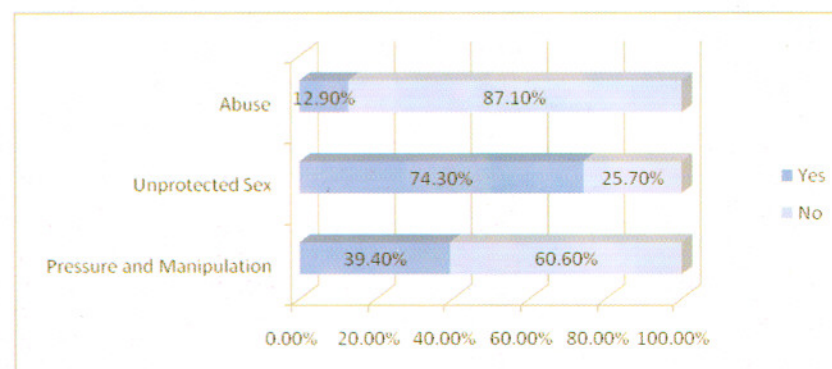
Fig. 19: Usefulness of media-materials on sex education and HIV and AIDS displayed in schools



Knowledge of Risk Behaviour

Having sex without protection and having sex with many partners were identified by respondents as the primary risk behaviours in relation to sex. Respondents identified the primary causes of teenage pregnancy as unprotected sex, financial pressure/manipulation and abuse respectively.

Fig. 20: Knowledge of Risk Behaviour

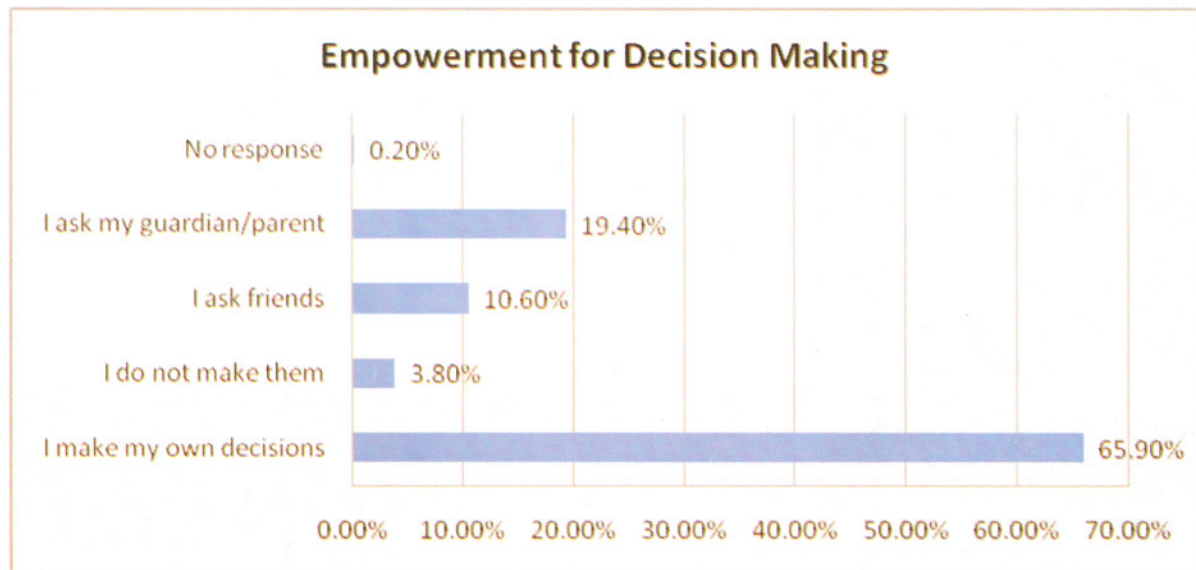


Decision Making and Empowerment

Ninety five percent of respondents reported that their attitude and behaviour towards sex had been positively affected by the information they received on sex education. As a result of sex education, two thirds of respondents were empowered to make their own

decisions regarding sexual matters. About one third of respondents still rely on either guardians or friends to make decisions (Figure 21).

Fig. 21: Empowerment for decision making



Participation

Only 18 percent of respondents had ever participated in activities that raise awareness about HIV and AIDS. Drama, peer groups and role plays are the most common activities used for raising awareness about AIDS. Respondents also received awareness through health clubs, talking to friends and from parents and guardians. More females (11%) than males (7%) participate in awareness raising activities (Table 2). About 7% had been involved with anti-AIDS campaigns, bible, community and health clubs; debates, poems, cultural dance, songs, Super Buddies, Youth Brigade, talking to family members and with friends. Seventy five percent of respondents had never participated in any HIV and AIDS awareness raising activities.

Table 2: Participation in activities teaching about HIV and AIDS

Gender	What activities do you participate in that teach you about AIDS?					
	Peer groups	Role plays	Drama	Talk shows	Campaigns	None
Male	25.9%	35.3%	53.1%	35.7%	80.0%	46.6%
Female	74.1%	64.7%	46.9%	64.9%	20.0%	53.4%
Total	100.0%					

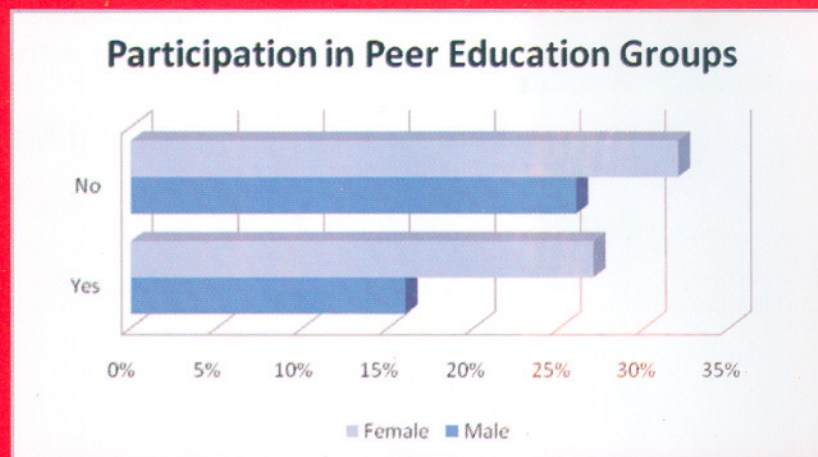
Participation in Peer Based Interventions/Programs

Less than half of school children had been part of a peer education group. About 68% of those that participated in peer groups had been 'active' members of the peer group.

When asked if they had ever been part of a peer education group, 24(16%) out of 154 male respondents said yes, while 40(26%) said no, 41(27%) females said yes, 49(31%) said no (Fig 22).



Fig. 22: Participation of males vs. females in peer education groups



3.3.2 Sexuality

Sexuality and Relationships

74 percent (389) respondents reported that they were not having a relationship and this may suggest the possibility of an extended period of abstinence for school going children. Only 26% admitted having either a boyfriend or girlfriend. There was no significant variation between the number of males and females that had a relationship. About two thirds of the respondents had a relationship with a student whereas one third had a relationship with a non-student (figures 23a and b).

Fig. 23a: Relationships (Boy/Girlfriend)

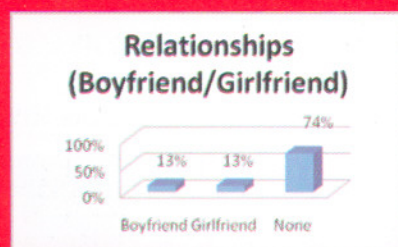
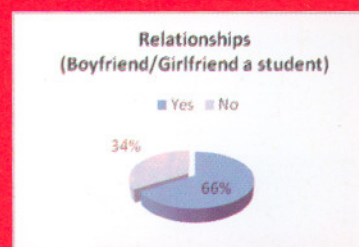


Fig. 23b: Relationships (Boy/Girlfriend a student)



Intergenerational Dynamics

About 80 percent of respondents started dating before their 16th birthday which is also the age of consent in Swaziland. 60 percent of respondents had a relationship with someone in their age group whereas 9% had a relationship with someone 5 years and older. 29 percent of respondents did not want to disclose the age of their partners. Age is normally a barrier to disclosure and therefore the bulk of those that 'don't know' the age of their partners could actually be going out with older people. Most respondents in the 10-18 cohort started dating before the age of consent and 12%

have relationships with persons 5 years and older than themselves. This suggests that adolescents have sexual relationships with much older people before the age of consent. Most respondents (70%) claimed that they entered a relationship out of their own volition; through love and not coercion (see figures 24 and 25).

Fig.24: Respondents involved in relationship/s

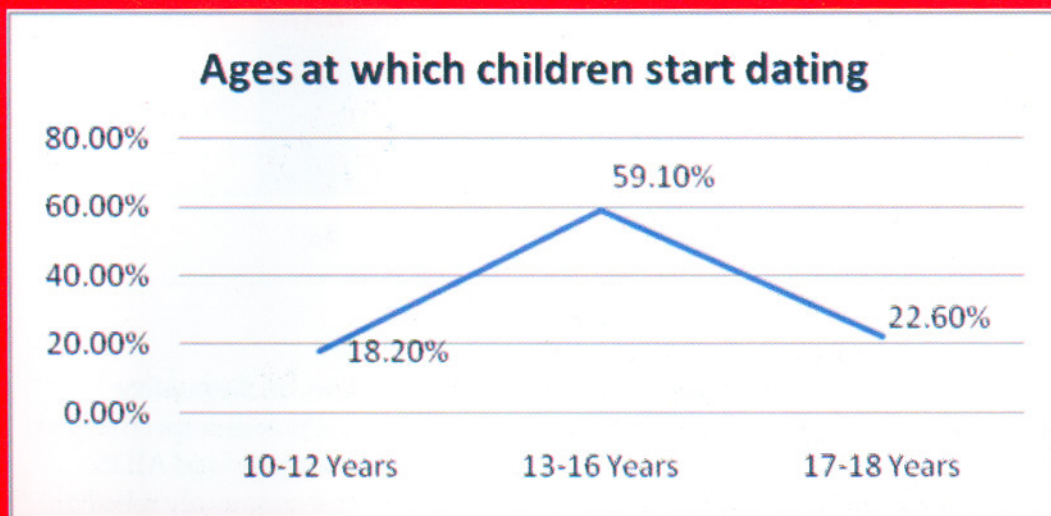
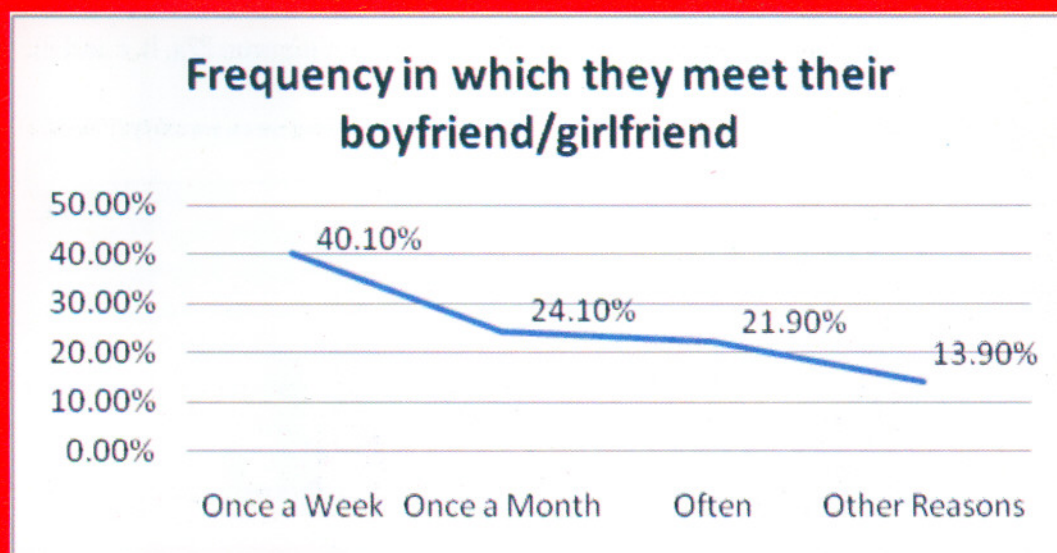


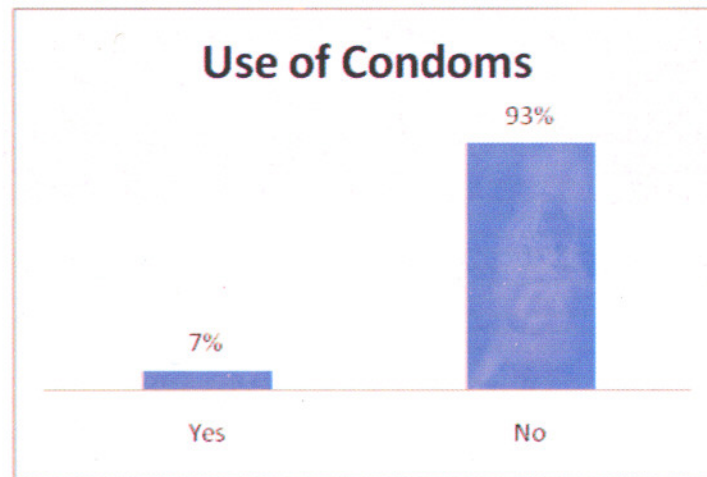
Fig.25: Depth of Relationships



Confidence about Sexual Activity

About 7% of respondents admitted to ever having used a condom and since the cohort comprises of the ages 10-18, this suggests early sexual debut as early as the 10th birthday. In the opinion of the researchers that carried out the interviews, the body language of some respondents who denied having ever used a condom suggested otherwise. This could mean that condom cultures have not been engrained in most respondents and therefore admission of condom use becomes taboo.

Fig.26: Use of condom



3.3.3 Sexual Rights and SRH

Most Relevant Other Person for Information on Sexuality

36 and 29 percent of respondents cited mothers and friends respectively as the people they mostly consult for information on sexuality and AIDS. Therefore friends and mothers were the people most commonly relied on to provide emotional support, validation and intimacy on issues related to sexual behaviour. Only 18% of the respondents understood information from teachers well. Therefore the mother is the most relevant other person where respondents solicit information on sexuality. (figures: 27a, b, c and d).

Fig. 27a: Information on sexuality (Mother)

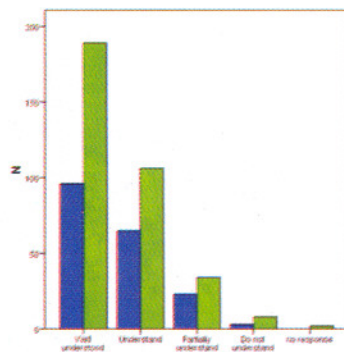


Fig. 27b: Information on sexuality (Friend/s)

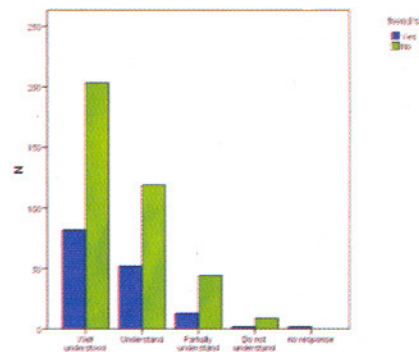


Fig. 27c: Information on sexuality (Teacher)

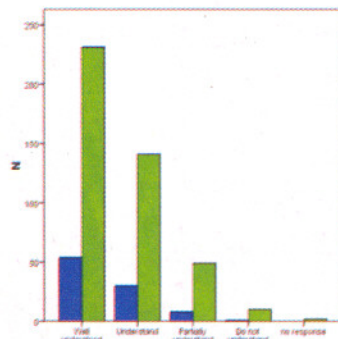
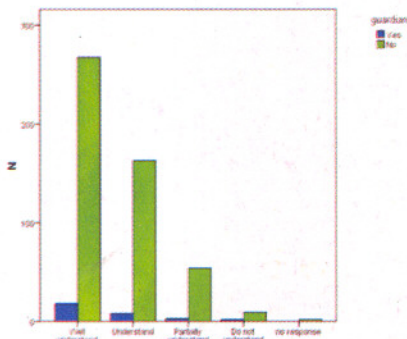


Fig. 27d: Information on sexuality (Guardian)



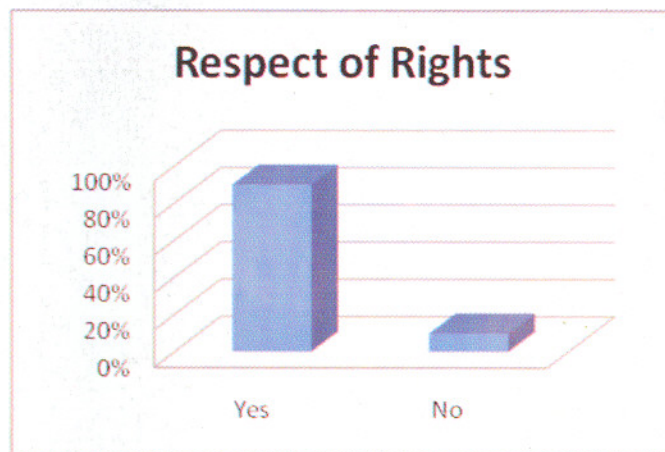
Knowledge of Sexual Rights

When asked about knowledge of their rights in respect of sex or having a relationship, about half of the respondents understand that they had a right to decide on whether or not to have sex. However only a small proportion (11%) knew they had a right to choose a partner; and only 20% knew they had a right of consent with respect to having a relationship. 17 percent of respondents did not know their sexual rights.

Freedom to Exercise Sexual Rights

About 90% of respondents submitted that people respected their sexual rights and 10 percent expressed that people did not respect their rights (figure 28).

Fig. 28: Respect of sexual rights

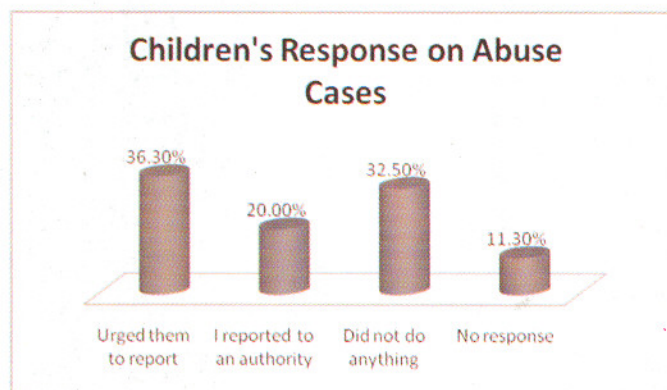


Sexual Abuse

About 18% of respondents were aware of a friend that had been sexually abused. During some interviews the respondents were very emotional over this question and some actually broke into tears suggesting that they themselves could have been the victims of sexual abuse.

In terms of reporting cases of sexual abuse, only 20% reported cases to an authority, 36 percent urged the victim to report and 32% did nothing about it (figure 29). Other measures that were taken include reporting to parents and the police, giving comfort and advice and sympathy.

Figure 29: Response to Cases of Sexual Abuse





**Child Protection in Action:
Access to Save the Children**

Due to the fact that it is the leading organization for championing the rights of children, knowledge of Save the Children was used as a proxy for knowledge of access to child protection services.

75 percent of respondents knew about SC-SWD and 25% had never heard about the organisation. 16 percent of respondents who had heard about SC-SWD understood its key role as protecting the rights of children. About 5% believed that SC-SWD's role was to provide school feeding and 2% believed that SC provided HIV programmes. About 0.02 % did not know what SC-SWD does.

CHAPTER FOUR

CONCLUSIONS AND RECOMMENDATIONS

4.1 Introduction

This baseline survey was carried out to help determine children's access to information on 1) HIV and AIDS prevention, 2) sexuality and 3) reproductive rights for in-school children. This chapter represents a summary of the conclusions and recommendations and it comprises of both programmatic and policy recommendations respectively.

4.2 Programme Recommendations

Supporting Children's Sexual Rights in Action

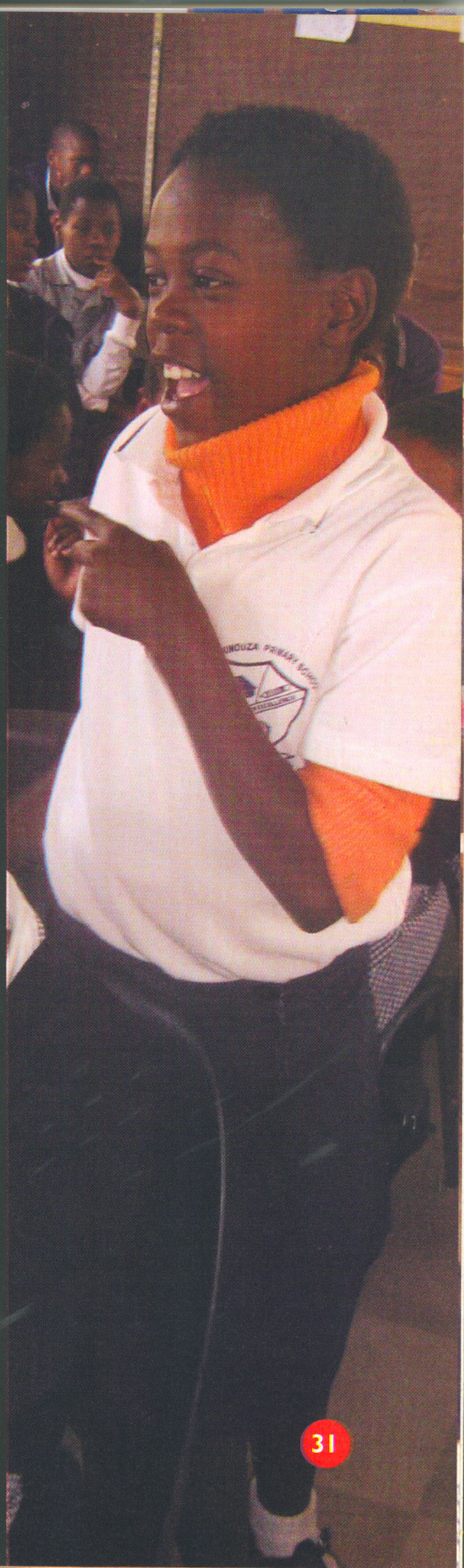
About 10% of respondents in the age group 10-18 believed people did not respect their rights. However many children were also not aware of what to do in circumstances where their rights are being impeded. Therefore SC should consider implementing a program for supporting 'children's rights in action.' This could be in the form of a cellular telephone hotline, a Questions and Answers domain, regular child opinion polls/surveys etc. This initiative could also be used to address the problem of children who fail to report cases of rights violation which they are aware of.

Bridging the Knowledge and Empowerment Gap

Children mainly lacked comprehensive knowledge about their rights in general and sexual rights in particular. Children's rights education including mainstreaming the UN-CRC in BCC media is imperative for the empowerment of children. Rights empowerment can go a long way in reversing children's (especially young girls) vulnerability to sexual abuse, manipulation and lack of confidence to decide on matters related to sexuality. Interventions focused on children's sexual rights would be consistent with the priorities of National Multisectoral Strategic Framework for HIV and AIDS 2009-2014 (NSF), which seeks to specifically prioritize interventions targeting girls age 10-14 as well as support programmes that empower girls to make informed decisions on their sexual and reproductive health (NERCHA, 2009).

Measuring Child Protection

The study showed that children have limited access to information on child protection. Local structures such as churches, community clinics, school committees and



families (i.e. child headed households).

Improving Dissemination of BCC

The findings suggest that the media has a low profile in disseminating information on child protection. The total number of children that access media information on child protection was quite low (less than 35%) thus showing that most children actually do not have access to information on child protection.

The media was also the third most effective source of information on child protection behind teachers and parents. However a child friendly media could be of great assistance in protecting and supporting children against abuse; and therefore it is vitally important to improve the role of the mass media in BCC interventions.

Mobilizing for a Sector-wide Approach

Soliciting the views of teachers was not part of the methodology of this baseline study. However the limited impact that schools and teachers appear to be making suggests that a wider process of investigation dialogue and empowerment involving teachers is required. Certain school subjects/disciplines i.e. Social Studies (in primary schools) comprised of useful information on HIV and AIDS. However the results of this study suggest that the dissemination of such information to children was limited. In view of this conclusion, the content of the school syllabus itself as well as decisions on its implementation becomes a paramount issue for discussion.

The HIV and AIDS Crisis Communication Strategy piloted by SHAPE had been designed to enable teachers to engage students in discussions on sexuality and HIV and AIDS. Therefore teachers were the primary implementing agents and they were trained in a cascade approach where a corps of 54 senior trainers (teachers) was trained and these went on to train Associate Trainers from the 300 participating schools (SHAPE, 2005:64). However the personal conduct and reputation of some of the Associate Trainers negatively influenced the reception of the programme. This suggests that





the impact of BCC knowledge disseminated by teachers also depends on the manner in which the teacher is perceived and accepted as a role model. It further challenged the assumption that all teachers can be effective HIV and AIDS prevention role models and pioneers.

The SHAPE evaluation also indicated that not all teachers were comfortable in discussing HIV and AIDS and Sexuality with pupils. It further revealed that the Associate Trainers rather than all teachers had essentially become 'the face of the fight against HIV and AIDS in their schools' (2005:66). The evaluation also found that the HIV and AIDS curriculum was relatively narrow and had a weak life skills component (2005:67).

Therefore the challenges outlined by the SHAPE evaluation as well as the results of this baseline report suggest that the effective participation of schools in BCC efforts aimed at preventing HIV and AIDS requires a sector-wide approach that includes engaging all stakeholders, particularly teachers, parents, policy-makers, Ministry of Education and NGO partners. A sector-wide approach can also address the possible inclusion of BCC methodologies in the teacher training curriculum. Therefore, mobilizing the education sector to play a more critical role in HIV prevention should be one of the pillars of SC-SWD's advocacy strategy. An SC-SWD programme link up in this area with UNESCO/EDUCAIDS should be seriously explored.

Program Partnerships

During the validation workshop for this report, stakeholders mapped out a roadmap which SC-SWD can explore for purposes of aligning the recommendations of this report with activities and programs of other actors within the thematic area of BCC, Sexuality and Sexual Rights. Table 3 outlines the outputs of stakeholders.

Table 3 Summary of Possible Program Partnerships

Thematic Area	National Actor	Program/Activity	Gaps	Possible Role for SC-SWD
Empowering Adolescent PLHIV	Baylor Clinic Support Group	National Peer training by PLHIV	Age consistent truths	Training of Trainers
Coordination of HIV&AIDS Information and Children's Rights in schools	Ministry of Education	Standardize HIV& AIDS information in schools	Additional Resources and information for students i.e. library materials	Act as peer reviewer of materials disseminated in schools
Empowering children's constituencies	Local governments and community leadership	Training community health clubs and peer educators	Knowledge of HIV authentic sources	Facilitate, coordinate training of health clubs
Children's participation	Ministry of Education, National Curriculum Centre	Development of curricula for BCC, Sexuality, Rights	No participation of children in development of BCC materials and curricular	Advocacy for children's participation

4.3 Policy Recommendations

HIV AND AIDS Prevention Knowledge

The majority of respondents from both study cohorts cited abstinence as the most effective measure against contracting HIV and AIDS. This suggests most children are aware of prevention interventions that promote abstinence. However positive reception of the abstinence message does not necessarily translate to its actual practice and therefore children still need increased knowledge about HIV and AIDS prevention. Similarly the NSF (2009-2015) has prioritized the provision of deeper knowledge of HIV and AIDS to key populations such as young people. The fact that respondents did not cite male circumcision as a prevention measure also suggests that its profile has to be raised. The NSF has prioritized male circumcision for young men aged 15-24.

Equipping Parents

Most respondents from the 6-9 age group relied on 'others' to provide them with information on sexuality whereas most respondents in the 10-18 cohort depended on mothers for information on sexuality. These findings underscore the need to acknowledge and optimize the relevance and role of parents in equipping children with critical life skills particularly with respect to sexuality.

Friends are most Significant 'Others'

The majority of respondents in both study cohorts cited friends as the most significant other persons with whom they discuss sexuality and HIV and AIDS. Therefore promoting quality friendships is pivotal in BCC interventions targeting children.

Preparing Children for Sexual Maturity

The survey revealed that children are actually not well prepared for sexual maturity despite the fact that some children (especially girls) mature quite early. The reality of early sexual debut for many young children as well as their involvement in age-disparate relationships make it necessary to prepare and equip children with the necessary life skills they need for engaging in relationships.

About one third of the respondents that admitted to having a relationship were dating a non-student and this highlights the extent to which children are exposed to either age-disparate relationships or to relationships with people that are less exposed to BCC information. It is therefore pertinent to adequately inform and prepare children for age-disparate relationships as well as for relationships with out-of school youth. Frequency of dating also increases the likelihood of sexual activity. In the survey about 62% of students that reported having a relationship went on a date at least once a week. Therefore it is vital to empower children for relationships.

Condom Cultures

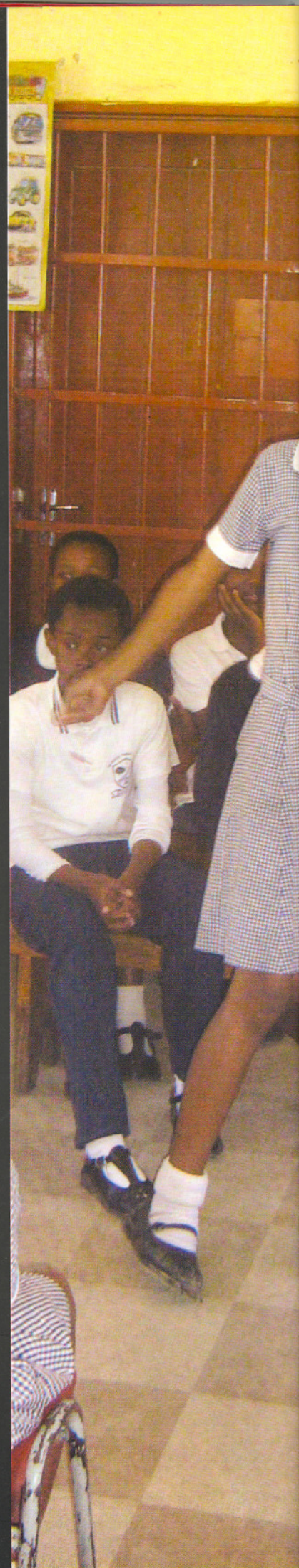
The fact that most respondents aged 10-18 identified sex without protection and having sex with many partners as primary risk behaviours provides an opportunity to intensify messages that emphasize the efficacy of using condoms and delaying sexual debut.

Breaking the Silence on Sexuality

The findings suggest that a significant proportion of children do not discuss sex with anyone and this veil of silence is indicative of the stigma and taboo that still pervades young children and communities regarding sexual matters. There is therefore a need for interventions that will promote greater dialogue as well as help break the rigid taboos that inhibit the discussion of sexuality among young children.

Helping Teachers to 'Communicate' Effectively

Only 18% of the respondents (aged 10-18) well understood the information disseminated by teachers on HIV and AIDS and sexuality. Furthermore the low significance placed on the effectiveness of teachers in disseminating information on sexuality suggests that the potential of the school in implementing promising interventions is also under-exploited. These discrepancies point to a need to build the capacity of teachers in life skills training as well as improve the IEC media they currently use. The current approach of mainstreaming BCC, sexuality and rights knowledge into other school subjects should also be reviewed to avoid subject bias against life skills education. Developing a specific subject encompassing BCC, children's rights, sexuality and sexual and reproductive health is one of the options that have to be considered.



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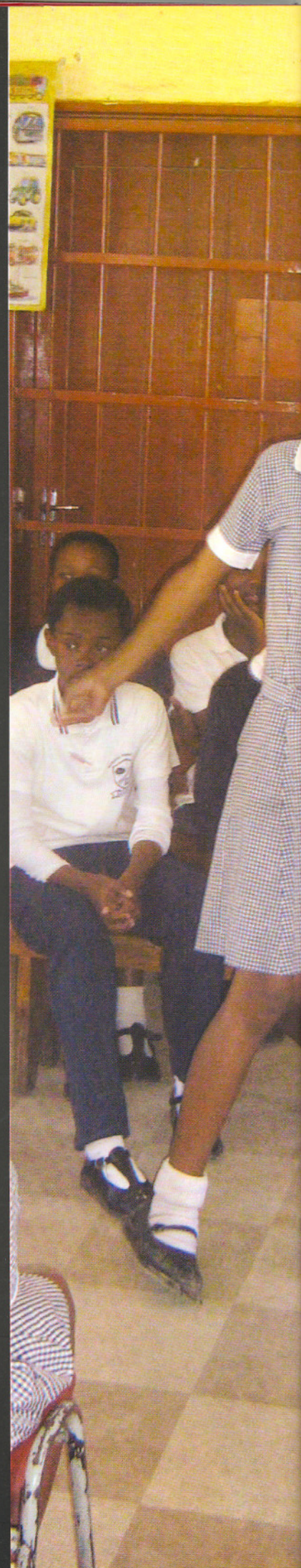
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Focusing on Young Children (below age 10)

Due to the age range included in its sample this report somehow represents a pioneering work in Swaziland because most of the studies and surveys that were carried out on access to BCC for children largely focused on children 10 years and older. For example the SHAPE study targeted children aged 10-19 and the SDHS focused on children aged 12-14 and the youth aged 15-24. Therefore limited information is available on the behavioral practices, sexuality, values and attitudes of young children (i.e. 6-9). A broader paradigm shift is therefore required in order to develop comprehensive strategies and interventions targeting young children.

Investing in Boys

More females than males were generally more knowledgeable about HIV and AIDS. Boys also trailed behind girls in most of the BCC knowledge indicators. This discrepancy highlights the need to urgently bridge the knowledge gap through enhancing and intensifying interventions targeting boys. Gender and masculinities are some of the vectors that impel the drivers of the AIDS epidemic. It is therefore imperative to provide gender training for boys in order to mitigate the negative effect of male chauvinism and negative traits associated with male identity, the politicization of sexuality and the consequent alienation of women. A gendered BCC curriculum that primarily targets male participation is recommended.

Reaching Out-of School Youth

Almost a third of all students that were dating had a relationship with a non-student. Therefore it is imperative to develop BCC interventions and materials targeting out of school youth. The information for out-of school youth should be of equal standard and quality with that of in-school children.

Empowering Mentors and Significant 'Others'

About one third of respondents aged 10-18 still rely on either guardians or friends to make decisions regarding sexual matters. Therefore increased investment in interventions that empower and enhance the 'child protection' competency of guardians and others is necessary.

The mother was the most relevant person from whom children solicit information on sexuality. Therefore it is imperative to also develop IEC materials aimed at informing and enhancing the capacity of guardians to assist children on matters of BCC and sexuality. Guardian focused interventions can be effective when they are also founded on a 'rights' framework. Therefore guardians must be exposed to child friendly information on sexual to ensure positive outcomes for children.

There is also a need to intensify BCC activities that empower significant others (i.e. friends, relatives) who provide knowledge and support to young people on BCC and sexuality.

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LEGAL INSTRUMENTS

ACRWC African Charter on the Right and Welfare of the Child

United Nations (1989) Convention on the Rights of the Child

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