

HIV and AIDS Knowledge among Orphans and Vulnerable Children in KwaZulu-Natal, South Africa

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Key Findings

Almost three-quarters of OVC aged 10-17 years had insufficient AIDS knowledge.

Insufficient AIDS knowledge was a problem in every age group.

Introduction

South Africa is home to almost 6 million people living with HIV and/or AIDS – the largest epidemic in the world [1]. Youth represent a particularly vulnerable group: worldwide, they account for almost half of all new infections [1]. In South Africa, 5% of young men and 14% of young women aged 15-24 years were HIV-positive in 2009 [1].

Youth who have been orphaned or otherwise made vulnerable by AIDS are at elevated risk for acquiring the virus. A study in South Africa found that orphaned youth were one and a half times more likely than non-orphans to be sexually active [2]. Other studies in the region have similarly demonstrated a disproportionate likelihood of early sexual debut, high risk partnerships, and HIV infections among orphans [2-4]. A lack of adult supervision [5, 6] may contribute to risk taking among orphans and vulnerable children (OVC). Youth who are living with a sick parent or who have lost a parent to AIDS are also more likely to experience discrimination, depression, and poverty than their non-OVC peers [7-10] – all risk factors for sexual risk taking [11]. Moreover, life skills and sexual health programming in schools is a primary vehicle for HIV and AIDS education among young people in South Africa, yet OVC are less likely than their peers to be attending school [12].

In the context of high HIV prevalence, adequate HIV-related knowledge becomes a critical tool for prevention. Yet, a recent survey found that less than one-third of youth in South Africa had accurate knowledge of HIV (i.e., they could both name two correct ways of preventing HIV transmission and rejected common misconceptions about AIDS) [13]. In addition to this universal need for improved HIV and AIDS knowledge among youth, a particular imperative exists to educate OVC about how to protect themselves. Many OVC programs are in the process of integrating HIV and AIDS education into existing services or designing new interventions (e.g., after school clubs) that explicitly respond to this need. In order to support the effective design of these interventions, this brief presents information on the current level of HIV and AIDS knowledge among OVC program beneficiaries in KwaZulu-Natal, the province with the highest HIV burden in the country [14].

The study detailed here is part of the Enhancing Strategic Information project (ESI), funded by the United States Agency for International Development (USAID) in Southern Africa. ESI supports the availability of high quality health systems information that contributes to sustainable policy planning and programmatic decision-making. Tulane University School of



Public Health and Tropical Medicine works in partnership with the prime ESI funding recipient, John Snow Incorporated, to produce knowledge that will improve existing practices and guide future investment in OVC programming.

Study Methods and Sample

The findings presented here are drawn from the baseline assessment of a longitudinal study designed to assess the efficacy of a range of interventions for OVC. The study sample includes children newly enrolled in OVC programs operating within predominately rural areas in 7 districts of KwaZulu-Natal province. Baseline surveys were administered to 1782 children ages 10-17 and their primary caregivers between April and June 2010. Consistent with program eligibility criteria, 87% of children were orphans (single or double), 44% lived with a chronically ill adult, and 98% lived in households with monthly incomes under 2500 Rand. Notably, almost all of the children (98%) were enrolled in school at the time of the survey. Further details on the study aims, methodology and baseline sample characteristics are available elsewhere [15].

HIV and AIDS knowledge was assessed through children's responses to a series of questions drawn from the Demographic and Health Survey questionnaire [16]. Respondents were asked if they had ever heard of AIDS; those who answered affirmatively were asked whether they thought it could be prevented. Those who responded that HIV was preventable were asked the open-ended question "What can a person do to avoid getting AIDS?" Finally, respondents who had heard of AIDS were asked four yes/no questions representing common misconceptions. Children were classified as having insufficient AIDS knowledge if they had not heard of AIDS, believed it could not be prevented, or could not correctly identify misconceptions. Descriptive analyses presented here illustrate levels of HIV and AIDS knowledge and misconceptions among children in the sample.

Key Findings

The majority of OVC had insufficient HIV and AIDS knowledge regardless of age

Almost three quarters (71%) of children demonstrated insufficient AIDS knowledge. Specifically, almost a fifth (17%) reported that they had not heard of AIDS. Among those who had heard of AIDS (n =1472), 13% did not believe there was anything a person could do to avoid contracting it. Misconceptions were a primary driver of the prevalence of insufficient knowledge overall, with 63% of those who had heard of AIDS reporting at least one of the following misconceptions: a healthy-looking person cannot have the virus; transmission can occur by mosquito bites, sharing food or witchcraft (see Table 1).

Table 1. HIV and AIDS misconceptions among OVC who had heard of AIDS

Misconceptions concerning transmission (n =1472)	
Has at least one AIDS misconception	63%
Can get HIV from mosquitoes	39%
A healthy looking person cannot have HIV	33%
Can get HIV via sharing food	18%
Can get HIV from witchcraft	16%

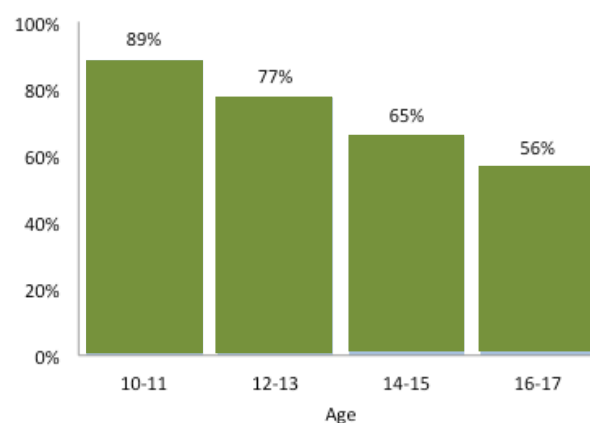
Moreover, respondents lacked knowledge about how to prevent HIV infection. Table 2 presents children's categorized responses to the question "What can a person do to avoid HIV/AIDS?" in two ways: first, as a percentage of only those children in the sample who had heard of AIDS, and second, as a percentage of all children in the sample; the latter is presented in order to better quantify the level of prevention knowledge across the entire OVC population represented in the study. Among all children interviewed, only 61% responded spontaneously that HIV/AIDS could be prevented by using condoms; 38% by abstaining from sex; and 30% by avoiding blood transfusions. Other prevention strategies were named by less than 10% of children in the sample.

Table 2. HIV and AIDS prevention strategies reported without prompting

HIV and AIDS prevention strategies named	Among OVC who had heard of AIDS (n = 1472)	Among all OVC (n = 1782)
Use condoms	85%	61%
Abstain from sex	53%	38%
Avoid blood transfusions	42%	30%
Avoid sharing razors/blades	13%	9%
Limit sex/be faithful to one partner	9%	6%
Limit number of sexual partners	6%	4%
Avoid sex with people who have many partners	6%	5%
Avoid sex with prostitutes	2%	2%

Figure 1. Insufficient HIV and AIDS Knowledge by Age

HIV and AIDS knowledge was lowest among younger children and rose with age (see Figure 1); however over half of 16-17 year olds still demonstrated insufficient knowledge. Male and female children, however, exhibited equivalent levels of knowledge.



Programmatic Implications

HIV and AIDS education should focus on both imparting new knowledge and dispelling misconceptions

Given that almost three-quarters of OVC in this sample had insufficient knowledge, comprehensive HIV and AIDS education should be integrated into OVC programming for all ages. It is notable that most of the children in the current sample were enrolled in school, which may call into question the quantity and quality of school-based programming in these communities. Clearly, need exists for additional activities to promote adequate HIV and AIDS-related knowledge among OVC, especially given their potential high risk for infection. Nearly one-fifth of the sample had not heard of AIDS and among those who had, one-third did not believe it could be prevented; thus, educational strategies and materials should be oriented towards delivering core information on the disease, including how to prevent transmission.

There is also, however, a need to focus specifically on misconceptions such as those reported by the majority of OVC in the sample. One-third of children believed that a healthy person could not have HIV; once young people become sexually active, the erroneous belief that partners who appear healthy pose no risk might make them less likely to protect themselves (e.g., through abstinence or condom use). Further, the mistaken belief that transmission can occur through sharing food has the potential to exacerbate stigma towards HIV infected persons; this may be particularly salient in contexts of high HIV prevalence, such as KwaZulu-Natal. Programs should accordingly pay equal attention to prevention strategies and dispelling common misconceptions. Finally, accurate and comprehensive HIV and AIDS knowledge is only one component of an effective prevention strategy; OVC programs must continue to address known HIV risk factors that are particularly prevalent in OVC populations, such as poverty and psychosocial distress.

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Suggested Citation: Thurman, T.R., and R. Kidman (2011). *HIV and AIDS Knowledge among Orphans and Vulnerable Children in KwaZulu-Natal, South Africa*. New Orleans, Louisiana: Tulane University School of Public Health and Tropical Medicine.

Support for this project is provided by the United States Agency for International Development (USAID/Southern Africa) under contract No. GHS-I-00-07-00002-00 under Task Order No. GHS-I-03-07-00002-00. Enhancing Strategic Information Project (ESI) in Southern Africa is implemented by John Snow, Inc. in collaboration with Tulane University School of Public Health and Tropical Medicine. The views expressed in this document do not necessarily reflect those of USAID or the United States Government.

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