

***BARRIERS TO CONDOM UTILISATION AMONG MOBILE POLICE  
OFFICERS IN PARAMILITARY CAMPING SITES: A CASE OF SONDELA  
CAMP IN KAFUE RURAL DISTRICT***

**By**

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## **ABSTRACT**

The research was conducted to establish the barriers associated with condom utilization among mobile police officers in Sondela paramilitary camp in Kafue rural district. The study was prompted by the fact that Zambia police service had scanty information on officers' condom utilization and since there had been STIs, pregnancies and also failure to achieve 100% use of condoms among mobile police officers in Sondela, a need arose to establish factors that could have led to this situation.

The sample size was determined to be 240 respondents. We used simple random sampling method to select respondents. A research design was cross sectional and data was collected using a self administered questionnaire. The study was approved by the UNZA graduate forum, and cleared by UNZA Research Ethics Committee and Police high command.

Consistency condom use was estimated at 32.5%. Multivariate analysis revealed that predictors of consistency condom use were: age, low level of education, lack of adequate information and care giving about condoms and a belief that condoms promote promiscuity. Arising from these findings, Police command should conduct HIV/AIDS sensitization among mobile officers targeting age category of 25-34 years dispelling myths regarding condom use, provide in-service courses to mobile police officers and train service providers on consistency condom use for effective service delivery. Embrace male circumcision services for male police officers; introduce the condom wallet intervention where a police officer on operational duty is provided with a condom wallet filled with condoms. These suggestions will at a large scale increase the consistency use of condoms among mobile officers and benefit other police mobile camps in the Zambia.

## DECLARATION

I hereby declare that to the best of my knowledge the work presented in this study, for the masters in Public Health has not been presented either wholly or in part for any other master's in Public Health degree and is not currently submitted for any other degree.

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## **STATEMENT**

I, **Mulenga Fred** hereby certify that this work presented for the degree of Master in Public Health, is in all entirely the results of my own independent investigations. The various sources to which I am indebted are gratefully acknowledged in the text and in the references.

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## APPROVAL

This dissertation of Mulenga Fred is approved in partial fulfilment of the requirement for the award of the degree in Master of Public Health by the University of Zambia.

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## **DEDICATION**

I dedicate this dissertation to the following; my almighty God for the preservation and fullness of my life and all police officers who got infected of HIV&AIDS whilst on national duty. Furthermore, my dear dad Michael Mulenga and mum Fostina Kapampa can not be forgotten for bringing me up as a disciplined child, Sister Dorothy Mulenga who took me to my first grade is also dedicated. Furthermore, I whole heartedly dedicate this dissertation to my dear wife Catherine K. Mulenga and my beloved children, namely; Edith, Kapampa and My boy twins Joshua and Japhet (J&J). All these are dedicated for their distinguished, individualized support rendered to me during my study period.

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## ACRONYMS

<b>AIDS</b>	ACQUIRED IMMUNODEFICIENCY SYNDROME
<b>DCP</b>	DEPUTY COMMISSIONER OF POLICE
<b>DEPTS</b>	DEPARTMENTS
<b>DIVIPOL</b>	DIVISIONAL POLICE
<b>FSWS</b>	FEMALE SEX WORKERS
<b>HBC</b>	HOME BASED CARE
<b>HRD</b>	HUMAN RESOURCE DEVELOPMENT
<b>HIV</b>	HUMAN IMMUNODEFICIENCY VIRUS
<b>IDUS</b>	INTRAVENOUS DRUG USERS
<b>IG</b>	INSPECTOR GENERAL OF POLICE
<b>I.E.C</b>	INFORMATION, EDUCATION & COMMUNICATION
<b>MED</b>	MEDICAL
<b>MHA</b>	MINISTRY OF HOME AFFAIRS
<b>MOH</b>	MINISTRY OF HEALTH
<b>NAC</b>	NATIONAL AIDS/TB/STIS COUNCIL
<b>PEER EDU</b>	PEER EDUCATION
<b>REC</b>	RESEARCH ETHICS COMMITTEE
<b>STIS</b>	SEXUALLY TRANSMITTED INFECTIONS
<b>SRS</b>	SIMPLE RANDOM SAMPLING
<b>UNAIDS</b>	THE JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS
<b>U.S.A.</b>	UNITED STATES OF AMERICA

<b>UNZA</b>	UNIVERSITY OF ZAMBIA
<b>UNZAREC</b>	UNIVERSITY OF ZAMBIA RESEARCH ETHICS COMMITTEE
<b>TECH</b>	TECHNICAL
<b>PARA</b>	PARAMILITARY
<b>VCT</b>	VOLUNTARY COUNSELING AND TESTING
<b>W H O</b>	WORLD HEALTH ORGANIZATION
<b>ZDHS</b>	ZAMBIA DEMOGRAPHIC HEALTH SURVEY
<b>ZUSBS</b>	ZAMBIA URBAN SEXUAL BEHAVIOURAL SURVEY
<b>ZSBS</b>	ZAMBIA SEXUAL BEHAVIOURAL SURVEY
<b>ZPS</b>	ZAMBIA POLICE SERVICE

## **DEFINITIONS**

<b>COMPOL</b>	Commissioner of Police. This is the second in command of Zambia Police Service.
<b>DCP</b>	Deputy Commissioner of Police. This is the third man in command of Zambia Police Service.
<b>DIVIPOL</b>	Divisional Police. It refers to the provincial command and other units that report directly to police high command in Lusaka.
<b>IG</b>	Inspector General of Police. This is the overall commander in Zambia Police Service.
<b>MHA</b>	Ministry of Home Affairs. This is one of the government ministries in the country with various departments such as Police and prisons, it looks after home affairs matters.
<b>MOBILE POLICE OFFICERS</b>	Refers to officers who spend not less than one month on operations away from home.
<b>MOBILE CAMP</b>	Refers to sites that are specifically meant for officers working away from home for not less than a month.
<b>OPS</b>	Operations. This is a department that attends all forms of public order situations in the nation.
<b>PARA</b>	Paramilitary. It's a combatant unit specialized in operations.
<b>SONDELA MOBILE CAMP</b>	This refers to a training site situated about 50Kms away from Kafue urban district. It is always active with sometimes police officers being camped for re-fresher trainings in various Police fields.

**TECH**

Technical. It refers to directorate in charge of police communication and transport system.

**ZPS**

Zambia Police Service. This is a department that maintains law and order in Zambia.

# CHAPTER ONE

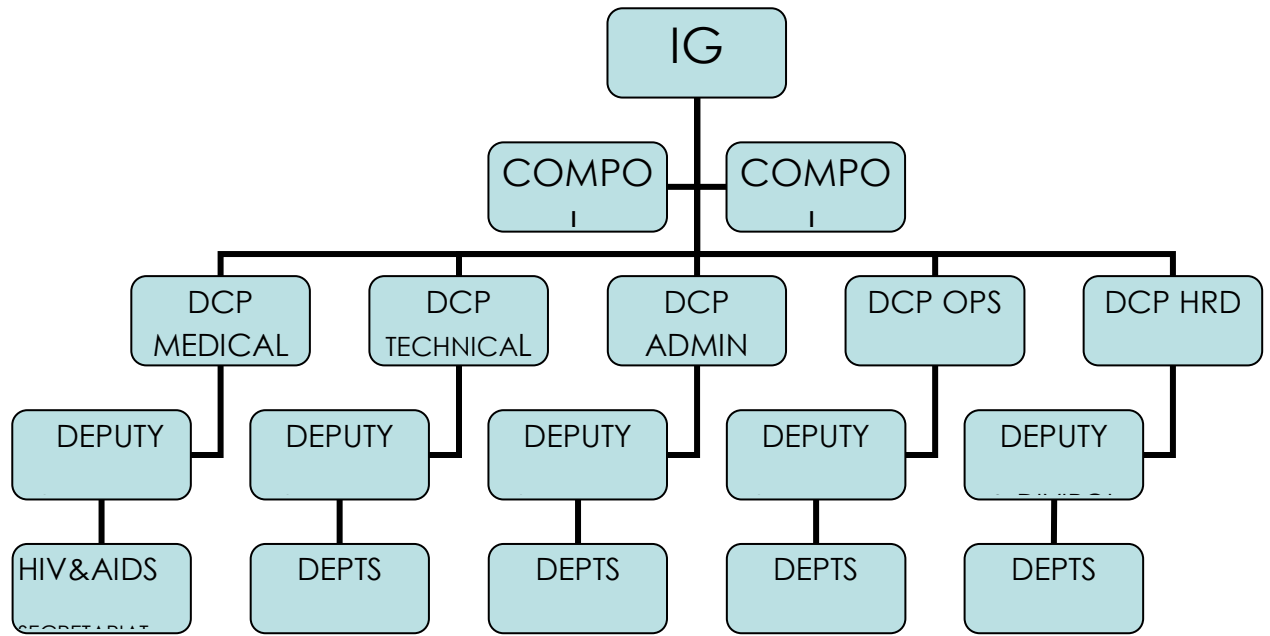
## 1.0. INTRODUCTION

### 1.1. Background information

The number of people living with HIV worldwide has risen from around 8 million in 1990 to 33 million today, and is still growing. Around 67% of people living with HIV are in sub-Saharan Africa. More than 25 million people have died of AIDS since 1981 with Africa having 11.6 million AIDS orphans (UNAIDS et al, 2008). Zambia's HIV prevalence is estimated at 14.3%, showing a reduction from 16% as reported in 2002 (Central Statistical Office et al, 2009). HIV has not spared the police service in Zambia. Although its' HIV prevalence is still unknown, an estimate of 50 to 100 officers die annually due to HIV related illnesses (ZANARA, 2005). Zambia Police Service is a department under the Ministry of Home Affairs with an estimated population of 19,000 uniformed staff and 5000 civilian personnel.

#### 1.1.1 STRUCTURE OF ZAMBIA POLICE SERVICE





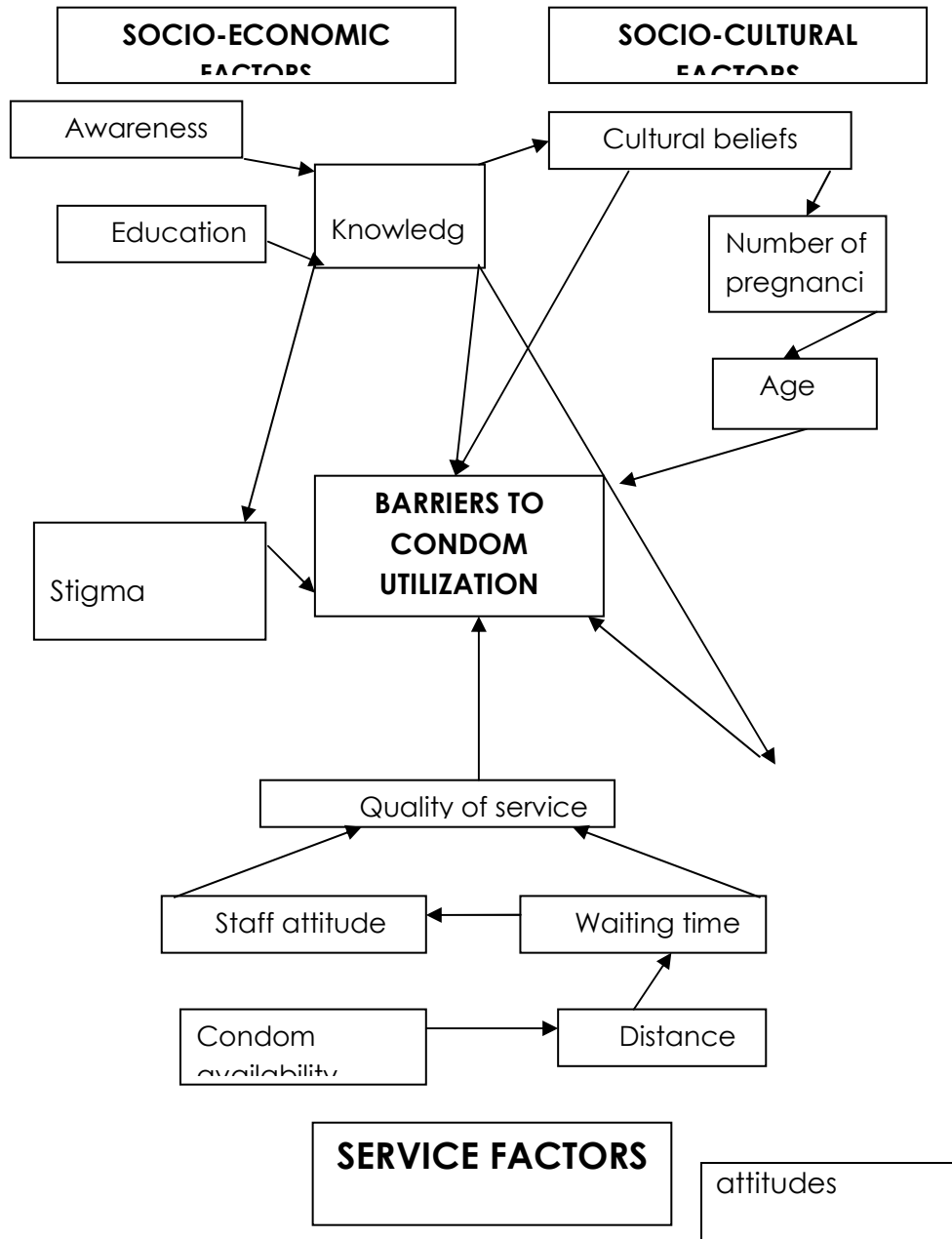
*The Medical unit has the HIV secretariat which works with other cooperating partners to provide interventions of HIV/AIDS. These include Voluntary Counseling and Testing (VCT), Information Education and Communication (IEC) materials, Peer Education, Positive Living and Home Based Care activities, (ZANARA, 2005). One of the sites where HIV/AIDS activities are being conducted is Sondela camp which is the biggest subunit of paramilitary unit. It's about 50 km away from Kafue urban district with an estimated Police population of 500.*

## **1.2. STATEMENT OF THE PROBLEM.**

The estimated police population in Zambia is nineteen thousand (19,000). On average, hundred (100) officers die in their prime ages of service every year, most of which are associated with HIV/AIDS related illnesses (ZANARA, 2005). According to Police monthly returns, a mobile VCT was conducted in 2009, among 120 traffic Marine Police officers who camped in Sondela for six months from January to June of whom 47.0% tested HIV positive. Furthermore, Sondela camp recorded 10% sexually transmitted infection (STI) cases out of its' disease burden by the end of 2008. Furthermore, the Police unit provides routine medical screening tests to the mobile police officers on their arrival in the area. A total number of 3800 maximum condom packets were supplied each quarter to this mobile camp by the end of 2008. At the end of the year, condom audit was done which revealed that about 1500 maximum condom packets remained uncollected (ZANARA, 2005).

In light of the mentioned health problems in this area such as STI, pregnancies, huge number of uncollected condoms, it is necessary to determine factors that are associated with condom utilization.

### 1.2.1 Problem analysis diagram



### 1.2.2 Justification of the study

**The study was prompted by the fact that Zambia police service had scanty information on officers' condom utilization and since there had been STIs, pregnancies and also failure to achieve 100% use of condoms among mobile police officers in Sondela, a need arose to establish factors that could have led to this situation.**

## CHAPTER TWO

### 2.1. LITERATURE REVIEW.

According to UNAIDS et al (2008) condom use is a critical element in a comprehensive, effective and sustainable approach to HIV prevention and treatment. Prevention is the mainstay of the response to HIV/AIDS. Condoms are an integral and essential part of comprehensive prevention and care programmes and their promotion must be accelerated. Condoms have played a decisive role in HIV prevention efforts in many countries. Condoms have helped to reduce HIV infection rates where AIDS has already taken hold, curtailing the broader spread of HIV in settings where the epidemic is still concentrated in specific populations, condoms have also encouraged safer sexual behavior.

Low and inconsistent use of condoms was declared in a Prevention convention resolution (2010) as one of the key drivers which is propelling HIV/AIDS pandemic world wide. Dorozynski (1994) shows that a survey by a French agency that fights AIDS indicates that the number of condoms used by Europeans varies from 1.7 to 3.8 per person per year. In 1992 about 150 million condoms were used in Spain, an average of 3.8 per person. In Britain, where the average cost of a condom is much lower, a total of 152 million were sold, representing 2.7 condoms per person per year. In France, where the cost is slightly higher, 2.0 condoms are used per person per year. The cost of condoms is highest in the Netherlands, where their use is lowest, 1.7 per person per year. In France, legislation adopted at the beginning of the century which banned contraceptive advertisements, and this regulation was repealed only in 1987. Condoms had practically stopped being used in France by the end of the 1960s, having been replaced by oral contraceptives. In addition, the use of condoms in France became associated with prostitution and illicit sex. In 1970 condoms were used by 26% of people using contraception in Britain; in France the proportion of 22% was reached only last year (2009). Condoms are generally bought in pharmacies: 80% in Spain, 75% in Italy, 53% in Britain, and 48% in France. It is stated that about 2.8 billion condoms are

produced every year worldwide while Japan is the greatest consumer, using 58% of that total.

Ali et al (2004) conducted a study to assess the contraceptive effectiveness of condoms versus oral contraceptive pills and estimated the reproductive consequences of a major shift from pill to condom use in 16 developing countries including Dominican Republic, Guatemala, Kenya, and Zimbabwe. The findings were as follows; in the 16 countries, the median per cent of married couples currently using condoms was 2%, compared with 13% for the pill. Condom users reported a higher 12-month failure and higher method-related discontinuation rates than pill users. Condom users were more likely to report subsequent abortion following failure and also more likely to switch rapidly to another method. It was revealed that condom users were more likely to experience method- or user-failure than pill user in the absence of competing risks; the 12 month failure probability for condom users was about 9%. Nonetheless, Ali et al (2004) shows that pills do not prevent HIV infection other than pregnancies but condoms also help to protect one from contracting HIV/AIDS and other sexually transmitted infection.

Kwiatkowski et al (1999) conducted a research on predictors of increased condom use following HIV intervention with heterosexually active drug users in the USA; it was found that 15% participants reported using condoms during their sexual intercourse, thus, revealing low condom use in this study. In a related study, Kanya et al (1993) conducted a study on barriers to condom use in an urban village of Kampala-Uganda where it was found that the prevalence of consistent condom use in Uganda was one of the lowest in Africa (about 10%). The most frequently mentioned problem in this study was lack of education about proper use and effectiveness of condoms. Participants denied believing in common condom-related myths in Uganda such as: "Condoms can disappear inside a woman and she has to be operated on to remove it," or "Condoms have small holes that could allow a germ to go through." Respondents revealed that Condoms were available in drug shops and private clinics but needed more diversified outlets. Reliable condoms that do not break easily are expensive; there is need for government to recommend and popularize a uniform, reliable and cheap condom. Government, religious leaders, and other concerned bodies should not preach

conflicting messages about condoms; and education intervention should be gender and age strata specific. It was concluded that lack of education about, familiarity with condoms and their cost were prominent barriers to using condoms.

Another study conducted by Fact Sheet (2008) among 287 women arrested for drug use in St. Louis, Missouri, found that 78 of them (27%) had sex with a police officer, often as a result of coercion; 26% said they were raped and 55% said they had sex because the officer promised not to arrest them in return but not all the cops kept that promise. Almost all women who had sex with a policeman, 96%, did so with an officer on duty, and 74% had sex with one officer more than once. Only 53% of women who had sex with a police officer always used a condom in such encounters.

Cort and Modeste (2007) conducted a study to establish attitudes associated with condom use among high school and university students in Zimbabwe. The study investigated the extent to which knowledge of AIDS is associated with two components of the Health Belief Model; attitude toward condom use, and intentions to use condom in future sexual encounters. The results indicated that knowledge of AIDS was not significantly related to any of the two dependent variables. However, belief in the efficacy of condoms, and lack of barriers to the use of condoms were significantly related to both dependent variables. These findings indicate that one may have high level of knowledge but it does not guarantee that such a person would use condoms.

Similarly, Roth et al (2001) conducted a study on barriers to condom use in India, he focused on the consistent and correct use of condoms coupled with how risk reduction education strategies continue to play an important role in the reduction and prevention of HIV/AIDS transmission. The study findings provided some insights on the need to address issues of privacy regarding condom purchase and use in India. Most notably, the lack of privacy in stores and the social stigma associated with condom use were indicated as the most significant barriers to condom use. Asiamah (2004) reports that condom use among Police Officers in Ghana was low, only 50% of officers who had casual sex used condoms, a police officer on operational duty are provided with a condom wallet filled with condoms. The wallet is worn on his belt as part of his official uniform. The condom wallet is not intended to promote promiscuity, but to serve as a

life jacket against HIV. Surveys conducted in the year 2000, showed significant increase in condom use as 65% of police officers who had casual sex used condoms. The rate of condom use continued to increase every year, and in 2003, surveys showed that all police officers (100%) who had casual sex used condoms. The barriers to condoms use were curtailed as condoms became more easily available, and both police officers and their spouses discussed condoms freely. The condom wallet has generated a lot of interest and fun on condoms among police officers, which has led to very significant increase in condom use in the police. In addition, it is more interesting that police wives did not have problems with policemen carrying condoms to operational duties. Furthermore, it was recommended that a simple condom wallet technology, has led to a universal condom use by police officers in casual sex. It is against this background that, the condom wallet is highly recommended for use by other Uniformed Personnel on operational duties. Berman (2002) in Washington DC reports that Population Services International researchers found that trust in one's partner was the main reason for not using condoms with marital or regular partner in Africa, and dislike of condoms was the most important reason for not using them with a casual partner, in what is apparently the first multi-country study of barriers to condom use. Price and lack of availability of condoms historically have been barriers to condom use.

Ritzenthaler (2005) reveals that in a study on HIV/AIDS conducted in Ghana among armed forces, a reduction in HIV prevalence was observed among the ranks from 4.2% in 1989 to an estimated 2.0% at the end of 2003. The Ghana Police Force reported significant changes in knowledge and behavior since launching its program in 1998. Approximately 36% of police identified police stations as a source of condoms in 2002, compared to 0.6 in 2000. During that same period, reported condom use with non-regular, non-commercial partners every time in the past 12 months increased from 20.8% to 50.8%. Tlou et al (1992) conducted a study on barriers to condom use among urban Tswana women which revealed that women in Gaborone had a wide range of experiences and attitudes about condom use. Some had never used condoms, some had had negative experiences, and others had used condoms with high satisfaction. Partner objections and difficulties in negotiating sexual issues with partners were major barriers to initiation of condom use to prevent HIV infection. Many women felt condoms



were easier to use with casual partners than with a husband or live-in boyfriend because condom use implied lack of trust between partners. Own physical discomforts associated with condom use and concerns about the condom remaining inside the woman also discouraged some women. Reduction of other sexually

transmitted disease symptoms and protection against pregnancy were the major advantages that made some women more willing to use condoms.

Wolfe (1993) examined context-specific factors associated with condom use among injecting drug users (IDUs) and their sexual contacts in the USA. It was found that condom promotion efforts potentially violating relational trust are bound to fail. Therefore, there is need for vital approaches de-emphasizing trust to promote condom use among mobile police officers. Zellner (2003) conducted a study on condom use and the accuracy of AIDS Knowledge in Côte d'Ivoire. It was found that condom use remained low in Côte d'Ivoire, despite an increasing prevalence of HIV and widespread awareness of how the virus is transmitted. Furthermore, it revealed that accuracy of knowledge about AIDS did not significantly predict condom use. It was concluded that the level of accuracy of AIDS knowledge did not predict the likelihood of recent condom use in this sample. Efforts to increase educational attainment in Côte d'Ivoire might have been more effective in increasing condom use than a focus on improving the accuracy of AIDS knowledge. Population Council (2001) conducted a demographic and health survey in Côte d'Ivoire and revealed that when asked how HIV is contracted, 92% of men and 80% of women mentioned at least one correct means of transmission. However, when asked about their inclination to use condoms, only 23% of Ivoirian men and 7% of Ivoirian women indicated that they had ever used a condom. Thus, information about links between knowledge and condom use is important for the development of appropriate interventions. Collumbien et al (2001) show that Orissa, which is one of the most impoverished states in India has poor reproductive health and the use of condoms and other reversible contraceptives is uncommon. It further reports that a cross-sectional population-based survey carried out in 1998 in the four coastal districts of Orissa among 2,087 men aged 18-35 years collected data on fertility preferences, sexual behavior and condom use. Levels of use and need for condoms were estimated separately for sexual activity within and outside

marriage. The results were as follows: Ninety percent of all condoms were used for sex within marriage (44% for spacing and 46% for limiting births). Condoms were used during 3% of marital sex acts and 15% of nonmarital sex acts. Two-thirds of the unmet need for condoms was for premarital or extramarital sex (53% and 13%, respectively). The conclusions were that condoms should be promoted differently among different target groups: as an effective way to prevent HIV and other sexually transmitted diseases among the minority of men who engage in high-risk sexual behavior, as a means of preventing both pregnancy and disease among young unmarried men and women. Yomi et al (2002) reports about a qualitative research conducted in Yaounde and Douala, Cameroon; on barriers to condom use, it was found that the following were barriers to condom use; condom availability, factors related to the nature of the product, attitudes about condoms and the risk of STD infection, and economic, psychological, cognitive, situational, cultural, and contextual factors.

Guttmacher et al (1997) conducted a study comparing sexual activity and condom use among adolescents in New York and Chicago public schools. The findings indicate that rates of condom use were 55.5% among sexually active continuing students in Chicago and 60.8% in New York. While New York students had condoms available for free or at a low charge, Chicago students had to obtain condoms from sources outside school in 1994. The students from both cities had similar demographic profiles; and the research demonstrated that increases in sexual activity were associated with age. Condom use improved among students with multiple sexual partners. A school condom availability study in Los Angeles found that the percentage of male or female students reporting sexual intercourse did not change with school condom availability. However, condom use among sexually active students increased from 37% to 50%. The percentage of males using condoms at first intercourse increased from 65% to 80%. Intention to use condoms was also high. A total of 418 public schools made condoms available through a variety of strategies.

A study by Wilson et al (1990) examined associations of AIDS knowledge, perceived susceptibility to HIV, efficacy of preventive measures, severity of HIV infection, cues to action, barriers to action, and alcohol/drug use on one hand, and intended condom use on the other among Zimbabwean adolescents in probation homes. Proportions of

86% of males and 83% of females were reportedly sexually experienced; 28% of these males and 14% of these females reported consistent condom use. Those who believed parents and boyfriends/girlfriends thought condoms should be used were 2.27 and 2.13 times as likely to plan to use them. Those who were embarrassed to get condoms from a clinic, who thought those using condoms were promiscuous, or that the pleasure of unprotected sex was worth the risk of HIV were 3.87, 3.42, and 3.40 times as likely to plan to use condoms, respectively. The belief in the efficacy of condoms was the principal predictor of intended condom use. The results suggested that AIDS education might have been improved by emphasizing that condoms protect babies and families. In addition, by making the efficacy of condoms a central AIDS education theme, through the use of as many approaches as possible to persuade adolescents that condoms are effective and by removing barriers to their use, use might have been improved. Barriers to condom use included ignorance about condoms, about obtaining them, and about using them properly.

Furthermore, Morris et al (2009) states that female sex workers and their clients remained a high risk core group for HIV in Africa. Sexual behavior of a sample of female sex workers (FSW) along the Trans-Africa highway from Mombasa, Kenya to Kampala, Uganda surveyed the availability of male condoms and lodgings in Kenya along the highway trucking stops where transactional sex occurs. The results were that condom use by FSW for all sexual liaisons was 79% in Kenya compared to 74% in Uganda. Kenyan FSW were more likely to use a condom by an adjusted odds ratio of 2.54 compared to Ugandan FSW. Condom use with regular clients was 50.8% in Uganda compared with 68.7% in Kenya. The number of sex workers reporting 100% condom use was 26.8% in Kenya and 18.9% in Uganda. Bars and lodges in Kenya compared to Uganda were more likely to have condom dispensers, 25% versus 1%, respectively; distribute or sell condoms, 73.9% versus 47.6%; and have more weekly condom distribution, 4.92 versus 1.27 condoms per seating capacity. Data indicate that in both countries condom use for FSW was suboptimal with regular partners, and greater condom use by Trans-African highway FSW in Kenya compared to Uganda might have been related to availability. It was concluded that targeted interventions were warranted for FSW and truck drivers to prevent HIV transmission in this group.

Population Reference Bureau (2010) states that among police personnel and condom use with sex workers increased from 69% to 85 % between 1999 and 2001 in Cambodia. Data indicated, however, that the program still had some distance to go before reaching the 100% level: 22% of sex workers in the 2002 reported that their clients did not use condoms. Cambodia Country AIDS profile (2001) shows that Cambodia responded to the early HIV/AIDS epidemic quickly and effectively by launching massive educational campaigns. Targeted programs aimed at brothel-based sex workers reduced seroprevalence from 43% in 1998 to 29% in 2002 within this population; and reduced HIV infection among urban. It was also shown that the proportion of Police who frequently used the services of sex workers reduced from 6 % to 3%.

Egger et al (2000) conducted a study in Latin America, where motels rented rooms for commercial and non-commercial sex. The impact of providing health-education material and condoms on condom use in Managua, Nicaragua was investigated. The results were that 11 motels were mainly used by sex workers and their clients and eight were mainly used for non-commercial sex. A total of 6463 couples attended the motels in 24 days. On 3106 (48.0%) occasions, at least one used condom was retrieved. Condom use was more frequent for commercial sex than for non-commercial sex. Condom use increased for commercial and non commercial sex workers if condoms were available in rooms. Direct handing of condoms to couples was similarly effective for commercial sex but less effective for non-commercial sex. The interpretation was that in Latin America; motels were key locations for promoting the use of condoms. Making condoms available in rooms was the most effective strategy to increase condom use; these findings had important implications for HIV-prevention policies.

According to Holmes et al (2004), condoms are good at helping to prevent HIV infection and other related STIs provided they are correctly and consistently used. A study conducted by Ali et al (2004) reveals that condom use was a neglected HIV intervention in marriages. Ekstrand et al (2004) reports that 1535 HIV negative male STD patients completed an interviewer-administered survey on AIDS-related knowledge, beliefs and behaviors as part of their participation in a behavioral HIV risk reduction trial in two municipal STD clinics in the city of Mumbai, Maharashtra. The results were that 92% of the men reported sex with a Female Sex Worker (FSW) in their lifetime and 75% of

the men reported sex with a FSW in the past 3 months. Condom use was low: 43% of the men stated that they never used condoms with FSWs, 44% reported inconsistent use, and only 13% reported always using condoms. Men who perceive a greater number of barriers to condom use (such as little condom availability, embarrassment, and decreased pleasure) were more likely to have unprotected sex with FSWs. Other correlates of unsafe sex with FSWs included a greater perception that their peers were unsafe, and less comfort using condoms. In addition, 54% of the total sample reported having sex with FSWs

under the influence of alcohol, these men were significantly more likely to report unsafe sex with FSWs.

Trinitapoli (2009) conducted a study on religious teachings and influences on the ABCs of HIV prevention in Malawi. The study examined the relationship between religion and HIV risk behaviors in rural Malawi, giving special attention to the role of religious congregations, the organizations with which rural Africans have most immediate contact. Multi-level models revealed that religious affiliation and involvement were not correlated with the sexual behavior of congregation members, but that beliefs about appropriate sexual behavior and particular congregational characteristics were associated with adherence to A, B, and C. Individuals belonging to congregations led by clergy who frequently delivered formal messages about HIV, monitor the sexual behavior of members, and privately encourage condom use reported greater adherence to the ABCs of HIV prevention; suggesting that religious congregations are relevant for the sexual behavior of members and for better understanding the forces shaping individual behavior in the context of the African HIV/AIDS epidemic.

Hall et al (2008) conducted a study that explored whether wives of men entering alcoholism treatment are at risk for sexually transmitted infections (STIs) exposure as a result of their husbands' sexual risk behaviors. The proportion of alcoholic men who reported one or more extramarital affairs in the previous year (14%) was significantly higher than that of the community sample (4%). Additionally, only 2 alcoholic husbands and one non alcoholic husband reported that his wife was aware of the extramarital relationship. For both groups none of the men who engaged in extramarital

relationships reported consistent use of condoms when having sexual intercourse with their wives or with their extramarital partners. These results suggest that wives of alcoholic men are unknowingly placed at risk for indirect exposure to STIs as a result of their husbands' sexual risk behaviors, thus, infidelity in treatment-seeking alcohol-abusing men represents a significant public health issue. Central Statistical Office et al (2009) indicated a slight increase with about three quarters of women and men knowing that continued comprehensive and consistent use of condoms is a means of preventing the spread of HIV in Zambia. They also reviewed that among those having higher-risk sex, 37% of women and 50% of men reported that they used a condom at the last sexual encounter. Central Statistical Office et al (2003) showed that condom use still remained very low (12% among women and 19% among men). One of women and 44% of men reported that a condom was used the last time they had sex with a non-cohabitating partner.

***Central Statistical Office (1999) reports that a survey was conducted in order to examine patterns of condom use in Zambia; examine exposure to advertising and promotion concerning condom use; and examine family planning practices and knowledge. Overall, 40% of respondents reported condom use outside marriage, and about 8% reported condom use in marriage. Levels of condom use remained well below the required to arrest the HIV epidemic in Zambia. Socioeconomic and reproductive factors were associated with condom use within and outside of marriage among urban pregnant women in Zambia. Kankasa et al (2005) conducted a cross-sectional questionnaire survey on condom use among 470 pregnant women in Lusaka. Condom use was reported much lower than among women who were having extramarital affairs. It was recommended that there should be the implementation of family planning with emphasis on condom use, and empowering women by assisting with their economic independence. Benefo (2004) stipulates that a study was carried out to assess whether Partner and***

*relationship characteristics are associated with condom use in Zambian non-marital relationships as in many other sub-Saharan African countries. It was revealed that condom use was far below the level needed to alleviate serious threats to sexual and reproductive health. It was concluded that condom promotion programs and interventions in Africa must take into account the relationship characteristics of intended participants, paying special attention to gender differences.*

*According to National AIDS Council (2005a), condom use decreased between 2003 to 2005, from 26% to 24% among females and 40% to 38% among men. Similarly, National AIDS Council (2005b) prevention theme document indicates that a gap exist regarding condom use in Zambia.*

## CHAPTER THREE

### 3.0 RESEARCH QUESTION AND OBJECTIVES

#### 3.1 RESEARCH QUESTION.

**What factors are associated with condom utilization among mobile Police officers of Sondela camp in Kafue rural district?**

### 3.2 RESEARCH OBJECTIVES

#### 3.2.1 General objective

- To identify barriers to condom utilization among mobile police officers in Sondela camp Paramilitary camp in Kafue rural District.

#### 3.2.2 Specific objectives

- To assess consistence condom use among mobile police officers
- *To assess the availability of condoms in Sondela mobile police camp.*
- *To assess the level of knowledge about condom utilization among mobile police officers.*
- *To identify beliefs associated with condom utilization among mobile police officers.*



## CHAPTER FOUR

### 4.0 RESEARCH METHODOLOGY

#### 4.1 Introduction

The purpose of this study was to determine factors assumed to influence condom utilization among mobile police officers. This section focuses on research methods which included among others; conceptual framework, study design, study site, study population, sample size determination, sampling methods, eligibility criteria, data collection procedures, study limitations, ethical considerations and data management procedures.

##### 4.1.1 Study Design

The study design was cross-sectional.

##### 4.1.2 Study Setting

The study site was Sondela Paramilitary Police camp in Kafue rural district with a population of 500 mobile police officers. The site was selected because of being situated in a rural area with limited access to services. The police command is the only supplier of health needs including condoms. In addition, the mobile police officers have the monopoly of financial resources and likely to sexually exploit the financially incapable women from surrounding communities.

##### 4.1.3 OPERATIONALISATION OF VARIABLES.

TABLE 1: OPERATIONALISATION OF VARIABLES.

VARIABLES	OPERATIONAL	INDICATOR	MEASUREMENT
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	<b>DEFINITION</b>		
<b>DEPENDENT VARIABLE</b>  Condom Utilization	Making practical and effective use of condoms	<ul style="list-style-type: none"> <li>- Full utilization (consistent)</li> <li>-Low utilization (inconsistent)</li> <li>- No utilization</li> </ul>	<ul style="list-style-type: none"> <li>- Had used condoms in all sexual encounters for the past 12 months.</li> <li>- Had irregular use of condoms for the past 12 months</li> <li>-No use of condoms for past 12 months</li> </ul>
<b>INDEPENDENT VARIABLES</b>  Education	A state where a Police officer had gone through formal educational process	<ul style="list-style-type: none"> <li>-Very educated</li> <li>-Moderately educated</li> <li>- Semi educated</li> <li>- Not educated</li> </ul>	<ul style="list-style-type: none"> <li>- Had gone up to college and above</li> <li>- Secondary level</li> <li>- Primary level</li> <li>- No school</li> </ul>
Distance	The length of the space between the respondent's home and condom source.	<ul style="list-style-type: none"> <li>-Near</li> <li>-Far</li> <li>- Very far</li> </ul>	<ul style="list-style-type: none"> <li>- Less than 30 minutes walk from respondent's home to the health facility'</li> <li>-30 to an hour's walk</li> <li>- More than an hour's walk</li> </ul>
Cultural beliefs	Ones traditional beliefs towards condom use.	<ul style="list-style-type: none"> <li>- Positive</li> <li>- Negative</li> </ul>	<ul style="list-style-type: none"> <li>- One has no reservation and appreciates benefits of condom use.</li> <li>- One has reservation and does not appreciate condom use and</li> </ul>

			its benefits.
Age	Ones years of birth	<ul style="list-style-type: none"> <li>- Young</li> <li>- Medium</li> <li>- Old</li> </ul>	<ul style="list-style-type: none"> <li>- Up to 34 years old</li> <li>- 35 to 40 years old</li> <li>- More than 40 years</li> </ul>
Knowledge	Police officer having knowledge about the condom use.	<ul style="list-style-type: none"> <li>- Knowledgeable</li> <li>-Partially knowledgeable</li> <li>-Not knowledgeable</li> </ul>	<ul style="list-style-type: none"> <li>- One is able to describe condoms, able to mention name of types being used, and its benefits.</li> <li>-One is able to mention something about condoms.</li> <li>- One has or has not heard about condoms, but is not able to state its use and benefits.</li> </ul>
Availability of service	Availability of condoms at condom source	<ul style="list-style-type: none"> <li>- Available</li> <li>- Erratic</li> <li>- Not available</li> </ul>	<ul style="list-style-type: none"> <li>- Condom always available</li> <li>- Condom not always available</li> <li>- Condom never available.</li> </ul>
Waiting time	Time police officer arrives at the condom source and the time one is attended to.	<ul style="list-style-type: none"> <li>- Less than 30 minutes</li> <li>- 30 minutes</li> <li>-30 minutes to one hour</li> <li>- More than one hour</li> </ul>	<ul style="list-style-type: none"> <li>- No waiting</li> <li>- Waiting for sometime</li> <li>- Waiting for a long time</li> <li>- Waiting for a very long time.</li> </ul>
Beliefs	What one believes that might make him use or not use condoms	<ul style="list-style-type: none"> <li>-Bad beliefs</li> </ul>	<ul style="list-style-type: none"> <li>- Beliefs that influence not using condoms</li> <li>-Beliefs that influence effective</li> </ul>

		-Good beliefs	use of condoms
Trust	<p>Not using condoms because you believe your partner is HIV-negative. Or using</p> <p>-Condoms because you believe your partner is HIV +ve</p>	<p>-Trust</p> <p>-No trust</p>	<p>-Not using condoms because you believe your partner is HIV-negative.</p> <p>- Using condoms because you believe your partner is HIV+ve</p>
Drunken state	<p>Not using condoms because one has intensively taken alcohol or using condoms even though one has intensively taken alcohol</p>	<p>Drunk</p> <p>Sober</p>	<p>-Not using condoms because one has intensively taken alcohol</p> <p>-Using condoms because one has not intensively taken alcohol</p>
Distance from condom source	-How far it is from condom source	<p>-Short distance</p> <p>-Long distance</p>	<p>-One can walk</p> <p>-Able to drive /cycle</p>
Waiting time	-Time spent to get a service	<p>-Short</p> <p>-Long</p>	<p>-Less than 30 minutes</p> <p>-More than 30 minutes</p>
Staff attitude	-Behaviour staff providing service to mobile police officers	<p>-Good attitude</p> <p>-Bad attitude</p>	<p>- Behaving badly towards a client</p> <p>- Behaving well.</p>

Stigma	-Not able to access and use condoms due to stigma	-Stigma	-One fails to access and use condoms for fear of people developing a negative attitude toward him/her
		-No stigma	-One accesses and use condoms without fear of people developing a negative attitude toward him/her

**Relationship between the dependent and independent variables.**

#### **4.1.3 LIST OF VARIABLES.**

#### **4.1.4 Dependent Variable**

Utilization of condoms

#### **4.1.5 Independent Variables**

Knowledge

Cultural beliefs

Education

Availability of condoms

Age

Distance from condom Source

Availability of Service

Care and information of service providers

Alcohol

Stigma

Condoms break easily

Trust

#### **4.1.6 Study Population**

Study population was 500 mobile police officers in Sondela paramilitary camp.

#### **4.1.7 Sample Size Determination.**

Sample size was determined by using EPI-INFO version 6, assuming a condom use rate of 50%, with worst expected at 45%, and considering a 95% confidence level. EPI-INFO calculation gave a sample size of 217 respondents plus 10% for non respondents, the total respondents was 238.7, and rounding off this value to the nearest 10, we got 240 respondents.

#### **4.1.8 Sampling Technique**

The 240 respondents were selected using a Simple random sampling (SRS) technique. A nominal roll of 500 listed police officers was obtained from the Sondela police command as our sampling frame.

#### **4.1.9 ELIGIBILITY CRITERIA**

##### **4.1.9.1 Inclusion Criteria.**

All resident mobile police officers in the camp who have been in service for at least 6 months from date of graduation from training were included in the study, and only mobile police officers willing to participate were included in the study.

##### **4.1.9.2 Exclusion Criteria.**

Mobile police officers not willing to participate were excluded from the study, and the officers not resident in Sondela camp were also excluded from the study.

#### **4.2.0 Pre-Test.**

The researcher conducted a pre-test in the city market mobile camp before the main study could begin, and then made some minor adjustments to the questionnaires.

##### **4.2.1 Study Limitation.**

The study was limited to Sondela mobile unit in Kafue rural district and its findings might not be generalized to the entire police population in Zambia.

##### **4.2.2 Ethical Consideration.**

Approval was sought from the University of Zambia Research Ethics Committee (UNZA REC), Police high command and after seeking a clearance from the graduate studies at UNZA. The nature and purpose of the study was explained to all participants, confidentiality and anonymity were assured, and participation was voluntary. Standard of care was guaranteed to all who consented or refused to participate. Only consenting participants were enrolled in the study. The researchers were obligated to provide all necessary clarification to the participants, and they were allowed to withdraw from the study at any point. A written informed consent for clients was signed before the questionnaire was administered. Respondents were not forced to sign the consent and those unwilling were left out. The researchers also gave their contact

addresses and telephone numbers in case of any quarries (See annex (i) for other details).

#### **4.2.3 Quality Control Checks**

Data was checked for accuracy, completeness, and consistent in responses. At the end of each day of data collection, the researcher checked all the questionnaires for any incomplete or missing information. A well completed questionnaire ensured consistent and quality of information collected. It also increased the statistical power of the study. Data were presented using tables.

#### **4.2.4 Plan for Data Processing and Analysis**

Before data entry, open ended questions were coded by assigning numbers to response categories, Data were computerized using Epi-data. Analysis was conducted using SPSS Version 17 computer Statistical package. The Chi-squared test was used to determine associations between qualitative variables. A multivariate logistic regression analyses was conducted to determine independent factors associated with consistent condom use. P-values  $\leq 0.05$  were considered significant.

#### **4.2.5 Dissemination and Utilisation of Results**

Dissemination of the research findings will mainly be through the reports that will be written for the Inspector General of police, the School of Medicine Medical library, the Department of Community Medicine and the Ministry of Home affairs as main policy makers. This study was funded by the USAID Zambia office, therefore, a copy of the final report will be sent to this organization. It is hoped that policy makers at different levels will able to utilize the research findings and recommendations to improve utilization of condoms among mobile police officers.



## CHAPTER FIVE

### 5.0 RESEARCH FINDINGS

#### 5.1 SAMPLE DESCRIPTION

A total of 240 participants were enrolled into the study. Table 2 shows the distributions of demographic characteristics and consistent condom use between sexes.

**TABLE 2: SEX STRATIFIED FREQUENCIES OF DEMOGRAPHIC VARIABLES AND CONSISTENT CONDOM USE**

Item description	Category	Female	Male	Both sexes
		Total=77	Total=163	N=240
		% (n)	% (n)	% (n)
<b>Age (years)</b>	18-24	37.7 (29)	46.0 (75)	43.3 (104)
	25-34	62.3 (48)	42.3 (69)	48.8 (117)
	35+	0.0 (0)	11.7 (19)	7.9 (19)
<b>Level of Education</b>	Secondary	68.8 (53)	68.1 (111)	68.1 (164)
	College and above	31.2 (24)	31.9 (52)	31.7 (76)
<b>Rank</b>	Subordinates	90.9 (70)	94.5 (154)	68.3 (164)
	Superior	9.1 (7)	5.5 (9)	31.7 (76)
<b>Marital</b>	Married	46.8 (36)	50.9 (83)	49.6 (119)
	Widowed	2.6 (2)	2.5 (4)	2.5 (6)
	Single	49.4 (38)	41.1 (67)	43.8 (105)
	Divorced/Separated	1.3 (1)	5.5 (9)	4.2 (10)
<b>Denomination</b>	Catholic	18.2 (14)	36.2 (59)	30.4 (73)

	CMML	1.2 (1)	0.6 (1)	0.8 (2)
	New apostolic	16.9 (13)	6.7 (11)	10.0 (24)
	Pentecostal	27.2 (21)	17.1 (28)	20.5 (49)
	Reformed church	0.0 (0)	1.8 (3)	1.3 (3)
	SDA	16.9 (13)	16.8 (27)	16.7 (40)
	UCZ	16.9 (13)	16.8 (27)	16.7 (40)
	Witness	2.6 (2)	4.3 (7)	3.8 (9)
<b>Consistent condom use</b>	Yes	36.4 (28)	30.7 (50)	32.5 (78)
	No	63.6 (49)	69.3 (113)	67.5 (162)

Most of the respondents were male 163 (67.9%), and in the age group 18 to 24 years 181 (75.4%). Table 1 also shows that 49.6 % (119) of the respondents were married. It also shows that most of the respondents had attained secondary education 68.3% (64). About a third of the respondents were Catholics 30.4% (73). Only 7% (16) of the respondents were superior officers. Overall 32.5% of the respondents consistently used a condom with no sex difference (36.4% of females and 30.9% of males used a condom consistently;  $p=0.380$ ).

### **5.2.1 SOCIO-DEMOGRAPHIC FACTORS ASSOCIATED WITH CONSISTENT CONDOM USE IN BIVARIATE ANALYSES**

Of the socio-demographic factors considered in Table 3, only education was significantly associated with consistent condom use ( $p<0.001$ ).

**TABLE 3: SOCIO-DEMOGRAPHIC FACTORS ASSOCIATED WITH CONSISTENT CONDOM USE**

<b>Factor</b>	<b>Category</b>	<b>Consistent condom use</b>	<b>p value</b>
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		<b>Yes</b> <b>Total=78</b>	<b>No</b> <b>Total=162</b>	
<b>Sex</b>	Female	35.9 (28)	30.2 (49)	0.380
	Male	64.1 (50)	69.8 (113)	
<b>Age (years)</b>	18-24	48.7 (38)	40.7 (66)	0.084
	25-34	48.7 (38)	48.8 (79)	
	35+	2.6 (2)	10.5 (17)	
<b>Education</b>	Secondary	52.6 (41)	75.9 (123)	<0.001
	College or higher	47.4 (37)	24.1 (39)	

## 5.2.2 CONDOM-RELATED FACTORS ASSOCIATED WITH CONSISTENT CONDOM USE IN BIVARIATE ANALYSES

The following factors were significantly associated with consistent condom use: received adequate care or information on condoms ( $p=0.008$ ); condoms promote promiscuity ( $p<0.001$ ); condoms break easily ( $p=0.016$ ); and condoms suppress sexual pleasure ( $p=0.012$ ) as shown in Table 4.

**TABLE 4: CONDOM-RELATED FACTORS ASSOCIATED WITH CONSISTENT CONDOM USE IN BIVARIATE ANALYSES**

<b>Factor</b>	<b>Category</b>	<b>Consistent condom use</b>		<b>p value</b>
		<b>Yes</b> <b>Total=78</b>	<b>No</b> <b>Total=162</b>	
<b>Condoms readily</b>	Yes	82.1 (64)	85.8 (139)	0.107

<b>available</b>	No	12.8 (10)	5.6 (9)	
	Sometimes	5.1 (4)	8.6 (14)	
<b>Received adequate care or information on condom</b>	Yes	32.1 (25)	24.1 (39)	0.008
	No	56.4 (44)	43.8 (71)	
	Substandard	7.7 (6)	24.1 (39)	
	Not sure	3.8 (3)	8.0 (13)	
<b>Condoms promote promiscuity</b>	Yes	94.9 (74)	63.0 (102)	<0.001
	No	5.1 (4)	27.2 (44)	
	Not sure	0 (0)	9.9 (16)	
<b>Condoms break easily</b>	Yes	12.8 (10)	17.3 (28)	0.016
	No	75.6 (59)	57.4 (93)	
	Not sure	11.5 (9)	25.3 (41)	
<b>Condoms suppress sexual pleasure</b>	Yes	15.4 (12)	13.6 (22)	0.012
	No	75.6 (59)	61.1 (99)	
	Not sure	9.0 (7)	25.3 (41)	
<b>Feels stigmatized to use condom</b>	Yes	56.4 (44)	56.2 (91)	0.507
	No	38.5 (30)	34.6 (56)	
	Not sure	5.1 (4)	9.3 (15)	

### 5.3 FACTORS INDEPENDENTLY ASSOCIATED WITH CONSISTENT CONDOM

#### USE

Table 5 shows factors that were independently associated with consistent condom use. Compared to respondents who were of age 35 years or older, respondents who were of age 18-24 years and those who were of age 25-34 years were 2.15 and 1.91 times, respectively, more likely to consistently use a condom. Respondents who had secondary level of education were 38% less

likely to consistently use a condom compared to respondents who had attained tertiary level of education. Compare to respondents who indicated that they were not sure whether they received adequate care or information on condoms, respondents who reported that they received adequate care or information on condoms were 2.18 times more likely to consistently use a condom; and respondents who reported that they received inadequate care or information on condoms were 57% less likely to consistently use a condom. Finally, respondents who reported that condoms promote promiscuity were 90% less likely to consistently use a condom compared to the respondents who reported otherwise.

**TABLE 5: FACTORS INDEPENDENTLY ASSOCIATED WITH CONSISTENT CONDOM USE**

<b>Factor</b>	<b>Category</b>	<b>OR</b>	<b>95% Confidence Interval</b>
<b>Age (years)</b>	18-24	2.15	1.16, 4.00
	25-34	1.91	1.03, 3.52
	35+	1	
<b>Education level</b>	Secondary	0.62	0.45, 0.85
	College and higher	1	
<b>Received adequate care or information on condom</b>	Yes	2.18	1.18, 4.03
	No	1.48	0.86, 2.53
	Substandard	0.43	0.20, 0.94
	Not sure	1	
<b>Condom promote promiscuity</b>	Yes	0.10	0.03, 0.29
	No/not sure	1	



## CHAPTER SIX

### 6.0 DISCUSSION OF RESEARCH FINDINGS

This study aimed at finding out the barriers to condom utilization among the mobile police officers in Sondela paramilitary camp in Kafue rural district of Lusaka province in Zambia. This chapter, therefore, presents a discussion of the main findings from the study and identified number of barriers to condom utilization among the mobile police officers. This discussion has been structured in line with objectives of the study.

#### **Bivariate analysis**

We found that the majority (69.9%) of the respondents were male police officers. This finding correlates with that of ZANARA (2005) which shows that there are more males than females in the system. The majority of the respondents (68.3%) had attained secondary education and many of the respondents were subordinate officers. This also compares well with that of the Central Statistical Office et al (2009) which shows that more men have attained higher education than females in Zambia.

Furthermore, the study revealed that consistent use of condoms was low at 32.5%. This finding is in tandem with the declaration in the Prevention convention resolution (2010) that inconsistent use of condoms is one of the key drivers which is propelling HIV/AIDS pandemic world wide. Kanya et al (1993) conducted a study on barriers to condom use in an urban village of Kampala-Uganda and found the prevalence of consistent condom use in Uganda to be one of the lowest in Africa (about 10%). This finding compares well with the result of this study that shows the prevalence of consistent condom use among mobile police officers to be low. Similarly, Kassie et al (2008) reported that consistent condom use with non regular partners among police officers in Ethiopia was 63%. These findings suggest that police officers are at risk of contracting sexually transmitted infections, including HIV.

Most of the comparable studies show slightly higher consistent condom utilization than revealed by the current study. It could be attributed to the fact that the mobile police population is operational (mobile) and has limited sources and supplies of condoms, while static populations in the other studies may have been well catered for in terms of condom provision. Being away from home on duty for a minimum of six months may have lead officers to have sex with partners who were not their spouses. The low consistent condom utilization findings among the mobile police officers might probably be even lower considering the fact that the findings were based on the respondents' trust that answers given were true. Nevertheless, these findings have given a good insight about the utilization of consistent condom use among the mobile police officers.

### **Multivariate analysis**

After the multivariate analysis was conducted only age, level of education, care and information giving by service providers and that condoms promote promiscuity were significantly independently associated with consistent condom use. Compared to respondents who were of age 35 years or older, respondents who were of age 18-24 years and those who were of age 25-34 years were 2.15 and 1.91 times, respectively, more likely to consistently use a condom. It is pleasing to note that the age group 18-25 years consistently used condoms more than any other age group because this is a very sexually active age group (Central Statistical Office et al, 2009).

The finding that respondents who had secondary level of education were 38% less likely to consistently use a condom compared to respondents who had attained tertiary level of education compares well with that of Lagarde et al (2000) who revealed that the educational level of a male partner is a major determinant of condom use within non-spousal partnerships in 4 cities of sub-Saharan Africa. Education of the male partner appeared to be more important than education of the female partner probably reflecting that it is mostly the male partner who decides on the use of a condom. It was



concluded that these findings call for special efforts to reach men and women with low education attainment.

Compared to respondents who indicated that they were not sure whether they received adequate care or information on condoms, those who received adequate care or information on condoms were more likely to consistently use a condom. A service provider is expected to have adequate information to provide the service to the clients. In reference to this point, mobile police officers reported low consistent use of condoms partly because of lack of knowledge on condoms. One would therefore, suggest that the Police command re-trains the service providers so that they can be equipped with adequate knowledge on condoms so that they impart the same knowledge on the mobile police officers.

Finally, respondents who reported that condoms promote promiscuity were 90% less likely to consistently use a condom compared to the respondents who reported otherwise. This finding shows that this is a serious problem among mobile police officers. Hence, the Police command should deal with this problem through intense sensitization with targeted messages that dispel myths about HIV/AIDS.

## **CHAPTER SEVEN**

### **7.0 CONCLUSION AND RECOMENDATIONS**

#### **7.1 CONCLUSION**

Overall 32.5% of the respondents consistently used a condom with no sex difference (36.4% of females and 30.9% of males consistently used a condom). Most of the respondents were male 163 (67.9%) and in the age group 18 to 24 years 181 (75.4 %). In conclusion, consistent use of condoms among mobile police officers was low, and lack of knowledge on condoms was associated with its non consistent use.

#### **7.2 RECOMENDATIONS**

- Police high command should conduct HIV/AIDS sensitization among mobile officers targeting mainly those below the age of 35 years; and the message should include facts on myths regarding condom use.
- Police high command should consider providing in-service courses to mobile police officers in order to increase the level of education among the mobile police officers in order to address the consistent use of a condom compared to respondents who had attained tertiary level of education.
- Police high command should train service providers on condom use for effective service delivery considering that respondents who reported that they received adequate care or information on condoms were 2.18 times more likely to consistently use a condom
- Police high command should consider introducing the condom wallet intervention where a police officer on operational duty is provided with a condom wallet filled with condoms; this intervention has worked well for Ghana (Asiamah, 2004).

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**9.0. ANNEX I: QUESTIONNAIRE**



**THE UNIVERSITY OF ZAMBIA**

**SCHOOL OF MEDICINE**

**DEPARTMENT OF COMMUNITY MEDICINE**

**(STRICTLY CONFIDENTIAL)**

**TITLE: Barriers to condom utilization among mobile police officers in paramilitary  
camping sites: A case of Sondela camp in Kafue rural district.**

Questionnaire no [.....]

Code number [.....]

Section code [.....]

Date [.....]

Name of interviewer [.....]

## INSTRUCTIONS TO RESEARCH ASSISTANTS

1. Always greet the respondent and introduce yourself.
2. Explain the purpose of the study and ask for permission to interview the participant.
3. Make the respondent sign the consent form before you start the interview.
4. Assure the respondent of maximum confidentiality.
5. Participants should not be forced to be interviewed.
6. Where the respondent is unwilling to take part in the study, politely thank him/her and then leave.
7. Do not write the name of the respondent on the questionnaire. Write the appropriate responses in the spaces or boxes provided and then thank the respondent at the end

## RESPONDENTS

**Note:** We appreciate you for your time taken to answer these few questions. Kindly try to be as

honest as possible with the responses; ***please do not leave any blanks.***

## SECTION A

### Demographic characteristics

**For official use only**

**(Fill in all the blanks and tick where applicable✓)**

Q1. Sex

a) Female

b) Male

Q2. How old were you at your last birthday?

a) 0-14

b) 15-17

c) 18-24

d) 25-34

e) 35 and above

Q3. Marital status

a) Married

b) Widowed

c) Single

d) Divorced

e) Separated

Q4. What is your denomination?

a) Catholic

b) Protestant

c) Moslem

d) Any other, specify

Q5. Occupational level

a) Subordinate & other ranks

b) Superior

Q6. Level of education

- a) None
- b) Primary
- c) Secondary
- d) College and above

**SECTION B**

**Condom utilization (Fill in all the blanks and tick where applicable✓)**

Q7. At your last sexual act did you do it with your regular or non-regular partner?

- a) Regular
- b) None regular
- c) Not sure

Q8. The last time you had a sexual act with your partner; did this partner get drunk of alcohol?

- a) Yes
- b) No
- c) Don't Know

Q9. Did you use a condom the last time you had sexual intercourse in the last 12 months?

- a) Never used them
- b) Used only sometimes
- c) Always used them
- d) Not sure

Q10. Did you use a condom consistently for the last 12 months during sexual intercourse?

a) Never used them

b) Used only sometimes

c) Always used them

d) Not Sure

Q11. If you did not use condoms consistently with your partner(s) last 12 months,

what could be the reason(s)? **Circle all that apply.**

a) I trusted my partner(s)

b) I do not like condoms

c) Was under the influence of alcohol

d) We are planning to marry

e) Condoms were not available

f) Partner did not want

Q12. Are you willing to use a condom in the next sexual encounter?

a) Yes

b) No

c) Not sure

## SECTION C

### Service delivery of condoms (Fill in all the blanks and Tick where applicable✓)

Q13. Is your home in a walking distance from the clinic?

a) Yes

b) No

c) Not sure

Q14. If your answer to Q13 is No, what mode of transport do you use?

a) Bicycle

b) Bus/car

c) Walking

d) Ambulance

Q15. Do you think that adequate care and information about condom use was given to you at the centre where you accessed them?

a) Yes

b) No

c) Substandard

d) Not sure

Q16. In your opinion whom do you think should conduct the condom distribution?

a) Doctors and Nurses

b) Any health personnel

c) Health and social workers

d) Any one

e) Other, specify

## SECTION D

**Condom availability (Fill in all the blanks and tick where applicable√)**

Q17. Are condoms readily available in your area?

a) Yes

b) No

c) Sometimes

Q18. What places do you know of where a person can get condoms?

a) Government hospital

b) Mobile clinic

c) Police HIV/AIDS coordinators office

d) Local shop

e) Other specify [.....]

Q19. When condoms are available, are they free?

a) Yes

b) No

c) Don't Know

**SECTION E**

**Knowledge about condom use (Fill in all the blanks and tick where applicable√)**

Q20. Have you ever seen a condom?

a) Yes

b) No

Q21. In your own way, define a condom [.....].

Q22. In your opinion, why should one use

condoms in sexual encounters? [.....]

Q23. What is your source of information on condoms?

a) Friends

b) Media and press

c) Health personnel

d) Personal experience

## SECTION F

### Social and cultural beliefs (Fill in all the blanks and tick where applicable<sup>√</sup>)

The following are statements about condoms, please state whether you agree or disagree by indicating yes /no on each statement.

Q24 Condoms promote promiscuity.

a) Yes

b) No

c) Not sure

Q25. Condoms suppress sexual pleasure.

a) Yes

b) No

c) Not sure



Q26. Condoms break easily.

a) Yes

b) No

c) Not sure

Q27. Condom use is for non believers (wrong doers).

a) Yes

b) No

c) Not sure

Q28. The last time you had sex **with** a condom, did you enjoy the act?

a) Yes

b) No

c) Not sure

Q29. Do you believe condom use can help prevent you from contracting HIV& AIDS.

a) Yes

b) No

c) Not sure

Q30. Condoms contain HIV.

a) Yes

b) No

c) Not sure

## SECTION G

### Stigma towards condom use (Fill in all the blanks and tick where applicable<sup>v</sup>)

Q31. Do you feel stigmatized to access condoms for sexual use?

a) Yes

b) No

c) Not sure

Q32. If your answer to the preceding question is yes,

give reasons [.....]

Q34. Everyone who uses condoms has HIV&AIDS.

a) Yes

b) No

c) Not sure

Q35. Is it acceptable for females to buy condoms?

a) Yes

b) No

c) Not sure

....THE END...

**THANK YOU FOR YOUR COOPERATION**

## **ANNEX (II): INFORMATION SHEET FOR THE RESPONDENTS**

### **Project title:**

**Barriers to condom utilization among mobile police officers in paramilitary camping sites:**

**A case of Sondela camp in Kafue rural district.**

**Name of the Principal Investigator:** Fred Mulenga

**Institution of the principal Investigator:** University of Zambia, School of Medicine,  
Community Medicine.

**Affiliation/Status of the Principal Investigator:** Student of Masters in Public Health.

### **Purpose of the study**

We invite you to participate in a study of barriers to condom utilization among mobile police officers in Sondela paramilitary camp site of Kafue rural district. The main objective of this study is to come up with factors that are associated with condom utilisation among mobile Police in their sexual encounters. Recommendations will also be given to policy makers.

### **Procedures**

Specifically, we are going to give you a questionnaire with few questions about you condom utilisation, you will take less than 15. The information that you will provide during the study will be kept confidential. Only the interviewer and researcher will have

access to the questionnaires and results. The information will be destroyed after the study.

### **Benefits**

Your participation to this study is voluntary and you have the right to refuse to participate or to answer to any question that you feel comfortable with. If you change your mind, you have the right to withdraw at any time.

### **Participants Reimbursement**

Participants will not be compensated for their time and effort in this study. However, a drink and snack will be given to the participants who consent to participate in the interview.

### **Confidentialities**

All information collected throughout this study will be kept confidential. However, the details resulting from this study will be used to complete this report and be disseminated to Police high Command, USAID/ZAMBIA office and University of Zambia.

### **Reliability**

Participants may be uncomfortable answering some questions on condom utilization. Every effort will be made to stress confidentiality among participants and guarantee that results from this study will be solely by the research team.

### **Study Discontinuation**

The study may be discontinued at any time by Zambia police Service or regulatory authorities.

**CONTACT PERSON:**

Please feel free to contact the persons below at anytime if you have any questions about participating in this study:

**For questions about your rights as a research subject, contact:****The Chairperson**

Chairperson of the Research Ethics Committee,  
University of Zambia/University Teaching Hospital,  
Nationalist Road, Lusaka, Zambia.

UNZA Research Ethics Committee,

PO BOX 50110,

Lusaka, Zambia.

Telephone: 260-021-1-256067

**E-mail:** [unzarec@zamnet.zm](mailto:unzarec@zamnet.zm)

**For questions about this study or a research-related injury, contact:**

Prof K, S Baboo

UNZA, School of Medicine,

Dept. of Community Medicine

P.O. Box 50110,

Lusaka, Zambia.

Fax: 260-1-256181

**The Principal investigator,**

Mulenga Fred- Cert Occ Health, Bsc(ed), Post grad-Dip HR/LAW

Master's Student in Public Health

C/O UNZA, School of medicine,

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PO Box 50110

Lusaka, Zambia.

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**E-mail: [Mpundupalo@yahoo.com](mailto:Mpundupalo@yahoo.com)**

**ANNEX III: INFORMED CONSENT FORM**

**CONSENT TO PARTICIPATE IN THE RESEARCH PROJECT**

The purpose of this study has been explained to me including its risks, benefits and confidentiality. I understand the purpose of the study. I further understand that;

If I agree to take part in this study, I can withdraw at any time without having to give an explanation and that taking part in this study is purely voluntary.

I \_\_\_\_\_ (NAMES)

Agree to take part in both the interview (or in the study).

Signed/Thumbprint \_\_\_\_\_ Date \_\_\_\_\_ (Participant)

Signed \_\_\_\_\_ Date \_\_\_\_\_ (Witness)

Signed \_\_\_\_\_ Date \_\_\_\_\_ (researcher)





**Attachment research ethics approval**

**Attachment police command approval**