

**A STUDY TO DETERMINE KNOWLEDGE ON HIV/AIDS AND  
SEXUAL BEHAVIOUR OF JUNIOR SECONDARY SCHOOL  
YOUTHS IN KABWE DISTRICT**

**BY**

**EVA MPHEZA MUSONDA WONANI**

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DISTRICT**

**By**

**Eva Mpheza Musonda Wonani.**

**Zambia Registered Nurse 1988 ( Kitwe)**

**Trauma Care Nursing, 1997. (The Crompton Durban RSA )**

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## **ABBREVIATIONS**

AIDS –Acquired Immune Deficiency Syndrome

ARHE –Adolescent Reproductive Health Education

CBOH-Central Board of Health

CDC –Curriculum Development Centre

CHEP –Copperbelt Health Education Project

CIDA –Canada International Development Agency

CSO –Central Statistic Office

DHS –Demographic Health Survey

DHIO –District Health Information Office

HIV –Human Immune Virus

IEC –Information Education and Communication

KAP –Knowledge Attitude and Practice

MOE –Ministry of Education

MOH –Ministry of Health

NASCP –National AIDS/STD Control Program

NGO –Non-Governmental Organisation

NPA-National Population

PPAZ –Planned Parenthood Association of Zambia

PRB –Population Review Bureau

ZSBS –Zambia Sexual Behavioural Survey

SFFH –Society For Family Health

STD –Sexually Transmitted Disease

STI –Sexually Transmitted Infection

UNICEF –United Nations International Children’s Emergency Fund

UNAIDS –United Nations Programmes on HIV/AIDS

UNFPA –United Nations Population Fund

USAID –United States Agency for International Development

WHO –World Health Organisation

YAZ –Youth Alive in Zambia

YFC –Youth Friendly Corner

ZDHS –Zambia Demographic Health Survey.

## DECLARATION

I hereby declare that the work presented in this study for the Degree of Bachelor of Science in Nursing has not been presented either wholly or in part for any other degree and is not being currently submitted for any other degree.

SIGNED.....*PL for E. Wonani*.....DATE.....*26/07/02*.....

## CANDIDATE

APPROVED.....*PL Wamba*.....DATE.....*20.5.02*.....

## SUPERVISING LECTURER

## STATEMENT

I hereby certify that this study is entirely the outcome of my independent investigations. The various sources to which I am greatly indebted are gratefully and clearly acknowledged in the text and in the references.

*for*  
SIGNED.....*E. Wonani*.....

DATE.....*26<sup>th</sup> July 2002*.....

**CANDIDATE**



## **DEDICATION**

This study is dedicated to Nompilo and Cedrico, my favourite siblings, it is a matter of time; my late husband Drico, forever a major part of us; my late dad, C.S. always at heart and mum who it was always a heartache to leave at a time she needed me most.

## **ABSTRACT**

*The main aim of this study was to determine the knowledge on HIV/AIDS and sexual behaviours of Junior Secondary School Youths in Kabwe District. The problem was identified as a result of the increasing cases of HIV positive school youths, the high cases of STIs and incomplete abortions attended to in the District health centres.*

*Literature reviewed looked at the knowledge of the school youths on HIV/AIDS and their sexual behaviour, and the factors that may influence the two variables. Literature revealed that knowledge though vital, alone was not adequate in promoting positive sexual behaviour, factors like cultures socio-economic peer influence, and media had roles to play in influencing sexual behaviours of the school youths.*

*The sample comprised 50 youths, half from grade eight and half from grade nine who were systematically sampled from a randomly selected school.*

*To collect data, self administered questionnaires comprising open ended and closed ended questions were administered to the respondents. The study was of a cross sectional descriptive nature.*

*According to findings, 58% of the respondents had medium to high levels of knowledge on HIV/AIDS and the difference in the knowledge levels between*

*the two grades was minimal, with 60% grade nine and 56% grade eight having the same levels of knowledge.*

*The majority of respondents were not dating, (56%) while 54% had already had sexual intercourse, 10% had indulged in sex out of curiosity while 44% as a result of peer pressure. Results also showed that 28% always used condoms during sex, while 16% never.*

*Majority of the respondents, 46% were abstaining, while 34% were indulging in risky sexual behaviour, more females (47.1%) than males (27.3%) were indulging in risky sexual patterns.*

*However, results showed that 65.2% of the respondents with medium to high levels of knowledge on HIV/AIDS were also abstaining from sexual intercourse.*

*Recommendations made included the need for close collaboration between MOE and MOH to fight the scourge, revision of school curriculum and improvement of IEC approaches to the school youths, making the services aimed at teaching the youths on HIV/AIDS matters user-friendly, regular monitoring and revision of HIV/AIDS programmes, involvement of youths in planning and implementing these programmes, improving teaching and counselling skills.*

## **CHAPTER ONE**

### **1.0 INTRODUCTION**

#### **1.1 BACKGROUND INFORMATION**

Zambia is a landlocked country with an area of 752,612 square kilometres situated within the sub-Saharan African region. It shares borders with Zaire and Tanzania in the north; Malawi and Mozambique in the east; Zimbabwe and Botswana in the south; Namibia in the southwest; and Angola in the west. Administratively, it is divided into nine provinces and 73 districts Zambia Demographic Health Survey (ZDHS, 1996).

The main economic activity of Zambia after independence focused on copper mining. This industry flourished, till the mid 1970s. In the late 1970s, Zambia like all emerging economies was affected by the world economic recession. Copper mining reached its peak in 1976, then it started fluctuating till it finally fell really low by 1996, because of factors such as high cost of production due to the fall in grade ore, lack of investment in advanced technology; and inability to cope with the over valued exchange rate. The mines started to close operations with a lot of them getting privatised. Hence, the government embarked on divergence of the economic activities, which included focusing on agriculture.

Although emphasis on agriculture was made in the Second Republic, the agricultural sector remained under developed. Agriculture by 1995 was contributing 15% of Zambia's Gross Domestic Production and employing 75% of the labour force. It was

expected to provide food and industrial raw materials to rural and urban consumers and producers. 90% of this farming population consists of small-scale farmers, 10% medium-scale and 3% large-scale farmers. The main crop is maize, which takes up 75% of the cultivated land. In 1995, the government launched the Agricultural Sector Investment Program. (ASIP) to boost agricultural production and streamline marketing of agricultural inputs and produce. 42 million hectares of land are suitable for agriculture but only 2.5 million is utilised for this purpose. Only 50,000 hectares of this farming land is irrigated, the rest depends on rainfall, which has been erratic for years resulting into low production (ZDHS 1996).

Politically, from 1964, Zambia gained independence from her British colonial masters adopting a multiparty system of government. In the course of the 27 years of the first republic, the governance system reverted to one party state, which was converted to multiparty system of governance with the Movement of Multiparty Democracy taking over government in 1991. This government adopted a Structural Adjustment Programme. (SAP) which included liberalised market economy and privatisation exercises of industries. It was hoped that the people of Zambia would benefit economically as the government privatised industries and parastatals. The initiation of the SAP required the introduction of cost-sharing measures in the social services such as schools and health care system. Thus the level of living for the populace, dwindled as a lot of people were rendered jobless and cost sharing strained their budgets. People suffered a lot for deprivations. This forced them to prioritise their home expenditure. Unfortunately most family priorities were not focussed on education. They focused on acquisition of food and its security.

This meant that some school youths had to drop out of school to seek alternative sources of livelihood that entailed among other things the exchange of sex for money, living on the streets to earn an income and indulging in criminal activities. Some of the youths still in school have had to exchange sex for school fees. This coupled with other practices like initiation ceremonies, where in some tribes, for example the Ngonis, the young girl is introduced to sexual intercourse by an elderly reputable man in society selected by her parents, or the use of unsterilised instruments for circumcision, meant unquestionable exposure to HIV/AIDS infection.

Human Immunodeficiency Virus (HIV) is the virus that causes Acquired Immune Deficiency Syndrome (AIDS). It destroys the body's ability to fight infection. The illness manifests through presentation of opportunistic infections such as herpes zooster, oral and pharyngeal candidiasis, tuberculosis, chronic gastro enteritis, cryptococcal meningitis, pneumonia, idiopathic drug reactions and extensive neuropathy. A person may be infected for many years without presenting any symptoms, but pass on the infection to others (Central Board Of Health, 1997).

HIV infection is transmitted mainly through sexual contact, intravenously through blood transfusion with unscreened blood, transplacental to the foetus in utero, to an infant through breast milk and in the use of unsterilised needles for injections. The infection is very fatal, no cure has been found so far but several drugs have proved effective in treating opportunistic infections and in improving the immune status of patients (CBOH, (1997).

HIV/AIDS was first recognised as a public health problem in Zambia in 1984, and has since then claimed the lives of many people of all ages, putting a lot of strain on the economy and health services of the country. The HIV epidemic has major impacts on the socio-economic development and public health development in that it threatens to arrest the hard-won gains in sectors like health, education, agriculture and human resource development (Luo, 1999).

Nearly half of all HIV infections world wide occur in people under 25 years; over 33 million people world wide have HIV, at least a third of these are aged between 0 and 24 years, nearly 3 million new infections occur annually among the youths including 1.7 in Africa and 700,000 in Asia and the Pacific (UNAIDS, 2000). This situation is very serious because these youths are supposed to be the future leaders but with ill health and shortened lifespan, the country is deprived of the much-needed human resource. The frequent episodes of ill-health mean less hours in schools and training for the school going, resulting in less trained manpower and low production in future and above all, over utilisation of health services exerting a strain on the already strained health services, especially in third world countries.

Globally, more than half of the new HIV cases occur among youths aged between 15 and 24 years. In Africa, an estimated 1.7 million youths between 10 and 24 years are infected annually. In Zambia, prevalence rates for females range from 16.9 to 18.7%, while for males it ranges between 7.1 to 9.3% (UNAIDS, 2000). What this entails is that while the government overstretches its budget in order to meet the health needs of these youths, there will be no productive age group to develop the country's economy in future.

In Zambia, emphasis on prevention of HIV/AIDS is focussed on abstinence from sex before marriage, faithfulness to one sexual partner, and the encouragement of the use of condoms. The Ministry of Health (MOH) in collaboration with Ministry of Education (MOE) have spearheaded various campaigns to contain HIV spread by disseminating information of HIV through the school curriculum. The dissemination of information through the school curriculum has targeted mainly the youths of Zambia.

These youths are of interest to the nation because they are future leaders and are also a vulnerable age group. It is at this stage that emotional and sexual development occurs. There is a tendency to explore and experiment to meet sexual gratification. Sometimes the use of alcohol and drugs may expose them to HIV/AIDS by engaging in unprotected sex.

MOE has incorporated HIV topics in the grade seven science, which covers the causative organism, the mode of spread, and signs and symptoms management of patients, preventive measures and dietary issues. MOE has also provided Macmillan reading books in primary schools for grade seven and secondary school pupils up to grade nine, these are in the form of stories with helpful information about HIV/AIDS at the end of the story. Clubs like anti-AIDS clubs have been set up in schools. Young teens, Youth alive, and Asserting Sexual Attitudes among Youths Internationally, on the Copperbelt, have been formed to utilise peers to educate their colleagues in preventive measures such as how to protect themselves from infection, and how to care for one who is ill. Youth friendly corners, (YFC) to counsel the youth



on various issues including HIV/AIDS, have been set up in most of the health centres in Zambia.

NGOs like Planned Parenthood Association of Zambia (PPAZ), Society For Family Health (SFFH), and governmental organisations like CBOH, have through television, radio and news bulletins or magazines produced advertisements, phone-in and educational programmes, and even written articles to help contain the spread of HIV/AIDS.

The media and pressure from peers and older men/women may expose young girls and boys to become sexually active. Older men/women may bribe young boys/girls gifts and money in exchange for sex. School-going youths may be forced into sexual relationships with their teachers or older men and women in order to finance their education or for better grades from their teachers (UNAIDS, 1999). In most cases where there are age differences between the young girl/boy and the lover, it is difficult for the young one where requested for sex to negotiate for safer sex or the use of a condom for protection against HIV/AIDS infection. This has led to youths indulging in unprotected sex and has contributed greatly to an increase in HIV incidence. In Kenya, a study revealed that 22% of the females in the sample aged between 15 and 19, tested HIV positive as compared to males (4%) of the same age group, but by the age 30, male prevalence levels exceeded those of females, (National AIDS/STD Control Programme, 1998). This shows a pattern of behaviour that female youths are usually having relationships with older men, where negotiation for safe sex may be compromised.

## 1.2 STATEMENT OF THE PROBLEM

Despite all the efforts by government to educate the youth on HIV/AIDS, the knowledge base of these youths is expected to be high, and with the awareness of how serious this illness is, it would be expected that sexual behaviour of these youths would be modified in such a way that they protect themselves from getting infected. Unfortunately, this is not the case, the incidence of HIV positives cases have continued to rise among the school youths in Kabwe district.

In 1998 in Kabwe district, the number of HIV positive cases among the school youths aged between 14 and 19 were 7 and by the year 2000, it had risen to 61. This meant that in the next ten to twelve years these cases will have died from AIDS with the progression of the illness, depriving the town of the needed productive age group.

Besides the increasing numbers of HIV infections, the youths are practising unprotected sex as evidenced by the number of unwanted pregnancies which result into incomplete abortions, i.e. 211 in 2000; and STIs, which were 61 in the same year (DHIO, 2001). This can be assumed to be a portion of the whole picture as a lot of cases go unreported, i.e. those that keep the pregnancy to full term and those that successfully carry out abortions. Others come with complications of sepsis or secondary infertility or may end up dying. In many settings, youths with unplanned pregnancies are more likely than women in their twenties or thirties to seek out an abortion. Typical reasons for this include mistimed pregnancy, fear of being expelled from school, anxiety about motherhood, uncertainty about partner and financial constraints. Between 1980 and 1990, a number of African countries found 38% to 68% females seeking medical care for abortion related complications. Although

abortion is legal, in most parts of Africa, its complications are a major cause of death in Sub-Saharan Africa, and 99% of school youths do it illegally. Africa has the highest abortion death rates in the world, an estimated 680 deaths per 100,000 abortions while Asia has 283 per 100,000 and the developed world has 1 per 100,000 abortions (Population Review Bureau, 2001).

STIs have been said to facilitate the spread of HIV/AIDS. In Kabwe district, the number of STI infection treated was 61 for the year 2000. The fact that school youths are being treated for STIs, is an indication that they are actually indulging in risky sexual behaviour.

Over 330 million cases of STIs other than HIV occur every year. While females suffer the most serious complications of STIs i.e. infertility and cervical cancer, infection in males is an important link in the chain of HIV transmission. A person with an untreated STI, maybe 6 to 10 times more likely to pass on or acquire HIV during sex. The risk increases by 10 to 100 fold in the presence of genital ulcers common in syphilis, chancroid or herpes. Some STIs can be treated with antibiotics, many males go untreated, delay treatment or use remedies when infected. In some settings, such infections are a taboo, they are seen as meant for the low class and dirty. In other places it is seen as a badge of honour and proof of sexual conquest (UNAIDS, 2000). The above types of behaviour expose the youths to the risks of contracting HIV/AIDS.

It was with this background that the researcher was left to wonder what the youths in Kabwe know about HIV/AIDS and how this knowledge relates to their sexual behaviour.

### **1.3.JUSTIFICATION OF STUDY**

No studies have been conducted to assess the knowledge of youths on HIV/AIDS and sexual behaviours among them in Kabwe district. Therefore, the researcher was motivated to carry out a study to determine knowledge on HIV/AIDS and the sexual behaviour of the school going youths. It is hoped that this study will identify areas in the knowledge gap on HIV that need emphasis or adjustment and to make recommendations to appropriate authorities to improve the knowledge of the youths so as to bring about desired behavioural changes to prevent the spread of HIV/AIDS. This study will also be an evaluation of the YFC's, anti-AIDS clubs', and school curriculum's effectiveness in the improvement of school youths' knowledge on HIV/AIDS and in turn, sexual behaviours.

### **1.4. FACTORS INFLUENCING KNOWLEDGE ON HIV/AIDS AND SEXUAL BEHAVIOURS OF SCHOOL YOUTHS.**

A lot of factors can influence youths' knowledge on HIV/AIDS sexual behaviour.

#### **CULTURAL FACTORS**

Traditional beliefs and other religious beliefs can affect the perception of youths regarding HIV/AIDS. For example a person brought up in a polygamous home may have knowledge on HIV but may find nothing wrong with polygamy or having more than one sexual partner, and may not even see the dangers involved in its practice. In

a similar manner, one with strong Christian values may find abstinence from premarital sex the norm. Sexual cleansing is another traditional belief that may quicken the spread of HIV/AIDS, especially in cases where a youth, by tradition is requested to sexually cleanse the widow or widower.

## **SOCIO-ECONOMIC FACTORS**

Joblessness of guardians and parents could put the youths under undue pressure to meet basic needs and school requirements. The youths may indulge in sexual relationships with older or married partners in exchange for money or school favours, this pattern exposes them to risks of contracting HIV. Sometimes, poverty in the home may deprive the youths access to media, books and other vital information on HIV/AIDS, resulting in a low level of knowledge. Meanwhile, those from well-off homes would have access vital information on the website, adequate reading materials on the subject or even access to well informed organisations and people hence, having a high level of knowledge.

Peer pressure, may either negatively or positively reinforce the knowledge youths have on HIV. Whatever knowledge the youth have on HIV/AIDS, is easily passed on to fellow peers. Misconceptions are disseminated so fast that a uniform behavioural pattern can be easily observed, youths who have wrong information would easily pass it on to their peers. This would lead to poor level of knowledge. Youths discuss sexual relations with their peers. This would arouse interest in the others to try. On the other had this pressure can also be channelled to disseminate information to promote positive sexual behaviour.

Recreation facilities are of vital importance to the youths as they keep them busy and away from mischief due to idleness. It is a known fact that the saying, "An idle mind is the Devil's workshop". The youths usually indulge in a lot of harmful activities when they have too much time on their hands with little or nothing to do. Involvement in substance/drug abuse, which is rampant in the country may expose them to behaviours that predispose them to HIV infection.

### **HEALTH SERVICE FACTORS**

Availability of counselling services, as can be seen in Zambian health centres where youth-friendly corners have been set up to address the sexual health needs of the youth, are essential in improving knowledge of the youths on HIV/AIDS and effecting positive sexual behaviour. These are vital in educating and communicating with youths on sexuality. They must be convenient and readily available for the use of the youths.

Staff attitudes can affect the youths' utilisation of these services. The youths need one who can maintain confidentiality, and listen to them and not condemn them. The issue of accessibility comes into play because help must be readily available and easy to utilise. Such services must offer privacy and facilitate development or rapport. Whether these institutions are active or effective is another issue. Youths who were attended to by staff with good attitude are more likely to come to the clinic often and encourage their colleagues to do the same. This leads to high levels of knowledge.

## **SOURCE OF INFORMATION**

Information obtained from health personnel is believed to be reliable and accurate, unlike some information from peers. The youths need to get into a system where they seek information on health issues from reliable sources who are health personnel, then, will they have high levels of knowledge on HIV/AIDS.

The media, such as Television, radio and bulletins written and produced by professionals are also a reliable source of information and therefore do improve the knowledge of youths and help modify their behaviours. On the other hand, the media in its entertainment form conveys the message to youths that sexual relationships can be casual and risk taking. This, results into poor levels of knowledge and risky sexual behaviour.

Teachers and parents need to have good knowledge for them to share it with the youths. When they lack information on HIV/AIDS, the youths in turn get misinformed because the immediate adults surrounding them lack information. Information must be given at a time when the youths are not yet exposed to sexual intercourse, initiation of sexual intercourse varies between individuals, making it so difficult for the policy makers ascertain at what age to teach HIV/AIDS related-topics. Television is not always a good source of information because some programmes are not appropriate for the youths.

Anti-AIDS clubs in schools were initiated to provide accurate and reliable information on HIV/AIDS to youths so as to promote positive sexual behaviour. Members of these clubs are expected to have high levels of knowledge and not to

indulge in risky sexual behaviour, such clubs are the sort of support systems that are providing IEC on HIV/AIDS in Zambia. These clubs are run by the youths themselves but facilitated by teachers. Youths who are counselled at youth friendly corners and/or are members of school clubs, where youths are taught HIV/AIDS are more likely to be more knowledgeable and have positive sexual behaviour than those who do not attend.

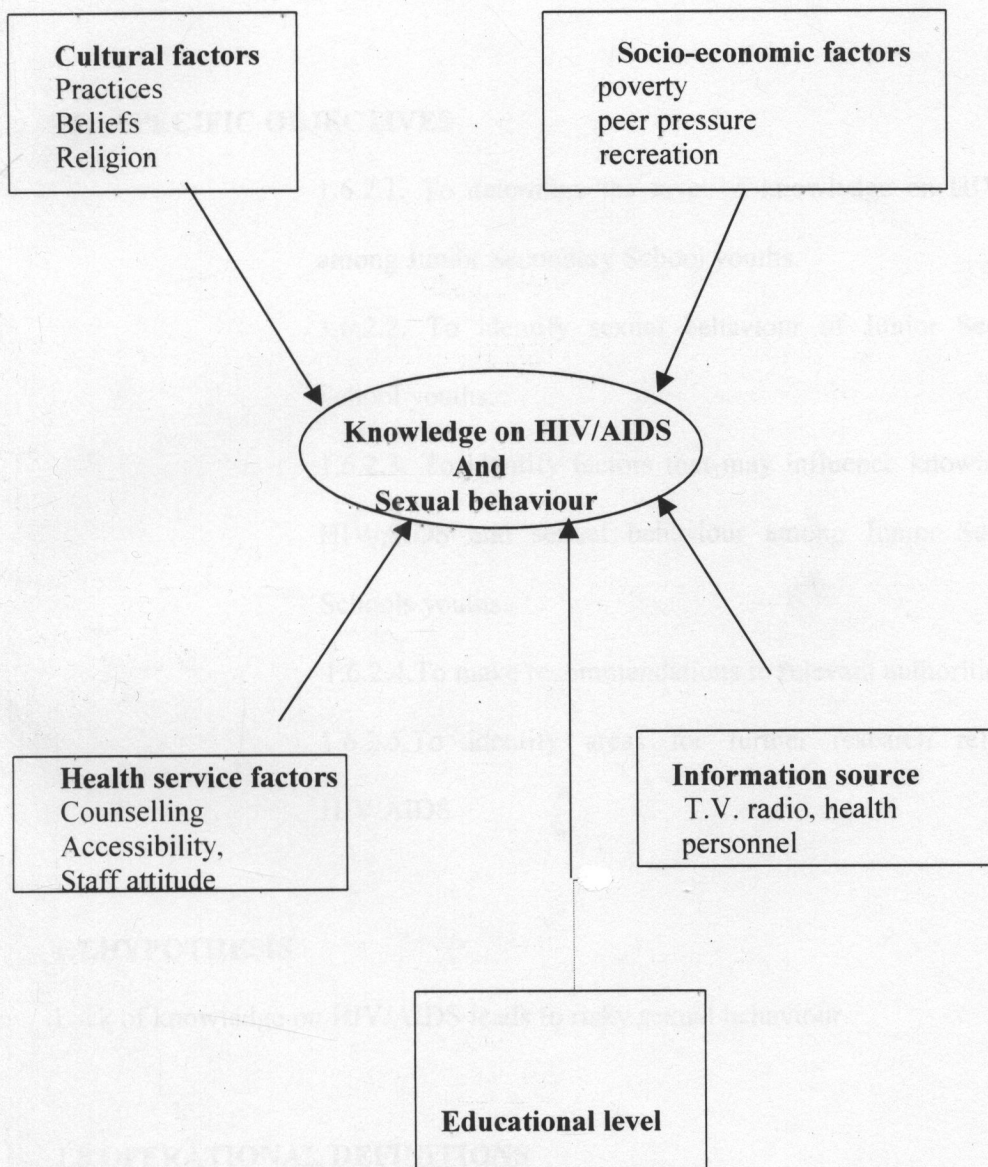
Peers are not always a good source of information, those that receive accurate information will share this to improve their colleagues' knowledge and therefore sexual behaviour while those misinformed will in turn misinform their colleagues. Peers tend to convince themselves more than adults do to youths. Anti-AIDS clubs utilise this peer effect by equipping the youth with proper information so that they share it with their peers, this improves their knowledge and promotes positive sexual behaviour.

## **EDUCATIONAL LEVEL**

In grade seven when HIV/AIDS lessons are introduced, they are in story form and hence entertain the youth. As they progress to secondary levels these lessons are incorporated in science lessons. In upper secondary, the biology lessons reinforce this topic. The youths in secondary school are given more information on HIV/AIDS than those in lower primary schools because of the differences in maturity levels. It is therefore expected that the youths in secondary schools have high levels of knowledge than those in primary school.



**1.5. FACTORS THAT MAY INFLUENCE KNOWLEDGE ON HIV/AIDS  
AND SEXUAL BEHAVIOUR OF JUNIOR SECONDARY SCHOOL  
YOUTHS**



## **1.6.STUDY OBJECTIVES**

### **1.6.1.GENERAL OBJECTIVE**

To determine knowledge on HIV/AIDS and sexual behaviour among Junior Secondary School youths in Kabwe district.

### **1.6.2.SPECIFIC OBJECTIVES**

1.6.2.1. To determine the level of knowledge on HIV/AIDS among Junior Secondary School youths.

1.6.2.2. To identify sexual behaviour of Junior Secondary School youths.

1.6.2.3. To identify factors that may influence knowledge on HIV/AIDS and sexual behaviour among Junior Secondary Schools youths.

1.6.2.4.To make recommendations to relevant authorities.

1.6.2.5.To identify areas for further research related to HIV/AIDS

## **1.7.HYPOTHESIS**

Lack of knowledge on HIV/AIDS leads to risky sexual behaviour.

## **1.8.OPERATIONAL DEFINITIONS**

**1.8.1.** Junior Secondary Youths are pupils form grades 8 to 9.

**1.8.2.** Risky sexual behaviour refers to patterns of behaviour in relation to sex that may lead to death due to HIV infection.

- 1.8.3.** Unprotected sex refers to sexual intercourse with maximum contact between the male and female genitals, or between same sex genitals, or oral sex.
- 1.8.4.** Sexually active youth refers to youths capable of having sexual relationships or currently involved in one.
- 1.8.5.** Sexual behaviour denotes patterns of conduct in relation to sexual intercourse
- 1.8.6.** Knowledge on HIV/AIDS refers to the ability to state the causative organism, mode of spread, preventive measures of HIV and being aware that it is fatal.
- 1.8.7.** Peer Pressure refers to amount of force or influence exerted by age mates or colleagues.
- 1.8.8.** Counselling refers to a process of giving advice, or providing information on HIV/AIDS.

## 1.9 VARIABLES AND CUT OFF POINT

Variable	Indicator	Cut off point
Knowledge	Scores	
	0-low	0-6
	Med-high	7-12
Sexual behaviour	Abstain	Never had sex
	Safe	Always use condom
	Risky	No condom, multiple partners, casual sex, oral/anal sex

## **CHAPTER TWO**

### **2.0. LITERATURE REVIEW**

#### **2.1. INTRODUCTION**

Education on HIV/AIDS is the first step in modifying sexual behaviour of every Human being. This does not pertain to Zambia only but all over the world. HIV/AIDS has left no race, age, continent, nation and nor social group untouched, everyone is affected. It is when people are empowered with accurate information on HIV, that they may see the need to protect themselves from infection. The generation, who are today's adolescents, will not be spared from the scourge unless all societies gather courage to develop effective preventive programmes aimed at the youth who may be experimenting with sexuality and sexual orientation, who may have to sell sex in order to survive or who may be involved in drug use (Diclement, 1992).

What this meant was that these infections probably occurred ten years or less before these ages of 20-29, such that infection occurs in adolescence but manifests in early adult life. The other observation is that there is a notable level of transmission from older men to younger women indicated by the differences in the infection rates between the sexes. In 1998, the estimated HIV prevalence rate for Zambia was 19.7% in urban among the 15-49 year olds and 28% in rural areas. What it meant was that among those over 15 years, nearly one out of five was already infected and would die in the next 2-12 years, i.e early adult life (CBOH, 1999).

The youths are of great concern because with their sexual development, comes a tendency to explore and experiment in sex, in order to meet sexual gratification, this is usually done with inadequate knowledge and sometimes under the influence of drugs or alcohol. They may engage in unprotected sex, thereby exposing themselves to HIV infection.

The onset of sexual activity marks the beginning of exposure to pregnancy as well as to potential health hazards including HIV/AIDS and other STIs. Each day, 500,000 youths are infected with an STI. An individual with an STI is more vulnerable to HIV infection. Half of all HIV infections, i.e. 8,000 a day, occur in youths under 25 years. Young girls are particularly vulnerable to sexual transmission of HIV. They are more likely than boys to be uneducated, to be coerced or raped, and to be enticed into sex by older, stronger or richer men (UNFPA, 2001).

Literature has been discussed under global, regional and local perspectives, looking at studies on knowledge, sexual behaviour and other factors affecting the two variables, in the Junior Secondary School youths.

## **2.2 GLOBAL PERSPECTIVE**

The global picture on HIV/AIDS focuses on third world countries. One is left to wonder as to whether the third world inhabitants are aware of this situation. Over 33 million people worldwide are infected with HIV and 95% of these are in the third world. An everyday estimation of 16,000 new infections occurs mainly in sub Saharan Africa (WHO, 2001).

In Argentina, a descriptive analysis on knowledge on HIV/AIDS of 425 secondary school youths from four schools, and their attitudes, was conducted. The sample comprised 425 students who were given multiple choice question (MCQ) self-administered questionnaires. Results showed that 89.9% had accurate knowledge on HIV/AIDS and TV was cited as the source of their information. Despite this theoretical knowledge being high, 13.7% believed HIV/AIDS was curable and condom use was very low, modal age at first intercourse was 15 years (Giagnorio, 1998). Knowledge of these youths was generally high but condom use was low. This shows that the knowledge the students had was not sufficient to influence behavioural change.

It has been speculated that imparting the youth with knowledge on sexuality education encourages sexual activity. A study was conducted in the USA that refuted such speculations. Findings did in fact indicate that community members were in agreement that youths needed to be protected from unplanned pregnancies, STIs/HIV, through receiving information on these and abstinence. 90% of the respondents supported the inclusion of abstinence in the school curriculum (Hickerman, 2000).

A study was conducted on sexually active teen girls at an urban adolescents health centre in New York, to assess the extent of male condom use among youths and the acceptability of femdom (Female condom). Condom use was very low and technical skills on femdom use were lacking. Peer facilitated teaching sessions were given emphasising femdom and negotiating skills, then followed up a month later. The results showed that more teen girls were now aware of the risks of unprotected sex and through the encouragement from their peers, condom use was very high and the

demand for condoms increased (Boyer, 1998). This shows the positive effect of peer education in influencing sexual behaviour at their level, the youths were free enough to have their doubts clarified on the use of condoms and how to practically use them.

In 1995, the Bangladesh Rural Advancement Committee set up an Adolescent Reproductive Health Education (ARHE) programme to provide information on reproductive health to youths in rural areas. This programme succeeded by mobilising the community in involving parents and teachers. This helped break the silence and shame about sensitive topics related to reproduction e.g. HIV/AIDS. Till to date this programme has been known to improve relationships between parents and youths, reaching rural areas that were one time neglected in the fight against HIV/AIDS (Rashid, 2000). Parental consent and support in educating the adolescents on sexuality issues related to HIV/AIDS is very important, it reinforces positive sexual behaviour. Here it meant that the parents and teachers spoke one language and averted misconceptions in educating the youth on HIV/AIDS.

A sexual risk profile for adolescent Hispanics was taken at University of Illinois in USA. Results were that each year there were approximately one million pregnancies and three million STDs among the youths. A randomised cross sectional sample of 425 Hispanic high school youths were interviewed about age at first sexual contact, frequency and type of sexual intercourse, and condom use. Results showed that mean age at first sexual contact was 14.3 years, mean number of partners was 3; 52% had sexual intercourse: 49% vaginal, 24%, 12% anal and 6% had all three, 41% were sexually active teens having sex more than once a month; 85% used condoms only once in their relationship and 30% always used condoms during intercourse (Alba,



1999). This showed that the youths were practising risky sexual behaviours predisposing themselves to HIV infection. It is therefore important to give them the right information on HIV/AIDS so that they can abstain or practice safer sex.

In Mexico, sexual and reproductive health of youths were analysed in a study which revealed that sexual activity begun between 14 and 15 years of age for boys and 15 and 16 years for girls. The issues of unwanted pregnancies, abortion, STIs/HIV were being tackled in primary and secondary schools by the health services. Rights of privacy, confidentiality, responsibility and informed consent were being taken care of according to the Family Care International Law. Families, schools and the rest of the community were working together. The unity of the community in fighting AIDS improved the sexual behaviours of the school youths (Barajas, 2000).

Promoting the reproductive health and rights of young people remains a controversial topic in many countries, involving sensitive issues of sexuality and potential rights and duties. UNFPA works within country programmes and with national partners to advocate for programmes and policies that foster the reproductive health of all people especially youths (UNFPA, 2001). Involving key players like parents and government officials could alert the youths on the dangers and impact of HIV/AIDS, therefore improve the knowledge and sexual behaviours.

### **2.3 REGIONAL PERSPECTIVE**

In many parts of Africa, traditional forms of sex education in initiation ceremonies have lost importance. Open discussion on sexual matters are sanctioned, schools have not adequately taken up the task, so the young learn about sex from peers and media

This information is not always accurate. This leads to adolescents lacking information on HIV transmission and its dangers (UNAIDS, 1999). This type of information source may positively or negatively influence sexual behaviours of youths. The western media has for a long time in its entertainment form portrayed that sexual relationships can be casual and risk taking which is contrary to the traditional African emphasis on fidelity in marriage and no sex before marriage. Peer education when lacking knowledge, will in a similar fashion impart information detrimental to the sexual health of the youths resulting in resulting in risky sexual behaviour.

Kamara (1999) assessed the need for youth sexual health programmes and the provision of a culturally appropriate and locally sustainable HIV/AIDS programme. It was concluded that there was a great need for effective sustainable approaches for reaching youths. The statistics showed that the then running programmes were ineffective in containing the spread of HIV/AIDS.

Monasch (1998) conducted a study in sub Saharan Africa. The study aimed at comparing the knowledge, awareness and risk perception among female youths between 15 and 24 years. Results indicated that 98% of the youths had heard of HIV/AIDS, awareness was high but misinformation on who gets infected and mode of spread, were equally high, majority believed that just because they were faithful to their partners, they were at no risk. Results showed that the countries with the highest HIV rates had high knowledge on its prevention.

In Senegal, a ten year AIDS prevention programme for strategy was set up to, inform youths about STD and AIDS, describe development of STDs/AIDS, and evaluate its

effect on the school youths' AIDS-related knowledge and preventive behaviours. A pre-test post-test evaluation was conducted. 1272 youths participated in the survey and training workshops. Results were that 45% remained sexually active, 80% male and 20% female; the youths who had attended the AIDS educational programme were more knowledgeable than those that remained in the control group and more than 50% had modified their sexual behaviours (Papa, 1998). This showed that knowledge appropriately imparted modifies sexual behaviour.

A project was embarked on in Zimbabwe to create confidence, inform and assert adolescent girls so as to make informed decision and choices, being aware of their reproductive health and rights in avoiding HIV/AIDS infection. Base line KAP surveys were conducted in seven secondary schools in one district. The target group was 14-19 year olds. Workshops were conducted and evaluated at the end of each year in the three-year project. Results showed a reduction of HIV prevalence among the girl adolescents in their area and an assertive girl who is able to say no, to sexual intercourse if she is not yet ready for it (Dembedza 1999). Traditionally, women have always been expected to be submissive to men, even where the issue of sex comes in, men decide when and where to have sex, women simply succumb, this is also passed on from generation to generation. Boys are taught to take the leading role and girls are taught to submit, hence the need to assert girls with skills that will help them negotiate for safe sex later in life. This study has shown that equipping girls with such skills helps both Sexes practise safe sex.

Mutembi and Mwesiga (1999), conducted a study on the obstacles in HIV/AIDS prevention among school youths in Tanzania. The aim was to establish the fact that

cultural and social values prohibit many parents from free discussion on matters related to sex with their children and to find means of breaking such taboos. 1,700 families were studied of youths from 12-18 years through interviews. Results showed 85% parents with adequate knowledge on HIV transmission and dangers but only 3% shared this knowledge with their children. 97% parents had difficulty discussing such issues with their children. 80% of the youths had inadequate knowledge on HIV and safe sex. Some youths had died as HIV/AIDS victims and many more who were blood donors, were HIV infected. Social taboos here were a major barrier in parent to child, sex education, increasing the chances of HIV infections and transmission among the youths. Lack of knowledge, here is seen to result in risky sexual behaviour leading to transmission of HIV infection. Cultural beliefs interfered with the passing on of information on HIV/AIDS from parents to the youths.

In Malawi, an investigation of community based communication networks of adolescent girls in rural areas for HIV/AIDS prevention messages revealed that girls between 9-10 years had already learnt about sex from friends, and initiation ceremonies were conducted after the girls had started indulging in sex. This was in most cases at the age of ten. Practices commonly seen included the use of drying agents in the vagina before sex and the issue of multiple partners. 66% indulged in sex for money and gifts and condom use was non-existent because it interfered with sexual pleasure. Most girls had older men for lovers mainly for monetary gain and same age boys for pleasure, International Centre for Research on Women, (ICRW 1994). This meant that initiation ceremonies were conducted late, after the youths had already learnt about sex from other sources and found it hard to modify their sexual behaviour. Another point to note is that social economic pressures enticed these

youths to sell sex to older partners and revert to younger partners for pleasure which rapidly increased the chances of HIV infection spread. The issue of females aiming to please the male partner cannot go without comment, the girls were practising dry sex to please the men who were not providing any sexual pleasure in return, hence, the maintaining of peer lovers. Dry sex predisposes to HIV infection. The sexual behaviours in this study were highly risky.

In Kwazulu Natal, which has been known to have the highest incidence rates of HIV in South Africa, Drama approach to HIV/AIDS (DRAM AIDE) was formed in secondary schools to educate the youths on the same and it produced positive behavioural change which had been measured against HIV incidence over an unspecified period (Harvey et al, 2000). This meant that peer education in form of drama was effective in modifying the sexual behaviour of youths reducing the incidence of HIV. When peer education is effectively utilised, the information is very appropriate for the age group, at a level they understand and creates a sense of ownership in the educators.

Some beliefs among peers influence sexual behaviours, a Brazilian youth commented in a survey that real men do not fall sick and should be able to take sexual risks, in the same survey a Zimbabwean youth commented that sex was only real when a boy ejaculated into a girl; this was all in an aim to justify the non usage of condoms during sex by the youths (SAFAIDS, 2000). This showed that misconceptions shared among peers had strong bearings on the youths' sexual behaviours.

A South African HIV prevention initiative promotes positive sexual behaviour among youths, reducing the incidence of the teenage pregnancy, HIV/AIDS and other STIs. It uses radio, adverts, Television, website, newspaper, teen hotline and Love Train to bring its messages across (POPULI, 1998).

#### **2.4. LOCAL PERSPECTIVE**

In Zambia, knowledge on HIV/AIDS infection transmission, signs and symptoms and prevention is generally high though it is not always accompanied by positive sexual behavioural patterns.

In Kasama, at a Basic School, a KAP survey was conducted on youths between 13 to 15 years of both sexes and from both rural and urban settings; on HIV/AIDS. 81% of the urban sample and 85% of the rural sample were sexually active with a good knowledge base on HIV/AIDS and its impact, but they were not practising safer sex Maarungu (1995). This meant that knowledge had no impact on their sexual behaviour.

Feldman (1993) conducted a study on sexual behaviour among male youths in Zambian Secondary schools. These youths had knowledge on HIV/AIDS, but when it came to condom use as a protective device against infection, they believed that American manufactured condoms were strategically pored in order to facilitate the spread of HIV among the Africans. These boys were willing to indulge in unprotected sex than use the mentioned condoms. Probably if the commodity providers or health personnel had explained and clarified such misconceptions, or even found out the source of such information, a lot of risks to HIV infection would have been averted.

The knowledge here was good but misconceptions led to risky sexual behaviour, this was a wrong source of information

Mwiinga and Chomba (1998) carried out a KAP study in Lusaka Secondary Schools on youths to evaluate HIV knowledge, attitudes and practices, and to discuss the performance of anti-AIDS clubs in these schools. Results were that 67% had knowledge on HIV, some misconceptions on HIV transmission were present, 25% had negative attitudes towards people infected with HIV; 44% youths were sexually active, mean age at first sexual intercourse was 13; 76% of the sexually active had multiple partners with inadequate condom use (44%) which was inconsistent, sources of information were the media, peers and anti-AIDS clubs. The percentage of knowledge here was not very encouraging, coupled with misconception on the transmission of HIV/AIDS and the risky sexual patterns, promote the spread of infection. Probably the sources of information were not very reliable and effective.

Malibata (1994) carried out a study to look at sexual practices among secondary school youths in Lusaka and recommendations for safer sex practices as primary prevention for AIDS. It was conducted in three secondary schools of Lusaka, on 100 youths; 51 boys and 49 girls. Results showed that almost half sexes ie 40.8% girls and 62.7% boys, were involved in penetrating sexual intercourse; while 22.4% girls and 15.7% boys were practising oral sex, anal sex was less popular with only 2% of the girls and 3.9% of the boys practising, it, 24.5% of the girls practised dry sex with only 4.8% of them being aware that it promoted HIV transmission; 42.3% had never heard about dry sex. This meant that a lot of school youths were practising unsafe sex and exposing themselves to HIV infections.

In Lusaka, Mfula (1999) conducted a study on knowledge and attitudes towards sexual intercourse in this era of HIV/AIDS, on a group of youths between 11 and 19 years. All were aware of HIV and its dangers, main source of information was peers and rarely from parents and teachers. Such peer education could be channelled into organised ventures to impart accurate and appropriate knowledge to fellow peers on HIV/AIDS and its dangers.

A good example is where a group of youths between 10 and 14 years in anti-AIDS clubs were given 150 resource materials to redesign. After they did so, only 50 of the materials were found to be useful. It was concluded that when youths are actively involved in such programmes, it enhances their ownership, at an appropriate language level, which enables them to readily use and understand the available resources (Chalowandya et al, 1999)

Literature on studies conducted in Kabwe urban was unavailable, however, a ZDHS of 1996 revealed that a sample comprising boys and girls between 15 to 19 years in Central Province, awareness on HIV/AIDS was very high with 19.8% of the sample saying it was impossible to prevent HIV infections and 30.7% not knowing any means of prevention this adds up to 50.5% not knowing how to protect themselves from infection (CSO, 1996). Awareness of HIV infection is not adequate in the fight against AIDS, accurate knowledge and preventive methods can help change sexual behaviours of the youth to a great extent.



## 2.5. SUMMARY

A review of literature has indicated that a lot studies have been conducted world wide to asses the knowledge people have on HIV/AIDS, as has been discussed in this chapter, and is a good basis for programme formulation in the fight against this scourge. HIV/AIDS has left no corner of the earth untouched, hence the need for all nations to map up co-ordinated strategies to combat its spread.

Literature reviewed on the subject of school youths' knowledge on HIV/AIDS and their sexual behaviour has revealed that where knowledge was high on HIV/AIDS, behavioural patterns were modified whereas in some, it was revealed that knowledge alone was not sufficient to modify behaviour. Traditional beliefs and cultures sometimes interfered with dissemination of information from well-informed parents, on HIV, to their children, Peer influence had major roles to play in the level of knowledge on HIV/AIDS and in sexual behaviours. The fact is that the youth are indulging in sexual activity and it is time the parents and teachers realised this reality in order to unite efforts to educate the youth on HIV issues before they become sexually active.

Literature review has revealed that knowledge on HIV/AIDS is generally high, in most cases this knowledge is not sufficient to influence sexual behavioural change. Economic pressures, peer influence, traditional beliefs, backgrounds passed from parents to children, and misconceptions, all have a bearing on how these youths relate or behave sexually The patterns of behaviour seem similar across the globe. Literature review has also revealed that no such study has been conducted in Kabwe district.

## **CHAPTER THREE**

### **3.0. RESEARCH METHODOLOGY**

#### **3.1. INTRODUCTION**

The purpose of this study was to determine knowledge on HIV/AIDS and Sexual behaviour of Junior Secondary School Youths. To achieve this, a descriptive quantitative research design was chosen. Descriptive design was chosen because it helps assemble new information about the subjects.

#### **3.2. RESEARCH DESIGN**

A research design is a scheme of action or a framework for answering the research question or questions. It includes the research setting, operational definitions, assumptions, relationships between variables, delimitations, sample, sampling procedure, instrument, approach to be used, method of data analysis, ethical issues and use of the data (Treece and Treece, 1986).

A descriptive study design was used, which was also quantitative. It was descriptive in that the researcher systematically collected and presented data, giving a clear picture of the situation. The design was also quantitative because answers to the study were categorised, and quantified in numeric forms.

#### **3.3. RESEARCH SETTING**

Kabwe District is the headquarters of Central Province, situated 140 kilometres from Lusaka with an area of 1, 5777 square kilometres. It shares boundaries with Kapiri on the north-west and Chibombo on the south-east.

The population is approximately 221,229 with a population density of 136 square kilometres (Kabwe District Action Plan, 2000). The study was conducted in Kabwe Urban District on secondary school-going youths in one of the five secondary schools, Bwacha. The five secondary schools include Kalonga, Highridge, Kabwe High, Caritas and Bwacha. This urban area was chosen by the Researcher due to the increasing HIV positive cases of school youths, the abortion rates and the high STI cases in these youths.

### **3.4. STUDY POPULATION**

The term population refers to the entire number of units under study or the whole or all the inhabitants Treece and Treece (1986). This comprised all Junior Secondary School youths. The study units comprised male and female youths. This group of youths was selected because it was assumed that they had received their HIV/AIDS information as stipulated in the School Education Curriculum and considering the age group, most of these youths are assumed sexually active in view of the Zambia Sexual Behavioural Survey (1998).

### **3.5. SAMPLE SELECTION**

'Sample selection is a process of selecting a portion of the population to represent the entire population,' (Treece and Treece, 1986). Only one secondary school, Bwacha was selected using lottery method by making a list of the five schools on separate pieces of papers and placing them in a bowl, shuffling them around and randomly selecting one for the study. The school was therefore randomly selected for the study.

### 3.6. SAMPLING METHOD

'Sampling method is the process by which the study subjects are chosen from larger population' (Polit and Hungler, 1997). Simple random and systematic sampling methods were used. Simple random sampling 'is where a sampling frame is created by enumerating all members of a population of interest and then selecting a sample from the sampling frame through completely random procedures' (Ibid, 1997). The first subject was selected randomly by assigning numbers to each respondent on separate pieces of paper and shuffling them around in a bowl, then picking out one of the papers, the subsequent subjects were selected using the sampling frame to obtain a total of 25 for each grade.

'Systematic sampling is the selection of study participants such that every kth person or element in a sampling frame or list is chosen,' (Polit and Hungler, 1997). The list of all the youths in grades eight and nine was compiled from the class register and divided by 25 for each grade to get a sampling frame for each group.

Grade 8 :  $51+50+57+52+55= 265/25=10.6$  so every 11<sup>th</sup> subject was picked.

Grade 9:  $54+57+57+50+50= 268/25=10.7$  again every 11<sup>th</sup> subject was picked for the study. The first subject was selected randomly using lottery method, then the subsequent subjects were selected using the sampling frame to obtain a total of 25 for each grade.

### 3.7. SAMPLE SIZE

'A sample is a subset of a population selected to participate in a research study', (Polit and Hungler, 1997). A sample of 50 was utilised for the study, 25 respondents from grade eight and 25 from grade nine. These were all from Bwacha Secondary school.

### **3.8. DATA COLLECTION TOOL AND TECHNIQUE**

Data collection is gathering of information needed to address a research problem, (Polit and Hungler, 1997). Self-administered questionnaires were used with both open-ended and closed-ended questions to collect data. A questionnaire is a measuring instrument that can be used to measure characteristics of a given population with regard to sex marital status, religion occupation and state of health. It contains a printed form, with a set of questions that the respondent is required to answer (Cormark, 1984).

The questionnaire comprised three sections, i.e. section A, requesting for demographic data, section B enquiring on knowledge on HIV/AIDS, and section C enquiring on sexual behaviour of the youth. The questionnaires were administered to the youths by the researcher. The youths were assembled in the school hall. The purpose of the study, use of findings and the assurance of privacy and confidentiality were all explained to the respondents. Reading of the instructions was done in their presence. Consent was then obtained from the respondents, then the questionnaires were distributed to each subject. The questionnaires were checked for completeness before the youths left the hall. Data was collected the same day by the researcher.

### **3.9. PILOT STUDY**

A pilot study is defined as 'a small-scale version or trial run of a major study whose main function is to obtain information for improving a project or for assessing its feasibility.' (Polit and Hungler, 1998). This was conducted at one of the secondary schools in Kabwe, Kalonga Secondary school. This school was not included in the main study.

Questionnaires were given to five randomly selected pupils, which was 10% of the main study. In the pilot study, methodology used was exactly like that for the main study. After conducting the pilot study, it was observed that two questions were ambiguous; they were omitted from the main study. Three open-ended questions were closed for the main study.

### **3.10. ETHICAL CONSIDERATIONS**

Ethics can be defined as 'a system of moral values that is concerned with the degree to which research procedures adhere to professional, legal and social obligations to the study participants,' (Polit and Hungler, 1997).

Permission was requested from the Supervising lecturer at the Department of Post Basic Nursing, UNZA, District Education Officer in Kabwe and the Headmaster from the secondary school under study. After a brief explanation of the study purposes, consents were obtained from the respondents before administering the questionnaire. Confidentiality and anonymity was assured, no names appeared on the study tool. The respondents responded from their usual environment so they were not exposed to any physical or emotional danger or harm.

## **CHAPTER FOUR**

### **4.0.DATA ANALYSIS AND PRESENTATION OF FINDINGS**

#### **4.1. INTRODUCTION**

This chapter provides some information from fifty Junior Secondary School Youths, male and female, systematically selected from Bwacha Secondary School in Kabwe. 25 respondents were from Grade eight and the other 25 were from Grade nine. The data collected was manually analysed.

#### **4.2.DATA ANALYSIS**

Data was sorted and checked for completeness then recorded accordingly. Responses to closed-ended questions were entered on a data master sheet and those from open-ended were categorised then coded. Data was analysed using a calculator. Cross tabulations of variables was done to show the relationships between these variables. Pie charts, frequency tables and percentages were compiles to draw meaningful presentation of data and make inferences from the sample. The sample being small, i.e. 50 respondents, parametric method of testing hypothesis was used in order to obtain reliable and valid findings of the study.

#### **4.3. PRESENTATION OF FINDINGS**

Raw data from questionnaires was recorded, analysed and interpreted. This data would have been meaningless to the researcher and readers if it had not been categorised and presented in such a manner as to draw meaningful inferences from it. Data was presented in tabular and pie chart form for easy accessibility of information and summary.

**TABLE ONE:**  
**DEMOGRAPHIC DATA (n=50)**

<b>Variable</b>	<b>Frequency</b>
<b>Age</b>	
13-16 years	37 (74%)
17-20 years	13 (26%)
<b>Total</b>	<b>50 (100%)</b>
<b>Sex</b>	
Female	17 (34%)
Male	33 (66%)
<b>Total</b>	<b>50 (100%)</b>
<b>Religion</b>	
Christian	50 (100%)
Other	0 (0%)
<b>Total</b>	<b>50 (100%)</b>
<b>Adequate financial support</b>	
Yes	42 (84%)
No	8 (16%)
<b>Total</b>	<b>50 (100%)</b>
<b>Educational level</b>	
Grade eight	25 (50%)
Grade nine	25 (50%)
<b>Total</b>	<b>50 (100%)</b>
<b>Awareness of YFCs</b>	
Yes	18 (36%)
No	32 (64%)
<b>Total</b>	<b>50 (100%)</b>
<b>Utilisation of YFCs</b>	
Yes	14 (28%)
No	7 (14%)
N/A	29 (58%)
<b>Total</b>	<b>50 (100%)</b>
<b>Awareness of anti-AIDS club</b>	
Yes	21 (42%)
No	29 (58%)
<b>Total</b>	<b>50 (100%)</b>



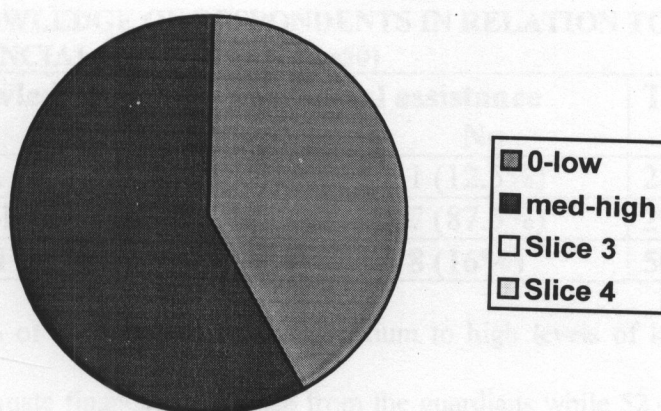
**TABLE ONE CONTD.**

Variable	Frequency
<b>Membership to club</b>	
Yes	6 (12%)
No	16 32%)
N/A	28 (56%)
<b>Total</b>	<b>50 (100%)</b>

Half of the respondents (50%) were aged between 13 and 15 years. All the respondents 100% were Christians with the majority of them (66%) being male. Most of the respondents, (84%) had adequate financial support from their guardians, half of them, (50%) were in grade Nine. Majority of the respondents, (64%) were unaware of the presence of YFCs in their community and (58%) were unaware of anti-AIDS clubs in their school.

**PIE CHART ONE.**

**LEVEL OF KNOWLEDGE ON HIV/AIDS (n=50)**



58% of the respondents had medium to high levels of knowledge on HIV/AIDS.

**TABLE TWO:**  
**KNOWLEDGE IN RELATION TO RELIGION. (n=50)**

Level of knowledge	Religion		Total
	Christian	Other	
0-Low	21 (42%)	0	21(42)
Med-high	29 (58%)	0	29(58)
<b>Total</b>	<b>50(100%)</b>	<b>0</b>	<b>50(100)</b>

All the respondents,(100%) were Christians, with 58% of them having medium to high levels of knowledge on HIV/AIDS.

**TABLE THREE:**  
**KNOWLEDGE OF RESPONDENTS IN RELATION TO FINANCIAL ASSISTANCE (n=50)**

Knowledge level	Financial assistance		Total
	Yes	No	
0-low	20 (47.6%)	1 (12.5%)	21 (42%)
Med-low	22 (52.4%)	7 (87.5%)	29 (58%)
<b>Total</b>	<b>42 (84%)</b>	<b>8 (16%)</b>	<b>50 (100%)</b>

87.5% of the respondents with medium to high levels of knowledge had inadequate financial assistance from the guardians while 52.4% respondents with adequate financial assistance also had the same level of knowledge.

**TABLE FOUR:**  
**KNOWLEDGE OF RESPONDENTS IN RELATION TO**  
**EDUCATIONAL LEVEL. (n=50)**

<b>Knowledge level</b>	<b>Grade Eight</b>	<b>Grade Nine</b>	<b>Total</b>
0-low	11 (44%)	10 (40%)	21 (42%)
Med-high	14 (56%)	15 (60%)	29 (58%)
<b>Total</b>	<b>25 (50%)</b>	<b>25 (50%)</b>	<b>50 (100%)</b>

60% of the grade nine and 56% of the grade eight youths had medium to high levels of knowledge on HIV/AIDS.

**TABLE FIVE:**  
**KNOWLEDGE OF THE RESPONDENTS IN RELATION TO**  
**UTILISATION OF YFCS.(n=50)**

<b>Knowledge level</b>	<b>Utilisation of YFCs</b>			<b>Total (%)</b>
	<b>Yes</b>	<b>No</b>	<b>Unaware</b>	
0-low	7 (53.8%)	4 (50%)	10 (34.5%)	21 (40%)
Med-high	6 (46.2%)	4 (50%)	19 (65.5%)	29 (60%)
<b>Total</b>	<b>13 (26%)</b>	<b>8 (16%)</b>	<b>29 (58%)</b>	<b>50 (100%)</b>

50% of the respondents with medium to high levels of knowledge on HIV/AIDS, were making use of YFCs in their community while 65% with the same level of knowledge were unaware of the presence of this service among them.

**TABLE SIX:**  
**KNOWLEDGE OF RESPONDENTS IN RELATION TO THEIR**  
**UTILISATION OF ANTI-AIDS CLUB. (n=50)**

Knowledge level	Utilisation of anti-AIDS club			Total
	Yes	No	N/A	
0-low	2 (33.3%)	6 (37.5%)	13 (46.4%)	21 (42%)
Med-high	4 (66.7%)	10 (62.5%)	15 (53.6%)	29 (58%)
<b>Total</b>	<b>6 (12%)</b>	<b>16 (32%)</b>	<b>28 (56%)</b>	<b>50 (100%)</b>

66.7% of respondents with medium to high levels of knowledge utilise anti-AIDS club in the school



**TABLE SEVEN:**  
**SEXUAL BEHAVIOUR (n=50)**

VARIABLE	FREQUENCY
<b>Dating</b>	
Yes	22 (44%)
No	28 (56%)
<b>Total</b>	<b>50 (100%)</b>
<b>Sexual intercourse</b>	
Yes	27 (54%)
No	23 (46%)
<b>Total</b>	<b>50 (100%)</b>
<b>Sex with whom</b>	
Regular partner	17 (34%)
Casual partner	10 (20%)
N/A	23 (46%)
<b>Total</b>	<b>50 (100%)</b>
<b>Why had sex</b>	
Financial	1 (2%)
Peer pressure	22 (44%)
Curiosity	5 (10%)
N/A	23 (46%)
<b>Total</b>	<b>50 (100%)</b>
<b>How many partners</b>	
Zero	0 (0%)
1	19 (38%)
2-5	5 (10%)
5+	3 (6%)
N/A	23 (46%)
<b>Total</b>	<b>50 (100%)</b>
<b>Condom use</b>	
Always	14 (28%)
S/times	5 (10%)
Never	8 (16%)
N/A	23 (46%)
<b>Total</b>	<b>50 (100%)</b>

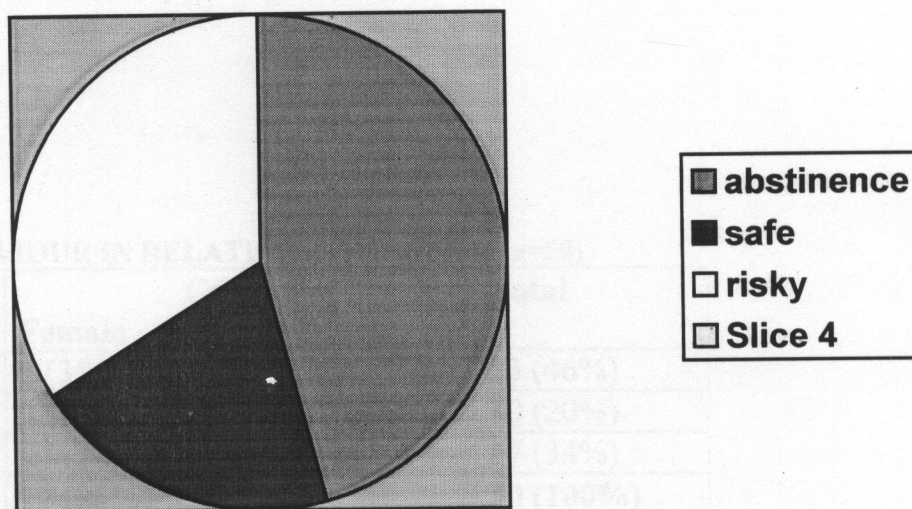
**TABLE SEVEN CONTD.**

<b>VARIABLE</b>	<b>FREQUENCY</b>
<b>Why condom use</b>	
Protection	19 (38%)
For comfort	1 (2%)
Easily available	1 (2%)
Partner suggest	1 (2%)
N/A	23 (46%)
<b>Total</b>	<b>50 (100%)</b>
<b>Type of sex practice</b>	
Anal	2 (4%)
Vaginal	24 (48%)
Oral	5 (10%)
Masturbation	7 (14%)
N/A	23 (46%)
<b>Total</b>	<b>50 (100%)</b>
<b>Practise dry sex</b>	
Yes	6 (12%)
No	21 (42%)
N/A	23 (46%)
<b>Total</b>	<b>50 (100%)</b>
<b>Use of alcohol/drugs before sex</b>	
Yes	1 (2%)
No	26 (52%)
N/A	23 (46%)
<b>Total</b>	<b>50 (100%)</b>

56% of the respondents were not dating while 44% were. 54% of the respondents had already had sexual intercourse of which 20% was with casual partners while 54% was with regular partners. The reason sited for indulging in sexual intercourse was mainly out of peer pressure (44%), curiosity was 10 %. The majority of respondents 38% had had one sexual partner while 6% had more than five. The commonest type of sex being

practise was vaginal penetration (48%) and masturbation at 14%. Only 12% of the respondents had indulged in dry sex. 28% of the respondents always used condoms during sex while 16% had never used them during sex, the main reason for condom use was cited as for protection in 38% of the respondents. The use of alcohol/drugs prior sex was only 2% with 52% not practising it. Suggestions to improve the knowledge and sexual behaviour of the youths were 16% encourage abstinence, encourage condom use 12% increase anti-AIDS clubs, with 56% having no suggestions

**PIE GRAPH TWO:**  
**SEXUAL BEHAVIOUR (n=50)**



46% abstained, 34% were indulging in risky sexual behaviour and 20% were practising safe sex.



**TABLE EIGHT:**  
**SEXUAL BEHAVIOUR IN RELATION TO AGE (n=50)**

<b>Sexual behaviour</b>	<b>Age</b>		<b>Total</b>
	<b>13-16yrs</b>	<b>17-20yrs</b>	
Abstinence	21 (56.8%)	2 (15.4%)	23 (46%)
Safe	4 (10.8%)	6 (46.1%)	10 (20%)
Risky	12 (32.4%)	5 (38.4%)	17 (34%)
<b>Total</b>	<b>37 (74%)</b>	<b>13 (23%)</b>	<b>50 (100%)</b>

56.8% of respondents aged between 13 and 16 years were abstaining from sexual intercourse while 38.4% of those aged between 17 and 20 were practising risky sex.

**TABLE NINE:**  
**SEXUAL BEHAVIOUR IN RELATION TO GENDER (n=50)**

<b>Sexual behaviour</b>	<b>Gender</b>		<b>Total</b>
	<b>Female</b>	<b>Male</b>	
Abstinence	6 (35.3%)	17 (51.5%)	23 (46%)
Safe	3 (17.6%)	7 (21.2%)	10 (20%)
Risky	8 (47.1%)	9 (27.3%)	17 (34%)
<b>Total</b>	<b>17 (34%)</b>	<b>33 (66%)</b>	<b>50 (100%)</b>

51.5% of the respondents were abstaining from sexual intercourse while 35.3% of the females were indulging in risky sexual behaviour.



**TABLE TEN:**  
**SEXUAL BEHAVIOUR IN RELATION TO FINANCIAL SUPPORT.**  
**(n=50)**

Sexual behaviour	Financial support		Total
	Adequate	Inadequate	
Abstinence	17 (40.5%)	6 (75%)	23 (46%)
Safe	9 (21.4%)	1 (12.5%)	10 (20%)
Risky	16 (38.1%)	1 (12.5%)	17 (34%)
<b>Total</b>	<b>42 (84%)</b>	<b>8 (16%)</b>	<b>50 (100%)</b>

75% of the respondents with inadequate financial support were abstaining from sex while only 40.5% with adequate financial support were also abstaining.

**TABLE ELEVEN:**  
**SEXUAL BEHAVIOUR IN RELATION TO UTILISATION OF**  
**YFCS. (n=50)**

Sexual behaviour	Utilisation of YFCs			Total
	Yes	No	N/A	
Abstinence	3 (23.1%)	1 (14.3%)	19 (63.3%)	23 (46%)
Safe	4 (30.8%)	1 (14.3%)	5 (16.7%)	10 (20%)
Risky	6 (46.2%)	5 (71.4%)	6 (20%)	17 (34%)
<b>Total</b>	<b>13 (26%)</b>	<b>7 (14%)</b>	<b>30 (60%)</b>	<b>50 (100%)</b>

71.4% of non users of YFCs were involved in risky sexual behaviour while 64.6.2% of those utilising YFCs had risky sexual behaviour.

**TABLE TWELVE:**  
**SEXUAL BEHAVIOUR IN RELATION TO MEMBERSHIP TO**  
**ANTI-AIDS CLUB. (n=50)**

Sexual behaviour	Membership to the anti-AIDS club			Total
	Yes	No	N/A	
Abstinence	0	9 (53%)	14 (51.9%)	23 (46%)
Safe	1 (16.7%)	4 (23.5%)	5 (18.5%)	10 (20%)
Risky	5 (83.3%)	4 (23.5%)	8 (29.6%)	17 (34%)
<b>Total</b>	<b>6 (100%)</b>	<b>17 (100%)</b>	<b>27 (100%)</b>	<b>50 (100%)</b>

Non of the respondents who were members of anti-AIDS club were abstaining from sex, while 83.3% of the members were indulging in risky sexual behaviour.

**TABLE THIRTEEN:**  
**LEVEL OF KNOWLEDGE IN RELATION TO SEXUAL**  
**BEHAVIOUR. (n=50)**

Knowledge level	Sexual behaviour			
	Abstinence Total	Safe	Risky	
Zero-low	8 (34.8%)	5 (50%)	8 (47.1%)	21 (42%)
Med-high	15 (65.2%)	5 (50%)	9 (52.1%)	29 (58%)
<b>Total</b>	<b>23 (46%)</b>	<b>10 (20%)</b>	<b>17 (34%)</b>	<b>50 (100%)</b>

Majority of respondents (65.2%) with medium to high levels of knowledge were abstaining from sexual intercourse.

## **CHAPTER FIVE**

### **5.0. DISCUSSION OF FINDINGS AND IMPLICATIONS FOR THE HEALTH CARE SYSTEM**

#### **5.1. INTRODUCTION**

The study aimed at determining the knowledge on HIV/AIDS of junior secondary school youths and their sexual behaviours. The study was prompted by the increasing number of HIV positive school youths, the high rates of incomplete abortions, school youth pregnancies and increase of STI cases. The researcher sought to explore knowledge and sexual behavioural patterns in relation to HIV/AIDS of these youths.

The sample comprised 50 systematically sampled school youths, 25 from grade eight and 25 from grade nine. The findings will be discussed and the implications for the health care system will be presented in this chapter.

#### **5.2. SOCIO-DEMOGRAPHIC DATA**

Section A of the questionnaire, (appendix 1) comprised questions on demographic data of the respondents. It had a total of thirteen questions, a combination of open-ended and closed-ended questions. The study was on junior secondary school youths between the ages of 13 to 19 years. The majority of the respondents, (66%) were between 13 and 16 years, ( table 1). This could be due to the fact that the Zambian educational programme commences first grade at a minimum age of six or seven with a few older exceptions. By the time the school youths get to grade eight and nine , their

ages vary from 15 and 17 years (CDC, 2000). The majority of the respondents commenced primary school at the recommended age.

In the study, the majority of respondents were boys. With so many boys in such a small group, it is evident that the educational policy of equal learning opportunities for both boys and girls has a long way to go before it becomes reality.

Before the introduction of the Advancement for Girl Education in Zambia, the educational policy and practice harshly discriminated against schoolgirls. Parents did not always see the need to educate a girl, hence rushed her into premature marriage or she would become a victim of the 'sugar daddy' syndrome because of socio-economic dependence on men exposing her to the dangers of HIV/AIDS. (Mwale, 1997).

This trend has existed for a long time such that with school fees being paid in government schools, most families would opt to send a male child to school than female child. Males are always considered to be bread-winners though this is not the ideal picture in most countries, Zambia included. This probably explains why the majority of respondents were male, (table 1).

All the respondents, 100% were Christians. This was expected because the majority of denominations in Zambia are Christian, some cases of Moslems, Hindus and Cults can be found but are usually of foreign nationals. Besides this, Zambia was declared a Christian nation by the then President F.T.J.

Chiluba when he came into political power in the Second Republic. This could probably be why so many Zambians have Christian inclinations.

The majority of the respondents, 84% ( table 1), had adequate financial support from their guardians. Poverty has been seen to exert some pressure on the youths to indulge in risky sexual behaviours in order to meet their financial needs. In the study, findings indicate that most of these youths had enough financial support. This meant that the guardians could afford the cost-sharing fees in the government school and buy the needed books and uniforms to enable their dependants benefit from the Zambian educational system. This is contrary to NPA (1993) which reported that as a result of the SAP, government has had to reduce expenditure on social sectors such as education, resting the responsibility of educating children primarily with parents. Most of these parents being called to do so, were already overburdened by the rising inflation, unemployment and other cost sharing demands. The situation then was that more than 250,000 youths between the ages of seven and fourteen were not attending school.

Half of the respondents, 50% (table 1) were in grade eight and the other half was in grade nine. These grades were selected because they are the first two years of secondary school life, these youths have reached adolescence, there was need to assess their knowledge on HIV/AIDS which is believed to have been initiated as from grade seven, and relate it to their current sexual behaviour (Mandonna, 1996). In a way it assesses the effectiveness of the HIV/AIDS lessons in the educational curriculum.

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62% of the respondents were unaware of the presence of YFCs in their community. What this implies is that these centres have not been effectively publicised and are not actively involving youths. Youths are supposed to be sole owners, actively involved in the programme design and service delivery (Barnett and Schueller, 2000). For youths to efficiently use these centres, they need to be hostile free to facilitate easy confidential communication. Only 28% of the respondents were utilising the service, this service is under-utilised.

To be successful, YFCs need to consider approaches of delivery that involve the community like peer motivators and educators, school involvement, parents and church associations, record keeping must be up to date and confidential, and finding out the needs of the youths or their interests before planning for programmes, is essential for the programmes to run smoothly (Ibid, 2000).

According to findings of the study, only 42% of the respondents were aware of the presence of anti-AIDS club in the school, 56% of them were unaware. This could imply that the club was inactive. On the issue of membership, 12% of the respondents were members. By 1990, there were almost 2000 registered anti-AIDS clubs in Zambia but many were inactive. A lot of money had been channelled into their activities but the benefits have not yet borne fruit, (UNAIDS, 1999).

### 5.3. KNOWLEDGE ON HIV/AIDS

Section B of the questionnaire comprised questions on the knowledge of the school youths on HIV/AIDS. There was a total of nine questions, both open-ended and closed-ended. Knowledge on HIV/AIDS is the foundation to modified sexual behaviour. It is when people know what is involved that they can do something about what is involved. While knowledge alone is not always adequate to modify this behaviour, it is the basis for programme formulation, and the starting point. Research findings showed that 58% of the respondents had medium to high levels of knowledge, ( pie chart 1 ). The knowledge level of a literate group as the respondents in the study would have been expected to be high. There is so much information being disseminated on the media, at school, in churches and in health centres, activities like World AIDS day celebrations, drama performances by NGOs. It is not possible that these activities go unnoticed.

In a DHS conducted in 1995, the knowledge of youths aged between 15 and 19 years was 98.5% for males and 99.3% for females. A closer scrutiny of this knowledge revealed that 16.4% males and 28.1% females had misconceptions on the mode of spread and preventive measures. This finding agrees with a report from CBOH (1998), explaining that adolescents are less knowledgeable than adults on HIV/AIDS and condom use. It could be that knowledge on HIV/AIDS is being considered as knowledge in its totality, not awareness. Awareness, however, is only a superficial measure of knowledge, an important question is whether adolescents know how to prevent HIV (USAID, 2001).



The study findings indicate that 58% of the Christian respondents had medium to high levels of knowledge, (table 2). All the respondents were Christians, this could be due to the fact that Zambians from the early days of civilisation, adopted the Christian Faith from the British colony and abandoned their native beliefs generally. Non-Christian beliefs are very rare in Zambia and found mainly among the foreigners.

The church is playing a major role in educating the youths on HIV/AIDS and emphasizing on abstinence before marriage. When the idea of churches taking part in an adolescents' reproductive and sexual health programme was first hinted in the Pacific nation of Papua New Guinea in 1997, churches thought the idea was preposterous. Three years later, the churches signed up as partners to the government in such programmes saying, "Our children are growing up in an environment where AIDS and STDs are all around them and many are getting infected and dying, churches are not immune to this problem,"(UNAIDS, 1999).

The majority of the respondents, (87.5%) with inadequate financial support from their guardians had medium to high levels of knowledge. ( table 3). The less privileged are usually considered to have less access to information from T.V., radio, books, internet facilities, magazines and health centres because of user fees. The findings of this study indicates that the knowledge was accurate and reliable. This does not concur with other findings that indicate that youths from underprivileged homes are usually deprived of accessibility to vital information on HIV/AIDS. For example, mass media

HIV/AIDS in the USA has focussed on promotion of personal communication channels such as telephone help lines, and testing or counselling services. Less emphasis has been placed on promotion of safer behaviour itself (Romer and Hornik, 1992). This is an effective way of providing options to youths in relation to HIV/AIDS and helping them modify their behaviour willingly. In Zambia, educative programmes like 'Your health matters, lifeline, our neighbourhood and Sister Evelina' are broadcast on the radio to disseminate information on HIV/AIDS on a wide scale of listeners (CBOH, 2001). This could imply that those with adequate financial assistance from guardians are involved in more sophisticated ventures than listening to radio/T.V. broadcasts, which are more of the entertaining nature.

Results from the study indicated that 60% of the respondents in grade nine had medium to high levels of knowledge on HIV/AIDS, while 56% of the grade eight had the same level of knowledge, (table 4). There was no significant difference in the knowledge levels of the two groups, probably due to the fact that they both had received the information on HIV/AIDS as stipulated in the school curriculum. The knowledge levels of these two groups are therefore expected to be similar in that respect.

Findings also did indicate that only 36% of the respondents were aware of the presence of YFCs in their community with only 28% utilising them, (table 1). Youths are supposed to be actively involved in program design and service delivery (Barnett and Schueller, 2000). These centres need to be hostile free in order to facilitate easy and confidential communication. The

service is under utilised. Youths are usually inquisitive and freer to speak to someone older but not their parent. The fact that youths do not use this service to the maximum could be that it is inactive or exists by name.

To be successful, YFCs need to consider approaches of delivery that involve the community like peer motivators and educators, school authorities, parents and church associations. Record keeping and finding out what needs the youths want met or what programmes they are interested in is essential for the programmes to run smoothly, (Ibid, 2000).

The findings of the study showed that 42% of the respondents were aware of an anti-AIDS club in the school, 56% were unaware of its presence, this could imply that they were inactive in the school. On membership to this club, only 12% of respondents were members. If this club was active, probably even the knowledge and sexual behaviour of the youths would have been expected to be very high. It is supposed to be a reliable and effective source of information on HIV/AIDS. By the 1990s there were almost 2000 registered anti-AIDS clubs in Zambia but many were inactive. A lot of money had been channelled into their activities but the benefits have not yet borne fruit (UNAIDS, 1999).

#### **5.4. SEXUAL BEHAVIOUR**

Section C of the questionnaire comprised eleven questions on the sexual behaviours of school youths. The sexual behaviour of youths is dependent on many factors apart from knowledge. The findings of the study showed that 56% of the respondents were in a relationship or dating at the time of the study (see table 7). This is a normal developmental process because

change is the hallmark of adolescence which happens to be the transition from childhood to adulthood. Change is in the form of physical, emotional, mental and social characteristics. They usually move toward independence from parents and elders and establish new interests and relationships (Barnette and Schueller, 2000).

There is an atmosphere of independence as compared to the primary school life in terms of peers, teachers and parents. They now freely interact with the opposite sex depending on how they have been prepared emotionally for this developmental stage, they may get into intimate relationships. Dating is normal, it gives them an opportunity to get to know about the opposite sex. 54% of the respondents had already indulged in sexual intercourse, (table 7). Sometimes the youths indulge in sexual intercourse out of curiosity. Sometimes it is done in order to please the group they belong to as a sign of maturity. Without being aware of the consequences, these youths end up getting pregnant, or with an STI/AIDS (CBOH, 2001).

Early sexual activity poses health risks for young women and men. Most youths having sex for the first time do not use contraception and therefore, end up pregnant. Others are usually unaware of the dangers of unprotected sex, therefore contracting HIV/AIDS and other STIs.

In Zambia between 1994 and 1998, a DHS had revealed that 39% of male youths between 15 and 19 years had already indulged in sex before the age of 15, and 22% of female youths had also done the same (PRB, 2001). These actions usually end in STI/HIV infection acquisition, unplanned

pregnancies, incomplete abortions. Instead of a youthful carefully calculated growing period, the prime of their youth is marred by misery, ill-health and if they continue being sexually active, they infect a large portion of their peers or other partners. The females are more vulnerable to HIV infection because of under development of the vagina and uterus.

For the majority that was abstaining, they need to be encouraged to delay the initiation of sexual intercourse. This group is very vulnerable because youths tend to listen more to each other and easily influence each other than they do adults.

*Findings showed that while 34% of the respondents had sex with a regular partner, 20% did so with a casual partner. This exposes them to the risks of contracting HIV/AIDS. Faithfulness to one partner, has been encouraged in all HIV/AIDS campaigns. The YAZ group is concentrating on skills that promote a sense of responsibility in the youths if they are to indulge in sexual activity.*

The majority of respondents,(44%) indulged in sex out of peer pressure. While the fact that peer influence is a major contributor to youth sexual behaviour is acknowledged by a lot of organisations, they also see a way to turn this influence around to produce desired behaviour. UNAIDS, (1999) explains that though young people's understanding of life is influenced by parents and adults, it is developed both with and among peers. These groups of close friends shape the youths' understanding of social relationships.

With encouragement, such influence can channel correct information on HIV/AIDS and sexual behaviour.

38% of the respondents, being the majority had only one sexual partner which shows a degree of stability in sexual relations, what is not known is whether this was the beginning of their sexual relationships or whether it had been like this for a long time. Youths need to be responsible for their sexual behaviours, what may seem to be private, for example a sexual act, is not usually so as it affects many people in their lives. For instance if that act results into the contracting of HIV/AIDS, parents will be involved in their care financially. Emotionally, physically and socially, which makes it no more a private matter (UNAIDS, 2000).

Findings of the study showed that 28% of the youths were always using condoms during sex while 16%, (table 7) never did so. Condom use has always been advised to the youths who cannot abstain. While the majority of the respondents who were using condoms did so always, a smaller group (16%) were taking major risks that could result into HIV infection, it could be that the sources of condom supply, i.e. health centres were not youth receptive, or that they did not know where to obtain the same. In agreement with this, a UNAIDS, (1999) report indicated that in the year 1994 a group of NGOs in Lusaka realised that the existing primary health clinics were not meeting the health needs of the youths, so they joined the MOH and the district council in organising an informal working group to identify these health needs and develop a strategic plan. This was the birth of YFCs.

The majority of respondents who were using condoms stated that they did so for protection, (38%) table 7. This could be as a result of the many television and radio campaigns on condom use.

Most of respondents who had indulged in sex practised vaginal penetration (48%), anal sex(4%) and oral sex(10%), is an indication that these youths know more about sex than adults are willing to accept. Some of the sexual practices in use are not common in the Zambian set up. Findings also showed that only 12% of these respondents were practising dry sex, which is not expected in the school youths. Kevin Barnaby, a Youth for Education and Sexuality trainer noted that his major obstacle in conducting his programmes was denial among adults of the realities of teenage sexuality. His greatest concern was that there were youths sexually active in schools and their parents were insisting that these youths were not ready for such issues (UNFPA, 1996). For as long as adults continue to fight the anti-AIDS programmes, the infection will continue to spread. Adults cannot control these sexual practices among the youth, but by providing advice and accurate information in good time they can help direct sexual behaviours of the youths.

Findings of the study did indicate that alcohol and substance abuse prior sex was uncommon with only 2% of the respondents being involved, (table 7). The use of such substances compromise the ability to make responsible choices like negotiation for safe sex or even the practical aspect of safe sex, one fails to use discretion and ends up taking unnecessary risks. It could

probably be due to the fact that an anti Drug/substance abuse club exists in the school which may be very active and effective.

The majority of the respondents (56.8%) aged between 13 and 16 years were abstaining while 15.4% of those between 17 and 20 years were also abstaining. ( table 8). This could be an indication that the younger group is at risk of being influenced by the older group of which 38.4% were indulging in risky sexual behaviour.

In many parts of Africa, traditional forms of sex education in initiation ceremonies have lost importance, open discussion on sexual matters are sanctioned, the schools have not adequately taken up the task, therefore the youth learn from peers. This information is usually inaccurate. Girls get sexually involved with older partners, these partners are usually of the belief that the girls are free from HIV infection (UNAIDS, 1999).

The findings of the study revealed that the majority of the male respondents, (51.5%) were abstaining while the majority of female respondents, (41.1%) were indulging in risky sexual behaviour, (table 9). Boys and men are generally believed to be less in control of their sexual urges than girls and women. The picture was different in the study. It could be that the girls are involved with older men where they may be having difficulties negotiating for safer sex and most of the male youths have not yet indulged in sexual intercourse. Rwenge (2000), states that girls are particularly likely to engage



in risky sex for economic reasons than boys, which negatively influence their power to use condoms during sexual intercourse.

The majority of respondents with inadequate financial support were abstaining from sex, (75%) while only (40.5%) with adequate financial support were also abstaining, (table 10). Literature disagrees with this in that it is a woman's and girl's relative lack of power over their bodies and sexual lives, supported and re-enforced by their social and economic inequality that make them such a vulnerable group in contracting HIV. Sex is exchanged for food, money, jobs or promotion. Younger boys may also offer sexual favours for money from older women in order to meet financial need (AIDS, 2000).

The findings of the study showed that 71.4% of the respondents who were not utilising YFCs were involved in risky sexual behaviour while 63.3% of those unaware of this service were also indulging in risky sexual patterns, (table 11). This implies that YFCs are either non-functional or inactive because this service is solely for the youths' use and welfare. If the youths are not making use of it, it simply means that it is non-existent. YFCs are situated in all the health centres of Kabwe District, Bwacha is no exception. Being able to talk about one's problems including concerns about one's sexuality, and seeking support are important first steps for boys and girls to protect themselves against unsafe sexual practices (UNAIDS, 2000).

UNICEF (2001) identified some factors contributing to risky sexual behaviour as being unavailable inaccessible or inaccurate information, loss

of control of parent, school and adult communication, and absence or lack of access to social services due to non supportive policies and legislation. Unless the Zambian government tackles the issue of HIV/AIDS with the aggression it deserves, the youth population will be wiped out and there will be no future leaders. The government needs to monitor HIV/AIDS programmes with special attention and financial support. The youth will continue to indulge in sexual activity, hence the need to inform them, direct them and counsel them along the way in order to protect them from infection.

The findings in the area of anti-AIDS club membership revealed that 83.3% of the respondents being members, were indulging in risky sexual behaviour, while 53% of non members were abstaining. What this indicates is that the members are not practising what they learn and teach in the club, they are not good role models for potential members, (table 12). 49% of the respondents were unaware of the presence of this club within the school. The club could be existing on register but no activities being ventured.

Research studies revealed that anti-AIDS club members had influenced their peers positively in their role as peer educators. School pupils thought the clubs provided correct information on HIV/AIDS (Chintomfwa, 1993). With so many years having passed, with anti-AIDS clubs being introduced in schools, it could be that the organisers have run out of fresh ideas and the youths are bored with the same activities. What is needed is imaginative personalities like artists to come up with ideas to revamp the clubs. The world is changing so fast, people need to move with the times. Probably this

was the case in the above findings due to the fact that maybe the youths with inadequate financial support having lost parents or a parent from HIV/AIDS learnt best how to avoid infection after the experience in the home.

## **5.5. KNOWLEDGE AND SEXUAL BEHAVIOUR**

While knowledge and sexual behaviour of the school youths are expected to go hand in hand, it is not always the case. Literature review showed that not in all cases where the knowledge level was high, that sexual behaviour was positive. In some cases knowledge was mistaken for awareness. In the study, findings showed that majority of the respondents who had medium to high levels of knowledge were also abstaining from sexual intercourse. Contrary to these findings, Chambeshi and Fetters, (1998) after a study on knowledge, attitude and sexual behaviour on a group of school youths concluded that while knowledge and awareness of HIV/AIDS were generally high, risky sexual behaviour remained common.

Educational factor in the fight against HIV/AIDS is not an easy but an effective tool if properly done and executed from a point of clear understanding of the issues. Young people should be made aware of all the options to protect themselves. Knowledge does improve sexual behaviour if tactfully imparted to the youths and at the right time.

The hypothesis that inadequate knowledge on HIV/AIDS leads to risky sexual behaviour has been accepted, the majority of respondents with

medium to high levels of knowledge (65.2%) were also abstaining from sexual intercourse, (table 13).

## **5.6. IMPLICATIONS TO THE HEALTH SYSTEM**

HIV/AIDS is a very serious issue that deserves no chance taking. Every individual has the right to information on this infection and most especially the vulnerable groups.

The study revealed that the youths are not receiving much information from health care providers. The YFCs are not meeting the targeted objectives, which means that youths with problems are not utilising health personnel in an attempt to find solutions to their problems. This implies that health personnel need to be the educators of these youths on HIV/AIDS and its dangers. They have been trained to address such issues, they happen to be the best information providers and therefore able use every opportunity to teach according to the situation, as these youths come to the clinic. Visual aids like posters could be used to emphasize these lessons.

Most times, the youths turn to colleagues for information who may happen to be misinformed. This results in many getting HIV infection and other STIs and not seeking medical attention in good time, but in the process infect many others. The end result is that the health care system becomes congested, over-utilised depleting medical supplies. Health worker have the skills aimed at winning the confidence of these youths by providing privacy

and confidentiality, and in so doing developing rapport necessary for counselling sessions.

It takes two to twelve years for HIV infection to progress into AIDS and finally death, which deprives the health sector of 'would have been' health personnel. Besides this the treatment of opportunistic infections resulting from HIV infection is very expensive, putting considerable strain on the delivery of quality health services in Zambia. The average length of stay for AIDS patients is assumed to be 30 days or more (CBOH, 1999).

This means that health workers will spend more time on these patients than on preventive care in the community. There will be shortage of staff, depletion of available resources and long bed occupancy depriving other patients of care and attention deserved. Congestion and overcrowding will be common features facilitating cross infection to patients and staff, therefore compromising care.

When health workers spend a lot of time educating and counselling these youths, the end result will be that most of them will abstain from sex or practise safe sex, therefore reducing the numbers of ailing youth from opportunistic infections, cases of unplanned pregnancies or sexually transmitted infections. An educated youth will result in healthy adults and therefore a healthy nation.

It may seem as though most people know all there is to know about HIV/AIDS but it is not the case. Health education needs to be intensified

stressing issues like the need to change lifestyles, mode of transmission, signs and symptoms and even the consequences of HIV infection. Health workers need to therefore collaborate with communities like schools, homes and churches for their co-operation (Mwape, 1997).

Health workers need to be in the fore front in mobilising and incorporating the community members like the schools and churches to ensure that the youths receive accurate and appropriate information on HIV/AIDS. They should be in the forefront of educating the parents and teachers in an attempt to break the silence surrounding sex and AIDS.

Youths will continue to participate in sexual behaviour despite the prevalence of HIV/AIDS. Many sexually active youths have unprotected sex and do not use contraception. Those using condoms, do so inconsistently that is why STIs and HIV prevalence is so high among the youths, and so are pregnancies and abortions.

Health workers need to bear in mind that not all the youths will abstain from sexual intercourse, so they need to be flexible in handling counselling sessions. They need therefore teach them protection skills like condom use and disposal.

## **CHAPTER SIX**

### **6.0. CONCLUSION AND RECOMMENDATIONS**

#### **6.1. CONCLUSION**

The assessment of knowledge on HIV/AIDS among junior secondary school youths in Kabwe District was worthwhile in providing base line data for program formulation in fighting the scourge. The youths did not have adequate information on HIV/AIDS.

While 58% of the respondents had medium to high levels of knowledge, 42% is too much for zero to low levels of knowledge for Zambian youths, this is because they have lived in era of HIV/AIDS since the early 1980s. The educational system stipulates the introduction of HIV/AIDS and sex lessons as from grade seven, but 4% of the respondents claimed not to have heard about HIV/AIDS. It is possible that these lessons are being omitted in both primary and secondary school lessons.

While anti-AIDS clubs exist, they are inactive . Some respondents from grade eight and grade nine were not even aware of the presence of anti-AIDS club and those that were members were still indulging in risky sexual behaviours.

While the majority of the respondents (46%) were abstaining, 34% of them were indulging in risky sexual behaviour, (pie graph 2). Considering the level of their education, i.e. junior primary, 34% of risky sexual behaviour is not a good sign, these youths have been exposed to a lot of information on

HIV/AIDS by the educational curricular and otherwise, it would have been expected that such risks are avoided. UNAIDS, (1999) identifies adult support as the biggest need young people around the world have expressed, understanding from parents, teachers and leaders, who they can turn to and trust, who will listen as they explain what they are experiencing and how to cope. They need a confidant to cope with their sexuality issues. There was a positive correlation between high levels of knowledge and sexual behaviour. Knowledge seems to help in modifying sexual behaviour.

## **6.2. RECOMMENDATIONS**

1. Health workers need to develop strategic plans of disseminating information on HIV/AIDS and its impact.
2. Health workers need to get involved in anti-AIDS clubs through planning, implementing, monitoring and evaluation with teachers and pupils. They need to ensure that these clubs remain active.
3. Health workers need to show apathy to youths who come for counselling or consultation, offering them all the available options to ensure healthy habits. Their records must be kept confidential.
4. There is need to teach mothers and fathers coming for antenatal, postnatal, family planning and children's clinics on the need to break the silence surrounding HIV/AIDS and sex in order to ease dialogue with their children from early in life.



5. AIDS lessons in school health programmes need to be revised in order to capture the attention of the school youths. These lessons need to be intensified earlier in primary school. The heads of the schools need to periodically monitor these lessons and take note.
6. Teachers' training colleges need to include training skills in the field of sex education and HIV/AIDS and refresher courses for those already in the teaching field.
7. MOE and MOH need to work together in designing the curriculum for school on HIV/AIDS and consult each other at regular intervals.
8. More studies need to be conducted to evaluate both the HIV/AIDS teachings in primary and secondary schools on a larger scale to identify the source of the inertia.
9. 10. Studies need to be carried out on the effectiveness of YFCs in the health centres.

### **6.3. LIMITATIONS OF THE STUDY**

The sample size was small due to limited funds and the time for the study. Generalisation to a larger population cannot be made.

Most of the respondents did not have anything to suggest on how to improve the youths' knowledge and sexual behaviour. They claimed not to have any suggestions.

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### **SEMI-STRUCTURED QUESTIONNAIRE**

**A study to determine Knowledge on HIV/AIDS and Sexual behaviour of Junior Secondary School Youths in Kabwe district.**

Serial no.....

Date.....

Grade.....

#### **Instructions to the respondent:**

1. Please DO NOT indicate your name on the questionnaire.
2. Information given will be treated as confidential.
3. Tick your answer, you may have more than one response in some questions, tick as necessary, e.g.
  - a)
  - b)
  - c)
4. Open-ended questions must be answered in the spaces provided.
5. Give responses honestly, this is NOT a test.
6. Please answer ALL questions.
7. If not sure, please seek clarification from the researcher.
8. DO NOT write in the boxes on the extreme right.
9. Thank you your co-operation.

**SECTION A**

**DEMOGRAPHIC DATA**

1. How old are you?.....

2.What is your sex?

a) Female

b) Male

3.What is your religion?

a) Christian

b) Moslem

c) None

d) Other, (specify).....

4.Do you get adequate financial support from your guardian?

a) Yes

b) No

5.If no to no. 4 explain why.

a) Guardian unemployed

b) Not enough money in the home for all

c) Other (specify).....

6. In what grade are you?

a) Eight

b) Nine

7.Do you know of any Youth Friendly Corners in your community?

a) Yes

b) No

8. If yes to no.7 do you use such services?

a) Yes

b) No

9. Give reasons for your answer in no. 8.....



10. Is there an anti-AIDS club in your school?

a) Yes

b) No


--

11. If yes to no.10, are you a member?

a) Yes

b) No


--

12. Give reasons for your answer in no.11

.....

.....

--

13. Where can one obtain condoms?

a) Shops

b) Health centres

c) Society For Family Health

d) School clubs

e) Bars

f) Others, (specify).....


--

## **SECTION B**

### **KNOWLEDGE**

14. Have you ever heard of an illness called AIDS?

a) Yes

b) No


--

15. If yes to no.14, what causes AIDS?

a) Mosquito bites

b) HIV virus

c) Witch craft

d) Do not know


--

16. If yes to no. 14, where did you hear about AIDS from?

a) T.V./Radio

b) Friends

c) School

d) Health centres

e) Others, (specify).....


--

17. How can one get HIV/AIDS?

a) Sexual intercourse

b) Blood transfusion with unscreened blood

c) Mosquito bites

d) Contaminated razor blades and needles

e) Sharing bathrooms and toilets


--

- f) Breast milk to babies
- g) Don't know

☐  
☐

18. How can a person avoid getting HIV/AIDS?

- a) Abstain from sex
- b) Use a condom
- c) Avoid sex with prostitutes
- d) Take medicines
- e) Hygiene
- f) Don't know

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☐

19. Is there a cure for AIDS/HIV?

- a) Yes
- b) No

☐  
☐
☐

20. If yes to no. 19, where can such a cure be obtained from?

- a) Hospital
- b) Traditional healer
- c) Abroad
- d) Others, (specify).....

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21. How does a person with HIV look?

- a) Thin
- b) Ordinary
- c) Sick
- d) Don't know

☐  
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☐

22. What are the common problems people with HIV/AIDS suffer from?

- a) Diarrhoea
- b) Fever
- c) Sores on the body
- d) Chest infection/T.B.
- e) Don't know

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## **SECTION C**

### **SEXUAL BEHAVIOUR**

23. Are you currently dating?

- a) Yes
- b) No

☐  
☐
☐

24. Have you ever had sexual intercourse?

- a) Yes

☐
☐

b) No

25. If yes to no. 24, whom did you have sex with?

a) Regular partner

b) Casual partner

c) Other, (specify).....


--

26. Why did you engage in sexual intercourse?

a) For financial reasons

b) Under peer pressure

c) Out of curiosity

d) Other, (specify).....


--

27. How many sexual partners have you had?

a) None

b) One

c) Two to five

d) More than five


--

28. What type of sex do you practise?

a) Anal

b) Vaginal penetration

c) Oral

d) Masturbation

e) Other, (specify).....


--

29. Have you ever indulged in dry sex?

(sex where medicines, agents or sponges are used to dry the normal vaginal fluids before sex).

a) Yes

b) No


--

30. How often do you use condoms when having sex?

a) Always

b) Sometimes

c) Never


--

31. If yes to no.30, why do you use condoms?

a) To protect self

b) They are comfortable

c) They are readily available

d) Partner suggested use


--



e) Other,(specify).....

33. Do you discuss issues on HIV/AIDS with your partner(s)?

a) Yes


b) No

--

34. Have you or your partner ever used drugs or alcohol before sex?

a) Yes


b) No

--

35. Any suggestions on how to improve the sexual behaviour of junior secondary school youths?

.....  
.....

--

**THANK-YOU**

Yours faithfully  
M. M. M. (Mrs.)  
COURSE CO-ORDINATOR  
DEPARTMENT OF POST BASIC NURSING



**THE UNIVERSITY OF ZAMBIA**  
**SCHOOL OF MEDICINE**  
**DEPARTMENT OF POST BASIC NURSING**

Telephone: 252453  
Telegrams: UNZA. LUSAKA  
Telex: UNZALUZA 44370  
Fax: +260-1-250753  
E.mail: [pbnu@coppernet.zm](mailto:pbnu@coppernet.zm)

P.O. Box 50110  
Lusaka, Zambia

16<sup>th</sup> May 2001


Dear sir/Madam,

This serves to introduce Mr/Mrs/Ms. EVA MPHEZA M. WOMANI, a Fourth Year BSC (Nursing) student in the Department of Post Basic Nursing, School of Medicine, University of Zambia. The student is undertaking a Research Study in partial fulfilment of the above mentioned degree.

The Research Topic for study is A STUDY TO DETERMINE KNOWLEDGE ON HIV/AIDS AND SEXUAL BEHAVIOUR OF JUNIOR SECONDARY SCHOOL YOUTHS IN KABWE DISTRICT

We shall be most grateful if you could access the student to information on the subject or clients and any other assistance the student may require.

Yours faithfully

  
C.M. Ngoma (Mrs.)  
COURSE CO-ORDINATOR  
DEPARTMENT OF POST BASIC NURSING

University of Zambia,  
School of medicine,  
Department of Post Basic Nursing,  
P.O. Box 50110R.W.  
Lusaka.

The District Educational Officer,  
Ministry of Education,  
P.O. Box 80197,  
Kabwe.

Dear Sir,

Re: request for permission to collect data.

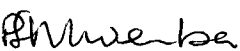
I am a fourth year student at the above institution requesting for permission to collect data from one of your schools. My study is aimed at determining the knowledge on HIV/AIDS and the sexual behaviour of junior secondary school youths in Kabwe district.

I hope my letter will meet your prompt response.

Thanking you in advance. Yours faithfully,

Eva M. Wonani.



  
for /Head of Department



REPUBLIC OF ZAMBIA

# MINISTRY OF EDUCATION

Bwacha High School  
P.O. Box 81051  
Telephone: 224309  
KABWE  
CENTRAL PROVINCE

30th November 2001

Miss Eva M. Wonani,  
The University of Zambia,  
School of Medicine,  
Department of Post Basic Nursing  
P.O. Box 50110 R.W.,  
LUSAKA

Dear Madam,

RE: PERMISSION TO COLLECT DATA IS  
GRANTED TO YOURSELF

This serves to inform you that your request to collect data  
on "determining the knowledge on HIV/AIDS and Sexual behaviours  
of Junior Secondary Youths in Kabwe District," is granted to you.

You come to conduct your questionnaire to Grades 8 and 9 pupils  
on 4th December, 2001 in a classroom comprising of 50 pupils

Yours faithfully

P.T. KABANDAMA  
HEADMASTER  
BWACHA HIGH SCHOOL

/es\*

\*Property of UNZA Library



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