

Factors that make children vulnerable to HIV/AIDS: A case of Lindi District Council

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Declaration

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Abstract

Tanzania has documented risky and abusive behaviors to children, 10% of young people 15-19 years old have had their first sexual intercourse before the age of 15 years. 38.3% of girls and 30.7% of boys aged 13 -17 years old experienced three or more incidence of sexual violence. UNICEF highlights the critical information gap in adolescence hindering strategic planning to address the needs and rights of children. This study aimed at determining what the factors are that make children vulnerable to HIV; design interventions that address children's vulnerabilities and prevent HIV infection.

This was interpretive qualitative study using focus group discussions and semi structured interviews in determining factors that make children vulnerable to HIV/AIDS. Interpretive validity was used to ensure accuracy of study findings. The data was collected from a sample of 2 social welfare officers, 18 most vulnerable children aged 11–17 years and 18 caregivers of respondent children. The research used purposive sampling and stratified random sampling in selection of respondents. The data analysis was done through coding the information collected then categorizing into themes. The interpretation was guided by comparison of findings with existing literature. The researcher obtained Certificates of ethical clearance from Tanzanian National Institute for Medical Research and The Research Ethics Committee at Stellenbosch University.

The study found that all respondent had awareness of HIV. Caregivers were able to articulate two main routes of HIV transmission. While sexual transmission of HIV came up in all groups; knowledge of mother to child transmission of HIV did not come out during the discussion. Some parents demonstrated a degree of denial of reality about their children's sexual relations; none of the parents could validate their position.

Entertainment in the community was perceived as a contributing factor to HIV vulnerability of children. Parents expressed hardship in controlling children because the time children spend in entertainment is when they are involved in activities including meeting with men and have sex. Lack of parental guidance was associated with the culture of rite of passage. Poverty and parental

irresponsibility were associated with prevalence of transactional sex while culture was said to be a factor for trans-generational sex. Child abuse came out strongly from the men's group as contributing to children's vulnerability to HIV/AIDS. It was reported men and women alike in the community are perpetrators of child abuse.

Children recommended education on HIV/AIDS and moral/ religious practices to address children vulnerability. Women proposed Government actions against people living with HIV/AIDS that depicted stigma and discrimination in the society. These included requiring the Government to give people living with HIV drugs to control their sexual desires or imprison them as a way to keep them away from children and leaving the community free from HIV.

Interventions for addressing vulnerability to HIV/AIDS for children in this context should focus on empowering children and parents, promote behavior change and address economic blockade. This study recommends interventions focusing on improving access to information and health services and household economic strengthening.

Opsomming

Tanzanië het riskante en onregmatige gedrag teenoor kinders van dié land gedokumenteer. Daaruit blyk dat 10% van jongmense tussen die ouderdom van 15-19 jaar voor 15-jarige ouderdom die eerste keer seksueel aktief was. 38.3% van meisies en 30.7% van seuns tussen 13-17 jaar het reeds drie/meer voorvalle van seksuele geweld ervaar. Die Verenigde Nasies se Kinderfonds, UNICEF, beklemtoon die ernstige inligtingsgaping by adolessente, wat strategiese beplanning met die oog op kinders se behoeftes en regte bemoeilik. Hierdie studie was daarop toegespits om te bepaal watter faktore kinders kwesbaar maak vir MIV, en om intervensies te ontwerp om kinders se kwesbaarheid te hanteer en MIV-infeksie te voorkom.

Die studie het van fokusgroepgesprekke en semi-gestruktureerde onderhoude gebruik gemaak om te bepaal watter faktore kinders kwesbaar maak vir MIV/vigs. Vertolkende geldigheidskontroles is uitgevoer om die akkuraatheid van die studiebevindinge te verseker. Die data is van 'n steekproef van twee maatskaplike welsynsbeamptes, 18 kwesbare kinders van 11-17 jaar, sowel as die versorgers van hierdie kinders ingesamel. Die navorsing het doelgerigte steekproefneming en gestratifiseerde ewekansige steekproefneming gebruik om respondente te kies. Die navorser het etiekgoedkeuringsertifikate van die Tanzaniese Nasionale Instituut vir Mediese Navorsing sowel as die Universiteit van Stellenbosch se Navorsingsetiekkomitee verkry.

Die studie het getoon dat alle respondente bewus is van MIV. Versorgers kon die twee vernaamste maniere van MIV-oordrag beskryf. Hoewel seksuele oordrag van MIV in alle groepe ter sprake gekom het, is MIV-oordrag van moeder na kind nie geopper nie. Sommige ouers het 'n mate van ontkenning oor die realiteit van hul kinders se seksuele verhoudings getoon; nie een van die ouers kon staving vir hul standpunt voorsien nie.

Vermaak in die gemeenskap word as bydraende faktor vir MIV-kwesbaarheid beskou. Ouers het genoem dat hulle sukkel om hul kinders te beheer, aangesien die kinders aan vermaak in aktiwiteite soos ontmoetings met mans en seksuele omgang betrokke raak. Armoede en ouerlike onverskilligheid speel 'n rol in die voorkoms van 'transaksieseks', terwyl kultuur as faktor in

seks tussen en oor generasies aangevoer word. By die mansgroep het kindermishandeling as beduidende bydraende faktor tot kinders se kwesbaarheid vir MIV/vigs na vore getree. Na bewering is mans en vroue ewe skuldig aan kindermishandeling in die gemeenskap.

Kinders het opvoeding oor MIV/vigs en morele/godsdienstige praktyke aanbeveel om kwesbaarheid te verminder. Vroue het regeringsoptrede teen mense met MIV/vigs aan die hand gedoen, wat tot stigma en diskriminasie in die samelewing sal lei. Hulle stel onder meer voor dat die regering MIV-positiewe persone van middels moet voorsien om hul seksuele drange te beheer óf hulle moet aanhou om hulle weg te hou van kinders en die gemeenskap van MIV te bevry.

Intervensies vir die vermindering van MIV/vigs-kwesbaarheid by kinders behoort klem te lê op die bemagtiging van kinders en ouers, die bevordering van gedragsverandering, en die opheffing van ekonomiese versperrings. Die studie beveel aan dat intervensies op die verbetering van toegang tot inligting en gesondheidsdienste sowel as die ekonomiese versterking van huishoudings konsentreer.

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List of abbreviations

AIDS	Acquired Immunity Deficiency Syndrome
DHHS	Department of Health and Human Sciences (United States of America)
DHS	Demographic and Health Survey
FGD	Focused Group Discussion
HBC	Home Based Care
HIV	Human Immunodeficiency Virus
ICRW	International Centre for Research on Women
IFAD	International Fund for Agricultural Development
ILFS	Integrated Labor Force Survey
ILO	International Labor Organization
IMAU	Islamic Medical Association of Uganda
MCDGC	Ministry of Community Development Gender and Children
MOFEA	Ministry of Finance and Economic Affairs
MOHSW	Ministry of Health and Social Welfare
NBS	National Bureau of Statistics
NCPA II	National Costed Plan of Action II
NGOs	Non- Governmental Organizations

NIMR	National Institute of Medical Research
ODI	Overseas Development Initiative
PMTCT	Prevention of Mother to Child Transmission of HIV/AIDS
REC	Research Ethics Committee
REPOA	Research on Poverty Alleviation
STIs	Sexually Transmitted Infections
TACAIDS	Tanzania Commission for AIDS
TB	Tuberculosis
UNAIDS	United Nations Joint Programme on AIDS
UNICEF	United Nations Children's Fund
URT	United Republic of Tanzania

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Daisy N. Kisyombe

CHAPTER ONE: INTRODUCTION

1.1 Introduction

HIV/AIDS in children has largely been studied from the perspective of vertical transmission i.e. mother to child transmission. These efforts are justifiable because the majority of children living with HIV/AIDS have acquired it through mother to sibling transmission. Research, however, shows evidence of risky behaviors relating to HIV transmission among children. Ten percent of women aged 20-49 years old in Tanzania reported to have had first sex before they were age 15 (NBS, 2013: 47). A formative research conducted by the International Centre for Research on women regarding the vulnerabilities of adolescent girls in Newala Tanzania revealed practices such as transactional sex as being out of necessity due to extreme poverty at household level and children being expected to meet the basic needs of the family as well as greed for material objects among girls. Worldwide there is a concerted move to eliminate the mother to child transmission of HIV; efforts are also showing promising results. The focus of interventions now should include a move to address other factors that make children vulnerable to HIV infection.

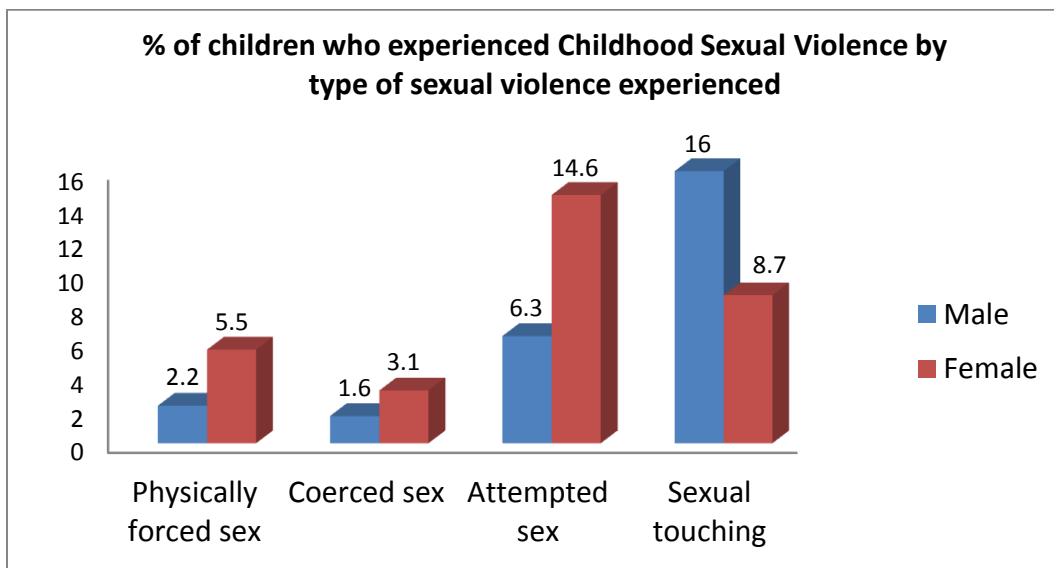
A UNICEF study highlights the information gap in adolescence data is largely for populations below 5 and 15-19 years old leaving early adolescence and older childhood as a critical gap hindering strategic planning to address the needs and rights of this group (UNICEF, 2011: 5). This study took on the interpretive qualitative research approach to determine the factors that make adolescent children (11 -17 years old) vulnerable to HIV infection. The study looked at the perspectives of children and parents in Lindi Rural district on these vulnerabilities and how they can possibly be addressed to protect children from HIV infection.

1.2 Background of the study

HIV/AIDS continues to be the major causes of human suffering in Africa despite over 20 years of interventions. Tanzania being one of the countries in Sub-Saharan Africa is not an exception. Currently research shows some shade of hope with the decreasing prevalence rate in the country. The 2011/2012 Tanzania HIV/AIDS and Malaria Indicator survey reports that HIV prevalence has dropped from 6% in 2007/08 to 5% in 2011/2012 (NBS, 2012:111). The study, however,

shows that prevalence among 15–19 years old group has stayed at the same rate of 1% (ibid). UNICEF further indicates 160,000 children 0-14 years old are living with HIV in Tanzania. Tanzania has also documented some risky behaviors among children including early sexual debut where data shows slightly above 10% of young people 15-19 years old have had their first sexual intercourse before the age of 15 years (TACAIDS, 2008:96). Child abuse practices contribute too many negative behaviors such as being abusive, turning into substance abuse as well as physical injury and emotional trauma. The data from a study on violence against children in Tanzania shows “nearly 6% of female 13–24 years in Tanzania reported to have physically forced sex before the age of 18” (MCDGC, 2011:29). The same study shows 38.3% of girls and 30.7% of boys aged 13-17 years old experienced three or more incidence of sexual violence (Ibid). The child abuse practices are putting children at risk of HIV infection. Figure 1.1 shows the prevalence of sexual abuse among children as reported by them and young people (13–24 years old) in the violence against children survey.

Figure 1.1: Types of childhood sexual violence



Source: Tanzania Violence against Children Survey, 2011

Factors such as stigma and discrimination, perceptions of gender roles and overstretched traditional social safety nets all exacerbate the HIV/AIDS vulnerability in the population.

Poverty and food insecurity also create desperation and apathy that impairs people's sense of judgment over the long term consequences of daily actions including risky behaviors predisposing people to HIV infection; disease impacts are felt hardest among the vulnerable populations. In Tanzania 2.5 million children are identified as being most vulnerable in the category of being infected. The vulnerability criteria is broad including but not limited to "child headed households, children living with elderly or chronically ill caregivers, children from destitute families, children in conflict with the law" (MOHSW, 2007: 9). Most of these children face the daily challenges of inadequate food, poor living conditions, and limited access to health care. They lack education opportunities such as progressing in school to higher level of education which has also been seen as a means of child protection particularly for girls.

By virtue of being vulnerable, these children are predisposed to yet another greater challenge that is susceptibility to HIV infection. Issues such as early marriages, poor skills for negotiation of safer sex, gender based violence all come into play against the vulnerable children. It is thus imperative there should be an understanding of these factors and how they specifically influence the children's vulnerability to HIV/AIDS in order to devise better interventions for protecting children.

1.3 Significance of the study

The study findings first and foremost are useful in helping vulnerable children and their caregivers understand the dynamics of HIV/AIDS and how that affects their quality of life. The qualitative nature of the study gave an in depth look at the lives of the most susceptible children and built an understanding of factors that exacerbate their vulnerabilities. The study highlights key issues that need action for protection of children within the study area and surrounding communities by virtue of proximity and people interactions and thus common practices. Time was spent with study participants after the interviews in responding to questions and clarifying the issues about HIV/AIDS that children and parents wished to know as part of sharing information about the infection.

The findings of this study reflect the design of appropriate interventions or improving the existing ones and therefore for addressing the vulnerabilities. The study findings provides inputs for the strengthening the national child protection systems and implementation of the second National Plan of Action for supporting the most vulnerable children in Tanzania (NCPA II). The two plans emphasize child protection and joint stakeholders' efforts in safeguarding them. The two Government documents serve as a guidance informing programs for supporting the most vulnerable children together with priorities and strategic direction. The study findings are useful to inform policy debate on child welfare since the Government of Tanzania is in the process of formulating their protection regulations and guidelines following the enactment of Law of the child Act 2009.

1.4 Research problem

Lindi District is one of the poorest and periphery areas in Tanzania with approximately 40% of people in the lowest wealth quintile (NBS, 2013). The region is also experiencing a significant inadequacy of social services including health and education. Eighteen percent of men and 29.1% of women in Lindi have no education where enrollment rate for secondary school stands at 17.1% for boys and 4.6% for girls (Ibid). The Lindi region is a predominantly polygamous society with high divorce rates and high level of multiple sexual partnerships. Early sexual debut is also reported in Lindi with 12% of women 15-24 years old and 21% of men same age reported to have has sex before age 15 (TACAIDS; 2008: 96). The high divorce rates has resulted in child neglect and lack of basic services for children as majority of them are from broken families ending up being cared for by their grandparents who have a reduced ability to provide for the children.

Poverty and lack of basic services have been associated with risky behaviors in relation to HIV/AIDS. A research on vulnerability of adolescent girls in Newala Tanzania shows parents usually compromise their involvement in the upbringing of their children for reasons including divorce and remarriage (ICRW, 2011: 11). The pre-existing conditions in Lindi provides for a fertile ground for vulnerability to HIV infection particularly for the children who lacks guidance and parental care due to economic or social reasons. It is important to identify the particular

vulnerability that children in Lindi District are facing and how an intervention can improve their lives and well-being. Existing knowledge provides substantial information about HIV/AIDS and vulnerabilities for people 15-49 years old.

The problem statement is thus: What are the factors that make children (11-17 years old) vulnerable to HIV/AIDS?

1.5 Aim of the research

The purpose of the study was to determine what the factors are that make children vulnerable to HIV; design the interventions that address the specific vulnerabilities and prevent children from HIV infection.

1.6 Research Objectives

This study specifically sought to achieve the following objectives:

- To identify the existing knowledge about HIV/AIDS vulnerabilities for children.
- To determine perceptions of HIV/AIDS vulnerabilities among children, caregivers and social workers.
- To identify ways of addressing the children's vulnerabilities to HIV/AIDS from children's point of view.
- To evaluate the factors that makes children vulnerable to HIV/AIDS.
- To suggest interventions for addressing children's vulnerabilities and protecting children from HIV infection.

1.7 Research methodology

This was an interpretive study using focus group discussions and semi structured interview methods of qualitative research in determining the factors that make children vulnerable to HIV/AIDS. Interpretive validity was used in ensuring the accuracy of the study findings. The type of validity refers to the accuracy in portraying the meaning attached by participants to what is being studied by the researcher (Johnson, 1997:285). Low inference descriptors by means of

direct quotes from participants were used in presenting the participants meaning to the issues being studied. The data was collected from a sample of 18 most vulnerable children (boys and girls) aged 11–17 years. Eighteen parents responded to the study through focus groups discussions. Two social welfare officers also participated in the study through semi structured in-depth interviews.

1.8 Limitations of the study

The study is a qualitative in nature and thus it explored the vulnerabilities from a small group of randomly selected people within a specific population of most vulnerable children in their own localities. By design of qualitative study; the results of this study cannot be extrapolated to the larger most vulnerable children population. The study rather sheds some light into the situation of these children to stimulate a debate and further in depth research and action to address HIV vulnerabilities among children. The study also used focus group discussions and semi-structured interviews to gather data. These methods while increases the validity of results by engaging respondents to a series of open ended questions and allowing room for explanations and probing they tend to reduce the reliability because there is no control to ensure the same questions are asked to different groups of respondents. The clarifications and explanations of the questions in the guide may also differ depending on the level of understanding of the respondents group.

1.9 Outline of chapters

This research is organized into five chapters. The first chapter is introductory covering the background to the study and those of the Lindi region and Lindi District. The problem statement, research question as well as significance and limitations of the study are part of first chapter. Moreover the chapter provides brief information on the study methodology.

The second chapter is dedicated to the conceptual framework of the study by providing a detailed review of literature where issues around vulnerability and HIV/AIDS in children are explored from secondary data sources.

The third chapter reflects research methodology focusing on research design and details of data collection including the target population, selection criteria and sampling procedure. The chapter also covers methods of data analysis, ethical consideration as well as issues of validity and reliability of the study.

The fourth chapter is about research findings, discussion and implication of the results.

Chapter 5 reflects recommendations and conclusion drawn from the researcher's perspective, key findings as well as secondary data.

1.10 Conclusion

The contents of chapter one contains an insight into the motivation for the study, background information as well as what the intentions are to achieve. The review of literature provides detailed insights into the existing body of knowledge. The report continues to review what information exists on HIV prevalence, adolescence in Tanzania, HIV vulnerability as well as resilience.

CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

The HIV/AIDS epidemic has dominated the health and development sector debate for over 30 years. Over the years there has been encouraging results in efforts being made by many institutions and people to control the epidemic. Among the encouraging positive results include the recently seen trend in reduction in numbers of newly HIV infected people and scale up of its treatment to the needy people. While this has moved HIV/AIDS from the perceived ‘death sentence’ to a manageable chronic illness; the battle is still on for the search of HIV vaccines, sustaining the impact of social and behavior change programs as well as ensuring comprehensive access to HIV treatment for the eligible people worldwide. “Literature review provides a framework for establishing the importance of the study as well as comparing the results with other findings” (Creswell, 2009:25). The following is the review of existing literature on the subject of children vulnerability and HIV/AIDS in the world, Africa and Tanzania specifically.

2.2 HIV/AIDS epidemic

A picture is provided of the HIV/AIDS epidemiology beginning with the global situation and narrowing it down to Africa and particularly in Tanzania.

2.2.1 The global picture

Globally HIV/AIDS’ new infection is on the increase amongst many population groups at different social levels. A joint UN report reveals a current worldwide situation where 34 million people (0.8% of world population 15-49 years) are living with HIV/AIDS which is a 17% increase from the new infection rates of 2001 (UNAIDS, 2012:14). There are 2.5 million adults and children worldwide newly infected with HIV in 2011 alone while 1.7 million adults and children died due to AIDS related causes worldwide (Ibid). The world has also seen a wide coverage of anti-retroviral drugs for people living with HIV/AIDS. Prevention of mother to child transmission of HIV is also been given high priority and in 2011 the efforts were made to expand access to dual prophylaxis and less on a single dose therapy for pregnant women (UNAIDS,

2012). The trend has significantly reduced morbidity and AIDS related death especially in areas with high HIV/AIDS rates. UNAIDS report estimates if all priority countries shifted to the current recommended dual prophylaxis, there would be a 20% drop in the rate of infection from mother to child (Ibid).

The global trend shows a decline in new infections among young people due to behavior change including increased condom use, reduced number of sexual partners and delayed age of first sex (UNAIDS, 2012:14). The prevalence among youth population reveals female aged 15-24 years are more affected (0.6%) than their male counterparts (0.3%) (UNAIDS, 2012:15); risk among children and young people is, however, still high in some population groups. UNICEF reports children and young people living with disabilities are incorrectly believed to be sexually inactive and thus left out of sexual, reproductive and HIV/AIDS programmes and as a consequence they are at high risk of being HIV positive (UNICEF, 2013: 26).

2.2.2 HIV/AIDS in Sub Saharan Africa

The Sub Saharan Africa region continues to host the largest number of people living with HIV/AIDS in the world with 23.5 million (nearly 1 in every 20 adults) living with the infection; making up to 69% of people living with HIV in the world (UNAIDS, 2012: 8). Within the region 1.8 million people were newly infected with HIV out of 2.5 million worldwide. Approximately 1.2 million adults and children died of AIDS related causes in Sub Saharan Africa out of 1.7 million people worldwide (Ibid). Sub Saharan Africa is also home to 90% of children who were newly infected with HIV in 2011 worldwide (UNAIDS, 2012:42). Despite the magnitude of the epidemic Sub Saharan Africa is challenged also by limited resources for proper care and management of HIV epidemic. Only 59% of pregnant women living with HIV in the region received the needed antiretroviral therapy or prophylaxis (Ibid).

UNAIDS (2012) report is projecting a critical need of international funding in filling the resource gap in HIV/AIDS financing. The report further warns the low income countries will have limited abilities to cover for the resource cutbacks from international donors. Availability of condoms for HIV prevention was challenged by inadequacy and unbalanced supply between male and

female ones in 2011. The year saw availability of an estimated 9 donor provided male condoms for every man (15-49 years) and 1 female condom for every 10 women (15- 49 years) (UNAIDS, 2012: 19). The Sub Saharan Africa situation is further aggravated by Tuberculosis and HIV co-infection. The region is home to 80% of all people living with both HIV and TB (Ibid). While antiretroviral treatment has proven to reducing the number of people living with HIV who acquire TB infection as well as reducing AIDS related deaths; only 46% of people living with both HIV and TB in Sub Saharan Africa initiated relevant treatment (UNAIDS, 2012: 60).

2.2.3 HIV/AIDS in Tanzania

The United Republic of Tanzania is one of the Sub Saharan Africa countries that are hard hit by HIV/AIDS epidemic. The country has a HIV prevalence rate of 5% among adult population i.e. 15–49 years (NBS, 2013). The National bureau of statistics points out the determinant factors for controlling the epidemic as being HIV related knowledge, social stigmatization, risk behavior modification, access to high quality services for STIs and antiretroviral drugs as well as provision and uptake of HIV counseling and testing (NBS, 2011: 209).

There are high levels of knowledge about HIV/AIDS in the general population. There is an indication that 71.1% of women and 70.3% of men 15-49 years knew about HIV prevention methods of using a condom and limiting sexual intercourse to one uninfected partner (NBS, 2011: 212). The same survey shows 48.2% of the population (men and women) have comprehensive knowledge about HIV. This is being able to articulate the HIV prevention methods as well as rejecting the two most common misconceptions about HIV. When compared 30.2% of adult women and 41.1% of adult men in Tanzania have acceptance attitudes towards people living with HIV (NBS, 2011: 218).

The expressed knowledge about HIV/AIDS in Tanzania is sharply contrasted by the demonstrated behaviors emphasizing the need to bridge the gap between knowledge and practices as part of controlling the epidemic. While 20.7% of men are reportedly having 2 or more sexual partners in the last 12 months preceding the survey, only 23.6% of those men used condoms during the last intercourse (NBS, 2011: 223). Provision and uptake of HIV counseling

and testing is crucial in controlling the epidemic. In 2010, 92.4% of Tanzanian women and 91.2% of men knew where to go if they need HIV testing (NBS, 2011: 266 -267). This indicates a significant investment towards provision of HIV testing on the side of Government and other development/public health stakeholders. The uptake of the services, however, is still a challenge with only 29.5% of women and 25.5% of men reporting to having tested and received their test results (Ibid).

2.2.4 HIV in Lindi

Lindi region is characterized by high levels of poverty with 40.6% of population being on the lowest economic quintile (DHS, 2010). Table 1.1 reflects key HIV/AIDS indicators for Lindi.

Table 1.1: Key HIV/AIDS indicators data for Lindi region

Name of indicator	Women/ girls	Men/ boys
Awareness of HIV prevention among 15- 49 years old	81.5%	76.3%
Knowledge of PMTCT	78.7%	62.0%
HIV counseling and testing in Ante Natal clinic	71.6%	
Married women reporting a co- wife	14.1%	
Accepting attitudes towards people living with HIV	25.5%	42.7%
Men reporting to have paid for sex		53.6%
Men who paid for sex and didn't use a condom		39.0%

Tested for HIV and received results in last 12 months	39.5%	28.1%
HIV prevalence among 15- 49 years old	4.3%	1.1%
HIV prevalence among youth 15- 24 years old	2.4%	1.6%
STI prevalence (STI/ genital discharge/ sore/ ulcer)	5.6%	6.5%

Source: Tanzania HIV/AIDS and Malaria Indicator Survey 2011/2012

2.3 Adolescence and HIV in Tanzania

“In Tanzania 50% of the population is children i.e. 0-18 years old” (MOFEA, 2010: 9). Despite being the largest majority in the country, children in Tanzania and particularly the rural majority are challenged by many factors such as limited or poor access to health care and particularly sexual and reproductive health and preventive services for adolescents. Other challenges include, *inter alia*, household level income poverty, poor quality of education, food insecurity and poor nutrition, violence and abuse, disintegration of communal values, HIV/AIDS related stigma and discrimination. Unfortunately, all the challenges are the fertile grounds upon which HIV epidemic thrives. Those factors also impair children’s resilience and resulting to being vulnerable to HIV infection.

“Over 95% of Tanzanian young people have heard about HIV/AIDS while 70% and more have knowledge of HIV prevention methods” (NBS, 2011: 210 -211). The comprehensive knowledge of HIV is relatively lower at 43.8% for girls and 36.8% for boys 15- 17 years old (Ibid). The practice is more of a challenge; although the data trends over the years shows an improvement on the practices the majority of people still display the disconnection between the high knowledge, positive attitude and the actual practice. Only 28.1% of girls and 13% of boys 15 – 17 years old actually have tested for HIV and received their results in the last 12 months preceding the survey (NBS, 2011: 241). Furthermore in terms of early sexual debut among young people; more girls

tend to have early sex debut than boys. Eleven percent of female adolescents 15-17 years old reported to have had sexual intercourse before their 15th birthdays as compared to 8.2% of adolescent boys of the same age (Ibid).

HIV/AIDS in children has traditionally been associated with mother to child transmission of the infection. Statistically the majority of children living with HIV are due to mother to child transmission. However, times have altered and human behaviors have also changed since poverty is knocking at the door and the infection is lurking in the background. Children are increasingly exposed to acts/practices that put them at risk of HIV infection. The acts of brutality against children and particularly sexual violence are rampant in Tanzania. The study on violence against children in Tanzania shows “29.1% of female children reported to have been forced into their first sexual intercourse before the age of 18” (MCDGC, 2011: 30). A similar finding was reported by REPOA where “30% of adolescent girls in Mwanza region reported their first sexual experience was a forced one” (REPOA, 2008: 7). The observed trends of adolescent risk behaviors coupled with limited knowledge of HIV/AIDS and violence against children clearly puts them at greater risk of HIV infection and calls for immediate action to protect these young ones from harm.

2.4 Dimensions of vulnerability

Vulnerability can be defined as susceptibility or exposure to a situation that can potentially be harmful to the person. Vulnerability to HIV/AIDS can be studied in many dimensions, ODI categorize vulnerability according to natural/environmental, lifecycle, economic, health and social dimensions (ODI, 2010:10). Gillespie (2005:6) categorize vulnerability according to means of survival, nutrition and health, poverty, education, psychosocial and societal. Vulnerability for the purpose of this study will be placed in the social and economic dimensions where the focus will be on stigma and discrimination, gender dynamics and poverty.

2.4.1 Stigma and discrimination

AIDS morbidity, stigma and discrimination have stood a firm ground in the communities despite the evidently high levels of knowledge about HIV/AIDS that people have displayed. Various

reasons have been accounted for in terms of stigma and discrimination, mostly relating to people's attitudes. A study on HIV/AIDS stigma and discrimination highlighted some contributing factors are "fear of casual transmission, fear of suffering and death as well as the burden of care" (Maman S, et al, 2009: 2274 -2275). The study shows behaviors associated with stigma such as social isolation of the PLHIV and their families is a result of the recounts of deterioration and death of people due to AIDS related illness.

A further important point raised in the study is "the burden of care instills feelings of hatred among care givers where some feel it is not fair a person gets infected with HIV and eventually overwhelm the family with their health needs" (Ibid). Studies further shows family income falls by 60% while expenditures increases up to four times, family savings are depleted and family goes into debt to care for a sick member infected with the disease (Ritcher,2004: 9). Whether the children are stigmatized as a result of having a family member living with HIV or are harboring the hatred feelings towards the sick family member due to deprivation they must face to accommodate the needs of the sick or merely process the hatred due to the overwhelming burden of nursing the sick family member; the outcome is the psychological effects may create desperation and desire to break loose from the situation and this impairs children's ability to make informed decisions. In the era of HIV/AIDS a child with impaired decision making skills is vulnerable to infection.

2.4.2 Gender inequality

The vulnerability to HIV/AIDS is also gender biased; women are more vulnerable to infection than men, however, when it comes to children the same dynamics are prevalent. "Women 15-16 years are up to six times more likely to be infected with HIV than young men of same age" (ILO, 2004, as cited by IFAD, 2006: 2). When looking at the gender dynamics in the light of HIV/AIDS it is important to evaluate how imbalanced gender relations in African societies shape the discussion. Safer sex practices among adolescent for instance are reliant on their ability to negotiate for safer sex with their partners. In Tanzania HIV/AIDS and Malaria Indicator survey; "7.3% of Tanzanian girls 15 -17 years old reported to have had higher risk intercourse with a man 10+ years older" (URT, 2008:104). When the sexual relationship is with an older person as

in the case of the highlighted data (where also older men are more powerful economically and/or socially) the negotiation powers becomes questionable. Furthermore women have long since been seen as disadvantaged when it comes to the burden of care for HIV/AIDS sick relatives.

Young girls are particularly taken out of school so as to take care of their sick parents. This further renders the girls vulnerable to issues such as early marriage and teenage pregnancy. School is one place where children learn not only self-confidence through intellectual advancement but also HIV prevention through school based related prevention programs. REPOA argues “ensuring children go to school, improving the quality of education they receive, improving opportunities for secondary, technical and higher education are critical elements of a framework for social protection to reduce the vulnerability of children” (REPOA, 2007:15).

Boys on the other side of the equation are also vulnerable as the gender dynamics in the communities are lenient towards men. Men in many societies are expected to have multiple partners for instance as a manhood prestige and be dominant in the relationships. “Women are expected to be dependent on men and also girls are socialized from the young age to play the subordinate role” (Wodi B, 2005: 2). Such patriarchal systems create vulnerability since boys as well as girls never learn the social skills such as communication necessary for negotiating safer sex or disclosure of HIV status between sexual partners.

2.4.3 Poverty and HIV/AIDS

“In Tanzania, 77% of people live in rural areas where poverty is more pronounced than urban areas” (REPOA, 2007: 2). The majority of children in rural areas are forced to work and earn income at a young age in support for the family weak economies. “Currently 23.5% of boys 7 - 13 years and 19.1% of girls the same age are in child labour” (ILFS, 2006 as cited by MOFEA, 2010: 62). AIDS morbidity can be found among the workforce and therefore children constantly finds themselves in situations where they have to work to compensate the loss income in the families. In many cases children are forced to work at the expense of their education and sometimes in hazardous environment such as fishing camps, mines, tobacco/tea plantations etc.

“More than half of those children working full time in Tanzania’s mines are orphans” (Pharoah et al, 2004: 76).

One of the devastating dimensions of poverty in Tanzania is food insecurity. It has been established “53.3% of the most vulnerable children in 5 regions of Tanzania are cared for by their grandparents while 59% are in female headed households” (Pact, 2012: 6). Pact further points out these most vulnerable children families have a diminished ability to produce enough food to meet their daily food intake requirements. Children once again finds themselves in situations where they have to go to school without food and often times with no hope of having a meal after school. At most these vulnerable families can afford two meals a day, often times from community contributions or bought from the meager income earned through seasonal labor.

It is clearly known a causal relationship exists between HIV/AIDS and poverty. While “HIV/AIDS impacts on productivity by attacking the most productive age (15 -49 years old) and affecting income and asset distribution” (Barnett et.al, 2002: 1) poverty also lead to desperations and feelings of seeking quick fixes to everyday problems and subsequently result in issues such as transactional sex. Poverty also limits people’s access to services including HIV preventive and care services.

2.5 Resilience

Resilience is explored within the context for the purpose of understanding the concept as well as understanding how people deal with vulnerabilities or copes with life stressors such as HIV/AIDS. Resilience is explained in three dimensions of “support, inner strengths/ self-esteem and interpersonal/social skills” (Grotberg, 1995). The paper further elaborates the three dimensions of resilience in terms of “trusting relationships, structure/order at home, presence of role models and access to services such as health, education, welfare and security under the pillar of support” (Ibid). Grotberg (1995) argues “resilience is built from early childhood, children must learn certain order and routine that they adhere to and also the consequences of violation of the routines”. Children also learn better through seeing and imitating the significant adults in their lives (usually primary caregivers) and thus “a presence of a role model in children’s lives is

important. The presence of a trusted significant adult in children's lives is paramount in developing trusting relationships. In the growth process "children must learn that there is someone who cares and is available to support them in case they come into danger / trouble" (Grotberg, 1995).

Another important pillar of resilience is the level of self-esteem individuals and especially children have of themselves. Here it is argued "children must develop feelings of being loved as well as ability to love other people" (Ibid). In the face of HIV/AIDS and mixed age sexual relations it is imperative that children develop this feeling of being loved from home and among the trusted adults around them. Children who are confident of the love they receive at home are less likely to fall into the traps of lust and illusions of love and thus more able to evade peer pressure.

Within the same pillar of self-esteem, "self- pride, autonomy and sense of responsibility empowers children to take control of their lives" (Grotberg, 1995). It further fosters children's innovation and decision making which is an important skill in sexual relations dynamics. The third pillar of resilience according to Grotberg is "social/ interpersonal skills including communication, problem solving, managing feelings, gauging self and others temperaments as well as seeking trusting relations". Children growing up in the wake of HIV/AIDS suffer extended periods of emotional stress and worries that impairs their interpersonal skills. It is also unfortunate that in Tanzania; the counseling and psychological support services are limited and where available they tend to be expensive and thus excluding poor populations. Vulnerable children in this case are once again left out of the important pillar of developing resilience.

2.6 Conclusion

The review reveals the depth of the HIV/AIDS epidemic as well as situation of children in Tanzania highlights the critical gap between the knowledge and practice. The gap emphasizes the point that HIV/AIDS interventions in Tanzania are yet to cause significant change in people's behavior. There is a reflection of the effects of poor decision making skills, in young people when it comes to relationships and handling peer pressure. There is evidence that shows the

significance of support systems in building children's resilience including trusting relationships and role models. The majority of children do not have such support as a result of the burden of care as well as disintegration of morals and traditional safety nets. The result is trans-generational sex where children are either forced to or willfully engaging in sexual relations with people 10 years or older.

This study aims at gaining more insights from the selected group of vulnerable children in one of the poorest regions in the country. The next chapter places methodology in context and justify its application used to study the population.

CHAPTER THREE: RESEARCH METHODOLOGY

3.1 Introduction

When conducting a scientific inquiry, it is imperative the steps taken into the inquiry are clear and replicable; research methodology outlines such research conduct. “Methodology is how we come to know by inquiring in certain ways” (Henning et al, 2004:15). Methodology for this matter practically stipulates the design, methods of inquiry including measurement instruments as well as data analysis.

This was a qualitative study which used an interpretive research approach to assist in solving the proposed problem. This kind of study relies on multiple types of subjective data and investigates people in particular situations in their natural environment (Denzin & Lincoln 1994 as cited by Christensen et.al, 2011). Qualitative research is geared towards the depth of understanding the variables rather than the quantity. “Unlike quantitative research which aims at hypothesis testing, qualitative research is mainly focused on understanding and describing local situations as well as theory generation” (Christensen, 2011: 53).

Qualitative research allows for in depth exploration and understanding of phenomena because it “utilizes open ended questions and interviews that can be guided by protocol but not restricted to predetermined variables” (Creswell, 2009:175). Qualitative research also gathers information from multiple sources of data which allows for broader perspective of the variables being studied. Qualitative research has disadvantage, it does not allow for generalization of findings. Moreover since qualitative research is largely interpretive inquiry, it is complex to separate the interpretation of researchers from their background, context and prior understanding of the phenomena (Ibid, 2009:176).

Interpretive validity is used in presenting the findings of this study to address researcher bias. This type of validity refers to the accuracy in portraying the meaning attached by participants to what is being studied by the researcher (Johnson, 1997:285). Low inference descriptors by means of direct quotes from participants were used in presenting the participants meaning to the issues being studied. Data and methods triangulations are also used to ensure corroboration of

information being presented. This was done by the use of multiple data sources and data collection methods in gathering the information.

The research focuses on vulnerable children where focus group discussions were conducted with adolescent girls and boys as well as their caregivers. Semi structured in-depth interviews were conducted to gain insight into the existing problem with social welfare officers. All the methods were used to identify the perceptions of vulnerabilities to HIV/AIDS and ways of addressing those aspects that could bring about physical or emotional harm.

Qualitative research explores subjects in their natural environment where they reside and function on a daily basis. This research to achieve this collected primary data from participants within their home village. An outline is provided of how the target group was selected, measurements as well as methods of data collection.

The sample was represented by interviewing 17 vulnerable children (10 boys and 7 girls). The children were identified through the existing list of most vulnerable children within the social welfare office in the district. This list is developed from a Government participatory process for identification of most vulnerable children. The process is done by the Ministry of Health and Social welfare in collaboration with local communities and stakeholders.

3.2 Respondent and Site Selection criteria

The study site was Lindi District Council where a district was selected due to being one of the remote districts in the country characterized by a culture of polygamy and early marriages. Lindi District is poor on all the basic indicators of well-being and according to the District's official website (www.lindi.go.tz/lindi_rural); Lindi district has 1 doctor for 107,441 patients.

The interviewed children were aged 11-17 years old. The age group was selected because this is an adolescence age category which has been documented to have many challenges particularly for girls. In Tanzania by the age of 16, one in ten adolescents has begun childbearing (UNICEF, 2011:14). The same report shows one in every 6 adolescent girls is getting married before the age 19 years (Ibid, 2011: 46). The research included 13 caregivers (4 male and 9 female) who are

parents and primary guardians of the most vulnerable children who are enrolled in the research. The caregivers were involved in the research as part of an attempt to understand the challenges faced in raising adolescents in this era of HIV/AIDS, poverty, moral decay and social economic demands of parenting as well as coping mechanisms that caregivers have.

Social welfare officers for Lindi District council were also interviewed in this study. This is because the social welfare officers are charged with the primary role of ensuring coordination of service provision for most vulnerable children in the district. The social welfare officers are also mandated under the Law of the Child Act (2009) to safe guard the welfare of children. These two major roles position social welfare officers as voices of authority within the district when it comes to children issues. Social welfare officers also through their role as counselors have in-depth knowledge of vulnerabilities and challenges that families face in care and support of children.

3.3 Sampling method

The research used purposive sampling for the selection of district social welfare officers. They hold in depth knowledge of the environment of the children in the study as well as the potential to further positively or negatively influence their life outcomes. Stratified random sampling was used for the selection of the children who would participate in the study. The strata was defined as the ward where children lived, vulnerability status i.e. the officially identified most vulnerable children as well as sex of the children. In this sampling method; a strata is defined and then subjects within the strata are randomly selected to participate in the study.

The random sampling was done by using a random number sequence generator (www.random.org/sequencies) to identify the most vulnerable children to be interviewed from the list of most vulnerable children. In order to get accurate gender representation; the boys were sampled separately from the girls. In the process; the list of constituencies in Lindi District were developed and a simple random selection using shuffling of folded papers containing the names of constituencies was done to determine a constituency for data collection. The process ended up with Mchinga constituency as a sampled study location.

The list of most vulnerable children from Mchinga constituency was then extracted from the National database and put in an excel document and then a random sequence of numbers was generated from the sequence generator in such a way that each child in the list had a randomly generated number from the sequence generator. Once all children were assigned a random number; the randomly generated sequence numbers were sorted from smallest to largest number. This action rearranged the children list at a random order. The top 12 children from each list (male and female list of names) were selected for the study.

Once the children were sampled; automatically their parents qualified for the respondents. The parents were then approached and asked for consent to participate in the research as well as consent for their children's inclusion in the research. Two youth peer educators were sought from a nearby Mchinga secondary school for participating as research assistants. The young people were selected by the teacher cum school counselor based on their active involvement in the school's club against corruption. The young people were given a brief orientation of the research and were asked to seek consent for the research from their peers (children selected as respondents in the study) once the parents had consented children's participation.

3.4 Measuring instruments

Semi-structured interview guides were used in exploring HIV/AIDS situation; poverty and its impacts, social problems and safety nets for children. Risks, impacts and interventions for HIV/AIDS in children were also explored using the guides. Focus group discussion (FGD) guides, were used in exploring children's perceptions of risks and vulnerabilities, resilience to vulnerabilities and risky practices.

3.5 Methods of data collection

Three semi structured interviews were conducted with two social welfare officers and one school teacher. Two focus groups discussions were held with parents of the children respondents. 3 focus groups discussions were also conducted with children where 2 discussions involved children 15 – 17 years old (1 for boys and 1 for girls). One focus group discussion included younger boys (11 – 14 years old). The intention was to interview a group of younger girls 11- 14

years old; however, the children were not available for the interview for various reasons including disability that prohibited participation, travelling outside of the community for school holidays or being away for various economic activities for the family.

3.6 Methods of data analysis

The data analysis was done through coding the information received during the interviews and focus group discussions. “Coding is the process of organizing materials into segments of text before bringing meaning to information” (Rossman & Rallis as cited by Creswell, 2009: 186). In coding the information, several steps were taken after transcription of data including ensuring the general understanding of the text through reading the raw data for general ideas, impression of depth, credibility and use of information as stipulated in the research design book (Creswell, 2009:185). The issues of interest were recorded and ideas that emerge as the reading continues. After the understanding of the broader content, the raw data was organized into text/segments of related topics. A most descriptive word out of the text was selected to form a code for the text. The code book was developed charting out the codes, brief description of the codes as well as reference (where the code were found) in the raw data. A group of related codes were categorized to form themes then raw data was grouped according to the themes. The themes informed the interpretation of data/information. The interpretation was guided by comparison of findings with existing literature to bring out divergence or concurrence with existing knowledge.

3.7 Ethical consideration

Research ethics is a set of guidelines to assist in conducting ethical research (Christensen et. al, 2011: 96). The book further elaborates that research ethical concerns are divided into relationship between science and society, professional issues as well as treatment of research participants (Ibid). While there are specific guidelines for conducting a scientific/empirical research in social sciences, care must be taken to ensure the scientific inquiry does not negatively impact on the research subjects. Protection of the intellectual property rights of researchers as well as promoting innovation and knowledge advancement is also paramount and thus strict rules against plagiarism and falsification of information.

In undertaking the research with human subjects; a great deal of ethical practice was considered in protecting the research participants as well as undertake a scientific inquiry that is replicable. The dilemma in social science research lie in balancing scientific methods of collecting empirical evidence and minimizing risks/potential harm affecting research participants (Creswell, 2009: 100). This research observed the many ethical considerations.

3.7.1 Ethical clearance

Certificates of Ethical clearance were sought first from the Tanzanian Ethical Committee for medical research at the National Institute for Medical Research (NIMR). Once the clearance was issued; ethical clearance from The Research Ethics Committee (REC) in Stellenbosch University where provided. In addition to ethical clearance; official request for permission to access the list of the most vulnerable children in Lindi District from the Commissioner for Social Welfare at the Ministry of Health and Social Welfare in Tanzania.

3.7.2 Non- coercion of respondents and informed consent

Voluntary participation was ensured of research respondents with no consequences for refusal to take part in the study. Informed consent was solicited where each respondent filled a consent form for participation upon explanation of the research objectives, process and implications. Consent for the case of children; in addition to securing the consent from parents; children were given a chance to assent i.e. “a child’s affirmative agreement of participation in research” (DHHS, 2009) or refuse based entirely on their free will.

A social welfare officer accompanied the researcher so as to provide psychosocial support and counseling for children if need arise in the course of data collection. The researcher was prepared to stop the process immediately when a sense of discomfort on children arises. Compensation of research participants’ time was provided in the form of beverages and bites.

3.7.3 Confidentiality of research participants

Participants were assured all information collected will be kept securely and used for the sole purpose of the research study. When a direct quote made from the data collected, no name will

be mentioned in relation to the quote. Participants were assured the recorded conversation between the researcher and respondents will be deleted as soon as the information is transcribed into text where it will be stored as notes; no voice recording will be kept after the research.

3.8 Conclusion

The outlined methodology presents the conceptualization of how this study was conducted. Sampling of respondents was done in three tiers where purposive sampling was used for social welfare officers; stratified random sampling for selecting the study group while simple random sampling to select respondents within the selected strata. Focus groups discussions with caregivers and children were held while in depth interviews were carried out with social welfare officers. As part of ensuring ethical practice of benefit for the study group; the researcher spent some time with respondents after the discussions to respond to questions they had regarding HIV/AIDS as well as clarifying some misconceptions that might arise. Chapter 4 will provide details of research findings from the various groups that participated in the data collection exercise.

CHAPTER FOUR: REPORTING AND DISCUSSION OF RESULTS

4.1 Introduction

The purpose of the research is to solve the problem: What are the factors that make children (11 - 17 years old) vulnerable to HIV/AIDS?

The objectives of the study relate to:

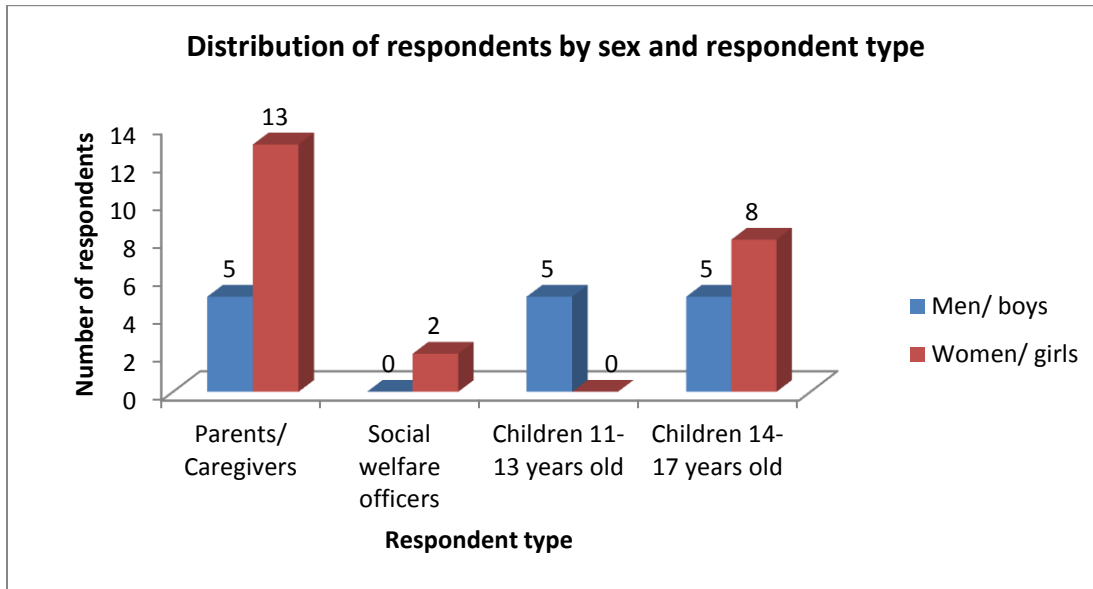
- To identify the existing knowledge about HIV/AIDS vulnerabilities for children.
- To determine perceptions of HIV/AIDS vulnerabilities among children, caregivers and social workers.
- To identify ways of addressing the children's vulnerabilities to HIV/AIDS from children's point of view.
- To evaluate the factors that makes children vulnerable to HIV/AIDS.
- To suggest interventions for addressing children's vulnerabilities and protecting children from HIV infection.

A review of the responses will highlight the degree of success to address the concerns and objectives of the study.

4.2 Respondents' demographic information

This study was a qualitative study involving focus group discussions with the most vulnerable children aged 11–17 years old and focus group discussion with parents/caregivers of the most vulnerable children respondents. The study also employed in-depth interview with social welfare/community development officers who are responsible for coordination of HIV/AIDS interventions as well as services for most vulnerable children in Lindi district Council. Figure 4.1 shows the distribution of respondents by type of respondents and sex.

Figure 4.1: Distribution of respondents by sex and respondent type



It should be noted the study aimed at interviewing children (boys and girls) in equal representation based on stratified random sampling. However, despite sampling 6 girls aged 11-13 for the study; sampled girls were not available in the village during the study time. This was either due to travels out of the village as it was school holidays or children disability where two of the girls were prevented to effectively participate in the study. The girls were excluded from study respondents as per inclusion/exclusion criteria stated in the study ethical clearance protocol. In the place of eliminated girls, parents were willing to replace them with their older siblings.

The study interviewed more women caregivers (13) than men (5). This was due to the majority of the sampled children was under the custodian of female caregivers (single parents' families). All interviewed women caregivers were farmers while the men caregivers included a school teacher, a Government employee and three farmers. One of the male respondents was a chairman of the most vulnerable children committee in the community. This is a voluntary committee formed out of the Government process of identifying the most vulnerable children. The committee is responsible for coordination of services to vulnerable children.

Out of the interviewed children; all boys (11-13 years old) were in lower primary school, 2 (14-17 years old) were in secondary school while 3 were out of school. Further 3 interviewed girls (14-17 years old) were in secondary school, 2 were out of school and 3 were in primary school.

4.3 Existing knowledge about HIV/AIDS vulnerabilities for children

In eliciting community knowledge about HIV/AIDS vulnerabilities for children community general information about HIV transmission were explored; all respondent groups had awareness of the infection. Caregivers were able to articulate two main routes of HIV transmission i.e. sexual transmission and contaminated blood in case of sharing impure sharp objects and blood transfusion. In some cases, there was evidence of extreme caution which could depict fear of HIV among community members.

As a case example; a male FGD participant mentioned stepping on spilled infected blood can lead to someone getting infected with HIV. While HIV contaminated blood could result in related infection to a person with an open wound; chances of one with open wound stepping into spilled blood are in reality very slim and could occur in cases for instance of accident which result in injuries and blood spill.

While sexual transmission of HIV was acknowledged by all groups; they referred only to man/woman vaginal sex and none of the groups was able to refer to anal or sex between men. Knowledge of mother to child transmission of HIV did not come out at all during the discussion as none of the groups was able to point out the route of HIV transmission.

The issue of children's vulnerability to HIV/AIDS indicated; many parents/caregivers although knowledgeable of the infection as well as children and young people risky behaviors; they demonstrated a degree of denial of reality. When talking about their children some parents acknowledged their daughters are matured but have not started sexual relations, however, none of the parents could validate her position. This was despite many parents (men and women) acknowledged children are engaged in sexual activities at as young as 14 years old. One female caregiver said "*Like my child is 14, she hasn't started sexual relations but she goes to the disco like others by escaping from home through jumping off the wall*". When asked how would she

know if the girl has not started sexual relations, she simply laughed and repeated “*she hasn’t started*” One of the female parents acknowledged her 14 year old daughter goes to the disco and come back late at night so what happens out there she would not know. “*She may be tempted like..... Here take this 500/-¹ and she get a person who is already infected with HIV and I wouldn’t know*”. The caregiver was referring to a girls being tempted by money to have sex with men albeit of unknown HIV status.

4.4 Perceptions of HIV/AIDS vulnerabilities

Men, women and children groups all perceived entertainment in the community as a contributing factor to HIV vulnerability of children. The type of entertainment that was seen to be a serious issue was video shows and disco; men and children groups also mentioned football tournaments and traditional dances. It was generally felt the entertainment provided a good avenue for mingling among children and young people and subsequently resulting to unsafe sexual practices. “*Entertainment is a problem for us as children go to the disco at night and comes back home very late and while you try to stop a child they have many ways and he/she will get out eventually*” according to a lamented male caregiver in FGD.

Another point raised as an emphasis on entertainment being a challenge for parents was that it is difficult for parents to control children because the time they spend in video shows is the time when they meet up with boys and men and have sex. Parents also added because of ignorance, when children meet up and have sex, they rarely if ever use protection and parents felt this happens because of ignorance and are all new to sexual practices.

Other caregivers associated children vulnerability with older men/women luring young girls and boys with money for sex. There were also reports of people living with HIV/AIDS deliberately luring young girls and boys and infecting them. “*People living with HIV especially men, when they find out that they live with HIV; they seduce young girls and give good money like 10,000/-*

¹ 500 Tanzania shillings is equivalent to 0.31USD

². *When a girl sees 10,000/- she doesn't think twice. Once a man gets the girl, next time he finds another girl*" according to a woman FGD participant.

In addition to video shows being seen as a meeting point and grooming site for sexual relationships; parents also mentioned an issue of showing pornographic video to children as a contributing factor to early sexual relationships among children. Parents emphasized in the process of watching the video; nobody pays attention that children are amongst the audience and thus being observant of what children are allowed to watch or not. The customer interest seem to be the focus of the entertainers and thus what the majority wants (and usually are older people) is what is shown regardless of who is present. This has resulted for children being exposed to pornography which according to parents/caregiver is where they learn issues of sexual relations and come out to practice in the community. *"Sometimes you find a child going to watch video and they are showing pictures of men and women having sex and sometimes without a condom, so when a child sees that, he/she knows oh! So this is good and when they go out they practice the same"* by a male FGD participant.

The incidences of rape and forced sex were reported as not common in Mchinga community. A caregiver in a female FGD affirmed *"I think the biggest factor is money because in this area we haven't heard about rape or forced sex"*. Men's group, however, had a slight different opinion where they felt rape does occur albeit not common in their community. One FGD respondent made an estimation of once in 3-4 years a case of rape can be reported.

Another perception emerging within a women's group was the issue of blind trust where caregivers and girls groups felt sometimes girl just choose to have unprotected sex with a man because they feel they have fallen in love. In this case, even if the girl does not get paid; she is just in love. A girl in FGD commented *"sometimes you find that a girl goes and have sex with a man simply because he is handsome and she wants to have sex with him even if he doesn't give her anything"*.

² 10,000/- Tanzanian shillings is equivalent to 6 USD.

4.5 Factors that makes children vulnerable to HIV/AIDS

Several issues came up during the study as being the main factors that makes children vulnerable to HIV infection. Among the factors are inadequate guidance and control, child abuse and discrimination, poverty and lack of information. Each of these factors is explained in detail in this section.

4.5.1 Lack of inadequate guidance and control for children

Parents in this study have shown some inadequacy on ways to support children and addressing their vulnerabilities to HIV/AIDS. Many parents blamed children's vulnerability on entertainment in the community and felt they have no control and thus they are left to do as they please. Parents also felt even the schools are unable to control children's behaviors. It was reported the schools are trying to have restrictions on children (for the school going children) but it is not working. It was also noted from the study community leadership didn't enforce bylaws for child protection. This issue came-up when participants in the FGD were asked whether the disco and video show entry has age restrictions are enforced to ensure children only have access to what is appropriate for their age.

Some parents expressed feelings of inadequacy in providing guidance to their children at the age when they become sexually active. *"For a boy; when they turn 18 then they become impossible and stubborn but for girls at 13- 14 they already start to be naughty and would feel like you are stupid every time you try to warn her"* by a male FGD participant lamented when expressing his frustration in inadequacy of parental guidance to children.

Lack of parental guidance was also associated by the culture of rite of passage. Traditionally in Lindi, children go through the rite of passage when they are going through puberty. According to FGD participants, this is the time when children are prepared to take up the roles of adulthood and when this time comes; children are put in isolation (camp) with older women/men as their trainers for several weeks. The training has traditionally been for children at puberty and was about how to handle marital obligations and general hygiene. The trends have now changed with time where parents are said to take children to these camps as early as 8 years old. The training

within the camps has also not evolved with the HIV/AIDS era where children as young as 8 years old are taken through the rite of passage and taught how to handle a husband/wife with little or no regard as to their age and level of information they are exposed to. The social welfare officer noted in the in-depth interview *“After the child has been through the rite of passage, the parents don’t have control over them as it is believed that the child is grown up”*.

In the men’s group; the emphasis on parental inadequacy in supporting their children was expressed in terms of parents’ reaction to teenage pregnancy where it was seen as a mix of good and bad thing for parents when a girl gets pregnant. A case example demonstrates how parents feel about teenage pregnancy.

A case of parenthood dilemma

The initial information for a child needs to be given from home but with globalization; children knows at least 70% of information and when a parent give information it may be outdated; Sometimes they get stuck in teenage pregnancy as you know the beginning is always hard but once she gets pregnant, then she will know how to go about because in the process of pregnancy she will attend clinic and be taught issues about pregnancy, family planning etc. The second child won’t come as easily as the first child; so that is helpful even for us the parents. When a child gets pregnant, it’s painful but once the child gets pregnant unexpectedly she comes back to her senses. So for us when a child gets pregnant it helps for the lesson to the child although as you know there is no gain without pain but at least it helps us in terms of teaching the child a lesson, so it’s a profit and a loss at the same time.

Temptation was mentioned as one of the factors that makes children vulnerable to HIV/AIDS. The factor was termed in several ways where some participants called it temptations; others expressed it as desire for material gains while others called it lust (tamaa). Girls reported many

of their peers in the community are often having sexual relations just so they can get money to buy material things.

While caregivers groups reported many children in the community are engaged in income generation activities mainly fishing for boys and collecting sea shells for selling for girls. The children, however, had a different explanation of the new materials they possess. While the boys validated the information provided by caregivers about how they earn income to buy new items; girls reported most of them have sex with men to get money to buy new clothing. The main group of men, girls considered to received the highest payment was the fishermen who are camping in the village. *“You see this place is a fishing camp and it’s usually full of men (fishermen) who will have sex with girls and pay up to 10,000/- Tshs. Once the girls find out that a certain fisherman gives good money to girls, they would attempt also to have sex with the man just so they also get the money to buy new dress”* by a girl FGD participant.

Caregivers reported they do see their children with new goods but they usually believe it is from various income generating activities young people are engaged in daily. Female caregivers reported insistently children have many income generation activities and particularly taking advantage of the ocean where girls are engaged in picking sea shells for selling while boys participate in fishing activities. The income gained from these activities is used to finance children’s personal needs. The hard reality that parents also acknowledges is children particularly girls often mix the income gained from their personal economic activities and the money gained from having sex with men.

According to caregivers and children groups; some parents make an effort to follow-up on their children and the information they provide to parents regarding material goods in their possession. The follow-up, however, lacked consistency and actions to ensure children do not fall into the same trap again once it is realized they had not been honest. On expressing the efforts done by parents to follow-up on their children; one female caregiver said; *“I ask where she got the dress but she can lie to me like I got the dress from my sister or brother..... but I am also an adult; so I will ask the brother / sister when they visit and if they say they didn’t give the girl a dress, then I know she lied to me, she must have gotten it from a man”*. What the caregiver could not express

was what actions she would take in such incidences that would help her child and protect her from risk of HIV infection through unprotected sex.

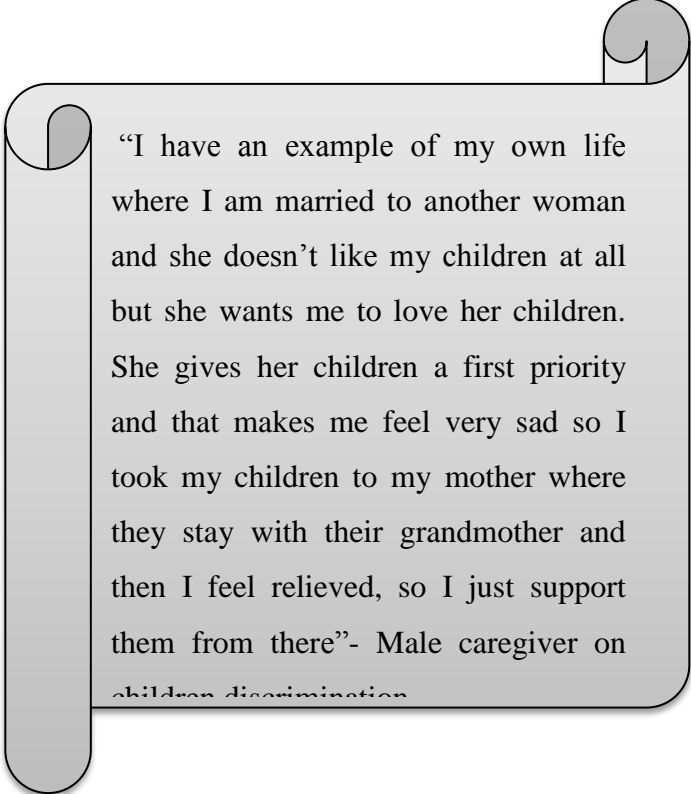
4.5.3 Child abuse

Child abuse was one of the factors that came out strongly from the men's group as contributing to children's vulnerability to HIV/AIDS. It was reported men and women alike in the community are perpetrators of child abuse. The most common form of child abuse reported is physical abuse in form of denial of basic needs such as food.

Children are also exposed to discrimination based on whether or not they are biological children of the caregiver. The issue of abuse and discrimination of children did not come up in women's group.

According to men caregivers, showing favoritism and discrimination against some children creates a sense of longing for attention in some where those who are discriminated against will tend to seek attention in all possible ways including falling into the trap of having sexual relationships and getting themselves in negative peer influence just in an attempt to fit in the social setting. When this is accompanied by

denial of basic needs such as food it makes children desperate to seek for alternative ways to get their needs including having unprotected sex to get money for basic needs. As one of the male caregiver elaborates; *“The abuse situation leads to infection because when a child is abused at home e.g. denied food at home; the child may get into relationship with a boy just so she gets food or clothes. This is very common and the abuse is common and done by both parents (men and women)”*.



“I have an example of my own life where I am married to another woman and she doesn't like my children at all but she wants me to love her children. She gives her children a first priority and that makes me feel very sad so I took my children to my mother where they stay with their grandmother and then I feel relieved, so I just support them from there”- Male caregiver on children discrimination

Further while children did not directly point out to their abuse and discrimination they reported feelings of unfair treatment by parents. Many children especially girls felt parents are unreasonable and would rebuke them for no apparent reason. Citing some examples of unfair treatment, the girls made reference to time when they fetch water where there is a queue delaying returning back home. The parents are often suspicious of girls' whereabouts and accusing them of taking longer to fetch water using it as a decoy to meet with boys.

The issue of child abuse was also associated with polygamy practice and high divorce rates which is very common in this society where parents are reported to showing favoritism for their biological children and discriminating their step children. The usual practice in the community is once parents have divorced the children stay with either one of the parents or with the grandmother if she is available to take in them after a divorce.

4.5.4 Broken marriages

Another factor for children's vulnerability to HIV infection that was mentioned during the discussion was broken marriages. It was reported during focus groups with female caregivers in many cases when marriage breaks, women (mostly grandparents) end up with the burden of child care while men walk away from all the responsibilities. Many children are said to end up with psychological trauma and little or no help from the society in dealing with the situation of broken families. In an interview with social welfare officer; it was reported divorce in this society is so rampant people barely take into consideration the negative effects that broken marriages have on children. Children are given little or no choice over this matter despite it has detrimental effects on their emotional health. *"Divorce and multiple marriages is a common occurrence which lead to children being psychologically affected as well as facing life difficulties that makes them take risk behaviors"* by a social welfare officer.

4.5.5 Trans-generational sex

The issue of trans-generational sex came up in discussion with female caregivers, girls as well as social welfare office. It was reported culturally in Lindi, it is an acceptable norm for older men to marry young girls; propagates sexual relationships among the generational gap within the

society. During the rite of passage girls are also taught sex with older men is acceptable. The society is also known for polygamous culture and thus majority of men have multiple marriages or multiple wives. This has been said to put young girls at risk of HIV because when they engage in sexual relationships with older men, who are usually divorced, already have other wives or has potential to marry another one. This makes it harder to practice safer sex and faithfulness within relationships.

One of the obvious consequences of this is prevalence of teenage pregnancies. Legally, a person can be prosecuted for getting a school going girl pregnant in Tanzania. However, legal action against people who gets children pregnant is in most cases not taken. This is because parents collude with people who get their children pregnant mainly for fear that if the person is reported to the authorities; he will be jailed and the daughter may miss on the chance of marriage. A social welfare officer reported in an in-depth interview *“Teenage pregnancies are very rampant; but it’s hard to track the extent of the problem because the large majority of families do settle issues of teenage pregnancies within the families and don’t report the cases to the Social Welfare Officer”*.

4.5.6 Poverty

Poverty is another factor that places children in situations where they are vulnerable to HIV infection. The men’s group discussed poverty in the light of parents failing to provide for basic services such as entertainment and information at home. While it was felt under normal circumstances parents should be able to afford some household items such as a TV set in their household and thus ensuring their children are watching videos at home in a controlled environment; the reality is children are lured into commercial video shows because such entertainment is not available at home. Commenting on the issue of poverty a male caregiver had the following to say; *“Another factor is poverty, there are things that are meant to be normal and a child should have/ find them at home but because of poverty we can’t afford those things. You find a girl goes to watch video and come home late at night when a parent should have had a video at home”*.

Poverty was also coupled with laziness and irresponsibility of some parents. In this case it was reported some parents take advantage of their girl children by making them work and fend for family needs by any means possible. This results in many girls engaging in transactional sex to make a financial contribution towards the family's needs. *“Poverty is a challenge in the community as people in this place are not hard working and in many occasions girls are expected to provide for their parents and siblings. The easiest way to get money for the girls is to get a man and have sex”*. A social welfare officer reported during the in-depth interview.

4.6 Ways of addressing the children's vulnerabilities to HIV/AIDS.

The Government from a children's perspective should play a big role in addressing HIV/AIDS vulnerability for children. Both boys and girls groups strongly recommended education about HIV/AIDS as a way of addressing children vulnerability. The boys group felt education alone is not enough because although some have received it they have not changed their behaviors. The group then insisted on morals and religious practices where they thought if young people get consistent reminder of religious teachings, it will help significantly to ensure they can practice abstinence and stay safe from HIV infections.

Parents and caregivers also stressed the importance of education. The caregivers thought education should be provided to all groups. Great emphasis was placed on older people with reason they do not know or are not informed about HIV/AIDS. Children and young people were seen as well informed to an extent that parents felt outdated by their children. Parents/caregivers pointed out children have more access to information through the NGOs that are present to educate through schools. This was said to leave out the larger community where children live but also leave out those who are not in school.

Women parents/caregivers also proposed Government actions against people living with HIV/AIDS that depicted the level of stigma and discrimination existing in the society as well as parents inadequacy in guiding and protecting their children. One of the proposals was the Government should take serious action against all people living with HIV/AIDS. These actions according to caregivers should include giving them medication that can control their sexual

desires. One of the female caregivers made a plea in the FGD *“what I ask the government is that they should control the people living with HIV. If there is medication to give, they should give them to reduce their sexual powers/ desires so they will not desire to have sex because in any case we can’t manage to control our children”* This statement depicts both the level of stigma in the community and parents’ inadequacy in protecting their children.

Others caregivers were proposing an ultimatum from the Government for all people living with HIV/AIDS and even imprisonment just to ensure that people living with it stay away from children and thus leaving the community free from infection as well as assuring their safety. A caregiver in a FGD stated *“if a person is tempting an old person at least they go willingly because they are matured but if someone is spreading the virus to children, action should be taken immediately even if imprisoning them so be it”*.

4.7 Service availability and social networks

The study found there are several interventions for HIV/AIDS in the district. The available services/interventions are mainly from local NGOs operating within the district as well as the Department of Community Development in the District Council Offices. The interventions include HIV prevention education and condom distribution; home based care services, voluntary counseling and testing for HIV. Other services focus on impact mitigation including supporting children who are made orphans and vulnerable due to AIDS related causes, legal support to them and widows.

The health centers were also said to provide health education including family planning education and HIV/AIDS counseling and testing. However, some of the services were reported to being discriminating against young girls and it was reported for instance that for them to get family planning services in most cases they have to bribe the health workers. *“Honestly, for young girls mostly what happens is bribe, they bribe a nurse 2000/- and get the injection. So for 5 girls its 10,000 and that’s how they get Family Planning injection”*. A woman caregiver reported when discussing the available health services and how accessible the services are for young people.

The study also found there are no health services within the Mchinga II community and the nearest health care center is approximately 5 kilometers away in Mchinga I. This already acts as a blockade to access health information and services. While one caregiver in the FGD reported being a home based care (HBC) provider and a counselor; little was known about her role within the group of caregivers. This is a clear indication the woman's service are yet to benefit community members outside the HBC provider's client group. It was also reported children rely heavily on their peers (trusted friends) for advice particularly when it came to issues of sexual relationships and reproductive health matters. It was further reported despite the health centre being far from the village girls have a good peer support system among friends where they usually accompany each other to the health centre when they need services. A woman caregiver reported when discussing girls' access to reproductive health services "*girls teach each other in the streets and go to get the family planning injections. Sometimes you find them in a group of up to six, waiting for each other at the clinic for getting their family planning injections and leave*". This provides a starting point for ensuring availability of health information and services within the community.

4.8 Conclusion

In conclusion, children in Lindi district are faced with many factors that make them vulnerable to HIV infection. The factors that came up in the findings from the study do not diverge from the existing literature. The findings still portray a divide between knowledge and practice with regards to HIV prevention. Issues of poverty, gender disparities, child abuse, stigma and discrimination all come into play to exacerbate the vulnerability situation of children in Lindi. The factors that emerged addressing poverty and challenging existing cultural practices will make a great difference in the lives of children in Lindi. This, however, is not an easy task and requires an investment in resources and time as behavior change programs have proven to require. In the next chapter recommendations will be made of what needs to be done to address children vulnerability in Lindi by linking the findings to interventions and best practices that can be replicated in the context.

CHAPTER 5: RECOMMENDATIONS AND CONCLUSIONS

5.1 Introduction

The preceding chapter has provided a detailed situation of the most vulnerable children in Lindi District. This final chapter discusses the achievement of objectives and provides a recommendation for HIV/AIDS implementers in Lindi on ways of addressing children's vulnerability to the infection. The study aimed at solving the problem of what are the factors that make children (11 -17 years old) vulnerable to HIV/AIDS?

In answering the research question; the study first wanted to identify the existing knowledge about HIV/AIDS vulnerabilities for children in the study location. The main aim was to understand what children as well as parents/caregivers knew, highlight information gaps as well as pick out some key misconceptions about HIV/AIDS where existent. The results showed the objective was achieved through pinpointing a relatively high knowledge about ways of HIV/AIDS transmission. The critical gap was found on mother to child HIV/AIDS transmission. Time was spent with participants to provide information on the knowledge gaps identified.

The second objective was set out to determine people's perceptions of HIV/AIDS vulnerabilities. While some perceptions were highlighted from the results of the study, it was difficult to elicit perceptions among young children (11-13 years). It appeared from the focus groups discussions the realities of HIV/AIDS were distant for them albeit there was some awareness of the infection. It is clear from the results the perceptions of vulnerabilities elicited from older children and parents/caregivers enforced the demonstrated knowledge of sexual transmission of HIV. The perceptions also seemed to enforce lack of information among children, peer pressure and poverty.

The third objective was to establish from the children's point of view what can be done to address HIV/AIDS vulnerabilities. In this instance education was consistently seen as a way of addressing HIV/AIDS vulnerabilities. This objective elicited some stigmatizing view points from caregivers which will need to be addressed in designing intervention. The fourth objective sought to draw from the discussions and emerging issues; factors that are making children vulnerable to

HIV/AIDS. In addressing this objective; an understanding was used of the prevailing situation and validating that with respondents' direct quotes. The recommendations drawn are addressing objective five of the research which was to suggest interventions for addressing children's vulnerabilities and protecting children from HIV infection.

5.2 Interventions to address vulnerabilities and protect children from HIV

The research findings revealed it is clear the available services are yet to reach the marginalized and remote populations which includes majority of children and young people. There is a need to expand the interventions to the populations that are not currently reached or are inadequately reached by HIV/AIDS information and services. Interventions for addressing vulnerability to HIV/AIDS for children in the context described in these findings should focus on empowering children and parents and promote behavior change as well as address economic blockade. This study will therefore recommend interventions focusing on those two dimensions of vulnerability.

5.2.1 Improving access to information and health services

The study found children rely heavily on their peers (trusted friends) for advice particularly when it came to issues of sexual relationships and reproductive health matters. It was further reported despite the health centre being far from the village; girls from Mchinga II have a good peer support system among friends where they usually accompany each other to the health centre when they need services. This provides a starting point for ensuring availability of health information and services within the community. The study is therefore proposing the following interventions:

a) Peer education program

Building on the existing trusting relationships reported especially among young people; individuals should be identified from the community that will be trained as peer educators. The identification should be based on community members' perspective on the persons trustworthy and if people feel comfortable having them as their health information providers. The identified individuals will need to be trained in peer education, HIV/AIDS, sexual and reproductive health

topics and provided with basic job aides such as condoms and reference materials for supporting their effective implementation of peer education program. The peer education program for young people should be community based and thus focusing on all young people regardless of whether they are in school. Local NGOs should also work with local schools to support the integration of HIV/AIDS education in the school timetable. The Government has already incorporated HIV/AIDS into school curriculum which makes it easier for NGOs to intervene and ensure compliance of school curriculum.

b) Good parenting skills building sessions

Peer education should be complemented with parenting skills building sessions for parents/caregivers. The study recommends community dialogues within small homogenous groups of parents/caregivers around challenges of parenting in the era of HIV/AIDS. Trained facilitators can work with parents to discuss and challenges and possible solutions to parenting in the era of HIV/AIDS. The dialogue will provide a platform for people to challenge some culturally accepted practices that render children vulnerable to HIV/AIDS. The dialogue will also be a platform for sharing with parents HIV/AIDS information in a safe environment among peers and thus empowering parents to open up and discuss dilemma and fears, get appropriate information and be able to pass on the information to their children.

c) Integrating HIV/AIDS education in religious institutions

Lindi District is predominantly a Muslim community with the majority of people being active and religious. This is an opportunity for integrating HIV/AIDS education within the Mosques and Madrassa (Islamic religious classes for children). The religious leaders will need to be trained on HIV/AIDS interventions from their perspective drawing examples from programs that have shown success elsewhere. The example of Uganda's Islamic Medical Association (IMAU) a UNAIDS documented case study of addressing HIV/AIDS from the spiritual perspective (UNAIDS, 1998) should be considered for developing a program that is fitting for Lindi context.

d) Mobile health services

The Government should work with the civil society organizations to strengthen provision of health services to Mchinga constituency through the use of mobile health services. This should be implemented in two ways in the first instance a team of Health workers from the Government Hospital can visit the community at least once a month and provide the health services. This will increase access to the service for people in Mchinga community without having to walk 5 kilometers to get the services. The other way of mobile health services is working with telecom companies to provide the mHealth services. This is an upcoming way of information dissemination where health messages can be sent to people through sms to their mobile phones. The messages could range from HIV drug adherence messages and reminders for people on ARVs for drug refill and times for taking the drugs. Other messages could be on HIV/AIDS information helpline where people can be reminded of a toll free number that they can call or text to receive more information about the disease.

5.2.2 Increase the families' ability to meet the basic needs

Poverty according to the study findings have led to some parents/caregivers exposing their children to risks just so they can get a daily bread. It is important to work with families of the most vulnerable children to strengthen the families' ability to meet their basic needs. Ability to meet the children needs in addition to skills in good parenting will also pave a way to ensuring child protection and prevention of abuse. The study is therefore recommending the following interventions;

a) Household economic strengthening

Several local and international organizations in Tanzania are implementing household economic strengthening interventions through community savings groups as well as provision of productive animals for keeping. The Government through District Council NGO coordination role should support the initiative by coming into agreement with local NGOs that can provide such services to the MVC families. While household economic strengthening is a sustainable way of ensuring services to children; this, however, is a behavior change program in a sense that

it should aim to transform caregivers spending habits, creating a culture of making savings as well as planning and decision making skills building. A close follow-up system should be set by the Government and local NGOs implementing the program to ensure caregivers do succeed in the program. This will ensure the outcomes of the interventions are benefitting the children.

b) Entrepreneurship and financial literacy training

Human capital investments in terms of training and mentoring support for business skills building is also paramount to the success of these interventions. Through resource mobilization initiatives; the private sector should be mobilized to contribute towards poverty reduction by funding the entrepreneurship skills and financial literacy training for parents/caregivers and children. This will be part of the private sectors' corporate social marketing strategy where "a corporation supports the development and/ or implementation of behavior change campaign to improve public health, safety, the environment or community well-being" (Kotler & Lee, 2005: 23). Banks in the case in Lindi can be mobilized to support the financial literacy and entrepreneurship skills trainings which will in turn see that more people are able to generate enough income and make savings thus increasing deposits to the banks.

In addition to making savings, MVC caregivers should be encouraged to buy assets as a protective measure against future shocks. Telecom corporations also stand to benefit in this endeavor because mobile money in Tanzania is a booming business and thus with more people engaging in the market; the mobile money service demand will increase and expand to the remote areas where currently it's not as popular when compared to urban areas.

5.3 Further research

The study is a qualitative in nature and thus it explored the vulnerabilities from a small group of randomly selected people within a specific population of most vulnerable children. By design of the study; the results cannot be extrapolated to the larger most vulnerable children population. There is a need therefore for a more rigorous study with quantitative and qualitative methods of data collection on the factors that make children vulnerable to HIV/AIDS. The quantitative

aspect will respond to the issue of representativeness of results while the qualitative aspect will look at the phenomenology of child vulnerability.

A further research will also be required to pinpoint best practices in addressing such vulnerabilities as will be highlighted by the study

5.4 Conclusion

From the literature review, it was noted that Gillespie (2005:6) categorized vulnerability according to means of survival, nutrition and health, poverty, education, psychosocial and societal. The findings of the study have substantiated those to be the factors behind children's vulnerability in Lindi District. Although Research on HIV/AIDS in Tanzania shows relatively high levels of awareness about HIV/AIDS, there is still a great need to bridge the gap between awareness and practice. This requires a transformative education to the communities where people will move beyond simply being aware to having knowledge and skills for addressing the HIV/AIDS challenge in their communities. Education also will open up children's opportunities by increasing their problem solving skills as well as improve self-esteem which is key to building resilience to social pressure and subsequently HIV prevention for children. Challenging negative cultural practices also will help in reducing children's vulnerability to HIV and increase the social status of women in the communities such as Lindi where polygamy, multiple sexual partners and trans-generational sex is culturally acceptable. This will require interventions that are intrinsically driven by the community that is made aware of the negative effects of the cultural practices in the welfare of the children within the society.

Appendix 1: Code book

No	Code	Brief Description of codes	Example from the data
1	Child abuse	This code is applied to text referring to violation of children rights through exposing children to pornographic materials , rape and forced sex	Sometimes you find a child going to watch video and they are showing pictures of men and women having sex
2	Desire/ temptation	The code is applied to text referring to children perception of reasons for engaging on practices	She thinks I should also go and get the money, she will to go with a man so she can also get money
3	Unsafe sex	The code is applied to text referring to practicing unprotected sex in the community	Also they just go without protection and this leads to infection
4	Education	The code is applied to text referring to the felt gap in, proposed ways to address children's vulnerability to HIV	To get education, like this when you come and educate us as an expert and we work together to help our children. We should educate them when they are matured we should

			sit with them and talk about HIV/AIDS
5	HIV/AIDS knowledge	The code is applied to text referring to community awareness of HIV/AIDS as well as methods which lead to people's awareness of HIV/AIDS	So for parents in 30's – 40's know about HIV/AIDS but those children born by older people don't have this information, so the children only find this from their sisters or brothers
6	Parental guidance	The code is applied to text referring to relationship between children and parents including communication and advice	We should try and be close to our children and teach them good morals like in the evenings sit with our children and explain how the world is nowadays
7	Peer support	The code is applied to text referring to mechanisms of support among children and young people in the community	Sometimes you find them in a group of up to six, waiting for each other getting their injections and leave. Boys don't go for advice and don't care about those things
8	Risky behaviors	The code is applied to text referring to intergenerational sex, alcohol and substance abuse	Sometimes even older people seducing young people although this is secretive

9	Sexual debut	The code is applied to text referring to age of sex initiation for children in the community	For boys usually is when they mature at around 14 years old, for girls it's as early as 12 years old
10	Sources of information	The code is applied to text referring to places or people that children go to when they need advice / information about HIV/AIDS and relationships	Boys honestly don't get the information/ advice There is nobody to give them the advice
11	Services availability	The code is applied to text referring to health and HIV/AIDS related services such as SRH, family planning, condom distribution, health education	I think there are people who are selected and distribute some drugs like condoms and Family Planning tablets

Appendix 2: Interview schedules

FGD guide for adolescents (14 -17 years)

Time: 45 minutes

The guiding questions

1. Please tell me what are the good things about being a child in this community? (What makes you proud of being a child in this community?)
2. Please explain to me the difference between HIV and AIDS
 - a) In your understanding; how can one become infected by HIV?
3. Who do you talk to when you need to talk about HIV/AIDS, relationships/love and why?
4. Please tell me what kind of risks do adolescents in this community face in relation to HIV infection? (What are the factors that makes adolescents vulnerable to HIV infection)
5. Why do you think these factors are putting adolescents at risk of being infected by HIV?
6. Where in this community can adolescents go when they need either of the following;
 - a) Information and advice/counseling about HIV/AIDS
 - b) Reproductive health Services
7. In your experience; when (at what stage in children's life) do parents in this community talk to their children about HIV/AIDS, relationships/ love, and why?
8. When (at what age) do adolescents in this community start engaging in sexual relationships?
9. How can we address the factors that make adolescents vulnerable to HIV and protect adolescents from infection?

Closing

The Researcher will end the discussions by thanking participants and providing age appropriate HIV/AIDS information that clarify misconceptions/ misinformation that came up during the interview.

FGD guide for children (11- 13 years)

Time: 45 minutes

The guiding questions

1. Please tell me what are the good things about being a child in this community? (What makes you proud of being a child in this community?)
2. Please explain to me the difference between HIV and AIDS
3. In your understanding; how can one become infected by HIV?
4. Who do you talk to when you need to talk about HIV/AIDS, relationships/love and why?
5. Please tell me what kind of risks do adolescents in this community face in relation to HIV infection? (What are the factors that makes adolescents vulnerable to HIV infection)
6. Why do you think these factors are putting adolescents at risk of being infected by HIV?
7. Where in this community can adolescents go when they need information and advice/counseling about HIV/AIDS
8. How can we address the factors that make adolescents vulnerable to HIV and protect adolescents from infection?

Closing

The Researcher will end the discussions by thanking participants and providing age appropriate HIV/AIDS information that clarify misconceptions/ misinformation that came up during the interview.

The Focus group discussion guide for Caregivers

Time: 1 hour

The guiding questions

1. Please tell me what are the good things about being a member of this community in relation to parenting? (What makes you proud as a parent in this community?)
2. Please explain to me the difference between HIV and AIDS
 - a) In your understanding; how can one become infected by HIV?
3. In your experience; who do children/ adolescents talk to when they need to talk about relationships/love and why?
4. When (at what age) do adolescents in this community start engaging in sexual relationships?
5. From your experience in this community, please tell me what kind of risks do adolescents in this community face in relation to HIV infection? (What do you think are the factors that makes adolescents vulnerable to HIV infection)
6. Why do you think these factors are putting adolescents at risk of being infected by HIV?
7. Where in this community can adolescents go when they need either of the following;
 - a) Information and advice/counseling about HIV/AIDS
 - b) Reproductive health Services
8. How can we address the factors that make adolescents vulnerable to HIV and protect adolescents from infection?

Closing:

The researcher will thank caregivers and seek written consent to talk to their children about the same topic

In depth interview guide for social welfare officers

Time: 1½ hour

In depth interview questions

1. Please give an overview of situation of vulnerable children in your District
2. Please give an overview of the situation of HIV in this district, and particularly for
 - a) young people vs. general population
 - b) Rural vs. Urban disparities
3. Who are the key stakeholders in HIV/AIDS in this district, what do they do and what is their target population?
4. In your experience, what do you think are the factors that drives the epidemic among young people in this district
5. Why do you think these factors (mentioned above) are the key drivers of the epidemic in this district?
6. Where in this community can adolescents go when they need either of the following;
 - a) Information and advice/counseling about HIV/AIDS
 - b) Reproductive health Services
7. What are the existing community structures / traditions that play a positive role in HIV prevention for adolescents?
8. What are the critical gaps in terms of HIV/AIDS interventions for adolescents in this district?
9. How can we address the gaps in HIV/AIDS interventions and strengthen the child protection systems to ensure reduced vulnerability of HIV among adolescents?

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