SOCIO-CULTURAL FACTORS INFLUENCING ACCESSIBILITY AND UTILIZATION OF HIV/AIDS PREVENTION INFORMATION AMONG OUT-OF-SCHOOL ADOLESCENTS IN RAKAI DISTRICT

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NOVEMBER 2012
DECLARATION

I, Lorna Muduwa, do hereby declare that this is my original work and has never been submitted for any award in any other institution of higher learning.

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DEDICATION

I dedicate this to piece of work to my Husband Ssemwanga Deogratius and Son Adrian Mark.
ACKNOWLEDGEMENT

I extend my gratitude to all contributors to the success of this dissertation. I am indebted to the out-of-school adolescents and other stakeholders that took time to respond to this research through filling in questionnaires and talking to me on numerous interviews. Special thanks to the Project manager for Rakai project who guided the procedure for data collection and; officials of Ministry of Health, Ministry of Gender, Labour and Social Development who allowed access to their resource centers and provided me with guidance on documentation relevant to this study. Further appreciation also go to sub county chiefs, the management of Rakai project for their contribution in provision of audio and printed HIV prevention messages targeting the youth as well as organizing focus group discussions. All your contributions have enabled this study to add to the body of knowledge to Makerere University and to the Social Sector Planning and Management course in particular.

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ABBREVIATIONS

ABC Abstinence, Being faithful and Condom use
AIC AIDS Information Centre
AIDS Acquired Immune Deficiency Syndrome
DOI Diffusion of Innovations Theory
FGD Focus Group Discussion
HIV Human Immunodeficiency Virus
IEC Information Education Communication
KDHS Kenya Demographic and Health Survey
MDGs Millennium Development Goals
MoH Ministry of Health
NGOs Non-Governmental Organizations
PIASCY Presidential Initiative on AIDS Strategy on Communication to Youth
SPSS Statistical Package for Social Scientists
STI/Ds Sexually Transmitted Infections and Diseases
UDHS Uganda Demographic Health Survey
VCT Voluntary Counseling and Testing
WHO World Health Organization
ABSTRACT

This study examined the information channels and the socio-cultural factors that influence accessibility to, and utilization of, HIV/AIDS prevention information among out-of-school adolescents in Kyotera County, Rakai District. Specifically, the study sought to examine how social and cultural factors had influenced accessibility and utilization of HIV/AIDS prevention information as well as the nature of information channels used in disseminating HIV/AIDS prevention information to out-of-school adolescents (12-19 years) in the area.

A descriptive survey research design was adapted where a total sample of 98 respondents including out-of-school adolescents, health workers and local leaders participated in the study. The primary data was collected using structured questionnaires for adolescents, interview guides for key informants and focus group discussion checklist for local and opinion leaders. Both qualitative and quantitative data were collected and analysed.

Research findings revealed that social and cultural factors had a negative influence on access and utilization of HIV/AIDS prevention information among out-of-school adolescents in Kyotera County. However, age and gender were significant among the social factors much as widow inheritance and age at marriage were significant among the cultural factors. The nature of HIV/AIDS prevention information disseminated included use of condoms during sexual intercourse, abstinence, being faithful to marriage partners, HIV testing before sexual intercourse and STDs treatment.

In order to increase access and utilization of HIV/AIDS prevention information, the study recommended addressing the risky traditional customs and practices, implement interventions to empower females to overcome submissiveness and inferiority in matters concerning their personal health, urging religious leaders to concentrate their efforts on educating people about HIV prevention, involving opinion leaders in behavior change interventions and above all, out-of-school adolescents should be involved in disseminating HIV/AIDS prevention information using approaches that appeal to fellow adolescents.
CHAPTER ONE
INTRODUCTION

1.1 Background to the Study

Over two decades since the Acquired Immune Deficiency Syndrome (AIDS) was first recognized (in 1981), and its agent the Human Immuno-deficiency Virus (HIV) identified in 1983, there is neither a cure nor a vaccine against the disease (Centers for Disease Control and Prevention, 2004). Interventions like Information, Education and Communication (IEC) intended to bring about changes in behaviour remain the principal means of preventing further spread. However, it is evident that despite massive action to inform the public about the risks, behavioural changes are not occurring as expected (World Bank, 2002). The infection has continued to expand rapidly and serious questions have begun to emerge as to the efficiency of the efforts undertaken in combating the illness (Aggleton, Chase & Rivers, 2004). Although experience has demonstrated that the HIV/AIDS epidemic is a complex, multifaceted issue that requires multi-dimensional social, economic, political and cultural strategies; there has been little documentation and analysis of socio-cultural factors that influence accessibility to, and utilization of, HIV/AIDS prevention information.

Despite its affects on all the social sectors of the population, the HIV/AIDS epidemic among adolescents is growing very fast partly because of young people’s vulnerability and low use of preventive services (Guiella and Madise, 2007). In spite of this, adolescents are also seen as a ‘window of hope’ because they have great potential for positive change of attitudes and behaviours. Focusing on young people is likely to be the most effective approach to confronting the epidemic, particularly in high prevalence countries. This was recognized at a global level by the 2001 UN General Assembly Special Session on HIV/AIDS who endorsed that “By 2003, establish time-bound national targets to achieve the internationally agreed global prevention goal to reduce by 2005 HIV prevalence among young men and women aged 15-24 in the most affected countries by 25% and by 25% globally by 2010” (UNICEF, 2005).

Logan, et al (2002) define social factors as “factors that impact groups of people similarly but are external to individuals” (p. 852), such as age, sex, religion among others. Mazrui (1986, p.
239) defines culture as ‘a system of interrelated values active enough to influence and condition perception, judgment, communication, and behavior in a given society’. Cultural factors on the other hand, involve a complex set of distinctive spiritual, material, intellectual and emotional features that characterize and define a society or social group (UNESCO, 2001). It encompasses ways of life, the fundamental rights of the person, value system, traditions and beliefs. In this study, the cultural factors considered include early marriage, cultural stigma and taboos, widow inheritance and dowry. Social factors on the other hand, include age, gender, religion, occupation and level of education. While some socio-cultural factors that influence access and utilization of HIV/AIDS prevention information vary depending on the tribe or ethnic grouping, a good number of them are similar (UNESCO, 2001).

Meanwhile, studies have shown that people often knowingly engage in sexual behaviour that places their health at risk, and it is being increasingly appreciated that a major factor that contributes to most-at-risk sexual behaviour is the cultural norms and values that exist in the community where the individual resides, especially among the people with whom an individual interacts and social groups to which they belong (Campbell, 2003). Raising awareness about HIV/AIDS prevention and protecting adolescents from adverse sexual outcomes has been challenging. Often the most vulnerable adolescents are those out-of-school because they are hard to reach and continuity of information flow is difficult due to their semi-illiteracy nature. In order to overcome these challenges, HIV/AIDS interventions must situate the sexual health needs of out-of-school adolescents within a broader context of proximate social and cultural needs, risk and vulnerability, recognizing that children and young people have “varying degrees of resourcefulness and resilience to cope with adversity” (Chase and Aggleton, 2006, p. 95). Despite this, the most serious shortcoming of institutional strategies and policies is the lack of consistent consideration of the societal and cultural aspects of HIV/AIDS prevention among adolescents1. Besides, the socio-cultural aspects that influence accessibility and utilization of HIV/AIDS prevention

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1 Adolescence is considered by WHO as ranging from 11 or 12 through 17 or 18 years of age. Youth is defined by the United Nations as the period 15-24 years. The term “young people” often is used to describe both groups—those between ages 10 and 24.
information/education/communication methods among adolescents have not been given adequate research attention.

Although adolescent statistics have only recently begun to be collected as a separate population data source, global estimates show that 11.8 million people living with HIV are between the ages of 15-24 (UNICEF, 2005). Globally, 40 percent of all new human immuno-deficiency virus (HIV) infections occur among 15–24 year olds; recent estimates being that 7,000 are infected each day (McManus and Dhar, 2008). These health risks are influenced by many interrelated factors, such as lack of access to HIV/AIDS prevention information, expectations concerning early marriage and sexual relationships, access to education and employment, gender inequities, sexual violence, and the influence of mass media and popular culture. Indeed, few sexual health services focus on the provision of HIV/AIDS prevention information to out-of-school adolescents (Neema et al, 2004). Consequently, few empirical studies have been carried out to examine information channels and the socio-cultural factors that influence accessibility to, and utilization of, HIV/AIDS prevention information among out-of-school adolescents.

Several million adolescents are out-of-school in rural and urban centres worldwide (UNICEF, 2006) and their numbers are rising steadily. These adolescents are particularly at risk of HIV/AIDS. Despair, feelings of abandonment and extreme poverty engender risky sexual behaviour. To some of the out-of-school adolescents like those living on the streets, survival sex, prostitution and rape are not uncommon, and sex and drug taking are often linked (SwartKuger and Richter, 1997; GOAL Uganda, 2001). Inevitably, consequences of risky sexual behaviour, such as HIV infection, remain secondary to day-to-day concerns with survival (GOAL Uganda, 2001). Access to formal information and services is often limited and the informal networks in which young people find themselves may not be supportive of protective health behaviour (Chase and Aggleton, 2006). Unlike school going adolescents who have direct access to HIV/AIDS prevention information\(^2\), greater opportunities and more choices in life; the out-of-school counterparts are difficult to reach, organize and monitor. For

\(^2\) Abstinence, being faithful, and condom use (ABC), HIV counseling and testing and treatment of STDs.
this reason, they have rarely been targeted by government and non-governmental programmes on HIV/AIDS prevention. Indeed, a study by Neema, et al (2004) revealed that out-of-school youths were considerably less informed about HIV/AIDS than school children. Therefore, despite the massive action to inform the public about the HIV/AIDS risks, information flow appears to be limited to those in the school system. It was not clear if socio-cultural factors have an influence on access and utilization of HIV/AIDS prevention information by out-of-school adolescents. This research therefore, sought to examine the socio-cultural factors that influence accessibility to, and utilization of, HIV/AIDS prevention information among out-of-school adolescents in Kyotera County, Rakai District.

1.2 Statement of the Problem

Many studies on HIV/AIDS in Uganda have identified the need to target rural youths especially those out-of-school with HIV/AIDS prevention messages (Ministry of Health, 2005; Uganda Aids Commission, 2004 and Neema et al, 2004). Out-of-school adolescents form one category of the vulnerable populations that have been less targeted by behaviour change and communication programmes, skills training and HIV/AIDS prevention information (Burns, Ruland, Finger, 2004). While there is evidence that out-of-school adolescents constitute nearly half of the adolescents between the ages of 12-19, they are less informed about HIV/AIDS prevention than in-school youths (UNICEF, 1992). In Kyotera County, Rakai District many of the youth engage in early and unprotected sex, early marriages and widow inheritance among others (World Vision, 2006). It is believed although not confirmed that, the reason for this is that out-of-school adolescents have had little access to information, lack self-confidence and are bound by social and cultural factors of their societies. Besides, they are rarely given the opportunity to learn about health issues and even in the rare instances where sensitization sessions are held; out-of-school adolescents are not specifically invited, made welcome and involved in discussion. Due to these controversies, it was necessary to examine the socio-cultural factors that influence accessibility to, and utilization of, HIV/AIDS prevention information among out-of-school adolescents in Rakai District.

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3 Behavior change and communication programs in Uganda include FPAU, The Care and Support Project, AIDS Information Centre/Commercial Market Strategies, VCT Communication Campaign and Straight Talk Foundation’s Straight Talk programme.
1.3 General objective

The general objective of the study was to examine socio-cultural factors that influence accessibility to, and utilization of, HIV/AIDS prevention information among out-of-school adolescents in Kyotera County, Rakai District.

1.3.1 Specific Objectives

The specific objectives of the study were:

1. To examine how social factors influence accessibility and utilisation of HIV/AIDS prevention information among out-of-school adolescents.
3. To assess the nature of information channels used in disseminating HIV/AIDS prevention information to out-of-school adolescents.

1.4 Hypotheses

1. Social factors have no influence accessibility to, and utilization of, HIV/AIDS prevention information among out-of-school adolescents.
2. Cultural factors have no influence accessibility to, and utilization of, HIV/AIDS prevention information among out-of-school adolescents.

1.5 Scope of the Study

This study was conducted in three selected sub counties of Kyotera County in Rakai district. The sub counties included Kalisizo, Kabira and Kyotera town council. The sub counties were selected due to the high number of out-of-school adolescents, high prevalence rate of HIV/AIDS and besides, no similar study had been conducted in the area. According to the 2002 HIV/AIDS surveillance Report, the HIV/AIDS prevalence rate in Rakai district was 12% in 2002. This prevalence is two times higher than the national average, which stands at 6.1% for 2002.

In its content scope, the study examined how social and cultural factors influenced accessibility and utilization of HIV/AIDS prevention information among out-of-school adolescents, and utilization of, HIV/AIDS prevention information among out-of-school adolescents.
adolescents. In addition, the nature of information channels used in disseminating HIV prevention information to out-of-school adolescents were investigated. The cultural factors considered include early marriage, cultural stigma and taboos, widow inheritance and dowry. Social factors on the other hand, include gender, age, religion, occupation and level of education. The information channels included both formal and informal channels. The information conveyed looked at the ABC strategy (Abstinence, Being Faithful or Using a Condom), life skills, counseling and HIV testing and treatment of STDs.

The time scope ranged from 2002 until December 2006 just before Universal Secondary Education (USE) was launched. With introduction of free secondary education, it was hoped that the number of out-of-school adolescents would drastically reduce. The study targeted out-of-school adolescents between 12-19 years of age because of the need to get those who had either dropped out-of-school at primary and secondary levels. Besides, this age group was experiencing sexual development yet with little information and experience in HIV prevention strategies.

1.6 Significance of the Study

The findings of this study will add to the body of knowledge about socio-cultural factors and the accessibility to and utilization of HIV/AIDS preventive information among out-of school adolescents. The Makerere University Community will also benefit when a copy of this study is deposited in Library and accessed by students/University community researching on a similar issue. Therefore, the study will help to inform other researchers who may wish to carry out similar studies by providing pertinent literature about the influence of socio-cultural factors on HIV/AIDS preventive information among out-of-school adolescents.

Further, the study will provide information to policy makers in the Ministries of Health and Education and Sports, which may be useful in designing appropriate HIV/AIDS policies that target out-of-school adolescents in Uganda, which ultimately will contribute to improved accessibility to and/or utilization of HIV/AIDS preventive information among out-of-school adolescents.
The study will be of importance to international donor agencies and non-governmental organizations that are supporting the adolescent reproductive health services in the country. This will enable them to prioritize the most crucial HIV/AIDS prevention services that out-of-school adolescents need today.

Lastly, the study has been undertaken with the primary objective of enabling the researcher obtain a Masters degree in Social Sector Planning and Management in Makerere University.

1.7 Theoretical framework

Due to diversity of the independent and dependent variables, this study was based on two theories: the Social Cognitive Theory (SCT) by Albert Bandura (Bandura, 1977) and the Diffusion of Innovation Theory formulated by Rogers Everett (Rogers, 1962). The former was used to inform the independent variables while the latter informed both moderating and dependent variables.

1.7.1 The Social Cognitive Theory (SCT)

The Social Cognitive Theory (SCT) by Albert Bandura (Bandura, 1977) defines human behavior as a dynamic and reciprocal interaction of personal factors, behavior, and the environment (Bandura, 1977; 1986; 1989). According to this theory, an individual's behavior is uniquely determined by each of these three factors. The personal factors include age, gender, education level, religion and occupation of an individual while environment factors include the cultural norms of the community where one lives.

The SCT ‘s strong emphasis on one's cognitions suggests that the mind is an active force that constructs one's reality, selectively encodes information, performs behavior on the basis of values and expectations, and imposes structure on its own actions (Jones, 1989). Through feedback and reciprocity, a person's own reality is formed by the interaction of the environment and one's cognitions. In addition, cognitions change over time as a function of maturation and experience (i.e. attention span, memory, ability to form symbols, reasoning skills).
The three factors environment, people and behavior are constantly influencing each other as illustrated in Figure 1.1. Behavior is not simply the result of the environment and the person, just as the environment is not simply the result of the person and behavior (Glanz, Rimer, & Lewis, 2002). The environment provides models for behavior.

Figure 1.1: The interaction of Social Cognitive Theory variables


1.7.2 The Diffusion of Innovation Theory

The Diffusion of Innovation Theory formulated by Rogers Everett (Rogers, 1962) posits that certain individuals (opinion leaders) from a given population act as agents of behavior change by disseminating information and influencing norms in their community (Rogers, 1983). It asserts people adopt new behaviours when they are convinced by an idea suggested to them by other members whom they trust. ‘When beneficial prevention beliefs are instilled and widely held within one’s immediate network, individuals’ behaviour is more likely to be consistent with the perceived social norms’ (Kelly, 1995).

Changes in behavior needed to halt the HIV/AIDS epidemic constitute what Rogers has labeled a “preventive innovation,” defined as “an idea that an individual adopts at one point in time in order to lower the probability that some future unwanted event may occur” (Rogers, 2003). In countries where HIV transmission occurs primarily through sexual
relations like Uganda, the specific behaviors include abstinence, being faithful (to an uninfected partner), or condom use - known as the ‘‘ABCs’’. Besides, influential people, communities, political and religious leaders, artists, and others well-known or respected people should spearhead HIV/AIDS awareness and campaigns, show best practices which contribute to risk reducing in order to be followed by others. Therefore, the Diffusion of Innovation Theory was found to be useful in diffusing safe sex messages particularly HIV/AIDS prevention information within groups or communities like the out-of-school adolescents.

1.8 Conceptual framework

The study conceptualized social and cultural factors as independent variables, accessibility and utilization of HIV/AIDS prevention information as the dependent variable while information channels were the moderating variables. The relationship is illustrated in Figure 1.1.
In the conceptual model in Figure 1.1, the cultural factors considered include early marriage, cultural stigma and taboos, widow inheritance and dowry. Social factors on the other hand, include gender, age, religion, occupation and level of education. The information channels through which HIV/AIDS prevention information can flow to the out-of-school adolescents include both formal and informal channels. The dependent variable focused on the ABC strategy (Abstinence, Being Faithful or Using a Condom), life skills, counseling and HIV testing and treatment of STDs. Therefore, socio-cultural factors influence the choice of information channels, which in turn influence accessibility and utilization of HIV/AIDS preventive information among out-of-school adolescents.
1.9 Definition of Key Terms

i) Social factors
According to Logan et al., (2002) social factors are defined as “attributes that impact groups of people similarly but are external to individuals”. In this study, the social factors considered include gender, age, religion, occupation, level of education.

ii) Cultural factors
Cultural factors involve a complex set of distinctive spiritual, material, intellectual and emotional features that characterize and define a society or social group (UNESCO, 2001). It encompasses ways of life, the fundamental rights of the person, value system, traditions and beliefs. In this study, the cultural factors considered include early age of marriage, cultural stigma and taboos, widow inheritance and dowry.

iii) Out-of-school adolescents
Across the globe, out-of-school adolescents are a diverse group which may have completed a certain school level but dropped out before starting the other, or never started school (UNAIDS, 1999). They may have jobs or be married, or may be girls who have been forced to quit school because they need to work in the home, are pregnant, or have babies. They work in factories, live on the street, hawk petty items in the market, stay at home for housework or child care, or are unemployed. They include married adolescents, boys and girls in rural areas, and girls who get pregnant and have to leave school. In most developing countries, girls are more likely to be out of school than boys. Other out-of-school adolescents live under the most challenging conditions and are marginalized from main-stream services and society. Street children, adolescent sex workers, orphans, child soldiers, and other such groups are generally, but not always, out-of-school (Chase and Aggleton, 2006). This research report focuses on out-of-school adolescent ages 12 to 19, who generally would be attending primary school and secondary school.

iv) HIV: Human Immunodeficiency Virus - weakens the immune system and can cause Acquired Immune Deficiency Syndrome. The virus is transmitted in blood, sexual fluids, and breast milk.
v) **AIDS**: Acquired Immune Deficiency Syndrome is an advanced stage of HIV infection. It generally occurs when the CD4 count is below 200/ml and is characterized by the appearance of opportunistic infections that take advantage of a weakened immune system.

It is important to note that the terms HIV and AIDS are often used together denoted by HIV/AIDS. UNAIDS (2001) explain, however, that HIV should be used on its own unless specifically referring to AIDS. This is because AIDS is just one stage of HIV infection and not everyone who is HIV positive has AIDS. In this piece of research however, the researcher used both HIV and AIDS together, unless directly quoting another source.

vi) **HIV prevention Information**

This focuses on the ABC strategy (Abstinence, Being Faithful or Using a Condom), life skills, counseling and HIV testing and treatment of STDs.
CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction
The literature is reviewed according to study objectives that included the influence of social and cultural factors on accessibility and utilization of HIV/AIDS prevention information, the nature of information channels used in disseminating HIV/AIDS prevention information and forms of HIV/AIDS prevention information for out-of-school adolescents. However, literature on the influence of Diffusion of Innovations (DOI) Theory on Access and Utilization of HIV/AIDS prevention information is presented first.

2.2 The Influence of Diffusion of Innovations (DOI) and Social Cognitive Theories on Access and Utilization of HIV/AIDS Prevention Information
Diffusion of Innovations (DOI) Theory provides useful insight into the difficulty of achieving the behavior change necessary to curb the HIV/AIDS epidemic in developing countries (Bertrand, 2004). Although the theory of DOI is very comprehensive, Rao and Svenkerud (1998) have identified the six DOI concepts that are most relevant to HIV/AIDS prevention:
Communication channels are the means by which a message is transmitted from one person to another; the innovation-decision process is an over-time sequence through which a target audience member passes. This sequence has five stages: awareness, knowledge, persuasion, adoption, and implementation; homophily is the extent to which two or more people who communicate perceive that they are similar to one another; an attribute is a characteristic of the innovation that may be perceived either positively or negatively; these include: relative advantage, comparability, complexity, trialability and observability; adopter categories or classifications of individual groups on basis of relative time at which they adopted a new idea, technique, or process; opinion leaders are people who are respected for their knowledge and reputation on some particular topic.

The above concepts provide a useful framework for analyzing the effectiveness of HIV/AIDS prevention programs in the handful of countries that have been successful in reducing HIV
infection rates like Uganda⁴, as well as the failure of prevention efforts to halt the epidemic in the majority of afflicted countries.

Social Cognitive theory which explains human behavior as a reciprocal relationship between behavior, environmental factors and personal factors, has found its applicability in various behaviors for primary prevention such as safe sex programs and problem solving skills (Ruland, 2005). It has also found its role in secondary prevention programs such as condom use promotion programs in sexually transmitted disease clinics (Sharma and Romas, 2008). Some of the social cognitive factors associated with consistent condom use and safer sex intentions in heterosexual college students have been identified to be higher HIV risk perceptions, positive attitudes towards condom usage, safer sex negotiation, higher safer sex perceptions of self-efficacy and fewer negative outcomes of condom use (Raj, 1996).

The Social Cognitive Theory further explains how people acquire and maintain certain behavioral patterns and can also be used for providing the basis for intervention strategies. This is the very justification for its use in this study. The theory is relevant in examining the socio-cultural factors that influence accessibility to, and utilization of, HIV/AIDS prevention information among out-of-school adolescents.

A study relating cognitive variables with utilization of HIV/AIDS information was conducted in India by McManus and Dhar (2008). The study found that the environment in which adolescents lived was sometimes not supportive. The negative parental, religious, community attitudes towards unmarried adolescents seeking HIV/AIDS information were also a barrier to access the services by adolescents. Besides, the parents may stop adolescents from using such services (ibid).

According to Bertrand (2004), DOI explains how a new practice (HIV/AIDS prevention information in this case) can diffuse through a given social system to the point it becomes a social norm. As Rogers explained (1995), when ‘‘trend setters’’ in a social group begin to

⁴ Bertrand (2004) indicates that a handful of countries in the developing world have been successful in curbing the spread of HIV/AIDS: Thailand, Uganda, Senegal, and, to a lesser extent, Cambodia.
model a new behavior to others, they alter the perception of what is normative. Subsequently, others will begin to adopt the new behavior. Ultimately, community members, regardless of whether they have had contact with the original trendsetters, are expected to adopt the new behavior as it diffuses throughout the community’s social networks. Members of the social system in question pass through the stages of the innovation-decision process (awareness, knowledge, persuasion, adoption, and implementation) at different rates, leading to the well-known categories of acceptors: from innovators to laggards.

On the other hand, DOI theory provides a compelling rationale for the failure of prevention efforts throughout much of the developing world. According to DOI, the pace of diffusion relates directly to the five attributes (characteristics) of the innovation, described earlier. By considering the five attributes in relation to the ABCs, it becomes clear why “preventive innovation” has been slow to diffuse in the large majority of developing countries. The handful of success stories indicates that it is possible to overcome these obstacles, but the challenge is immense. Despite the utility of DOI in explaining the slow diffusion of HIV/AIDS prevention techniques in developing countries, it is one of the theories that underscores the design or evaluation of HIV/AIDS prevention efforts (King, 1999).

2.3 The Influence of Social factors on Accessibility and Utilization of HIV/AIDS Prevention Information

According to Logan et al., (2002) social factors are defined as “attributes that impact groups of people similarly but are external to individuals”. In this study, the social factors considered include gender, age, religion, occupation, level of education. The literature on their influence on access and utilization of HIV/AIDS prevention information is presented in the sections below:

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5 Relative advantage, compatibility, complexity, Trialability and observability.
2.3.1 Gender and its influence on access and utilization of HIV/AIDS prevention information

Adomako (1991) posits that the degree to which men and women are able to control the various aspects of their sexual lives (their ability to negotiate the timing of sex, conditions under which it takes place, and the use of condoms) plays a critical role in determining their access and utilization of HIV/AIDS information. A study by Logan et al (2002) revealed that the sex-ratio imbalance in the African community can give rise to women’s difficulty in discussing and negotiating condom use with male sexual partners, thus denying them accessibility and use. The imbalance in the number of women and men results in fewer available male partners; therefore, women have less interpersonal power in relationships because men have more options available to them (Adimora et al., 2001; Logan et al., 2002).

Cultural norms also dictate sexual behavior. As Singhal & Rogers (2003) explained, culture can be a barrier or a facilitator in controlling the HIV/AIDS epidemic. One aspect of culture—the role of women in a given society is recognized as central to HIV/AIDS prevention. In many societies the inferior status of women makes them particularly vulnerable to HIV/AIDS since they are unable to practice safe sex methods. A faithful wife who suspects her husband of having multiple partners can not refuse to have sexual relations with him or negotiate condom use. Young women are often the victims of forced sexual relations, including by members of their own family.

Gender norms are deeply rooted in the socio-cultural context of each society and enforced by that society’s institutions and practices. Socio-cultural norms build notions of masculinity and femininity which in turn create unequal power relations between men and women. This power imbalance impacts women’s and men’s access to key resources, information, and their sexual interactions. It curtails women’s sexual autonomy and expands men’s sexual freedom and control over sexuality. Lower levels of interpersonal power can interfere with women’s ability to initiate discussions about condom use, due to concerns that the topic can lead to conflict and threaten the future of the relationship (Logan et al., 2002).
The gender role prescribed for women, or ‘femininity’, demands a submissive role, passivity in sexual relations, and ignorance about sex. It also restrains women from seeking and receiving information related to HIV/AIDS prevention. In some cultures motherhood is a key aspect of femininity, so the use of contraceptives such as barrier methods that prevent pregnancy and HIV present difficult and often insurmountable challenges for women and men in balancing their desire for children against HIV/AIDS prevention (WHO, 1992). In cultures where virginity is highly prized, young women attempt to preserve their virginity by practicing alternative sexual behaviors, such as anal sex which increases their vulnerability to HIV. In cultures where women are socialized to please men and defer to male authority, particularly in sexual interactions, Hirst (2004) notes that women sometimes engage in high risk sexual behavior such as vaginal douching (a process of rinsing or cleaning the vagina by forcing water or another solution into the vaginal cavity to flush away vaginal discharge or other contents) which they believe makes sex more pleasurable for their male partners.

In African tradition, women are often taught to leave sexual initiative to men and/or to behave in ways which “please men” (e.g. use of vaginal stimulants), whilst increasing risk to themselves. Besides, women are expected to limit their sexual relations, often to marriage or long-term partnerships. Men, meanwhile, are often encouraged to express their masculinity and increase their social status by having many partners/ lots of sexual experience, increasing their own risk of infection, but also that of their monogamous partners (Oppenheim-Mason, 1994). Besides, women, in some societies, are expected to keep silent about and tolerate the sexual behaviour of their male partners (Cohen and Reid, 1998). As part of the marriage contract, women are often expected to meet male sexual “needs” and thus do not feel able to refuse sex, or unsafe sex. Where male sexual pleasure/power is a dominant factor driving sexual relations, risks to the female partner are unlikely to be considered (Oppenheim-Mason, 1994).

There has been a tendency for women to be blamed as carriers of the virus as a result of public action against sex workers (Elias, 1991). This has contributed to a social stigma around HIV/AIDS, which brands women with AIDS as sexually “loose”. This can have negative side
effects by diminishing the attention to HIV/AIDS prevention information especially among the out-of-school adolescents.

People’s control over their sexual lives and choices is in turn shaped by gender-related values and norms defining masculinity and femininity (Tumushabe, 2006). These culturally-defined gender values and norms evolve through a process of socialization starting from an early stage of infancy. They determine and reinforce themselves through traditional practices such as wife sharing, widowhood related rituals, early marriage, female genital mutilation and the condoning of gender-based violence. These cultural practices, values, norms, and traditions have strong influences on the visible aspects of individual behaviors and are important determinants of men’s and women’s access and utilization of HIV/AIDS prevention information (WHO, 1992). In spite of having knowledge of their spouse’s extra-marital sexual interactions, women are often unable to protect themselves due to an imbalance of power within relationships created by economic and emotional dependence (Neema et al., 2004).

Various social, cultural, and religious norms produce and reinforce gender inequality and the stereotypical gender roles that underpin gender-based violence (Oyewumi, 1997). Gender-based violence is a key factor in increasing risk of contracting HIV. For millions of women, the experience or fear of violence is a daily reality and, increasingly, this denies them practicing HIV/AIDS prevention information. Studies from various countries have shown up to three fold increases in risk of HIV among women who have experienced violence as compared to those who have not (UNAIDS, 2000; Abate, 2001). Gender based violence is a violation of human rights and is identified as such by international human rights treatises. The Commission on Human Rights Resolution 2003/45 on Elimination of Violence Against Women notes:

“...Violence against women and girls, including rape, female genital mutilation, incest, early and forced marriages, violence related to commercial sexual exploitation, including trafficking, as well as economic exploitation and other forms of sexual violence, can increase their vulnerability to the HIV/AIDS and aggravate the conditions fostering the spread of HIV/AIDS”
2.3.2 Age and its influence on access and utilization of HIV/AIDS prevention information

Adolescence is a critical period of life, when relationships are formed, rules and cultural norms are tested, means for financial support are found and risk behaviours are experimented with (Ruland, 2005). Many of these limit the extent to which adolescents are willing to seek and utilize HIV/AIDS prevention information. It is believed that the majority of premature deaths in adult years are due to behaviours that are learned in adolescence: such as substance abuse, smoking, violence and unsafe sexual behaviour (Zwicker and Ringheim, 2004). Each year about 15 million adolescents aged 15–19 years give birth, as many as four million obtain an abortion, and up to 100 million become infected with a curable sexually transmitted disease (Outlook, 2005).

As awareness of HIV increases, there is evidence that men shift towards younger partners who are deemed less likely to be infected, whereby the greater age difference increases the risk of transmission (Oppenheim-Mason, 1994). In some societies, it has been observed that people believe that they can be cured of AIDS by passing on the disease to others (Grundfest-Schoepf, 1991: 756). In other cases, men who are HIV positive specifically seek out younger partners (virgins) in the belief that this may “cure” them. Since the young girls may not be economically self-reliant, they may yield to pressures from the old men thus failing to practice HIV/AIDS prevention information, however much they may have accessed it. It was therefore, the intention of this study to assess further the influence of other social factors in accessibility and utilization of HIV/AIDS prevention information especially among the out-of-school adolescents.

The Kenyan DHS in 2003 found that of women age 15-19 who had higher-risk sex in the past 12 months; only 4% indicated that this was with a man who was ten or more years older than them (KDHS, 2003). Inter-generational sexual relationships have been cited in Kenya and elsewhere as the reason behind the higher prevalence of HIV among young women (as compared to young men), but these data suggest that there must be other factors, perhaps related to their biological susceptibility. Although socio-cultural factors were not considered in influencing access and utilization of HIV/AIDS prevention information, this study
attempted to do so. However, a study conducted in Kenyan towns, Longfield (2004) found that among young women who engaged in inter-generational sex, the primary incentive for engaging in such relationships is financial and pressure from peers to find older partners. Such couples rarely used condoms. Material gain, sexual gratification, emotional factors, and recognition from peers were overriding the concern for STI/HIV risk. Women's ability to negotiate condom use were compromised by age and economic disparity.

2.3.3 Religion and its influence on access and utilization of HIV/AIDS prevention information

Religion and religious beliefs are the foundations of community life in a majority of societies. Religion prescribes ethical guidelines for many aspects of daily life and also navigates belief systems and norms surrounding sexuality. UNESCO (2001) noted that the majority of religiously tailored belief systems condemn premarital sex, contraception including condom use, and homosexuality. Some religions also advocate a submissive role for women, foster gender inequality in marital relations, and promote women’s ignorance in sexual matters as a symbol of purity. These stereotypes constructed by religion can inhibit access and utilization of HIV/AIDS prevention information and increase vulnerability to HIV infection. It was however, not clearly documented if religious beliefs played a significant role in influencing accessibility and utilization if HIV/AIDS prevention information among out-of-school adolescents in Rakai district, hence the need for the study.

HIV vulnerability caused by religious beliefs and practices is the result of religious institutions’ denunciation of HIV infection as sinful (Kisekka, 1991). Such religious judgments play a significant role in generating HIV- and AIDS-related stigma which increases vulnerability. Research has shown that religion also influences men’s and women’s exposure to HIV prevention messages, knowledge and perception of risks, and the practice of prevention (McManus and Dhar, 2008). Women have been found to be disadvantaged in seeking information about HIV/AIDS due to their religious beliefs. Religions advocating against condom use pose a serious challenge to preventing the spread of HIV in the communities where they operate. Similarly, religions that denounce homosexuality tend to
fuel stigma against those who engage in same sex behavior, thus indirectly increasing their vulnerability to HIV.

Religion, in spite of being a social determinant of vulnerability, has great potential for preventing HIV and reducing HIV- and AIDS-related stigma. Because of the influence religious leaders have on the community, they can play a significant role in behavior change interventions, including the promotion of condom use, to reduce HIV transmission and de-stigmatize HIV and AIDS.

2.3.4 Level of education and its influence on access and utilization of HIV/AIDS prevention information

Although, globally, countries with high literacy have lower levels of HIV-infection, in Sub-Saharan Africa the most affected countries are those with relatively high levels of education (UNAIDS, 1998). This may be because the social changes that accompany increased schooling are associated with other behavioural changes which increase risk and:

“this may be especially the case for women, who without education may have very much less social mobility and be exposed to a much narrower spectrum of social and sexual relationships” (UNAIDS, 1998: 21).

Evidence from Zambia shows that while older women with more years of schooling are more likely to be infected than their less educated peers, the pattern is much less pronounced among younger women (ibid.). This suggests behavioural changes are occurring as awareness of HIV/AIDS is increasing. Similar evidence is reported from Uganda and Tanzania (Kirunga and Ntozi, 1997; Barnett and Blaikie, 1992). This implies that access and utilization of HIV/AIDS prevention information is not influenced by the level of education but may be personal behaviour which may have been influenced by the level of awareness.

The Department for International Development (DFID) (2006) notes that one of the benefits of investing in secondary education is influencing and pushing for better choices in terms of sexual behaviour, reduction of infection rates and increased tolerance and support for people living with AIDS. HIV prevalence is considerably lower among both female and male teenagers in secondary school in Burundi, Eritrea, Mozambique, Tanzania, Uganda and
Zimbabwe. In Swaziland, two-thirds of teenage girls in school are free from HIV, while two-thirds of out-of-school girls are HIV positive. Secondary education has proved to be the single biggest factor in reducing the threat of HIV and AIDS for girls. In Uganda, young people who have been to secondary school are four times less likely to become HIV positive.

The World Bank (2002) noted the need by countries to accelerate efforts towards achieving Education for All (EFA) because of the critical role it can plays in preventing HIV/AIDS. It was further noted that prioritizing education was crucial for several reasons: First, *it has been proven to provide protection against HIV infection*. UNESCO (2000) indicates that a general basic education itself has an important preventive impact: it can inform children and youth and equip them to make healthy decisions concerning their own lives; bring about long-term healthy and safe behaviors; and give them the opportunity for economic independence—all fundamental to prevention and, therefore, hope. Second, *it is among the most powerful tools for reducing girls' vulnerability*. Girls' education can go far in slowing and reversing the spread of HIV by contributing to poverty reduction, gender equality, female empowerment, and awareness of human rights. It has crucial implications for female economic independence, delayed marriage, family planning, and work outside the home. It makes girls less prone to practices and attitudes that expose them to greater HIV risk or that promote non-assertive behavior or feelings of inferiority (The World Bank, 2002). Third, *education offers a ready-made infrastructure for delivery of HIV/AIDS prevention efforts* to large numbers of the uninfected population-schoolchildren—as well as youth who are in many countries the age group most at risk and; fourth, *education is highly cost-effective as a prevention mechanism*. Countries where the epidemic is not yet at crisis proportions will, by preventing AIDS through education, avoid the health care-related costs that have to be borne by worst-affected countries.

### 2.3.5 Occupation and its influence on access and utilization of HIV/AIDS prevention information

According to Cohen and Reid (1998), lack of an occupation was leading the youth to a feeling of hopelessness, drug trafficking, drug abuse and prostitution thereby denying many of the a chance to utilize HIV/AIDS prevention information. It is believed that there are thousands of
commercial sex workers and most of them are out-of-school adolescents. The consequence of childhood prostitution includes health problems resulting from physical abuse, early and unwanted pregnancy, STIs, HIV/AIDS, abortion as well as psychological problems, low self esteem, hopelessness and stigma.

In another study by Kissling (2005), a high prevalence rate was reported in the fishing communities along the shores of Lake Victoria. These communities documented high HIV prevalence rate (30%) as well as a very high rate of STIs, and there has been some research looking at factors that could be contributing to the high prevalence in these populations (Kissling, 2005), including the custom of jaboya⁶, where the fishermen demand sex from the women fish traders in exchange for product. It was not clear, however, if the fishing communities have adequate access to HIV/AIDS prevention information.

McNair and Roberts (1997) suggest that the failure of casual labourers to utilize HIV/AIDS prevention information was not because they had no time during day, but may be were preoccupied with other life challenges. For example, a person who is confronted with financial stress and underemployment may use alcohol to cope with hopelessness and depression and, in doing so, may engage in unprotected sex with her partner. Given this array of life circumstances, she/he may also engage in other behaviors that do not promote health—that is, inattention to healthy nutrition and inability to engage in proactive, preventive health screenings.

Richter (2009) revealed that the economic crisis had rendered women and girls, increasingly vulnerable to both labour and sex trafficking. Moreover, in times of financial hardship, women working in the commercial sex industry may stop demanding that their clients use condoms, for fear of losing business, increasing their risk of contracting HIV. During the 1997-1998 Asian crisis, many vulnerable women entered commercial sex work in informal settings as a result of the loss of alternative means of income generation (ibid). As actual

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⁶ A custom among the fishing communities in Kenya where the fishermen demand sex from the women fish traders in exchange for product.
demand for commercial sex declined in the context of the crisis (because of declining purchasing power), so did women’s bargaining power to negotiate condom use.

According to Pridmore (2007), it is not at all surprising if the poor adopt behaviors which expose them to HIV infection. It is not simply that Information Education Communication (IEC) activities are unlikely to reach the poor but that such messages are often irrelevant and inoperable given the reality of their lives. Even if the poor understood what they are being urged to do it is rarely the case that they have either the incentive or the resources to adopt the recommended behaviors. Indeed to take the long-view in sexual or other behaviors is antithetical to the condition of being poor. So HIV specific programmes are neglectful of the interests of the poor and are rarely if ever related to their needs. More generally it is the absence of effective programmes aimed at sustainable livelihoods which limit the possibilities of changing the socio-economic conditions of the poor. But unless the reality of the lives of the poor are changed they will persist with behaviors which expose them to HIV infection (and all the consequences of this for themselves and their families).

According to Bukusi (2006) fishing communities have been identified as among the highest-risk groups for HIV infection in countries with high overall rates of HIV prevalence. Men and women living in fishing villages across the world have been found to be between five and ten times more vulnerable to HIV than other communities. Their vulnerability stems from: the amount of time spent away from home; access to cash income; poor education; the ready availability of commercial sex in fishing ports; and sub-cultures of risk-taking and hyper-masculinity.

The highly mobile petty traders and transporters who are both men and women, moving between town to town, local markets and home to home on a daily and seasonal basis, also miss out chances of attending seminars or workshops where HIV/AIDS information is disseminated (Raj, 1996). In addition, the lack of women's rights in many communities makes them more vulnerable to infection; drug and alcohol abuse among men is another contributory factor. These factors may also deny the communities an opportunity to practice HIV/AIDS
prevention information like abstinence or condom use. It was therefore, the purpose of this study to investigate and provide information to close this knowledge gap.

2.4 The Influence of Cultural factors on Accessibility and Utilization of HIV/AIDS Prevention Information

Culture is central to HIV/AIDS prevention, care and support in Africa. The emergence of HIV/AIDS led observers to take the instrumental view of culture, which emphasizes the role traditional cultural institutions and practices play in shaping behaviors that lead to rapid infection rates (Mazrui, 1986). They argue that particular “rites and ceremonies … are incongruent with the modern way of life and observance of which tend to enhance the contraction, containment and spread of AIDS” (MOH, 1997).

Cultural factors involve a complex set of distinctive spiritual, material, intellectual and emotional features that characterize and define a society or social group (UNESCO, 2001). It encompasses ways of life, the fundamental rights of the person, value system, traditions and beliefs. In this study, the cultural factors considered include early age of marriage, cultural stigma and taboos, widow inheritance and dowry. The influence of cultural factors on access and utilization of HIV/AIDS prevention information is presented in the sections that follow.

2.4.1 Early Age of Marriage and its influence on access and utilization of HIV/AIDS prevention information

Early age of marriage is cited in literature as a major variable in HIV transmission. It curtails the social contacts and networks that play a vital role in transmitting HIV prevention information and supporting behavior change (Uganda AIDS Commission, 2006). In the West of Uganda, among the Bakiga, girls were thought to be ready for marriage at puberty or even before (Yeld, 1973). In the North, Lugbara girls often got married at age of 13 - 14 (Middleton, 1973). In the East, Iteso girls married at 14 - 15 and boys at 23 - 25 years. At this early age at which girls married, their bodies were not yet fully developed (WHO, 1992) neither were their cognitive abilities mature to seek and utilize health information like HIV/AIDS prevention information. Young girls marrying old men may end up seeking sexual satisfaction and reproductive fertility elsewhere. The age-gap discourages open communication required to ensure uptake of voluntary counseling and testing for HIV,
sharing information and test results as well as planning for safe sexual relations throughout the marriage. Among the Bakiga in Western Uganda, the older sons can have sex with young wives of their elderly father as long as she is not the biological mother (Moodie and Katahoire, 1991). It was not clearly documented, however, whether such cultural traditions have an influence on the access and utilization of HIV/AIDS prevention information especially among the out-of school adolescents. This study attempted to fill this information gap.

Trends in current data on new HIV infections suggest that the incidence of HIV is rising among married couples worldwide, with unsafe and unprotected heterosexual intercourse being the single most important factor in the transmission of HIV among them (Smith, Wold & Moore, 1992). Marriage, which greatly increases a person’s sexual exposure, has in itself become a risk factor for the out-of-school adolescents in many countries. The dramatic rise in the frequency of unprotected sex after marriage is driven by the implications of infidelity or distrust associated with certain forms of contraception such as condoms, a strong desire to become pregnant, and an imbalance in gender power relations. This results in girl’s increased inability to negotiate safer sex.

The majority of sexually active girls aged 15-19 in developing countries are married (UNFPA, 2005). Child marriage (marriage before age 18) remains a fact of life in South Asia, portions of Latin America, and many sub-Saharan African countries (ibid). Eighty-two percent of girls in Niger, seventy-five percent in Bangladesh, sixty-three percent in Nepal, fifty-seven percent in India and fifty percent in Uganda marry before the age of 18 (Oyewumi, 1997). If the present trend continues, over 100 million girls will be married worldwide before the age of 18 years in the next decade (Outlook, 2005).

Early marriage severely increases young girls’ vulnerability to HIV as they are most likely to be forced into having sexual intercourse with their (usually much older) husbands (Neema et al., 2004). Young girls have softer vaginal membranes which are more prone to tear, especially on coercion, making them susceptible to HIV and other STIs. Older husbands are more likely to be sexually experienced and HIV infected. The dramatic rise in young married
girls’ exposure to unprotected sex is driven by pressure to bear children and their inability to negotiate safe sex. The significant age gap in spouses also further intensifies the power differential between husband and wife, which in turn discourages the open communication required to ensure uptake of voluntary counseling and testing for HIV, sharing information and test results as well as planning for safe sexual relations throughout the marriage (Hirst, 2004).

Early marriage also curtails out-of-school adolescents’ socio-economic development and results in their social isolation which is increasingly identified as a predisposing factor for HIV risk. Besides, girls who are married at an early age also have low educational attainment and limited or no schooling options, limited control over resources, and little or no power in their new households (MoH, 2005).

Child marriages must be viewed within a context of force and coercion, involving pressure and emotional blackmail, as children lack the choice or capacity to give their full consent (UAC, 2006). Child marriage is a violation of human rights as it violates the right to freedom and growth of children. Gender inequality is both a cause and a consequence of child marriage.

2.4.2 Cultural stigma and taboos and their influence on access and utilization of HIV/AIDS prevention information

Cultural stigma and taboos (social bans), especially related to sex and sexual activities increase out-of-school adolescents’ denial to HIV/AIDS prevention information. The taboos associated with sex and knowledge of sex act as barriers to seeking knowledge of HIV prevention and to providing the treatment care and support needed by those infected and affected by HIV (UNESCO, 2001).

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7 Article 16 (2) of Convention on the Elimination of All Forms of Discrimination of Women considers the minimum age for marriage should be 18 years.
Cultural stigma related to HIV/AIDS is triggered by many forces such as a lack of understanding of HIV, myths about how it is transmitted, prejudice, lack of treatment, irresponsible media reporting, social fears about sexuality, fears relating to illness and death, and fears about illicit drugs and injecting drug use. The World Bank (2002) posits that HIV infection has come to be associated with socially condemned sexual behaviors and drug use for which individuals are often considered responsible. Besides, the stigma arising out of connotations of immorality associated with HIV and AIDS, ignorance about the disease also generates stigma.

The stigma and discrimination based on HIV status, in combination with deeply rooted stigmatizing attitudes and discriminatory practices towards women and girls, gay men, sex workers, and drug users, among others, creates conditions for HIV to flourish. For example, fear of stigma and discrimination prevents people vulnerable to HIV from seeking testing or HIV/AIDS prevention information (Mukasa and Nabaloni, 1998). Ignorance about one’s HIV status increases the person’s and their intimate partners’ vulnerability to HIV infection. Fear of stigma and discrimination also adversely affects people’s ability and willingness to disclose their positive test results to others. Stigma is also linked to power and domination throughout society as a whole. Ultimately stigma creates and is reinforced by social inequality (Centers for Disease Control and Prevention, 2004). It causes some groups to be devalued and ashamed, and others to feel they are superior (ibid).

The societal and cultural impact of the infection and disease can result in a general collapse of energy and hope for fighting the virus. The taboo, as such, and the widely spread rule of silence are just a few of the disastrous cultural effects of the revelation of the infection by the concerned person or his/her family (UNESCO, 2001). Stigmatization and rejection have been observed in many instances, especially in rural zones and among the poorest populations. In some countries, in the first phase of the epidemic at least, numerous cases of hesitation or denial were noticed with respect to the recognition of the scope of the disease and the seriousness of the challenge it posed for the country. In Uganda’s case and particularly in Rakai district, no documentation is available to show how cultural taboos have influenced
access and utilization of HIV/AIDS prevention information among out-of-school adolescents. This necessitated an empirical investigation to close the research gap.

2.4.3 Widow inheritance and its influence on access and utilization of HIV/AIDS prevention information

Widow inheritance is relevant to the out-of-school adolescents because community looks at out-of-school youth (17 – 19 years) as potential inheritors of the estates of dead relatives. This usually goes along with helping widows in performing masculine tasks like house building, splitting firewood and providing general security among others. According to UNICEF (1996), sexual inheritance of widows is common among the Bagishu, Basoga and Langi. Some tribes in south-western Uganda also still cherish widow inheritance. Low education, unemployment, dowry, widows' socioeconomic demands and the inheritor's greed for the deceased's wealth, influence widow inheritance (ibid).

The widespread practice of widow inheritance is most often blamed for the continuing spread of HIV/AIDS (Luke, 2002). Widows have been identified as a source of HIV due to the fear that their husbands may have died of the disease and they, too, are infected. As a result, the practice circulates these infected widows among inheriting men and puts men at risk of contracting AIDS. These assumptions, which stigmatize widows as “AIDS carriers,” are accompanied by little concern to access and utilize HIV/AIDS prevention information even if the information and facilities are readily provided in the community health facilities.

In African tradition, marriage and also widow inheritance were thought to reduce female promiscuity, as a single male (the husband or inheritor) could “control” a woman and satisfy her sexual desires. Thus, the inheritor served as a widow’s sole legitimate sexual partner. Within the new union, young widows were expected to continue childbearing with the inheritor, but any new children sired held the name of the deceased husband (Obbo, 1986). The practice also involved ritual sexual intercourse, known as “cleansing,” between the widow and her inheritor at the onset of the arrangement. Cleansing occurs in conjunction with other observances, such as shaving the widow’s head and preparation of a meal for the inheritor. The inheritor fulfilled other social functions as a husband as well. For example, the
inheritor may have stood in for the deceased husband in rituals, including acting the father figure during the marriage of a widow’s children.

Widow inheritance may localize the infection to a few households, as the infected woman would be attached to a single male (the inheritor) rather than circulating freely among men in the community (Adetunji and Oni, 1999). While the custom is risky for an individual inheritor, the practice contains the spread of disease within the entire population. A ban on widow inheritance, on the other hand, could actually accelerate the spread of HIV/AIDS. In the contemporary African context, unmarried or “unattached” women (such as divorced or separated women) are more likely to have numerous sexual partners, as they are often dependent on men for financial support, and these partnerships frequently involve unsafe sexual behaviors (Doyal, 1994). Widows who are no longer inherited and no longer receive traditional means of assistance would likely engage in high-risk behaviors with “outside” male partners in order to support themselves economically.

2.4.4 Dowry and its influence on access and utilization of HIV/AIDS prevention information

In some societies payment of bridal dowry is necessary when a man and woman marry. In parts of Africa the man pays the dowry to the woman’s family. Once the marriage is sealed with the dowry, the woman is considered “paid for” and often cannot leave her husband, should marital problems ensue. Even if her husband’s behaviour places her at risk of HIV infection, the woman may not be able to protect herself. Dowry confers a subordinate status on women and leaves them vulnerable to a legal system that does not recognize their status as wives when dowry has not been paid. Payment of dowry, however, helps partly explain the blatant regard of wives as property of their husbands or male brother’s -in- law or relatives. In theory, dowry is regarded as the main social means by which a bride’s productive and reproductive capacities are transferred from the bride’s family to the groom’s family (McFadden, 1994). Children for whom bride wealth has not been paid acquire the lineage of their maternal uncles. On the other hand a woman for whom bride wealth has been fully paid gives birth to children for the lineage of her husband. McFadden critiques the whole patriarchal system of culture as giving rise to conventions that treat women as the property of
men, fathers as natural guardians of children and include cultural norms which advise women to bear pain for the sake of unity of the family in the face of oppression such as domestic violence, incest, and so on.

Mukasa and Nabalonzi (1998) indicate that as bride wealth rates are increasing, many young men have to wait many years before they can marry. Their options are: a) to live with women and not be formally married; this option, which is widely prevalent in Uganda may encourage high risk sexual behaviour as unmarried men may be less inclined to be faithful to their partner; and b) to live alone until they are able to provide the bride's family with the bride wealth (which could amount to several years), in which case they may have multiple sexual partners, become infected with HIV and eventually infect their wives-to-be.

A study conducted in Kabarole and Gulu districts of Uganda revealed that in the past, when women got pregnant, men had to marry them, pay the bride wealth and assume responsibility for the children (Mukasa and Nabalonzi, 1998). These days, they often abandon the women they impregnate or else they do not (often cannot)-pay the bride wealth. If a man does not pay the bride wealth, the couple is not considered to be officially married, according to customary law, and women's status within the community is at best precarious. Lack of official recognition encourages a tendency of one of the partners to seek other sexual favours form other people who may be willing to do so. This increases the risk of HIV/AIDS infection among the cohabiting couple.

2.5 Nature of Information Channels used in Disseminating HIV/AIDS prevention information to Out-of-School Adolescents

Attention to context of young peoples' lives is widely recognized as crucial in the promotion of their sexual health (see Ingham, 2006), particularly where the environment itself presents significant barriers to protective behaviour. Aggleton, Chase and Rivers (2004) noted that principles of good practice for work with out-of-school adolescents also include: putting them first; ensuring gender equity; promoting meaningful participation; and adopting a rights-based approach. This sub-section presents literature about HIV information channels for the out-of-school adolescents.
2.5.1 Informal communication channels

The informal communication channels discussed in this sub section includes peers and relatives. Peer-to-peer communication⁸ has intuitive appeal as a way of effectively disseminating HIV/AIDS information to hard-to-reach adolescents like those in the rural Rakai district. It certainly has potential to generate meaningful participation and to address risk and vulnerability in context. The pros and cons of the method have been discussed at length (see Milburn, 1995; Turner and Shepherd, 1999). Much has been documented about what makes an effective peer educator. Prominent attributes include: being a credible communicator; a positive role model; and an empathic peer (UNAIDS, 1999). Much less has been written about the extent to which at-risk adolescents in resource-poor settings can successfully take on these attributes. Consequently, this study investigated whether the communication channel was being utilized to access and utilize HIV/AIDS prevention information by out-of-school adolescents in Kyotera county, Rakai district.

In a study about the effectiveness of street youth peer educators in HIV/AIDS prevention in urban Uganda, Mitchell et al. (2007) peer educator (commonly known as Baaba or “respected elder sibling”) messages were appropriately targeted, using participatory and lively channels. However, this was not always easy, particularly during seminars and dramas, which were generally conducted “under a tree”, with community members (young and old) gathering out of interest. However, other Baaba strategies, such as one-to-one discussions during night outreach, provided opportunity for highly targeted messages. In addition, keeping the delivery of prevention messages interesting and lively was a particular challenge. Baabas tended to rely on “tried and tested” methods such as drama and discussions, rather than experiment with innovative approaches. “Tried and tested” methods such as drama were clearly popular with their intended audience, however. Baabas sometimes also regurgitated the peer educator manual without necessarily understanding the underlying issues. In 2004, the Baabas themselves expressed a need to increase the use of other innovative and participatory

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⁸ Defined by Sciacca (1987) as “the teaching or sharing of health information, values and behaviours by members of similar age or status groups”
methods. This led to the development of a series of educational games that were subsequently presented at the national AIDS conference.

According to UNESCO (2001), after diagnosis of the disease, greater attention was paid to prevention, more specifically to the elaboration and implementation of Information/Education/Communication (IEC), aimed at behaviour change and, to some extent, medical support to those living with HIV/AIDS. In this respect, preventive education in school was expected to be the key instrument in checking the pandemic. However, the mainly cognitive and factual information propagated through the school system gradually appeared to have little effect because of its content and modalities. For example, the emotional and empathic attitudes related to the problem are more frequently found in non-school counselling activities. Moreover, this information is not available to children and young people who do not have access to schools, and therefore, by definition, is not addressed to the illiterate.

Indeed, Milburn (1995) revealed that whether it uses the school education channel or mass media, preventive education is far from reaching all rural areas (70% of the Indian population for instance). In urban areas, it does not reach the poorest and segregated groups, including disadvantaged young people like out-of-school adolescents (UNESCO, 2001). Moreover, preventive education frequently advocates condom use. In theory, this represents the best protection against the virus. However, its acceptability varies greatly, depending on societal and cultural environment. In many countries its use requires easy, private and anonymous access through distributors or wide distribution campaigns. Flat refusal to use condoms can be motivated by various and sometimes contradictory socio-cultural reasons. Thus, using condoms cannot be proposed without contextualizing the proposal within the confines of general health education and daily life conditions.

As far as relatives are concerned, adolescents get HIV/AIDS prevention information from traditional and modern sources. The senge⁹ still exists, albeit in weakened form, but the sex and HIV/AIDS prevention education provided are limited in nature maintaining one’s

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⁹ A traditional channel for the Baganda in which sex education is passed from older women to younger women
virginity before marriage (MOH, 2000). Although related to abstinence, it is not clear if after the break of virginity, women are able to practice other safe sex methods. For sex education, the sengas discuss labia elongation especially in Buganda. Since these traditional systems of communicating information about sex are wakening, peer groups, schools, churches, the media, traditional health practitioners, and NGOs have emerged as the most prominent sources of health information for young people in Uganda (Neema et al., 2004).

The senga figure is being revived, especially in the central region of Uganda (Gage et al., 2002). Some recent initiatives, for instance, by the Buganda Kingdom have tried to mobilize adolescents into what is popularly known as “ekisaakaate”\(^\text{10}\) to improve adolescents’ access to reproductive health and HIV/AIDS information and other resources for healthy sexual behavior, decision-making and to empower young girls with the skills to say “no” to unwanted sex, negotiate safer sex and delay their sexual debut if they were not yet sexually active. Unfortunately, most of the sexual, reproductive health and HIV/AIDS services are still situated in urban areas. Remote and rural areas remain largely underserved.

The communication gap between parents and adolescents is probably rooted in existing cultures, which treat sexuality as a sacred value system, implying that it is never openly discussed. Adolescents who discuss sexually related topics are usually considered to be “bagwenyufu” in Luganda; meaning morally spoilt (UNESCO, 2001).

2.5.2 Formal communication channels

The formal channels including mass media, drama, seminars, outreach activities, workshops, youth phone helpline are discussed.

Mass media (both print and electronic) help to raise awareness and improve knowledge of the HIV/AIDS epidemic. It can make people understand that there is an alternative to the situation within which they find themselves. Furthermore, mass media makes HIV/AIDS visible and puts it on the public agenda, which is a prerequisite for breaking the silence surrounding it. Many messages such as those on radio, posters, and television intend to combat the spread of

\(^{10}\) Luganda term used to imply meeting to discuss traditional and cultural values of the Baganda
HIV/AIDS but many of them are simply persuasive to the extent that they ignore the intended goal of the messages (UNESCO, 2001). Further still, the UNAIDS/UNESCO (2001) study indicates that some messages appear to encourage listeners to be sexually adventurous, such as “it feels good using a protector condom”. This message could encourage adolescents to explore to know and ‘practically’ experience the 'feeling good' or worse still compare sexually the use and non-use of a condom.

According to Pridmore (2007), choice of media to deliver mass HIV prevention education is linked to infrastructure development within countries. South Africa, for example, has extensive experience of using national television campaigns combined with a range of media information strategies whilst Mozambique has more experience of face-to-face delivery with some distance learning support materials, although radio now has broad coverage (Pridmore, 2007). These initiatives encourage individuals to reflect on their health and social choices, using real life ‘pro-social’ role modeling to develop positive group identity and solidarity, build a sense of empowerment, and strengthen supportive social networks. Interventions include television drama series, a daily radio program (broadcast in several official languages), booklets on related health topics, adult education and life skills materials, a children’s magazine and a publicity and advocacy campaign. External evaluations show it has influenced individual attitudes and social norms and suggest it has led to change in behaviour (Goldstein, et al, 2005). Having successfully worked in South Africa, it was not clear if the same can help to disseminate HIV/AIDS prevention information to out-of-school adolescents in Uganda. Consequently, a study to examine the nature of information channels used in disseminating HIV/AIDS prevention information to out-of-school adolescents in Rakai district was necessary. This necessitated the current study to take place.

In another respect, UNAIDS (1999) revealed that preventive information broadcast by the media reached very different proportions of the expected audience. Information was thus limited to the number of television and radio receivers of a given country and social group. Moreover, this information was frequently too general or sensationalized. Due to its technical modalities, it was neither targeted to specific audiences nor broadcast on a long-term basis as a continuous activity. Its probable therefore, that the HIV/AIDS prevention information was
never accessed by out-of-school adolescents like those living in the rural Kyotera county in Rakai district where this study was conducted.

Pridmore (2007) stated that public information campaigns have three things in common: they are media campaigns, they use marketing strategies, and they are social marketing programs. Attempts are made to alter public behavior through the use of mass mediated public service announcements on radio and television, advertisements in newspapers and magazines, as well as in-house publications. The campaigns frequently try to stop an undesirable behavior, such as smoking, risky sexual behavior, unlike product promotion which tries to start a behavior, such as product use.

Information, education and communication materials such as posters, newspapers, and other newsprint are access channels. *Straight Talk* and *Young Talk* newspapers supplied by Straight Talk Foundation have targeted in-school adolescents with messages concerning adolescent sexual and reproductive health (Neema et al., 2004). Created in 1993, *straight Talk* circulates on a monthly basis and addresses issues of sexuality, relationships, HIV, and other STIs.

Drama performances were found to be relatively effective at appealing to the public to change behaviour, however, in other occasions, drama was found to be ineffective. In a study of a drama campaign aimed at women, Adomako (1991) concluded that a fear-arousing campaign was effective in persuading women to perform a breast self-examination to check for tumors. By contrast, Larson and Milburn (1995) found that a drama about recycling was ineffective and attributed the failure to the use of a mass media program. According to Pridmore (2007), the majority of these campaigns, dating back as far as the 1940s, have had no effect on changing attitudes and behaviors. Some scholars point out that the lack of effectiveness of some of the drama campaigns may be attributed to the haphazard application of traditional persuasion concepts and a lack of systematic assessments of their results. However, the UAC (2006) observed that videos, films and drama have been used by NGOs to sensitize adolescents and the rest of the populace to HIV/AIDS.
Other communication channels of HIV/AIDS preventive information for the out-of-school adolescents include workshops/monthly discussions, home visits on adolescent sexual and reproductive health topics carried out by peer educators, a youth phone helpline and outreach activities from churches every Sunday. These were conducted by the Care and Support Project that was started as a pilot project to address out-of-school adolescents involved in transient trades who were not being reached with HIV/AIDS prevention, medical care and psychological/social support (MoH, 2006). Two particular challenges to the programs were that peer educators need continuous refresher training to strengthen and expand their counseling skills and information, education and communication materials were only available in English, which limited the number of people who could read them. Seminars conducted by NGOs such as AIC and The AIDS Support Organization, and by community health workers are another important information, education and communication medium.

2.6 HIV/AIDS prevention strategies relevant to out-of-school adolescents

HIV/AIDS prevention strategies relevant to out-of-school adolescents discussed in this section include the ABC approach, life skills, HIV counseling and testing and, treatment of sexual transmitted diseases (STDs).

2.6.1 The ABC approach (Abstinence, Being faithful and Condom use)

According to the MoH (2000), the National HIV/AIDS policy indicates that abstinence from sex particularly among unmarried persons shall be promoted as the most effective strategy for preventing HIV infection. For married couples or those in sexual relationships, mutual faithfulness following negative HIV results for both spouses/partners, shall be promoted as an effective strategy for preventing HIV infection. Where couples are discordant, referral to other providers of HIV/AIDS related services is recommended.

In 2002, the term ABC emerged as a dominant theme to represent the approaches that worked best in reducing the prevalence of HIV in Uganda (Tumushabe, 2006). These adolescent-friendly messages were developed by the Uganda Ministry of Health to emphasize Abstinence
until marriage (A), Being faithful for those in relationships (B) and use of Condoms if the first two fail (C) - the ABC approach (Makerere Institute of Social Research, 2003).

Meanwhile, adolescents’ sexual behaviour and attitudes towards condoms may be shaped by a range of social, psychological, and cultural factors. This has been demonstrated in urban Cameroon (Meekers and Klein, 2002) and Ghana (Adih and Alexander, 1999) where a supportive social environment was associated with higher use of condoms among youth. Although studies were not able to include social environment, psychological, and cultural factors in their analyses, evidence from other studies suggest that socio-cultural factors are the most common barriers to obtaining male condoms among sexually-experienced adolescents in Burkina Faso (Taro, 1997). Strong cultural taboos are especially restrictive for sexually active women (Mays & Cochran, 1988).

Consequently, a study about HIV/AIDS and Sexual-Risk Behaviors among Adolescents in Burkina Faso by Guiella and Madise (2007) revealed that the use of condoms was low and inconsistent among adolescents. Among those who were using condoms, there were significant differences by social and demographic characteristics. For example, use of condoms for non-cohabiting adolescents was much higher than use within cohabiting unions. This finding is consistent with results from other studies on young adolescents in unions, where the use of condoms is very rare (Zellner, 2003). On the other hand, Guiella and Madise (2007) noted that while one would expect adolescents whose sexual partner is a casual acquaintance to be more likely to use condoms compared to those whose partners are boy/girlfriend, findings showed that they were less likely to use condoms. This finding is consistent with results from an evaluation of a condoms social marketing campaign in urban Mozambique where fewer than half used condoms with casual partners. The authors concluded that the levels of condom use in non-regular partnership were considerably lower than what is needed to stop the HIV epidemic in Mozambique (Agha, Karlyn and Meekers, 2001). Another study on 1300 adolescents of 15-21 years old in a northern hemisphere context (from Miami, Atlanta and Providence in the USA), showed that whether or not they were with a regular or a casual sexual partner, adolescents had similar numbers of unprotected sex acts within a 3-months period (Guiella and Madise, 2007).
A possible interpretation for the low use of condoms among adolescents despite high levels of awareness of HIV/AIDS is that the majority of adolescents do not plan to have sex (Guiella and Madise, 2007). Therefore, one can conclude that the majority of adolescents are still engaging in risky behaviours despite their awareness of HIV. This situation has also been shown in another study in Côte d’Ivoire where accuracy of knowledge about AIDS did not significantly predict the use of condoms (Zellner, 2003).

Another negative perception of male condoms among adolescents is that many of them continue to state that condoms reduce pleasure during sex (Mays & Cochran, 1988). The use of familiar expressions like “you don’t eat banana with its peel” (Neema et al., 2004) or “you don’t take a shower with an umbrella” (Samuelsen, 2006) is illustrative of the situation. These attitudes have strong negative influence on condom use and there is a great challenge for prevention campaigns to develop efficient strategies to convince adolescents especially the out-of-school adolescents that the non-use of condoms can jeopardize their lives.

Other researchers have also reported low rates of partner condom use among Africans, who often cite reasons related to inconvenience, fear of reprisal, and negative perceptions about condom use (Wingood & DiClemente, 1998). Low rates of condom use are also consistent with research findings that many heterosexual Africans do not perceive AIDS to be a major health risk and consider themselves to be at low risk for acquiring HIV (Mays & Cochran, 1988). For many of them, low perception of risk is related to two beliefs: (a) AIDS is a disease that affects primarily White gay men (Mays & Cochran, 1988), and (b) being in a monogamous relationship protects them from HIV (Hobfall et al., 1993). Consequently, many heterosexual Africans may not consider unprotected sex with their partners as a risk factor for contracting HIV. It is not clearly documented, however, if the out-of-school adolescents in Rakai district access condom use information to enable them protect guard against HIV/AIDS infection.

Another important reason for non-use of condoms is that both sexually-active female and male adolescents report feeling safe with their partners (Guiella and Madise, 2007). Yet,
feeling safe depends very much on the type of partner and whether or not there are other concurrent sexual relationships. HIV prevention programs, while emphasizing fidelity, also need to educate adolescents on the importance of taking personal responsibility to remain negative.

However, a study by Zellner (2003) found a positive association between schooling and use of condoms with the odds of condoms use increasing with years of schooling. The converse of this finding suggests that the use of condoms among those who were not in school was very low. Given the low level of education in Uganda, it is important to develop programs and strategies to reach out-of-school adolescents so that they too can protect themselves by using condoms and taking advantage of other preventive services.

Most researchers who have investigated the role of ABC in the decline of HIV/AIDS in Uganda agree that the decline can be attributed largely to that approach. Yet there is disagreement regarding the role of each of the three prongs (A, B and C) in the decline. Some analysts attribute the decline to A and B, with C contributing minimally or insignificantly to the decline (MoH, 2005). Contrary to this claim, however, some other researchers (Pridmore, 2007; Aggleton et al, 2004) have shown that all three prongs changed substantially during the period of the HIV/AIDS decline in Uganda and that it is importance of all of these components in efforts to explain the decline.

However, in his study about the Politics of HIV/AIDS in Uganda, Tumushabe (2006) observed that the promotion of pre-marital abstinence, which was adopted as the lead strategy by the Ugandan government and its backers, was not a feasible approach.Apparently, death (which the politicians could not acknowledge as a victory) and condom use (which the Bush administration, the Republican Right and their emerging Pentecostal/evangelical churches in the United States and Uganda did not want to hear about) have been responsible for the Ugandan success story. He further revealed another element as the fact that pre-marital abstinence, which used to be harshly enforced in pre-colonial days, no longer worked since people were marrying later due to a better education and modern economic realities.
2.6.2 Life skills

According to the Ministry of Education and Sports/UNICEF (1996) life skills mean skills of knowing and living with oneself. The Life Skills Model uses a large variety of methods to teach adolescents certain skills needed in behavioral change. These skills are needed by an individual to operate effectively in society in an active and constructive way. The model was developed in Uganda as a result of the gaps identified in the 1990-1995 Basic Science and Health programme. Despite this programme, behaviour did not change towards the promotion of health living. The missing link between knowledge in Basic Sciences and Health Education and positive change was identified as the practical Life Skills. Hence the Government of Uganda and UNICEF, launched the Life Skills Initiative.

The following Life Skills were selected, based on a baseline study report on the level and type of skills among Uganda’s primary school children (Ministry of Education and Sports/UNICEF, 1996). They include Assertiveness (ASD), Coping with Emotions (CE), Friendship Formation (FF), Interpersonal Relationship (IR), Negotiations (NG), Non-violence Conflict Resolution (CR), Creative Thinking (CT), Peer Resistance (PR), Self Awareness (SA), Critical Thinking (CRT), Decision Making (DM), Problem Solving (PS), Effective Communication (EC), Coping With Stress CS) and Empathy (EM).

2.6.3 HIV Counseling and Testing

The general sequence in the counseling process for disease management involves pre-test counseling, testing, and post-test counseling. These two phases of counseling provide information to the individual seeking HIV/AIDS services. The National HIV/AIDS policy indicates that HIV/AIDS counseling and Testing shall be promoted as a strategy for strengthening prevention behaviour for those who test HIV negative and as an entry point into treatment, care and support for those who test HIV positive (MoH, 2000). HIV Testing shall not be a prerequisite for recruitment, accessing training or promotion for employees. However, government shall promote and facilitate access to voluntary, counseling and testing for people. Voluntary testing shall be at the consent of a person who shall retain the right to confidentiality. Voluntary disclosure of sero status to an appropriate authority shall be
encouraged, and confidentiality of such information shall be ensured; while any form of discrimination thereof shall be prohibited.

Consequently, over the past five years, there has been a significant increase in the number of people who have gone for counseling and testing (CT). The cumulative number of people tested through VCT has grown from 1.7m in 2005 (MoH, 2005). The number of VCT sites increased from one in 2000 to almost 1,000 countrywide (960) in 2006 (Uganda Aids Commission, 2006).

Issues have been raised concerning the adequacy of VCT in catering to the changing profile of the epidemic. The distribution of sites is skewed; 60% of the sites are based in the urban and peri-urban areas where only 20-30% of the population live, while only 40% of the CT centres are in rural Uganda where 70-80% of the population reside (Uganda Aids Commission, 2006). Mobile sites for remote rural areas are being promoted to cater for this imbalance. Home-based testing, door-to-door and public events testing have been introduced as well but uptake through these approaches is still slow (ibid).

2.6.4 Treatment of sexually transmitted infections (STIs)

STI control may be most effective as an HIV prevention strategy when initiated earlier in the course of national epidemics and when sexual risk behaviors are high (Orroth et al., 2003). In most developing countries, the greatest benefits from treating STIs almost certainly accrue from averting the morbidity and mortality caused directly by STIs rather than indirectly because of reduced HIV transmission.

According to the MoH (2000), the National HIV/AIDS policy indicates adolescents shall be given age appropriate information on other STDs and their relationship with HIV/AIDS. Prevention of STD infection and early treatment of STDs shall be promoted as good health practices and as HIV/AIDS prevention strategies particularly among the sexually active adolescents. School and community health facilities shall be equipped to treat common STDs or encouraged to refer such cases to facilities with appropriate capacity. The implication of
the above is that out-of-school adolescents access and utilize HIV/AIDS prevention information assuming that no socio-cultural barriers hinder them from doing so.

There has been sentinel surveillance of patients with sexually transmitted infections (STIs) since 1990 (MoH, 2000). HIV prevalence among STI patients has been declining almost without interruption since 2000. In 2005, 19.1% of STI patients were HIV positive compared with 21.5% in 2004 (Uganda Aids Commission, 2006). There was a decline in prevalence among all age groups in 2006 with the exception of the 35–44 age groups, in which prevalence from 2002 to 2006 had risen from 25.6% to 29%. By comparison, prevalence in the 25–34 age groups declined from 30.4% to 21.7% over the same period. There has also been a drop in the prevalence of some STIs, which could be attributed to increased awareness of the link to HIV, free treatment (and subsequent increased service uptake) and greater condom use.

Kibuka-Musoke (as cited in Olowo-Freers and Barton, 1992) found that STDs have negative and positive socio-cultural perceptions, which encourage some persons to brave sex with STDs. In some communities, persons who acquire gonorrhea are considered brave and of sexual prowess. Syphilis was, long ago, acquired through deliberate inoculation of young children with syphilitic discharge to confer immunity. Its acquisition was as such a positive thing and non-stigmatizing (Davis, as cited in Olowo-Freers and Barton, 1992).

Kamya (1991) found that individuals with untreated STDs often engage in sexual intercourse with their partners, even if the genital ulcer is painful, due to ignorance of the likely negative consequences. About 35% of in-school adolescents in Kampala don't even know that a single sex episode could cause a STD (Ssamula & Kirumira, cited in Olowo-Freers & Barton, 1992). Thus, some adolescents dare sex even when they have a STD. Measures that ensure optimal levels of fear about STD acquisition should as such be able to serve as psychologically distressing motivators for sexually active adolescents in adopting safer sexual behaviors.
2.7 Conclusion

From the foregoing literature, it was been made clear that there are scanty empirical studies about the influence of socio-cultural factors on accessibility to, and utilization of, HIV/AIDS prevention information among out-of-school adolescents in Kyotera county, Rakai District. Therefore, a research gap was evident in examining how social and cultural factors have influence accessibility and utilization of HIV/AIDS prevention information among out-of-school adolescents. The nature of information channels used in disseminating HIV/AIDS prevention information to out-of-school adolescents also needed to be investigated. This study has attempted to close the above mentioned research gaps.
CHAPTER THREE
METHODOLOGY

3.1 Introduction
The chapter focuses on the methodological aspects of the study. This includes research design, area of study, target population, techniques of sample selection, sample size and data collection methods. Data quality control and data analysis are also given while in the final part, we deal with ethical considerations and limitations to the study.

3.2 Research Design
The study used descriptive survey research design because of the nature of the variables that required normative data as well as description of views, perceptions and beliefs of respondents at one point in time (Amin, 2005). The study used both qualitative and quantitative approaches to collect primary data. Primary data was collected using questionnaires, key informant interview guides and focus group discussion checklist complimented with secondary data gathered through documentary research.

3.3 Study Area
This study was conducted in three selected sub counties of Kyotera County in Rakai district. The sub counties included Kalisizo, Kabira and Kyotera town council. The sub counties were selected due to the high number of out-of-school adolescents, high prevalence rate of HIV/AIDS and besides, no similar study had been conducted in the area. In addition, Kyotera town council had a community health education project-Rakai Project which was assumed to have disseminated HIV/AIDS information to adolescents in the area.

Rakai district is located in the South-Western region of Uganda bordering with Kalangala district in the East, Lyantonde in the West, Sembabule in the North and Masaka and Republic of Tanzania in the South. Rakai district consists of four counties: Kabula, Kyotera, Kooki and Kakuuto. According to UBOS (2005), Rakai district has a total population of 471,806 persons and a population growth rate of 2.8%.
3.4 Study Population
The study was carried out among out-of-school adolescents of 12 – 19 years of age, health workers, Rakai project staff and opinion leaders in the area. The out-of-school adolescents participated in the study because of their vulnerability to HIV/AIDS due to limited access and utilization of HIV/AIDS preventive information. Health workers and Rakai project staff on the other hand provided relevant information about the HIV/AIDS prevention. Opinion leaders guided the study in issues related to cultural values and practices that had an influence on accessibility and utilization of HIV/AIDS prevention information in the area.

3.5 Sample size
A total of 78 out-of-school adolescents participated in the study as primary respondents. In addition, 5 key informants and 15 focus group discussion participants were interviewed. In all, 98 respondents participated in the study. Table 3.1 presents the sample size description.

Table 3.1: Sample size description

<table>
<thead>
<tr>
<th>Sub county of location of respondents</th>
<th>Category of respondent</th>
<th>Sample size</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kalisizo Sub County</td>
<td>Out-of-school adolescent respondents (primary respondents)</td>
<td>26</td>
</tr>
<tr>
<td>Kabira Sub County</td>
<td>Out-of-school adolescent respondents (primary respondents)</td>
<td>26</td>
</tr>
<tr>
<td>Kyotera town council</td>
<td>Out-of-school adolescent respondents (primary respondents)</td>
<td>26</td>
</tr>
<tr>
<td><strong>Sub total</strong></td>
<td></td>
<td><strong>78</strong></td>
</tr>
<tr>
<td><strong>Key informants</strong> (one Health worker from each sub county and two Rakai Project staff)</td>
<td></td>
<td>05</td>
</tr>
<tr>
<td><strong>FGD participants</strong> (five participants from each sub county)</td>
<td></td>
<td>15</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>98</strong></td>
</tr>
</tbody>
</table>

*Source: Researcher’s sampling scheme*
3.6 Sampling techniques

The sampling techniques are categorized into selection of sub counties and selection of respondents as described in the sub-sections below:

3.6.1 Selection of sub counties

Due to constraints of time coupled with the scattered nature of respondents, the study adopted random sampling of respondents. Out of seven sub counties in Kyotera County, simple random sampling was used to select three sub counties for study. The process of simple random sampling involved writing all names of sub counties in Kyotera County on pieces of paper that were folded, put into a container. One paper was picked at random from the container without replacement, followed by another paper and finally the third paper. Consequently, Kalisizo Sub County, Kabira Sub County and Kyotera town council were selected for study. The sub counties were selected due to the high number of out-of-school adolescents, high prevalence rate of HIV/AIDS and besides, no similar study had been conducted in the area.

3.6.2 Selection of respondents

Due to lack of accurate records as well as the scattered nature of out-of-school adolescents in Kyotera county, the study adopted snowball sampling. Snowball sampling is supported by Amin (2005), that, it is ideal for locating individuals for the study where the researcher begins with few respondents who are difficult to locate using other means.

Using snowball sampling, the starting respondents were located with the assistance of local council 1 officials in Kabira Sub County and asked for assistance to locate the school leavers. This system is further explained by Creswell (2003), that, when the researcher has found a few of the individuals with the needed criteria, then these individuals are asked for assistance to locate others with similar characteristics. Both male and female out-of-school adolescents of 12 – 19 years were selected and issued with questionnaires. With the assistance of research assistants, translation to the local language was done for those who were not conversant with

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11 Kabira, Kalisizo, Kasaali, Kyotera town council, Kirumba, Lwankoni and Nabigasa sub counties.
English. In all, 78 out-of-school adolescent respondents participated in the study. This implies that 26 respondents were selected from each sub county.

The key informants like sub county health workers and Rakai project staff were selected by purposive sampling. Amin (2005:249) supports use of purposive sampling where the researcher is able to use his/her own judgment or common sense to select participants with relevant. Five key informants participated in the study. Likewise, opinion leaders for focus group discussions were also purposively selected among local council leaders, religious leaders, retired civil servants and other elderly persons in the area of study. The researcher preferred these groups of people because of the experience and knowledge of cultural values and practices of the people gained them overtime. A total of 15 persons participated in focus group discussions (FGDs).

3.7 Data Collection Methods and Instruments

The primary data were collected using structured interview, key informant interview and focus group discussion. The instruments used during collection of primary data are described hereunder:

- **A questionnaire**

A self administered questionnaire was the major instrument that was used in data collection from out-of school adolescents. Questionnaires were appropriate due to the large number of respondents. Besides, questionnaires collect a lot of information within a short time (Creswell, 2003). Questionnaires were administered to 78 adolescents. This helped to gather quantitative and qualitative information regarding information channels and the socio-cultural factors that influence accessibility to, and utilization of, HIV/AIDS prevention information among out-of-school adolescents in Kyotera county. The questionnaires comprised of both closed and open-ended questions formulated by the researcher. A sample questionnaire is attached to this study as appendix I.
- **Key informant Interview guide**

Key informant interview guide was designed and administered to key informants to capture qualitative information. These included sub county health workers and Rakai project staff. Key informant interviews were used because they facilitated face to face verbal responses which helped to obtain reliable and valid information behind participants’ experiences (Amin, 2005). Key informant interviews helped to get more information about information channels and the socio-cultural factors that influence accessibility to, and utilization of, HIV/AIDS prevention information among out-of-school adolescents in the area. Triangulation of information from key informant interviews and adolescent interviews enabled the researcher to arrive at appropriate conclusions.

- **Focus Group Discussion checklist**

Focus group discussion method was used because it allowed flexibility of the members to discuss freely on issues concerning social and cultural practices that influence access and utilization of HIV/AIDS prevention information among out-of-school adolescents in the area. Three focus group discussions were conducted in the three sub counties studied. Focus group discussions comprised of male and female local council leaders, religious leaders and retired civil servants in the area. Each focus group discussion conducted in a sub county/town council was composed of 5 persons. A sample focus group discussion checklist is attached to this study as appendix III.

**Documentary Review**

The main sources of secondary data included the following: Rakai project field reports, sub county/town council health reports, Internet, review of District health reports and publications. For orientation in the field, existing data sets like National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights were consulted.

3.8 **Data quality control**

Validity and reliability of the research instrument was measured as follows:
3.8.1 Validity of Instruments

Validity is the extent to which the instruments used during the study measure the issues they are intended to measure (Amin, 2005). To ensure validity of instruments, the instruments were developed under close guidance of the supervisor. After the questions are designed, they were pre-tested to a tenth of the adolescents outside the sample. This helped to identify ambiguous questions in the instruments and be able to make them simpler to be understood by respondents.

3.8.2 Reliability

Reliability is the extent to which the measuring instruments will produce consistent scores when the same groups of individuals are repeatedly measured under the same conditions (Amin, 2005). The study administered one type of questionnaire to out-of-school adolescent respondents and using Cronbach reliability test, Alpha values of 0.732 were attained implying that the tool was suitable for investigating information channels and the socio-cultural factors that influence accessibility to, and utilization of, HIV/AIDS prevention information among out-of-school adolescents in Kyotera county, Rakai District. Besides, most authorities (Creswell, 2003; Amin, 2005) accept the minimum alpha value of 0.5.

3.9 Data analysis

Data from the semi-structured interviews were coded and entered in a computer and Statistical Package for Social Scientists (SPSS) programme used to analyze it. The percentage number of respondents according to variables such as; sex, age, influence of social and cultural factors on access and utilization of HIV/AIDS information and so on were computed and presented using tables. Using simple regression analysis, the social and cultural factors were regressed against the dependent variable to determine their influence to access and utilization of, HIV/AIDS prevention information among the out-of-school adolescents.

Qualitative data was organized according to themes identified from research questions and analyzed using content analysis. Data from key informant interviews and FGDs were recorded, organized, interpreted and presented and discussed.
3.10 Ethical issues

At the onset of data collection, the researcher sought permission of sub county Chiefs/Town clerk in the areas of study who introduced the researcher to the lower local council leaders. Each questionnaire contained an opening introductory letter requesting for the respondents cooperation in providing the required information for the study. Care was taken not to seek information from out-of-school adolescents outside the 12-19 age category. The respondents were further assured of confidentiality of the information provided and that the study findings were to be used for academic purposes only. Respondents were further assured of their personal protection and that they had freedom of concent to be interviewed.

The next chapter presents, interprets and discusses the findings of the study. The presentation and analysis of data are based on the effective sample of 78 out-of-school adolescent respondents, 5 key informants and 15 focus group discussion participants as well as documentary evidence the researcher got access to.
CHAPTER FOUR
DATA PRESENTATION, ANALYSIS AND DISCUSSION

4.1 Introduction

In this chapter, data regarding information channels and the socio-cultural factors that influence accessibility to, and utilization of, HIV/AIDS prevention information among out-of-school adolescents in Kyotera County, Rakai District has been presented, analyzed and discussed. The presentation is arranged in line with the specific objectives that guided the study, including:

i) The influence of social factors on accessibility and utilization of HIV/AIDS prevention information among out-of-school adolescents,

ii) The influence of cultural factors on accessibility and utilization of HIV/AIDS prevention information among out-of-school adolescents, and

iii) The nature of information channels used in disseminating HIV/AIDS prevention information to out-of-school adolescents.

However, the biodata of respondents are presented first to provide a clear picture of out-of-school adolescents that participated in the study.

4.2 Biodata of respondents

Biodata of respondents also known as social factors in this study are presented in this section. They include; gender, age, religion, education level and occupation of respondents. The gender distribution of respondents is presented first.
Figure 4.1: Gender distribution of respondents

![Gender distribution chart]

Figure 4.1 indicates that 45% of the respondents were female while 55% were male. This implies that both sexes were adequately represented in the study.

Regarding age, the study targeted out-of-school adolescents between 12-19 years of age as shown in table 4.1.

Table 4.1: Age distribution of respondents

<table>
<thead>
<tr>
<th>Age-group</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>12 – 15 years</td>
<td>31</td>
<td>39.7</td>
</tr>
<tr>
<td>16 – 19 years</td>
<td>47</td>
<td>60.3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>78</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

*Source: Primary data*

Table 4.1 indicates that 60.3% of the respondents were in the age-group of 16 – 19 years while 39.7% were 12 – 15 years of age. Respondents in the 16 -19 years age-group were majority who needed to access HIV/AIDS prevention information because they are sexually active than those on the younger age-group.
Figure 4.2: Religion of respondents

Figure 4.2 above indicates that respondents belonged to different religious beliefs ranging from Roman Catholicism (32%), Anglican Protestants (24%), Islam (19.5%), Seventh day Adventists (9%) and the Pentecostal movement (15.5%). This implies that the results of the study incorporated views from different religious believers about access and utilization of HIV/AIDS prevention information.

Figure 4.3: Level of education
Figure 4.3 indicates that 51% of the respondents dropped out of school at primary level while 47% dropped out of school at ordinary level of education. Only 2% indicated that they dropped out of school at advanced level. This suggests that the majority of out-of-school adolescents that participated in the study could have had little exposure to HIV/AIDS prevention information while still in school.

Finally, the study investigated the occupations of out-of-school adolescents in the area of study. The findings are shown in Figure 4.4.

**Figure 4.4: Occupations of out-of-school adolescents (respondents)**

<table>
<thead>
<tr>
<th>Type of occupation</th>
<th>%ge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Taxi drivers</td>
<td>14.2</td>
</tr>
<tr>
<td>Security guards</td>
<td>3.6</td>
</tr>
<tr>
<td>Fishermen</td>
<td>23.8</td>
</tr>
<tr>
<td>Boda boda cyclists</td>
<td>58.4</td>
</tr>
<tr>
<td>Fishermen</td>
<td>1.8</td>
</tr>
</tbody>
</table>

Figure according to Figure 4.4, the majority of the out-of-school adolescents were engaged in boda boda¹² riding. A further 23.8% of the respondents were fishermen, 14.2% taxi drivers while 3.6% indicated that they were security guards. This implies that all respondents had fulltime jobs which possibly did not afford them time to attend to workshops, seminars and other communication channels for conveying HIV/AIDS prevention information.

¹² A form of public transport that uses a bicycle or motorcycle to transport people to places where vehicles may not access at any time of the day.
4.2 The influence of social factors on accessibility and utilization of HIV/AIDS prevention information among out-of school adolescents

This sub-section presents and discusses data for the study objective “to examine how social factors influence accessibility and utilization of HIV/AIDS prevention information among out-of school adolescents”. The social factors considered in this study include gender, age, religion, level of education and occupation. Before assessing how each of these had an influence on access and utilization of HIV/AIDS prevention information, an investigation was made to establish whether adolescents in Kyotera County had opportunities to access HIV/AIDS prevention information within their communities. The responses from out-of-school adolescents are presented in Table 4.2 below.

Table 4.2: Opportunities to access HIV/AIDS prevention information within the community

<table>
<thead>
<tr>
<th>Response</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>47</td>
<td>60.3</td>
</tr>
<tr>
<td>No</td>
<td>31</td>
<td>39.7</td>
</tr>
<tr>
<td>Total</td>
<td>78</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Source: Primary data

Table 4.2 indicates that 60.3% of the out-of-school adolescents were aware of existence of opportunities to access HIV/AIDS prevention information within their communities while 39.7% were not aware of the opportunities. This implies that the majority of the respondents had information on where they could access HIV/AIDS prevention information. According to one staff member of Rakai project, adolescents could access HIV/AIDS prevention information from health centers II and III where available, private health practitioners, outreach health workers, NGOs like Rakai project and World Vision in the area, mass media as well as any informed member of the community.

Consequently, the influence of gender, age, religion, level of education and occupation on accessibility and utilization of HIV/AIDS prevention information among out-of school
adolescents were investigated. The responses were categorized into agree, disagree or undecided as presented in Table 4.3.

Table 4.3: The influence of social factors on access and utilization of HIV/AIDS prevention information

<table>
<thead>
<tr>
<th>Influence of social factors on access and utilization of HIV/AIDS prevention information</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Agree</td>
</tr>
<tr>
<td>a) Gender has no influence on access and utilization of HIV/AIDS prevention information among out-of school adolescents</td>
<td>17 (22.4%)</td>
</tr>
<tr>
<td>b) Age has no influence on access and utilization of HIV/AIDS prevention information among out-of school adolescents</td>
<td>0</td>
</tr>
<tr>
<td>c) Religion has no influence on access and utilization of HIV/AIDS prevention information among out-of school adolescents</td>
<td>6 (7.7%)</td>
</tr>
<tr>
<td>d) Level of education has no influence on access and utilization of HIV/AIDS prevention information among out-of school adolescents</td>
<td>15 (19.2%)</td>
</tr>
<tr>
<td>e) Occupation has no influence on access and utilization of HIV/AIDS prevention information among out-of school adolescents</td>
<td>10 (12.2%)</td>
</tr>
</tbody>
</table>

Source: Primary data

Table 4.3 indicates that 97.3% of the respondents disagreed with the statement that age had no influence on access and utilization of HIV/AIDS prevention information among out-of school adolescents. This implies that age had an influence on access and utilization of HIV/AIDS prevention information. This finding agrees with Oppenheim-Mason (1994) evidence that men shift towards younger partners who are deemed less likely to be infected. Since the young girls are likely to be economically dependent, some may yield to pressures from the old men thus failing to practice HIV/AIDS prevention information, however much they may have accessed it. Besides, KDHS (2003) noted that inter-generational sex was common in Uganda and the neighbouring Kenya where the Kenyan DHS in 2003 found that of women age 15-19 who had higher-risk sex in the past 12 months; 4% indicated that this was with men who were ten or more years older than them. Material gain, sexual gratification, emotional factors, and recognition from peers were primary incentives for inter-generational sex (Longfield, 2004). It is possible that these incentives discouraged adolescents from utilizing HIV/AIDS
prevention information. In relation to this, one health worker from Kalisizo health centre lamented that:

“...due to their young age, adolescents do not take HIV prevention information seriously. Some make fun of it especially when health workers are demonstrating the use of condoms”

This implies that age of adolescents played a significant role in accessing and practicing HIV/AIDS prevention information among out-of-school adolescents in Kyotera County. The available literature also supports the finding above that some adolescents have a negative perception of condoms that they reduce pleasure during sex (Mays & Cochran, 1988). The use of familiar expressions like “you don’t eat banana with its peel” (Neema et al, 2004) or “you don’t take a shower with an umbrella” (Samuelsen, 2006) is illustrative of the situation. In support of the above, another respondent observed that out-of-school adolescents did not take HIV/AIDS prevention information seriously. Regarding this, one elderly man in a FGD held at Kabira Sub County has this to say:

“....mainly the young adolescents of 15 years and below appear to be serious when there are sensitization meetings. They usually sit and listen to presenters out of which they ask wise questions. Otherwise, many of the adolescents above this age are usually engaged in their conversations, others move to the shops while others are seen to be negotiating love affairs”

This implies that the age level of an adolescent may determine his/her level of concentration on HIV/AIDS preventive messages presented through community gatherings. These attitudes have strong negative influence on condoms use and there is a great challenge for prevention campaigns to develop efficient strategies to convince adolescents especially the out-of-school adolescents that the non-use of condoms can jeopardize their lives. This is inspite of Campbell (2003)s observation that very young adolescents who are not in school are more likely to be overlooked by program planners, less likely to receive skills training and reproductive health information, and at greater risk of sexual exploitation.

Regarding gender, 66.7% of the respondents disagreed that gender had no influence on access and utilization of HIV/AIDS prevention information among out-of-school adolescents. This suggests that gender had a significant influence on access and utilization of HIV/AIDS prevention information among out-of-school adolescents. This observation corroborates
Singhal & Rogers (2003) findings that many Indian societies, the inferior status of women makes them particularly vulnerable to HIV/AIDS since they are unable to negotiate safe sex methods. This implies that gender roles entrenched in the African society deprived self-esteem from the out-of-school adolescents in Kyotera county. With low self-esteem, out-of-school girls could not insist on seek or use of HIV/AIDS preventive methods to safeguard them against HIV/AIDS infection. This was confirmed by one Health worker from Kalisizo Health Centre III that:

“gender inferiority is a problem because you find that girls shy from discussing these issues because they are sex related and they cannot say “no” to a man or ask for condom use because the man is thought to be wiser than the girl to accept advice of how a sexual encounter can be handled”

In support of the above, one participant of a focus group discussion held in Kyotera town council said:

“….you find that to a big extent, boys have more access to HIV/AIDS prevention information than girls. Boys are able to come to sensitization meetings and get to learn more compared to girls who are always cooking and doing household work”

This implies that out-of-school girls; whether employed or not employed had limited chances of securing permission from their parents, guardians or employers to attend HIV/AIDS sensitization meetings. This is likely to have hindered access and utilization of HIV/AIDS prevention information especially that disseminated through community gatherings or where there was need for adolescents to leave homesteads. However, out-of-school girls remained with an opportunity to access HIV/AIDS prevention information from the print and electronic media in their homes or places of work as will be further investigated in section 4.4.

On the influence of religion, 63.5% of the respondents disagreed with the statement that religion had no influence on access and utilization of HIV/AIDS prevention information among out-of school adolescents. The influence of religion on access and utilization of HIV/AIDS prevention information was confirmed by Kisekka (1991) that HIV vulnerability caused by religious beliefs and practices is the result of religious institutions’ denunciation of HIV infection as sinful. Religions advocating against condom use pose a serious challenge to preventing the spread of HIV in the communities where they operate. In another finding,
McManus and Dhar (2008) noted that religion influences men’s and women’s exposure to HIV prevention messages, knowledge and perception of risks, and the practice of prevention. Because of the influence religious leaders have on the community, they can play a significant role in behavior change interventions, including the promotion of condom use, to reduce HIV transmission and de-stigmatize HIV and AIDS. This was supported by one Religious leader in a FGD held in Kyotera town council that:

“in Church of Uganda, the Mothers’ Union sensitizes females while the Fathers’ Union does the same for men. Sexual issues are considered important and there is no mincing of words when such a topic comes up; because we want our people to get adequate guidance on how to avoid conflict as well as deadly diseases like HIV/AIDS”

This implies that Mothers’ and Fathers’ Unions play a significant role in enabling married couples to access HIV/AIDS prevention information. This is further supported by the Uganda Aids Commission (2006) that religious institutions such as the Kampala Diocese, Uganda Catholic Secretariat, Diocese of Namirembe, and Uganda Muslim Supreme Council all have programs targeting adolescent sexual and reproductive health. In conclusion therefore, some practices like faithfulness in marriage and instruction on sexuality to the adolescents during initiation are practices that should be encouraged since they disseminate HIV/AIDS prevention information thus contributing to family preservation.

Regarding the level of education, 51.2% of the respondents disagreed with the statement that the level of education had no influence on access and utilization of HIV/AIDS prevention information among out-of-school adolescents. This means that the level of education had an influence on access and utilization of HIV/AIDS prevention information. This is more relevant for the HIV/AIDS prevention information presented in the print media which requires reading skills on the part of the readers. This probably explains DFID (2006) findings that HIV prevalence is considerably lower among teenagers in secondary school in Burundi, Eritrea, Mozambique, Tanzania, Uganda and Zimbabwe. In Swaziland, DFID indicates that two-thirds of teenage girls in school were free from HIV, while two-thirds of out-of-school girls were HIV positive. This partly implies that in-school adolescents get more chances of accessing HIV/AIDS prevention information than their counterparts who are out-of-school. Neema et al (2004) confirmed this observation that health services and programs targeting
adolescents such as free hotlines, phone-in radio programs, Internet and print media have been initiated, targeted at school-going children. The findings further agree with UNESCO (2000) that education itself has an important HIV/AIDS preventive impact because it helps to inform adolescents and equip them to make healthy decisions concerning their own lives; bring about long-term healthy and safe behaviors; and give them the opportunity for economic independence. Besides, Chase and Aggleton (2006) found that unlike school going adolescents who have direct access to HIV/AIDS prevention information, greater opportunities and more choices in life; the out-of-school counterparts are difficult to reach, organize and monitor. This confirms that access to information by such hard to reach adolescents is not easy and so the few pieces of information got may not be adequately utilized to prevent HIV/AIDS. This was the situation in Kyotera county, Rakai district.

As far as occupation was concerned, 44.9% of the respondents disagreed that occupation had no influence on access and utilization of HIV/AIDS prevention information among out-of-school adolescents. This implies that the occupation of the respondents had influence on access and utilization of HIV/AIDS prevention information among out-of-school adolescents. Bukusi (2006) supports the finding above that some occupations like fishing have been identified as among the highest-risk groups for HIV infection in countries with high overall rates of HIV prevalence. Their inability to access and utilize HIV/AIDS prevention information was influenced by the amount of time spent away from home; access to cash income; poor education; the ready availability of commercial sex in fishing ports; and sub-cultures of risk-taking and hyper-masculinity.

The study investigated the degree of access and utilization of HIV/AIDS prevention information (dependent variable). The responses were categorized into agree, undecided or disagree as presented in Table 4.4.
Table 4.4: Access and utilization of HIV/AIDS prevention information

<table>
<thead>
<tr>
<th>Utilization of HIV/AIDS prevention information</th>
<th>Responses</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Agree</td>
<td>Undecided</td>
<td>Disagree</td>
</tr>
<tr>
<td>a) I have abstained from sex until I get married to a suitable partner.</td>
<td>78 (100%)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>b) I am faithful to my future marriage partner</td>
<td>75 (96.2%)</td>
<td>3 (3.8%)</td>
<td>0</td>
</tr>
<tr>
<td>c) I use a condom whenever I play sex with a friend</td>
<td>44 (56.4%)</td>
<td>20 (26.3%)</td>
<td>14 (17.3%)</td>
</tr>
<tr>
<td>d) I have developed life skills that guide me to live a healthy and constructive life.</td>
<td>28 (36.5%)</td>
<td>17 (21.8%)</td>
<td>33 (41.7%)</td>
</tr>
<tr>
<td>e) I always seek HIV testing and counseling whenever I doubt my sexual practices</td>
<td>29 (37.1%)</td>
<td>6 (7.7%)</td>
<td>43 (55.0%)</td>
</tr>
<tr>
<td>f) I seek STDs treatment whenever I get infected.</td>
<td>39 (50.0%)</td>
<td>14 (17.3%)</td>
<td>25 (32.7%)</td>
</tr>
</tbody>
</table>

Source: Field research findings

Table 4.4 indicates that all respondents agreed that they had abstained from sex until marriage. This was supported by Tumushabe (2006) that the promotion of pre-marital abstinence which was adopted as the lead strategy by the Ugandan government and its backers was a feasible approach. A further 96.2% of the respondents revealed that they were faithful to their future marriage partners while 56.4% agreed that they used condoms whenever they played sex. Despite the above, only 37.1% of the respondents agreed that they always sought HIV testing and counseling whenever they had doubt about their sexual practices. However, 55% disagreed with the statement. Besides, 36.5% of the respondents agreed that they had developed life skills to guide them to live healthy and constructive lives. This implies that HIV/AIDS prevention information that involved the ABC approach had been accessed and utilized by the out-of-school adolescents despite the fact that HIV testing and counseling as well as life skills appeared to be less utilized.
Consequently, using simple regression analysis, the social factors were regressed against the dependent variable\textsuperscript{13} (accessibility and utilization of HIV/AIDS information) and findings derived as presented in Table 4.5.

Table 4.5: Simple regression analysis for social factors

<table>
<thead>
<tr>
<th>Model</th>
<th>Unstandardized coefficients</th>
<th>Standardized coefficients</th>
<th>t</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dependent variable (constant)</td>
<td>.465</td>
<td>.471</td>
<td>.986</td>
<td>.337</td>
</tr>
<tr>
<td>Gender</td>
<td>.782</td>
<td>.234</td>
<td>2.350</td>
<td>.030*</td>
</tr>
<tr>
<td>Level of education</td>
<td>.268</td>
<td>.247</td>
<td>1.083</td>
<td>.292</td>
</tr>
<tr>
<td>Religion</td>
<td>-.071</td>
<td>.263</td>
<td>-.270</td>
<td>.790</td>
</tr>
<tr>
<td>Age</td>
<td>.702</td>
<td>.291</td>
<td>2.407</td>
<td>.026*</td>
</tr>
<tr>
<td>Occupation</td>
<td>.132</td>
<td>.235</td>
<td>.559</td>
<td>.582</td>
</tr>
</tbody>
</table>

\* Significance at 0.05
Source: Computed from primary data

In the above regression analysis, it was found that 51.3\% (Beta = 0.513) of the change in the dependent variable was caused by age while 43.9\% (Beta = 0.439) of the change in the dependent variable was caused by gender. These social factors were significant at 0.05 level of significance. This implies that age and gender of out-of-school adolescents were the major social factors that influenced access to, and utilization of, HIV/AIDS prevention information among the out-of-school adolescents in Kyotera county, Rakai district. Other social factors like occupation, level of education and religion did influence access to, and utilization of, HIV/AIDS prevention information but were statistically insignificant. Therefore, the null hypothesis that social factors have no influence on accessibility to, and utilization of, HIV/AIDS prevention information among out-of-school adolescents was rejected.

4.3 The influence of cultural factors on access and utilization of HIV/AIDS prevention information among out-of-school adolescents

The second objective of the study was “to examine how cultural factors influence accessibility and utilization of HIV/AIDS prevention information among out-of-school adolescents”. In

\textsuperscript{13} The dependent variable focused on the ABC strategy (Abstinence, Being Faithful or Using a Condom), life skills, counseling and HIV testing and treatment of STDs.
this study, the cultural factors considered include early age of marriage, cultural stigma and taboos, widow inheritance and dowry as presented in Table 4.6.

**Table 4.6: Influence of cultural factors on access and utilization of HIV/AIDS prevention information**

<table>
<thead>
<tr>
<th>Influence of cultural factors on access and utilization of HIV/AIDS prevention information</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Agree</td>
</tr>
<tr>
<td>a) Early age of marriage has no influence on access and utilization of HIV/AIDS prevention information among out-of school adolescents</td>
<td>17 (22.4%)</td>
</tr>
<tr>
<td>b) Cultural stigma and taboos have no influence on access and utilization of HIV/AIDS prevention information among out-of school adolescents</td>
<td>3 (3.8%)</td>
</tr>
<tr>
<td>c) Widow inheritance has no influence on access and utilization of HIV/AIDS prevention information among out-of school adolescents</td>
<td>15 (19.2%)</td>
</tr>
<tr>
<td>d) Dowry has no influence on access and utilization of HIV/AIDS prevention information among out-of school adolescents</td>
<td>44 (56.4%)</td>
</tr>
</tbody>
</table>

*Source: Primary data*

The results of the study presented in table 4.6 indicate that 96.2% of respondents revealed that cultural stigma and taboos have an influence on access and utilization of HIV/AIDS prevention information among out-of school adolescents. This further was supported by UNESCO (2001) that cultural stigma and taboos (social bans), especially related to sex and sexual activities increase out-of-school adolescents’ denial to HIV/AIDS prevention information. An interview with one health worker from Kyotera town council revealed the causes of cultural stigma among the out-of-school adolescents as:

“Cultural stigma related to HIV/AIDS is triggered by lack of understanding of HIV, myths about how it is transmitted, prejudice, lack of treatment, irresponsible media reporting, social fears about sexuality, fears relating to illness and death, and fears about illicit drugs.

This implies that the causes of cultural stigma were personal arising out of connotations of immorality associated with HIV/AIDS and ignorance about the disease.
Regarding the early age of marriage, 65.4% of the respondents disagreed that the early age of marriage had no influence on access and utilization of HIV/AIDS prevention information among out-of-school adolescents. The finding was confirmed by Hirst (2004) that early marriage by one partner creates age-gap which discourages open communication required to ensure uptake of voluntary counseling and testing for HIV, sharing information and test results as well as planning for safe sexual relations throughout the marriage. Similar findings were revealed by one opinion leader during a FGD held at Kalisizo sub county that:

“…my niece got married to a HIV/AIDS infected man yet we had advised her to go for an HIV test before sexual intercourse with the man. We later realized that because the girl was much young than the man, her insistence on HIV test before sexual intercourse had been brushed off by the man”

This implies that out-of-school girls who got married too early lacked life skills of decision making, effective communication and critical thinking. Additionally, Smith et al (1992) findings indicate that incidence of HIV was rising among married couples worldwide, with unsafe and unprotected heterosexual intercourse being the single most important factor in the transmission of HIV among them. Besides, Neema et al (2004) observed that early marriage severely increases young girls’ vulnerability to HIV as they are most likely to be forced into having sexual intercourse with their (usually much older) husbands. Regarding this, one Rakai project staff said that:

“…my experience with the out-of-school community of Kyotera County has revealed that many girls who are married at an early age get isolated from their peers and eventually miss out on opportunities to access HIV/AIDS prevention information in their communities”

Table 4.6 also indicates that widow inheritance had an influence on access and utilization of HIV/AIDS prevention information among out-of-school adolescents (revealed by 51.2% of the respondents). One health worker from Kabira sub county supported this statement that:

“widow inheritance negatively influences access to, and utilization of, HIV/AIDS prevention information among out-of-school adolescents by isolating the inheriting partner, encouraging extra-marital affairs, stigmatizing widows, advocating for live sex and eventually spreading HIV infection to many male partners”.

65
According to Obbo (1986), advocating for live sex was partly due to the expectation that within the new union, young widows were expected to continue childbearing with the inheritor. Besides, Doyal (1994) revealed that widows who are no longer inherited and no longer receive traditional means of assistance would likely engage in high-risk behaviors with “outside” male partners in order to support themselves economically. This implies therefore, that widow inheritance was partly blamed for the continuing spread of HIV/AIDS as it was associated with habits of isolating partners from the mainstream networks that play a vital role in transmitting HIV/AIDS prevention information among out-of-school adolescents.

On the influence of dowry on access and utilization of HIV/AIDS prevention information, 56.4% agreed that dowry had no influence on access and utilization of HIV/AIDS prevention information among out-of-school adolescents.

In conclusion to the cultural factors, a simple regression analysis was conducted to establish the major cultural factor (s) that influenced access to, and utilization of, HIV/AIDS prevention information among the out-of-school adolescents. The findings are presented in Table 4.7

<table>
<thead>
<tr>
<th>Model</th>
<th>Unstandardized coefficients</th>
<th>Standardized coefficients</th>
<th>t</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Constant)Dependent variable</td>
<td>0.313</td>
<td>0.060</td>
<td>5.235</td>
<td>.000</td>
</tr>
<tr>
<td>Early age of marriage</td>
<td>0.146</td>
<td>0.396</td>
<td>4.469</td>
<td>.000*</td>
</tr>
<tr>
<td>Widow inheritance</td>
<td>0.160</td>
<td>0.505</td>
<td>5.235</td>
<td>.000*</td>
</tr>
<tr>
<td>Cultural stigma and taboos</td>
<td>0.063</td>
<td>0.075</td>
<td>2.009</td>
<td>.049</td>
</tr>
<tr>
<td>Dowry</td>
<td>0.096</td>
<td>0.024</td>
<td>3.047</td>
<td>.183</td>
</tr>
</tbody>
</table>

*Significance at 0.05 level
Source: Computed from primary data

In the above simple regression analysis, it was found that 50.5% (Beta = 0.505, Sig. = 0.000) of the change in the dependent variable was caused by widow inheritance. A further 39.6% (Beta = 0.396, Sig. = 0.000) of the change in the dependent variable was caused by early age of marriage. All these factors were significant at 0.05 level of significance. This implies that
widow inheritance and early age of marriage significantly influenced access to, and utilization of, HIV/AIDS prevention information among the out-of-school adolescents in Kyotera county, Rakai district. This agrees with MOH (1997) observation that “cultural rites and ceremonies … are incongruent with the modern way of life and observance of which tend to enhance the contraction, containment and spread of AIDS” p.49. The null hypothesis that cultural factors have no influence on accessibility to, and utilization of, HIV/AIDS prevention information among out-of-school adolescents was rejected.

4.4 The nature of information channels used in disseminating HIV/AIDS prevention information to out-of-school adolescents

The last objective of the study was to “assess the nature of information channels used in disseminating HIV/AIDS prevention information to out-of-school adolescents”. The study found out that several information channels were used to disseminate HIV/AIDS prevention information to out-of-school adolescents in Kyotera County.

Table 4.8: Channels of disseminating HIV/AIDS prevention information

<table>
<thead>
<tr>
<th>Information channel</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relatives</td>
<td>10</td>
<td>12.8</td>
</tr>
<tr>
<td>Peers</td>
<td>18</td>
<td>22.4</td>
</tr>
<tr>
<td>Outreach activities</td>
<td>6</td>
<td>7.7</td>
</tr>
<tr>
<td>Seminars</td>
<td>3</td>
<td>4.5</td>
</tr>
<tr>
<td>Community meetings</td>
<td>5</td>
<td>7.1</td>
</tr>
<tr>
<td>Radio</td>
<td>16</td>
<td>20.5</td>
</tr>
<tr>
<td>Drama</td>
<td>14</td>
<td>17.3</td>
</tr>
<tr>
<td>Workshops</td>
<td>6</td>
<td>7.7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>78</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

*Source: Field data*

It can be observed from Table 4.8 that the common source of HIV/AIDS prevention information for out-of-school adolescents in Kyotera County was their peers (this was revealed by 22.4% of the respondents). This implies that informal communication between peers was a major channel of transmitting HIV/AIDS prevention information among out-of-
school adolescents. This finding is supported by Mitchell et al. (2007) that peer-to-peer communication has intuitive appeal as a way of effectively disseminating HIV/AIDS information to hard-to-reach adolescents. Although not much was investigated about the extent to which out-of-school adolescents in resource-poor settings like in Kyotera county, can successfully disseminate factual HIV/AIDS information, UNAIDS (1999) indicates that an effective peer educator should be a credible communicator; a positive role model; and an empathic peer. However, a study by Mitchell et al. (2007) regarding the effectiveness of street youth peer educators in HIV/AIDS prevention in urban Uganda, found that peer educator (commonly known as Baaba or “respected elder sibling”) messages were appropriately targeted, using participatory and lively channels.

A further 20.5% of the respondents indicated that HIV/AIDS prevention information was disseminated by the radio. Other channels used in disseminating HIV/AIDS prevention information revealed by respondents included drama (17.3%), relatives (12.8%), workshops (7.7%), outreach activities (7.7%), community meetings (7.1%) and seminars (4.5%). The findings partly agree with World Vision (2006) baseline survey for Kakuuto county which revealed that the major sources of information on HIV/AIDS in Dwaniro sub county were through the radio, hospital and health units, community meetings, churches /Mosques, family members, news papers and TV. The role of relatives especially aunts and uncles to the children was also highlighted by MOH (2000) that she sensa (a traditional channel for sex education to be passed from older women to younger women) still exists, albeit in weakened form, but the sex and HIV/AIDS prevention education provided are limited in nature maintaining one’s virginity before marriage.

The church, print media, drama, NGOs and traditional health practitioners which are emerging as the most prominent channels of health information for adolescents in Uganda were not mentioned by respondents. This indicates that their role in disseminating HIV/AIDS prevention information in Kyotera County was still insignificant to the study target population (out-of-school adolescents). However, what may be certain is that the print media did not appeal to out-of-school adolescents probably because of their relatively low education levels to comprehend the relayed messages.
An investigation into the kind or nature of information disseminated was also conducted. The findings are presented in Table 4.9.

Table 4.9: Kind of HIV/AIDS prevention information disseminated to adolescents

<table>
<thead>
<tr>
<th>Type of information</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Being faithful to marriage partners</td>
<td>46</td>
<td>33.1</td>
</tr>
<tr>
<td>Abstinence until marriage</td>
<td>21</td>
<td>15.3</td>
</tr>
<tr>
<td>Using condoms during sexual intercourse</td>
<td>53</td>
<td>38.0</td>
</tr>
<tr>
<td>Testing for HIV/AIDS before sexual intercourse</td>
<td>12</td>
<td>8.6</td>
</tr>
<tr>
<td>Treatment of STDs</td>
<td>7</td>
<td>5.0</td>
</tr>
</tbody>
</table>

*Multiple response*

Table 4.9 indicates that the majority of the out-of-school adolescents (38%) reported as using condoms during sexual intercourse as the commonest form of HIV/AIDS prevention message relayed to them. Despite this, practical use of condoms among adolescents is reported by literature to be very low. For example, Guiella and Madise (2007) noted that while one would expect adolescents whose sexual partner is a casual acquaintance to be more likely to use condoms compared to those whose partners are boy/girlfriend, findings showed that they were less likely to use condoms. This finding is consistent with results from an evaluation of a condoms social marketing campaign in urban Mozambique where fewer than half used condoms with casual partners. A possible interpretation for the low use of condoms among adolescents despite high levels of awareness of HIV/AIDS is that the majority of adolescents do not plan to have sex (Guiella and Madise, 2007). Another negative perception of male condoms among adolescents is that many of them continue to state that condoms reduce pleasure during sex (Mays & Cochran, 1988). Therefore, one can conclude that the majority of adolescents are still engaging in risky behaviours despite their awareness of HIV. This situation has also been shown in another study in Côte d’Ivoire where accuracy of knowledge about AIDS did not significantly predict the use of condoms (Zellner, 2003).

A further 33.1% of the respondents indicated being faithful to their marriage partners as the kind of message relayed to them. This is supported by the National HIV/AIDS policy (MOH,
2000) that for married couples or those in sexual relationships, mutual faithfulness following negative HIV results for both spouses/partners, shall be promoted as an effective strategy for preventing HIV infection. Abstinence until marriage was mentioned by 15.3% of the respondents while testing for HIV/AIDS before sexual intercourse was reported by 8.6%. Only 5% of the respondents mentioned treatment of STDs. The findings agree with the Uganda Ministry of Health adolescent-friendly messages which emphasize Abstinence until marriage (A), Being faithful for those in relationships (B) and use of Condoms if the first two fail (C) - the ABC approach (Makerere Institute of Social Research, 2003).

In the final analysis therefore, the study found that peer-to-peer communication, community health workers, relatives (ssenga and kojja) and the radio were the common HIV/AIDS prevention information channels for out-of-school adolescents in Kyotera County. The church, print media, drama, NGOs and traditional health practitioners which have emerged as the most prominent channels of health information for adolescents in Uganda were not mentioned by respondents implying their limited coverage in the area. The nature of HIV/AIDS prevention information disseminated included use of condoms during sexual intercourse, abstinence, being faithful to marriage partners, HIV/AIDS testing before sexual intercourse and STDs treatment.
CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1 Introduction
This chapter presents summary, conclusions and recommendations of the study. The recommendations are proposed as a means of increasing accessibility and utilization of HIV/AIDS prevention information among out-of-school adolescents. Summary and conclusions on the other hand, involve salient issues found out in the study.

5.2 Summary
This study examined the information channels and the socio-cultural factors that influence accessibility to, and utilization of, HIV/AIDS prevention information among out-of-school adolescents (12 – 19 years) in Kyotera County, Rakai District. A total of 98 respondents including 78 out-of-school adolescents (primary respondents), 5 key informants and 15 focus group discussion participants participated in the study. The study involved both male and female adolescents. To a great extent, the study findings agree with the hypothesized variables in the conceptual framework that were developed to guide the study while others do not. The null hypotheses were also rejected. In all, however, the study found that socio-cultural factors played a great role in negatively influencing access and utilization of HIV/AIDS prevention information among out-of-school adolescents in Kyotera county, Rakai district.

Below is the summary of the study according to study objectives.

5.2.1 The influence of social factors on accessibility and utilization of HIV/AIDS prevention information among out-of-school adolescents
The social factors considered by the study include gender, age, religion, level of education and occupation. Results of the study revealed that adolescents had opportunities to access HIV/AIDS prevention information from health centers II and III where available, private health practitioners, outreach health workers, NGOs like Rakai project and World Vision in the area, mass media as well as from any informed member of the community.
Age had an influence on access and utilization of HIV/AIDS prevention information among out-of-school adolescents. This was agreed by 97.3% of the respondents. The young age of out-of-school adolescents made them vulnerable to pressure for sex from old men which denied these girls a chance to utilize HIV/AIDS prevention information especially abstinence until marriage.

A further 66.7% of the respondents revealed that gender had a significant influence on access and utilization of HIV/AIDS prevention information among out-of-school adolescents. Gender roles had a negative influence on access and utilization of HIV/AIDS information through the inferior status of out-of-school girls which made them unable to seek and utilize HIV/AIDS prevention information, low ability to negotiate the use of condoms or HIV testing, shying away from use of HIV/AIDS prevention information and women being denied permission by their husbands to attend HIV/AIDS prevention sensitization meetings in the area.

On the influence of religion, 63.5% of the respondents agreed with the statement that religion had an influence on access and utilization of HIV/AIDS prevention information among out-of-school adolescents. Religion advocated a submissive role for women thus denying a chance to married out-of-school girls to insist on use of HIV/AIDS prevention strategies. In addition, by discouraging the use of condoms and uttering religious judgments that generated stigma, religion inhibited out-of-school adolescents from seeking HIV/AIDS prevention information.

Education level had a negative influence on access and utilization of HIV/AIDS information through inability of out-of-school adolescents to read HIV/AIDS prevention information in the print media and; the finding that HIV/AIDS prevention messages were mainly presented in English and targeted schools in Kyotera County. In addition, low education levels encouraged early marriage which limits mobility and access to HIV/AIDS prevention messages among out-of-school adolescents.

Regarding occupation, 44.9% of the respondents agreed that occupation had an influence on access and utilization of HIV/AIDS prevention information among out-of-school adolescents. For example, the out-of-school child labourers were denied permission by their employers to
attend HIV/AIDS prevention campaigns in the community. Besides, the findings revealed that adolescents in self-employment lacked time to seek HIV/AIDS prevention information while adolescent sex workers were unable to utilize HIV/AIDS prevention information because they worked according to demands of their clients. The study concluded therefore, that 51.3% (Beta = 0.513) of the change in the dependent variable was caused by age while 43.9% (Beta = 0.439) of the change in the dependent variable was caused by gender. Therefore, age and gender were the significant social factors that influenced access to, and utilization of, HIV/AIDS prevention information among the out-of-school adolescents in Kyotera county, Rakai district. The null hypothesis that social factors have no influence on accessibility to, and utilization of, HIV/AIDS prevention information among out-of-school adolescents was rejected.

5.2.2 The influence of cultural factors on access and utilization of HIV/AIDS prevention information among out-of-school adolescents

The cultural factors considered include cultural stigma and taboos, early age of marriage, widow inheritance and dowry.

Regarding cultural stigma and taboos, the study found that cultural beliefs acted as barriers to seeking knowledge of HIV prevention among out-of-school adolescents. Secondly, the widely spread taboo of silence about one's HIV status was found to deny a learning experience to other adolescents who would then seek and utilize HIV/AIDS prevention information.

Early age of marriage had a negative influence on access and utilization of HIV/AIDS information because the age-gap between couples discouraged open communication required to ensure uptake of voluntary counseling and testing for HIV. Besides, early marriage curtailed the social contacts and networks that played a vital role in transmitting HIV prevention information and supporting behavior change among out-of-school adolescents.

Widow inheritance negatively influenced access to, and utilization of, HIV/AIDS prevention information among out-of-school adolescents by isolating the inheriting partner, encouraging extra-marital affairs, stigmatizing widows, advocating for live sex and eventually spreading HIV infection to many male partners.
On the influence of dowry on access and utilization of HIV/AIDS prevention information, 56.4% agreed that dowry had no influence on access and utilization of HIV/AIDS prevention information among out-of-school adolescents.

In conclusion, 50.5% of the change in the dependent variable was caused by widow inheritance while 39.6% of the change in the dependent variable was caused by early age of marriage. This implies that widow inheritance and early age of marriage significantly influenced access to, and utilization of, HIV/AIDS prevention information among the out-of-school adolescents in Kyotera county, Rakai district. The null hypothesis that cultural factors have no influence on accessibility to, and utilization of, HIV/AIDS prevention information among out-of-school adolescents was rejected.

5.2.3 The nature of information channels used in disseminating HIV/AIDS prevention information to out-of-school adolescents
The results of the study revealed that peer-to-peer communication, drama, relatives and the radio were the common HIV/AIDS prevention information channels for out-of-school adolescents in Kyotera County. This implies that both formal and informal communication channels were used for disseminating HIV/AIDS prevention information among out-of-school adolescents. The church, print media, drama, NGOs and traditional health practitioners which have emerged as the most prominent channels of health information for adolescents in Uganda were not mentioned by respondents implying their limited coverage in the area. The nature of HIV/AIDS prevention information disseminated included use of condoms during sexual intercourse, abstinence, being faithful to marriage partners, HIV/AIDS testing before sexual intercourse and STDs treatment. Although the nature of information disseminated to out-of-school adolescents agreed with the ABC approach which focuses on sexual intercourse as the major mechanism for HIV transmission, preventive information for other mechanisms of HIV infection14 were ignored.

14 Centers for Disease Control and Prevention. (2004) indicates that HIV transmission predominantly occurs through three mechanisms: sexual transmission, exposure to infected blood or blood products, or perinatal transmission (including breast-feeding).
5.3 Conclusions

The conclusions of the study are based on the study objectives.

1. All social factors had a negative influence on access and utilization of HIV/AIDS prevention information among out-of-school adolescents in Kyotera County, but age and gender were statistically significant.

2. Cultural factors had a negative influence on access and utilization of HIV/AIDS prevention information among out-of-school adolescents in Kyotera County, Rakai district.

3. It was concluded that both formal and informal communication channels were used to access HIV/AIDS prevention information channels for out-of-school adolescents in Kyotera County. The nature of HIV/AIDS prevention information disseminated included use of condoms during sexual intercourse, abstinence, being faithful to marriage partners, HIV/AIDS testing before sexual intercourse and STDs treatment.

Finally, the Social Cognitive and Diffusion of Innovation Theories provided practical application to explain how people adopt new behaviours. The theories provided useful insight into the difficulty of achieving the behavior change necessary to curb the HIV/AIDS epidemic in developing countries like Uganda. In this case, out-of-school adolescents were greatly inclined to their culture to the extent that what they had to obey their cultural values beliefs (early age of marriage, cultural stigma and taboos, widow inheritance and dowry) and societal norms even if they were a hinderance to access and utilization of HIV/AIDS prevention information. Nevertheless, not all cultural practices hinder utilization of HIV/AIDS prevention information. Practices like parental participation in the introduction and negotiation for children's marriages, fining boys who elope with girls and rewarding virginity at marriage may be good in prevention of HIV/AIDS infection.

5.4 Recommendations

Basing on the findings and conclusions of the study, recommendations have been made for government/policy level, religious organizations and community, and adolescents as presented below:
Government (policy level)

1. Efforts should be made by the government to address the risky traditional customs and practices connected with the refusal to access and utilize HIV/AIDS prevention information such as widow inheritance, early marriage, sexual and economic subordination of women. Apart from emphasizing the ABC approach, the government and NGOs should assist in animating African traditional structures, such as the family, the neighborhood, and the village community which used to uphold moral values, encourage and support them in their difficult task of serving as instruments of behaviour change essential for disseminating HIV/AIDS prevention information.

2. There is need for the government to implement interventions to empower women and girls to enable them overcome the cultural gender roles of submissiveness and inferiority in matters concerning their personal health. This can be done through training in life skills, vocational income generation skills as well as personal health skills like how to use a condom and others. This will help to improve the status of women, especially with regard to their ability to control their sexual interactions, to negotiate VCT, to be protected from abuse, and to have economic power to resist cultural practices like widow inheritance on the death of their husbands.

Religious organizations and the Community

1. Religious leaders should concentrate their efforts on educating and informing people about HIV/AIDS prevention including condom use. It is necessary for information to be disseminated prudently and responsibly to avoid ungrounded uncertainties or needless fears that create stigma. In order to handle this task, there is also a need to address the training of the clergy who are faced with this huge and seemingly overwhelming task of dealing with the HIV/AIDS pandemic. The program and curriculum should instill in the clergy the necessary knowledge, attitude, and skills to serve the community more effectively in the struggle against HIV/AIDS. In addition, they should be equipped with skills in program planning, development, implementation, and evaluation.
2. As advocated by the Diffusion of Innovation Theory, opinion leaders should be engaged in behavior change interventions such as promoting condom use and disseminating other messages about HIV/AIDS prevention. This task may require training in community mobilization approaches which can be effectively handled by NGOs or CBOs in the area. Opinion leaders in the community should be credible communicators who are positive role models for their information to be respected. Besides, outreach programs must involve the use of positive role models (male and female) in the media that break existing stereotypical images and beliefs of HIV. Consequently, strategies like one-to-one discussions during night outreach can provide opportunity for highly targeted HIV/AIDS prevention messages.

3. Communication between parents and children. Parents’ contribution should be considered as necessary and encouraged in reaching the youth in an integrated approach. More specifically, parents, especially women, should be given workshops on counseling, how to reach teenagers and communication skills; and specific workshops should be organized on parenting skills. NGOs and CBOs in collaboration with local governments should offer these skills to parents.

**Out-of-school adolescents**

1. The government and NGOs should introduce programmes that involve out-of-school adolescents in disseminating HIV/AIDS prevention information by using approaches that appeal to youth. Children and youth can make highly effective peer educators where they feel accountable to their peers, where they perceive benefits to the role, where they are able to assist peers on broader issues beyond HIV prevention (particularly rehabilitation), where they can make repeated contact with their peers, and where their work is backed up by broader capacity building and advocacy approaches. This should be implemented in Kyotera County, Rakai district.

2. Out-of-school adolescents should take heed to HIV/AIDS preventive advice given by staff of health workers, relatives, Ministry of Health to enable them live a healthy life. More advice is currently being given by religious and traditional leaders. Adolescents should avoid peer pressure by keeping themselves busy with useful activities such as small scale farming, petty trading or engaging in handcrafts.
5.5 Areas for Further Research

The results of the study have revealed a strong cultural influence on access and utilization of HIV/AIDS prevention information among out-of-school adolescents. However, the study did not cover the policy factors because they appear to have a significant influence on access and utilization of HIV/AIDS prevention information. Besides, there is need for studies to investigate the strategies that can be adopted to increase access and utilization of HIV/AIDS prevention information by out-of-school adolescents while minimally interfering with their cultural values.
REFERENCES


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APPENDIX I

QUESTIONNAIRE FOR OUT-OF-SCHOOL ADOLESCENTS IN KYOTERA COUNTY

My name is Lorna Muduwa, a postgraduate student of Makerere University and I am carrying out a study on the socio-cultural factors influencing out of school adolescents' accessibility and utilization of HIV/ AIDS prevention information. The findings and recommendations of this study are expected to be of research and academic significance in Rakai district and the rest of Uganda. Your responses will be kept confidential, but in case you need further clarifications regarding this research, please contact the researcher on: Telephone number 077450462 or Box number 722 Kampala, Uganda or the supervisor on: Telephone number 078452618.

SECTION A: BACKGROUND INFORMATION ABOUT OUT-OF-SCHOOL ADOLESCENTS (tick the right option or fill the right answer in the spaces provided)

Name of sub county of residence____________________________________________________

A1. Occupation of respondent…………………………………………………

A2. What is your age range? (Please tick under only one of them).

<table>
<thead>
<tr>
<th>Age</th>
<th>12-15 years</th>
<th>16-19 years</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

A3. Marital status


A4. Gender

1. Male 2. Female

A5. Highest education level attained (Please tick under only one of them).

<table>
<thead>
<tr>
<th>Qualification</th>
<th>1. No formal education</th>
<th>2. Primary Level</th>
<th>3. Ordinary level</th>
<th>4. Advanced level</th>
<th>5. Vocational training</th>
<th>6. Other (Please specify)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

A6. Religious affiliation __________________________________________

A7. Do you have opportunities to access HIV/AIDS prevention information within your community?________________________________________________________

A8. If YES, where do you access the information?_______________________

________________________________________________________
SECTION B: SOCIAL FACTORS
For each of the following statements, please indicate (by ticking) the extent to which you agree them, using the following scale: (Agree, Undecided, Disagree).

<table>
<thead>
<tr>
<th>Influence of social factors on access and utilization of HIV/AIDS prevention information</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Agree</td>
</tr>
<tr>
<td>a) Gender has no influence on access and utilization of HIV/AIDS prevention information among out-of school adolescents</td>
<td></td>
</tr>
<tr>
<td>b) Age has no influence on access and utilization of HIV/AIDS prevention information among out-of school adolescents</td>
<td></td>
</tr>
<tr>
<td>c) Religion has no influence on access and utilization of HIV/AIDS prevention information among out-of school adolescents</td>
<td></td>
</tr>
<tr>
<td>d) Level of education has no influence on access and utilization of HIV/AIDS prevention information among out-of school adolescents</td>
<td></td>
</tr>
<tr>
<td>e) Occupation has no influence on access and utilization of HIV/AIDS prevention information among out-of school adolescents</td>
<td></td>
</tr>
</tbody>
</table>

SECTION C: CULTURAL FACTORS
For each of the following statements, please indicate (by ticking) the extent to which you agree them, using the following scale: (Agree, Undecided, Disagree).

<table>
<thead>
<tr>
<th>Influence of cultural factors on access and utilization of HIV/AIDS prevention information</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Agree</td>
</tr>
<tr>
<td>a) Early age of marriage has no influence on access and utilization of HIV/AIDS prevention information among out-of school adolescents</td>
<td></td>
</tr>
<tr>
<td>b) Cultural stigma and taboos have no influence on access and utilization of HIV/AIDS prevention information among out-of school adolescents</td>
<td></td>
</tr>
<tr>
<td>c) Widow inheritance has no influence on access and utilization of HIV/AIDS prevention information among out-of school adolescents</td>
<td></td>
</tr>
<tr>
<td>d) Dowry has no influence on access and utilization of HIV/AIDS prevention information among out-of school adolescents</td>
<td></td>
</tr>
</tbody>
</table>
SECTION D: ACCESS AND UTILIZATION OF HIV/AIDS PREVENTION INFORMATION

For each of the following statements, please indicate (by ticking) the extent to which you agree them, using the following scale: (Agree, Undecided, Disagree).

<table>
<thead>
<tr>
<th>Utilization of HIV/AIDS prevention information</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Agree</td>
</tr>
<tr>
<td>I have abstained from sex until I get married to a suitable partner.</td>
<td></td>
</tr>
<tr>
<td>I am faithful to my future marriage partner</td>
<td></td>
</tr>
<tr>
<td>I use a condom whenever I play sex with a friend</td>
<td></td>
</tr>
<tr>
<td>I have developed life skills that guide me to live a healthy and constructive life.</td>
<td></td>
</tr>
<tr>
<td>I always seek HIV testing and counseling whenever I doubt my sexual practices</td>
<td></td>
</tr>
<tr>
<td>I seek STDs treatment whenever I get infected.</td>
<td></td>
</tr>
</tbody>
</table>

SECTION E: INFORMATION CHANNELS.

E1. What channels are used in disseminating HIV/AIDS prevention information in your area?

___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

E2. What kind of HIV/AIDS prevention information is disseminated to adolescents?

___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
E3. How can access to HIV/AIDS prevention information be increased among out-of-school adolescents?
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
E4. How can utilization of HIV/AIDS prevention information be increased among out-of-school adolescents?
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

THANK YOU FOR YOUR COOPERATION
APPENDIX II

INTERVIEW GUIDE FOR KEY INFORMANTS

**TOPIC:** Socio-cultural factors influencing the accessibility and utilization of HIV/AIDS prevention information among out-of-school adolescents.

1. How does gender influence the accessibility and utilization of HIV/AIDS prevention information among out-of-school adolescents?

2. How does age influence the accessibility and utilization of HIV/AIDS prevention information among out-of-school adolescents?

3. How do religious factors influence the accessibility and utilization of HIV/AIDS prevention information among out-of-school adolescents?

4. How does the level of education influence the accessibility and utilization of HIV/AIDS prevention information among out-of-school adolescents?

5. Do you think occupation influences the accessibility and utilization of HIV/AIDS prevention information among out-of-school adolescents?

6. Is dowry paid in this community? If yes, of what significance is this to the accessibility and utilization of HIV/AIDS prevention information among out-of-school adolescents?

7. How does widow inheritance influence the accessibility and utilization of HIV/AIDS prevention information among out-of-school adolescents?

8. In your opinion, do cultural stigma and taboos influence the accessibility and utilization of HIV/AIDS prevention information among out-of-school adolescents?

9. What information channels exist or are in place to pass information on to these out of school adolescents?
10. What recommendations can you suggest to improve on out-of-school adolescents’ accessibility to and or utilization of HIV/AIDS prevention information?

11. How can access to HIV/AIDS prevention information be increased among out-of-school adolescents?

12. How can utilization of HIV/AIDS prevention information be increased among out-of-school adolescents?

END
APPENDIX III

FOCUS GROUP DISCUSSION CHECKLIST

TOPIC: Socio-cultural factors influencing the accessibility and utilization of HIV/AIDS prevention information among out-of-school adolescents.

1. How does age influence the accessibility and utilization of HIV/AIDS prevention information among out-of-school adolescents?

2. How does sex influence the accessibility and utilization of HIV/AIDS prevention information among out-of-school adolescents?

3. How do religious factors influence the accessibility and utilization of HIV/AIDS prevention information among out-of-school adolescents?

4. How does the level of education influence the accessibility and utilization of HIV/AIDS prevention information among out-of-school adolescents?

5. Do you think occupation influences the accessibility and utilization of HIV/AIDS prevention information among out-of-school adolescents?

6. Is dowry paid in this community? If yes, of what significance is this to the accessibility and utilization of HIV/AIDS prevention information among out-of-school adolescents?

7. How does widow inheritance influence the accessibility and utilization of HIV/AIDS prevention information among out-of-school adolescents?

8. In your opinion, do cultural stigma and taboos influence the accessibility and utilization of HIV/AIDS prevention information among out-of-school adolescents?

9. What information channels exist or are in place to pass information on to these out of school adolescents? END