UNIVERSITY OF ZAMBIA

SCHOOL OF MEDICINE

DEPARTMENT OF POST BASIC NURSING

A STUDY TO DETEMINE HOW CULTURAL PRACTICES AND BELIEFS INFLUENCE THE SPREAD OF HIV/AIDS, LUSAKA.

KAMUWANGA CHAZE
REGISTERED MIDWIFE, UTH 1992
REGISTERED NURSE, UTH 1987

A RESEARCH STUDY SUBMITTED TO THE SCHOOL OF MEDICINE, DEPARTMENT OF POST BASIC NURSING, IN PARTIAL FULFILMENT OF THE REQUIREMENTS OF THE BACHELOR OF SCIENCE IN NURSING DEGREE (B.Sc. NSG).

DECEMBER, 2000.

STATEMENT

I hereby certify that this study is the result of my own labor and independent investigation. I have clearly indicated the various sources to which I am indebted throughout the text and in my reference.

SIGNED..... Kamuwanga...

DATE..... 9/2/2001.....

DEDICATION

This work is dedicated to Dallas Phiri for being very patient with me. He was a good boy when I was too busy and never their for him.

It is also dedicated to Mr. Nasilele Kamuwanga for being a caring, understanding and loving father. He was there for me when every thing seemed hopeless and nobody to turn to.

ACKNOWLEDGEMENT

I wish to acknowledge firstly my supervisor Mr Bupe Bwalya for patiently guiding me through this study. I greatly appreciate his professional advice and critical analysis. I also want to sincerely thank the following:

Mrs Ngoma for her generous support and advice.

Ministry of education headquarters, Lusaka province, and Heads of Arackan, Satung, Matero, and Kabulonga Secondary Schools for allowing me to carry out the research in their schools.

Mwata for *Likumbi Lya Mize* cultural association for organizing the Luvale traditional counselors for me.

Mamsa Siyunyi (Gender analyst) from GID for her support and for organizing Alangizi association members for me.

Ministry of Health for the sponsorship.

Mrs Mercy Mbewe for encouragement and the books she borrowed me during the study.

My friends and family for their continued support throughout the whole period I was studying.

All those who had assisted in one-way or another in making this study a success.

DECLARATION

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

SIGNED Kamuwanga DATE 9/8/2001

STUDENT

APPROVED ..... DATE .....

SUPERVISING LECTURER

UNIVERSITY OF ZAMBIA
DEPT. OF POST
BASIC NURSING
SCHOOL OF MEDICINE

STATEMENT

I hereby certify that this study is the result of my own labor and independent investigation. I have clearly indicated the various sources to which I am indebted throughout the text and in my reference.

SIGNED ..... Kamuwanga .....

DATE ..... 9/8/2001 .....

DEDICATION

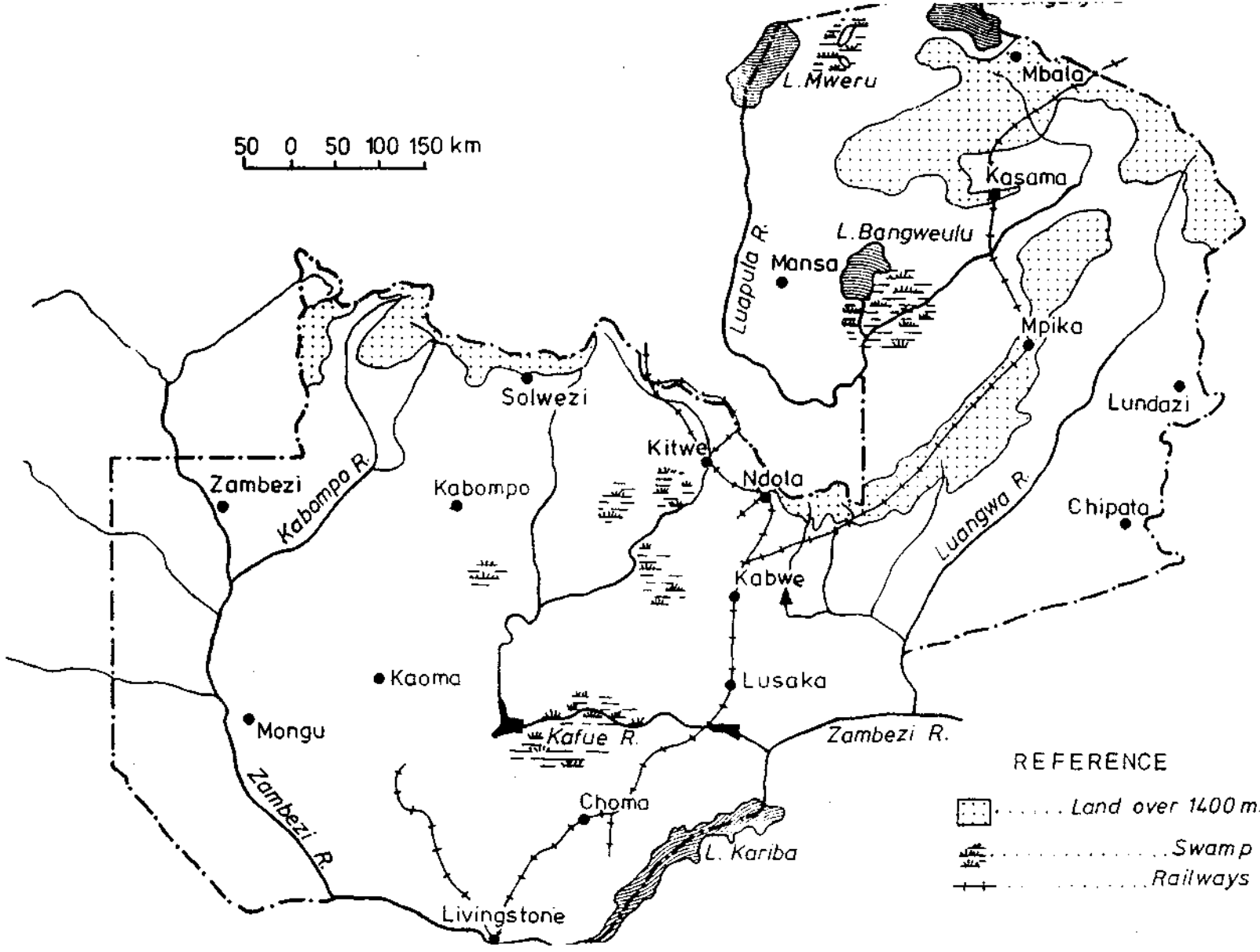
This work is dedicated to Dallas Phiri for being very patient with me. He was a good boy when I was too busy and never their for him.

It is also dedicated to Mr. Nasilele Kamuwanga for being a caring, understanding and loving father. He was there for me when every thing seemed hopeless and nobody to turn to.

TABLE OF CONTENTS

CHAPTER SIX

List of Tables


50 0 50 100 150 km
L. Mweru
Mbala
Kasama
L. Bangweulu
Luapula R.
Mansa
Mpika
Lundazi
Solwezi
Kitwe
Ndola
Zambezi
Kabompo R.
Kabompo
Luangwa R.
Chipata
Kabwe
Kaoma
Lusaka
Mongu
Kafue R.
Zambezi R.
Choma
L. Kariba
Zambezi R.
Livingstone
REFERENCE
Land over 1400 m.
Swamp
Railways

LIST OF TEXT BOXES

ABSTRACT

The study sought to determine how cultural practices and beliefs influence the spread of HIV/AIDS in Lusaka urban. The objectives of the study were to: examine how gender roles make girls and women vulnerable to HIV/AIDS, establish the actual significance of sex education in the spread of HIV/AIDS, explore the risks of HIV infection in the marriage patterns, establish the role of other forms of sex union in the spread of HIV/AIDS.

A cross sectional study was carried out from July to August 2000, in Lusaka urban. The researcher divided the eight health zones in Lusaka into four areas (i.e. two zones per area). Matero Girls, Kabulonga Girls, Satung Modern and Arackan Secondary Schools, were randomly selected from the four areas. Fifteen females were systematically selected from the senior classes of each school. Eighty traditional counsellors were purposively selected.

An open-ended interview questionnaire and focus group guide were used to collect data. Quantitative and qualitative data techniques were used to analyse data. The results revealed that several cultural practices are taught during initiation i.e. sex education lessons (e.g. dry sex, pulling labia minora), Gender roles (e.g. obedience, respect and submission), marriage patterns (e.g. polygamy and spouse inheritance) and Sexual unions (e.g. sexual cleansing).

The study also revealed that gender roles and pulling of labia minora ('playing') practices start at a tender age i.e. 9 years. The results show that it is problematic to discourage a negative practice because the cultural practices are interrelated. For instance, *lobola* gives a man 'legal' right to be sexually cleansed and for marriage to be recognised, dry sex works hand in hand with pulling labia minora and gender roles are part and parcel of every initiation lesson. The traditional counsellors' cultural interpretation of STI/TB/HIV/AIDS transmission is in conflict with the scientific interpretation in the HIV/AIDS prevention and control messages.

The study concluded that women are compelled to uphold cultural practices and beliefs to avoid being rejected by men for other women. It was recommended that all the stakeholders should be involved in the HIV/AIDS prevention and control programmes. Another recommendation was that there is also need to conduct another research on the same topic but on a larger scale (i.e. Nation wide), for results to be generalised to the rest of the country.

LIST OF ABBREVIATIONS

AIDS:	Acquired Immune Deficiency Syndrome.
CBOH:	Central Board of Health.
HIV:	Human Immuno Virus.
MOH:	Ministry Of Health.
NGO:	Non-Governmental Organization.
STI:	Sexually Transmitted Infections.
UNAIDS:	Joint United Nations Programme on HIV/AIDS
UNICEF:	United Nations Children's Fund.
UNESCO:	United Nations Educational Scientific and Cultural Organisation
US:	United States.
USA:	United States of America.
WHO:	World Health Organisation.

CHAPTER ONE

1 INTRODUCTION

Zambia is a land locked country covering an area of 752,614 square kilometers; it has a population of 10.4 million. Forty seven per cent of the population is below the age of 15 years and the dependency ratios are high.[1]

Zambia is divided into nine provinces namely: Lusaka, Central, Southern, Northern, Northwestern, Western, Eastern, Luapula and Copper belt. There are seventy three officially recognized ethno- linguistic groups.

Lusaka the capital city of Zambia is situated in Lusaka province. Zambia being the second most urbanized country in sub-Saharan Africa (after South Africa) has most of it's population concentrated along the line of rail. Lusaka City has a population of 1.3 million.[2] High population concentration in Lusaka has led to a proliferation of unplanned for shanty compounds, which has created many social problems. Social services are struggling to cope, and there is environmental degradation.

Zambia has not been spared from the AIDS epidemic which started in the late 1970s.The HIV infection global picture according to United Nations 1998 estimations show that there were 33.4 million people infected with the virus of which fifty per cent were women. Twenty-two and half million of the above were found in Sub Saharan Africa. Another 13. 9 million persons have already died from the disease since the beginning of the epidemic, mostly in Africa. About

---

[1] Duncan Tyrrel (1996); Prospects for Sustainable Human Development in Zambia, United Nations Systems, Lusaka page 19

[2] Ibid

590,000 infants now become infected each year, about ninety per cent of who are African children.[3]

It is evident from the above figures, that HIV/AIDS epidemic is more devastating in the Sub Saharan African countries i.e. South Africa, Mozambique, Namibia, Botswana, Zimbabwe, Zambia, Malawi, Congo D. R., Tanzania, Rwanda, Burundi, Uganda and Kenya, Togo, Sierra Leone, Nigeria, Ethiopia, Eritrea, Chad, Congo, Cote d'Ivoire, Guinea Bissau, Burkina Faso, Cameroon, Liberia and Lesotho.

The whole world has embarked on various educational campaign programmes to curb the HIV/AIDS epidemic scourge. The massive prevention intervention programmes in Zambia have included education of policy makers, traditional healers, church leaders, sex workers and the population at large, through workshops, print and electronic media. Yet, the figures of new cases are not going down i.e. number of AIDS cases is expected to rise from 93 000 in 1999 to 101 000 in 2004. HIV/AIDS is still affecting lives of millions of people. Lusaka province has the highest HIV prevalence estimates in Zambia. Lusaka urban has the highest values as shown in Table 1-1.

Owing to the magnitude of the HIV/AIDS problem there is need for a solution i.e. scientists to come up with a drug and researchers to come up with effective, and acceptable recommendations. A study done by MOH/CBOH in 1999 indicated that the following factors contribute to the spread of HIV in Zambia:

- ✓ Prevalence of Sexually Transmitted Infections (STI).
- ✓ Poverty and poor overall health.
- ✓ Low status of women.
- ✓ Urbanization and mobility.

---

[3] MOH/CBOH (1999): HIV/AIDS in Zambia, Lusaka, page 1.

- ✓ Early sexual activity.
- ✓ Cultural practices.[4]

Table 1-1: Zambia Hiv Prevalence Estimates By District

Province/district	HIV prevalence 15-49	HIV+ total 15-49	HIV+ urban 15-49	HIV+ rural 15-49	HIV+ total 50+	HIV+ 15+ older
Lusaka province	27.0%	192,556	170,294	22,262	9,574	202,130
Chongwe	19.6%	13,184	4,125	9,059	761	13945
Kafue	19.6%	16,114	5,042	11,072	931	17,045
Luangwa	18.7%	2,396	265	2,131	348	2,744
Lusaka Urban	29.5%	160,861	160,861	-	7,533	168,394

Source MOH/CBOH (1999) Page 72.

The vast majority of people in all cultures engage in sexual intercourse through out their adult lives. Sexual conduct is embedded in cultural practices since, customs, beliefs, and practices have a bearing on how the society functions. Hence, the researcher assumed that culture has a big role to play in the spread of HIV/AIDS in Zambia.

Surprisingly, HIV/AIDS is more pronounced in sub-Saharan Africa where the cultures are mostly patriarchal. In patriarchal cultures a woman's place in society is subordinate to that of a man. For instance being male is more than enough for a man's value, whilst a woman has to heighten her value by getting married, reproducing children and produce more food from her children's labour.

[4] Ibid

Although, most countries of the world have worked to improve women's education and employment opportunities most women still lag behind men. The *population crisis centre in ranking countries on the status of women found sub-*Saharan countries to rank among the lowest.[5]

1.1 STATEMENT OF PROBLEM

The World Health Organisation (WHO 1999) reported that unequal gender relations are driving the epidemic and women are disproportionately affected by the epidemic.[6]

Zambia is a country with diverse and multiple cultural practices of which some are beneficial to the community while others have contributed to the spread of HIV/AIDS, especially those pertaining to sexual and marital practices. The study therefore sought to determine how cultural practices and beliefs influence the spread of HIV/AIDS. The following were some of the researcher's assumptions of the cultural practices and beliefs that influence the spread of HIV/AIDS:

Gender Roles

A female is raised to be submissive to a male figure i.e. father, brother, male cousin, and uncle. During initiation, obedience and submission to her husband to be, is stressed. This gives the male figure an upper hand over a woman's life such that she has very little control over her sexuality and reproductive rights. This is more pronounced in situations whereby a man proposes marriage and pays *lobola.*

Lobola tends to place a woman in a position of property not a partner to her husband. Since, property does not make decisions, the woman has no reproductive rights. She cannot even decide whether to have children or not.

---

[5] Essex Max et al (1994): AIDS in Africa, Raven Press, New York, page 535

[6] WHO (2000): Impact of AIDS on Gender Roles, Geneva, page 223.

Further, she has no power to decide when to have sex or whether to have safe or unsafe sex.

Traditionally, family members are entitled to a woman's labour, food she produces and to her other day to day services. This sets a condition, which forces a woman to try by all means to provide for her family, even when she does not have a steady source of income. Considering many Zambians are living in abject poverty owing to among other things redundancies, high inflation rates and high cost of living.

Many women have been forced to adopt desperate coping strategies such as prostitution and petty trading. In Chainda, for instance some parents arrange with their daughters to trap rich men into marrying them. Such young girls find themselves getting into a cycle of early marriage and divorce.[7]

Some girls sell by the roadsides and they are vulnerable to being sexually abused by their male customers.[8] This practice is likely to increase the chances of young girls getting HIV infection. Since, a sexually abused person does not give consent, it is up to the abuser to use a condom or not use a condom.

Sex Education

A woman has to learn how to please her sexual partner. That is, through initiation ceremonies and bridal showers. She can be sent back for re-training if her husband is not satisfied with her performance. During initiation ceremonies girls are taught how to pull labia minora and how to dance during sexual intercourse. This is likely to preoccupy their young minds with preparing themselves for sex. Unfortunately, a learner always has to practice the skills learnt otherwise he/she forgets. This applies to the girls, and it is more likely to result in early sexual indulgence.

---

[7] Shinkanga Monica (1996): Child Sexual Abuse in Zambia, UNICEF, Lusaka, page 10.

[8] Ibid

The sex dance demonstrations focus on skin-to-skin type of sex i.e. unsafe sex. In some traditions the girls are showed where to find roots and herbs, which will keep their bodies hot. The roots and herbs also keep their introitus tight, hot and dry i.e. for dry sex. The girls are also advised never to say 'no' to sex whenever a husband demands. A male partner could also easily sexually abuse the woman who has been denied the right to refuse sex. Against this background perhaps it may be difficult to change the attitude of women towards unsafe sex practices. Since this is a norm in the Zambian culture.

The young girls are also told that when they please a sexual partner in bed he will give them gifts as tokens of appreciation. This might be the other reason why girls engage themselves in premarital sex. They could be testing their dexterity in bed. When they realize that they can get a lot of money they enter into prostitution.

Marriage Patterns

Marriage is held in very high esteem and a woman has to get married for her to gain respect in society. Some customs encourage early marriages as soon as a girl reaches puberty. Owing to the stigma associated to single hood, some women in desperation may give in to any man hoping to get married. The married women also have to try by all means to maintain their status quo. This is all to men's advantage because they can be promiscuous and practice unsafe sex, with their wives and concubines.

Polygamy is culturally accepted as long as a man can afford to look after more than one wife. The man can marry whenever he feels like marrying. Infact, fidelity is essential for females whilst infidelity is culturally acceptable for males. Men are allowed to have extramarital affairs. These practices encourage multiple sexual partners who may expose men and their sexual partners to HIV/AIDS.

The inheritance custom allows a brother, cousin, nephew or uncle to inherit both the property and the wife of the deceased relative. A niece, sister or cousin chosen by the deceased relative's husband is married to look after the

deceased's children. Despite the HIV/AIDS scourge, the family may honour the marriage, especially where there are riches involved.

Some communities allow a man to have an affair with a wife's female relative, for instance Bemba speaking communities. Such type of practice is referred to as "*Mpokeleshi*". This is another form of sexual abuse of young girls, which is likely to expose them to HIV/AIDS.

Other Forms Of Sexual Union

Sexual cleansing is practiced by most of the Zambian cultures. A widow or widower is allowed to have sex with her or his late partner's relative, regardless of the cause of death. The union can even result in marriage. "In some societies such as among the Yao and Chewa of Malawi and Zambia a girl who has reached puberty is sometimes coerced into having sexual intercourse with certain elders of the community.[9]" This is accepted as the norm. Such practices may contribute to the spread of HIV infection and unwanted pregnancies among the young girls.

Witchdoctors at times sleep with their clients as part of treatment especially for infertility. Traditional healers also recommend that their clients sleep with a virgin as a remedy for STIs, HIV and impotence and as a means of "juju" (witchcraft to get rich).[10]

This may make the virgins vulnerable to HIV infection. In view of the above stated factors, the study intended to determine how the cultural practices and beliefs influence the spread of HIV/AIDS. The study also aimed at ascertaining what role the policy makers and stakeholders can play in mitigating the negative cultural practices and beliefs.

---

[9] Mkandawire Richard, (1995): The Plight of a Girl Child in Commonwealth Africa, Commonwealth Youth Centre, UNZA, Lusaka, page 6

[10] Shinkanga Monica (1996): Child Sexual Abuse, UNICEF, Lusaka, page 11.

1.2 JUSTIFICATION

The cultural practices and beliefs are generally the same in most Zambian tribes. The sexuality facets of the Zambian culture place a female in a vulnerable position. For instance, a woman has been denied the right to refuse sex or decide to use a condom. The fact that women lack decision-making power on the issue that affects their sexuality poses a major challenge to the spread of HIV/AIDS. This is because patriarchy demands total control over women's bodies and lives making them powerless.

Therefore, there is need to explore cultural practices in order to determine their impact and to try and find ways to discourage harmful practices. The study examined the existing barriers to safe sex by looking at initiation ceremony. That is the most important practice, which enables girls to live according to cultural norms of their ethnic group.

The study enabled the researcher to make suggestions and recommendations to policymakers' and Stakeholders so that an enabling environment for safe sex by empowering women to control their sexuality and fertility could be created. It was hoped that the findings of the study would help to reduce the spread of HIV/AIDS and to restore the fundamental rights of women (i.e. sexual and reproduction) as Zambia is a signatory to these rights. It was also hoped that the study would also provide a useful insight to the prevailing vulnerability of women to HIV/AIDS perpetuated by negative cultural practices and beliefs.

The study was also undertaken in partial fulfillment of the Bachelor of Science in Nursing Degree Programme.

1.3 HYPOTHESIS

Cultural practices and beliefs influence the spread of HIV/AIDS.

1.4 OBJECTIVES

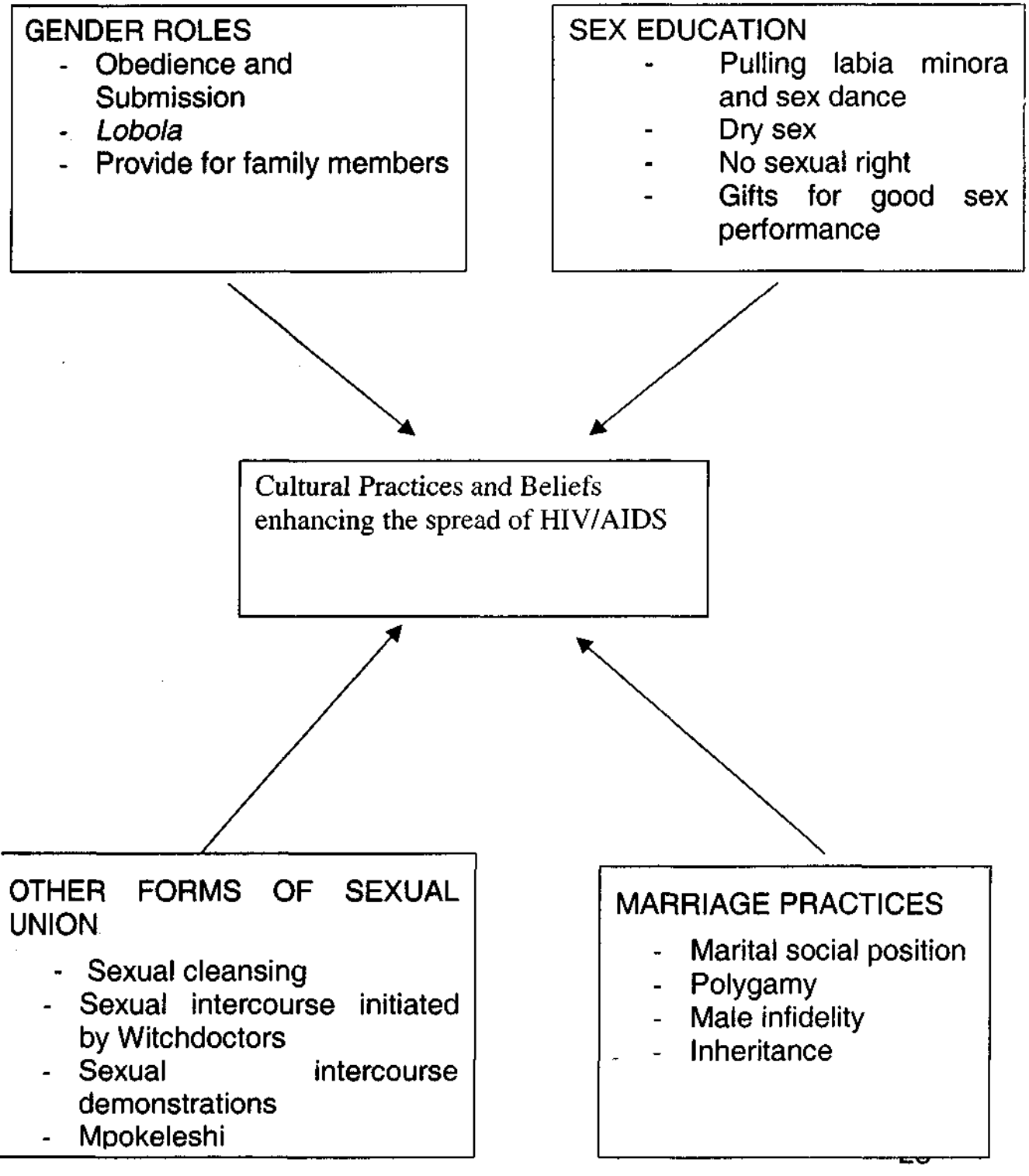
General Objective

To analyse the prevailing cultural practices and beliefs, and determines how they influence the spread of HIV/AIDS.

Specific Objectives

- ✓ The specific objectives of the study were:
- ✓ To examine how gender roles make girls and women vulnerable to HIV/AIDS.
- ✓ To establish the actual significance of sex education in the spread of HIV/AIDS.
- ✓ To explore the risks of HIV infection in the marriage patterns.
- ✓ To establish role of other forms of sex union in the spread of HIV/AIDS.
- ✓ To make recommendations to policy makers, and organizations dealing with women' s rights.

Figure 1: PROBLEM ANALYSIS DIAGRAM OF POSSIBLE CULTURAL PRACTICES AND BELIEFS INFLUENCING THE SPREAD OF HIV/AIDS



1.5 CONCEPTUAL DEFINITIONS

Culture

Culture is the integrated pattern of human knowledge, belief and behavior. It consists of: language, ideas, beliefs, customs, taboos, codes, institutions, tools, techniques, rituals, ceremonies, and folklore's. It also includes what we think, how we act, and what we own[11].

Gender

Gender is a concept that refers to the social difference as opposed to the biological ones, between women and men that have been learned, are changeable overtime and have variations both within and between cultures[12].

HIV/AIDS

HIV is the virus that causes AIDS; it destroys the biological ability of the human body to fight opportunistic infections such as TB. AIDS is a syndrome of opportunistic diseases with acquired immunodeficiency following infections with HIV.[13]

Epidemic

Epidemic is a term used to describe the outbreak of an infective disease affecting a large number of people at the same time in a limited specified area.[14]

---

[11] Giddens A. (1993): Sociology, Polity Press and Blackwell, Oxford.

[12] European Commission (1998) One Hundred Words for Equality: A Glossary Of Terms on Equality Between Women and Men, Luxembourg, page 31.

[13] MOH/CBOH (1999): HIV/AIDS in Zambia: Background, Projections, Impacts, Interventions, Lusaka, page 3.

[14] Vloke Marie (1996) Manual of Community Nursing and Communicable Diseases, Fifth edition, Juta and Company Limited, Cape Town, page 600

Pandemic

Pandemic is the term used to describe the outbreak of a worldwide epidemic. [15]

Safe Sex

Safe sex is practicing, abstinence, mutual monogamy, reducing number of sexual partners and using condoms.[16]

Sexual Abuse

Sexual abuse can be physical, verbal or emotional and includes: sexual touching and fondling, exposing children to adult sexual activity or pornographic movies and phonographs, having children pose, undress or perform in a sexual fashion on film or in person "peeping" into bathrooms or bedrooms to spy on a child, rape or attempted rape. It involves forcing, tricking, bribing, threatening or pressuring a child into sexual awareness or activity.[17] People who have suffered sexual abuse are more prone to low self-esteem earlier consensual, sexual activity and high-risk behaviors, such as multiple partners.

Norms

Norms are rules and expectations by which a society guides the behavior of its members.

Beliefs

Beliefs are specific statements that people define to be true.

---

[15] Ibid.

[16] Op Cit.

[17] Family Health International (1997), Reproductive Health of Young Adults: Contraception, Pregnancy and Sexually Transmitted Diseases, North Carolina, page

Dry Sex

Dry sex is the practice of using herbs to dry the vagina and make it tight for the purpose of giving the male partner more pleasure by increasing penile vaginal friction. This practice increases the likelihood of transmission through tears in the vaginal wall.[18]

Sexual Cleansing

Sexual cleansing is a common ritual where a widow/widower has sex with a relative of her late spouse. It provides risk for HIV transmission if one of the partner is infected.

Polygamy

Polygamy is a practice, which allows a man to have more than one wife.

1.6 INDICATORS AND CUT OFF POINTS FOR VARIABLES

Independent Variables

An independent variable is a variable assumed to cause changes in a dependent variable. In this study independent variables are the cultural practices, which have been tested if they influence the spread of HIV/AIDS, or not.

---

[18] Macwangi M. et al (1994): Women and AIDS in Zambia: Situation Analysis and Options for HIV/AIDS Survival Assistance, MOH, Lusaka, page 4

Table 1-1: Definition Of Operational Terms

Independent Variable	Indicator	Cut Off Points
Sex education	Pulling Labia minora Sex education No Sexual right Gifts for good sex performance	**1. If only one practice taught** If two practices taught If three practices taught If four practices taught
Gender role	• Obedience and submission Lobola Provide for family members Care for the Sick	If two practice taught If two practices taught If three practices taught If four practices taught
Marriage Pattern	Female position lower Polygamy Male infidelity Inheritance Custom Mpokeleshi	If two practices taught If three practices taught If four practices taught If five practices taught
Sexual unions	Sexual cleansing Sexual intercourse initiated by witchdoctors Sexual intercourse (live) demonstrations	If only one practice taught If two practices taught If three practices taught

1.7 DEPENDENT VARIABLES

Dependent variable is the variable that is affected by the independent variable. In this study the dependent variable is HIV/AIDS whose spread is dependent on the cultural practices.

TABLE 1.4 DEPENDENT VARIABLES

The dependent variables was tested as illustrated in the following diagram:

DEPENDENT VARIABLE	INDICATORS	CUT OFF POINTS
Age	Adolescent	10 – 19 years
	Youth	15 – 25 years
	Young adult	26 – 35 years
	Middle age	36 – 46 years
	Elderly	Above 46 years
Educational Level	Uneducated	No formal schooling
	Less education	Primary education
	Moderate education	Secondary education
	Educated	Post education
Marital status	**Single**	1. Single
	Divorced	2.Divorced
	Separated	3.Separated
	Widowed	4.Widowed
	Married	5.Married
Parity of respondent	2 or less children	Low
	3 or less children	Moderate
	Above 5 children	High

CHAPTER TWO

2 LITERATURE REVIEW

2.1 INTRODUCTION

There is a growing recognition that individual behavior occurs in a complex of social and cultural contexts. Many studies, which have been carried out world wide, in the African region, and in Zambia, have acknowledged the influence of culture on the spread of HIV/AIDS.

2.2 GLOBAL PERSPECTIVE

A study conducted by Mertens and Carael in 1989 on the new out look on AIDS revealed that AIDS has become an established disease in much of the world, exerting pressure on health systems and on development. The study also showed that new vulnerable populations continue to emerge, especially among young people and marginalized groups.[19] The World Bank HIV/AIDS study findings results cited in the 1992 Annual Report show that gender inequality is a major determinant of HIV spread and that inequality is greatly manifested in poverty.[20]

Moreover, the United Nations global studies on Women and AIDS in 1996 also showed that women are vulnerable to HIV/AIDS and are in need of protection of their human rights and fundamental freedoms, by improving their economical independence and legal status. The study also discovered that women are vulnerable because they lack power and control over their sexuality risk of contracting HIV infection. They would rather not jeopardize relationships with men on whom they are dependent economically. Hence, inequality may be a determinant for the marginalized groups.[21]

---

[19] Mertens E.T. and Carael M. A New Outlook for HIV/AIDS, Nov-Dec 1998, Number 6, WHO, page 3

[20] World Bank (1992); Annual Report, Washington D.C. page 55.

[21] WHO (1996): Women and AIDS, Geneva, page 18.

In another study conducted by Singer et al (1997) on socio-cultural factors contributing to risk behavior associated with HIV/AIDS on Ethno cultural communities found some common elements. The six-ethno cultural communities that were studied are: Canada (3 urban sites), Vancouver (South Asian and Chinese communities), Latin America and Montreal. Common elements, which, were demonstrated in the study, were socio-cultural differences between men and women in terms of power within relationships.[22]

Goldstein in 1994 studied AIDS in Women in Brazil and discovered that Brazil is one of the most unequal societies existing today, which has the third highest absolute number of people with AIDS. Male sexual freedom is protected in the name of sexual freedom for all, while women's sexuality remains unchanged and locked in Brazilian cultural norms. Women are not equals either in their sexual practices or outside their relationships. The vast majority of poor Brazilian women are powerless to demand shared responsibility in heterosexual relationships.[23] Hence, condom programmes are unlikely to succeed owing to the unequal power in relationships.

Brazilian women are under pressure to remain virgins until becoming "Noivas" (fiancées) and then become wives and mothers who vow fidelity. The following diagram illustrates behavior pattern expectations for marriage in Brazil.[24]

---

[22] Singer S.M. et al (1997): AIDS and Ethno Cultural Communities,Zambia Health Information Digest, Volume 4, Number 2, Apr-June 1997 UNZA, Lusaka, page 13

[23] Goldstein OM: AIDS and Women in Brazil: The Emerging Problem, Vol 39, Number 7, Oct 1994, Social Science and Medicine, Elsevier Science ltd, Aberdenshire, pp 928

[24] Ibid

Table 2-1: Sex Power Relations For Brazilians

FEMALE	MALE
Innocence (virginity)	Knowledge (sex experienced)
Passivity	Initiation
Boundary setter	Sexual transgressors

Source: Goldstein 1994, page 928.

Brazilian culture clearly categorizes practices by dividing activities and attitudes between those that belong to the public life the rua and another set that are private belong to the casa. The dichotomy is divided as follows:

Table 2-2: Brazilian Culture

RUA PRACTICE	CASA PRACTICES
Public	Private
Political	Personal
Dirty	Clean
Dangerous	Safe
Instability	Stability
Change	Continuity

Source: Goldstein 1994, page 928.

According to Goldstein (1994), casa is the place between four walls where time does not pass and history rarely knocks at the door. It constitutes practices that cannot undergo transformation, reform, or revolution. He also states that HIV/AIDS prevention programs are just partly successful.[25] HIV/AIDS interventions might be ending up in the rua and not succeed to penetrate the casa.

Studies done by WHO (1994) on 'AIDS: Images of the epidemic' state that in some parts of the world it is unacceptable for a "good" woman to take initiative in relationships. So unacceptable that many dare not bring up the subject of

[25] Opcit

safe sex even with their regular committed partners, to do so is to risk being rejected, beaten up, or even thrown out by men on whom in many cases they are dependent on, for economic survival and social status.[26]

Culturally, specific sexual preferences such as a desire for a dry or moist vagina, by men, may lead to use of different agents to please the men. According to a study by Runganga et al (1992) on: The use of herbal and other agents to enhance sexual experience shows that a preference for dry sex has been identified in several central and Southern African countries. This includes Zaire, Zambia, Malawi, South Africa and Zimbabwe. Dry sex is also practiced elsewhere in Africa as well as other countries such as Haiti, Saudi, Arabia and Cost Rica. Women who practice dry sex use a variety of traditional agents and pharmaceutical products to achieve the desired physical effects.[27]

The WHO study also showed that gender discrimination was a worldwide problem, which starts from birth onwards. Women have even been blamed for spread of STIs since time immemorial. Among certain peoples in Thailand and Uganda STIs are known as women's disease. Universally female prostitutes have been characterized as 'vectors' of disease. It is a description that completely ignores the role-played by their customers and that is strikingly never applied to men no matter how high their levels of infection.

Moreover, even people infected with HIV/AIDS by other routes blame prostitutes. For example, in the USA many men diagnosed with AIDS first blamed their infection on a prostitute. Only when interviewed at length did they admit to injecting drugs or having sex with men. In Uganda, women who stand out the structure of female subordination are blamed for HIV/AIDS spread.[28]

---

[26] WHO (1994): AIDS: Images of the Epidemic, France, page 58

[27] Runganga A. *et al* (1992): The use of Herbal and other Agents to Enhance Sexual Experience, Social Science Medicine, Volume 35, Number 1037, page 189.

[28] Op Cit.

According to studies done by Mersen subordination of women does not only include rape, and enforced prostitution but also norms such as double standard of virginity, fidelity and men's expectation that they will have automatic sexual access to any woman receiving their financial support.[29]

In most cultures, women are expected to remain faithful to their husbands while it is traditionally acceptable, for men to have more than one sexual partner. The wives are supposed to tolerate their husbands' infidelity. A woman may know that her partner is sleeping with other women yet she is likely to be drawn into an elaborate charade to protect his reputation and self-esteem at the expense of her safety. For example, a man who goes home smelling of a strange perfume asks his wife for sex and she agrees because she cannot say 'no' to him.[30]

Recent studies on AIDS done in 1994 by the UNESCO on countries in Africa, Asia and Latin America revealed that child prostitution is extremely common. Mersen 's study (1993) on Impact of HIV/AIDS reveals that young girls are also vulnerable because they marry or have sex with older boys, who have been sexually active longer and hence, are more apt, to have become infected themselves.[30]

At the XI International Congress on Virology in 1993, Mersen also stated that WHO recently estimated that half of all HIV infections to date have occurred in adolescents and adults under the age of twenty-five. Other studies conducted by Mersen and the World Bank on AIDS Impact show that, Worldwide HIV is now mainly transmitted by sexual intercourse, so the World Bank emphasizes the need to recognize HIV infection as an STI.[31]

---

[29] Mersen M.H. (1993): Speech on: Impact of HIV/AIDS, Population, Policies, Programs, International Round Table, WHO, Berlin, page 2.

[30] WHO(1994):AIDS Images of The Epidemic, Geneva, page 57.

[30] WHO (1994): AIDS; Images of the Epidemic, Geneva, page 55

[31] Mersen M.H. (1993): Speech on: The Global Impact of AIDS, XI International Congress On Virology, WHO, Glasgow, page 3

In another development, WHO studies on global AIDS show that the number of new cases in women is increasingly high. As a result in the updated Global AIDS Strategy the Council has identified the need to focus on women as one of the major challenges. The priorities being:[32]

- ✓ Developing female controlled prevention measures.
- ✓ Burden of care
- ✓ Sexual decision-making.
- ✓ HIV transmission risks associated with traditional practices.
- ✓ Religious practices.
- ✓ Female circumcision and infibulation.
- ✓ Post partum practices.
- ✓ Vaginal drying.

Further more, the WHO study also shows that the total number of AIDS cases in adults and children from late 1970s/early 1980s until late 1993 were as follows:[33]

Africa	67.0%
USA	13.0%
America	12.0%
Europe	5.0%
Oceania under	1.0%

2.3 REGIONAL (AFRICAN) PERSPECTIVE

HIV has taken toll on African communities and 11 million Africans have died of HIV/AIDS since its inception according to the speech of the vice president of

---

[32] WHO (1995): 1992 – 1993 Progress Report on: Global Programme on AIDS, Switzerland, page 7

[33] Ibid

the World Bank Madavo Caliso during the XI ICASA Conference 1999. The rates are 10-20 times those of America and Europe. The distribution is such that Southern Africa has highest rates.

Infact, ICASA 1999 Presenters highlighted that there is a high prevalence of cultural practices which promote the spread of HIV/AIDS in Africa and Zambia i.e. dry sex, polygamy, sexual cleansing, dowry and spouse inheritance.[34]

In sub-Saharan Africa where hetero-sexual transmission of HIV/AIDS predominates according to Mersen (1993), the number of new infections in women has overtaken those in men i.e. six women becoming newly infected for every five men. Also women tend to become infected at a younger age than men. Distribution of adult HIV prevalence in sub-Saharan Africa by sex is men = 45% and women = 55%. Pregnant women attending antenatal clinics are showing a high prevalence of infection. For instance, in Malawi, infection rose from about 3% in 1985 to over 30% in 1993.[34]

Gender dynamics is an additional factor that might militate against the use of condoms. Macwan'gi, et al's, study on Women and AIDS in Zambia, indicate that through out Africa, a woman's status is influenced considerably by her childbearing capacity.[35] Therefore, most women want or are pressured to have many children in keeping with prevailing cultural and social norms, even when they are medically unfit.

The lower economic status, lower education and consequent dependency on male partner gives a woman little leverage on the decision making process affecting her well being. Therefore, these norms may force a woman to get pregnant even when her health status is poor owing to HIV/AIDS.

---

[34]ICASA (1999):Public Sector Reforms and HIV/AIDS in Africa, Track 2, Session Number 14A,page V11,Lusaka.

[34] Mersen M.H. (1993): Speech on :Impact of HIV/AIDS, International Round Table; Population, Policies and Programmes, WHO, Berlin, page 2.

[35] Macwangi *et al* (1994): Women and AIDS in Zambia: Situation Analysis and Options for HIV/AIDS Suruival Assistance, MOH, Lusaka, page 1.

Unfortunately, the social safety net that informal rural institutions have traditionally provided to poor, vulnerable women are now threatening their very lives and families, that is, according to Topouzis study on HIV/AIDS in rural Sub-Saharan Africa in 1998. The practices in the rural Sub- Saharan Africa are: wife inheritance, sexual cleansing rites, polygamy and dry sex. Topouzis cites a story that attracted the print media in 1990, when "wife inheritance spurred AIDS rise in Kenya". A widow was forced by in-laws to be inherited by her late husband's brother. The man got infected and he infected other women before they all died of HIV.[36]

According to Civic and Wilson's study on impact of dry sex on condom use (1996) the participants in the focus group interviews reported that drying agents had physical and psychological consequences. Agents were used to dry and tighten a woman's vagina and also to serve as 'love portions' to attract sexual partners and ensure faithfulness. The study also explains that some women were reluctant to use condoms for fear of blocking the 'magic' of drying agents. Yet Participants primarily attributed condom breakage to excessive vaginal tightness. The study implies that practice of 'dry sex' is likely to cause high rate of condom failure.[37]

Women are generally brought up to be socially and sexually passive. This tends to limit their ability to communicate effectively with their partners or spouses in matters that pertain to sex. Socio-economic inequalities especially lack of access to education between men and women, grossly limit the ability of most women to protect themselves from HIV infection.[38]

---

[36] Topouzis Daphne (1998): The Implications of HIV/AIDS for Rural Development Policy and Programming: focus on Sub-Saharan Africa, FAO, UNDP, page 39.

[37] Civic D. Wilson D. (1996): Dry sex in Zimbabwe and Implications for Condom Use, Social Science Medicine, Volume 42, Number 1, page 91-98.

[38] Op cit

A study conducted in rural Malawi by Heiltzer- Allen et al on Women and AIDS in Malawi in 1994, found the following:[39] Girls start being prepared for marriage at an early age. Girls begin undertaking household tasks at five years of age, and do them regularly by the age of eight. Once a girl has started menstruating she acts like a mother whenever the mother is away. The girl is initiated a year before or in the year immediately after she began menstruating, so that she can live up to cultural norms. The ceremony teaches the girl about hygiene, sexuality, role of a wife, respect for elders and to behave properly as an adult in the community.

Once girls begin menstruating they are considered as grown ups who can take care of themselves. Girls are often encouraged to get married as soon as they finish Primary school education. The cultural norms allow them to even get married as soon as they start their monthly periods around the age of fourteen. This might mean that there is pressure to get married at a tender age. In matrilineal society the uncle (mother's eldest brother) of the girl and boy is the person who gives official permission to marry or divorce.

The girls in rural Malawi regard themselves as grown-ups after the initiation and also become eager to practice what they have learned from the Ankungwi (traditional counselors). In fact, some girls wait to be initiated before they can have sex. Mothers of the adolescent girls also expect them to have sex before marriage. It is also common for girls to have an older boyfriend (5years older or more) although no girl would admit it. Some girls are begged by their boyfriends to have sex or are forced to do it i.e. girls have no decision making power in their relationships.

For adolescent girls, the 'Sugar Daddy' phenomenon is the most heinous as urban employed men travel back to their rural communities in search of younger and 'clean' women. The allure of these men is that they are in the position to provide substantial enticement in the form of clothing, school fees

---

[39] Helitzer – Allen D. (1994): Women and AIDS Research Programme, Communications Net works of Adolesent Girls in Rural Malawi for HIV/STD prevention messages, International Center for Research on Women, Washington D.C. page41.

and other gifts. It is difficult for the girls who are under pressure to get married to refuse the urban men whose sexual lives is unknown.

Traditionally, a husband has the right to his wife's body and services. During initiation girls have to learn some physical movements to enhance the sex act and enticing body movements, which pleases men when performed during sexual intercourse. In some ethnic groups (Chewa especially) men who play the role of "hyena" undertake a ceremonial deflowering (intercourse with the girls). Sexual enhancement techniques information is shared between friends. This involves insertion of roots (in powder form) in the vagina to make it dry and the body hot (i.e. Dry sex practice) according to men's liking.

Polygamy, which allows a man to marry more than one wife, is practiced in Central Africa. Though the extent of polygamy is hard to determine in Malawi, some reports suggest that 25-33% of males more than the age of 40 may have more than one wife.

Helitzer-Allen (1994) 's concluding remarks on the findings were that a lot of HIV/AIDS preventive interventions have been carried out on electronic media, condoms are freely distributed at the hospitals and books written on cultural norms for each ethnic group. For example, a book on Chewa culture encourages the hyena (Fisi), to wear a condom when performing their ceremonial role. Yet, the HIV/AIDS continues to spread.

Helitzer-Allen observed that adolescent girls have not been reached because the disseminated messages are general and not specific to the intended audience. Traditionally, the audience is also believed to be invulnerable, and HIV is a disease of the outsiders. Helitzer- Allen remarked that initiation ceremonies encourage sexual initiation amongst adolescents so, if delayed 69 percent of girls will have their sexual initiation delayed.[40]

The vulnerability of women is exacerbated by historical trends, which have removed men from their families for lengthy periods of times. This increased

---

[40] Ibid

the acceptability of male sexual activity outside marriage relations and sanctioned the behavior of elderly men to use their wealth and prestige to seek sex with girls and young women.[41]

The gender identity also places men in compromising place exposing them to HIV/AIDS because of masculine identity. Campbell and Williams' study on HIV prevention on the miners in South Africa observed that the masculine identity or Macho identity also encourages the practice of unsafe sex owing to its connotations of fearlessness in the face of risks. Since unprotected sex is also a risk, males tend to have unprotected sex with many women to prove their Macho identity.[42]

According to Macwangi et al (1994), Women who have low esteem and who have been socialized into accepting male dominance in relationships or who feel insecure in relationships feel reluctant to insist on the use of condoms (i.e. Displease the partner) even when they know that their husbands or partners have multiple partners.[43]

The Namibia MOH's study, also found out that the regional obstacles to AIDS control seems to be resistance to condom use, taboo on the open discussion of sex, subordinate social and economic status of women, cultural practices or behaviors that facilitated transmission of HIV.[44]

During ICASA 1999, the major findings of one of the speakers' study on Women and AIDS were that: the advocates of dry sex include traditional counselors, street vending herbalists, and peer pressure. The speaker said

---

[41] Aoko M. *et al* (1998): Aids in Kenya: Socio-Economic Impact and Policy Implications, UN, Nairobi, page 155.

[42] Campbell and Williams B: Beyond the Biomedical and Behavioral: Towards an Integrated Approach to HIV Prevention in the Southern African Mining Industry, Social Science and Medicine, Volume 48, Number 11, June 1999, page 1635

[43] Macwangi et al (1994): Women and AIDS in Zambia: Situation Analysis and Options for HIV/AIDS survival Assistance, MOH, Lusaka, page3.

[44] MOH/NACP (1993): Situational Analysis of AIDS in Namibia, Windhoek, page 21.

that women do not enjoy dry sex but do it to secure their marriages. The ICASA Satellite meeting highlighted that HIV is sex driven infection and no human society can exist without casual sex[45].

The Women's Village findings were that, males have taken women as door mats/sex objects for too long, lack of communication and dialogue between couples stems from socialization and cultural barriers, with rural setting disadvantaged, and infidelity among husbands is condoned by society.[46]

Several studies carried out by WHO (1993), in Rwanda and Tanzania showed that younger women under 25 accounted for 20% of female AIDS, and young men for less than 9% of male cases. This means that age of infection is lower in females than in males[47]

Studies by Mersen (1993) on the impact of HIV/AIDS revealed that the greatest impact of deaths due to AIDS should be felt in Eastern and Central Africa. That is where in some cities up to one third of all adults is infected with HIV and where the adult mortality rate may more than triple. Already up to eighty percent of all hospital patients with HIV related diseases occupy beds on medical wards in some urban hospitals in Central Africa.[48]

Moreover, the United Nations (1998), studies on the demographic Impact of HIV/AIDS also show that the average life expectancy at birth in nine hardest hit countries with an adult HIV prevalence of 10% or more was projected to reach 48 years in 1995-2000. The life expectancy would have reached 58

---

[45] ICASA (1999): Women and AIDS, Satellite Meeting, Women's Village, Session number14BT3, Track 3, pages XV111,X1X,XLV11,Lusaka.

[46] Ibid.

[47] Mersen M.H. (1993): International Round Table: Population, Policies and Programmes, Speech on : Impact of HIV/AIDS, WHO, Berlin, page 2

[48] Mersen M.H. (1993): International Round Table: Population, Policies and Programmes, Speech on : Impact of HIV/AIDS, WHO, Berlin, page 2

years in the absence of AIDS, a loss of 10 years. This group includes Botswana, Kenya, Malawi, Mozambique, Namibia, Rwanda, South Africa, Zambia and Zimbabwe.[49]

In Southern Africa, there are plural healing systems that are traditional healers, biomedical healers and church healers (prophets). Yet majority of HIV/AIDS interventions strategies are strongly associated with western biomedical approach hence play a limited role in perceptions of health and healing.[50]The practices, which are not consistent with health messages, have been not addressed, and this might be encouraging negative attitudes to the Anti AIDS prevention campaign.

2.4 NATIONAL (ZAMBIAN) PERSPECTIVE

HIV/AIDS is a common health problem in Zambia. According to the POST Newspaper on Friday April 28 2000, Piot a UNAIDS representative, lamented the HIV/AIDS scourge in Zambia, and revealed that the number of teachers who have died in the 10 months of 1998 is twice the number of teacher's deaths in all of 1997. That is equal to two thirds of all teachers trained annually. Children are also withdrawn from school in order to contribute to household economy.[51]

The POST Newspaper also reported that David Dun the US Ambassador to Zambia has observed that Zambians have impressive levels of public awareness but lack behavioral change.[52] The behavior patterns, which are not

---

[49] Campbell and Williams B: Beyond the Biomedical and Behavioral: Towards an Integrated Approach to HIV Prevention in the Southern African Mining Industry, Social Science and Medicine, Volume 48, Number 11, June 1999, page 1635.

[50] Ibid.

[51] Salusela B: UNAIDS Calls for Saving People from AIDS, The Post, Friday, April 28, 2000, Number 1472, page 3.

[52] Ibid.

changing despite the massive anti-AIDS preventive measures, are worrying every concerned person (the researcher inclusive).

In Zambia, women generally lack complete control over their lives. According to studies conducted by CBOH/MOH on HIV/AIDS in 1999, females are taught from early childhood to be obedient and submissive to males, particularly males who command power such as a father, uncle, husband, elder brother or guardian.[53] This might have a potential of encouraging incest.

Lishebo (1994) study on Social Status in spoken interaction in two Lozi Dialects revealed that sexual differentiation of spoken interaction has to do with the division of labour between women and men. Like in many societies, the Kwangwa and Nyengo people use sex to allocate tasks, activities, rights, and responsibilities. He found out that the division of labour along gender lines is more rigid and polarized. For example hunting, looking after cattle, building houses are strictly duties for men. On the other hand the women' s duties include house keeping, collecting firewood and pounding maize.

The subordinate role assigned to the Kwangwa and Nyengo women, make them to produce words, phrases, and sentence patterns that are inherently weak. For instance, in Kwangwa if a woman wants to say 'my brother ' she says 'muhulwani' a weak term, where as a male speaker would say 'mukulwange' a stronger term. Hence Kwangwa men speak with more dignity than Kwangwa women. Similarly, when a Nyengo man says 'Kuambaula' a very rough pronunciation, a woman will say 'Kuambola' a prestigious pronunciation, meaning to chart. This study shows that social status in spoken interaction affects both Kwangwa and Nyengo dialects and that the differences are reflected when they speak their language.[54]

---

[53] MOH/CBOH (1999): HIV/AIDS in Zambia, Background, Projections, Impacts, Interventions, Lusaka, page 51.

[54] Lishebo V.L. (1994), Social Status In Spoken Interaction In Two Lozi Dialects At Buseko Market, University of Zambia, Lusaka, page 25.

Unfortunately the burden of caring for AIDS patients appears to be also falling primarily on women. As Lado (1992) noted, "whenever some one has to assume someone else "s role, it is the women who automatically assume men's roles and not vice versa." For instance, of the 168 'helpers' looking after inpatients Foster and Buve(1992) interviewed in Monze hospital, 75% , were women. Nkowane observed that nurses provide only limited care, with relatives providing most of the nursing care even while patients are in hospital.[55]

In an analytical study on HIV/AIDS Survival assistance the Institute for African Studies observed that relations between men and women further compound the role of poverty in the transmission of HIV/AIDS. The study also found that the position occupied by women is largely as a result of socio-cultural norms or practices, which, demand that they behave in a particular manner, and quite often derives them opportunities for economic independence.

The inferior social and economical status accorded to women directly increases their vulnerability to HIV because it limits their ability to control their sexual lives as well as protect themselves. That is, most women are in a "state of conditioned helplessness" to say no to unprotected sex. The state of affairs is worsened by the acceptance of male infidelity, which puts faithful married women at risk of HIV/AIDS infection. Therefore, the study concludes that the HIV/AIDS prevention strategies are under men not women's control. That is, faithfulness, abstinence and condom.[56]

In addition, MOH/CBOH (1999) studies on HIV/AIDS also indicated that women are taught to never refuse having sex with their husbands, regardless

---

[55] Foster Susan (1993): Cost and Burden of AIDS on The Zambian Health Care System: Policies to Mitigate The Impact on Health Services, USAID, Virginia.

[56] Institute for African Studies: Orphans, Widows, and Widowers in Zambia: A Situational Analysis and Options for HIV/AIDS Survival Assistance, UNZA, Lusaka page 17 .

of the number of partners he may have or his unwillingness to use condoms, even if he is suspected of having HIV or another STD.[57]

In the Shah, et al (1996) study on Reproductive health in Mtendere compound, the findings were that the sources of information on sex and reproductive health for girls are mainly grandmothers, aunts, sisters, friends and tumangánga (traditional healers). Unfortunately HIV/AIDS preventive measures might not be looking at these sources. The study also found that the general age of sexual initiation is about 12 for females and 14 for boys.[58]

Shah and Nkhama (1996) did a study on Adolescent Sexual and Reproductive health in Chawama compound and found that girls are advised on problems related to sex by traditional counselors. Girls from some tribes go through initiation ceremony at puberty when female relatives impart them with sexual knowledge and teach them the sex dance.

Shah and Nkhama observed that the adolescents are sexually active and girls are paid for sex. Unsafe sex is common, therefore the girls are more concerned about pregnancy whilst the boys are more concerned about STI. They also observed that adolescents living with both parents are least informed about sex and reproduction and also are least likely to be sexually active at an early age, because of fear and strict parents.

Unfortunately, the girls do not make decisions in the relationships. The boys confessed to Shah and Nkhama that it is them who take the initiative in proposing to a female partner, and it is the boys who make all the decisions related to sex in a relationship. The boy decides whether to use or not use a condom when having sex. Even if the female partner would like to have the boy use a condom, she does not usually suggest it. Such a suggestion is taken to imply that the girl may be carrying a disease, or the boy may ridicule

---

[57] Op Cit.

[58] Shah et al (1996): Listening to Young Voices; Participatory Appraisal on Adolescent Sexual and Reproductive Health in Peri-urban, Lusaka, Care International, page 16.

her by saying, "you don't love me". Some boys would punish such a one by pricking the condom. [59]

Chikotola, et al (1996) also conducted a study on Adolescent Sexual health and Reproductive health in seven peri urban compounds of Lusaka. That is in Chawama, Chelstone, Chilenje, Chipata, Mandevu, George and Kanyama compounds. The study also found that traditional counselors (Banachimbusa) are called upon to educate girls on all issues of life. Therefore, girls go through initiation ceremony to make "good wives". During initiation, the girl who was naughty is disciplined by being pinched, beaten and made to leak her mother's dirty feet.

Chikotola, et al observed that the girl is taught how to pull "Malepe" (Labia Minora) using African medicines like burnt mono fruits mixed with vaseline or salad i.e. to make them as long as a match stick. This is done to increase a man's pleasure when having sex for he plays with them and they hold the penis. The girl is also taught how to dance when having sex and how to behave in bed. For instance, she should lie quietly after the sexual act and tap softly to ask for permission to leave the bed if she wants to urinate.[60]

Unfortunately since the traditional counselors are not involved in the HIV/AIDS prevention they are most likely to spread contrary messages. Shah and Nkhama (1996) discovered that traditionally counselors also emphasize on the importance of keeping the vagina dry in order to please the man. Girls are encouraged to use some herbs and plant extracts to do so. Usually girls dry their vagina before having sex and if she forgets or is not aware of it, the boy will instruct her to dry herself. Separate groups of boys and girls as well as older men and women across all categories prefer "dry sex" to "wet sex". A

---

[59] Shah M. and Nkhama G. (1996): Listening to Young Voices Participatory Appraisal on Adolescent Sexual and Reproductive Health in Peri-urban, Lusaka, page 14.

[60] Chikotola B. et al (1996): Summary on Adolescent Sexual and Reproductive Health for Seven Peri urban Compounds Lusaka, Care International, page 36.

group of boys in Chawama told Shah and Nkhama that "dry sex" provides more pleasure to the boy because he can feel the skin better.[61]

The MOH/CBOH cross sectional studies carried out in 1998 on Sexual behavior revealed that four percent of men but 18 percent of women reported engaging in dry sex in their last encounter with a non regular partner. Two percent of adolescent men and 15 percent of adolescent women said they engaged in dry sex.[62]

The Post Newspaper in April 2000 reported that a 23-year-old woman insulted the wife of the man she was involved with by telling her that her husband had abandoned her because she had a "watery vagina". The judge upholding the claim observed that traditionally she would have been found guilty of bewitching her rival of prolonged menstruation. It seems that a wet vagina is a serious issue, which can disturb a marriage. Witchcraft is also recognized by the courts of law hence, there could be a possibility of the general public blaming witchcraft for HIV infection or believing that traditional healers have powers to heal them.[63]

In Zambia high social value is placed on marriage. In Chawama girls informed Shah and Nkhama (1996) that they agree to have sex with boys and men who promise to marry them, though only few of them keep their promises. Sifuniso (1998) during the Talk about AIDS Program in Senanga district also found out that majority of young girls plan to get married and raise families though some do not realize their dreams.[64] The high value placed on marriage encourages females to do anything to get married even if their lives might be at risk.

---

[61] Op Cit.

[62] MOH/CBOH (1999): HIV/AIDS in Zambia: Back ground, Projections, Impact, Interventions, Lusaka, page 23.

[63] Mulenga K: Fight Against Prostitution, Girl Child Abuse Requires Community Effort, Zambia Daily Mail, Friday, April 28, 2000, Volume 4, Number 101 page 6.

[64] Sifuniso M. (1998): Talk About Health Communities Discuss Their Health, Zambian Women Writers Association, Lusaka, page 1.

National Mirror on 30th June, reported a story about a 41-year-old woman who died while giving birth to her eighth child. Doctors had warned her during the birth of her sixth child that it would be highly risky falling pregnant again at her age. The deceased continued bearing children because her husband insisted after threatening divorce. The reporter, Chibuta concluded that it is expected in the Zambian society where women want to remain married at all costs and can go against a doctor's advice. Decisions affecting sexual health are precisely reserved for men.[65]

Traditional marriage patterns in Zambia accept polygamy. The MOH/CBOH 1999 studies on HIV/AIDS reveals that polygamy is commonly practiced in rural areas. The study findings show that about one third of married women in Southern Province are in polygamous unions. About one-fourth of women in Northern Province are also in such marriages. However, polygamy does not seem to discourage unfaithfulness because male infidelity is also generally acceptable which has put faithful married women at risk of HIV/AIDS infections.[66]

The burden of care placed on females includes looking after the sick, and house chores. The MOH/CBOH 1999 studies on HIV/AIDS also observed that the feminine role of caring for the sick members of the family makes girls more vulnerable when AIDS affects a household. It is girls, more often than boys, who have to share or totally assume care-giving responsibilities for siblings and ailing parents. In fact precaution is not taken when caring for a sick relative. In order to shoulder these responsibilities the girls have to leave school prematurely and enter marriages of convenience just to have someone to share parental responsibilities with.[67]

---

[65] Chibuta S (2000): A Woman Dies Because Of Child Bearing, National Mirror, Lusaka, page 4.

[66] MOH/CBOH (1999): HIV/AIDS in Zambia: Background, Projections, Impacts, Interventions, Lusaka, page 23.

[67] Ibid.

Sexual abuse (especially girl child), which is often reported in the Newspapers in Zambia, may expose the abused to HIV infection. Shinkanga (1996) study on Child Sexual Abuse in Luangwa district and Chainda compound of Lusaka discovered that child sexual abuse is prevalent in Zambia. She observed that there is a new culture of childhood marriages in Zambia to 'beat up' the spread of HIV infection. Young girls and boys (sometimes 9-12 years) are engaged or married off with consent from the parents of both sides.

Unfortunately, parents also pair off smaller children sometimes to "reduce running round with truck drivers". However most of these children are divorced within a short time. In Chainda, marrying off children (under 14 years) to older men was one way for parents to increase their income, i.e. from payment of dowry and damages.[68]

The young girls who are married off at a tender age are at higher risk of HIV/AIDS. Their reproductive organs are physiologically immature to provide an effective barrier to HIV transmission. However, it is most likely that the young boy and girls do not even realize that they are being abused. The youths in the peri urban areas of Lusaka told Chikotola et al (1996) that sexual activity could be done willingly by both partners or through being forced.

The common type of relationship where there is a high level of consent are that of sexual activity with friends, cousins, neighbor, brother-in-law/sister-in-law and sex between grandfather and granddaughter, though not common. There is also a high level of consent for sexual relationships among poor families. Girls from poor families enter into sexual relationships for money. Mothers give consent for such activities so those daughters can support the family or become pregnant and get married.

In the same study, girls confessed that boys in school touch some parts of girls' bodies and sometimes pinch them and when they ask them to have sex they have to agree. It seems girls cannot say "no" to sex though STIs are

---

[68] Shinkanga M. (1996): Child Sexual Abuse in Zambia, UNICEF, Lusaka, page 12.

very common among the boys. For instance, a group of boys between the ages of 15-18 in George Compound mentioned that suffering from STIs is part of growing up. A group of boys in Chilenje said that they seek help from traditional healers on matters concerning STIs for fear of the penis being cut at the hospital.[70]

Early divorces may also predispose them to multiple sexual partners. According to the Daily Newspaper on Friday 28 April 2000, Studies by Lusaka based NGOs revealed that most of the Lusaka based prostitutes who have been interviewed confessed that they do not take pride in sex work. But they seem not to have options, because of the poverty in their midst.[65] There could be a possibility that families could have forced the prostitutes into it.

In Zambia, there is also what is known as cross border prostitution. For instance, the Daily Mail Newspaper on Friday 28 April 2000 reported that there is rampant cross border sexual exploitation and Zambian girls are being trafficked for commercial sex. The Daily Newspaper had a story of a 40-year-old woman of Lusaka's Garden Compound's only child now living in Europe as a prostitute without her mother's knowledge. The mother was shocked to learn that the girl who had gone on the street to earn a living through prostitution had left the country. Another vise, common in Zambia is sexual harassment at work places. The government has realized that females are often abused at their work places. As a result the Ministry of Labor and Social security (1993) medium term plan for 1994-1998 period highlights the need to protect females from sexual harassment and from demands for sexual favors in their work environment.[71]

---

[70] Chikotola B. *et al* (1996): Summary on Adolescent Sexual and Reproductive Health for Seven Peri urban Compounds, Care International, Lusaka, page 36.

[65] Mulenga K. Fight Against Prostitution, Girl Child Abuse, Requires Community Effort, Zambia Daily Mail, Friday, April 28, 2000, Volume 4, Number 101, page 6.

[71] MOH/Ministry of Labour Social Security (1993): Combating HIV/AIDS/STD at Work place: Second Medium Term Plan 1994-1998, Zambia National AIDS/STD/TB/Leprosy, page 9.

A cross sectional study on," sexuality: the difficult topic" was carried out by Mutonyi (1997) in Chikankata. The study showed that traditional institutions teach sexuality as merely an indulgence in sexual intercourse. Sexuality is presented as a power symbol for men and submission for women. Therefore, sexuality was taught in reference to gender, i.e. girls were put in Initiation seclusions to be taught woman hood skills whilst boys were taught life saving skills.

The study further explains how the society is sex negative, that is the society-is:-[72]

- ✓ Covert (i.e. closed in terms of giving out information) rather than overt (i.e. being able to express the topic on sexuality freely).
- ✓ Practicing double messages: Adults say the youth should not learn about sex and yet they are the ones enticing young people into sex (the sugar dad syndrome).
- ✓ Lacking explanations as reflected in Table 2-3.
- ✓ Allowing many societal sanctions: sex is plainly exposed in many activities but no skills to handle it are given to anyone. Therefore, people tend to experiment at it.
- ✓ Denial of existence of one's Sexual being: People are simply told to abstain from sex without the right tools and skills being given to them.
- ✓ Denying people access to information and services.

Literature review therefore, shows how gender affects sexuality and the negative sex attitudes, which may influence people's responses towards the Anti AIDS messages.

---

[72] Mutonyi S. (1997): Sexuality: The Difficult Topic, Chikankata Health Services and AIDS Management, Mazabuka, page 40-43.

Table 2-1: Traditional Habits Expressing sexuality Development in Children (Based on the Zambian experience)

NO	Traditional Practice	Meaning or Intention
1	Expressing breast milk into the prepuce (fore skin of penis), of a baby boy.	To Keep the fore skin of the penis open so that the child does not develop phymosis which would inhibit sexual enjoyment when he grows up.
2	Pulling the labia minora in young girls.	It reflects the women's role of submission and desire to satisfy the man sexually. The long labia minora is meant to hold the penis of the man tightly and the size of the labia reflects a 'good' sexually satisfying woman. It is meant to help arouse the man by allowing him to play with the labia before engaging in sex.
4	Use of 'Didos' i.e. insertion of fingers, which have been lubricated with local jelly (from herbs) into the vagina	Practiced by girls in the North western province of Zambia, and in other places, to break the hymen and keep the vagina big in preparation for easy sex.

Source: Mutonyi (1997): Sexuality the Difficult Topic page 42.

2.5 CONCLUSION

The sexual cultural patterns which seems to be dominating world wide is that of men being superior and women assuming a subordinate position. Women have to please men sexually by never saying "no" to sex, being initiated, and practicing dry sex. These practices seem to be more marked in the developing world.

The HIV/AIDS preventive measures are mainly concerned with protecting the rights of citizens to act freely in terms of sexual choices, to urge public to use condoms and practice safe sex. These may be unsuccessful where unequal power relations exist. New anti-AIDS strategies, which address the gender

inequality, must therefore be formulated in order to enhance greater effectiveness in battling the scourge.

Cultural acceptance of harmful behaviours and practices like dry sex, sexual cleansing, partner inheritance and polygamy could also be blamed for the rapid HIV/AIDS spread. Cultural expectations or beliefs often limit compliance to the interventions of preventive measures. Traditional counsellors who teach the young girls during initiation need to be targeted by the anti-AIDS programmes. New culture-integrated measures need to be formulated to fight HIV/AIDS by directly addressing dangerous cultural practices. The veil of secrecy that surrounds the whole traditional sex culture needs to be lifted if modern anti-AIDS programmes are to have the desired impact.

CHAPTER THREE

3 METHODOLOGY

3.1 INTRODUCTION

The methodology is concerned with the development, testing and evaluation of research instruments and methods used in research investigations. That is the goal is to ensure reliability and validity in the data collection tools.

3.2 STUDY DESIGN

A cross sectional study of secondary school going adolescents and traditional counselors from the seven major tribes in Zambia, was carried out between July and August 2000. A cross sectional study describes or explains the relationship between variables at a particular point in time. It was chosen because it was less expensive.

The study used both qualitative and quantitative techniques. The qualitative approach was employed to explore those human experiences that cannot be quantified. Quantitative methods were used to generalize the study results with regard to the unit of analysis.

3.3 STUDY SETTING

The study was carried out in Lusaka urban. Lusaka is the capital city of Zambia and it has a population of 1.717 million (with .860 males and .857 females). Lusaka urban has the highest prevalence of HIV in the whole province. In addition it has a number of peri urban compounds where initiation ceremonies are not uncommon.

The District Management Team has divided Lusaka urban into eight zones, which have twenty-three health centers. For the purpose of this research, these were grouped into four i.e. two zones per area in the: east, west, north and south. Recognized traditional counselors from the seven major tribes of Zambia, (i.e. Bemba, Kaounde, Lozi, Lunda, Luvale, Ngoni and Tonga) were purposively selected from these four areas.

Further, four secondary schools were randomly selected by use of rotary from the same four areas. That is two co-education schools and two single sex, girls only schools..

3.4 STUDY POPULATION

The unit of analysis was the secondary school senior adolescent girl aged 14-19 years. The information was supplemented with data from recognized traditional counselors from the seven major tribes of Zambia. Altogether sixty adolescents were interviewed and seventy-nine (79) elderly women and one elderly man in eight focus groups.

SAMPLE SELECTION

A sample size of 60 respondents was selected in two stages as follows:

In the *first stage* thirty adolescent girls were systematically sampled from two co-education secondary schools, namely Satung Modern School and Arackan secondary School (i.e. fifteen from each co-education school at senior level) in two of the four zones.

In the *second stage* thirty adolescent girls were systematically selected from two girls' schools from two of the four zones namely Matero Girls and Kabulonga Girls School. That is fifteen girls from each girls' school at senior level.

A systematic sample was selected from population of students of a school. The total sample was sixty. The number of the first student to be included in the sample was chosen randomly, by blindly picking one out of the sampling interval numbered pieces of paper. The sampling interval started from the number that was picked first.

This has the advantages that it is less time consuming and easier to implement. Its main disadvantage is that it may lead to bias if the sampling interval coincides with systematic variation within the study population. For example, if the K^{th} number keeps falling on individuals with same characteristics like denomination or tribe.

In the first and second stages the groups were first randomized then every K^{th} number was picked.

That is,

$$K = \frac{\text{SIZE OF POPULATION}}{\text{SIZE OF SAMPLE}}$$

Sample size Determination:

The researcher used a sample size of sixty respondents. This sample size was calculated using the formula:

$$N = \frac{P(100 - p)}{e^2}$$

where n = sample size

p = Proportion of school going adolescents

e = standard error.

The level of adolescents in Lusaka was assumed to be 25% (i.e. between 20-30%) of the total population. With the level of confidence of 95% and an interval of 20-30%

$$n = \frac{25(100 - 25)}{2.5^2}$$

$$\mathbf{n = \frac{25 \times 75}{6.25}}$$

Systemic Random sampling of the population of 300 was done to have a manageable sample size of 60

A random sample is the selection of a sample such that each member of a population (sub population) has an equal probability of being included. The systematic sampling is the selection of study participants such that every K^{th} person (element) in a sampling frame or list is chosen.

$\frac{300}{60} = 5 \qquad 5 = K^{th}$

The third stage comprised of data collection using focus group discussions and seventy-nine elderly women and one elderly Lunda man who are well-recognized traditional counselors were purposively sampled.

3.4.1 DATA COLLECTION AND TECHNIQUES AND TOOLS

The principle investigator collected the data in person. In the first stage and second stages a structured interview was used to gather information. Focus group discussions were used in the third stage. These techniques consisted of the following:

INTERVIEWS

An interview is a data collection technique that involves oral questioning of respondents, either individually or as a group.

The interviews were moderately flexible using structured questionnaire. The interview schedule was chosen as a data collection tool due to the following advantages: -

- ✓ Extra information can be gathered through spontaneous remarks of respondents i.e. facts, sensitive issues, opinions, attitudes and suggestions of informants.
- ✓ The interview enables the collection of context related information.
- ✓ Questions can be presented in the same order and same manner.
- ✓ An interview permits clarification of questions that are not clear.
- ✓ The interview has a higher response rate than written questionnaires since all questions are likely to be answered.
- ✓ It is easier for the researcher to make observations and pick up non-verbal cues.

DISADVANTAGES

- ✓ Presence of researcher can influence responses of respondents.
- ✓ Records of events may be less complete than with observations.
- ✓ There is observer bias if information is not scheduled
- ✓ The information is more difficulty to analyze in a standard way.

FOCUS GROUP DISCUSSIONS

Focus group session was an in-depth loosely structured discussion in which a small number of people (ten) under the guidance of the researcher talked about cultural practices and beliefs relevant to the spread and prevention of HIV/AIDS.

The principal characteristics of the participants in the focus Group discussions were that they be experts in the area of traditional counseling. The group consisted of elderly women who are recognized traditional counselor in their area of residence and other parts of Lusaka. This enabled the study have a wider representation of the Zambian culture. The discussions helped the researcher to know the content of the current lessons taught during initiation. Each session took 1½-2 hours and participants were encouraged to talk freely.

The researcher guided the discussion according to topic guided by the written set of questions provided in the annex. The focus group discussions approach was chosen with the following were the advantages in mind:

- ✓ It is efficient and can generate a lot of dialogue..
- ✓ Can be used to supplement information on community knowledge, beliefs, attitudes and perceptions.
- ✓ Could also be utilized to develop appropriate messages for Health Education programmes.

Its disadvantages include:

- ✓ Some people may be uncomfortable expressing their views or describing their experiences in front of a group.
- ✓ Some people can dominate the discussion.
- ✓ They are time consuming. If consensus is not reached, the Focus Group Discussions has to be held again.

The original intention of holding only one focus group discussion with representation of traditional counsellors from the seven major tribes of Zambia proved to be culturally unacceptable to the discussants. Therefore, the discussions were conducted according to ethnic groups. That is Bemba group in Kaunda Square, Ngoni group in Chazanga, Tonga group in Matero, Luvale group in Northmead, Lozi group in Chilenje, Kaonde and Lunda groups in Kanyama. An extra eighth group was Alangizi Association members, which was a mixed group (i.e. from different ethnic groups). They were all purposively selected.

3.6 DATA ANALYSIS AND PRESENTATION

Data was analysed manually. Both quantitative and qualitative data were used. Quantitative Data was derived from the information collected from the adolescents while the focus groups discussion generated most of the qualitative data.

Codes were assigned to responses, which were recorded on a master sheet. Tables, cross tabulations and text boxes have been used to present the findings. Contextual analysis was carried out and the responses were thoroughly analyzed and arranged according to themes, content and narratives.

3.5 ETHICAL CONSIDERATION

Ethics are 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. A research ethical committee always has

to agree and write an approval before a research can take place. A written letter has to be written by higher authorities or leaders where there is no committee.

The researcher obtained ethical clearance by written permission from the Permanent secretary of the Ministry of Education and provincial director, who wrote copies to the Heads of secondary schools. Written permission was obtained from the District Health Management Team and the Town clerk for Lusaka Urban District Council before conducting the study in the peri urban compounds. Verbal consent was also obtained from the community leaders, School Heads and the respondents before the interviews and discussions. The purpose of the study was explained to them.

Confidentiality was strictly observed since the topic is highly sensitive. The interviews and discussions were held in privacy. The responses have been treated confidentially. No names were written on the interview schedule.

3.6 PILOT STUDY

A pilot study was undertaken in order to identify problems early and obtain information for improving the project and for assessing feasibility of the study, i.e. it tested the validity and reliability of the data collection instruments.

A pilot study was carried out on a small group of pupils at Kabwata Basic School who had similar characteristics to those in the actual study. Ten adolescents (i.e. one sixth of the group that has been studied) were randomly selected. A pilot focus group discussion was also held in Kabwata with the Lozi traditional counselors. The pilot study revealed the need to increase the number of focus group discussions from one to eight.

3.7 DISSEMINATION AND UTILISATION OF FINDINGS

Funds permitting, the study findings, draft report and recommendations will be made available and accessible to policy makers, and Secondary Schools where the study was carried out. The researcher will also discuss the study findings with the traditional counselors (i.e. through a one day meeting with them).

Study findings and recommendations will also be circulated to Non Governmental Organisations, which advocate for women in Lusaka. That is NGOCC, YWCA, ZARD, PPAZ, and WILDAF.

A copy of the study will be submitted to the school library and another copy will be submitted to Ministry of health (my sponsors) so that other researchers can have access to the study.

CHAPTER FOUR

4 DATA PRESENTATION AND ANALYSIS

The results of this study are presented in two sections. The first section presents the demographic characteristics of the respondents. The second section presents the initiation ceremony practices and beliefs. Four schools were chosen at random from within Lusaka Urban namely, Matero Girls, Kabulonga Girls, Arackan High School and Satung Cooperative Modern School. Fifteen respondents were systematically drawn from each school bringing the total sample size to 60.

Section A:

Table 4-1: Demographic Characteristics of Respondents by Study Site

	SCHOOL				
	Matero (n=15)	Kabulonga (n=15)	Satung (n=15)	Arackan (n=15)	Total N=60
Age Group					
14 – 15	3	1	-	-	4 (6.6%)
16 – 17	10	9	8	5	32 (53%)
18 – 19	2	5	7	10	24 (40%)
Religious Denomination					
Catholic	3	5	3	2	13 (21.6%)
Jehova's Witness	3	1	1	1	6 (10%)
Protestant	9	9	11	12	41 (68%)
Total	15	15	15	15	60 (100%)
Residential Area					
Low Density	-	7	1	2	10 (16.6%)
Medium Density	9	7	1	11	28 (46.6%)
High Density	6	1	13	2	22 (68.3%)
Total	15	15	15	15	60 (100%)
Grade					

Table 4-1 continued

10	15	-	8	-	23 (38.3%)
11	-	15	6	-	21 (35%)
12	-	-	1	15	16 (26.6%)
Total	15	15	15	15	60 (100%)
Whom Living With					
Parent	12	13	1	12	45 (75%)
Uncle/Aunt	1	1	1	2	6 (10%)
Brother/Sister	1	1	13	1	8 (13.3%)
Cousin	1	-	-	-	1 (1.6%)
Total	15	15	15	15	60 (100%)
Daily Activities					
Household chores	15	15	15	15	60 (100%)
Drawing water	-	-	-	-	-
Selling or farming	-	-	-	-	-
Total	15	15	15	15	60 (100%)

Table 4.1 shows that the majority of the respondents were clustered around 16- 17 (53.3%) and 18 – 19 (40 %) age groups. Only a minority was in the 14 – 15 (6.6) age group. It can be observed that the majority of the respondents were Protestants (68%).

Information presented on table 4.1 shows that most of the Satung respondents (13) lived in high-density area. The majority of the Arackan respondents (11) lived in the medium density area. Kabulonga respondents had an equal distribution in the low density (7) and medium density (7) areas. Matero had most of its respondents in the medium density (9) and high density (6). It can further be observed that most of the respondents were in the medium density (46.6%) and high- density (36.6%) areas.

A large proportion of the respondents were in grade 10 (38.3 %) and grade 11 (35%). Also noticeable, from table 4.1, is that majority of the respondents (75%) lived with their parents. Most of those who lived with brother\sister

were from Satung (5). No differences exist in the daily activities performed at home since 100 percent of the respondents perform household chores.

Table 4-2 Characteristics of Guardian/Parents of Respondents

Characteristics	No.	%
Employment status of guardian/parent		
Formal employment	38	63.3
Informal employment	16	26.6
Unemployment	6	10.0
Total	60	100.0
Source of Income if unemployed		
Dependent on uncle	3	5.0
Dependent on brother	2	3.3
Dependent on sister	1	1.6
Total	6	1.0
Whether respondent looks for money to meet school requirement or not		
Yes	32	53.3
No	28	46.6
Total	60	100.0

Analysis on characteristics of respondent's guardian/parents shown on table 4.2 reveals that 63.3% were in formal employment, and 26.6% were in informal employment. Only 10% were unemployed. The source of income for the unemployed was handouts from an uncle (3), a brother (2) and a sister (1). The table further shows that the income for the unemployed and employed was inadequate so 53.3% of the respondents looked for money elsewhere to meet their school requirements, whilst 46% did not.

Table 4-3 Distribution of Respondents Sources of Information on Sexuality

Source of Information	Frequency	Percentage
Friends	37	61.6
Grand Mother	5	8.3
Traditional Counsellor	5	8.3
Aunt	3	5.0
Radio / Television	3	5.0
Anti Aids Club	3	5.0
Church Women	2	3.3
Cousin	1	1.6
Sister	1	1.6
Total	60	100.0

Table 4.3 shows that friends were the commonest (61.6%) source of information on sexuality among the respondents.

Table 4-4 Respondents Exposure to Initiation

Initiated	Frequency	Percentage
Yes	24	40
No	36	60
Total	60	100

Table 4-4 shows that 40% were initiated and 60% were non-initiated.

Table 4-5 Distribution of Lessons Taught During Initiation

Rank (1=Most common)	Lessons Taught	Scores
1.	How to look after a man	20
2.	How to behave	5
3.	How to handle a man during sex	4
4.	Respect	4
5.	Personal hygiene	1
6.	Dry sex	1
Total		35

The highest score was the lesson on how to look after a man (20). The lowest score were the lessons on personal hygiene (1) and dry sex (1).

Table 4-6 Distribution of Respondents on Whether Initiation is Important or Not

Initiation Important	Frequency	Percentage
Yes	60	100
No	-	-
Total	60	100

Table 4-6 shows that all (100%) the respondents said that initiation is important.

Table 4-7 Reasons For the Importance of Initiation

Reasons for the importance of initiation	**Frequency**	Percentage
It prepares a girl; for marriage	59	98.3
It teaches how to handle a man during sex	1	1.6
Total	60	100

Table 4-7 shows that nearly every (98.3) respondent said that initiation prepares a girl for marriage. Table 4-8 The Lessons Taught in Sex Education

Sex education lesson	Yes		No	
	Frequency	Percentage	Frequency	Percentage
Pulling labia minora	60	100.0	-	-
STI/HIV/AIDS	2	3.3	58	96.6
No sexual right	60	100.0	-	-
Expect gifts for good sex performance	60	100.0	-	-
Total No = 60 (100%)				

Table 4-8 shows that 100% of respondents were taught pulling labia minora, no sexual right and to expect gifts for good sex performance as part of sex education lessons. The majority (96.6%) of the respondents also said that STI/HIV/AIDS is not taught whilst a few (3.3%) said that STI/HIV/AIDS is taught.

Table 4-9 Content of Lessons Taught in Gender Roles

Gender Role	Yes		No	
	Frequency	Percentage	Frequency	Percentage
Obedience submission	60	100	-	-
Lobola	60	100	-	-
Provide for family members	60	100	-	-
Care for the sick	60	100	-	-
Total N = 60				

Table 4-9 shows that all (100%) the respondents were taught obedience and submission, *lobola* and to provide for family members as part of gender roles. It can also be observed that the majority (98.3%) of the respondents were taught to care for the sick as part of gender roles and only 1.6% was not taught to care for the sick as part of gender roles.

Table 4-10 Content of lessons Taught in Marriage Patterns

Marriage Patterns	Yes		No	
	Frequency	Percentage	Frequency	Percentage
Female position lower than the male's	60	100	-	-
Polygamy	60	100	-	-
Male fidelity	60	100	-	-
Inheritance custom	27	45	33	53
Mpokeleshi	27	45	33	53
Total N = 60				

Table 4-10 shows that all (100%) the respondents were taught that female's position is lower than a male's position, polygamy, and male infidelity as part of marriage pattern lessons. The T able also shows that 45% were taught the inheritance custom and *mpokeleshi* as part of the marriage patterns.

Table 4-11 Content of Lessons Taught in Sexual Unions

Sexual Unions	Yes		No	
	Frequency	Percentage	Frequency	Percentage
Sexual Cleansing	52	86.6	8	3.3
Sexual Intercourse with witchdoctors	1	1.6	59	98.3
Sexual intercourse demonstrations	60	100	-	-
Total N = 60				

Table 4-11 shows that 86.6% of the respondents said that sexual cleansing was taught whilst 13.3% did not say so. 1.6% said that sexual intercourse with witchdoctors was taught whilst 98.3% did say that it is taught. All (100%) said that sexual intercourse demonstrations are carried out.

Table 4-10 Content of lessons Taught in Marriage Patterns

Marriage Patterns	Yes		No	
	Frequency	Percentage	Frequency	Percentage
Female position lower than the male's	60	100	-	-
Polygamy	60	100	-	-
Male fidelity	60	100	-	-
Inheritance custom	27	45	33	53
Mpokeleshi	27	45	33	53
Total N = 60				

Table 4-10 shows that all (100%) the respondents were taught that female's position is lower than a male's position, polygamy, and male infidelity as part of marriage pattern lessons. The T able also shows that 45% were taught the inheritance custom and *mpokeleshi* as part of the marriage patterns.

Table 4-11 Content of Lessons Taught in Sexual Unions

Sexual Unions	Yes		No	
	Frequency	Percentage	Frequency	Percentage
Sexual Cleansing	52	86.6	8	3.3
Sexual Intercourse with witchdoctors	1	1.6	59	98.3
Sexual intercourse demonstrations	60	100	-	-
Total N = 60				

Table 4-11 shows that 86.6% of the respondents said that sexual cleansing was taught whilst 13.3% did not say so. 1.6% said that sexual intercourse with witchdoctors was taught whilst 98.3% did say that it is taught. All (100%) said that sexual intercourse demonstrations are carried out.

Table 4-12 The Most Important Initiation Lesson to Remember

Initiation Lesson	Frequency	Percentage
Sex education	60	100
Gender role	-	-
Marriage Patterns	-	-
Sexual Unions	-	-
Total	60	100

Table 4-12 shows that there is emphasis on sex education (i.e. 100% response) as the most important of all the initiation lessons.

Table 4-13 Whether or Not Sex Dance Is Important

Sex dance important	Frequency	Percentage
Yes	60	100
No	-	-
Total	60	100

Table 4-13 shows that all (100%) the respondents said that sex dance is important.

Table 4-14 Reasons for Importance of Sex Dance

Rank (1=most common)	Importance of Dance	Score
1	To satisfy a man during sex	30
2	To please a man during sex	27
3	To give a man sexual appetite	13
4	For a man to enjoy sex	9
5	For a woman not feel pain during sex	1
	Total	87

Analysis of the reasons for the importance of sex dance shown on Table4-14 reveals that majority of the responses were to satisfy a man during sex (37) and to please a man during sex (27). A few of the responses were that sex dance is performed to give a man sexual appetite (13), for a man to enjoy sex (9) and for a woman not to feel pain during sex (1).

Table 4-15 Whether or not Respondents Had Pulled Labia Minora

Ever pulled labia minora	Frequency	Percentage
Yes	60	100
No	-	-
Total	60	100

It can be observed in Table 4-15 that all (100%) the respondents had pulled their labia minora.

Table 4-16 Reasons For Pulling Labia Minora

Rank (1=most common)	Reasons for Pulling Labia Minora	Frequency	Percentage
1	Every girl does it	27	45
2	To hold the penis during sex	17	28.3
3	To satisfy a man during sex	11	18.3
4	Not to be left by a man	5	8.3
5	To deliver fast during labour	2	3.3

Table 4-16 shows that respondents had varied reasons for pulling their labia minora. The majority (45%) pulled their labia minora because every girl does it. The other responses were: To hold the penis during sex (28.3%), to satisfy a man during sex (18.3%) and to deliver fast during labour (3.3%).

Table 4-17 Whether or Not Dry Sex is Important

Dry sex important	Frequency	Percentage
Yes	60	100
No	-	-
Total	60	100

Table 4-17 shows that all (100%) the respondents said that dry sex is important.

Table 4-18: Reasons why Dry Sex is Important

Rank (1=most common)	Importance of dry sex	Score
1	Not be left by a man	44
2	To be a real woman	28
3	To satisfy a man during sex	11
4	To make the body nice	1
	Total score	84

Table 4-18 shows that majority (44) of the scores were that dry sex makes a woman not to be left by a man. The minority scores were that makes a female: to become a real woman (28), to satisfy a man during sex (11), and to make the body nice (1).

Table 4-19: Who Should Practice Dry Sex?

Who Should Practice Dry Sex?	Frequency	Percentage
Adolescents	1	1.6
Every married woman	4	6.6
Every female	55	91.6
Total	60	100

It can be observed from Table4-19 that the majority (91.6%) of the respondents said that every female should practice dry sex. Few respondents said that adolescents (1.6%) and every married woman (6.6%) should practice dry sex.

Table 4-20: Respondents Right To Refuse Sexually Cleansing An In-Law

Right To Refuse Sexually Cleansing An In-Law	Frequency	Percentage
Yes	-	-
No	60	100
Total	60	100

Table 4-20 shows that none (100%) of the respondents had the right to refuse to sexually cleanse an in law (i.e. husband of a close female relative).

Table 4-21: Reasons Why Respondents Had No Right To Refuse Sexually Cleansing An In-Law

Reasons Why Respondents Had No Right To Refuse Sexually Cleansing An In-Law	Frequency	Percentage
Parents have to speak for me	43	71.6
Adults have to speak for me	17	28.3
Total	60	100

Table 4-21 shows that majority (71.6%) of the respondents said that their parents have to speak for them. A minority (28.3%) said that adults have to speak for them.

Table 4-22:Distribution of Respondents by whether or not they had had sex

Ever had sex	Frequency	Percentage
Yes	54	90
No	6	10
Total	60	100

It is noticeable on Table 4-22 that a higher proportion (90%) of the respondents had had sex, and only a small proportion (10%) had had no sex.

Table 4-23:Distribution of respondents by whether they had had sex with or without condom

Had sex without condom	Frequency	Percentage
Yes	52	96.6
No	2	3.3

The observed pattern of sexual practices in Table 4-23 is that a higher proportion (96.6%) had had sex without a condom (i.e. unprotected sex) and a lower proportion (3.3%) had had sex with condom (i.e. protected sex).

Table 4-24:Distribution of the reasons Respondents gave for having had sex without condom.

Rank (1=most common)	Reason for sex without a condom	Percentage
1	Boyfriend decided	32
2	Was too young to think of pregnancy.	20
Total Score		52

Information represented on Table 4-24 shows that a boyfriend decides whether to have protected sex or unprotected sex (35) and that to some extent age also influences the practice of unprotected sex (23).

Table 4-25:Respondents' looking for money to meet school requirements in relation to whom they live with.

Whom respondent lives with	Look for money		Row total
	Yes	No	
Parent	21	24	45 (75%)
Sister/brother	8	-	6.6
Uncle/aunt	3	3	91.6
Cousin	-	1	1 (1.6%)
TOTAL	32 (53.3%)	28(46.6%)	60 (100%)

Table 4-25 shows that even though the majority of respondents, stay with their parents (21), a high proportion (53.3%) of them still look for money to meet their school requirements.

Table 4-26: Source of information on sexuality by type of guardian

Source	Guardian				Total	
	Parent	Sister/brother	Uncle/aunt	Cousin	Number	%
Friends	26	6	4	1	37	61.6
Aunt	3	-	-	-	5	8.3
Anti-AIDS club	3	-	-	-	3	5
Grand mother	2	2	1	-	5	8.3
Church women	2	-	-	-	2	3.3
Sister	1	-	-	-	1	1.6
Cousin	1	-	-	-	1	1.6
Radio/television	2	-	1	-	3	5
Total	45	8	6	1	60	100
Percent	75	13.3	10	1.6	100	

Table 4-26 shows that friends (61%) were the main source of information despite whom the respondents lived with. Further observation show their parents were the majority (75%) and had a variety source of information.

Table 4-27: Distribution of whom the dependant lives with in relation to employment status

Whom live with	Employment status			Total	Percent
	Formal	Informal	Unemployed		
Parent	29	12	4	45	75
Sister/brother	4	2	2	8	13.3
Uncle/aunt	5	1	-	6	10
Cousin	1	-	-	1	1.6
Total	39	15	6	60	100
Percent	65	25	10	100	

According to Table 4-27 above, the majority of the respondents (65%) lived with a guardian who was in formal employment. The unemployed few (10%) were parents and sister/brother.

Table 4-28: Sources of information on sexuality in relation to whether or not they were initiated.

Source	Initiated			
	Yes		No	
	Number	Percent	Number	Percent
Fiends	8	13.3	29	48.3
Grand mother	5	8.3	-	-
Traditional counsellors	5	8.3	-	-
Aunt	2	3.3	1	1.6
Radio/television	1	1.6	2	3.3
Anti AIDS club	1	1.6	2	3.3
Church women	-	-	2	3.3
Sister	1	1.6	-	-
Cousin	1	1.6	-	-
Total	24	40	36	60

Table 4-28 shows that those who had been initiated made use of a variety of sources of information. However, the major source information among both the initiated and the uninitiated is friends (13.3%).

Table 4-29: Source of information on sexuality in relation to whether or not they had sex

Source	Ever had sex			
	Yes		No	
	Number	Percent	Number	Percent
Fiends	5	8.3	32	53.3
Grand mother	-	-	5	8.3
Traditional counsellors	-	-	5	8.3
Aunt	-	-	3	5
Radio/television	1	1.6	2	3.3
Anti AIDS club	-	-	3	5
Church women	-	-	2	3.3
Sister	-	-	1	1.6
Cousin	-	-	1	1.6
Total	6	10	54	90

Table 4-29 shows that 90% of the respondents had had a sexual experience. The 90% also had variety sources of information on sexuality. Table 4-29 also shows that those with friends as their source of information were the majority both among those who had had sex (53.3%) and those who had no sex (8.3%).

Table 4-30: Condom usage by source of information on sexuality

Source	Ever had sex			
	Yes		No	
	Number	Percent	Number	Percent
Fiends	1	1.6	31	51.6
Grand mother	-	-	5	8.3
Traditional counsellors	-	-	5	8.3
Aunt	-	-	3	5
Radio/television	-	-	2	3.3
Anti AIDS club	1	1.6	2	3.3
Church women	-	-	2	3.3
Sister	-	-	1	1.6
Cousin	-	-	1	1.6
Total	2	3.3	52	86.6

Table 4-30 shows that few (3.3%) respondents, who had used condoms had limited sources of information on sexuality whilst the majority (86.6%), who had not used condoms had variety sources of information.

Table 4-31: Sexual experience in relation to whom they live with

Whom live with	Ever had sex		Total	
	No	Yes	Number	Percent
Parent	4	41	45	75
Sister/brother	1	7	8	13.3
Uncle/aunt	1	5	6	10
Cousin	-	1	1	1.6
Total	6	54	60	100
	10	90	100	

Table 4-31 shows that only a few (10%) respondents were virgins among whom those who lived with their parents were the majority. The majority (41) of those who had had sex also lived with their parents.

Table 4-32: Initiation experience in relation to content of sex education

Sex education lesson content	Initiated				Uninitiated			
	Yes		No		Yes		No	
	Num	%	Num	%	Num	%	Num	%
Pulling labia minora	24	40	-	-	36	60	-	-
STI/HIV	-	-	24	40	2	3.3	34	56
No sexual right	24	40	-	-	36	60	-	-
Expect gifts for good sex performance	24	-	-	-	36	60	-	-

Table 4-32 shows that the responses that were given by both the initiated (40%) and non initiated (60%) were the same, i.e. yes for pulling labia minora, no sexual right and expect gifts for good sex performance. All (40%) of the initiated said no for STI/HIV so did the majority (56.6%) of the non-initiated. Insignificant (3.3%) different views were given by the non-initiated concerning STI/HIV.

Table 4-33: initiation experience in relation to gender role lessons content

Gender role lesson content	Initiated				Uninitiated			
	Yes		No		Yes		No	
	Num	%	Num	%	Num	%	Num	%
Obedience and submission	24	40	-	-	36	60	-	-
Lobola	24	40	-	-	36	60	-	-
Provide for family members	24	40	-	-	36	60	-	-
Care for the sick	24	-	-	-	35	58.3	1	1.6

Table 4-33 shows that the responses given by the initiated (40%) and non initiated (60%) for gender role lessons content were similar. One (1.6%) non-initiated respondent gave a different view on the caring for the sick part.

Table 4-34: initiation experience in relation to marriage patterns lesson content

Marriage pattern lesson	Initiated				Uninitiated			
	Yes		No		Yes		No	
	Num	%	Num	%	Num	%	Num	%
Female position lower	24	40	-	-	36	60	-	-
Polygamy	24	40	-	-	36	60	-	-
Male infidelity acceptable	24	40	-	-	36	60	-	-
Inheritance custom	21		3	5	35	58.3	1	1.6
Mpokeleshi	11	18.3	13	21.6	16	26.6	20	33.3

Table 4-34 shows that the responses given by the initiated (40%) and non initiated (60%) were the same. Both stated that female position lower, polygamy and male infidelity are part of the marriage patterns lessons content. Inheritance custom and *mpokeleshi* had no and yes responses from both the initiated and non-initiated.

Table 4-35: Initiation experience in relation to sexual unions lesson content

Sexual union lesson content	Initiated				Uninitiated			
	Yes		No		Yes		No	
	Num	%	Num	%	Num	%	Num	%
Sexual cleansing	4	6.6	20	33.3	32	33.3	4	6.6
Sexual intercourse initiated by witch doctors	-	-	24	40	1	1.6	35	58.3
Sexual intercourse demonstrations	24	40	-	-	36	60	-	-

Table 4-35 shows that responses given by both, the initiated (40%) and non initiated (60%) for sexual union lessons content, were similar. Only one

(1.6%) non-initiated respondent gave a yes response for sexual intercourse initiated by witchdoctors as being part of the lessons.

Table 4-36: Most important lesson to remember by initiation status

Initiation lesson	Initiated		Uninitiated	
	Number	Percent	Number	Percent
Sex education	24	40	36	60
Gender role	-	-	-	-
Marriage patterns	-	-	-	-
Sexual unions	-	-	-	-
Total	24	40	36	60

The emphasis by both the initiated and non-initiated in Table 4-36 was on sex education, which had 100% yes responses from both sides.

Table 4-37: Reasons for pulling labia minora by initiation status

Reasons for pulling labia minora	Initiated			
	Yes		No	
	Number	Percent	Number	Percent
Every girl does it	3	5	24	40
They hold the penis during sexual intercourse	12	20	5	8.3
To sexually satisfy a man	4	6.6	7	11.6
Not to be left for another woman	5	8.3	-	-
Total	24	40	36	60

Table 4-37 shows that initiated respondents (40%) had various reasons for pulling their labia minora. The majority of the non initiated (40%) did it because 'every girl does it' i.e. to avoid being the odd one out.

Table 4-38: The importance of sex dance by initiation status

Rank (1=most common)	Reasons why sex dance is important	Initiated		Total
		Yes	No	
1	To satisfy a man sexually	16	21	37
2	To please a man	15	12	27
3	It is an appetizer for the man	2	11	13
4	It is for a man to enjoy sex	5	4	9
5	For a woman not feel pain during sex	1	0	1

Table 4-38 shows that majority of the respondents i.e. initiated and non initiated, said that sex dance is performed to satisfy a man sexually (37) and to please a man (27).

Table 4-39: Opinion on who should practice dry sex by initiation status

Who should practice dry sex	Initiated			
	Yes		No	
	Number	Percent	Number	Percent
Every female	22	36.6	33	55
Every married woman	1	1.6	3	5
Adolescents	1	1.6	-	-
Total	24	40	36	60

Table 4-39 shows that the emphasis of who should practice dry sex was on every female i.e. by both initiated (22) and non initiated (33) respondents.

Table 4-40: Virginity status by initiation status

Initiated	Ever had sex			
	Yes	Percent	No	Percent
Yes	23	38	1	1.6
No	31	51.6	5	8.3
Total	54	90	6	10

Table 4-40 shows that the majority of the respondents had had sex whether initiated (23) or not (31).

CHAPTER FIVE

5 DISCUSSION OF FINDINGS

5.1 INTRODUCTION

The result of this study are based on the analysis of responses of 60 school going female adolescents and 8 focus group discussions held with traditional counsellors in Lusaka Urban. The study focused on initiation ceremony in order to analyse the cultural practices and beliefs females are subjected to which may make them vulnerable to the HIV/AIDS scourge.

5.2 DEMOGRAPHIC CHARECTERISTICS

According to Table-4-1, the majority of the respondents were clustered around 16-17 (53.3%) and 18-19 (40%) age groups. All the respondents belonged to some religious denomination. Majority (68.3%) of them were Protestants and a minority were Catholics (21.6%) and Jehovah's witnesses (10%). The majority of the respondents were from the medium density (46.6%) and high-density (36.6%) areas. A large proportion of the respondents were in grade 10 (38.5%) and grade 11 (35%).

Most (75%) of the respondents lived with their parents (Table 4-1). The study results showed that majority (63.3%) of the respondent's guardian/parents were in formal employment and only a minority (10%) were unemployed (Table 4-2). This shows that respondents were mainly sent to school by guardian/parent who had a source of income. The unemployed who were parents and sister/brother i.e. nuclear family (Table 4-25) lived on hand outs from uncle, sister or brother (Table 4-02).

Income for both employed and unemployed guardians/parents was inadequate. Therefore, most (53.3%) of the respondents looked for money elsewhere to meet their school requirements (Table 4-02). Majority (21) of those who looked for money elsewhere to meet their school requirements lived with their parents (Table 4-25).

Looking for money to meet school requirements can be a risky venture. That is the girls may be tempted to look for money from men who will demand for sexual favours in return. Mersen (1993) observed that men expect automatic sexual access to any woman receiving their financial support.

5.3 INITIATION

5.3.1 Definition Of Initiation

Participants in the eight focus group discussions were asked to define initiation to gauge their understanding of the term. Their responses were as follows:

- ✓ It is preparation of a girl child for adulthood.
- ✓ It is announcing to the community that a girl is now ready for marriage.
- ✓ It is a time to learn how to look after a man.

The focus groups differed in the way they answered the question. The Kaonde definition put more emphasis on sex education. The Lozi, Lunda and Luvale emphasized on sex education and marriage. The Ngoni did not link marriage to initiation definition. The Tonga put more emphasis on the woman's reproductive role i.e. ability to bear

Text Box 5-1:Extract of field notes on Alangizi

Initiation is changing a girl from childhood to adulthood by teaching her cultural practices like sex dance, and beliefs like how to look after her self during menses. It is an announcement to the family; friends and neighbours which makes her parents proud because their daughter has reached an age when she can get married and the family will be respected.

children. In all the discussions, there was some tendency to emphasise more on some aspects of the ceremony than others.

5.3.2 Purpose Of Initiation

According to the traditional counsellors the purpose of initiation is to:

- ✓ Allow neutral people (not a close friend or relative), to teach a girl child about how to prepare her body for sex and what to do during sex.
- ✓ Prepare the initiatee for marriage.
- ✓ Check if an initiatee had 'played'.

Discussions with the different groups brought out the term 'play' when referring to pulling labia minora. Surprisingly, Shinkanga (1996) found out that sexual intercourse between child to child and child to adult is also referred to as 'playing'.

- ✓ Change an initiatee to an adult way of looking at things and behaving. That is, not being open and speaking in parables.
- ✓ Teach the initiatee to respect and fear men and elders.
- ✓ Make an initiatee submissive to men and elders.
- ✓ Emphasise on the value of virginity.

Generally, the main emphasis is on conformity. The initiatee is expected to take lessons from a neutral person seriously so as to conform to whatever she is taught.

The checking and

Text Box 5-2: Extract from field notes on Alangizi

Anthu a chabe a yenela kugwapo.i.e.neutral people must teach. The girl child will hence, be fearful and mor attentive to them. A parent cannot teach her own child because of the things taught and done which one cannot do on her own child.The 'things' include checking the menstrual blood, telling her how to behave during menses, how to look after her marriage and "*ku ona ngati e nkhala ko mulukolo*" i.e. checking if she 'played'. Men reject her if she never 'played'

touching of the girl's labia minora by strangers (neutral people) who are ruthless is a frightening situation for her, since they are tempering with her privacy at a tender age. The girl child may become confused and fearful, feel insecure and develop a low self-esteem resulting in her being vulnerable to sexual abuse. The tempering with her privacy could also mean that she ceases to regard her body as her own.

Time and again during the discussions the traditional counselors talked about a wife's body as 'his body' i.e. belonging to the husband. This gives 'legal' right to others to play with her body without her consent. This may make her vulnerable to sexual molestation since respect, submission and fear of men are emphasised in the same vane.

Chikotola *et al* (1996) found out how conformity to the teachings about fear, respect and submission is enhanced. That is the girl who was naughty is disciplined by being pinched, beaten and made to lick her mother's feet.

5.3.3 Lessons Which Complement Initiation

The following were the responses from traditional counsellors on lessons, which complement initiation:

- ✓ Pulling labia minora (i.e. playing).
- ✓ Housework.
- ✓ Submission.
- ✓ Whom to tell when she starts menstruating.
- ✓ Alangizi also claimed to discourage young girls from indulging in sex.

Focus group discussions with traditional counsellors also revealed that the main focus of the complementary lessons is on pulling labia minora ('playing'). This was supported by the evidence from the respondents, which indicates that 100% had pulled their labia minora (Table 4-13). The study also revealed that there are various gender roles inculcated in a girl child, for instance

submission. This compels the initiatee to take up an inferior position and let other people (parents and elders) make decisions for her.

The discussants said that people who teach the complementary lessons are: cousin, friend, aunt, grandmother and a good elderly female neighbour. Shah *et al* (1996) also mentioned the same sources with an addition of *tuman'ganga* (traditional healers). In this study, the respondents added sister, radio/television, Anti AIDS club and churchwomen as the other sources for complementary lessons (Table 4-03). This means that school going adolescents have a wider base for the source of information.

5.3.4 Qualification For Initiation

The traditional counselors gave the following responses as the qualification for initiation:

- ✓ Immediately after the first monthly period.
- ✓ 13-16 years of age.
- ✓ When a girl is betrothed.
- ✓ When breasts have developed.
- ✓ When one can keep secrets.
- ✓ When one has pulled labia minora.
- ✓ Immediately a girl discharges an egg i.e. before her first period. "A girl has to be observant to see a small egg" (Lundas only)

From this study, it is evident that it is not every girl that is initiated. To do so one has to meet certain qualification as mentioned above.

5.3.5 Reasons For Initiation During Adolescence

The discussants in the focus groups stressed that a girl should be initiated during adolescence for the following reasons:

- ✓ It is our tradition.

- ✓ It is important for an initiatee to get married.
- ✓ It helps an initiatee not to be rejected by a man for other women.
- ✓ It prepares an initiatee for sex.
- ✓ It makes an initiatee obedient, submissive and respectful.

Table 4-06 show that all (100%) of the respondents said that initiation is important. Majority (98.3%) of the respondents said that it is important because it prepares a girl for marriage while 1.6% said that it teaches a girl how to handle a man during sex (Table 4-07). This shows that the importance of initiation is for a girl to get married and not to be rejected by a man for other women.

The discussants emphasised that an initiatee has to be an adolescent i.e. for her to master the practices and not be rejected by men for other women. The researcher was told by traditional counsellors that it is good to teach an adolescent so that she already knows everything by the time she grows old. Infact, the discussants in the focus groups were not for the idea of delaying initiation because of education except for Alangisi. This means that they want to instil their practices and beliefs in the young girls as early as possible so that they will not depart from them when they grow old.

Text Box 5-3: Extract, field notes on Lunda.

A girl should be initiated when she is still young i.e. around 15-19 years. This is the time when the body is still fresh and flexible to learn the sex dance and 'play'. If the girl is old, the skin is stiffened i.e. labia minora.Therefore, when an old girl 'plays' the labia minora will be bruised, develop ulcers and peel off. The bones also make a lot of noise when she tries to wriggle her waist for the sex dance and it takes long for her to learn.Yet, if young it will not take long to teach a girl how to 'play' and the labia minora will be long within a short period. Teaching the young girl the sex dance is also not difficult because she learns fast since the bones are still fresh.

Helitzer- Allen (1994) observed that initiation influences girls to have sex at an early age, so she recommended the delaying of initiation in order to delay sexual initiation. This study also found out that majority (38.3%) of the

initiated had had sex (Table 4-40). However, it is problematic to recommend the delay of initiation due to the issues raised in Text Box 5.03.

5.3.6 Aims Of Initiation Lessons

The parents/guardians allow the girl to be initiated for a purpose and want to achieve a lot of things. According to discussants the aims of the initiation lessons is to ensure that the initiatee:

- ✓ Will have a decent marriage.
- ✓ Will be respected and not divorced.
- ✓ Should have a good attitude.
- ✓ Should bring joy and honour to her parents.
- ✓ Should be submissive to her husband.
- ✓ Should become a counsellor (added by Alangizi).
- ✓ Should be able to produce a lot of children (added by Tongas). The reproductive role seems to be the main focus in the Tonga culture. This means that if a wife is advised to use condoms because the husband is HIV positive or not to have children because she has HIV/AIDS she will not follow the medical advice.

The graduate who is taught to bring joy to others not herself will most likely not expose her sexual abuse experience or even that of her child. She will always avoid stigmatising her family.

Text Box 5-4: Field notes extract from Bemba.

Every married woman should not listen to negative stories and negative friends because she will lose her marriage and the same friends will take over her marriage.She should not tell her friends if her husband does not have sex with her or sleeps out. She must pretend that they have sex and he does not sleep out. She must not even react negatively but treat the man as if nothing has happened. She must listen to what he wants and do what ever he wants."

Box 5-4 shows that another aim for initiation lessons is to encourage subordination and male infidelity.[73] If this is the case how then can the Zambian society be able to reduce the incidence and prevalence of HIV/AIDS?

5.4 CULTURAL BELIEFS

Cultural beliefs impact greatly on the attitude towards HIV/AIDS. The following are the cultural beliefs taught during initiation:

- ✓ Sharing a bed with a man when bleeding per vagina causes him to develop a chronic cough.
- ✓ Sexual intercourse when bleeding per vagina causes a man to develop HIV/AIDS.
- ✓ Cooking or adding salt to food when bleeding per vagina causes men and children to have chronic coughs i.e. TB and HIV/AIDS.
- ✓ A woman's pubic hair causes ulcers or pus discharge in her partner's penis.
- ✓ Sex during the first 3-6 months after delivery damages or kills the baby.
- ✓ It is taboo to insult a man.
- ✓ A man's proposal for sex should not be turned down.
- ✓ A woman who initiates sex is a prostitute.

---

[73] NB Text Box 5-4 supports the WHO (1994) findings on Women, Sex and AIDS in relation to monogamy.

The cultural beliefs focus on preventing men and children from getting sick i.e. by a woman observing them. This shows that a woman is looked at as the source or cause of sickness that is HIV/AIDS, TB and STI (pus discharge from the male penis). Similar beliefs were also observed in Uganda and Thailand by WHO (1994).

Text Box 5-5: Extract field notes on Bemba.

Men are unstable; a man may demand sex from a woman who is bleeding. If she agrees, he will start thinning and be diagnosed as AIDS. A woman who has aborted should have her next menses before she can have sex. If she does not wait her, male partner will start thinning and die, '*ni makowesha*'. That is this disease termed AIDS. Even a long time ago it was there, we used to call it '*mankowesha*'.

The findings mean that the cultural response to HIV/AIDS prevention messages is unfavorable owing to the misinterpretation of STI/HIV/AIDS and TB transmission.i.e. Cultural adaptation. Can the HIV/AIDS prevention be successful when its transmission has been misinterpreted?

5.5 TEACHING METHODS

The study revealed that there are several teaching methods used during initiation ceremony. These methods as mentioned by focus group discussants include:

- ✓ Demonstrations.
- ✓ Songs.
- ✓ Role-plays.
- ✓ Riddles.
- ✓ Drawings.
- ✓ Sieve and *lubango.*
- ✓ Chitenge.
- ✓ Soil.

Text Box 5-6: Field note extract from Ngoni

A girl is taught how to communicate to her husband in regards to her monthly period. For example, she should put red beads on the bed whenever she is bleeding so that he does not ask for sex. After her period, she puts white beads to inform him that she is free to have sex.

- ✓ Discussions.
- ✓ Beads.

The communication taught is a closed method, which does not encourage open discussion in regards to sex or sexuality. This means that the couple cannot discuss the issue of safe sex. ICASA (1999) findings were that lack of communication and dialogue couples stems from socialisation and cultural barriers.

5.6 CULTURAL PRACTICES

The study revealed that there are several practices taught during initiation. These include:

- ✓ How to behave during menses.
- ✓ How to dance the sex dance.
- ✓ How to prepare traditional food.
- ✓ All the sex education lessons.
- ✓ How to communicate with her husband i.e. use beads to inform him that she is menstruating or not menstruating.
- ✓ How to look after a man.

When teaching about cultural practices the main emphasis is on sex education. For instance, all (100%) the respondents said that the most important initiation lesson to remember is sex education (Table 4-12). The most important lessons in sex education are sex dance (*ku denya*), dry sex and pulling labia minora. In addition, all the traditional counsellors stressed the role of a real woman in satisfying a man or a spouse. The majority (20) of the respondents added that an initiatee learns how to look after a man (Table 5-05).

5.7 SEX EDUCATION

Sex education is the main focus of initiation ceremony. The following were responses for the lessons taught:

- ✓ Respect, obedience and submission to adults and men.
- ✓ Role-plays and demonstrations are carried out to teach the girl the positions to take.
- ✓ Skin to skin sex is stressed during the lessons.
- ✓ Wiping herself with a cloth after sexual intercourse.
- ✓ Demonstrations and return demonstrations on how to wriggle the waist softly are carried out i.e. sex dance.
- ✓ Beads for waist are prepared.
- ✓ The girl is advised to always keep the shaving kit ready i.e. a face cloth, razor blade, small dish and soap for them to shave each other with her husband. Only the Lozis do not advise them to shave each other but the girl has to keep her pubic area well shaved at all times.
- ✓ The girl is advised to respond whenever a man demands to have sex i.e. never say 'no' to sex.
- ✓ The girl is taken to the bush to show her roots for dry sex. Even men who go to *Mukanda* are shown roots for their virility.
- ✓ The girl is advised that the man will be very generous and pay *lobola* quickly and she will not be rejected if she passes the test on the wedding day. That is do all that she has been taught. This encourages the graduates to adhere to whatever is taught.
- ✓ The girl is advised to wash the penis in warm water and wipe it after sex, which is in accordance with STI prevention messages.

The Kaonde advise the girl to clap and thank a man after sex. Alangizi who are trained HIV/AIDS counsellors as well as traditional counsellors left out the shaving, beads for the waist and responding whenever a man demands for sex in their discussions. Yet, during the discussion there were some girls preparing beads of assorted sizes and colours in the adjoining room. The researcher was asked to buy or press an order for beads. This shows that Alangizi teach what other traditional counsellors teach but their HIV/AIDS training puts them in an awkward situation.

The emphasis on respect, submission and obedience enhances subordinate vulnerability of women. That is women are less likely to control how, when and where sex takes place. No wonder, the girls when asked why they had sex without a condom, simply said that 'my boyfriend decided' (Table 4-24). Forty percent of the initiated and sixty percent of the non-initiated respondents said that pulling labia minora, no sexual right and expecting gifts for good sex performance are part of the sex education lessons content (Table 4-32).

According, to the research by the Institute for African Studies (1993) the lack of sexual right places women in a "state of conditioned helplessness," this puts them at risk of HIV/AIDS. Gender roles, which make females vulnerable to HIV/AIDS, are emphasised during sex education lessons. This makes it difficult for females to negotiate for safe sex practice with their male spouses despite being enlightened on HIV prevention.

Moreover, HIV prevention and control is unfavourable in an environment where females are inculcated with norms which support skin to skin sex, wiping the penis with fingers and never say no to sex. Worth noting also is that the emphasis in sex education lessons is that sexual intercourse is mainly for a man's satisfaction even though a woman is taught to thank a man for sex. During the 1999 ICASA Conference in Lusaka, Zambia the major findings and highlights in the women's village, were that men do not look at women as partners but as sex objects.

During the discussion with Alangisi, they said that they advise their graduates to go for HIV test with their fiancés. The couple will then be free to marry and have skin-to-skin sex if they are HIV negative. They have not looked at

HIV/AIDS that develops whilst the couple is already married. These teachings endanger a couple. For instance, Lozi culture does not encourage a female to see the penis. She is advised not to look at a man when he is undressing. She can touch the penis but not look at it. This is very dangerous because the man might have an STI, which the female will be exposed to without knowing.

Text Box 5-7: Extract field notes On Lozi.

A female should never look at or see a man's penis. She should also never say no to sex

The researcher was told that among certain ethnic groups men enter where a girl is being taught i.e. among the Chewa, Lunda, Kaonde and Luvale but their role in the teaching was not explained. The men's role in the teaching is most likely to provide practical demonstrations of the lessons. Helitzer Allen (1994) found out that in some ethnic groups Chewa especially (in Malawi), the *fisi* role was to provide practical demonstration for the initiated girls. The Chewa who were in the Ngoni discussion group could have concealed the information about the *fisi*. This is because of secrecy in the Zambian culture if dealing with someone from a different ethnic group i.e. an outsider.

5.7.1 Pulling Labia Minora

Pulling labia minora termed 'playing' was one of the sex lessons emphasised through out the discussions with traditional counsellors. Unlike other practices, pulling labia minora is commenced at a very tender age i.e. a girl starts preparing her body for sexual intercourse as early as 9 years old.

Text Box 5-8: Extract from field notes on Luvale.

Young girls form a group with a minimum number o 3 or more and go to the bush. They get *Mulya* sticks and herbs, which they use to pull labia minora i.e. 'play.' Whilst 'playing' they find out about each person's progress. For example, they would say, "my friends how far have you reached? I can now insert one stick, two sticks, three sticks..." Until the labia minora are long.

Playing in groups encourages girls to be very open with each other and copy practices from each other. No wonder the responses on Sex education (Table 4-32), Gender roles (Table 4-33), Marriage unions (Table 4-35) and

Sexual unions (Table 4-35) content were more less the same for the initiated and non-initiated. The girls were subjected to peer pressure because of playing in groups, for instance, majority (24) of the non-initiated pulled their labia minora because every girl does it. This blind following is to avoid being the odd one out (Table 4-37).

- ✓ The following responses were given by traditional counsellors to explain the necessity of pulling labia minora:
- ✓ For a woman to be a real woman.
- ✓ A man enjoys and has sexual satisfaction when he has sex with a female who has 'played.'
- ✓ The pulled labia minora give a man appetite when he touches or sees them.
- ✓ A man is pleased by pulled labia minora.
- ✓ The pulled labia minora puts a man in position; they hold his penis during sexual intercourse.
- ✓ The pulled labia minora keeps a man aroused.
- ✓ The pulled labia minora are for a man to play with during fore play.
- ✓ The pulled labia minora assist a man to ejaculate fast.
- ✓ A female who has pulled labia minora is not rejected or left by men for other women.
- ✓ The pulled labia minora give man strength.
- ✓ The pulled labia minora prevents the vagina from making sounds during sexual intercourse.
- ✓ The pulled labia minora works hand in hand with dry sex. That is, they provide 'breaks' in the entrance during sexual

penetration. Traditionally, a woman is made to believe that the long labia minora will maintain her spouse.

The 'playing' practice is similar to genital mutilation practiced in other cultures in that it is done to appease men. A female has to temper with her labia minora to fulfil the requirement of 'every woman,' from a tender age and through out her life i.e. a lifetime duty of 'every female.' As a woman 'plays' (i.e. pulls her labia minora), she is expected to 'play' with a man (i.e. have sexual intercourse) through out her lifetime. Alangizi told the researcher that 'every woman' has to always have a man she pleases and satisfies sexually unless she is abnormal.

Text Box 5-9: Extract field notes on Luvale.

The man plays with the long labia minora during sex. The labia minora shrink with every delivery and monthly period so 'playing' is an on going exercise, because every man wants them. The pulled labia minora are 'doors' that hold the penis and provide 'breaks' during sexual penetration. If they are not there, the vagina will be watery. A female is turned down (rejected) on the wedding day if she has no 'doors' i.e. pulled labia minora.

Therefore, sex is viewed as an innocent act ('play'), unfaithfulness is encouraged whilst abstinence is condemned in the Zambian culture. This is in conflict with the HIV/AIDS prevention, which depicts unsafe sex as a deadly practice. One wonders if the indigenous Zambians have accepted the 'Abstinence ili che' programmes.

Chikotola *et al* (1996) observed that a girl is taught to pull labia using African herbs for them to increase a man's pleasure and hold the penis during sexual intercourse. Mutonyi (1997) also observed the same findings and stated that it is a reflexion of a woman's role of submission and desire to satisfy a man's sexuality. In this study, all (100%) of respondents had pulled their labia minora i.e. 'played' (Table 4-15) and majority (90%) of them had had sex i.e. 'played' (Table 4-22).

5.7.2 Sex Dance

Sex dance is taught during initiation. It is a very important lesson, which determines the length of initiation. The researcher was told that an initiatee

has to reach perfection before the traditional counsellors think of terminating the initiation.

Text Box 5-10: Field notes extract on Luvale.

The sex dance is very important. A female should not sleep like a log when with a man in bed. The waist must really rotate smoothly. That is to make him ejaculate prematurely, enjoy sex and be aroused. If the sex dance is not well performed, a man will fail to be aroused and have sex.

The following responses were given by traditional counsellors to explain the importance of sex dance:

- ✓ For a man to enjoy sex.
- ✓ To give a man sexual satisfaction.
- ✓ To give a man strength.
- ✓ Not to be rejected by men.
- ✓ To be a real woman.
- ✓ To arouse a man and keep him in position.

The points raised for the importance of sex dance are similar to those for puling labia minora except that the 'breaks' were not mentioned. The focus groups discussants emphasised that beads and sex dance work together. Helitzer Allen (1994) also observed that girls are taught enticing body movements to please a man during sexual intercourse.

All (100%) of the respondents said that sex dance is important (Table 4-13) and they gave reasons similar to the ones mentioned by the discussants. Dancing also causes premature ejaculation. Male condom reduces sensitivity of the glans penis during sexual intercourse resulting in delayed ejaculation (Sellers 1995, page 940). This is in contrast with the premature ejaculation encouraged by pulling of labia minora and sex dance practices.

5.7.3 Dry Sex

Dry sex is widely practiced in Africa. HIV/AIDS prevention discourages its practice because it puts the woman at risk of getting HIV/AIDS if the partner is infected with HIV. Civic and Wilson (1996) stated that dry sex practice is

responsible for high rate of condom failure. The traditional counsellors who are aware of this development try to avoid talking about dry sex as being part of their lessons. That is to avoid being condemned. Yet, during one of the discussions, group members took herbal porridge for dry sex during lunch and they shared the herbal powder after the discussion.

This suggests that being enlightened does not stop one from practising dry sex but encourages her to conceal information to avoid condemnation.

Traditional counsellors gave the following responses for the necessity of dry sex:

- ✓ It makes a woman to be a 'real woman.'
- ✓ It helps a woman not to be divorced or rejected by men in preference for other women.
- ✓ It makes a man enjoy sex and have sexual satisfaction.
- ✓ It makes the body hot, vagina tight and dry i.e. what 'all men' want.
- ✓ It makes the body desirable to men.
- ✓ It makes a man virile.
- ✓ It works hand in hand with pulled labia minora i.e. labia minora provide 'breaks' at the entrance whilst dry sex provide 'breaks' inside the vagina and increases friction during sexual intercourse. That is what 'all men' want.

Shah and Nkhama (1996) found out that boys, girls, older men and women prefer dry sex to wet sex. The boys said that it provides more pleasure and they can feel the skin better. All (100%) of the respondents said that dry sex is important (Table 4-17) and gave similar reasons to those mentioned by the traditional counsellors (Table 4-18). The majority (91.6%) of the respondents said that every female should practice dry sex (Table 4-18). This shows that the respondents are also most likely to practice dry sex.

Focus groups representing the Northwestern ethnic groups i.e. Luvale, Lunda, and Kaonde also said that they teach and practice dry sex. This finding is contrary to Mutonyi (1997) 's observation that girls from the North western province use 'didos' to break the hymen and hymen and keep the vagina big in preparation for easy sex. In this study, the Northwestern traditional counsellors emphasised that they discourage a female from having a loose vagina during sexual intercourse. However, she is taught to use herbs to widen her vagina before childbirth for easy delivery.

It seems women have no choice where dry sex practice is concerned. They obey the traditional rule whether they like it or not. ICASA (1999) research findings on women and AIDS were that the advocates of dry sex include traditional counsellors, street vending herbalists and peers. Women do not enjoy dry sex but do it to secure their marriage. These findings are in line with Text box 5.11.

The issues raised in Text box 5.11 could be some of the reasons for child sexual abuse and sugar daddy syndrome in Zambia i.e. elderly men want young girls whose vaginas are tight. From the sex education lessons, it can be deduced that lovemaking is mainly for a husband 's pleasure. Sex is

Text Box 5-11: Extract from field notes on Tonga.

Herbal porridge helps to put a woman 's body in position especially immediately after every monthly period. The vagina tightens and the body becomes hot. When in bed with a man a female's body temperature should be higher than that of a man.

If the outside of the body and the hands are cold, it means the vagina is also cold.

Traditionally, it is a rule for every female to eat herbal porridge, whether educated or uneducated. A man whose spouse does not practice dry sex will notice a difference during sexual intercourse with her friend who practises dry sex. He will reject or divorce the one who does not practice dry sex.A man does not want a big, cold and watery vagina (a cold vagina is always watery) but a hot, tight and dry vagina. A man must always feel that he has had sex with a 'real' woman.

for men and it does not matter whether a woman reaches orgasm or is satisfied.

5.8 TYPES OF MARRIAGES

Marriage is very important in the Zambia culture. The main thing to achieve after initiation is a decent marriage, which brings joy and honour to parents. The various types of marriages mentioned by the traditional counsellors were:

- ✓ Monogamy.
- ✓ Polygamy.
- ✓ Spouse inheritance.
- ✓ Mpokeleshi.
- ✓ Elope marriages.

All the groups generally practice monogamy and polygamy type of marriages. All the ethnic groups except for Alangizi teach spouse inheritance. The Lozi do not practice sexual cleansing yet they practice spouse inheritance and *mpokeleshi.*

Text box 5.12 shows that the sexual and reproductive rights of women are abused because of the nature in arrangements for marriage. That is the right to choose whether or not to marry and to found and plan a family, source: IPPF Charter on Sexual and Reproductive Rights (1995).

Text Box 5-12: Extract field notes on Tonga.

A woman may get into a monogamous or polygamous marriage, it is accepted. There are three ways of getting married.

A man may decide to get a woman by force without getting her father's consent i.e. elope marriage.

A girl's parents/guardians will force a man who pregnant her to marry her. This type of marriage does not usually last because the man is sexually fed up of her .A man may pay *lobola* and decently get a girl. This is a long lasting marriage.

Although, polygamy is accepted it has its own consequences because a man is free to have extra marital affairs, divorce and remarry. This puts both married

and unmarried women on a life long competition for men. Therefore, how can it be possible to discourage negative cultural practices like dry sex, which assist women to entice men?

5.8.1 Significance Of *Lobola*

Traditionally, *lobola* is paid for a woman when she gets married. The following responses were given for the significance of *lobola*:

- ✓ It is a token of appreciation.
- ✓ It is for recognition of marriage.
- ✓ It legalises marriage.
- ✓ It is a value of a female.
- ✓ It is our tradition (Bemba only).
- ✓ It is lending something (Lunda only).
- ✓ It is for a woman's identity (Luvale only).
- ✓ Parents to benefit materially (Luvale only).
- ✓ It is buying or paying for a woman (Tonga only).

The Bemba, Lozi, Luvale and Tonga view *lobola* as a value of a female, so they emphasised more on virginity. Alangisi, Kaonde, Luvale and Ngoni view it as a legal right over a man's

Text Box 5-13: Extract field notes on Luvale.

Lobola is very important. Every parent says that he/she will earn something from her/his daughter when she grows up. If *lobola* is not paid, the marriage is not recognised and it is termed *'mapoto.' Lobola* also brings respect and makes the woman free. Every woman of whatever age has to be paid for, though the price varies according to age and if one has had sex before. *Lobola* is high for a virgin. All of the cultural practices including sexual cleansing can only be performed if *lobola* was paid.

wife, children and for sexual cleansing. From the responses, it is easy to see why a woman assumes a subordinate position.

Lobola also brings up the issue of sexual cleansing which has really been spoken against in all of the HIV/AIDS prevention programmes. It is difficult to address sexual cleansing without considering the *lobola* issue which gives a man 'legal' right to be sexually cleansed.

Infact, 100% of the respondents said that *lobola* is part of the gender roles lessons content (Table 4-09). Table 4-20 also shows that none of the respondents has any right to refuse to practice sexual cleansing. This stems from the traditional practice carried out when someone dies. For instance, during the funeral parents or adults speak for the girl child who has been chosen to sexually cleanse a male in law (Table 4-21).

This problematic if the sexual cleansing choice or idea originates from the same parents or adults because the adolescent will simply obey them. Infact, the discussants told the researcher that parents or elders select the girl or woman for the sexual cleansing, spouse inheritance and *mpokeleshi* practices. No wonder gender roles are emphasised in all the initiation lessons, that is to ensure conformity.

5.8.2 Roles Of A Married Woman

A woman is expected to perform a lot of roles when she gets married. The following are the roles of a married woman:

- ✓ Mother to every one in the home.
- ✓ She is a housekeeper.
- ✓ She is a helper to the elderly (Lozi only).
- ✓ She is a friend to every one.
- ✓ She is a counsellor to the young and old.

Text Box 5-14: Extract from field notes on Kaonde.

A woman should keep the house tidy and clean at all times. She is a mother to every one in the home i.e. she provides food for the family and nurses the sick. She is friendly to the visitors, family members and neighbours.

- ✓ She is a nurse to the sick.
- ✓ She is a role model.
- ✓ She is a helper to her husband (Lozi only).
- ✓ She is a provider of food and clothes.
- ✓ The child bearing and rearing should continue (Tonga only).

Generally, emphasis is on the role of being a mother and housekeeper. The role of child bearing and rearing is vital in the Tonga culture. Therefore, the Tonga discussants emphasised on enlarging the family and producing children to work in the fields. Macwan'gi *et al* (1994) indicate that through out Africa, a woman's status is influenced by her childbearing capacity. Hence, women are pressured to have children even if they are medically unfit to have children.

All (100%) of the respondents fulfil the role of keeping the house tidy and clean (Table 4-01). A married woman is expected to fulfil all the roles in Text box 5.14. With the home-based care programme in place, a woman nurses the TB/HIV AIDS patients in the home. Foster (1994) had similar observations. She observed that it is mainly women who care for the sick in the hospitals.

Since, no precautions are taken like wearing protective clothing, the woman is at risk of getting infected by a sick family member. Majority (98%) of the respondents said that caring for the sick is part of the gender roles (Table 4-09). Hence, caring for the sick is every woman's duty.

5.8.3 Expectations Of A Graduate

Practice makes perfect, hence a graduate is expected to put what she has learnt into practice. The responses from focus groups discussants on when a graduate is expected to start practicing what she has been taught were:

A graduate is expected to start practicing what she has learned immediately she graduates.

A graduate is expected to practice respect and submission immediately, and sex education lessons when she has a spouse (Ngoni only).

Only the Ngoni specified when a graduate should start practicing what she has learnt from initiation otherwise all the focus group emphasised that it should be immediately. Since girls are expected to start, practicing whatever they have been taught immediately they graduate then early sex initiation is not a taboo but a norm in the Zambian culture. When a parent pays some one neutral to instil such messages in a young girl it means they are authorising her to practice whatever she learns. This is what makes sex education enhance HIV/AIDS spread. Table 4.29 shows that no respondent whose information source was a traditional counsellor had had no sex or used condoms as shown in Table 4.30.

Text Box 5-15: Extract field notes on Luvale.

Immediately upon graduation, a girl should not wait for marriage for her to start dancing. A real woman will start practising what she learnt during initiation. She should really dance so that a man feels nice and observes that she has really been taught and decides to marry her. That is how men marry. If she does not practice, he will think that she is a log who does not know anything. She should perform whatever she was taught unless she has not been initiated. A man will ask her if she does not perform so she should really show him that she has been taught.

The emphasis on the immediate practice of lessons learnt by the graduate contradicts the emphasis on virginity. It is difficult for a girl who has been advised to never say 'no' to sex and to practice what she has learnt immediately she graduates, to keep her virginity. Infact, the counsellors only complained about adolescents being naughty because they have sex before initiation. Text box 5.15 shows that a woman can only impress a man by practising what she learnt during initiation. Therefore, a girl upon graduation may be tempted to test her dexterity.

5.8.4 The Difference Between An Initiated And Non Initiated Woman

The girl learns a lot of beliefs and practices during initiation, which she will practice upon graduation. Some of the differences mentioned by the focus

group discussants between the initiated and non initiated were as shown in Table 5-1.

The researcher was told by the focus group discussants that the non-initiated female could never compete with an initiated female. The focus groups further explained that men for not practicing cultural practices 'always' reject a non-initiated female. She is also the source of TB/HIV/AIDS because she does not observe the cultural beliefs. This means that a non-initiated woman is marginalized, because she is not knowledgeable of the cultural beliefs and practices as her initiated counterpart.

There is however a general agreement that the main difference is that the initiated has respect, right size of labia minora and knows cultural beliefs and practices. However, the researcher found out that the non-initiated respondents were quite knowledgeable of the initiation lessons content as well.

The non-initiated and initiated respondents gave the same responses for the importance of initiation ceremony (Table 4.07), gender roles lessons content (Table 4.33), Marriage patterns lessons content (Table 4.34) and the most important initiation lesson (Table 4.36). They also gave similar responses for the sex education lessons content (Table 4.32) and sexual union lesson content. Infact, the non-initiated were as knowledgeable concerning the importance of sex dance (Table 4.38) and dry sex (Table 4.39) as their initiated counterparts.

The significance of these findings is that there is sharing of information among the initiated and non-initiated adolescents. The non-initiated value whatever information is passed on to them, for example, they can even pull their labia minora because every girl does it (Table 4.37).

Table 5-5-1: Difference Between An Initiated And Non Initiated Woman

INITIATED	NON INITIATED
✓ Knows the cultural beliefs and practices.	✓ Does not know the cultural beliefs and practices i.e. she is half-baked.
✓ Has the right size of labia minora because she was checked and advised by traditional counsellors.	✓ Does not have the right size of labia minora because traditional counsellors did not check her.
✓ Has respect.	✓ Has no respect and she is rude.
✓ Is submissive.	✓ Is not submissive.
✓ Is obedient.	✓ Is disobedient.
✓ Is flexible.	✓ Is not flexible.
✓ Is an expert in sex dance and dry sex.	✓ Is not an expert in sex dance.
✓ Is never rejected by men because she is irresistible, appetising and satisfying to her spouse.	✓ Is rejected by men because she does not satisfy a man.
✓ Knows how to behave during her menses.	✓ Does not know how to behave during her menses.
✓ Is hard working	✓ Is not hard working.

It is clear from text box 5-16 that an initiated woman has a higher position than a non-initiated. This is all because of the practices she adheres to like pulling labia minora, sex dance and dry sex. Therefore, to make her stop practising them may be problematic. After all sex is between two people and

Text Box 5-16: Extract field notes on Alangizi.

An initiated woman knows how to satisfy a man. She gives him appetite and makes sex enjoyable for him. Wherever a man is he thinks about her and is not attracted to other women because she is irresistible. Therefore, he does not reject her or divorce her.

no one will be labelled for practising dry sex. This is a big challenge to the HIV/AIDS prevention messages. The woman is in a competition whether married or unmarried so it may be difficult for her to break the rules of the game and fight a losing battle.

5.8.5 Changes That Have Taken Place In The Initiation Lessons Content

A lot of changes have taken place in the Zambian society. The discussants cited the following changes:

- ✓ *Mpokeleshi* is now uncommon especially in the urban areas.
- ✓ Some traditional counsellors have commercialised initiation and exclude some lessons in sex education, for in stance dry sex practice.
- ✓ Initiation ceremony is delayed for some i.e. school going adolescents.
- ✓ Sex education is delayed for some until they are engaged or have finished school.
- ✓ Alangizi have had to change their content by including HIV/AIDS in sex education.

Alangizi encourage HIV test before marriage, though they did not tell the researcher the number of people they have counselled who have gone for a test.

Text Box 5-17: Extract field notes on Ngoni.

Nothing has changed in the content in all the Eastern province ethnic groups. The only change is the sex dance beat, which has become too fast.

HIV/AIDS epidemic is not perceived as a problem that should make the other counsellors change their content to include it in their lessons. The propagation of the same old

sex education messages encourages resistance to change, which is being passed on to the young generation.

5.9 CHALLENGES FACED BY TRADITIONAL COUNSELLORS

The challenges faced by traditional counsellors in relation to the content of what they teach are:

- ✓ TB and HIV/AIDS cases have increased because of ignoring cultural beliefs.
- ✓ It is now difficult to teach sex dance because of delayed initiation.
- ✓ It is also difficult for the initiatee to 'play' due to delayed initiation.
- ✓ Nowadays marriages are delayed i.e. not immediately upon graduation, or no marriages at all i.e. a lot of spinsters not getting married.
- ✓ Virginity on wedding day is no longer there (Bemba only).
- ✓ There are a lot of marital problems due to lack of respect and ignoring lessons taught during initiation.
- ✓ We have had to include HIV/AIDS in our lessons because of an increase in the number of people getting infected (Alangizi only).
- ✓ Girls are naughty because they do not adhere to what they are taught (Luvale only)
- ✓ Girls lack respect for elders because the initiation period is too short to ensure conformity to the

Text Box 5-18: Extract field notes on Ngoni.

Some girls do not follow every thing they have been taught i.e. dos and don'ts of cultural beliefs in relation to menses. Hence, a lot of people have AIDS and T because of not adhering to culture.

teaching before graduation (Luvale only).

- ✓ Initiation is being blamed for prostitution yet the non-initiated girls hire us to teach them the same condemned stuff before they get married.

Generally, every one agreed that the increase in the numbers of TB/HIV/AIDS cases was due to initiated and non-initiated ignoring the cultural beliefs. It seems that the scientific TB/HIV/AIDS transmission messages are in conflict with cultural beliefs. The cultural interpretation also encourages traditionists to view the TB/HIV/AIDS victims and patients as people who have broken the cultural norms (i.e. stigmatisation)

From Text box 5.18 it appears that as long as the dos and don'ts of cultural beliefs are observed a person cannot get infected with HIV and TB. Therefore, there is no need to practice safe sex. In the researcher's view, this kind of teaching enhances TB/HIV/AIDS spread.

5.9.1 Introduction Of Safe Sex In Marriage

The promotion and introduction of safe sex in all sexual relationships is vital for the prevention and control of HIV/AIDS. Traditional counsellors are the best people to promote safe sex since they are the ones who prepare girls for marriage. Their teachings are even upheld by the non-initiated females who are said to be

Text Box 5-19: Extract from field notes on Kaonde.

We just find the issue of condoms at the clinic. They are not used in the homes. Condoms are not taught during initiation. A girl is just taught about child bearing. If your husband wants to use condoms he will send you to get them, but if he does not want then do not get them. When using condoms men do not feel the sweetness.

half-baked. Alangizi told the researcher that even the pastors' wives privately hire them to teach their daughters, though they publicly denounce them.

The following were the responses from traditional counsellors to how safe sex can be introduced in marriages:

- ✓ It is impossible to introduce safe sex in marriage for the following reasons:
- ✓ A girl is taught to have skin-to-skin sex and wipe the penis with hands.
- ✓ A girl is taught not to deny a man sex, because he will go for other women.
- ✓ A girl is also told that extra marital sex is allowed for men, even to divorce her and remarry another woman.
- ✓ A girl is told that only women abstain when they are bleeding per vagina and after delivery.
- ✓ A girl is told that it is only a woman who should be faithful.
- ✓ Condoms are discouraged, unheard of because they destroy marriage.

Alangizi stressed that abstinence is abnormal and every normal woman should have a man she pleases and satisfies. The Bemba group emphasised that HIV/AIDS has always been there and having sex with a woman who is bleeding per vagina can only transmit it. Safe sex practices were out right rejected by all the traditional counsellors. All the focus groups pointed out that it is impossible or difficult to introduce safe sex in marriages.

Alangizi lamented that the gender rights advocates are spinsters and divorced women who want to destroy culture and cause broken marriages. The gender rights advocates are educated women in NGOs who are trying to address the women's "state of conditioned helplessness" brought about by the gender roles. They teach women to be assertive and promote girl child education. It seems Alangizi cannot accept their messages even if they mean well because

of their marital status. Whatever the gender rights advocates fight for also seems to be in conflict with tradition i.e. especially gender roles lessons which are part of every lesson content that Alangizi teach.

The traditional counsellors' failure to change their practices is similar to Goldstein (1994)' s findings in Brazil about the 'casa' that constitutes practices that cannot undergo transformation, reform or revolution.

Introduction of safe sex in marriage seems to be a taboo because the traditional counsellors were first taken aback by the question. A man is not expected to abstain or stick to one sexual partner. He is the one who should decide whether to use a condom or not.

CHAPTER SIX

6 IMPLICATION, CONCLUSION, RECOMMENDATIONS AND THE STUDY LIMITATIONS

6.1 IMPLICATION OF THE STUDY FINDINGS

The study revealed how cultural practices and beliefs heighten the vulnerability of females to HIV/AIDS. Majority (53.3%) of the respondents looked for money elsewhere to meet their school requirements which is a risky venture. That is the girls may be tempted to look for money from men who will demand for sexual favours in return.

The findings of this study revealed that during initiation neutral people (strangers) check and touch a girl's private parts. This gives 'legal' right to others to play with her body without her consent. It may make her vulnerable to sexual molestation since respect, submission and fear of men are emphasised in the same vane.

The gender roles like respect and fear, inculcated in a girl child compels her to take up an inferior position and let other people make decisions for her. Therefore, she is less likely to control how, when and where sex takes place. For instance, she cannot negotiate for safe sex nor refuse to sexually cleanse a male in law. This makes her vulnerable to getting infected by an HIV positive sexual partner.

The most important lessons of initiation i.e. pulling labia minora, dry sex, skin to skin sex, never say 'no' to sex and obey elders and men, focus on how to sexually please a man. These lessons may create behavioural patterns, which are resistant to the HIV/AIDS prevention interventions.

HIV/AIDS prevention interventions discourage negative practices like dry sex and sexual cleansing. However, the study findings show that it may be fruitless to focus on one practice since the practices are interrelated. For instance, pulling labia minora works hand in hand with dry sex and *lobola* gives a man 'legal' right to be sexually cleansed.

Furthermore, the results explain how cultural beliefs are in conflict with HIV/AIDS intervention messages. That is cultural beliefs interpret the transmission of STI/HIV/AIDS unscientifically. For example, cooking or adding salt to food when bleeding per vagina causes men and children to have TB and HIV/AIDS. Hence, the cultural beliefs may negatively influence how people act, and respond to HIV/AIDS epidemic.

The cultural beliefs and practices draw a line between women. That is those who uphold them are termed 'real' women who can never be rejected by men, while those who do not uphold them are not 'real' women and are rejected by men. Therefore, irrespective of HIV/AIDS intervention messages women may still uphold the negative cultural practices and beliefs.

The results show that the current HIV/AIDS prevention and control interventions may not make an impact among the ethnic groups. Those who are enlightened like Alangizi and one Tonga traditional counsellor, choose to be silent about the negative practices. Yet, they continue practising the same, for instance dry sex.

Safe sex, which is encouraged in HIV/AIDS prevention and control interventions, was out right rejected by the traditional counsellors. They all said that it is impossible or difficult to introduce safe sex in marriage. Therefore, the probability of a married woman getting HIV/AIDS from an infected spouse is high because HIV/AIDS preventive and control measures are prohibited in marriage.

6.2 CONCLUSION

This study based on questionnaires and focus group discussions has confirmed the hypothesis i.e. cultural practices and beliefs influence the spread of HIV/AIDS. The study findings show that there are similarities in cultural practices and beliefs across ethnic boundaries in Lusaka urban, which are widely accepted and practised.

The study has revealed that a girl learns some cultural practices like pulling labia minora before initiation. During initiation, cultural practices and beliefs are intensified. Those who do not uphold them (especially the non initiated

females) are 'rejected' by men for those who uphold them. They are also blamed for transmission of HIV/AIDS because they have sex despite per vaginal bleeding.

There is secrecy and unwillingness to mix and share information and experiences among traditional counsellors from different ethnic groups. This is a draw back on HIV prevention because the ethnic groups may benefit from each other by sharing information and being open about the information.

6.3 RECOMMENDATIONS

6.3.1 National Level

This study, which was limited to senior secondary school girls in Lusaka urban, has revealed a lot of negative cultural practices and beliefs that need to be addressed.

- ✓ It is very urgent that research be conducted on a wider scale to establish the magnitude of the problem in Zambia. The study should include males to paint a clearer picture.
- ✓ There is need for the HIV/AIDS Secretariat programme officers to take into account the prevailing negative cultural practices and beliefs in the HIV/AIDS prevention and control strategies.
- ✓ A national response to HIV/AIDS epidemic is required, in which the stakeholders will all be involved at every level. That is the government, donors, NGOs, chiefs, traditional healers, cultural association representatives and religious leaders.

6.3.2 Sector Level

The respondents mentioned friends, television, Anti AIDS club and traditional counsellors as their sources of information on sexuality. Therefore, it is important to target their sources of information, to ensure positive response to HIV/AIDS prevention.

- ✓ The media should intensify the HIV/AIDS prevention and control messages.

- ✓ Education: The Anti AIDS clubs should be supported and promoted. The school curriculum should include sexuality and HIV/AIDS lessons.

- ✓ Health: The Ministry of health should work closely with Ministry of social welfare and culture, Gender in development and NGOs to sensitise cultural groupings and traditional counsellors about the effects of the negative cultural practices and beliefs on HIV/AIDS.

6.3.3 District And Community Level

Cultural practices and beliefs cannot be changed single handed, so there is need to involve the community members, especially the custodians of culture. That is chiefs, headmen, traditional healers, traditional counsellors, traditional association representatives, pastors and priests.

- ✓ There is need to educate community leaders like chiefs, pastors and politicians on HIV/AIDS prevention and control for the programme to be appreciated.

- ✓ There is also need to educate women on how to protect themselves when caring for AIDS relatives without stigmatisation of the AIDS patients.

- ✓ The study was not exhaustive so the witchdoctor initiating sex issue was not tackled. There is need to carry out a research on the issue using a different forum at the community level.

6.4 LIMITATIONS OF THE STUDY

1. The pilot study findings revealed that it was not possible to interview traditional counsellors from the seven major ethnic groups of Zambia in one focus group discussion as was intended. This was only possible for Alangizi Association

members, though even in that group the Kaonde, Luvale and Lozi members did not turn up for the discussion.

2. The changes in the composition of the groups increased the sample size from 71 to 140. This is because there were ten traditional counsellors in each of the eight focus group discussions (i.e.80) plus sixty female school going adolescents.

3. The researcher had planned to focus on females but Alangizi demanded the participation of Lunda man they teach with, therefore the study did not focus on women alone as was intended. Instead, the study also encompassed men.

4. The researcher observed that there is a great deal of secrecy about what is taught. That is, the sensitive and top secretive information was not allowed to be recorded, and she also had to probe for traditional counsellors to reveal some of the teachings. This means that a lot of information might have been concealed.

5. The study was limited to Lusaka urban where everything is commercialised so the researcher had to part with a lot of money.

6. The study was academic therefore it had limited time and inadequate funding which made it impossible to conduct the study on a larger scale (i.e. nation wide) to make the findings easier to generalise to the rest of the study population.

REFERENCES

1. Aoko M. et al (1998) AIDS in Kenya: Socio-Economic Impact and Policy Implications, U.N., Nairobi.

2. Campbell and Williams B. Beyond the Biomedical and Behavioural: onwards an Integrated Approach to HIV Prevention in the Southern African Mining Industry, Social Science and Medicine, June 1993 Volume 48; Number 11.

3. Chikotola B. et al (1996), Summary on Adolescent Sexual and Reproductive Health for Seven Peri-Urban Compounds, Care International, Lusaka.

4. Civic D. and Wilson C., Dry Sex in Zimbabwe and Implications for Condom Use, Social Science Medicine, July 1996,Volume 42; Number 1.

5. Duncan T. (1996), Prospects for Sustainable Human Development In Zambia, United Nations Systems, Lusaka.

6. Essex M. et al (1994), AIDS in Africa: Impact of AIDS on Gender Roles, Raven Press, New York.

7. European Commission (1998) One Hundred Words for Equality: A Glossary Of Terms on Equality Between Women and Men, Luxembourg, page 31.

8. Family Health International (1997), Reproductive Health for Young Adults: Contraception, Pregnancy and Sexually Transmitted Diseases, North Carolina.

9. Foster Susan (1994): Cost and Burden of AIDS On The Zambian Health Care System: Policies to Mitigate The Impact on Health Services, USAID, Virginia.

10. Giddens A. (1996), Sociology, Polity Press and Blackwell, Oxford.

11. Goldstein O.M., AIDS and Women in Brazil: The Emerging Problem, Social Science Medicine, October 1994, Volume 39; Number 7.

12. Helitzer-Allen D. (1994), Women and AIDS. An Investigation of Community Based Research Programme of Adolescent Girls Communications Networks in Rural Malawi for HIV/STD Prevention Messages, International Centre for Research on Women, Washington D.C.

13. ICASA(1999): Public Sector Reforms and HIV/AIDS In Africa, Track 2, Session Number 14A, Lusaka.

14. ICASA(1999) Women and AIDS, Satellite Session,and Women's Village, Session Number 14BT3,Track 3, Lusaka.

15. Institute for African Studies (1993): Orphans, Widows and Widowers in Zambia: A Situational Analysis and Options for HIV/AIDS Survival Assistance, UNZA, Lusaka.

16. Lishebo V. L. (1994), Social Status In Spoken Interaction In Two Lozi Dialects At Buseko Market, University Of Zambia, Lusaka.

17. Macwang'i et al (1994) Women and AIDS in Zambia: Situation Analysis and Options for HIV/AIDS Survival Assistance, M.O.H., Lusaka.

18. Mersen M.H. (1993) Speech on: Impact of HIV/AIDS, Population, Policies, Programs, International Round Table, W.H.O., Berlin.

19. Mersen M.H. (1993) Speech on: The Global Impact of AIDS, XI International Congress on Virology, W.H.O., Glasgow.

20. Mertens E.T. and Carael M. A New Outlook for HIV/AIDS, Nov – Dec 1998, Number 6, WHO.

21. MOH/CBOH (1999) HIV/AIDS in Zambia: Background, Projections, Impacts, Interventions, Lusaka.

22. MOH/NACP (1993) Situational Analysis of AIDS in Namibia, Windhoek.

23. MOH/Ministry of Labour and Social Security (1993) Combating HIV/AIDS/STD at Work Place: Second Medium Term Plan 1994 – 1998, Zambia National AIDS/STD/TB/Leprosy, Lusaka.

24. Mulenga K. Fight Against Prostitution, Girl Child Abuse, Requires Community Effort, Zambia Daily Mail; Friday, April 28, 2000, Volume 4, Number 101, Lusaka.

25. Mkandawire R. (1995) The Plight of a Girl Child in Commonwealth Africa, Commonwealth Youth Centre, UNZA, Lusaka.

26. Mutonyi S. (1997) Sexuality: The Difficult Topic, Chikankata Health Services and AIDS Management, Mazabuka.

27. Republic of Zambia, (1996),Gender Statistics Report, CSO, Lusaka.

28. Runganga et al (1992), The Use of Herbal and Other Agents to Enhance Sexual Experience, Social Science Medicine, June 1992, Volume 35, Number 1037.

29. Salusela B., UNAIDS Calls for Saving People from AIDS, The Post, Friday, April 28, 2000, Number 1472.

30. Shah M. et al (1996) Listening to Young Voices: Participatory Appraisal on Adolescent Sexual and Reproductive health in Peri-Urban, Care International, Lusaka.

31. Shah M. and Nkhama G. (1996), Listening to Young Voices: Participatory Appraisal on Adolescent Sexual and Reproductive Health in Peri-Urban, Lusaka.

32. Shinkanga M. (1996) Child Sexual Abuse in Zambia, UNICEF, Lusaka.

33. Sifuniso M. (1998), Talk about Health: Communities Discyuss their Health, Zambian Women Writers Association, Lusaka.

34. Singer S.M. et al (1997), AIDS and Ethno Cultural Communities, Zambia, Health Information Digest. April – June 1997, UNZA, Lusaka.

35. United Nations Population Division (1998) The Demographic Impact of HIV/AIDS, Geneva.

36. Vloke M. (1996) ,Manual for Community Nursing and Communicable Diseases, Juta and Company Limited, Cape Town.

37. UNAIDS (1999), The UNAIDS Report, Switzerland.

38. UNAIDS (1999) Gender and HIV/AIDS: Taking Stock of Research, Programme, Switzerland.

39. WHO (1994) ,Images of the Epidemic, France.

40. WHO.(1995), 1992 – 1993 Progress Report on: Global Programme on AIDS, Switzerland.

41. WHO. (1996), Women and AIDS, Geneva.

42. World Bank (1992), Annual Report, Washington D.C.

APPENDIX 1

ALANGIZI ASSOCIATION OF ZAMBIA

Alangizi Association of Zambia was established on 14th October 1997, as a body of experts in Zambian traditional and cultural values. The offices are at Evelyn Hone College in Lusaka, where the chairperson works. The association is comprised of male and female traditional counsellors representing the ethnic groups in Zambia.

The association was formed to address complications in society owing to abandoning traditional ceremonies and culture. For example rampant divorces due to no premarital teaching on meaning of marriage, increased cases of HIV/AIDS due to corrupted behaviour among both the young and old, girl children leaving school prematurely due to pregnancies and girl children being impregnated by their relatives.

The association gives a chance to young men and women of getting adequate marriage education. It teaches the youth the traditional norms and values in life on a continuous basis from an early age, to reduce cases of HIV/AIDS, unstable marriages and divorces. The association also maintains a positive Zambian traditional culture in intermarriages.

- Alangizi association is funded by:
- Gender in Development (GID) at Cabinet office.
- Society for Family Health.
- Ministry of Community.
- Zambia Information Services.
- Women and Law in Southern Africa.

However, the Association members are mainly found in Lusaka and Copperbelt provinces where the offices are. The national committee is in Lusaka, and its members work with other NGOs that are mainly in gender related issues.

The members of the public are free to hire Alangizi counsellors at an agreed amount with them. The advantage of hiring them is that they will teach the girl cultural practices and beliefs of her and her spouse's ethnic group and also sensitise her about HIV/AIDS.

APPENDIX 2

QUESTIONAIRE FOR FEMALE ADOLESCENTS AT SECONDARY SCHOOL LEVEL

TOPIC: THE STUDY ON: HOW CULTURAL PRACTICES AND BELIEFS INFLUENCE THE SPREAD OF HIV/AIDS

DATE.....

NAME OF SCHOOL.....

INSTRUCTIONS TO INTERVIEWER

1. Introduce yourself to respondents.
2. Explain the purpose of the interview
3. Assure the respondents of confidentiality and anonymity by explaining that all information to be collected will be confidential and identification will be anonymous.
4. Encourage the respondents to feel free during the discussion.
5. Ensure that all questions are answered
6. Thank the respondent at the end of the interview

SECTION A. BIOGRAPHIC DATA

1. Where do you live? .....

2. Sex (a) Male [ ]

(b) Female [ ]

3. What was your age at your last birthday?

[a] 10 – 11 [ ]

[b] 12 – 13 [ ]

[c] 14 – 15 [ ]

[d] 16 – 17 [ ]

[e] 18 – 19 [ ]

4. What is your religious denomination?

[a] Catholic [ ]

[b] Protestant [ ]

[c] Moslem [ ]

[d] Hindu [ ]

[e] Other (specify].....

5. What grade are you in?

[a] Grade 8 [ ]

[b] Grade 9 [ ]

[c] Grade 10 [ ]

[d] Grade 11 [ ]

[e] Grade 12 [ ]

6. Whom do you live with?

[a] Parents 1 [ ]

[b] sister/brother 2 [ ]

[c] uncle/aunt 3 [ ]

[d] Cousin 4 [ ]

[e] Other (specify) .....

7. Is your guardian/parent employed?

Yes 1 [ ] No 0 [ ]

8. If no what is the source of income for the household?

.....

9. Do you look for money to meet some of the school requirements?

Yes 1 [ ] No 0 [ ]

10. If yes why? .....

11. What are the daily activities you are expected to perform at home?

[a] House hold chores 1 [ ]

[b] Drawing water 2 [ ]

[c] Farming 3 [ ]

[d] selling 4 [ ]

Other(specify).....

SECTION B. INITIATION CEREMONY PRACTICE

12. What is your source of information on sexuality?

[a] Mother 1 [ ]

[b] Aunt 2 [ ]

[c] friends 3 [ ]

[d] Radio/Television 4 [ ]

[e] Traditional Counsellors 5 [ ]

[f] Other (specify).....

13. Have you been initiated?

Yes 1 [ ] No 0 [ ]

14. If yes what were you taught during initiation period?

.....

15. Do you think that the initiation ceremony is important?

Yes 1[ ] No 0[ ]

16. If yes can you explain?

.....

Do the content of the lessons include the following:

17. Sex education?

1. Pulling labia Yes [ ] No [ ]

2. STI/HIV Yes [ ] No [ ]

3. No sexual right Yes [ ] No [ ]

4. Expect gifts for good Yes [ ] No [ ]

sex Performance

5. Others specify.....

18. Gender role?

1. Obedience and submission Yes [ ] No [ ]

2. Lobola Yes [ ] No [ ]

3. Provide for family members Yes [ ] No[ ]

4. Care for the Sick Yes [ ] No [ ]

5. Others specify.....

19. Marriage patterns?

1. Female position lower Yes [ ] No [ ]

2. Polygamy Yes [ ] No [ ]

3. Male infidelity Yes [ ] No [ ]

4. Inheritance custom Yes [ ] No [ ]

5. Mpokeleshi Yes [ ] No [ ]

6. Others specify.....

20. Sexual Unions?

1. Sexual cleansing Yes [ ] No [ ]

2. Sexual intercourse initiated by witchdoctors Yes [ ] No [ ]

3. Sexual intercourse (live) demonstrations Yes [ ] No [ ]

4. Others specify.....

21. Of all the lessons you were taught which one is the most important one to remember?

[a] Sex education [ ]

[b] Gender role [ ]

[c] Marriage patterns [ ]

[d] Sexual unions [ ]

[e] Other (Specify) .....

22. Have you ever pulled labia minora?

Yes [ ] No [ ]

23. If yes explain why you had to pull your labia minora?

.....

24. Is the sex dance important?

Yes [ ] No [ ]

25. If yes explain why sex dance is important

.....

26. Do you think dry sex is important?

Yes [ ] No [ ]

27. If yes why:.....

28. Who do you think should practice dry sex?

[a] An adolescent [ ]

[b] A young woman without a child [ ]

[c] A young woman with children [ ]

[d] Every female [ ]

[e] Other (Specify) .....

29. If you were to lose a close female relative, and her husband's family choose you to cleanse him, would you have any right to refuse?

Yes [ ] No [ ]

30. If no why would you not have any right to refuse?

.....

31. Have you ever had sex? Yes ( ) No ( )

32. Have you ever had sex without a condom?

Yes [ ] No [ ]

33. If yes why did you have sex without a condom?

APPENDIX 3

FOCUS GROUP DISCUSSION GUIDE FOR TRADITIONAL COUNSELORS

DATE OF MEETING

PLACE:

SIZE OF AUDIENCE:

TIME STARTED: **TIME ENDED**:

FACILITATOR:

RECORDER

INTRODCTIONS

1. Self introduction.
2. Explain the purpose of the discussion
3. Assure the discussants of confidentially by explaining that information recorded will be confidential, so they should feel free.
4. Thank them for participating.

FOCUS GROUP DISCUSSION OPEN PLENARY DISCUSSION QUESTIONS

1. What is the definition of initiation ceremony in:- Lozi?, Ngoni?, Bemba?, Luvale?, Tonga?, Kaonde?, Lunda?,
2. What is the purpose of initiation ceremony?

3. What lessons is a girl expected to learn from the other sources, which complement initiation?

4. Who qualifies to be initiated?

5. What do you always want to achieve at the end of the initiation ceremony?

6. What are the cultural practices taught during initiation ceremony? (state)

7. What are the traditional beliefs taught during the initiation ceremony?

8. What method of teaching do you use during initiation ceremony?

9. Describe the content of what you teach in sex education.

10. Is it necessary for a woman to: -

    i. Pull labia minora?

    If yes why?

    ii. Perform the sex dance?

    If yes why?

    iii Practice dry sex

    If yes why?

11. Do you encourage girls to engage in a monogamous type of marriage or any other type of marriage?

12. What is the significance of Lobola?

13. Describe the roles you teach the girls to perform when they get married?

14. When is the graduate expected to start practicing what she has been taught?

15. Is there a difference between a person who has been initiated and a person who has not been initiated?

16. What has changed in the content of what you are teaching today from what was taught ten years ago?

17. Why do you think initiation ceremonies are still important to a adolescent?

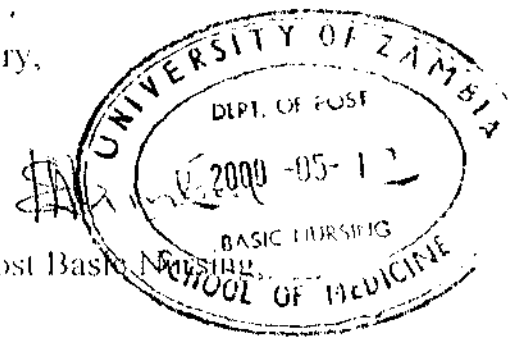
18. What are the challenges you face in relation to the content of what you teach?

19. How can safe sex practices be introduced in marriages?

University of Zambia,
School of Medicine,
Department of Post Basic Nursing
P.O. Box 50110,
Lusaka.
16 th June, 2000.

The Permanent Secretary,
Ministry of Education,
Lusaka.

UFS The Head,
Department of Post Basic Nursing,
Lusaka.



Dear Sir/Madam,
Re: RESEARCH STUDY REQUEST

Iam a fourth year student in the Department of Post Basic Nursing, School of Medicine University of Zambia, pursuing a Bachelor of Science Degree.

As partial fulfilment for my degree programme, Iam required to carry out a research study in order to graduate. My chosen topic of study is: A Study to determine how cultural practices and beliefs influence the spread of HIV/AIDS in Lusaka.

I intend to first collect data from a random sample of adolescents Kabwata Basic School to test my tools in first week of July. Then I will systematically random sample four Secondary Schools (i.e. two Co education and two Girls' School) from which I will interview female adolescents during the months of July and August 2000. The purpose of this letter is to kindly ask for permission to enable me carry out the study in the of Lusaka urban.

Thanking you in advance.
Yours faithfully.

KAMUWANGA CHAZE.

University of Zambia,
School of Medicine,
Department of Post Basic Nursing
P.O. Box 50110,
Lusaka.
16 th June, 2000.

The Permanent Secretary,
Ministry of Education,
Lusaka.

UFS The Head,
Department of Post Basic Nursing,
Lusaka.

Dear Sir/Madam,
Re: RESEARCH STUDY REQUEST

Iam a fourth year student in the Department of Post Basic Nursing, School of Medicine University of Zambia, pursuing a Bachelor of Science Degree.

As partial fulfilment for my degree programme. Iam required to carry out a research study in order to graduate. My chosen topic of study is: A Study to determine how cultural practices and beliefs influence the spread of HIV/AIDS in Lusaka.

I intend to first collect data from a random sample of adolescents Kabwata Basic School to test my tools in first week of July. Then I will systematically random sample four Secondary Schools (i.e. two Co education and two Girls' School) from which I will interview female adolescents during the months of July and August 2000. The purpose of this letter is to kindly ask for permission to enable me carry out the study in the of Lusaka urban.

Thanking you in advance.
Yours faithfully.

KAMUWANGA CHAZE.

University of Zambia,
School of Medicine,
Department of Post Basic Nursing
P.O. Box 50110

16 th June, 2000.

The Director,
DHMT,
Lusaka.

UFS The Head,
Department of Post Basic Nursing,
Lusaka.

Dear Sir/Madam,
Re: RESEARCH STUDY REQUEST

Iam a fourth year student in the Department of Post Basic Nursing, School of Medicine University of Zambia, pursuing a Bachelor of Science Degree.

As partial fulfilment for my degree programme, Iam required to carry out a research study in order to graduate. My chosen topic of study is: A Study to determine how cultural practices and beliefs influence the spread of HIV/AIDS in Lusaka.

I intend to collect data from random sample of Traditional counsellors (Bana Chimbusa) during the months of July and August 2000. The purpose of this letter is to kindly ask for permission to enable me carry out the study in the peri-urban areas of Lusaka urban.

Thanking you in advance,
Yours faithfully,

KAMUWANGA CHAZE.

P. O. Box 50827
Lusaka
Tel: 235554
Fax. 236429

In reply please quote
No.....

MINISTRY OF HEALTH

LUSAKA DISTRICT HEALTH MANAGEMENT BOARD

28th July, 2000

The Kamuwanga Chaze
Dept of Post Basic Nursing
University of Zambia
LUSAKA.

Dear Madam,

RE: STUDY TO DETERMINE HOW CULTURAL PRACTICES AND BELIEF INFLUENCE THE SPREAD OF HIV/AIDs IN LUSAKA URBAN DISTRICT

Your request to conduct the above study through our urban Clinic has been authorised. You are however informed that the DHMT is not responsible for bana Chimbusas but if there are some, then authority is granted.

We hope the results of the study will be disseminated to the DHMT.

Dr. B. Tambatamba-Chapula
Acting Manager Planning and Development
for DISTRICT DIRECTOR OF HEALTH

Lusaka City Council

Director of Public Health
Telegrams: "CITY"
Telephone: 252480
Ext.
Verbal Enquiries to:
Mr .....

PUBLIC HEALTH SERVICES DEPT.
CIVIC CENTRE
P.O. Box 30789
LUSAKA
Republic of Zambia

Reference: PHD/6/1/8
SSBK/alk
Your Ref:

23rd June, 2000

Mr Kamuwanga Chaze,
University of Zambia,
School of Medicine,
Dept. of Post Basic Nursing,
P.O. Box 50110,
LUSAKA.

Dear Sir,

re: RESEARCH STUDY REQUEST

Reference is made to your letter dated 16th June, 2000 concerning the above captioned subject matter.

May I inform you that my office has no objection to your Study of determining how cultural practices and beliefs influence the spread of HIV/AIDS in Peri Urban areas of Lusaka.

Yours faithfully,

DR. CHIBESA S. WAMULUME
DIRECTOR OF PUBLIC HEALTH

c.c. The District Director of Health - LUDHMT

...should be addressed to:
... Secretary to the Ministry of Education
... by name.

Telephone ...251319

In reply please quote
No. .....

REPUBLIC OF ZAMBIA

MINISTRY OF EDUCATION

ME/7/6/7

P.O. ...
...

The Provincial Education Officer,
Lusaka Province
P.O. Box 50021E
LUSAKA

7th July, 2000

Dear Sir/Madam,

RE: RESEARCH STUDY REQUEST

I write to request that you allow Chaze Kamuwanga a forth year UNZA Student to carry out a study to determine how cultural practices and beliefs influence the spread of HIV/AIDS in Lusaka.

She intends to collect data from a random sample of adolescents from Kabwata Basic School to test her instruments and later systematically random sample four Secondary Schools from which female adolescents will be interviewed.

Results from such studies will be useful to identify strategies for remedies and control of the HIV/AIDs infections.

Your favourable response will be appreciated.

Yours faithfully,

IRENE MALAMBO
HIV/AIDS CO-ORDINATOR
For/PERMANENT SECRETARY
MINISTRY OF EDUCATION

...All correspondence should be addressed
to the District Education Officer
Tel: 251826

In reply please quote:
DEO/LU/1/1/10
No. ... ...

REPUBLIC OF ZAMBIA

MINISTRY OF EDUCATION

DISTRICT EDUCATION OFFICE
P.O. BOX 502
LUSAK

7th July, 2000

The Head
Kabwata Primary School
LUSAKA

RE: RESEARCH STUDY REQUEST (HIV)AIDS;

I write to introduce Ms. Chaze Kamwanga a fourth year student at UNZA who wishes to under take a research study at your School.

Please co-operate and allow her to conduct her research.

M.S. Phiri
Continuing Education Officer
for/DISTRICT EDUCATION OFFICER
LUSAKA URBAN

All correspondence should be addressed to the Provincial Education Officer

Telegraph No. 250655

In reply please quote

No. .....

REPUBLIC OF ZAMBIA

MINISTRY OF EDUCATION

PROVINCIAL EDUCATION OFFICER
LUSAKA PROVINCIAL HEADQUARTERS
P/B RW 2.E
LUSAKA

13th July, 2000

The Head,
Kabulonga Girls High School,
LUSAKA.

RE: RESEARCH STUDY VISIT

I wish to introduce Chaze Kamuwanga a fourth year student at UNZA school of medicine.

Please allow her to carry out her research work in your school.

for/ F.C. Chisala (Mrs)
Senior Inspector of Schools (HE)
PROVINCIAL EDUCATION OFFICER
LUSAKA PROVINCE

/rb

REPUBLIC OF ZAMBIA

MINISTRY OF EDUCATION

PROVINCIAL EDUCATION OFFICER
LUSAKA REGIONAL HEADQUARTERS
P/B RW 21L
LUSAKA

13th July, 2000

The Head,
Matero Girls High School,
LUSAKA.

RE: RESEARCH STUDY VISIT

I wish to introduce Chase Kamuwanga a fourth year student at UNZA school of medicine.

Please allow her to carry out her research work in your school.

F.C. Chisala (ACI)
F.C. Chisala (Mrs)
Senior Inspector of Schools (HE)
for/PROVINCIAL EDUCATION OFFICER
LUSAKA REGION

/ro

18/07/2000

The Head
Arakan High School.
LUSAKA.

Dear Lt Col Mizinga

As discussed yesterday I would like to introduce Ms Kamwanga a student at UNZA Medical School who wishes to undertake a Research Study on fifteen girls at your school.

Kindly Please assist her in her work.

Yours Sincerely

F. C. Chisala.
S.L.S. HC
for PEO.

18