

THE UNIVERSITY OF ZAMBIA

SCHOOL OF MEDICINE

DEPARTMENT OF POST BASIC NURSING

**ACCEPTANCE AND UTILIZATION OF CONDOMS IN THE
PREVENTION OF HIV/AIDS AMONGST CHRISTIAN MEN IN
MWINILUNGA**

By:

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ZRN: NDOLA 1993

ZRM: LUSAKA 1996

*SRK
MEL
LUP
2005*

**A research study submitted to the Department of Post Basic
Nursing, School of Medicine, University of Zambia
in partial fulfillment of the requirements for the award of the
Bachelor of Science Degree in Nursing.**

January, 2005

ACKNOWLEDGEMENT

It is with great appreciation that I would like to acknowledge the following people:

- Mrs. P. Ndele, the University of Zambia lecturer for her patience, guidance and tolerance while supervising me in this study;
- My sponsors Africa Development Bank (ADB) through Central Board of Health (CBoH)/Ministry of Health (MoH), for awarding me the scholarship and giving me the study leave to pursue my Bachelor of Science Degree in Nursing at the School of Medicine, University of Zambia;
- Mwinilunga District Health Team for their unrelenting support during my training;
- Special thanks to my dear husband, Nathan and my children – Tehillah and Nkisu for their support and understanding during the long hours of writing this report denying them the much needed care and love;
- To Linda and Wendy for typing this script.
- Above all, praise be to God Almighty for his Grace which has been and is sufficient for me throughout my training.

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ABBREVIATIONS

ADB	-	Africa Development Bank
AIDS	-	Acquired Immune Deficiency Syndrome
CBoH	-	Central Board of Health
CBOs	-	Community Based Organizations
CSO	-	Central Statistical Office
DHO	-	District Health Office
EDGS	-	End of Decade Goal Survey
FBO	-	Faith-Based Organization
FGD	-	Focus Group Discussion
HIV	-	Human Immunodeficiency Virus
MDHB	-	Mwinilunga District Health Board
MOFNP	-	Ministry of Finance and National Planning
MoH	-	Ministry of Health
NCDP	-	National Commission for Development Planning
NGOs	-	Non-Governmental Organization
PHC	-	Primary Health Care
STD	-	Sexually Transmitted Diseases
STI	-	Sexually Transmitted Infection
TB	-	Tuberculosis
UNAIDS	-	Joint United Nations Programme on HIV/AIDS
WHO	-	World Health Organization
ZDHS	-	Zambia Demographic Health Survey

DECLARATION

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

Signed: Dupili Date: 05-04-2005

(Candidate)

Signed: M. M. M. M. M. Date: 5 April 05

(Supervisor)



STATEMENT

I hereby certify that this study is entirely the result of my own independent investigations and efforts.

The various persons and sources to which I am highly indebted are clearly acknowledged in the text and references

Signed: Apili.....

(Candidate)

DEDICATION

I dedicate this study to my very supportive husband Nathan, my daughters Tehillah and Nkisu for their patience and understanding when they needed the love and care that I owe them.

I also dedicate this study to my mother, father, sisters, my dear brother and humble nephews Frank and Brighton for their support during in training.

ABSTRACT

HIV/AIDS is an epidemic which is threatening to wipe out the entire human race if there are no preventive interventions put in place to minimize its spread. These interventions should be made available to all people and each individual will have to make a choice on what is best applicable and practical to do. Every sector, organization or grouping should be utilized in effecting the preventive measures being advocated for. One such influential human organization is the church or faith-based organizations.

The title of this study is Acceptance and Utilization of Condoms in the Prevention of HIV/AIDS amongst christian men in Mwinilunga. The main objective is to determine the factors that influence the acceptance and utilization of condoms in the prevention of HIV/AIDS among christian men in Mwinilunga. The specific objectives are to determine the level of acceptance of condoms among christian men, determine the level of utilization of condoms among christian men, determine the factors that influence the acceptance and utilization of condoms and make recommendations to all the concerned parties on how to increase condom use among christian men in order to prevent HIV/AIDS. The study was conducted between 23rd August and 1st October, 2004.

Literature was reviewed globally, regionally and at the national level that showed factors associated with the acceptance and utilization of condoms among christian men. Among these factors are economic, religious, service and social cultural factors.

A non-intervention descriptive exploratory type of study was done, it is both quantitative and qualitative. Before undertaking the main study, a pilot study was carried out in Makeni, south of Lusaka to test the instrument after which changes were made where necessary.

A sample of 50 christian men attending various church meetings were conveniently selected for structured interviews and focus group discussions. The coding, editing and data processing were done using a scientific calculator. The

statistical data analysis presentation were done using contingency tables, pie charts, bar charts and frequency tables.

The findings of the study revealed that the majority of the respondents were aged between 25-34 years (50%). The majority of the respondents were married 66%, 40% were Lunda and belonged to New Covenant Church. This could be attributed to the fact that marriage is universal in Zambia and people marry at any age sometimes as early as 16 years; and the study was conducted in a predominantly Lunda speaking area. Apart from that, the study also found that the majority of the respondents 23(46%) had attained college level of education and were in formal employment 23 (46%). This could be attributed to some cultural practices where families may opt to marry off their daughters instead of sending them to school therefore it is not surprising that the same son who was empowered with the education would easily find formal employment.

The findings on men's knowledge on condoms revealed that all the respondents had heard of the word condom, with 94% knowing that a condom meant a sheath used to protect one self from contracting STI/HIV/AIDS. 94% knew where to get condoms from and 90% knew that condoms were readily available in Mwinilunga. This could imply that extensive health education has been done using various means of communication.

In terms of acceptance of condom use, the majority 26(52%) of the respondents condemned the use of condoms. 74% of the respondents stated that their denominations do not discuss issues of condom use since the church was silent or divided on the subject. On average, 80% of the respondents did not accept to use condoms as a method of preventing HIV/AIDS, though this view was not shared with the men from the secular world as indicated in the ZDHS 2002 report which indicates that 72.2% of Zambian men think that they themselves could get male condoms and use in the prevention of HIV/AIDS.

In reference to utilization, the majority of the men 56% had used a condom before with 64% of them using it sometimes. Of those who did not use a condom, the majority 55% felt that religion did not allow. On average, the majority 52% of

the men did not use condoms while 22% utilized condoms. This is consistent with survey ZDHS 2002, which indicates that overall condom use is as low as 19% among men in Zambia.

The findings of the study showed that the majority of the respondent 31 (62%) had adequate or medium level of knowledge, 13(26%) had high level of knowledge while 6(12%) had low knowledge. It is also true to state that the study found that the majority of the respondents 40(80%) would not use condoms as a method of preventing HIV/AIDS while only 10(20%) were willing to use condoms. In addition, the study revealed that condom utilization was low 22% as compared to non-utilization at 52%. The study found an association between knowledge and acceptance and utilization of condoms in the prevention of HIV/AIDS. Respondents were able to make informed choices and decisions of either accepting or not accepting condom use; and or utilizing or not utilizing condoms in the prevention of HIV/AIDS. In this regard, the findings indicate that the level of acceptance was as low as 20% while that of utilization was 22%. The basis of the low acceptance and utilization are derived from the Christian principles of being faithful and sticking to one's sexual partner, using condoms as contraceptives for those that are married; and only using them as a preventive measure if the couples are discordant. Singles simply abstain.

The study also revealed that the age group of 25-34 was the majority (52%) in not accepting the use of condoms and these were seen to be in the majority amongst the married men (70%). This therefore means that the two hypothesis which stated that "younger men are more likely to accept condom use than older men" and "married men are more likely to use condoms than single men," have been rejected. While the findings have failed to reject the third hypothesis which states that " the more the faith based organizations advocate for condom use in the prevention of HIV/AIDS, the more likely the condoms will be accepted and utilized by Christian men."

The following are some of the recommendations made to be considered by MoH and other stake holders for considerations to curb the spread of HIV/AIDS:-

- ❖ The MoH needs to collaborate with other faith based organizations mother bodies such as Church Health Association of Zambia (CHAZ), Christian Council of Zambia, when developing policies or Information Education and Communication materials in regard to the prevention of HIV/AIDS particularly that which has a focus on condom use.

- ❖ A community-based research needs to be done at a large scale on acceptance and utilization of condoms among Christian men in Mwinilunga in the prevention of HIV/AIDS.

- ❖ Issues of condom use and HIV/AIDS to be discussed in predominantly male service organizations including such places as recreation clubs and bars.

CHAPTER ONE

1.0 INTRODUCTION

BACKGROUND INFORMATION

Zambia is a landlocked country covering an area of 752,612 square kilometers about 2.5% of the total area of Africa, in sub-Saharan Africa. It shares borders with the Democratic Republic of Congo (DRC) Tanzania in the north; Malawi and Mozambique in the east; Zimbabwe and Botswana in the South; Namibia in the southeast and in the west. (EDGS, 2000).

For administrative purposes, Zambia is divided into 9 provinces and 72 districts. Of the 9 provinces 2 are predominantly urban, namely Lusaka and Copperbelt provinces while the remaining ones – Central, Eastern, Luapula, Northern, Western, Southern and North-western are predominantly rural provinces. Four of ten Zambians live in urban areas. (Z.D.H.S, 2003)

Zambia lies between 8 and 18 degrees south latitude and between 20 and 35 degrees east longitude. It has a tropical climate and vegetation with three distinct seasons. The cool dry winter from May to August, a hot dry season during September and October, and a warm wet season from November to April. (ZDHS, 2003)

Zambia has a mixed economy consisting of a modern urban sector that follows the line of rail and a rural agricultural sector. In 1991, liberalized market oriented economy was introduced, parastatals were privatized and due to various reasons others were liquidated. Copper mining which is the country's main economic activity, had experienced a decline in copper prices in the mid – 1970s. There was a sharp rise in oil prices and this led to deterioration in the economy.

Structural Adjustment Programme (SAP) was introduced in the 1980s to revamp the economy but this has failed and has contributed to poverty of the majority of Zambians. Currently around 73 percent of Zambians are classified as poor. Poverty is more prevalent in rural areas than urban areas (83% and 53% respectively). (MOFNP, 2002)

The Zambian population has rapidly increased over the past 20 years as follows: 1980 5-7 million, 1990 - 7.8 million and 2000 – 10.3 million (and of the latter 5, 070, 891 are male while 5, 229, 109 are females).

With a growth rate of 2.9 percent per annum in 2000 the annual population growth rate has shown a decline from 3.1 between 1969-80, 2.7 between 1980-90 and 2.9 between 1990-2000. During the 1990-2000 intercensal period, the growth varied province by province, ranging from 1.3 percent in Copperbelt (which had the largest population of 1,527,294 persons) province to 4.3 percent in Northern province. The smallest population in 2000 was recorded in North Western province with 539,822. (Nsemukila, 2000)

Although Zambia is sparsely populated by international standards, it is one of the highly urbanized countries in sub-Saharan Africa with an increase in population density from 7.5 people per square kilometer in 1980 to 10.4 in 1990 and 13.7 in 2000. The average density in 2000 ranged from 65 people per square kilometer in Lusaka province to 5 people per square kilometer in north-western province (ZDHS, 2003)

During the first decade and a half after independence, Zambia did not view the high rate of population as a development problem. In 1984, the National Commission Development Planning (N.C.D.P), was given a mandate to initiate a draft policy which was revised in 1996 with new objectives taking into account the concerns of HIV/AIDS, poverty and gender issues. Among the objectives of the policy are:

- To contribute to the reduction of HIV/AIDS and other Sexually Transmitted Infections so as to improve the general health status of the population.
- To improve the population's access to appropriate, affordable and high-quality reproductive health services including family planning and sexual health in order to have a healthy nation, (National population policy, 1989).

In 1991, the Zambian government introduced radical health reforms characterized by a move from a strongly centralized health system. This was aimed at improving the quality of life of all Zambians by reforming the health sector. An important component of the health policy reform is the restructured Primary Health Care (PHC) program. The PHC programme has been reformulated with particular attention being paid to rural and peri-urban areas where the health needs are the greatest. Particular emphasis is on 10 health priorities amongst which HIV/AIDS is one of them. Implementation of all PHC programmes is based on the principles of PHC, which includes community participation and intersectoral collaboration. This entails that Ministry of Health is not the only player in the provision of health care though it is the key player in health care delivery (ZDHS, 2003).

Since HIV/AIDS was first recognized in 1981, an estimated 60 million men, women and children have become infected with the virus worldwide. Nearly half of all persons who acquire HIV are under age 25 and most die before 35 years age. By 2000, 22 million people had died of AIDS and approximately 13 million children under the age of 15 had lost one or both parents to AIDS. The number of AIDS orphans is expected to rise to 40 million by 2010. (Gayle, and Lamptey, 2001).

HIV/AIDS is now the fourth leading cause of death worldwide and the single leading cause of death in Sub-Saharan Africa. In sub Sahara Africa, AIDS imposes a huge burden on the health infrastructure. At least persons who occupy more than 60 percent of the hospital beds suffer from HIV-related diseases. In some countries such as Botswana, Zimbabwe, life expectancy is plummeting while infant and child mortality is increasing. Other countries with a sharply reduced growth rate include Malawi, Namibia, South Africa, Swaziland and Zambia. (Gayle, and Lamptey, 2001).

Zambia is one of the countries in sub-Saharan Africa with a very high prevalence rate of HIV/AIDS and this has a dramatic and increasing impact on all sectors. Fylkesne, 1995, reported that the incidence rate of new infections was going to be on the decline, at least in urban areas. This might have indicated that particular population groups had changed their behavior favorably. There was need for time of observation to provide scientific evidence (HIV/AIDS Bibliography, 1996).

However, in Zambia, on average one in every 5 adults is infected with HIV. Eighty four percent of Zambians diagnosed as having AIDS are aged between 20 and 39 most of who are enormously active and have young children to support. (National HIV/AIDS/STI/TB intervention strategic plan 2003).

Since HIV/AIDS remains a major concern in Zambia due to its high prevalence rates among both the youths and adults. The Ministry of Health /Central Board of Health in conjunction with the National HIV/AIDS/STD/TB with the support of donors or cooperating partners have developed an intervention strategic plan stating programmes to be implemented to care for the HIV/AIDS clients and prevention of spread of HIV/AIDS. (ZDHS, 2003)

In addition, national facilitation team has been formed to ensure that local responses are aired and expanded. Participating members of the team are drawn

from national and local networks and organizations that are keen to develop human capacity as part of their response to HIV/AIDS. Facilitating the team's work are the community health association of Zambia and the Salvation Army with the support from United Nations program on HIV/AIDS, (UNAIDS, 2002).

When AIDS first came onto the world scene, many people in the faith based organizations had a skewed view of the disease and whom it affected (Graham, 2003). There was no place or time in which to consider what the cause of the disease. HIV positive people in the church were condemned and stigmatized because church members were not expected to get the infection since they were to be obedient to the church teachings of fidelity and abstinence. The church stood aloof despite the immense influence in the community. Faith Based Organizations (FBO) was oblivious to the fact that the members could actually be sexually active as to have extra marital sexual affairs and were not abstaining before marriage. As a result there stigmatization of those who were HIV/AIDS positive. (SAFAIDS, P.2, 2003).

Faith based organizations (F.B.O) in Zambia range from christianity to Muslim. In other parts of Africa representatives from Christian and Muslim communities have teamed up to form world council of churches to form a formidable unit to address a lot of issues and much more to spell out the role of church in combating HIV/AIDS. This body has recommended that all options including abstinence, fidelity and condoms need to be presented to empower people to make responsible decisions regarding HIV prevention. (SAFAIDS, 2003,P.2)

However, the Catholic Bishops worldwide do not advocate for the use of condoms. The Zambia Episcopal Conference, (2002), states that the condom is immoral and destructive of the dignity of a person. "Safe sex" or "protected sex" means abstinence before marriage and fidelity in marriage," the other churches also advocate for abstinence and fidelity, while condom use is more of a method of family planning.

In addition, the Christian churches in Zambia have been vigilant in speaking out on behalf of its members concerning such factors as showing pornographic material on television (namely banning channel 'O' on Zambia National Broadcasting Corporation television station) and the controversial Big Brother Africa programme. The church has also condemned in strongest terms child defilement in relationship to spread or prevention of HIV/AIDS.

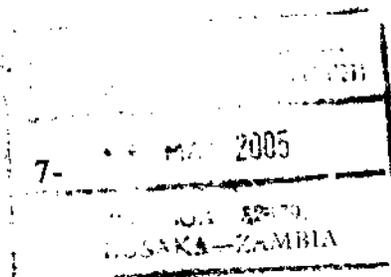
It is a well-known fact that in many parts of the world, women live in a male dominated society according to the customs and traditions. This situation is not different in Zambia. It is just as predominant in the Christian church as is in the secular world. The role of christian men is to lead while the women are to learn in quietness and submission. This means that the men remain decision makers at church and at home including when to use condoms.

There are several preventive and promotive activities that are being conducted within Zambia involving the community, neighborhoods, people living with AIDS, faith based organizations and several partners in fighting HIV/AIDS in the form of; condom distribution, mainstreaming HIV/AIDS programs in all government departments and private sector. Dissemination of facts on HIV/AIDS through various tools (media, youth friendly services) is provided as well as having themes such as "Men make a difference" or "Involving men in uniform" in the prevention of HIV/AIDS. The other interventions which are put in place as cited from the National HIV/AIDS/STI/TB intervention strategic plan, 2002-2005, include:

- Empower the vulnerable groups in negotiating sex.
- Strengthen public sector distribution of free condoms by increasing distribution points.
- Make condoms available at affordable prices (social markets).
- Promote the use of male and female condoms.

- Create conducive environment for the private sector to manufacture and distribute condoms countrywide.
- Strengthen technical and management capacities of CBOs and FBOs.
- Provide technical support to HIV/AIDS technical committees, ministries, business community, religious groups, NGOs and CBOs.
- Support partnership initiatives.

This study therefore seeks to determine the level of acceptance and utilization of condoms in prevention of HIV/AIDS amongst christian men in Mwinilunga.



1.2 STATEMENT OF THE PROBLEM

HIV/AIDS remains one of the most serious health problems in the world and the current situation is probably worse than anticipated in the early 1990's. This is evidenced by a total of 40 million people who were living with HIV/AIDS and of these 37.1 million were adults (18.5 million women) and three million children below 15 years. More over, the biggest tragedy is the growing number of orphans estimated at 14 million worldwide of which 11 million are in Africa. (WHO-UNAID, 2001)

HIV/AIDS makes a severe development crisis in sub-Saharan Africa, which remains by far the worst affected region in the world. Approximately 3.5 million new infections occurred in 2001, bringing to 28.5 million the total number of people living with HIV/AIDS in sub Saharan Africa. Fewer than 30,000 people estimated to have been benefiting from anti-retroviral drugs at the end of 2001 (UNAIDS, 2002)

There is no single factor, biological or behavioral that determines the spread of HIV infection. Most HIV infections in sub-Saharan Africa occurs through heterosexual intercourse, with unsafe blood transfusions and unsafe injections accounting for a small fraction (UNAIDS, 2002). The key factors that are likely to increase vulnerability to HIV in sub-Saharan Africa are poverty, discrimination, sexual inequality, the inadequacy of health and social services, rapid urbanization, a migrant labor force and inappropriate developmental projects. Poverty maybe the main reason why women and adolescents are either sold into prostitution or become prostitutes and have little control regarding safe sexual practice such as condom use. Economic dependence and the desire to have children may be some of the reasons why many women continue to have unprotected sex with husbands or partners they know have other sexual partners.

In Zambia, more than 50 percent of the population is less than 19 years of age and constitutes the most vulnerable group to HIV infection. Currently 20 percent of the adult population aged between 15-49 are living with HIV. By 2001, an estimated 1200,000 persons were infected with HIV and the prevalence rate stands at 21.5 percent (UN AIDS, 2002). For women in all age groups, HIV prevalence is more than twice as high in urban areas as in rural areas, and exceeds 40 percent in age groups 30-34 and 35-39. Among men, HIV prevalence in urban areas is twice that in rural areas for most age groups.

The adult mortality rate is categorically around 25 percent higher in urban than rural areas in Zambia. Lusaka, Copperbelt and Southern provinces have the highest rates; and Northern, North western and Luapula have the lowest infection rates. Meaning that the patterns of HIV prevalence; adult mortality is nearly 60 percent higher in Lusaka, Copperbelt, and Southern Province than in Northern, North-Western and Luapula. (ZDHS, 2002)

It is common knowledge that the church in Zambia is just as affected by HIV/AIDS pandemic as any other institution in the country. Members of the various Faith Based Organizations are either affected or infected despite being a member of religious groups, which teach fidelity in marriage and abstinence or chastity before marriage. Though not many church members have come out to declare their HIV status, there is evidence of a number of cases of divorces, abortions or pregnancies amongst the youths or adults. This entails that the membership is having church sexual relationship, which result in the above incidences. Suffice to say that no matter how much the church may teach these precepts, individuals are sexually active and indulge in sexual relations. Compliance to the church teaching bores down to the individuals ability to consciously decide to either accept or reject the teachings despite their level of maturity in the faith.

The church's voice on condom use is mainly related to its use as a mode of family planning method and not in the prevention of HIV/AIDS. Only discordant couples may be encouraged to use condoms. The Catholic Church has condemned the use of condoms as family planning as well as in the prevention of HIV/AIDS in the strongest terms as it attributes its use to "promoting promiscuity and being immoral, and destructive of the dignity of a person". (The Zambian Episcopal Conference, 2002).

1.3 FACTORS THAT MAY INFLUENCE THE ACCEPTANCE AND UTILISATION OF CONDOMS IN THE PREVENTION OF HIV/AIDS AMONG CHRISTIAN MEN

CLIENT FACTORS

The educational level of men may have a bearing on acceptance and utilization of condoms. Educated men are likely to access condoms than men of low educational level as they may be more knowledgeable of the benefits of condom use and know where to access them.

Previous experience of the men may have a bearing on the men as they relate to either the negative or positive experience they went through. A man may have had unpleasant experience where he ended up with a Sexually Transmitted Infection (S.T.I) due to tearing of the condom or if he did not use a condom and ended up with an STI.

The age of the man and marital status may have a role to play on how men will accept and utilize condoms. It has been observed that younger men are more likely to get condoms from which ever point as compared to older men. Many married men may get condoms than single Christian men for fear of being viewed as being promiscuous. Chastity is considered to be the norm among Christians.

Positive attitudes of men towards the prevention of HIV/AIDS are likely to influence men to utilize condoms while negative attitudes may influence the men negatively so that they end up not using the condoms.

Men in formal employment are most likely educated and may have knowledge on how detrimental HIV/AIDS infection can be in relation to reducing productivity and loss of man hours ultimately interfering with their role of being a bread

winner or source of income. Those in informal employment may tend to take things for granted as they assume that resources may always be at their disposal.

Men who have access to information either by listening to the radio, reading print material or other educational tools may be more likely to use condoms as compared to their colleagues who are not well informed.

SOCIO-CULTURAL FACTORS

In the cultural setting, men are seen to be decision-makers and this influences all the activities in the home. Women are taught to be obedient and submissive to their husbands. They are also made to believe that it is a sign of prestige for women to bear more children for their husbands. Therefore they can go through an ordeal of unprotected sex if the man so demands.

The cultural belief that having sex with a virgin can cure HIV/AIDS is yet another factor which may contribute to men not using the condom. It is believed that the virgin will cleanse a man of all of the sexually transmitted infections including HIV/AIDS by having unprotected sex with such a one.

As an act of love for their husbands, women may not demand for the use of a condom even when they know that their husbands are promiscuous or have several sexual partners. Other women or couples may feel that the use of a condom is an indication of infidelity or adultery by either partner.

RELIGIOUS BELIEFS AND PRACTICES

Christian denominations and churches especially the Roman Catholic Church preaches against condom use as a mode of contraception or prevention of HIV/AIDS. All Christian churches including Muslims teaching regard sexual

activity as sacred and when done outside legal marriage as being sin against God. They encourage abstinence until one is married. This is universally accepted in all churches.

Some churches, however, have no problems with its members using condoms as a mode of contraceptive although it does not expect its members to be promiscuous.

ECONOMIC FACTORS

Economic status may influence a man's health seeking behavior including collecting condoms. Low economic status men who live far from health facilities cannot afford to travel long distances for condoms. They may not have the financial means even if conditions were available at the local store.

If the man cannot afford to buy a condom at the local store, then he may not be able to afford other cost sharing expenses at the health post especially in rural areas where the poverty levels are so high.

SERVICE FACTORS

One of the service delivery factors that may affect utilization of condoms is erratic condom supply. It has been observed that sometimes CBoH or MoH do not deliver drug kits to health centers in which condoms are contained. Being in the rural areas, the local stores may not have condoms either. This inconsistent supply may also influence utilization of condoms.

Distance to the health center is more likely to be a hindrance of health services in rural areas especially where clients have to walk a long way to the center.

The other factor is the availability of condoms where the condoms are quite plentiful, people may very well comply with their use and even acceptance may not be a problem. Sometimes the strict clinic schedule of adhering to certain days may affect the client's attitude.

Community based distribution, where the men are not in "good books" with the community-based distributor, this may act as a barrier and they may not access the condoms, even though condoms may be plentiful.

Sometimes outreach activities are not conducted according to the action plan due to non-availability of transport or other logistics. The outreach activities may be just as inconsistent to the schedule that the clients are not provided with much needed information, counseling and condoms.

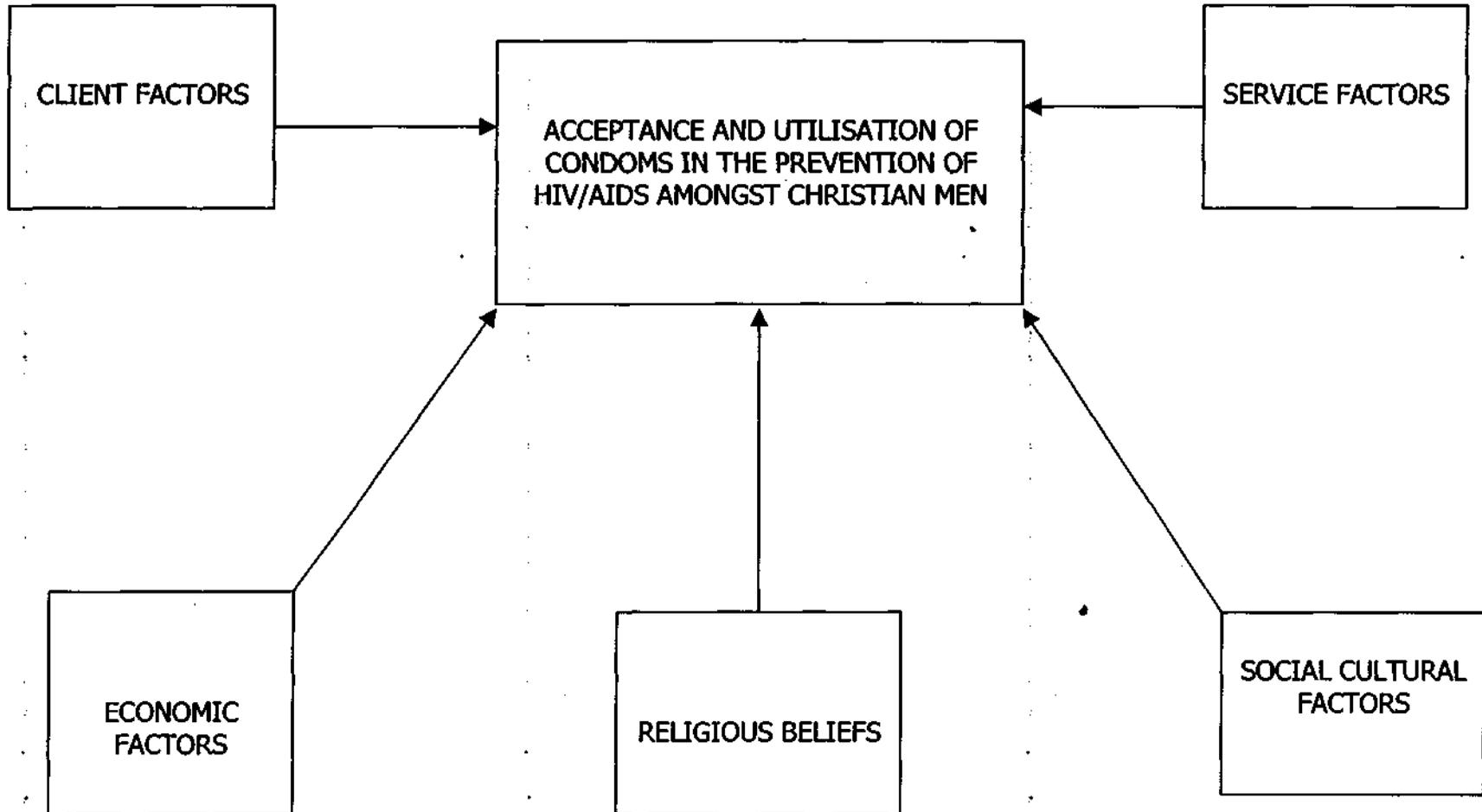
The rural health facility may lack professional health workers due to staff shortage. Or where the staff is available, he or she may be forced to use the scheduled work plans to effectively attend to the clients.

Privacy is an important factor in the provision of condoms in that the men do not often find it easy to approach health workers, as the existing infrastructures are inadequate. Some men may need to find out how to use the condoms and the health workers attitude may not be welcoming.

Information education communication is a key to knowledge that positively affects behavior of an individual. Inadequate sensitization of men by service providers on the condom may contribute to under utilization.

The above discussed factors may in one way or another affect or influence the acceptance and utilization of condoms by men, especially those from faith based organizations.

1.4 DIAGRAM OF POSSIBLE FACTORS INFLUENCING ACCEPTANCE AND UTILISATION OF CONDOMS IN THE PREVENTION OF HIV/AIDS AMONGST CHRISTIAN MEN



1.5 JUSTIFICATION OF THE STUDY

This study strives and seeks to determine the acceptance and utilization of condoms in the prevention of HIV/AIDS among christian men.

Mwinilunga houses quite a good number of Christian denominations. It has 24 health centers and 100 health posts are distributing condoms to the community. In this community there are christian and non-christian men.

In view of the above, the study will attempt to identify factors influencing the acceptance and utilization of condoms in HIV/AIDS prevention among christian men. This study is being carried out in partial fulfillment for the award of Bachelor of Science Degree in Nursing.

In addition, not many studies of this nature have been conducted in Mwinilunga District. It is hoped that the findings will be used in the formulation of policies, strategies, programmes and for evaluation of the existing ones. It will ensure maximum utilization of condoms in the prevention of HIV/AIDS amongst christian couples or individuals who are at risk or vulnerable.

1.6 RESEARCH OBJECTIVES

1.6.1 GENERAL OBJECTIVES

To determine the factors influencing the acceptance and utilization of condoms in the prevention of HIV/AIDS among christian men.

1.6.2 SPECIFIC OBJECTIVES

1. To determine the level of acceptance of condoms among christian men.
2. To determine the level of utilization of condoms among christian men
3. To determine the factors that influences the acceptance and utilization of condoms.
4. To make recommendations to all the concerned parties on how to increase condom use among Christian men in order to prevent HIV/AIDS.

1.7 RESEARCH HYPOTHESIS

1. The more the Christian faith-based organizations advocate for condom use in the prevention of HIV/AIDS, the more likely that it will be accepted and utilized by christian men.
2. Married men are more likely to use condoms than single men.
3. Younger men are more likely to accept condom use than older men.

1.8 OPERATIONAL DEFINITIONS

These are the assigned meaning to variables and will describe the activities required to measure it in the research study

Acceptance:	This is the act of agreeing with and approving condom use.
Prevention:	This is the act of stopping of HIV/AIDS infection by use of condoms.
Utilization:	This is the ability to use a condom for the purpose of HIV/AIDS prevention.
Under utilization:	The failure by men to use the condoms in the prevention of HIV/AIDS.
Christian:	A person who believes in Jesus Christ as their lord and savior, and believes in the teachings of Jesus.
Condom:	This is a sheath or covering made to fit over a man's erect penis.
Safer sex:	Sex that does not easily predispose one from being infected with HIV through the use of condoms or non penetrative method where the penis is not allowed to penetrate into the vagina.
Men:	Male within the reproductive age of 15-49 years old.

1.9 VARIABLES AND CUT-OFF POINTS

1.9.1 VARIABLE

This is the quality, property or characteristic of persons, objects or phenomena that change or can take different values.

1.9.2 INDEPENDENT VARIABLE

These are variables that are assumed to cause, contribute, determine or influence the problem under study. These include:

- Age
- Marital status
- Knowledge
- Attitude

1.9.3 DEPENDENT VARIABLE

These are used to describe or measure the problem under study. These are the assumed effects or responses to the independent variables. These are:

- Acceptance
- Utilization

1.9.4 VARIABLE AND CUT OFF POINTS

VARIABLE		INDICATOR	CUT OFF POINTS
Dependent	Acceptance	<ul style="list-style-type: none">• Acceptance• Unacceptable	<ul style="list-style-type: none">• Scored 6-10• Scored 0-5
	Utilization	<ul style="list-style-type: none">• Low• Medium• High	<ul style="list-style-type: none">• Non user 0-3• Sometimes 4-6• Always 7-10

CHAPTER TWO

2.0 LITERTURE REVIEW

2.1 INTRODUCTION

When AIDS first emerged as a disease over 20 years ago, only few people could predict how the epidemic would evolve and fewer still could describe with any certainty the best ways of combating it. It is known from experience that AIDS can devastate regions, distabilise national development, widen the gap between the rich and poor nations, and push already stigmatized groups closer to the margins of society. Since the AIDS pandemic started many governments, Non-Governmental Organizations, medical experts, private and other organizations have expressed concern and have made concerted efforts to try and reduce the spread of the disease, and to alleviate suffering of HIV/AIDS victims.

In this literature review, literature will be arranged into global, regional and national perspectives.

2.2 GLOBAL PERSPECTIVE

AIDS was first described in 1981. It is theorized that various strains and sub-types of HIV originated through multiple mutations of animal retroviruses, which facilitated a "species leap" to humans. Through back-estimating the time needed to achieve the existing varieties of viral mutations, it appears this jumps from animal to humans probably occurred in the late 1930s or early 1940s (Lamprey and Gayle, 2001).

HIV/AIDS is the fourth largest cause of death worldwide today. Despite its widespread reach, the epidemic is still in its early stages. The statistics of HIV/AIDS pandemic state that, this is a global problem requiring a global response. Already 22 million people around the world have died of AIDS. Nearly twice that many, 40 million are now living with HIV and most of these are likely to die over the next decade or so (www.info@avert.org). Approximately 13 million children under the age of 15 have lost one or both parents to AIDS and the

number of AIDS orphans is expected to exceed 40 million by 2010 (Lamptey and Gayle, 2001).

At the beginning of the 21st century, HIV/AIDS prevalence among healthy adults has exceeded 20% in seven countries in the developing world, 11 million in Latin America, 4 million in Asia and 1 million in Eurasia. In contrast, HIV/AIDS prevalence in the United States was 0.6% at the end of 2000 (Lamptey and Gayle, 2001).

In Asia, despite well-documented and successful HIV prevention programmes in few countries, the HIV/AIDS epidemic continues to spread in Asia and the Pacific. This region serves as a reminder that no country is immune to a serious HIV epidemic. In fact, the region as a whole is a home to more people living with HIV/AIDS than any other besides sub-Saharan Africa (an estimated 6.6 million people at the end of 2001, including the 1 million adults and children who were newly infected with HIV in that year with less than 30,000 people on antiretroviral treatment). The factors facilitating the rapid spread of HIV/AIDS pandemic are mainly infecting drug users, sex workers and men who have sex with men (UNAIDS, 2002).

The UNAIDS, 2001 report estimates that 800,000 adults, 520,000 of them men became infected in south-east Asia during the year 2001 and by the end of the same year, the region was estimated to have 6.1 million adults and children living with HIV/AIDS (www.info@avert.org).

In Eastern Europe and Central Asia, HIV/AIDS is spreading rapidly through countries of this region, which continues to experience the fastest-growing epidemic in the world. In 2001, there were estimated 250,000 new infections, bringing to 1 million the number of people living with HIV/AIDS. Less than 1,000 people are estimated to be receiving antiretroviral treatment (UNAIDS, 2002). Several factors are creating a fertile setting for the epidemic namely, opening of borders has drawn several countries in the region into the globalized circuits of drug trafficking, mass unemployment and economic insecurity beset much of the region. The rigid social control of the past has eroded and new common norms and values are yet to become firmly grounded (UNAIDS, 2002).

There has been a rise in levels of gonorrhoea and syphilis across Western Europe since 1995. This seems to imply that people are forgetting safer sex messages (Sky News, 2002). In addition, scientists from the Public Health Laboratory Service in the United Kingdom and the European Center for the Epidemiological Monitoring of AIDS in France are also concerned that HIV prevention messages are being lost and the people are becoming complacent. This is in view of the rising numbers of new acquired HIV infections which has increased by 20% (uk.news@yahoo.com).

Nicoll and Harmers, 2000, stated that, complacency over HIV prevention efforts had set in among many individuals and some governments. They warned that sex was becoming more risky and that HIV rates could rise again. The study also suggested that new strategies were needed to prevent the transmission of HIV because the AIDS campaign from the late 1980s and 1990s seem to have been forgotten (www.uk.news@yahoo.com).

The epidemic in Latin America and the Caribbean is reported to be well established and is in danger of spreading more quickly and more widely in the absence of effective responses. An estimated 1.9 million adults and children are living with HIV (a figure that includes the estimated 200,000 people who acquired the virus in 2001). Some 1.5 million people are living with HIV/AIDS in Latin America and 420,000 in the Caribbean. At the end of 2001, an estimated 170,000 people living with HIV/AIDS were receiving antiretroviral treatment. HIV/AIDS is now a leading cause of death in some of the countries in this region. Factors helping the drive in the spread of HIV is a combination of unequal socioeconomic development and high population mobility spurred by high rates of unemployment and poverty (UNAIDS, 2002).

The HIV pandemic is highly diverse; most of the transmission in Central American countries and countries in the Caribbean coast occurs through sex between men and women. The HIV/AIDS epidemic continues to escalate among the people of Caribbean Islands that are chiefly known for cruise ships, ports and vacation beach getaways made popular by affluent Americans. Ironically, this is because these islands have become popular among tourists particularly those engaged in sexual tourism (AIDS Alert, 2001).

The global HIV/AIDS prevention combines society-wide strategies with particular focus on those parts of the population most at risk (UNAIDS, 2002). Men may qualify to be in the at risk group due to the following reasons:

- Men's health is important but receives inadequate attention in most settings and men are less likely to seek health care than women.
- Men's behavior puts them at risk of HIV in that men are more likely than women to have multiple sexual partners as well as using injectable drugs.
- Men's behavior puts women at risk of HIV; HIV is more easily transmitted from men to women than vice versa.
- Unprotected sex endangers both men and women. Many men, who have sex with men also have sex with women.
- Men have traditionally been thought of as hard to reach and difficult to recruit, (UNAIDS, 2001).

The successful intervention package which has been successful worldwide include:

- Use of informal contacts, key informants and leads to access the population.
- Peer health promotion and education.
- Outreach activities.
- Condom social marketing and distribution
(Gayle and Lamptey, 2001)

2.3 REGIONAL PERSPECTIVE

In the countries of the Middle East and North Africa, the visible trend is also towards increasing HIV infection rates, though still at a very low level in most countries. Currently an estimated 80,000 people acquired the virus in 2001, bringing to 500,000 the number of people with HIV/AIDS. Unfortunately, factors driving the spread of HIV in most of these countries are still too seldom analyzed systematically although it appears that sexual intercourse remains the dominant route of transmission and significant outbreaks of HIV infection are occurring among injecting drug users. Other conditions that favor HIV spread are high

levels of population mobility, socioeconomic disparities and complex emergencies (UNAIDS, 2002).

In sub-Saharan Africa, AIDS first appeared to be a disease of wealthy men who could afford to travel, to have multiple sexual partners and to pay for sex. Nevertheless, the HIV epidemic has now affected the poor. AIDS has now affected every country in the world, but sub-Saharan Africa has been most affected. The 10 most heavily affected countries in the world are all in Africa. HIV/AIDS is a crisis of unprecedented magnitude in sub-Saharan Africa. Almost 80% of the 22 million deaths from AIDS since the beginning of the epidemic have occurred in Africa, (Human Rights Watch, 2001: p 6).

About 95% of people living with HIV live in the sub-Saharan Africa (WHO, 1998:5). At least 13 million Africans have already died from AIDS and over 24 million Africans are currently living with HIV/AIDS (African Journal, 2001:68).

Approximately 36.1 million people are infected with HIV worldwide and of these 70% or nearly 25.3 million people live in sub-Saharan African (African Journal, 2001). Life expectancy in sub-Saharan Africa is now 47 years; it would have been 62 years without AIDS (UNAIDS, 2002). The number of orphaned children by AIDS will increase from 9 million -2001 to 20 million – 2010 (USAID, UNICEF, UNAIDS, 2002) in Africa.

West Africa is relatively less affected by HIV infection though the prevalence rates in some large countries are increasing. For example, Ivory Coast is already among the 15 worst affected countries in the world (UNAIDS, 2001).

Condoms are key to the prevention of spread of HIV/AIDS infection in Africa. Studies conducted have confirmed that when condoms are used correctly, they are an effective means of preventing HIV infection in women and men. An estimated 6-9 million condoms are distributed annually and in sub-Saharan Africa alone the condom gap has been estimated at 2 billion a year (UNAIDS, 2002).

A measure of success in the reduction of a number of HIV/AIDS cases in Uganda has been attributed to a number of factors amongst which is the increased

condom use amongst sexually active people. To be precise between 1989 and 1995, for men, the proportion of people who said that they had ever used condom increased from 15% to 55% and for women from 6% to 39% (UNAIDS, 1995). Even religious groups such as the Islamic Medical Association and Muslim religious authorities have made statements that education on the use of condoms is acceptable among Islamic teaching and is necessary to defend communities against AIDS (UNAIDS, 2002).

However, the use of condoms has not necessarily received a thunderous welcome among all members of the society. In Zimbabwe, particularly the Catholic Church reject condom as an answer to AIDS prevention as this is regarded to be a morally bankrupt solution to the much more fundamental problem of immoral degenerate social mores (Wermth, 1991).

Historically, the church has been slow to accept the changing nature of human relationships. Over time, social economic and cultural conditions have been transformed and the church's view that sexual expression is only morally permitted in a life-long, monogamous, heterosexual marriage has been thoughtfully challenged. Even those who went to accept the church's view are limited in their ability to live it. Other faith traditions as well as governments and the world have recognized this reality and promote the "ABCs" for prevention, "Abstain, Be faithful, use Condoms", (SAfAIDS, Dec. 2002).

The church's traditional message of abstinence before marriage and monogamy after, is very often a fiction in the light of having cultural norms contradicting religious teaching, especially in the case of something as near to home as sexual behavior. The church leaders have failed to acknowledge the fact that people are engaging in sexual relations and in contrast to the truth, the church is rather focusing on combating HIV transmission by eradicating stigma and discrimination, while in South Africa some churches have been active in the campaign for medication to prevent mother to child transmission. In other parts of Africa, certain churches have gone out to undermine public health strategies and even disseminate false information in order to prove their point. One Archbishop thundered by saying "using condoms results in disabled babies", (Paterson, 2002).

Apart from that another Bishop in Zimbabwe believes that both abstinence and fidelity are God-given methods of HIV prevention and the fact that HIV prevalence is on the increase is no arguments against abstinence and fidelity but against money-making methods, (UNAIDS, 2002).

An appeal from an HIV positive Anglican Priest could best address the varying conflicts on condom use when he said, "Religious divisions over condoms are unhelpful. We should accept the 'multifrontline' approach to HIV prevention and choose which line to fight on without attacking those fighting on other fronts", (Ahrtag, 1996)

In addition, an author from Zimbabwe advocates for the use of condoms since it prevents HIV transmission and states that those who know that they are HIV positive and do not use a condom are murderers. He was writing in support to World Council of Churches statement which recommends that all options including abstinence, fidelity and condoms need to be presented to empower people to make responsible decisions around HIV prevention (Hatendi, 2003).

2.4 NATIONAL PERSPECTIVE

HIV/AIDS is contributing to the most profound reversal of development gains made in Zambia over the past 27 years. HIV/AIDS is the most critical development and humanitarian crisis Zambia faces today.

"Currently, 19 percent of the adult population aged 15-49 are living with HIV. By June 2000, there were about 830,000 people over the age of 15 reported to be living with AIDS. Of these, 450,000 were women while 380,000 were men. The peak ages for HIV among females is 20 to 29 years while that for males is 30-39 years. Younger women aged 15-19 is 5 times more likely to be infected compared to males in the same age group. It is estimated that 25% of pregnant women were HIV positive. Approximately 39.5% of babies born to HIV positive mothers were infected with the virus." (National AIDS Intervention Strategic Plan, 2002-2005).

Currently, the HIV prevalence rate is roughly 20% (119.7%) among adults: Residence is closely associated with HIV levels. HIV prevalence is twice as high in urban areas as in rural areas (23 percent and 11 percent respectively). There are also variations in infection levels among women and men by age and residence for women in all age groups, HIV prevalence is more than twice as high as in urban areas as in rural areas and exceeds 40% in age group 30-34 and 35-39. Among men, HIV prevalence in urban areas is twice that in rural areas for most age groups, (ZDHS, 2003).

In the 2001-2002 ZDHS, men's attitude towards condom use indicate that 77% of men feel condoms are effective in the prevention of HIV and other diseases, while 36% believe that a woman has no right to tell a man to use a condom. Men in rural areas are almost twice as likely to think that a woman has no right to tell a man to use a condom as those in urban areas. The proportion of male respondents holding this view decreases with increasing level of education. Overall, condom use is low (12%) among women and 19% among men, (ZDHS, 2003).

In the study conducted by Himwila, 2000, it is indicated that 12% of male respondents said that condoms in marriage was a sign of an admission to having extra marital sexual relations while 4% of the respondents said husbands did not want the practice and 12% said it was against religion. This revealed that even if there was adequate knowledge, married men and women did not use condoms for various reasons (HIV/AIDS Bibliography, 2002).

Another study conducted by Mumba, 1999 in Kawambwa 'investigating the rate of HIV/AIDS and use of condoms,' indicates that 36% of the 816 HIV/AIDS clients were married. Most of the married couples in the sample did not agree to condom use in the prevention of HIV/AIDS, (HIV/AIDS Bibliography, 2002).

The Council of Churches representative during an interview on radio Phoenix stated that in Zambia, the churches refuse to encourage the church members to use condoms because the church is called to uphold moral principles and talking about condoms can make people to leave these principles, (Matale, 2004).

However, as an individual, Mrs. Matale stated that she would encourage the use of condoms particularly in marriages and for the sake of the faithful partner particularly women who are not in a position to say no the husbands sexual demands, or in discordant couples. This particularly emerged from the experience she has had in dealing with orphans in Matero where one grandmother has had to deal with 22 grandchildren left by her children who have died of HIV/AIDS, (Matale, 2004).

Another religious organization involved in HIV/AIDS programmes, Life and Choice representative in the same interview indicated that women are particularly willing to use female condoms since they were more willing to use condoms and there did not seem to be so much of a problem with their husbands, since they were using female condoms, (Mwanza, 2004).

2.5 CONCLUSION

The literature by various authors reveals that the prevalence of HIV/AIDS globally, regionally and nationally is still growing despite the concerted efforts being made by governments, non-Governmental Organizations and other organizations to try and curb the scourge.

The factors contributing to the spread of HIV/AIDS are population mobility (i.e. poverty and unemployment) tourism and social interactions, and economic hardships. The most common modes of transmission are sexual intercourse, and injections of drugs. Women are the most affected compared to the men due to the occurrence of heterosexual relations though men to men sexual interactions are also becoming common.

In Zambia, the situation is not any different from the above. The younger women are more susceptible than younger men of the similar age. Men's attitude towards condom use is yet another factor which requires to be explored further particularly with a focus on religious influence in order to achieve the intended HIV/AIDS prevention among Zambian couples (married, cohabiting or casual relations).

CHAPTER THREE

3.0 RESEARCH METHODOLOGY

3.1 RESEARCH DESIGN

"A research design is a scheme of action (framework) for answering research question or problem" (Treece and Treece, 1986).

After formulating the specific problem thoroughly and reviewing relevant literature, a workable strategy – the research design is developed. It contains all the important information related to strategy and describes the instruments. To achieve this main objective, a non-interventional descriptive exploratory study design was used which was both qualitative and quantitative.

A descriptive study involves the systematic collection and presentation of data to describe or define characteristics of a phenomena or person as they naturally occur (Polit and Hungler, 1995).

This research design was found to be appropriate by the researcher for the following reasons:

- It is less costly and time consuming.
- It involves getting information directly from respondents in their natural environment, which eliminates the subjection of respondents to unpleasant conditions; hence cooperation of the subjects will be more easily obtained.

This study was qualitative because data was quantified in numerical values and percentages. This enabled the researcher to make statistical inferences. The study was also qualitative because it endeavored to determine the acceptance and utilization of condoms in the prevention of HIV/AIDS among christian men. It also attempted to identify various possible factors associated with this particular problem, a subject of major concern in the study.

3.2 RESEARCH SETTING

3.2 RESEARCH SETTING

This study was conducted in Mwinilunga, which was renowned for pineapple growing in the second republic. Mwinilunga has peri-urban and rural areas. The district has a projected population of 160 038 at a growth rate standing between 2.6 to 4.3% as per 2000 C.S.O estimation. The district is served by 2 first level hospitals, 24 health centers, 100 health posts and these facilities are either under the government or missionaries. All these facilities are all distributing condoms.

Mwinilunga district was chosen conveniently. It is accessible and has 46,411 men of the total population.

3.3 STUDY POPULATION

"A study population is an aggregate or totality of all subjects, objects or members that conform to a designated set of specification" (Polit and Hunglar, 1995).

The study population comprises of Christian men who are found in the reproductive age who are living in both peri-urban and rural areas of Mwinilunga district. The study population is 29% of the total population of Mwinilunga.

3.4 SAMPLE SELECTION

The sample was drawn from the study population in order to obtain a representative sample from the population. The study sample was selected by a non-probability sampling method called convenience sampling.

In convenient sampling, the sample was drawn from a section of the study population that was easily accessible and not all elements of the population were given an equal chance of being included in the sample. The method was suitable for collection of data since christian men can only be found in specific places at a particular, that is Sunday services, prayer meetings or bible study groups on specific days.

3.5 SAMPLE SIZE

A sample size is a subject of a population selected to participate in the research study, (Polit and Hunglar, 1995).

The sample size comprised of 50 respondents, considering time and other resources under which the study was conducted. The sample was taken in 5 groups of 10 respondents in order to have at least 5 Christian denominations sampled as these were representative of the Christian men in Mwinilunga. 6-12 church leaders were drawn for a focus group discussion (FGD). While an equivalent number of Christian women were drawn for a FGD as a control group.

3.6 DATA COLLECTION TECHNIQUE

Data collection is the gathering of information to address a research problem and qualitative or quantitative techniques can be used to collect data.

The researcher was responsible for data collection. 5 research assistants were trained on data collection to ensure speedy data collection from respondents considering the limited in which the research was conducted.

Data collection was conducted over a period of 6 Weeks during the month of September 2004.

A mix of data collection methods was used. The advantage of using a combination of methods is that the information collected by different methods complemented each other in analyzing the characteristics of condom use acceptors; maximized the quality of data collected and reduce bias.

In this study 2 types of quantitative techniques where used, which are:

- Interview
- Focus group discussions.

3.6.1 INTERVIEW

"The term interview refers to verbal questioning of respondents by the investigator to collect data and involves interaction between people" (Dempsey and Dempsey, 1986).

There are two basic types of interviewing; structured and unstructured. For this study the researcher utilized and developed a structured interview schedule in order to accommodate respondents who could not read and write.

3.6.2 FOCUS GROUP DISCUSSION

"The FGD is a technique that allowed the researcher to examine the points of view of a number of individuals as they share their opinions or concerns about a topic in an interactive manner" (Dempsey and Dempsey, 1995).

The focus group was conducted in an informal setting. The discussion was tape-recorded and the chief investigator moderated the discussion.

3.7 DATA COLLECTION TOOL

The study will use a mix of data collection tools, which include a structured interview questionnaire and focus group discussion guide (refer to appendix 1 and 2).

3.7.1 STRUCTURED INTERVIEW SCHEDULE

"In a structured interview schedule, a list of prepared questions is formulated which the researcher believes will provide a format for the respondents' answers". (Dempsey and Dempsey, 1986).

The interview schedule was designed to solicit information and it had both closed and open-ended questions. Open-minded question availed an opportunity to the researcher to explore and clarify issues.

The interview schedule also acted as a guide on what type of questions to ask in order to obtain information on required variables of the study. The questions were written in English and translated in the local language commonly spoken in Mwinilunga during the interview.

The advantages of using a structured interview schedule are:

- Literate and illiterate respondents were interviewed.
- Misunderstandings were corrected there and then.
- Rephrasing questions while retaining the same meaning led to clarification of questions and answers.
- The tool was quite easy to administer considering the limited time of conducting the study.
- Analysis and interpretation of data was easily accomplished.

However, the interview schedule has limitations, which includes the following:

- It is not cost effective for a large number of people.
- It is time consuming for the interviewers when conducting the interviews.
- Training is needed for the research assistants.

3.7.2 FOCUS GROUP DISCUSSION GUIDE

This is an in-depth interview with a small number of people. The researcher chose FGD as a method of collecting in-depth information from men on acceptance and utilization of condoms among Christian men.

The information that was collected from the FGDs complemented that which was obtained from the interviews.

The researcher formulated questions, which acted as a guide during the focus group discussions. These questions were translated into the local language during the discussion.

The advantages of using the guide are:

- It allows for clarification of questions.
- It allows the researcher to probe and be able to get richer information.
- A lot of information or data is collected in a short period of time.

However, it may be difficult to collect sensitive information from individuals in the group; talkative members can dominate the discussion and some members may just become passive.

3.8 PILOT STUDY

"A pilot study is a small-scale study conducted before the main study on a limited number of subjects from the same population" (Brink, 1996).

A pilot study was conducted to facilitate validity and reliability of the tools. The sample comprised of 5 men who were randomly selected for the interviews. The pilot was undertaken in Makeni, South of Lusaka.

The purpose for carrying out a pilot study was to identify problems with the tool; investigate the feasibility of the proposed study and detect any possible flaws on the data collection tools by using the tool.

After the pilot study, the format and presentation of the questions in the interview schedule; were reviewed and the changes were made where necessary.

3.9 ETHICAL AND CULTURAL CONSIDERATION

The researcher wrote a letter (appendix VI) to the DHO for Mwinilunga District Health Board (MDHB) for permission to carry out the research in the district. This was done in recognition of their authority and to gain their support and cooperation during the study and consent from MDHB was granted. Apart from that, a written consent was sent to the District Commissioner of Mwinilunga to

seek permission to carry out the study in the district and permission was granted (annex vii).

Protection of human rights of the respondents was ensured by providing an informed verbal consent, anonymity and confidentiality by not indicating their names on the questionnaires though a unique identifier number on the interview schedule for each respondent was used. Every information collected during an interview was treated as totally confidential.

CHAPTER FOUR

4.0 DATA ANALYSIS AND PRESENTATION OF FINDINGS

4.1 DATA ANALYSIS

The raw data was collected, sorted out and then grouped into categories. The questionnaires were edited for completeness, uniformity, accuracy and consistency and then data was coded.

The responses from closed-ended questions were entered on the master sheet, while responses from the open-ended questions and FGD were categorized in different groups and then coded

The analysis of data was done manually using a scientific calculator.

4.2 STATISTICAL ANALYSIS AND PRESENTATION OF FINDINGS

The findings of the study are presented in frequency tables, percentages, cross tabulations, bar graphs and pie charts.

The use of graphs and bar charts in the presentation of the findings will make the work presentable and easily understood by the readers of the research study.

The frequency tables will summarize the results of the study in a way that will enable readers to be able to understand the findings of the researcher study. Cross tabulation of the variables will help to show clearly the relationship between variables and then the researcher will be able to draw meaningful inferences.

FIGURE 1

The majority that 50% of the respondents were in the age group of 25-34.

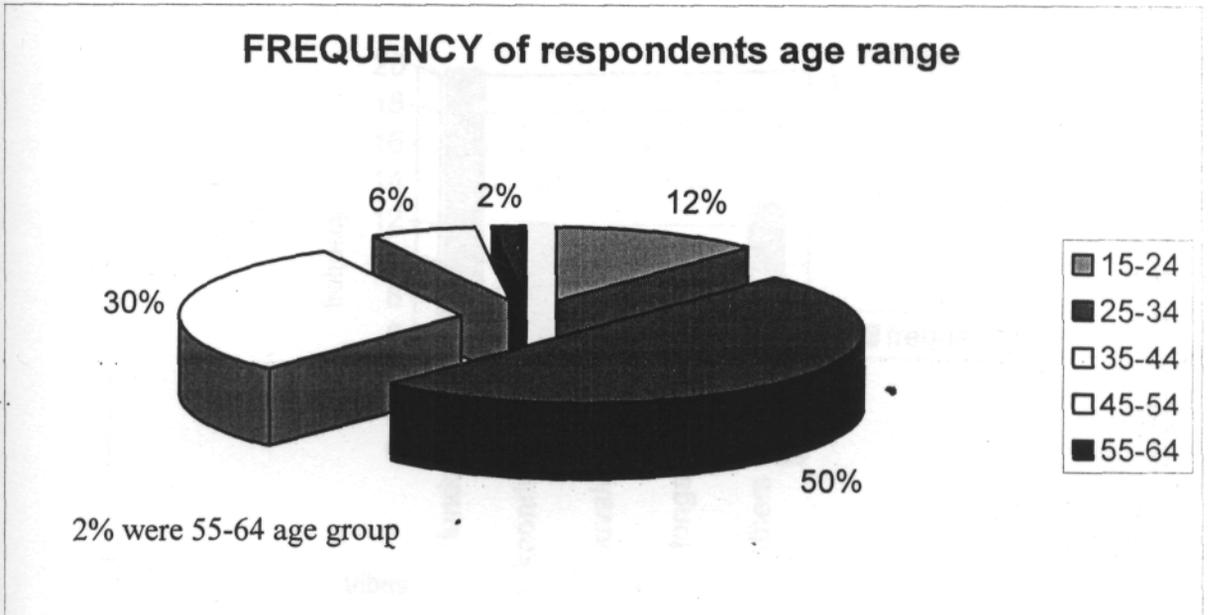
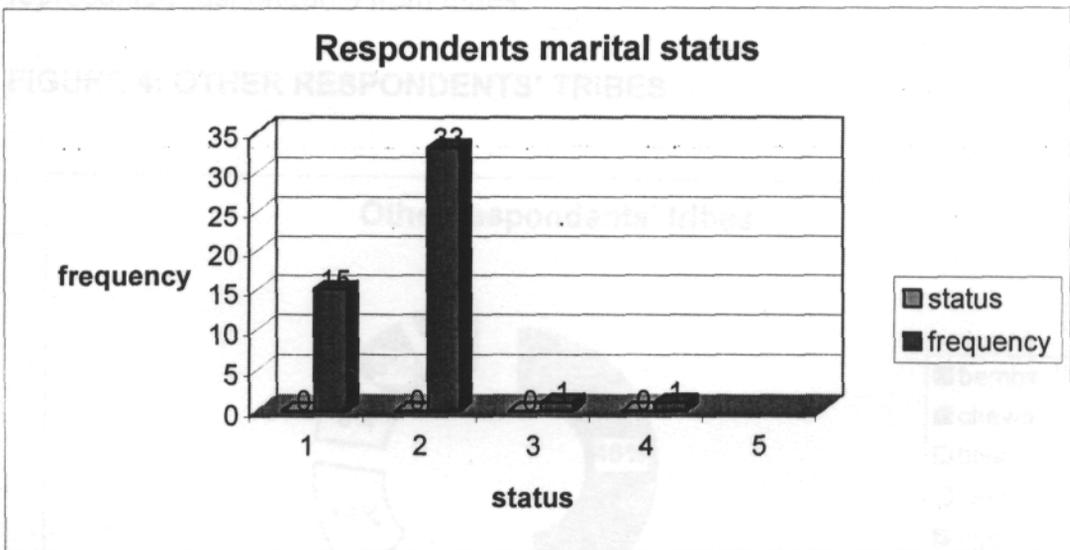


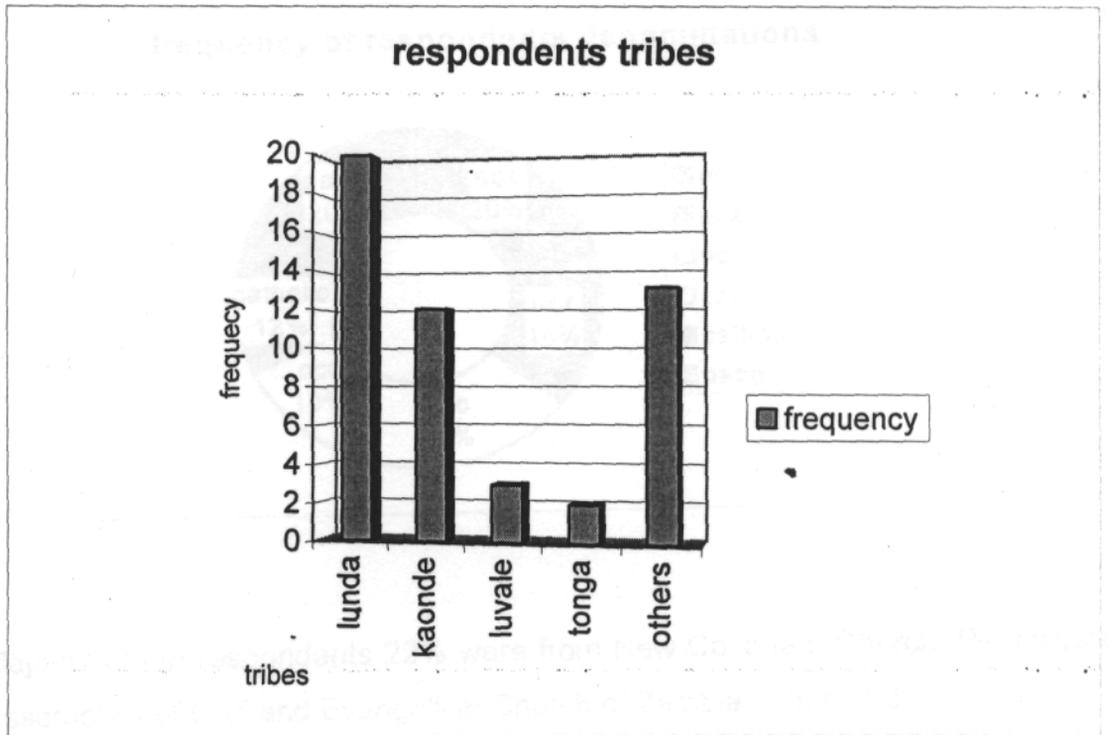
FIGURE 2: RESPONDENTS MARITAL STATUS (n=50)



Key 1-single 2-married 3-divorced 4widow

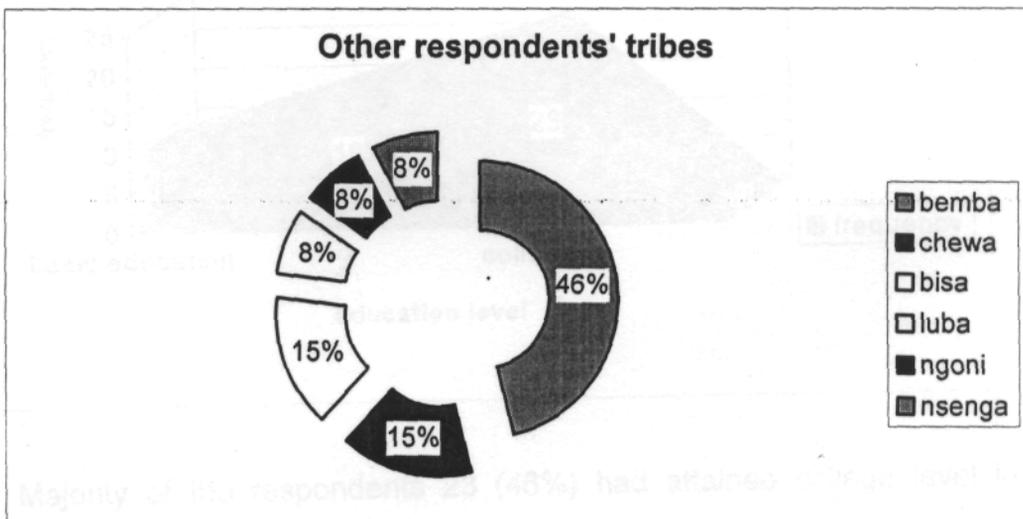
The majority of the respondents 33 (66%) were married, while 15 (30%) were single.

FIGURE 3: RESPONDENTS TRIBE (n=50)



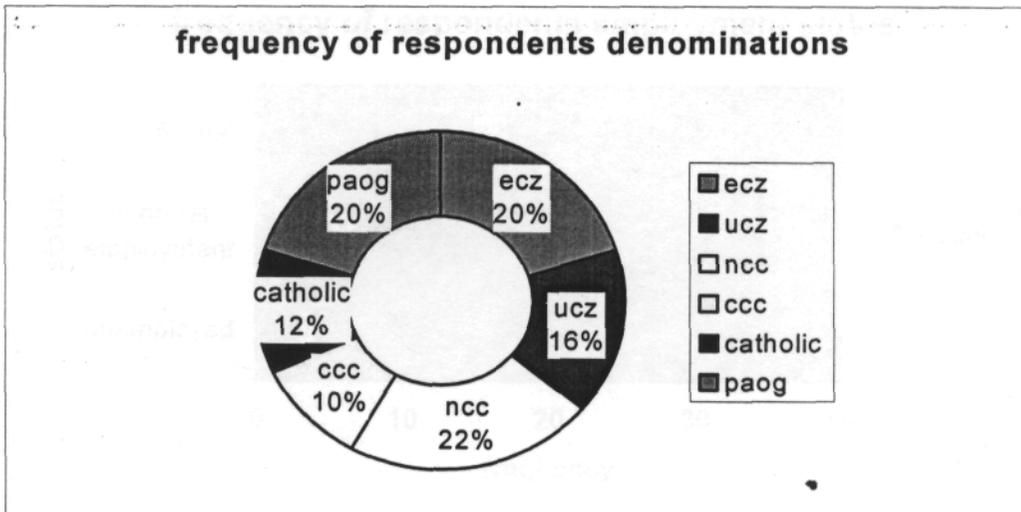
Majority of the respondents 20 (40%) were Lunda. While 13(26%) the others represented respondents from tribes.

FIGURE 4: OTHER RESPONDENTS' TRIBES



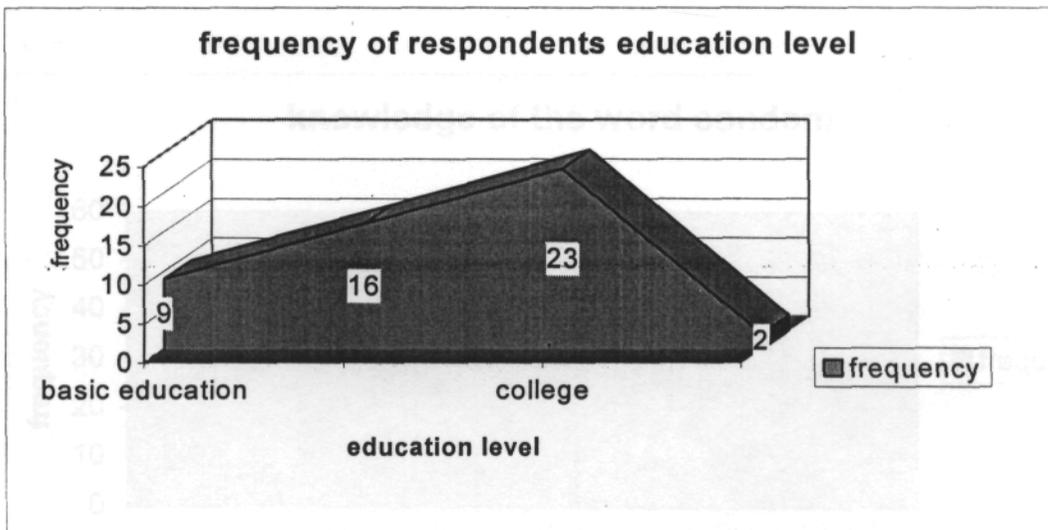
Majority of the respondents 46% in the category of other tribes were Bemba.

FIGURE 5: RESPONDENTS RELIGIOUS DENOMINATION (n=50)



Majority of the respondents 22% were from New Covenant Church. Pentecostal Assemblies of God and Evangelical Church of Zambia both had 20% each.

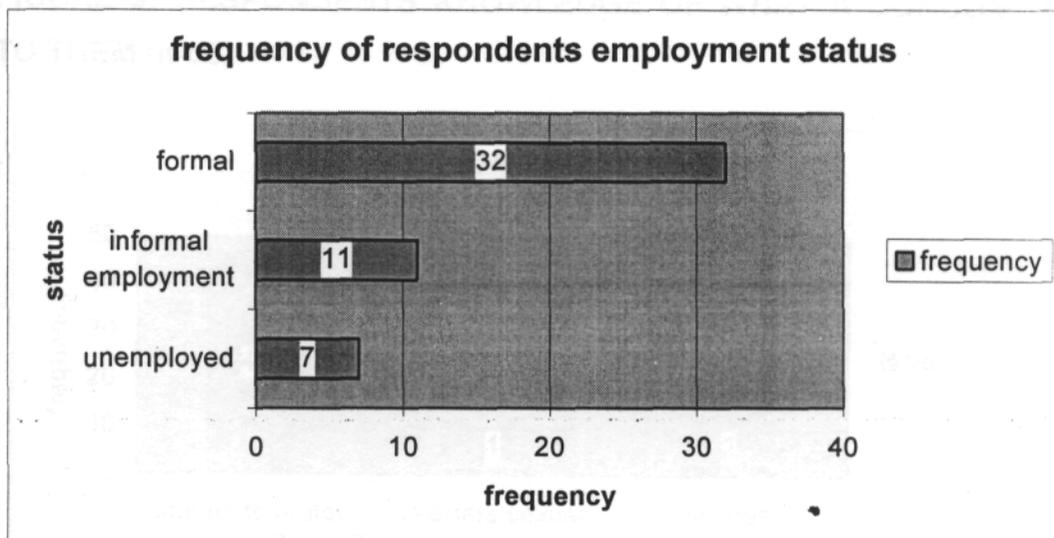
FIGURE 6: RESPONDENTS EDUCATIONAL LEVEL (n=50)



Majority of the respondents 23 (46%) had attained college level in terms of education while 16 (32 %) had attained secondary school.

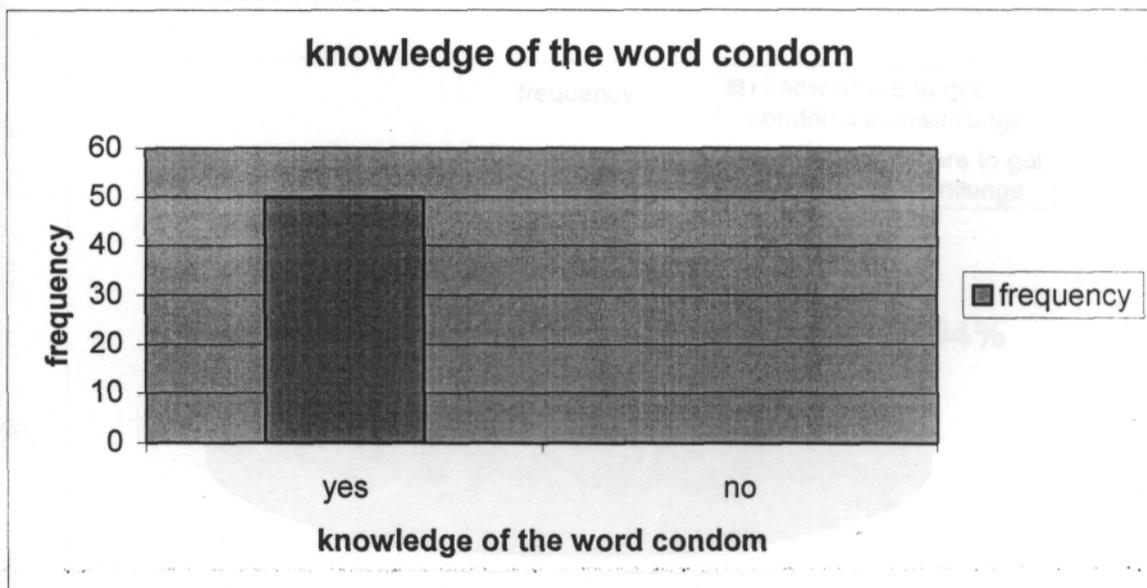
The table shows that all 100% the respondents had heard of the word covenant.

FIGURE 7: REpondents EMPLOYMENT STATUS (n=50)



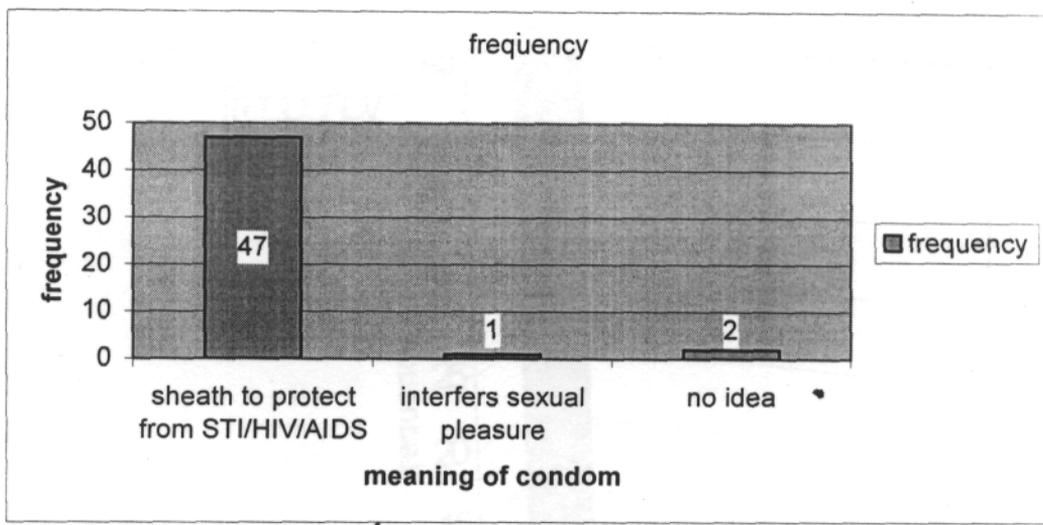
Majority of the respondents 32 (64%) were in formal employment, while 11 (22%) are in informal employment.

FIGURE 8: RESPONDENT WHO HAD HEARD OF THE WORD CONDOM (n=50)



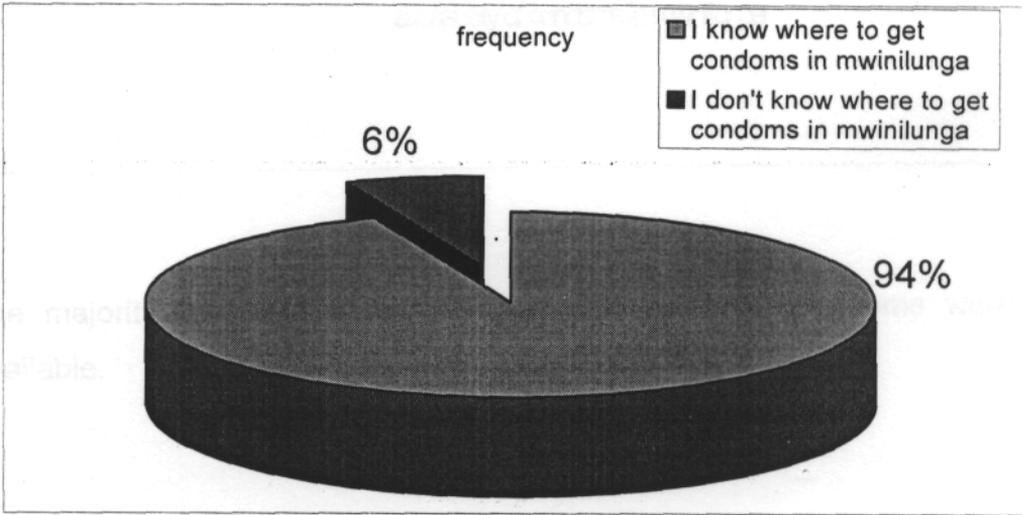
The table shows that all 100% the respondents had heard of the word condom.

FIGURE 9: RESPONDENTS KNOWLEDGE OF WHAT A CONDOM MEANS TO THEM (n-50)



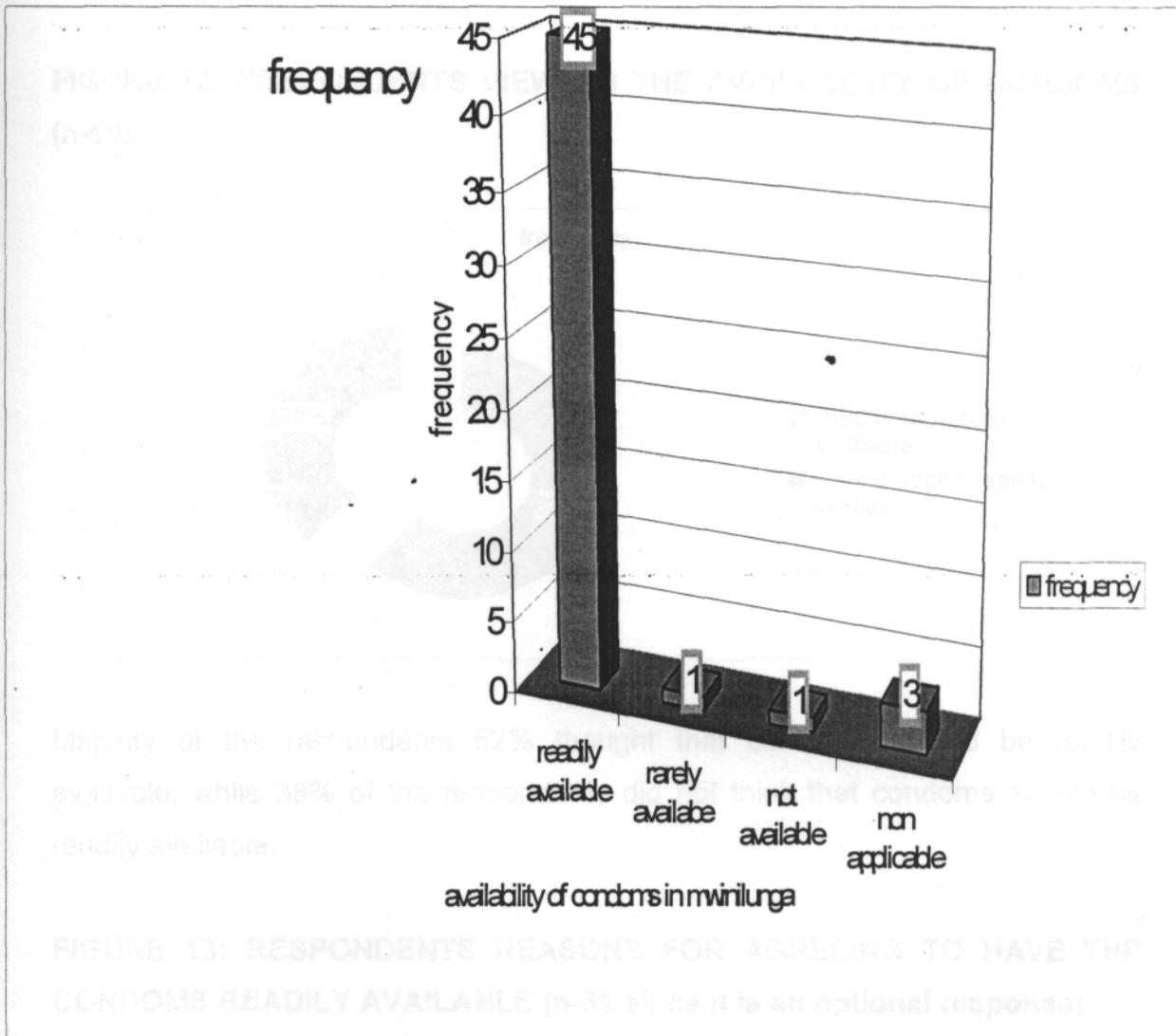
Majority 47 (94%) of the respondents knew that a condom meant a sheath used to protect oneself from contracting STI/HIV/AIDS.

FIGURE 10: RESPONDENTS KNOWLEDGE OF WHERE TO GET CONDOMS IN MWINILUNGA (n-50)



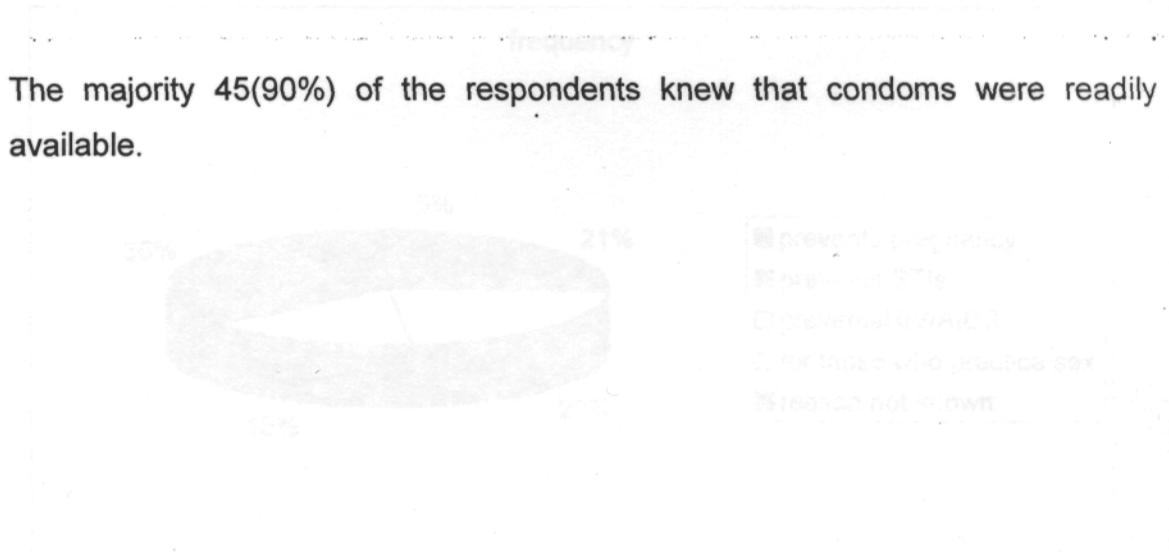
Majority 94% of the respondents knew where to get condoms while 6% did not know where to get condoms in Mwinilunga.

FIGURE 11: RESPONDENTS KNOWLEDGE OF HOW AVAILABLE THE CONDOMS ARE IN MWINILUNGA (n=50)



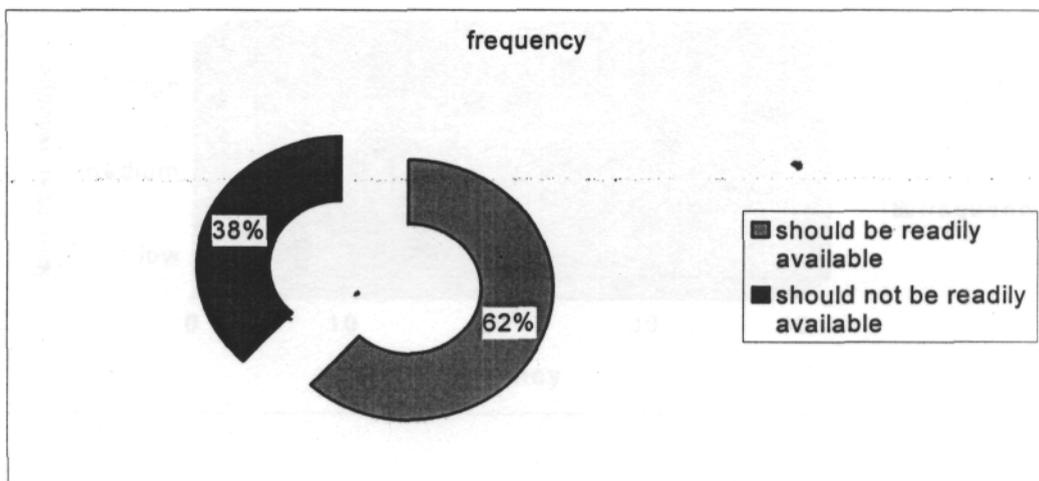
Majority of the respondents 90% (45) knew that condoms were readily available, while 38% of the respondents (19) knew that condoms should be readily available.

FIGURE 13: RESPONDENTS REASONS FOR AGREEING TO HAVE THE CONDOMS READILY AVAILABLE (n=31 since it is an optional response)



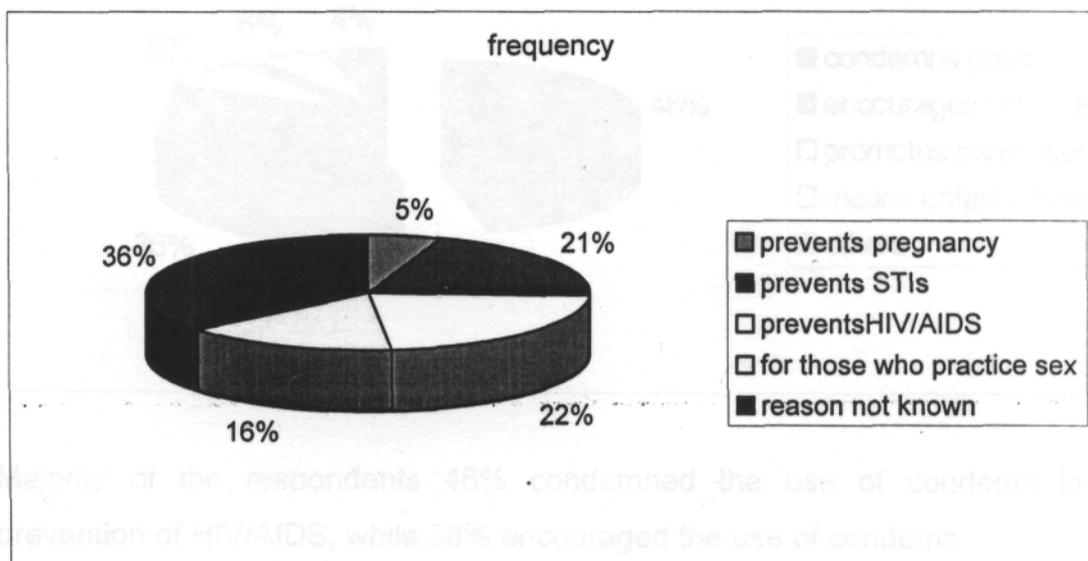
The majority 45(90%) of the respondents knew that condoms were readily available.

FIGURE 12: RESPONDENTS VIEW ON THE AVAILABILITY OF CONDOMS (n-50)



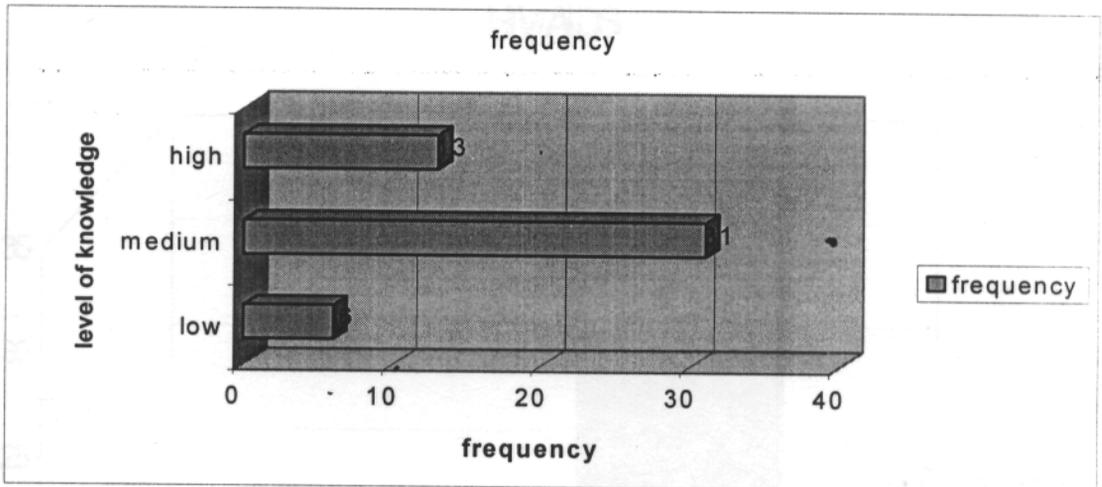
Majority of the respondents 62% thought that condoms should be readily available, while 38% of the respondents did not think that condoms should be readily available.

FIGURE 13: RESPONDENTS REASONS FOR AGREEING TO HAVE THE CONDOMS READILY AVAILABLE (n-31 since it is an optional response)



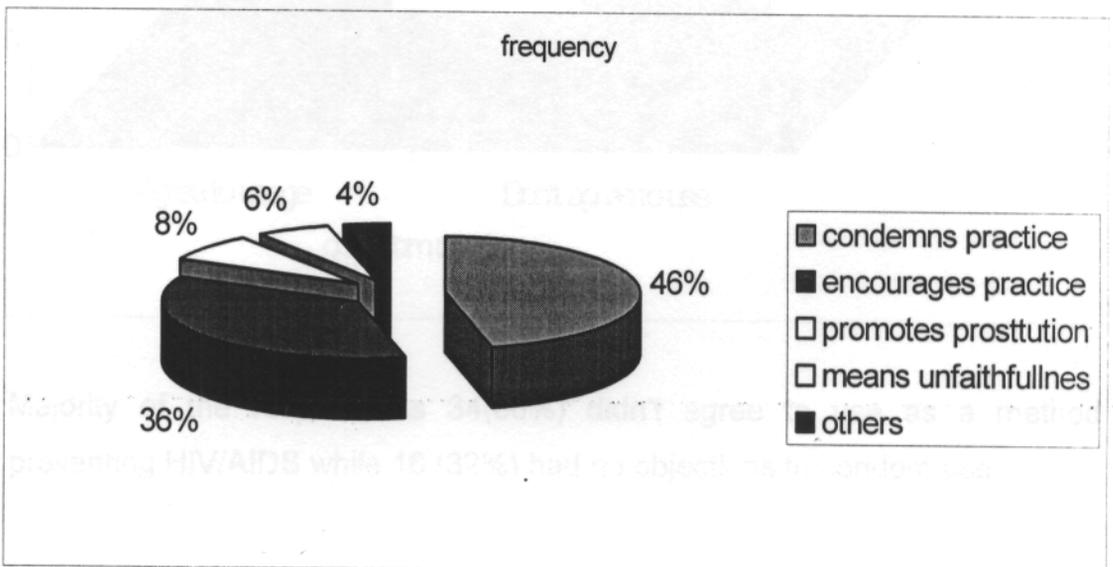
Of the respondents who opted to have the condoms readily available, 36% did not want to share the reasons for this response. While 5% thought that condoms could be used as a method of contraception.

FIGURE 14: RESPONDENTS LEVEL OF KNOWLEDGE (n=50)



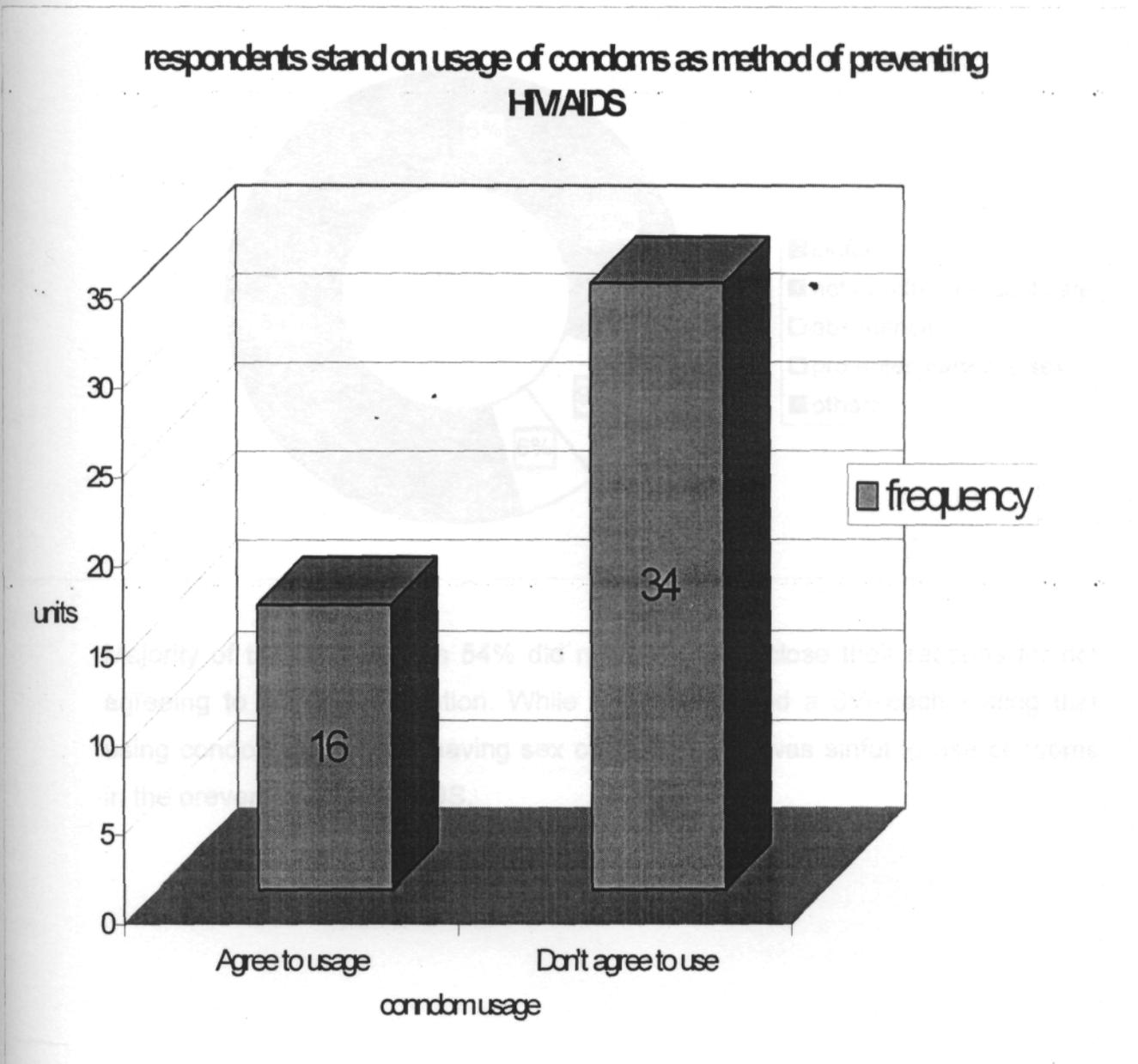
Majority of the respondents 31 (62%) had medium level of knowledge while 6 (12%) of the respondents had low knowledge.

FIGURE 15: RESPONDENTS ATTITUDE TOWARDS CONDOM USE



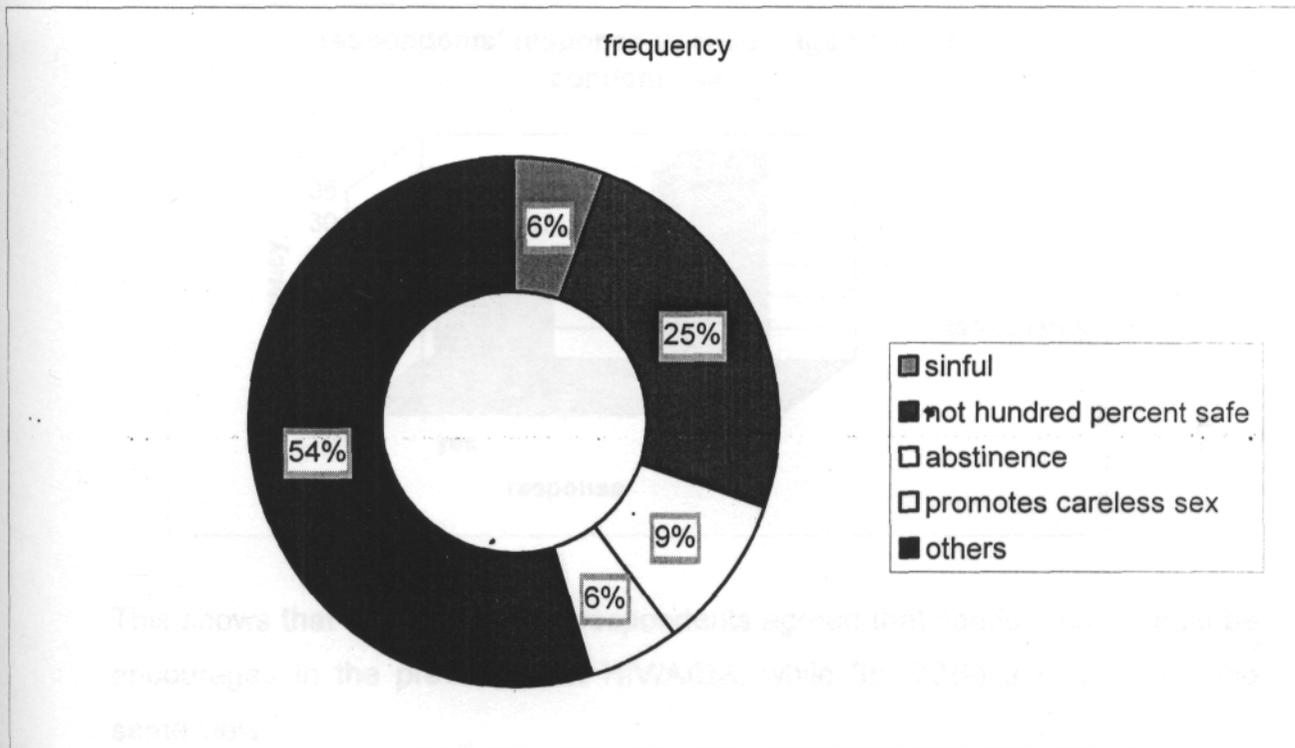
Majority of the respondents 46% condemned the use of condoms in the prevention of HIV/AIDS, while 36% encouraged the use of condoms.

FIGURE 16: RESPONDENTS RESPONSE TO USE OF CONDOMS AS A METHOD OF PREVENTING HIV/AIDS (n-50)



Majority of the respondents 34(68%) didn't agree to use as a method of preventing HIV/AIDS while 16 (32%) had no objections to condom use.

FIGURE 17: RESPONDENTS REASONS FOR NOT AGREEING TO UTILIZATION OF CONDOMS AS A MODE OF PREVENTING HIV/AIDS (n-34 it is an optional response)

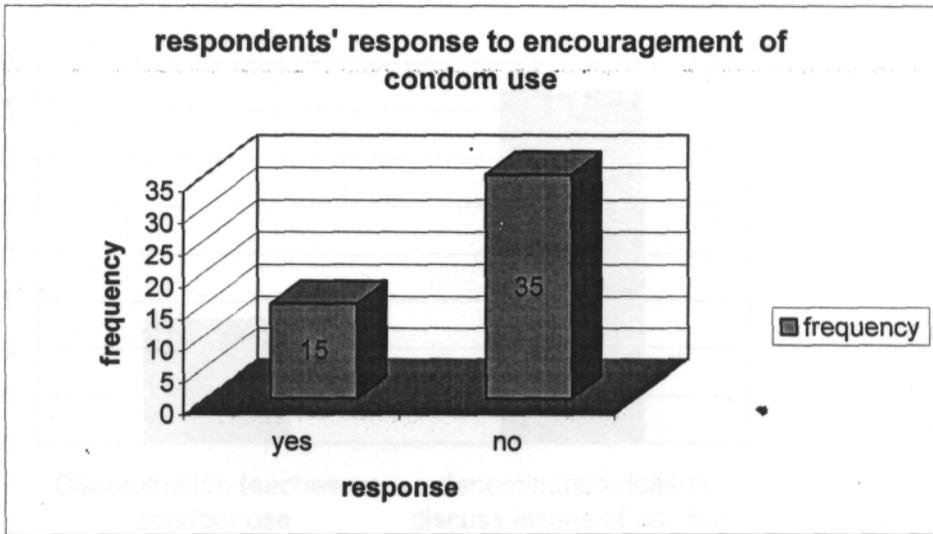


Majority of the respondents 54% did not want to disclose their reasons for not agreeing to condom utilization. While two groups had a 6% each stating that using condoms promoted having sex carelessly or it was sinful to use condoms in the prevention of HIV/AIDS.



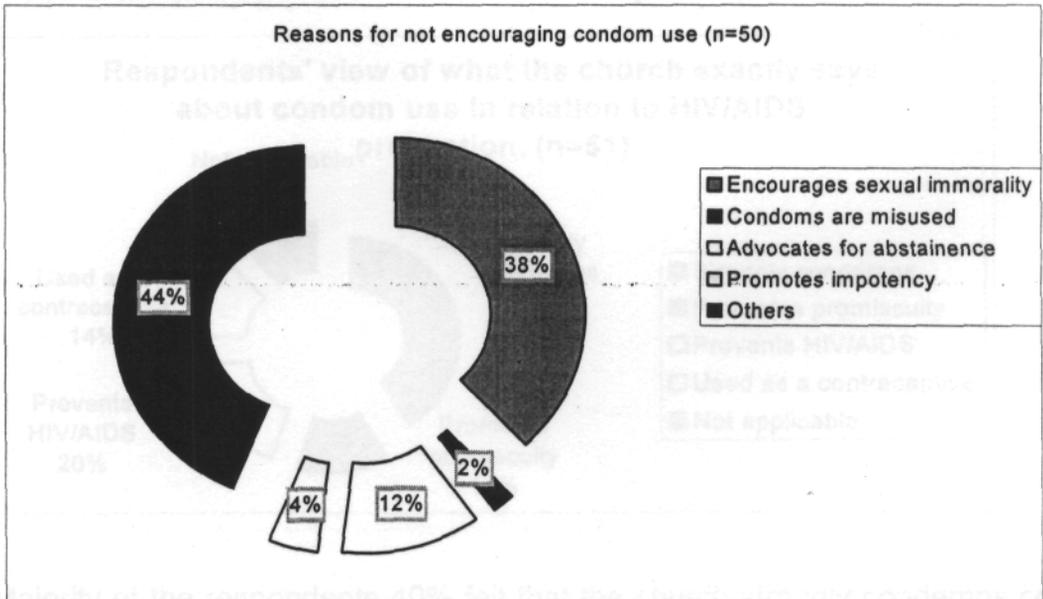
This shows that 44% respondents had various reasons for not endorsing condom use, while 4% felt that condoms promote immorality.

FIGURE 18: RESPONDENTS STAND ON ENCOURAGEMENT OF CONDOM USE (n-50)



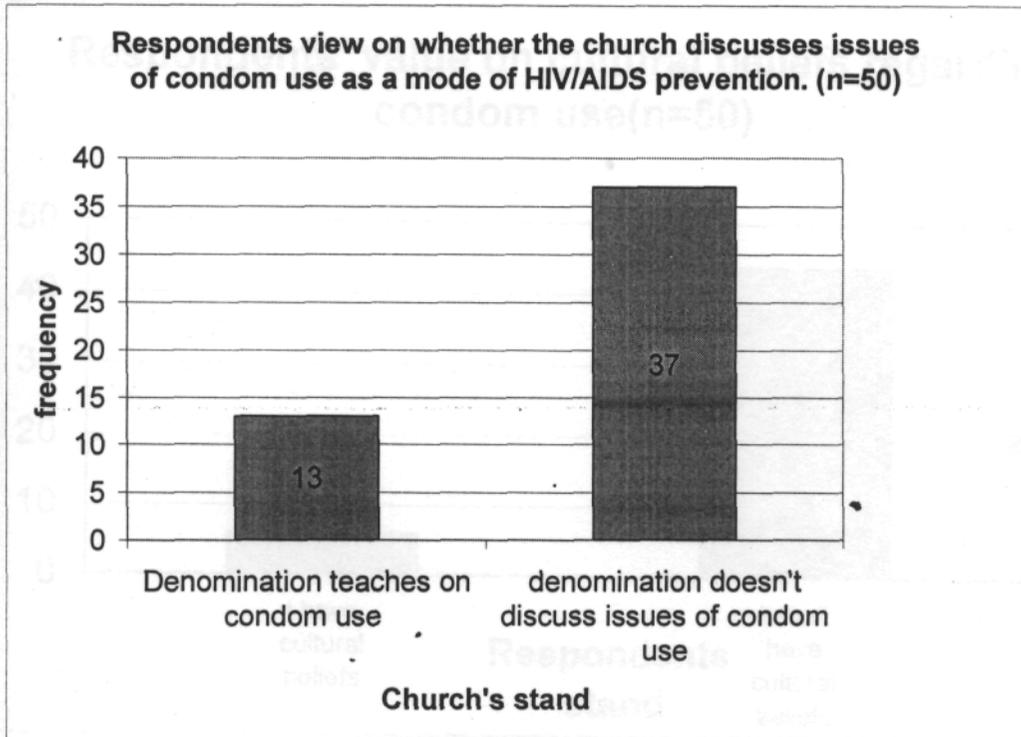
This shows that 15 (30%) of the respondents agreed that condom use should be encouraged in the prevention of HIV/AIDS, while 35 (70%) did not share the same view.

FIGURE 19: RESPONDENTS REASONS FOR NOT ENCOURAGING CONDOM USE (n-35)



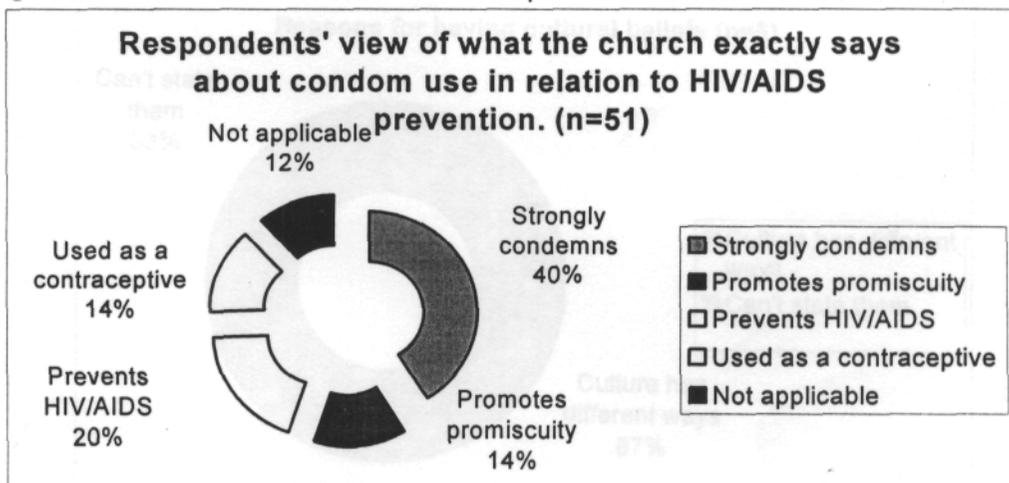
This shows that 44% respondents had various reasons for not encouraging condom use, while 4% felt that condoms promote impotency.

FIGURE 20



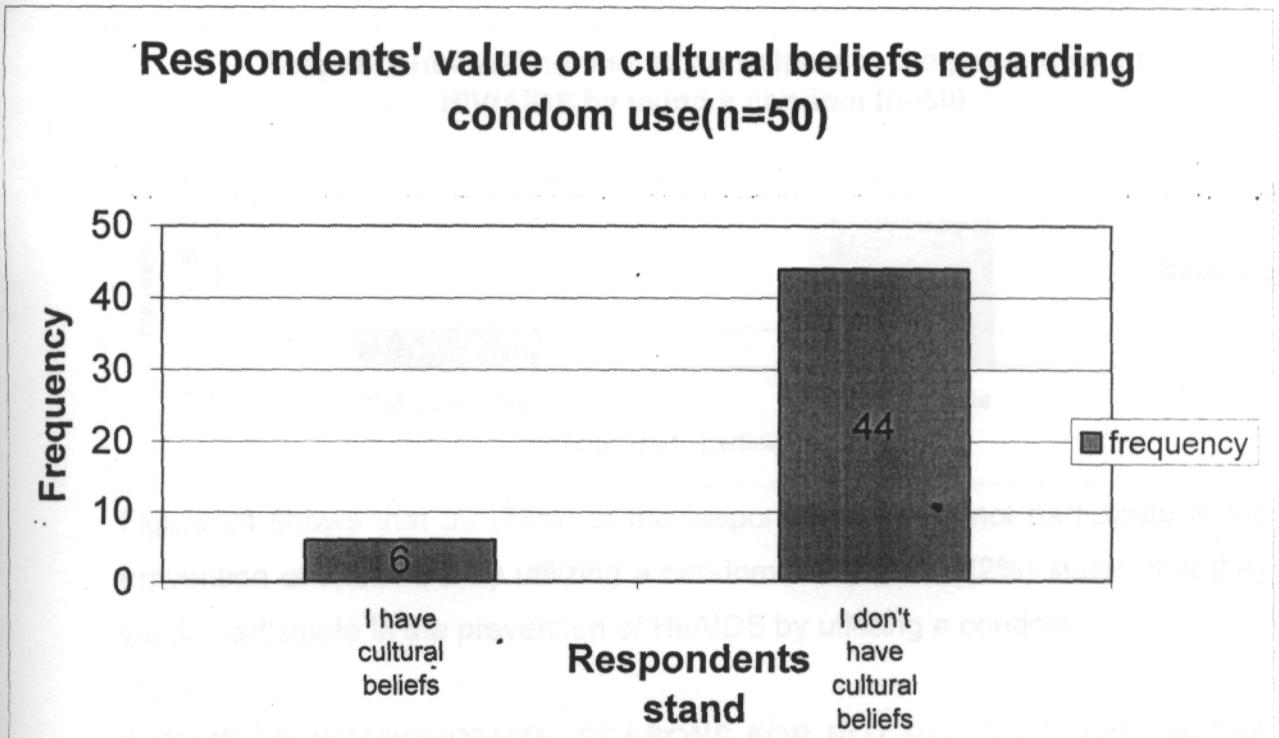
Majority of the respondents 37(74%) stated that the their denomination does not discuss issues of condom use in their church while 13 (26%) stated that their church teaches condom use.

FIGURE 21: (n=51 because there were multiple responses)



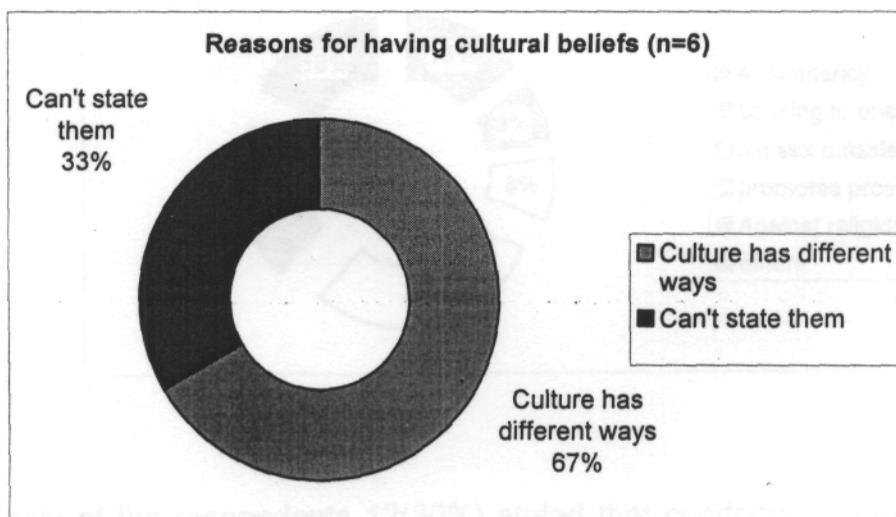
Majority of the respondents 40% felt that the church strongly condemns condom use as a method of preventing HIV/AIDS. While 12% felt that it was not applicable.

FIGURE 22



Majority of the respondents 44 (88%) did not have cultural beliefs in regards to condom use, while 6 (12%) had cultural beliefs in regards to condom use.

FIGURE 23: (n=6 optional response)



Majority of the respondents 67% thought that culture had different ways of preventing sexually transmitted diseases, while 33% could not state their reasons.

FIGURE 24

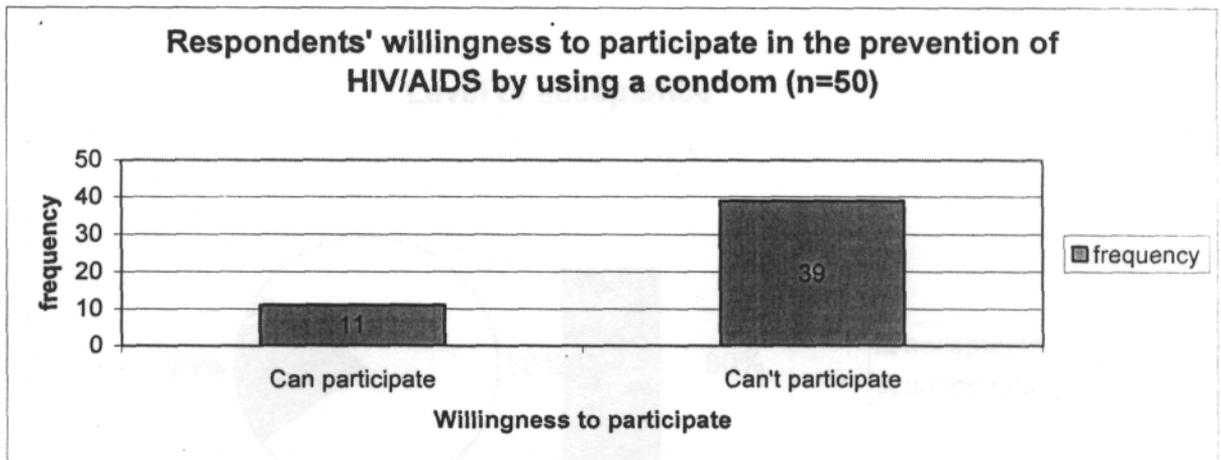
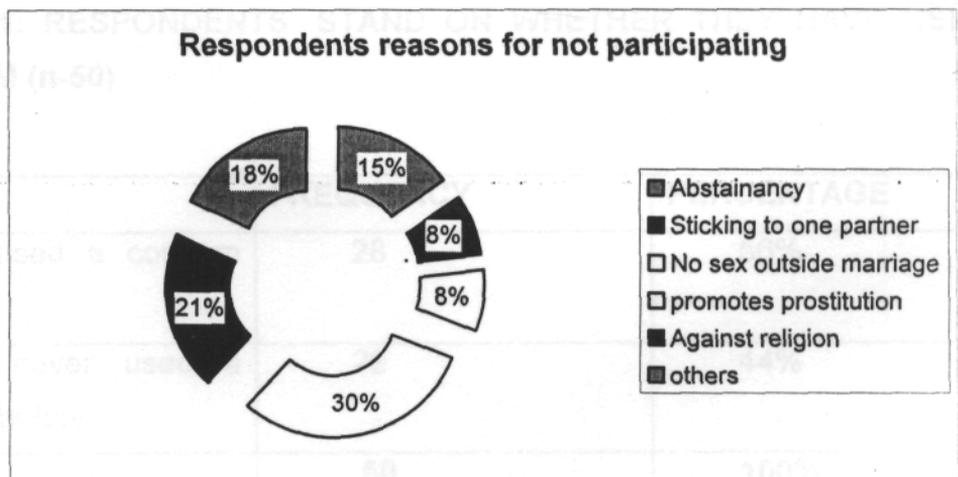


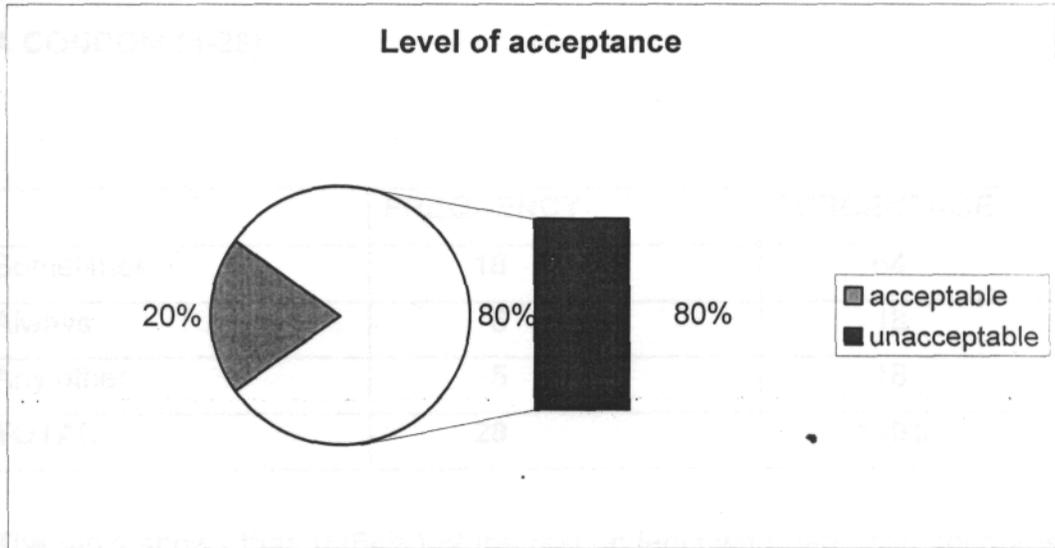
Figure 24 shows that 39 (78%) of the respondents would not participate in the prevention of HIV/AIDS by utilizing a condom. While 11 (22%) stated that they would participate in the prevention of HIV/AIDS by utilizing a condom.

FIGURE 25: RESPONDENTS' REASONS FOR NOT PARTICIPATING IN THE PREVENTION OF HIV/AIDS BY UTILISING A CONDOM AS CHRISTIAN MEN (n=39 because it is an optional response)



Majority of the respondents 12(30%) stated that condoms promote prostitution. While 21% (8) of the respondents felt that condom use was against their religion.

FIGURE 26: RESPONDENTS LEVEL OF ACCEPTING CONDOM USE AS METHOD OF PREVENTING HIV/AIDS AMONG CHRISTIAN MEN. (n-50)



The figure shows that 10(20%) of respondents would accept to use condoms as method of preventing HIV/AIDS, while 40(80%) would not use condoms as method of preventing HIV/AIDS.

TABLE 1: RESPONDENTS' STAND ON WHETHER THEY HAVE USED A CONDOM (n-50)

	FREQUENCY	PERCENTAGE
I have used a condom before	28	56%
I have never used a condom before	22	44%
TOTAL	50	100%

The table shows that 56% of the respondents had used a condom before, while 44% had never used a condom before.

TABLE 2: RESPONDENTS' RESPONSE TO HOW OFTEN THEY HAVE USED A CONDOM (n-28)

	FREQUENCY	PERCENTAGE
Sometimes	18	64
Always	5	18
Any other	5	18
TOTAL	28	100%

The table shows that 18(64%) of the respondents who had used condoms used them sometimes. 5(18%) used them always. 5(18%) had used them once in a while.

TABLE 3: RESPONDENTS' REASONS FOR NOT USING A CONDOM (n-23)

	FREQUENCY	PERCENTAGE
Religion does not allow	12	55%
Tradition doesn't allow	2	9%
I do not approve	2	9%
Any other reasons	6	27%
TOTAL	22	100%

The table shows that 55% of the respondents stated that religion does not allow. While 27% had other reasons for not using the condom.

TABLE 4: OF THOSE WHO HAD USED A CONDOM, WHOSE DECISION WAS IT THAT THE CONDOM IS USED (n-28)

	FREQUENCY	PERCENTAGE
Myself	9	32%
Wife	1	3.5%
Couple	15	54%
Health care provider	2	7%
Any other	1	3.5%
TOTAL	28	100%

The table shows that of the respondent who used condoms, 15(54%) as couples made the decision to use condoms, while 1(3.5%) of the respondents allowed his wife to make the decision.

TABLE 5: RESPONDENTS' RESPONSE TO WHETHER THEY DISCUSSED THE USE OF CONDOMS WITH THEIR PARTNERS (n-50)

	FREQUENCY	PERCENTAGE
I do discuss with my partner	25	50%
I do not discuss with my partner	20	40%
Not applicable	5	10%
TOTAL	50	100%

The table shows that 50% of the respondent's discussion matters of condom use with their partner. While 10% stated that it was not applicable.

TABLE 6: RESPONDENTS VIEW ON WHETHER CHRISTIAN COUPLES OR INDIVIDUALS SHOULD USE CONDOMS IN THE PREVENTION OF HIV/AIDS (n-50)

	FREQUENCY	PERCENTAGE
Yes	15	30%
No	35	70%
TOTAL	50	100%

The table shows that the majority of the respondents 70% stated that condoms should not be used as method of preventing HIV/AIDS among christian couples or individuals. While 15% thought condoms could be used.

TABLE 7: RESPONDENTS' REASONS FOR NOT USING CONDOM (n-35 optional responses)

	FREQUENCY	PERCENT
Singles abstain	6	17%
The married stick to their partners faithfully	7	20%
Tempts one to sexual immorality	5	14%
Promotes prostitution	3	9%
Religion does not allow	7	20%
Not 100% safe	2	6%
Others	5	14%
TOTAL	35	100%

The table shows that two sets of respondents had 20% each stated that married couples should stick to their sexual partners faithfully or religion does not allow. While 17% indicated that singles abstain.

TABLE 8: RESPONDENTS REASONS FOR USING A CONDOM (n-15 optional responses)

	FREQUENCY	PERCENTAGE
Used as a contraceptive	3	20%
Used if couple is discordant	4	26.7%
Prevents STI/HIV/AIDS	6(+2*)	40%
Aids is infecting anybody therefore use condoms	2	13.3%
TOTAL	15	100%

* Multiple response

The table shows that 40% of the respondents who were using condoms thought that condoms prevented STI/HIV/AIDS. 26% stated that condoms could be used by discordant couples.

TABLE 9: LEVEL OF UTILIZATION (n-50)

LEVEL	FREQUENCY	PERCENTAGE
Low (non user)	26	52%
Medium (sometimes)	13	26%
High (always)	11	22%
TOTAL	50	100%

The table shows that 11(22%) of the respondents utilized condoms. While 26(52%) did not utilize the condoms.

TABLE 10: RESPONDENTS' KNOWLEDGE IN RELATION TO AGE (n-50)

AGE	KNOWLEDGE			TOTAL
	Low	Medium	High	
15-24	1 (16.6%)	3 (9.7%)	2 (15.3%)	6 (12%)
25-34	1 (16.6%)	17 (55%)	6 (46.2%)	24 (48%)
35-44	3 (50%)	10 (32.3%)	4 (30.8%)	17 (34%)
45-44	-	1 (3.2%)	1 (7.7%)	2 (4%)
55-64	1 (16.6%)	-	-	1 (2%)
TOTAL	6 (12%)	31 (62%)	13 (26%)	50 (100%)

The table shows that 62% of the respondents had medium knowledge of which 55% were aged between 25-34 followed by 32.3% who were aged between 35-44 years.

TABLE 11: RESPONDENTS' KNOWLEDGE IN RELATION TO MARITAL STATUS (n-50)

MARITAL STATUS	KNOWLEDGE			TOTAL
	Low	Medium	High	
Single	1 (16.6%)	9 (29%)	5 (38.5%)	15 (30%)
Married	5 (83.3%)	21 (67.7%)	7 (53.8%)	33 (66%)
Divorced	-	1 (3.2%)	-	1 (2%)
Widower	-	-	1 (7.7%)	1 (2%)
TOTAL	6 (12%)	31 (62%)	13 (26%)	50 (100%)

The table shows that the majority of the respondents (66%) were married and 83.3% of them had low knowledge, 67.7% had medium knowledge while 53.8% had high knowledge.

TABLE 12: RESPONDENTS' KNOWLEDGE IN RELATION TO TRIBE.

(n-50)

TRIBE	KNOWLEDGE			TOTAL
	Low	Medium	High	
Lunda	2 (33.3%)	14 (45.2%)	4 (30.7%)	20 (40%)
Kaonde	2 (33.3%)	6 (19.4%)	4 (30.7%)	12 (24%)
Luvale	-	3 (9.7%)	-	3 (6%)
Tonga	1 (16.6%)	-	1 (7.7%)	2 (4%)
Others	1 (16.6%)	8 (26%)	4 (30.7%)	13 (26%)
TOTAL	6 (12%)	31 (62%)	13 (26%)	50 (100%)

The table shows that 62% of the respondents had medium knowledge and 45.2% of them were Lunda followed 26% other tribes..

TABLE 13: RESPONDENTS' KNOWLEDGE IN RELATION TO DENOMINATION. (n-50)

Christian DENOMINATION	KNOWLEDGE			TOTAL
	Low	Medium	High	
ECZ	1 (16.7%)	6 (19.4%)	3 (23%)	10 (20%)
UCZ	1 (16.7%)	4 (13%)	4 (31%)	9 (18%)
NCC	2 (33.3%)	8 (26%)	1 (7.7%)	11 (22%)
CCC	-	5 (16.1%)	-	5 (10%)
Catholic	-	1 (3.2%)	4 (31%)	5 (10%)
PAOG	2 (33.3%)	7 (22.6%)	1 (7.7%)	10 (20%)
TOTAL	6 (12%)	31 (62%)	13 (26%)	50 (100%)

The table shows that both NCC and PAOG had low knowledge scoring 33.3%, while UCZ and Catholic had high knowledge 31% each.

TABLE 14: RESPONDENTS' KNOWLEDGE IN RELATION TO EDUCATIONAL LEVEL. (n-50)

EDUCATIONAL LEVEL	KNOWLEDGE			TOTAL
	Low	Medium	High	
Basic education	2 (33.3%)	5 (16.1%)	2 (15.4%)	9 (18%)
High secondary school	2 (33.3%)	10 (32.3%)	6 (46.2%)	18 (36%)
College	2 (33.3%)	12 (39%)	5 (38.5%)	19 (38%)
University	-	4 (13%)	-	4 (8%)
TOTAL	6 (12%)	31 (62%)	13 (26%)	50 (100%)

The table demonstrated that 62% of the respondents had medium knowledge though 46.2% of the respondent had high knowledge followed by 39% at college level who had medium knowledge.

TABLE 15: RESPONDENTS' KNOWLEDGE BY EMPLOYMENT STATUS.

EMPLOYMENT STATUS	KNOWLEDGE			TOTAL
	Low	Medium	High	
Unemployed	-	3 (9.7%)	3 (23%)	6 (12%)
Informal employment	3 (50%)	7 (22.6%)	2 (15.4%)	12 (24%)
Formal employment	3 (50%)	21 (67.7%)	8 (61.5%)	32 (64%)
TOTAL	6 (12%)	31 (62%)	13 (26%)	50 (100%)

The majority of the respondents who were in formal employment had medium level of knowledge 67%, while others in the same category had high knowledge 61% and 50% had low knowledge.

TABLE 16: RESPONDENTS' ACCEPTANCE BY AGE.

AGE	ACCEPTANCE		TOTAL
	Unacceptable	Acceptable	
15-24	5 (12.5%)	1 (10%)	6 (12%)
25-34	21 (52.5%)	5 (50%)	26 (52%)
35-44	12 (30%)	3 (30%)	15 (30%)
45-54	1 (2.5%)	1 (10%)	2 (4%)
55-64	1 (2.5%)	-	1 (2%)
TOTAL	40 (80%)	10 (20%)	50 (100%)

The table shows that 80% of the respondents did not accept to use condoms in the prevention of HIV/AIDS with those between 25- 34 age group 52.5%ge group agreed to use the condom.

TABLE 17: RESPONDENTS' ACCEPTANCE BY MARITAL STATUS.

MARITAL STATUS	ACCEPTANCE		TOTAL
	Unacceptable	Acceptable	
Single	10 (25%)	4 (40%)	14 (28%)
Married	28 (70%)	6 (60%)	34 (68%)
Divorced	1 (2.5%)	-	1 (2%)
Widower	1 (2.5%)	-	1 (2%)
TOTAL	40 (80%)	10 (20%)	50 (100%)

The table illustrates that 80% of the respondents did not accept to use condoms as a method of preventing HIV/AIDS amongst whom the married were the majority 70%.

TABLE 18: RESPONDENTS' ACCEPTANCE BY TRIBE.

TRIBE	ACCEPTANCE				TOTAL	
	Unacceptable		Acceptable			
Lunda	16	(40%)	4	(40%)	20	(40%)
Kaonde	10	(25%)	2	(20%)	12	(24%)
Luvale	2	(5%)	1	(10%)	3	(6%)
Tonga	2	(5%)	-		2	(4%)
Others	10	(25%)	3	(30%)	13	(26%)
TOTAL	40	(80%)	10	(20%)	50	(100%)

The table shows that 40% of the Lundas' did not accept condom use. While 30% of the other tribes accepted the use of condom in the prevention of HIV/AIDS.

TABLE 19: RESPONDENTS' ACCEPTANCE BY DENOMINATION.

Christian DENOMINATION	ACCEPTANCE				TOTAL	
	Unacceptable		Acceptable			
ECZ	9	(22.5%)	1	(10%)	10	(20%)
UCZ	6	(15%)	2	(20%)	8	(16%)
NCC	10	(25%)	1	(10%)	11	(22%)
CCC	4	(10%)	1	(10%)	5	(10%)
Catholic	4	(10%)	2	(20%)	6	(12%)
PAOG	7	(17.5%)	3	(30%)	10	(20%)
TOTAL	40	(80%)	10	(20%)	50	(100%)

The table shows that 80% of the respondents did not accept condom use in the prevention of HIV/AIDS. Respondents were from NCC 25% while those from PAOG 30% accepted condom use.

TABLE 20: RESPONDENTS' ACCEPTANCE BY EDUCATION LEVEL.

EDUCATIONAL LEVEL	ACCEPTANCE		TOTAL
	Unacceptable	Acceptable	
Basic education	8 (20%)	1 (10%)	9 (18%)
High secondary school	14 (35%)	2 (20%)	16 (32%)
College	16 (40%)	7 (70%)	23 (43%)
University	2 (5%)	-	2 (4%)
TOTAL	40 (80%)	10 (20%)	50 (100%)

The table shows that 70% of those who have attained college education accept the use of a condom though 40% of the same group does not accept its use in the prevention of HIV/AIDS.

TABLE 21: RESPONDENTS' ACCEPTANCE IN RELATION TO EMPLOYMENT STATUS.

EMPLOYMENT STATUS	ACCEPTANCE		TOTAL
	Unacceptable	Acceptable	
Unemployed	5 (12.5%)	2 (20%)	7 (14%)
Informal employment	10 (25%)	1 (10%)	11 (22%)
Formal employment	25 (62.5%)	7 (70%)	32 (64%)
TOTAL	40 (80%)	10 (20%)	50 (100%)

The table shows that 80% did not accept use of the condom in the prevention of HIV/AIDS with 62.5% of those in formal employment in the same category accepted its use.

TABLE 22: RESPONDENTS' UTILIZATION IN RELATION TO AGE.

AGE	UTILISATION			TOTAL
	Low	Medium	High	
15-24	6 (23%)	-	-	6 (12%)
25-34	9 (34.6%)	11 (84.6%)	5 (45.5%)	25 (50%)
35-44	9 (34.6%)	2 (15.4%)	4 (36.4%)	15 (30%)
45-54	1 (3.8%)	-	2 (18.2%)	3 (6%)
55-64	1 (3.8%)	-	-	1 (2%)
TOTAL	26 (52%)	13 (26%)	11 (22%)	50 (100%)

The table shows that 52% of the respondents are non-users of condoms though respondents in the age range of 25-34 (84.6%) used the condoms sometimes and 45.5% always use condoms.

TABLE 23: RESPONDENTS' UTILIZATION BY MARITAL STATUS

MARITAL STATUS	UTILISATION			TOTAL
	Low	Medium	High	
Single	9 (34.6%)	4 (30.8%)	2 (18.2%)	15 (30%)
Married	16 (61.5%)	9 (69.2%)	8 (72.7%)	33 (66%)
Divorced	1 (3.8%)	-	-	1 (2%)
Widower	-	-	1 (9.1%)	1 (2%)
TOTAL	26 (52%)	13 (26%)	11 (22%)	50 (100%)

The table shows that the majority 33(66%) of the respondents were married with 16 (61.5%) being non-user.

TABLE 24: RESPONDENTS' UTILIZATION BY TRIBE

TRIBE	UTILIISATION			TOTAL
	Low	Medium	High	
Lunda	12 (46.2%)	4 (30.8%)	4 (36.4%)	20 (40%)
Kaonde	9 (34.6%)	2 (15.4%)	1 (9.1%)	12 (24%)
Luvale	1 (3.8%)	1 (7.7%)	1 (9.1%)	3 (6%)
Tonga	1 (3.8%)	1 (7.7%)	-	2 (4%)
Others	3 (11.5%)	5 (38.5%)	5 (45%)	13 (26%)
TOTAL	26 (52%)	13 (26%)	11(22%)	50 (100%)

The table shows that the majority 52% of the respondents were non-users with the Lundas' in majority 46.2%.

TABLE 25: RESPONDENTS' UTILIZATION BY DENOMINATION

DENOMINATION	UTILIZATION			TOTAL
	Low	Medium	High	
E.C.Z	8 (31%)	2 (15.4%)	-	10 (20%)
U.C.Z	4 (15.4%)	1 (7.7%)	3 (27.3%)	8 (16%)
N.C.C.	7 (27%)	2 (15.4%)	2 (18.2%)	11 (22%)
C.C.C.	1 (3.8%)	3 (23%)	1 (9.1%)	5 (10%)
CATHOLIC	1 (3.8%)	2 (15.4%)	3 (27.3%)	6 (42%)
P.A.O.G	5 (19.2%)	3 (23%)	2 (18.2%)	10 (20%)
TOTAL	26(52%)	13 (26%)	11 (22%)	50 (100%)

The table shows that most of the respondents were non-users at 52%, with ECZ 31%, followed by NCC.

TABLE 26: RESPONDENTS' UTILIZATION BY EDUCATIONAL LEVEL.

EDUCATIONAL LEVEL	UTILISATION			TOTAL
	Low	Medium	High	
Basic Education	7 (27%)	1 (7.7%)	1 (9.1%)	9 (18%)
High Sec School	10 (38.5%)	4 (31%)	3 (27.2%)	17 (34%)
College	8 (31%)	7 (54%)	7 (63.6%)	22 (44%)
University	1 (4%)	1 (7.7%)	-	2 (4%)
TOTAL	26 (52%)	13 (26%)	11 (22%)	50 (100%)

The table shows that the respondents who had attained college education always used condoms at 63.6%, they also used condoms sometimes at 54% though the respondents in the high secondary school category were non-users at 38.5%.

TABLE 27: RESPONDENTS' UTILIZATION BY EMPLOYMENT STATUS.

EMPLOYMENT STATUS	UTILISATION			TOTAL
	Low	Medium	High	
Unemployed	6 (23%)	-	1 (9.1%)	7 (14%)
Informal Employment	8 (31%)	1 (7.7%)	4 (36.4%)	13 (26%)
Formal Employment	12 (46.2%)	12 (92.3%)	6 (46.1%)	30 (60%)
TOTAL	26 (52%)	13 (26%)	11 (22%)	50 (100%)

The table shows that 60% of respondents in formal employment with 46% always used condoms. 92% of the same category used condoms sometimes while the same group had respondents who were non-users at 46%.

CHAPTER FIVE

5.0 DISCUSSION AND INTERPRETATION OF FINDINGS

The research study was done to determine the Factors influencing acceptance and utilization of condoms among christian men in the prevention of HIV/AIDS in Mwinilunga. This topic was chosen with a view of establishing the extent to which faith-based organizations are involved in the dissemination of information about HIV/AIDS prevention by encouraging condom use among their members

The sample consisted of 50 respondents and these were sampled conveniently. The denominations where these respondents were sampled came from churches with large populations and were basically drawn from a health center with a largest population coverage population in the district.

The study came up with significant findings on acceptance and utilization of condoms among Christian men and the factors associated to these variables.

5.1 CHARACTERISTICS OF THE SAMPLE

The study subjects were men in the childbearing age of 15 to 49 with an exception of one respondent who volunteered to participate since he insisted that his contributions to the study would of great help aged was 54. The majority was aged by between 25-34 (50%). The majority of the respondents were married (66%), 40% were Lunda while those of the other tribes that participated in the study, 46%, which was the majority, were Bemba. The majority of the respondents were from New Covenant Church, while the Catholic Church represented 12 %. This could be attributed to the fact that marriage is universal in Zambia and people marry at any age some times as early as 16 years and the proportion of child bearing may well extend over 50 years in men (Nsemukila, et al, 1998).

The majority of the respondents 23(46%) had attained college level of education and were in formal employment 23(46% figure 6). This may be attributed to some cultural practices where families may opt to marry off their daughters instead of

sending her to school. They would rather send their sons to school whatever the cost. Therefore it is not surprising that the same son who was empowered with the education would easily find formal employment.

5.2 MEN'S KNOWLEDGE ON CONDOMS.

The findings on men's knowledge on condoms revealed that all the respondents had heard of the word condom, with 94% of them knowing that a condom meant a sheath used to protect one self from contracting STI/HIV/AIDS (figure 9). 94% of the respondents knew where to get a condom in Mwinilunga and 90% of them knew that condoms were readily available in Mwinilunga (figures 10 and 11 respectively). This could mean that extensive health education campaign has been done through pamphlets in local languages, Radio 1 on ZNBC on Sister Evelyn's programmes in local languages as well as the efforts of local health center staff.

Amongst the respondents, 62% stated that condoms should be readily available and of these respondents the majority 36% did not want to share the reasons for agreeing to have the condoms readily available. On average majority of the respondents had medium knowledge on condoms while 12% had low knowledge. This data collerates with information from the ZDHS report of 2002, which indicates that in Zambia 83% of the men with various levels of education, knew the source for male condoms, in a study population of 2,145 men in the 9 provinces.

5.3 MEN'S ACCEPTANCE OF CONDOM

In terms of acceptance of condom use, the majority 26(52%) of the respondents condemned the use of condoms with 18(36%) not agreeing to its usage as method of preventing HIV/AIDS (figure 15). Of the respondents who did not agree to the use of condom, 54% did not want to state reasons for its none use (figure 17). Apart from that, the majority 35(70% - figure 18) of the respondents did not encourage the use of condom in the prevention of HIV/AIDS because 38% (figure 19) of them felt that the practice encourages sexual immorality. This may mean that christian men in this study want to base their conduct on christian

principles of abstinence before and being faithful and sticking to their sexual partner in marriage.

Apart from that, 74% (figure 20) of the respondents stated that their denominations do not discuss issues of condom use because the majority 40% (figure 21) of the churches strongly condemn condom use. Most of the respondents 88% (figure 22) did not have cultural beliefs regarding condom use but the majority 78% (figure 24) of the respondents would not want to participate in the prevention of HIV/AIDS as christian men while 30% felt it promotes prostitution (figure 25). On average, 80% of the men did not accept to use condoms as a method of preventing HIV/AIDS (figure 26). However, this view is not shared with the rest of the men because ZDHS 2002, indicates that 72.2 % of the Zambian men think that they themselves could get a male condom and use it in the prevention of HIV/AIDS. This could be attributed to the fact that the study cited was done among men from the secular world, not taking christianity into consideration.

5.4 MEN'S UTILIZATION OF CONDOMS

In reference to utilization, the majority of the men 56% (table 1) had used a condom before with 64% of them using it sometimes (table 2). Of those who did not use a condom the majority 55% felt that religion does not allow (table 3), while for those who had used a condom the majority 54% couples were the ones who made the decision to use a condom (table 4). 50% of the respondents usually discussed issues of condom use as a couple (table 5). The majority 70% of the respondents thought that as christian couples or individuals should not be used as a method of preventing HIV/AIDS (table 6). This was attributed to 2 views which stated that married couples should stick to their partners faithfully 20% while the other view was that religion did not allow 20% (table 7). This may be a reflection of the fact that, in the Christian teachings, couples are encouraged to communicate in all aspects of their daily living in such programmes as 'Marriage Encounter or Couples Meetings.' Therefore it is not surprising to find couples discussing issues of condom use, when or when not to use a condom.

On the other hand, the other responses stated that condoms could be used to prevent HIV/AIDS as well as prevent pregnancy 40% (table 8). On average, the majority 52% of the men did not use condoms while 22% utilized condoms. This is quite consistent with survey by ZDHS, 2002, which indicates that overall, condom use is as low 19% among men in Zambia. This could be attributed to the fact that condoms have been said to interfere with sexual pleasure as alluded to by such comments as "it is like eating a sweet with a wrapper on". In addition, culturally, men are the ones to choose when to abstain, use a condom or not, for whatever reason.

5.5 CROSS TABULATIONS OF KNOWLEDGE, ACCEPTANCE AND UTILIZATION IN RELATION TO DEMOGRAPHIC CHARACTERISTICS

Most of the respondents who had medium level of knowledge 62% were aged between 25-34 years. The only 56 years old man was amongst those who had low knowledge. The majority of the respondents 66% who were married had low knowledge though some of them had medium knowledge 67.7% as well as high knowledge 53.8% (table 11). This can be attributed to the fact that the age group of 25-34 would have completed secondary school and college levels of education. They are also mostly in formal employment and they are also exposed to a lot of information education and communication materials on HIV/AIDS issues.

The study reflected that of the respondents who had medium knowledge 62%, the Lundas' had the highest representation at 45% (table 12). In terms of knowledge in relation to denomination, the majority of the respondents had medium level of knowledge though NCC and PAOG had the lowest level of knowledge at 33% (table 13). This could be because the study was conducted in a predominantly Lunda speaking area. In relation to denomination, it may mean that New Covenant Church (NCC) and Pentecostal Assemblies of God (PAOG) do not teach or discuss openly HIV/AIDS issues.

The majority of the respondents who had high knowledge in relation to educational level were those who had attained secondary education with 46%.

The majority of the respondents had medium level of knowledge scored 67.7% belonged to those who were in formal employment. This group had respondents who had high level of knowledge 61.5% (table 15). This may also be due to the fact the high level of education enabled the respondent to have access to IEC materials on HIV/AIDS.

The study also found that most of the respondents 80% who did not accept the use of a condom in the prevention of HIV/AIDS, 52.5% were aged between 25-34 (table 16). This age group collerates with the Zambian norm of having individuals marry before 34. This is also the group, which is educated and can therefore make informed choices and decisions about HIV/AIDS and condom use issues.

Acceptance of condom use by marital status indicated that the married men 70% did not accept condom use. However, the same group had a high score for accepting to use condoms for HIV/AIDS prevention (table 17). This information tallies with another study conducted in Kawambwa, which indicated that most of the married couples did not agree to condom use in the prevention and control of HIV/AIDS (Mumba, 1999). These respondents do not want to use condoms because they want to live by christian principles of being faithful and sticking to their sexual partners. But they did agree that condoms could be used by discordant couples.

In addition, the study found that of the 80% of the respondents who did not accept condom use were from NCC with 25% (table 19). This could be attributed to the fact that HIV/AIDS issues are discussed openly therefore the members may be reluctant to accept condom use.

In relation to educational level, the majority of respondents (70%) who had attained college education were more likely to accept condom use as well as not accept condom use as reflected by the 40% amongst those who did not accept condom use (table 20). Acceptance in relation to employment status, the study indicated that the majority of those who did not accept condom use 62% were those in formal employment and the same category had the highest score 70% in terms accepting to use condoms (table 21). This may be attributed to the fact that there is a positive relationship between the level of education and being in formal

employment such the respondents in this two categories are both more exposed to IEC materials through the various channel of the media. Therefore, they are most likely to make informed choices and decisions.

In terms of utilization by age, the majority of the respondents 11 (84.6%) used condoms sometimes were in the group of those aged between 25-34 and the same category always used condoms 5(45.5%) though condom utilization among all the age groups is low 26(52% - table 22). Apart from that, statistics of utilization by marital status indicate that the respondents who were married were the majority of the respondents with 8(72.7%) who always used condoms, 9(69%) using condoms sometimes while 16(61.5%) being non-users (table 23). Among married christian men, the study findings found out that 16(61.5%) were not utilizing condoms. This meant that they were being faithful and sticking to their partners as per biblical teaching. 9(69%) were sometimes using condoms which may mean that they were using condoms as a form of contraceptive or as a form of protection from STI/HIV/AIDS when they "strayed." Those who were always using condoms (as well as married) 8(72.7%) could have known their HIV status or were discordant couples.

Moreover, the study also found that the majority of the respondents who did not use condoms were Lunda 46.2% while the other tribes 45% utilized condoms (table 24). There is no significant difference in the condom utilization between the Lundas', the predominant tribe and other tribes.

Utilization in relation to denomination revealed that the majority of the respondents Evangelical Church of Zambia (ECZ) 8(31%) were amongst the overall non-users of condoms (table 25). Most respondents in the category of having attained college education 7(63.7%) always used condoms, they also used condoms sometimes 7(57%) though the respondents in the high secondary school category were non-users (table 26). This may be due to the fact that these are single christian men who are practicing biblical principles of abstinence.

The study also found that respondents in the formal employment in relation to utilization had the majority of those who used condoms sometimes 12(92%), non-users 12(46.2%) and are always using condoms 6(46.1% - table 27). Those

in the formal employment category are those who are enlightened and are therefore able to make informed choices of whether to use condoms or not depending on their HIV status.

5.6 KNOWLEDGE, ACCEPTANCE AND UTILIZATION

The study has found that the majority of the respondents 31(62%) had adequate or medium level of knowledge, 13(26%) had high level of knowledge while 6(12%) had low knowledge. It also true to state that the study found that the majority of the respondents 40(80%) would not use condoms as a method of preventing HIV/AIDS while only 10(20%) were willing to use condoms. In addition, the study revealed that condom utilization was low 11(22%) as compared to non-utilization at 26(52%). The study found an association between knowledge and acceptance and utilization of condoms in the prevention of HIV/AIDS. In that, respondents were able to make informed choices and decisions of either accepting or not accepting condom use; and or utilizing or not utilizing condoms in the prevention of AIDS/HIV. It was like the more enlightened the men were about condom use the less likely they were to accept or utilize the condoms as method of preventing HIV/AIDS.

In this study most of the respondents condemned the use of condoms and they were not for the idea that condoms be advertised as part of the solution to the prevention and control of HIV/AIDS. Majority of the respondents was basically saying condoms were meant for non-believers who needed them for their promiscuous conduct. This is in line with the overall attitude of the church at the onset of the HIV/AIDS pandemic which general looked at HIV/AIDS as a disease of sinners. Hence, churches slow entry into the fight against HI/AIDS campaign.

The study also revealed that the age group of 25-34 was the majority 21(52%), in not accepting the use of condoms among these were married men 28(70%). This therefore means that the two hypotheses which state that "younger men are more likely to accept condom use than older men" and "married men are more likely to use than single men", have been rejected. While the findings have failed reject the third hypothesis which states that "the more the faith based

organization advocate for condom use in the prevention of HIV/AIDS, the more likely that condoms will be accepted and utilized by christian men."

However few of the respondents felt that the reason why there was such a negative attitude was that the church was divided as well and silent about the condom use in relation to the prevention of HIV/AIDS. The respondents in the FGD felt that people leading these churches should be brought together to address this issue since they were more in the position of influencing others into taking affirmative actions.

From these findings, the majority of the respondents were aged between 25-34 years with moderate level of knowledge due to their level of education and being in formal employment. In addition, this enabled the respondents to make informed choices and decisions about accepting or not accepting condom use; and or utilizing condoms. In this regard, the findings indicate that the level of acceptance was as low as 20% while that of utilization was as low as 22%. The basis of the low utilization and acceptance are derived from the christian principles of being faithful and sticking to one sexual partner, using condoms as contraceptives and only using them as a preventive measure if couples are discordant. Singles simply abstain.

5.7 IMPLICATIONS FOR THE HEALTH CARE SYSTEM.

The study results showed that most of the men had adequate knowledge 31(62%) about condoms. Despite the knowledge, acceptance and utilization of condoms amongst christian men was low. As a result, most of them did not seek to collect or buy condoms from the health facilities or buy them from the local stores. Singles resorted to abstaining while the married men resorted to sticking to their sexual partners.

It was quite evident from the study, that the respondents were well informed about condoms from the various sources of information but that did not influence the level of acceptance and utilization amongst the christian men.

Therefore, there was need for the health professionals to consider creating opportunities to talk about condom use amongst the married christian couples or the younger men on the right kind of supportive environment. There was also need to engage the christian leaders in conversation at national level to realistically and openly discuss issues of condom acceptance because the deaths from HIV/AIDS included those who belonged to faith based organizations. It was also important to include Christian women in these discussions as the study revealed that the decision to use condoms was largely made on agreement as a couple (51%).

The challenges to the health care system is to review IEC strategies and create new ones that are client oriented in the dissemination of information on condom use. This can be achieved by involving the faith based organization in the development of these educational materials to help come up with the right kind of information tailored to meet the requirements of their followers. There is also need to have these denominations address the issues of condom use in the right fora like couples fellowships or youth meetings guided by the influential members of the church such as the Pastor or Reverends.

5.8 PLAN FOR DISSEMINATION OF FINDINGS

Dissemination of findings is the process through which research findings are circulated to the other researchers and the public.

The findings from this study will be disseminated by having copies of the proposal given to the district health office, medical library, developing an article which will be part of upcoming research abstracts, or nursing research journals. In addition, the investigator intends to take advantage of any workshops to be held in the district to discuss research findings as well as other religions large gathering particularly for Christian leaders conferences.

CHAPTER SIX

6.0 CONCLUSION, LIMITATIONS AND RECOMMENDATIONS

6.1 CONCLUSION

The evaluation of acceptance and utilization of condoms among christian men in Mwinilunga in the prevention of HIV/AIDS revealed that all the men had heard of the word condom and knew that it meant a sheath that prevents the transmission of STI/HIV/AIDS. However, due to the various reasons the level of acceptance was as low as 20% while the level of utilization was as low as 22%. The study also revealed that despite the moderate level of knowledge 62%, this did not have an impact on the level of acceptance and utilization of condom use.

This implies that there was need for dialogue between the health professionals the church leadership at all levels. Unless something is done, the general populace in the church pews will die unless the church comes up with bold and decisive preventive measures in the fight against HIV/AIDS.

6.2 LIMITATIONS OF THE STUDY

- The major limitation of the study was that it was done along side with other courses during the academic year.
- The lack of adequate funding made it impossible for the researcher to collect data from other health centres in the outskirts of the district.
- The funding for the research project could only allow few respondents to be sampled, which made generalization of findings difficult.

6.3 RECOMMENDATIONS

On the basis of the finding of this study, the following recommendations have been made for the health centers and MOH.

6.3.1 HEALTH CENTRES

- I. The health care providers to review the IEC strategies and programmes as the christian community may appear to be 'a hard to reach group', particularly the men.
- II. The health care providers need to be trained in the communication skills to enable them be more sensitive to their clients and be able to accurately articulate issues and then communicate to this group of clients.
- III. Issues of condom use and HIV/AIDS to be discussed at predominantly male service organizations including such places as recreation clubs and bars.

6.3.2 MINISTRY OF HEALTH

- I. Deliberate policies should be put in place have some clergymen be part of the facilitation body of HIV/AIDS seminars or workshops so that their experiences could be shared.
- II. Ministry of Health to dialogue with faith based organizations in order to come with measures of preventing HIV/AIDS.
- III. The ministry of health needs to collaborate with other faith based organization mother bodies like Church Health Association of Zambia (CHAZ), Christian Council of Zambia, etc when developing policies or IEC materials in regard to prevention of HIV/AIDS especially that which has focus on condom use.

IV. A community-based research needs to be done at a large scale on "acceptance and utilization of condoms among christian men in Mwinilunga in the prevention of HIV/AIDS."

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APPENDIX I

**THE UNIVERSITY OF ZAMBIA
SCHOOL OF MEDICINE**

DEPARTMENT OF POST BASIC NURSING

INTERVIEW SCHEDULE FOR CHRISTIAN MEN

Date: _____

Center: _____

Serial Number: _____

Identifier No: _____

INSTRUCTIONS FOR THE INTERVIEW

1. Introduce yourself to the respondents before starting the interview.
2. Explain the purpose of the interview and ask for permission to interview the participants.
3. Participants should not be forced to be interviewed
4. Do not write respondents names on the interview schedule.
5. Assure anonymity and all information should be kept confidential.
6. Tick or Write responses in the space provided.
7. Please ask all questions.
8. Thank the respondents at the end of each interview.

SECTION A: DEMOGRAPHIC CHARACTERISTICS

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1. How old were you on your last bvg birthday? _____

2. What is your marital status?

(a) Single

(b) Married

(c) Divorced

(d) Widowed

3. What is your tribe?

(a) Lunda

(b) Kaonde

(c) Luvale

(d) Luchazi

(e) Tonga

(f) Other (specify) _____

4. What is your Christian denomination?

(a) CMML

(b) UCZ

(c) NCC

(d) CCC

(e) Catholic

(f) Others (specify) _____

5. What is your highest educational level?

(a) Never been to school

(b) Basic education

(c) High secondary education

(d) College

(e) University

(f) Any other (specify) _____

6. What is your occupation?

(a) Unemployed

(b) Informal employment

(c) Formal employment

--

SECTION B: DATA ON KNOWLEDGE

7. Have you heard of the word 'condom'?

(a) Yes

(b) No

--

8. What does a condom mean to you?

(a) Sheath used to protect STIs including
HIV/AIDS

(b) Interference of sexual pleasure

(c) Impotence

(d) No idea

--

--

9. Do you know where you can get condoms in Mwinilunga?

(a) Yes

(b) No

--

10. If "Yes" to question 9, how available are the condom?

(a) Readily available

(b) Rarely available

(c) Not available

(d) Non applicable

--

11. Do you think that condoms should be readily available?

(a) Yes

(b) No

--

12. If the answer to question 11 is "Yes" kindly explain.

13. What is your attitude towards the use of condoms?

14. Would you use condoms as a method of preventing HIV/AIDS?

(a) Yes

(b) No

15. If the answer to question 14 is "No", give reasons?

16. Do you think condom use should be encouraged?

(a) Yes

(b) No

17. If the answer to question 16 is "No", give reasons.

18. Does your denomination teach or discuss issues on allowing
Condom use as a mode of HIV/AIDS prevention?

(a) Yes

(b) No

19. What exactly does your denomination say about condom use?
In relation to HIV/AIDS prevention?

(a) Strongly condemns condom use

(b) It promotes promiscuity

(c) It supports condom use in the prevention
of HIV/AIDS

(d) Condoms can be used for contraception only

(e) Not applicable

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20. If not applicable, kindly explain.

21. Do you have any cultural beliefs regarding condom use?

(a) Yes

(b) No

22. If "Yes" to question 21, please give reasons.

23. As a Christian man do you think you should participate in the prevention of HIV/AIDS by utilizing a condom?

(a) Yes

(b) No

24. If "Yes" or "No" to the above question kindly explain.

SECTION D: CONDOM UTILISATION

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25. Have you ever used a condom?

- (a) Yes
- (b) No

26. If "Yes" to question 25, how often?

- (a) Sometimes
- (b) Always
- (c) Never
- (d) Any other (specify) _____

27. If "No" to question 25, what are the reasons for not using a condom?

- (a) Did not know about it
- (b) Want to have more children
- (c) Religion does not allow
- (d) Traditional does not allow
- (e) I do not approve
- (f) Any other (specify) _____

28. If "Yes" to question 25, whose decision is that you use a condom?

- (a) Myself
- (b) Wife
- (c) Couple
- (d) Health care provider
- (e) Any other (specify) _____

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29. Do you discuss condom use with your partner?

(a) Yes

(b) No

30. Is your partner in favor of condom use?

(a) Yes

(b) No

(c) Not applicable

31. If not applicable in question 30, kindly give reasons.

32. Do you think Christian couples or individuals should use condoms in the prevention of HIV/AIDS?

(a) Yes

(b) No

33. If "No" to question 32, kindly explain.

34. If "Yes" to question 33, kindly explain.

THANK YOU FOR PARTICIPATING IN THE STUDY

THE UNIVERSITY OF ZAMBIA
SCHOOL OF MEDICINE

DEPARTMENT OF POST BASIC NURSING

FOCUS GROUP DISCUSSION GUIDE

Target: _____

Number in the group: _____

Date: _____

Place: _____

1. Have you ever heard of condom?
2. What is a condom?
3. Do you think condoms should be used in HIV/AIDS prevention?
4. In your own opinion do you consider condom use in the prevention of HIV/AIDS to be compatible with Christian teaching or principles?
5. Are there cases of pregnancies, fornication or adultery in the church? If yes, how does the church deal with such cases?

Thank you for participating in the study

APPENDIX III: WORK SCHEDULE

	TASK TO BE PERFORMED	DATES	RESPONDENTS PERSON	PERSON REQUIRED	DAYS
1.	Literature review	Continuous	Researcher		
2.	Finalizing research proposal	24 th May – 27 th Aug. 2004	Researcher		97 days
3.	Data collection tool	24 th May – 27 th Aug. 2004	Researcher		97 days
4.	Clearance from National and Funding Authorities	30 th Aug. 5 th Sept. 2004	PBN supervisor, Ethical Committee for Research		7 days
5.	Conducting pilot study	6 th Sept. 12 th Sept. 2004	Researcher		7 days
6.	Amendment of data collection tool	13 th Sept. – 19 th Sept. 2004	Researcher		14 days
7.	Data collection (actual study)	20 th Sept. 3 rd Oct. 2004	Researcher and Assistant		28 days
8.	Data analysis	4 th Oct. – 31 st Oct. 2004	Researcher/ Statistician		28 days
9.	Report writing	1 st Nov. 28 th Nov. 2004	Researcher		14 days
10.	Draft report to PBN	29 th Nov. 12 th Dec. 2004	Researcher		28 days
11.	Finalizing of report	13 th Dec. – 9 th Jan. 2004	Researcher		29 days
12.	Handing in report	10 Jan 2005	Researcher		
12.	Monitoring and evaluation	Continuous	Researcher/supervisor		

APPENDIX IV: Gantt chart

	task to be performed	Responsible person	May	Jun	July	AUG	SEPT	OCT	NOV	DEC	JAN
1.	Literature review	Researcher	←							→	
2.	Finalizing research proposal	Researcher	←			→					
3.	Data collection tool	Researcher	←			→					
4.	Clearance from National and Funding Authorities	Supervisor				↔					
5.	Conducting pilot study	Researcher					↔				
6.	Amendment of data collection tool	Researcher					↔				
7.	Data collection (actual study)	Research team					↔				
8.	Data analysis	Researcher						↔			
9.	Report writing	Researcher							↔		
10.	Draft report to PBN	Researcher								↔	
11.	Finalizing of report	Researcher									↔
12.	Monitoring and evaluation	Researcher	←								→

APPENDIX V:

RESEARCH BUDGET

BUDGET CATEGORY	UNIT COST (K)	QUANTITY	TOTAL
STATIONERY			
(a) Bond paper	27,000.00	4	108,000.00
(b) Pens	500.00	10	5,000.00
(c) Rubbers	500.00	2	1,000.00
(d) Pencils	500.00	10	5,000.00
(e) Notebooks	500.00	4	2,000.00
(f) Tipex	8,000.00	2	16,000.00
(g) Stapler	25,000.00	1	25,000.00
(h) Staples	5,000.00	2 boxes	10,000.00
(i) Files	5,000.00	2	10,000.00
(j) Scientific calculator	60,000.00	1	60,000.00
(k) Flip chart	20,000.00	2	40,000.00
(l) Markers	5,000.00	4	20,000.00
(m) Tape recorder	250,000.00	1	250,000.00
(n) Audio tapes	10,000.00	2	20,000.00
SUBTOTAL			572,000.00
PERSONNEL			
(a) Lunch allowance			
(i) Researcher	50,000.00	10 days	500,000.00
(ii) Research Assistants	50,000.00	5 x 10 days	250,000.00
(iii) Statistician	50,000	4 days	200,000.00
(b) Transport		10 days	
(i) Research Team	10,000.00	55	550,000.00
(c) Other allowances	10,000.00	respondent s	
SUBTOTAL			3,850,000.00
SECRETARIAL SERVICES			
(a) Diskettes	3,000.00	2	6,000.00
(b) Bag for stationery	25,000.00	2	50,000.00

(c)	Questionnaire	2,000.00	6	12,000.00
(d)	Questionnaire	200.00	420 pages	84,000.00
	photocopying	2,000.00	100 pages	200,000.00
(e)	Research report writing	200.00	500 pages	100,000.00
(f)	Research report			
	photocopying	80,000.00	1	80,000.00
(g)	Typing and binding			
	proposal	150,000.00	5	750,000.00
(h)	Binding report			
SUBTOTAL				1,282,000.00
TOTAL				5,704,000.00
CONTINGENCY 10%				570,400.00
GRAND TOTAL				6,274,400.00

RESEARCH BUDGET JUSTIFICATION

A research study requires many items, some of which are as follows

1. STATIONERY

Stationery is required for typing research proposal, writing research report as well as typing and printing the report. In addition, questionnaires will be produced for the exercise. Notebooks will be for all documentation during data collection and analysis, while the diskettes will be used for storage of all the data.

The scientific calculator will be needed for data analysis while the tape recorder will be used to record the focus group discussions or individual interviews of church leaders with a big population of church members. Stapler and staples will be needed for securing the

questionnaires, typex for corrections of questionnaires during the data analysis period and files for keeping all documents. Markers and flip charts will be for data analysis before computing.

2. PERSONNEL

Lunch allowance for the investigator and research assistants for 10 days of data collection will be required. Transport money will be needed for movements to and from the data collection points. Other allowances will be used as part of allowance for the respondents so that they are motivated in participating fully in the interviews as well as being a token of appreciation.

3. SECRETARIAL SERVICES

The investigator will pay for all the typing, printing and photocopying services, and will use the bags for carrying questionnaires. Money will be needed for building research proposal and report.

CONTINGENCY

The ten percent (10%) contingency is necessary to cover all of the unforeseen circumstances during the research and is calculated from the total budget.

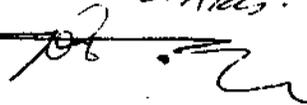
P. O. Box 160003
MWINILUNGA

17th August, 2004

The District Director of Health
Mwinilunga District Health Board
P. O. Box 160003
MWINILUNGA

Republic of Zambia Mwinilunga District Health Board
01 SEP 2004
District Director of Health P.O. Box 160003, Mwinilunga

*I have no objection
I hope that you yourself
should talk to individual
Church leaders in order
for them to appreciate
your research study on the
HIV and Aids.*



UFS: The Head of Department
Post Basic Nursing
School of Medicine
P. O. Box 50110
LUSAKA

Dear Sir/Madam,

Re: PERMISSION TO CONDUCT A RESEARCH STUDY IN THE CHURCHES

I am a fourth year student in the School of Medicine, Department of Post Basic Nursing of the University of Zambia undertaking a B.Sc. degree in Nursing. As part of the fulfillment to complete the training, I am required to conduct a research study.

My topic of study is **"Acceptance and Utilization of Condoms in the Prevention of HIV/AIDS among Christian Men in Mwinilunga"**.

In this respect, I seek permission to collect data and conduct the research in the Christian churches in the district catchment area (Kanyihampa Rural Health Centre catchment area).

Your assistance in the matter will be highly appreciated.

Yours faithfully,

Mulenga H. M. Lupili
Mulenga H. M. Lupili

- c.c. In-Charge, Kanyihampa Health Centre ✓
- c.c. Church Leader of Pastor

2004

No objection to
Study as it will go
the office a baseline
the acceptance & Utilization
of Condoms. *Handwritten signature*

APPENDIX VII

P. O. Box 160003
MWINILUNGA

17th August, 2004

The District Commissioner
Mwinilunga District
P. O. Box 3610001
MWINILUNGA

Handwritten signature

IFS: The Head of Department
Post Basic Nursing
School of Medicine
P. O. Box 50110
LUSAKA

Dear Sir/Madam,

Re: PERMISSION TO CONDUCT A RESEARCH STUDY IN YOUR CHURCHES

I am a fourth year student in the School of Medicine, Department of Post Basic Nursing of University of Zambia undertaking a B.Sc. degree in Nursing. As part of the fulfillment to complete the training, I am required to conduct a research study. My topic of study is **"Acceptance and Utilization of Condoms in the Prevention of HIV/AIDS among Christian Men in Mwinilunga"**.

In this respect, I seek permission to collect data and conduct the research in the Christian churches in the district.

Your assistance in the matter will be highly appreciated.

Yours faithfully,

Handwritten signature

Julenga H. M. Lupili

*Property of UNZA Library



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