CHAPTER ONE
INTRODUCTION AND BACKGROUND TO THE STUDY

1.0 Introduction

The reduction of individual risk usually focuses on the individual and his/her behavior. A Copperbelt Health Education Project (CHEP) Newsletter, reviewed the experience of school-based Anti AIDS clubs in Zambia and it stated that given the inability of integrating the teaching of HIV/ AIDS prevention in the curriculum, Anti AIDS clubs have sprung up to fill this gap. Basic and High school teachers and pupils are organizing and facilitating anti AIDS clubs on a voluntary basis. These clubs educate children in basic life skills that place emphasis on healthy norms, values, attitudes and knowledge sometimes even before they engage in risky sexual behavior. In so doing, Anti AIDS clubs strive to combat serious diseases, such as HIV/AIDS, by furnishing the youths with an understanding of the dangers of the disease and helping them make informed decisions with regard to these issues, (p. 32).

In spite of the negative news we hear every day about the spread of the disease especially in Southern Africa, where the majority of new cases are reported in the world, the good news is that community and general perceptions are increasing and this includes more and more people being sensitized (Kiirya, 2004). Life skill approaches to HIV/AIDS education looks at the development of individuals, their ability to think critically, build up self-respect, as well as respect for their peers, and plan for their future. Regarding the question of whether psychosocial abilities are the life skills that help people think, feel, act and interact as individuals and members of society, Anna Maria Hoffman, Program Specialist with UNESCO Division for the Promotion of Quality Education argues that well implemented life skills approaches to HIV/AIDS and education can reduce risk by delaying the age of first sex,

increase condom use, reduce the number of sexual partners, promote early treatment of STDs, promote access to voluntary and confidential counseling and testing, as to reduce other forms of risky behavior, (2008, p. 167).

This study explores whether school going adolescents that are actively involved in HIV/AIDS activities, are able to refrain from Risky sexual behavior, this being unprotected sex. It further investigates whether these pupils are able to disseminate the HIV/AIDS message and influence their peers positively. HIV infection must be approached by action to reduce individual risk, and on the other hand, tackle the broader contextual, environmental and social factors that make adolescents vulnerable.

1.1 Background of the Study

HIV is seen as a threat to the stability of entire nations and regions because it is affecting the most productive members of the society. While HIV and AIDS has become a global phenomenon, the disease has still been most pronounced in developing countries particularly Sub-Saharan Africa. The focus of this study was to explore the effects that come about when adolescents are involved in HIV/AIDS activities. Having interacted with adolescents as an HIV/AIDS activist, this researcher wondered why adolescents were still getting pregnant and reported new infections amongst them still prevalent. This was an indication that they were indulging in unprotected sex, despite the vast sensitization country wide. This researcher also wanted to find out whether those that were actively involved in the Anti-AIDS Club were able to influence their peers or not. There was also a question as to whether they were considered as role models by their peers.

According to Agyei-Mensah (2001) the spread of the disease has reached pandemic proportions in most parts of the African continent. The report states that the numbers of people infected with HIV keeps on increasing particularly among the young people, (p. 68). The first HIV/AIDS case was reported in Zambia in 1985. Initially, the epidemic of HIV and AIDS cases was in the urban areas, but it soon became clear that all parts of the country are affected. According to the Zambia Demographic and Health survey of 2002 and 2007, the adult HIV prevalence decreased slightly in 2001-2002 ZDHS and the 2007 ZDHS, from 16 to 14 percent, respectively. In terms of gender, the prevalence rates are markedly higher in adolescent females than in the males in all provinces. According to a UNAIDS report (2002), "AIDS has killed more than 700 000 adults and children and estimates that another 1.6 million Zambians will die by 2014, if this trend is allowed to continue".

Table 1: Trends in HIV prevalence by age adapted from the Zambia Demographic and Sexual Survey (2007)

Age Range	**ZDHS 2001-2002 HIV+**	**ZDHS 2007 HIV+**	**ZDHS 2001-2002 HIV+**	**ZDHS 2007 HIV+**	**ZDHS 2001-2002 HIV+**	**ZDHS 2007 HIV+**
15-19	**FEMALES**	**FEMALES**	**MALES**	**MALES**	**TOTAL**	**TOTAL**
	6.6%	5.7%	1.9%	3.6%	4.6%	4.7%
20-24	19.3%	11.8%	4.4%	5.6%	11.4%	8.7%

The study conducted by Kiirya (2004, p 106), in Uganda, suggests that "HIV-risk sexual behaviors vary with sex, age, residence, educational status of adolescents". The study further discovered that the married female adolescents, those living in the rural area and the least educated were the groups that exhibited significantly higher levels of most of the HIV-risk

sexual behaviors. This study also found that cultural beliefs that stated that delayed sexual intercourse could lead to loss of sexual potency forced adolescents in these societies to indulge in sexual intercourse, for fear of the belief. Kiirya further states that most "societies discriminate those that delay in sex and this leads to promotion in early indulgence in sexual intercourse (p. 97)".

From studies in Kenya by NACC (2002) and UNAIDS (2004), have argued that females are thought to be more vulnerable to unwanted sex than males because of norms that encourage an unequal power balance between the two groups. Stepp, (2005) postulated that adolescents constituted a significant portion of those affected by HIV/AIDS and their risk level was compounded by the fact that this stage is characterized by intense sexual drive and experimentation with sex without protection and lack of frank discussion of sexual issues with them by adults, because of social cultural factors. A 2008 Guttmacher Institute study conducted among American adolescents, aged between 15 -19 years, discovered that adolescents engaged in vaginal sex and that the prevalence of both vaginal and oral sex among them has remained steady over the past decade. A study in the United States, by Ryan, et al (2003), on adolescents and sexuality, found that "most adolescents were still sexually active and may behave in ways that may put them at risk for sexually transmitted diseases and HIV (p. 163)".

A longitudinal study on American and Nigerian adolescents' sexual behavior, by Roscoe and Kruger (2002), found that as a result of being afraid of being infected by HIV and its health complications, adolescents intended to or have made changes in their sexual behaviors and reported lower engagement in unsafe sexual behavior. From a survey by Toroitich-Ruto (2000), it was found that HIV/AIDS infection among Kenyan adolescents came about almost entirely by sexual intercourse. In this study, most teenagers reported having had sexual

intercourse and most teenage girls had been coerced or forced into first intercourse. Additionally, most of them had had unprotected sexual intercourse and with multiple partners. This study further found that 44 percent of the male adolescents felt that one was at no risk of getting AIDS and 36 percent thought that the risk of getting HIV/AIDS was small if one stopped having sexual intercourse. Only 3 percent thought that chances of getting AIDS were moderate and great respectively if one stopped sex completely. This study further found that on its respondents, 23 percent of the males and females said that starting to use condoms provided no risk of getting AIDS, while 28 percent of males and 32 percent of the females thought that having only one sexual partner provided no risk of getting AIDS. Further 21 percent of adolescent males and 24 percent of females said that reducing the number of one's sexual partners gave no risk of getting AIDS. However, 0.7 percent of the males and 6 percent of the females thought that there was a great risk of getting AIDS if one did not change behavior. These findings show that the relationship between perceived risk and reported behavioral change was rather weak. Those who said that they felt little or no personal risk of HIV infection were almost as likely to report a modification of behavior as those who feel at high risk. One possible reason was that respondents who had changed their behavior reported little or no risk.

Surveys in Botswana, Zimbabwe, Namibia and Zambia, conducted by UNICEF of 2006 and the recent Zambia Demographic and Sexual Survey (2007), found that young girls, between 19 and 24, were often preferred by older men who believed that unprotected sex was less likely to lead to infection, and that sexual intercourse with a virgin would cure a sexually transmitted disease, including AIDS. The Namibian Knowledge, Attitudes, Practice and Behavior survey, conducted by UNICEF in 2007, among adolescent students, discovered that "male and female respondents showed much the same risk profile with regard to the five most

common risk activities: multiple sexual partners, sex with an unfaithful partner, sex with someone much older, sex against one's will and possibly having a STI (pp. 87-88)". However, there were some significant differences between the types of sexual risks taken by males and females. The study found that males were more likely to be put at risk by means of their direct actions, whereas females were put at risk through the actions of their partners.

Rising's (2003), study in Zambia, revealed that adolescents started having sexual relationships at an early age and that they had these sexual relationships mainly to get sexual experience. In this study, however, many of the students interviewed believed in the idea of no sex before marriage. This study was conducted on the Copperbelt and Northern Provinces, and it was discovered that girls seemed to leave the decision whether to have sex or not to the boys. The majority of the girls thought that when they were in love with someone, they should prove their love by having sex. The 2007 Zambia Demographic and Health Survey found that there was a high percentage of adolescents that engaged in higher-risk sex and it was highest among those aged 15-19 years, which constituted 52 percent of the research population". A study done by Nshindano and Maharaj (2008, p. 112), also revealed that the majority of the adolescents felt that that there was nothing wrong with having multiple partners, as long as those involved were getting what they wanted out of the relationships.

This study found that female adolescents were having multiple sexual partnerships for financial reasons because this allowed them to satisfy their material needs. Their male counterparts were having multiple sexual partners in order for them to gain status and a sense of belonging. The majority of the respondents in this study felt that peer pressure was a major barrier to changing one's own behavior. They explained that in most cases a person may want to change their behavior yet feared to be ridiculed or loss of status among their peers.

In an attempt to prevent or reduce the spread of HIV and AIDS among adolescents in Africa, researchers, cited in this research, suggest that school-based HIV/AIDS prevention programs are the most effective, in terms of disseminating sexual reproductive health information. Studies by Kaaya et al., (2002) and Malambo (2002) asserted that initiating these programs when children were at a younger age and developing, would assist in preventing risky sexual behavior even later in life". A study by Mouli (1991), cited in Malambo (2002, pp. 157-159), indicated that most teachers were of the view that HIV and AIDS prevention programs should be done at an early age, before adolescents started experimenting with sexual behavior. However, other teachers, at the time of the study, were hesitant to talk about sex, but only wished to do this if incorporated in other programs, such as human biology, religious education or behavioral science.

Since the advent of HIV/AIDS in the early 1980s, peer education has become an increasingly popular tool to reach adolescents (UNAIDS, 1999, p.48). Research findings by Turner and Shepherd (1999) stated that peer education was more cost effective than other methods because peers were a credible source of information and empowering for those involved. This method utilized an already established means of sharing information and advice. It was further established that peers were more successful than professionals in passing on information because people identify with their peers. Peers can reinforce learning through constant interaction and contact because adolescence is a period when peers tend to have more influence than authority figures such as parents and teachers, peer leaders can model positive patterns of behavior, (pp. 83-87).

Campbell and Mikhail, (2002), define 'Peer Education' as that which involves the training and use of individuals from the target group to educate and support their peers. They state that Peer-led interventions were based on the assumption that behavior was socially influenced

and that behavioral norms were developed through interaction. They further indicated that by using peers as resources, information, skills and caring could be communicated in a better climate.

Bandura (1996, pp. 87-90), states that Peer education should empower adolescents through teaching them to look at hindrances to behavior change. The study further states that Peer education should provide a context in which a group of peers can collectively renegotiate their peer identities, empower young people with confidence and sexual negotiation skills, as well as a sense of "youth ownership" of health information and health interventions. This is where young people saw that they themselves had a key role to play in HIV prevention, rather than seeing it as the responsibility of distant medical experts. This combination of confidence, negotiating skills and ownership contributed to a sense of increased self-efficacy amongst young people, which increased the likelihood that they will felt that they were in control of their lives (pp. 97-99)".

1.2 Statement of the Problem

According to the Zambia Sexual and Behavior Survey (2009) there is still a high prevalence of HIV/AIDS amongst adolescents in Zambia. Research findings indicate that despite sound knowledge about sexual health risks, many young people are still at risk because of high-risk sexual behavior. Many HIV/AIDS preventive interventions that use diverse approaches have been implemented in Zambian schools over the past decade. The introduction of Anti-AIDS Clubs and Peer educators in Secondary schools has been one way of trying to address the issue of risky sexual behaviors, which may lead to HIV infection. It is one preventive program which the Government has put in place and it is supported by Zambia's cooperating partners.

A survey by Mukoma (2001) among adolescents in Lusaka colleges, found that "Peer education and support can be effective among adolescents because friends are their main sources of information about sexual practices, and peer influence often motivates their behavior (p 24)". This study suggests that there was need for innovative programs in schools because they helped to promote and maintain safer sexual behavior. It proposes that in order to have access to HIV and AIDS information, education peer education and support programs have to be implemented in schools. According to (Campbell & Fouls, 2002), HIV and AIDS-related peer education in schools often aims at and results in postponing sexual involvement and promoting condom use. This is done through sharing information about HIV, providing role models that promote healthy behavior, demonstrating negotiation skills and providing individual support. A study by Cartagena, et al., (2006) and UNICEF Ghana, (2002) found that the effectiveness of peer education and support in an HIV context contributed to higher levels of knowledge, changed attitudes and self-efficacy, as well as changed sexual behavior patterns. This, according to Smith et al., (2000), included behavior patterns regarding condom use, delay of sexual activity based on changed sexual norms and young people influencing their friends to avoid unprotected sex (p.36).

As evidenced by the literature on this subject, peer influence has an adverse impact on any adolescent's life style. However its impact on changing behaviour, either negatively or positively, has not received as much attention as basic HIV/AIDS information channels.

1.3 Significance of the problem

Research findings suggest that adolescent involvement in addressing HIV and AIDS issues can contribute to a delayed onset of sexual activity, and can therefore contribute to the prevention of HIV and AIDS amongst adolescents. It is envisaged that the information that

will be generated by this study would provide authorities with an overview of how effective the Anti-AIDS clubs have been. The study is important because it will attempt to establish whether membership to an Anti-AIDS club had any effect on an adolescent's risky sexual behavior or not. It is hoped that the findings of this study will give focus to school authorities, policy makers and private institutions and assist the stake holders to come up with appropriate interventions.

1.4 Main Objective

The main objective of this study was to investigate whether belonging to an Anti-AIDS Club or being a Peer educator has any relationship with engagement into risky sexual behavior.

1.5 Research Objectives

In order to achieve the main objective, the study will focus on the following specific objectives:

1. To find out how common it is for young people to have sex.
2. To find out if their close friends have been engaged in sex.
3. To determine pupils' risky sexual behaviors.
4. To find out if belonging to an Anti-AIDS club or being a Peer Educator reduces risky sexual behavior.
5. To find out whether peer educators or members of the Anti-AIDS club are viewed as role models by their peers.

1.6 Research Questions

1. How common is it for adolescents to engage in risky sexual behaviour?
2. What influence does belonging to an Anti-AIDS club have on the reduction of risky sexual behavior?
3. How does information from Anti-AIDS club members help in reducing risky sexual behavior among adolescents?
4. How do activities performed by Anti-AIDS club members succeed in reducing risky sexual behavior amongst their peers?
5. Are Peer educators regarded as role models by their peers?

1.7 Theoretical Framework

When undertaking a peer education program, the objectives are often to reinforce positive behaviors, to develop new recommended behaviors, or to change risky behaviors in a target group. Fields of health psychology, health education, and public health provide relevant behavioral theories that explain this process. These theories provide a theoretical base that explains why peer education is beneficial. The Diffusion of Innovation Theory is one of the approaches used in peer education. This study is therefore based on the Diffusion of Innovation Theory by Rogers (1983). It emphasizes that influential leaders and respected individuals influence norms by disseminating information through one-to-one contacts and group discussions. It recognizes friendship groups and social networks as important routes of communication and change. It looks at how new ideas are communicated, accepted by target group or population.

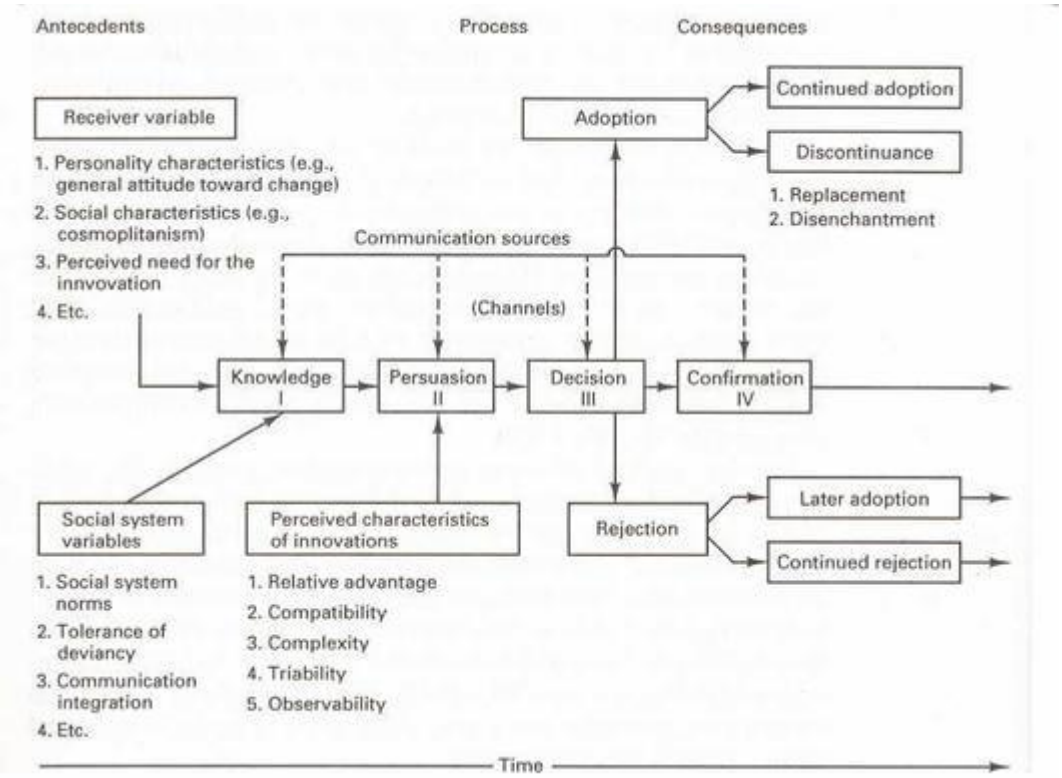
The theory has three major components which are as follows:

a) The communication channels which are used for dispensing an idea or new message.

b) Opinion leaders who should stand out, in terms of morals, who are able to dispense the message in a simple and straightforward way.

c) Time and Process – required to reach community or group. People receive/accept messages at different time intervals.

THE DIFFUSION OF INNOVATION MODEL



Source: Rogers (1995)

CHAPTER TWO
LITERATURE REVIEW

2.0 Introduction to Literature Review

This chapter will review literature HIV/AIDS and pupil focused activities, mostly Anti-AIDS Clubs. The literature will review previous studies related to the study. Assumptions are that pupils that are actively involved in Anti-AIDS activities involve themselves less in Risky sexual behaviors compared to their peers that are not. Another assumption is that the pupils that are members of the Anti-AIDS club or the peer educators are regarded as role models by the other pupils. As this is a global challenge, the literature will explore works from a global perspective and then what has been reviewed here in Zambia. The review of literature will first start with HIV/AIDS knowledge among adolescents, and this will be followed by sections on adolescents and sexual behavior, Anti-AIDS clubs and behavior change and lastly the impact of peer education among learners.

2.1 Adolescents and HIV/AIDS

Studies by Rasing (2003) have explained that adolescence is one of the most captivating and complex transitions in the life span (p. 39). As children transition from childhood to adulthood, they undergo many physical, emotional and behavioral changes. These changes include very fast physical growth, the rise of reproductive sexuality, new social roles, and growth in thinking, feelings and morals. The National Academies Press (1999, pp.1-2), states that the sequence of pubertal changes is relatively predictable and consistent; however, their timing is extremely variable.

The terms “adolescent”, “youth”, and “young people” are defined differently but these three terms are used interchangeably. According to WHO/UNICEF/UNFPA 1989 jointly refer to

people between the ages of 10 and 19 as adolescents, those persons between 15 and 24 as youth and the larger group 10 to 24 as young people. Nearly 50% of the world's population is under 25 (UNFPA 2003). The threat of HIV pandemic to young people cannot be over emphasized. According to UNAIDS, (2001), young people between the ages of 15 to 24 account for 30% of all people living with HIV/AIDS. UNAIDS (2008) estimates showed that young people under 25 accounted for about half of all new HIV cases in adults in 2007 and more than half of them still lack accurate and comprehensive information about how to avoid exposure to the virus. The indication that less than 40% of young people globally have accurate and comprehensive knowledge about HIV (UNGASS indicator 13) is unacceptably low and consequently worrisome, (p. 49).

2.2. Adolescents' knowledge, attitudes, perceptions and prevention of HIV and AIDS

Despite all efforts, HIV and AIDS keeps on spreading especially among young people making it even harder to control. This is evident by the number of new infections being recorded throughout the world, more especially in Southern African countries. The fight against the scourge and epidemic of HIV and AIDS is, and continues to be one of the biggest challenges facing the world today. The impact of the disease touches on the lives of the global community in different predictable and unpredictable ways.

Though the severity of the crisis is obvious, 'Biochemical and pharmaceutical development of vaccines continue to have limited success; current drugs available can suppress the virus but they do not cure HIV infections or AIDS" (The National Institute of Allergy and Infectious Diseases (NIAID), 2009).

Therefore, promotion of prevention strategies needs to be intensified in order to put a final stop the spread of HIV, especially new infections amongst adolescents. According to Ocran and Danso (2009), "Rates of infection with sexually transmitted diseases have continued to increase among teenagers". The study refers to Roscoe and Kruger (1990) in the article titled: 'Late adolescents' knowledge and its influence,' which concluded that although adolescents' knowledge of HIV transmission might have improved over the past few years, their risk-related behaviors remain unchanged. This, no doubt can be linked to Adolescents' sexual behavior and knowledge, attitudes, perceptions towards HIV and AIDS.

Numerous studies have been done on adolescents' sexuality, knowledge, attitudes, and/or behaviors relevant to HIV and AIDS in order to improve the overall sexual behavior of adolescents. It is important at this point to consider such surveys of adolescents. A random sample surveyed by Strunin and Hingson (1987) of 860 adolescents, 16 to 19 years of age, concerning their knowledge, beliefs, attitudes, and behaviors regarding AIDS indicated that 70% of them were sexually active (having sexual intercourse or other sexual contact) but only 15% of them reported changing their sexual behavior because of concern about contracting AIDS, and only 20% of those who changed their behavior used effective methods, (pp. 130-133).

Studies by Buysse, (1996) and Gray & Saracino, 1989), revealed that there adolescents were engaging themselves in unsafe sexual behaviors such as sex with many sexual partners and negative views about condom use. There was also a low rate of behavior change even after learning about HIV and AIDS. These findings corroborated with the findings by Gray & Saracino, (1989), that a moderate to high knowledge level of AIDS may not be a predictor of safe sexual behavior practices. However, a study conducted by Roscoe & Kruger, (1990) on adolescents suggests that one-third had refrained from sexual behavior because of "fear of the

disease". A study conducted in Kenya on the effects of HIV/AIDS, by Toroich-Ruto, (2000) indicated that there were still low levels of AIDS knowledge among college students. This research indicated that a large proportion of their samples were lacking accurate knowledge of the causes and prevention of AIDS transmission.

A study of health behavior among youths in Kenya by Volk & Koopman (2001), revealed that knowledge about HIV modes of infection could not predict condom use. According to the authors of this study, the failure of perceived susceptibility to predict behavior most likely resulted from the youths' misconceptions about the origins and transmission of AIDS. For these individuals, misconceptions, or lack of accurate knowledge about AIDS, resulted in inaccurate assessments of susceptibility. This finding suggests that "perceived susceptibility must be accompanied with accurate knowledge in order to bring about behavioral change, (p. 96)".

A study by Slonim-Nevo and Mukuka (2005) on Zambian adolescents discovered that adolescents had moderate to high levels of knowledge about HIV and AIDS across all cultures in Zambia. These findings have been supported by the 2007 ZDHS report which reveals that knowledge of HIV and AIDS is high among all adolescent groups in Zambia.

This corroborates with the findings by Gray & Saracino (1989) that a moderate to high knowledge level of AIDS may not be a predictor of safe sexual behavior practices". A Knowledge, Attitudes, Practices and Behavior (KAPB), survey conducted by UNICEF (2006) on Namibian youths, found that Knowledge about HIV/AIDS and its modes of transmission was high among pupils between the age group of 15-24 years. A study conducted by Guiella and Madise (2004) in Burkina Faso among youths, aged between 12-19 years, showed that gaps in knowledge regarding adolescents' sexual behavior persisted. These studies, however,

have not come up with findings at to what motivated young people to initiate first sex, to have multiple sexual partners, or not to use protection such as condoms.

The Zambia Sexual Behavior Survey (2005 and 2007), report discovered that more than 95% of adolescents know that HIV can be avoided. The report, however states that adolescents still do not want to go for an HIV test because of fear of stigmatization and that quite a number of Zambian adolescents know the source of condoms but very few indicated that they had used them or were ready to use them. Studies on Adolescent knowledge about HIV and AIDS and condom use and misconceptions, in the Zambia Demographic and Sexual Survey (2007) and in Malawi, by Ntata et. al. (2008), found, that both males and females had the same level of HIV and AIDS-related knowledge. Respondents in these studies felt that they were not at risk of acquiring HIV infection, and knew where to get condoms and the males knew how to use them while very few of the females knew how to use the female condoms. The studies further found that most students had multiple sexual partners and this trend was very common across the study population. Society for Family Health (2007), in Macha, Zambia (Southern Province) also discovered that there were still some gaps in adolescents' knowledge about HIV and AIDS, reproductive health and sexually transmitted infections. This evaluation revealed that adolescents still thought HIV and AIDS could be caused by witchcraft and that sex would not be enjoyable with a condom. Most males in this study were of the opinion that there was nothing wrong with having more than one sexual partner.

Nshindano and Maharaj (2008), conducted their research in Lusaka on adolescents (19-24 years) in tertiary education, and found that adolescents had high levels of knowledge of STIs, including HIV and condom use but they still indulged in risky sexual behavior. This was evidenced by the high rates of teen age pregnancies, abortions, new STI and HIV infections. They suggested that there be extra combined efforts to reduce the percentage of new

infections among the youths. This study found that HIV transmission in Zambia was mainly through unprotected sex. They agreed with findings by the Central Board of Health Report (2003) that these careless sexual behaviors had led to new HIV infections and Sexually Transmitted Infections (STIs).

2.3 Overview of the HIV Epidemic in Zambia

The Zambia's policy on HIV and AIDS came into being in 2005 and outlines Zambia's national response to HIV and AIDS. Zambia's HIV and AIDS policy has evolved from one narrowly focused on blood screening and public awareness programs to what the government now describes as "an all-embracing approach," (Zambia Country Progress Report (2011, p 68). The policy strategies are:

i) Prevention of HIV and STD transmission, reduction of personal and psycho-social impact of HIV and AIDS and STD, mobilization of all sectors, and all communities for HIV and AIDS prevention and care

ii) Provision of care and reduction of socio-economic consequences of HIV and AIDS.

iii) Providing the framework for addressing the HIV/AIDS/STI/TB situation.

v) Looking at the causes and factors that are responsible for the transmission of these infections and how this affects the country.

vi) Equipping the youths with knowledge and life skills as a way of preventing HIV infection.

vii) Training of health personnel in counseling children and young people about the dangers of early sex, unwanted pregnancies and the importance of preventing infection (pp. 99-107).

It however, does not clearly indicate the inclusion of peers counseling each other or Anti-AIDS clubs. The Zambia Country Progress Report (2011, pp. 121-122), indicates that the HIV epidemic was generalized, meaning, that it was spreading throughout the population and not only in specific population groups. Its findings were that most of new infections were estimated to occur in unprotected sexual intercourse between men and women. Reflecting the practice of females preferring older sexual partners than themselves and vice-versa, the age-sex structure of the epidemic has cross over patterns with the percentage infected at younger ages higher among females than among males. The report further indicates that the percentage of people infected in Zambia was consistently about twice as high in urban than in rural areas. The percentage was also higher among females than among males. The report further indicates that, "there was a reduction of people infected by HIV in all the groups by sex and area of residence. This finding, however was with the exception of men aged 15-49 years, in rural areas. The report records an increase in percentage in this group from 8.9 per cent in 20012001 to 11.0 per cent in 2007. The report goes on to indicate that in the most recent Zambian estimates for 2007, the percentage of adults between 15-49 years infected, in urban areas was 23.1. It was 10.8 in rural areas. Among the provinces, the highest percentage of the population 15-49 years with HIV in 2007 was in the urban area (pp. 132-133)".

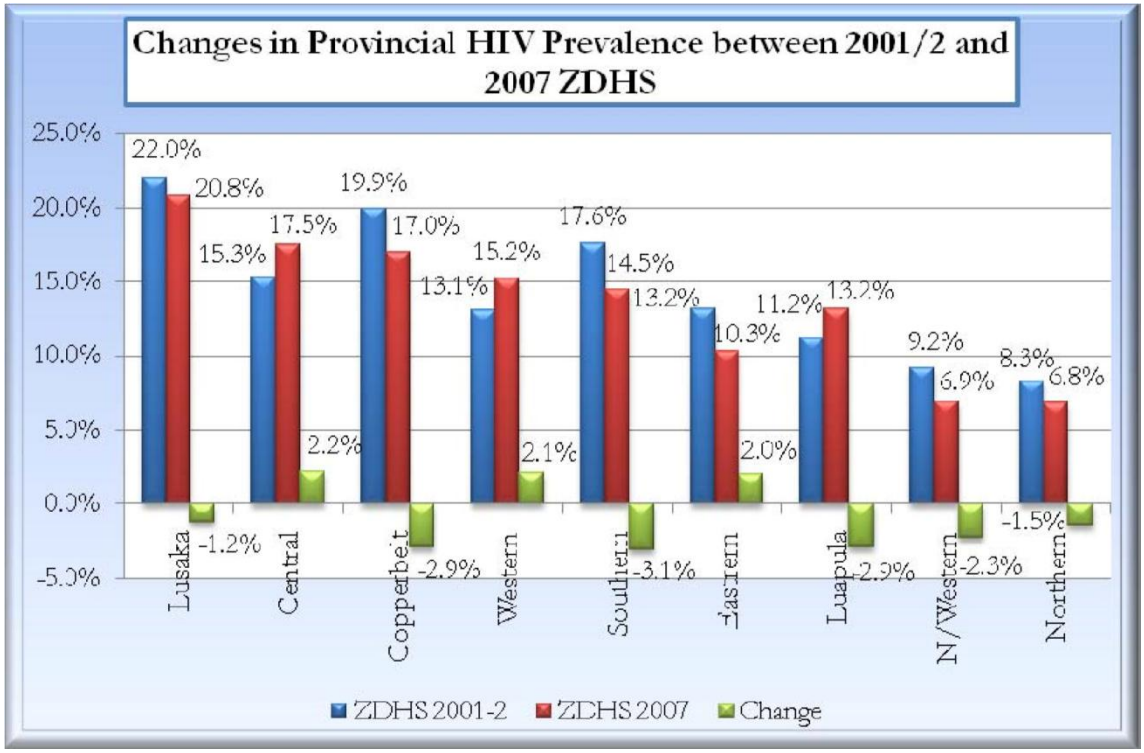
The Millennium Development Goals Progress report of 2013 indicates that "The number of Zambians infected with HIV has dropped to 14.3 percent of the population". The report further states that "Zambia has achieved and surpassed the MDG target for IV prevalence of 15.6 percent". This report nonetheless indicates that the prevalence rates in Lusaka, Copperbelt, Southern and Western Provinces "remain higher than 14.3 percent". This report also indicates that new HIV infections are still high throughout the country, especially among adolescents.

According to the Zambian country Biennial Report (2012), Zambia has experienced a high level HIV and AIDS epidemic for close to two decades. The report states that even though the overall HIV and AIDS epidemic appears to be trending down, it is not yet significant. It explains that a disease significantly wanes if there are fewer new infections than deaths from the disease. However, HIV prevention efforts have not yet succeeded in reducing the infection rate below the death rate, that is, new infections below 0.2 per cent per year. Although the rate of new infections had stabilized, the absolute number of new HIV infections increased due to the growing population emphasizing the urgent need to reduce the rate of new infections to below 0.2 per cent per year. The rate of new infections in 2011 in the population 15 years and older was estimated at 1.10 per cent in the total population, 0.86 per cent among males and 1.12 per cent among females (pp. 59-61).

This report further discloses that comprehensive AIDS knowledge was highest in women and men with the highest in school education. The HIV and AIDS prevalence was unfortunately also the highest in these groups, suggesting that "structural factors such as socio-economic and gender inequality and cultural factors were more important than individual factors in the dynamics of the HIV and AIDS epidemic in Zambia". It refers to some Qualitative research and surveys that indicated that "transactional sex ‐ the exchange of favors of money for sex – was common, and relative wealth was a strong inducement to start multiple sexual relationships (p. 75)".

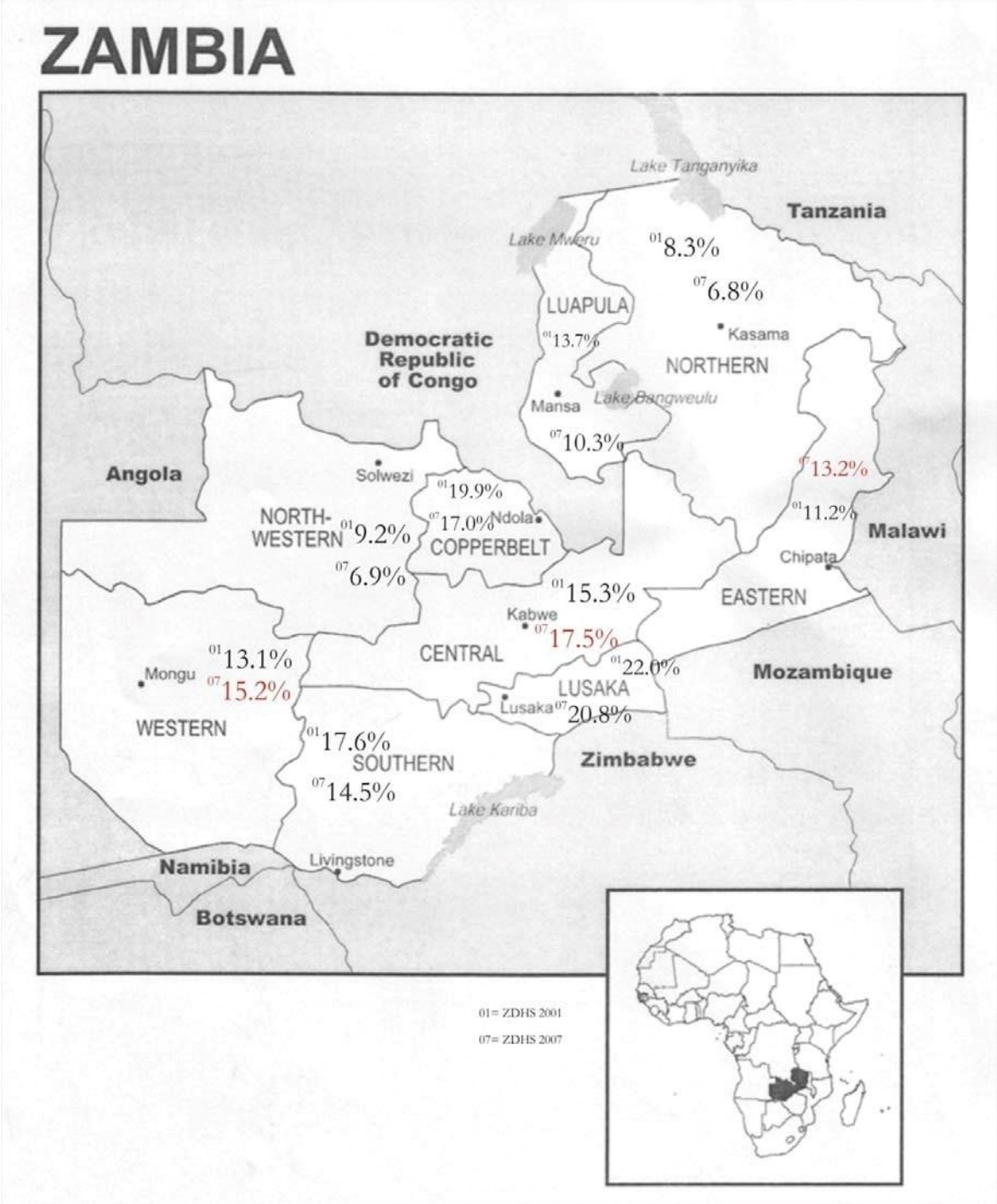
The graph and map of Zambia below indicates the prevalence rate of HIV infection according to provinces and as reported by the Zambia Demographic Health Survey of 2001 and 2007.

Fig 1**: Trends in provincial HIV prevalence between ZDHS 2001/2 and 2007**



(Source: ZDHS, 2007)

Fig 2: Trends in provincial HIV prevalence between ZDHS 2001/2 and 2007



SOURCE: Zambian country Biennial Report (2010)

2.4 Towards Universal Access to HIV information in Zambia

Zambia has HIV and AIDS strategic frameworks and with the financial and technical support of Cooperating Partners, many interventions for attaining universal access were implemented in prevention, treatment, care and support. The Zambia Country Report indicates that since the UNGASS declaration in 2001, Zambia has produced four report indicating the achievements towards the declaration. The report indicates that in 2012, "a consultative process was carried out in February and March in 2012 to compile indicators and achievements made towards the declaration". The report states that a harmonized monitoring and evaluation system has been created in Zambia, which is periodically reviewed alongside the review of HIV and AIDS strategic plans.

Information extracted from the Zambia Report (pp. 184-186), outlines that the UNGASS targets are as follows:

- Reduction of sexual transmission of HIV by 50 per cent by 2015
- Reduction of transmission of HIV among people who inject drugs by 50 per cent by 2015
- Elimination of mother-to-child transmission of HIV by 2015 and substantially reduce AIDS related maternal deaths
- To have 15 million people living with HIV on antiretroviral treatment by 2015
- Reduction of tuberculosis deaths in people living with HIV by 50 per cent by 2015
- Reach a significant level of annual global expenditure (US$22-24 billion) in low- and middle-income countries
- Critical enablers and synergies with development sectors

The Zambia Report's conclusion is that prevention strategies were at the core of reducing the sexual transmission HIV. In this report it was outlined that the tendency by mainstream society to disapprove of, and sometimes harshly punish, behavior such as illicit drug use, sex

between men, and sex work has been a major constraint in implementing some prevention activities. This societal disapproval has meant that people engaged in these behaviors are not adequately covered by programs and epidemiological surveillance systems, even though they are among the most likely to be exposed to HIV. This remains a problem in Zambia although non-governmental organizations are increasingly making efforts to reach heterosexual sex workers and men engaged in sodomy in prisons. The Drug Enforcement Commission in its programs to re-habilitate drug addicts has also incorporated HIV prevention. All these were being done in a way that does not draw the ire of the mainstream society which implies an inadequate effort on these groups.

2.5 National HIV and AIDS Strategic Framework

At the end of the Fifth (2002–2005) National HIV and AIDS strategic framework, HIV prevention coverage was considered to be extremely low. Only a fraction of people at risk of HIV exposure had meaningful access to basic prevention services. Very few adults aged 15–49 years had access to voluntary counseling and testing and an even smaller proportion of pregnant women were offered services for preventing mother-to child HIV transmission. A major commitment was made to close this gap in the sixth strategic framework, 2006-2010. In the 2006–2010 National HIV and AIDS strategic framework, eight areas of focus within the prevention theme were defined as follows:

1. Prevent sexual transmission of HIV with a special emphasis on youth, women and high risk behaviors;
2. Prevent mother to child transmission;
3. Prevent HIV transmission through blood and blood products;

4. Prevent HIV transmission in health care and other care settings and promote access to post exposure prophylaxis treatment;
5. Improve access to and use of confidential counseling and testing;
6. Mitigate stigma and discrimination against HIV;
7. Prevent HIV transmission through intravenous drug use; and
8. Support development and participation in HIV vaccine clinical trials (p. 107).

According to the Zambia Country Biennial Report, the 2011-2015 NASF is the third HIV and AIDS intervention strategic plan being implemented in Zambia. It follows the 2006-2010 intervention frame work. Adoption of a human rights approach and gender sensitivity are two of the nine guiding principles of the 2011-2015 NASF. The NASF acknowledges that an enabling legal and policy environment is central to the promotion of a rights-based approach to HIV and AIDS. It contributes to reducing vulnerability to infection, mitigating the impact of HIV and empowering communities to respond appropriately. To ensure that the NASF had a strong gender perspective throughout the development process, consultations were held with the Gender Steering Committee including the Gender in Development Division. Apart from the focus on gender and human rights, the NASF reflects a strong evidence base and focuses on results, (pp. 117-118).

The Zambian Report (2010) indicates that the overall rating of strategy planning efforts in Zambia's HIV programs in 2011 has remained at 7out of 10. It was at 7 and 8 in 2009 and 2007 respectively. The government has demonstrated a significant level of support for the national HIV response. The Cabinet Committee of Ministers on HIV and AIDS has called for more ambitious targets including eliminating rather than reducing mother to child transmission of HIV. The National Health budget for 2012, announced at the end of 2011, is 45 per cent higher than the 2011 budget in absolute terms. However, in proportion to the

national budget, the health budget is still below the 15 per cent Abuja commitment. In addition the GRZ has increased its budget for ARVs from USD 5 million in 2011 to USD 10 million in 2012.

The 2013 Millennium Development Goals Report for Zambia is an analysis of how the country has progressed in achieving the eight Millennium Development Goals (MDGs). These Goals are based on the Millennium Declaration, which was signed by 189 countries – including in September 2000. After this, there was also an agreement by member states at the 2005 World Summit. There was a period set -1990-2015, in which countries were supposed to access their progress on the commitments made during the declaration. There are Eight (8) Millennium Declaration goals and the sixth one is entitled "Reverse the spread of HIV & AIDS, malaria and other major diseases".

The progress report indicates that with the 2015 deadline approaching, Zambia's progress on many of the MDG targets is encouraging. Nonetheless, the country is still confronted by challenges that hold back key policy and institutional reforms, and consequently the overall pace of implementation. Issues of policy direction and consistency, as well as institutional capacities to deliver, must therefore underpin efforts to both accelerate and widen progress, (p.10).

2.6 Anti-AIDS Clubs and Behavioral change

Trafford (2002, p. 67) states that when the HIV/AIDS epidemic was first discovered, Uganda was amongst the first countries that came out in the open and declared that it was one of the most affected and the country took bold steps to address this. The research indicates that the country's leadership, opinion leaders and the people of Uganda decided to embrace the ABC Method in order to change the attitudes and behaviors that were spreading the HIV. According to a Harvard study, the HIV rates reduced and dropped to about 50% within eight years. The study credits abstinence education in reducing HIV/AIDS in Uganda. Museveni (2004) in his commentary on HIV entitled 'Behavioral Change Is the Only Way to Fight AIDS' cited Uganda as being excellent in this direction. According to a study by William Ocran and Maclean Yaw Danso (2009), "Behavioral change is the responsibility of the individual and not the community, (p.57)." They explained that the latter could provide enabling environment within which the former can effect behavioral change.

The Zambian Government together with its cooperating partners realized that to fight this pandemic, effective HIV prevention programs that focused on adolescents, were crucial. One of the preventive interventions was the formation of Anti-AIDS Clubs in Schools in 1987 because it was understood that youth education and prevention programs have been used as primary ways of decreasing the rate of HIV infections among adolescents. It can be summed up in three letters ABC (A=Abstinence, B=Be Faithful, C=Condoms).

Several analyses have hinted that peers in the schools are the most important source of information on sexuality for adolescents. Where there is education there is an opportunity for effective HIV prevention. Attitudes, beliefs, and/or intentions have been described by many theories as proximal determinants of behavior. Consequently, changes in attitudes toward abstinence and condoms, and perceptions of personal risk or susceptibility to HIV should be

the main goals in any HIV/AIDS prevention program .Schools have proven to be ideal platforms for health initiatives, including HIV awareness education. Teaching children about the threat of HIV and providing age relevant and gender sensitive information, not only about how the virus is spread but also how it can be prevented, is essential if adolescents are to be protected".

A research by Kalichman, et al., (2007), discovered that it was still common in Zambia for young people, to have multiple sexual partners, and this facilitated the transmission of HIV. In agreement with other studies outlined above, Campbell & Mac Phail (2002) found that adolescents did not practice protected sex and because of the negative results of earlier HIV prevention measures, which concentrated on abstinence, the focus is now towards preventive interventions, including Anti-AIDS clubs, being implemented in schools (p.65).

Logan, et al (2002), indicated that school-based programs need to be in short intervals and in the form of drama and, participative school-based programs. Rasing, (2003) indicated that the school was one of the appropriate places for HIV/AIDS interventions and some other literature indicates that HIV/AIDS programs that allow youth participation are more effective and tend to address the concerns and needs of young people better. Studies have indicated that several individual oriented intervention programs have been put in place to eliminate risky behavior among adolescents, but do not seem to have achieved the required results. There is still no cure for HIV and AIDS available, so the only way to prevent HIV infection is to avoid behaviors that put adolescents at risk. Attitudes towards AIDS and/or those persons with AIDS may also help predict behavior change; however the existing literature is inconclusive. Findings by Aiken et al., (2001), on adolescents, indicated that in addition to knowledge and attitudes about AIDS, literature on health behaviors have focused on the role of individuals' perceived susceptibility to AIDS as a motivator of behavioral change (p. 89).

As part of the HIV/AIDS Unit World Food Program (2006), there have been efforts to include HIV/AIDS activities in all of its school interventions. This is in collaboration with school Anti AIDS clubs and WFP Ethiopia is encouraging other schools to form Anti-AIDS clubs and also provides materials like posters and leaflets to start Anti-AIDS Club activities. Club coordinators are trained in management, facilitation techniques, adolescent reproductive health, life skills, peer education and how to work with partner organizations. Anti- AIDS Clubs, on the Copper belt Province of Zambia, are spearheaded by Copper belt Health Education Project (CHEP). They train the peer educators who are mostly leaders or members of Anti-AIDS Clubs. The main aim of the formation of the Anti-AIDS Clubs was to ensure that children and youths develop and maintain behaviors that will reduce their risk of contracting STDs and HIV/AIDS and encountering other sexual and reproductive health problems. This organization aims at empowering children and adolescents with life skills that make them more self-confident and able to make rational decisions. The Anti-AIDS Clubs are extracurricular activities, which children at the school decide to join. In schools were these clubs are, peer educators are given time, like during assembly, where they teach fellow pupils through talks, drama, puppet shows or poems. Copper belt Health Education Project uses music, drama, group discussions and role plays to raise AIDS awareness among school children, particularly in rural areas. In 2003, through its in-school youth program, the CHEP educated some 25,000 students using these methods. According to the CHEP in-School Program Manual, the curriculum for Anti-AIDS Clubs follows mainly the curriculum used in the peer educators' training manual. However, the club members are free to decide what topics should be covered each time they meet. The peer educators, who are members of these clubs, are taught assertiveness techniques, decision making, survival and negotiation skills,

and forms of sexual pleasure other than sexual intercourse. They also discuss issues related to gender and sexuality.

Sexual behavior, as can be seen, especially in adolescents, is not easy to change. Simply telling them that certain behaviors put them at risk for STIs or HIV is generally insufficient. For example, a person must know which practices can put an them at risk (knowledge), must believe that "people like him or her" can be at risk (attitude), and must believe that he or she is at risk (attitude) before that person can take action to change his or her own behavior (practice). Interventions, which the Anti-Aids clubs through CHEP have addresses all three levels, and youths must know what to do to protect themselves, must feel that they have the ability to effect change, and must have the skills and resources to do so. Most important, they must have willing peer and a supportive environment.

Rasing, (2003) indicates that the school was one of the appropriate places for HIV/AIDS interventions and some other literature indicates that HIV/AIDS programs that allow youth participation are more effective and tend to address the concerns and needs of young people better (p.55).

2.7 Impact of Peer Education among Learners

AIDS education for young people plays a vital role in global efforts to end the AIDS epidemic. Despite the fact that HIV transmission can be prevented, each year millions of people become infected with the virus; almost half of these new infections are among people under 25 years old. Providing young people with basic AIDS education enables them to protect themselves from becoming infected. Schools play a pivotal role in providing AIDS education for young people.

According to Koula Merakou and Jenny Kourea-Kremastinou (2006, P. 96), peer education appears to be a promising method in promoting risk-reduction behavior among young people. Although, as a pedagogical method, it began being applied in health education and especially for HIV/AIDS prevention during the 1980s. In recent years, this method has been popular in health education because of the interaction it brings between peers.

Not only do schools have the capacity to reach a large number of young people, but school students are particularly receptive to learning new information. Therefore schools are a well-established point of contact through which young people can receive AIDS education. There has now been more emphasis on the use peer education in the fight against HIV and AIDS. According to Campbell (2004), Peer education was developed in reaction to the perceived shortcomings of more individual-oriented approaches such as traditional didactic health education (seeking to provide information to individuals), and self-empowerment approaches (seeking to increase individuals' health-related behavioral skills and their motivation to perform health enhancing behaviors).

Kirby, Obasi and Laris (2006) have stated that the health need of 'adolescents have not been adequately addressed, especially that regarding their reproductive health needs'. These researchers also state that research which aims at investigating the effectiveness of youth focused programs in changing high risk sexual behaviors is scarce. Because of this concern, advocates of peer education are of the view that it is better to target the peer group or the community rather than the individual. According to Campbell, (2004), peers are an important influence on young peoples' sexual behavior, and that young people are most likely to change their behavior if they see that 'liked and trusted peers are changing theirs.

2.8 Adolescents' perception of peer educators

In a paper presented by Joanne McDonald and Jill Grove at the 2nd International Conference on Drugs and Young People Exploring the Bigger Picture (2001), in Melbourne, they stated that the process or way by which an adolescent becomes a peer educator may affect whether he/she is perceived as a true or near peer and whether or not they are influential in their age group.

They stated that peer educators may volunteer, may be selected by teachers or may be voted for by their peers. They however, emphasized that Peer educators who had been selected by teachers may not be considered as a peer by the other peers. A Kenyan Research update on the Girl Guides' HIV/AIDS Peer education Program (2005) stated that "Peer education can be misleading if the peer educator lacks adequate knowledge and cannot communicate appropriate messages. A peer educator may also lack the maturity, skills and knowledge to respond to challenges from their peers and the community".

2.9 Summary of the Reviewed Literature

The review shows that there was a lack of literature on whether membership to an Anti-AIDS club has any influence on an adolescent's risky sexual behaviour. In fact most of the literature available seems to be focused more on Knowledge, Attitudes and Behaviour. The studies that have been reviewed were mostly emphasizing on the impact of peer education but did not specifically point out whether membership to the club is able to influence an adolescent's risky sexual behaviour and whether the intended audience (non-members) valued the message being disseminated

The literature reviewed has shown that there are a lot positive effects associated with peer education. Literally thousands of studies have examined peer influence in adolescence. The body of evidence suggests that one of the most powerful and consistent predictors of adolescent risk behavior are whether an individual has friends who also engage in that behavior. Such associations have led many social scientists to conclude that peers exert considerable influence on adolescents.

In conclusion it can be said that adolescent's risky sexual behaviour is not only a significant problem in Zambia, but other countries as well. It is especially important therefore to examine whether getting adolescents actively involved in Anti-AIDS programs can help to change their behaviour and whether their behaviour impacts negatively or positively; in as far as HIV/AIDS prevention is concerned.

CHAPTER THREE
METHODOLOGY

3.0 Introduction

This chapter discusses the methodology that was used in data collection, analysis and interpretation. The key areas in this chapter are the research design, sampling procedure, sample size, data collection and analysis method and ethical consideration

3.1 Research Design

This was a descriptive study which used the qualitative method in data collection and analysis. The qualitative design helps reveal the nature of the multiple perceptions and attitudes that adolescents have about those that are actively involved in the Anti-AIDS activities at their school. In qualitative studies, past knowledge and prejudices are bracketed in order to seek a deeper, detailed and complete understanding of the phenomena under study (Leedy and Ormrod, 2001).

3.2 Study Population

Data was collected from pupils who are members and non-members of an Anti-AIDS club and peer educators. The pupils were all those aged between 15 and 18 from High schools in Chingola. A sample of such pupils is appropriate for this study because this age group constitutes a significant portion of those affected by HIV/AIDS and their risk level is compounded by the fact that this stage is characterized by ‘intense sexual drive and experimentation with sex without protection.

3.3 Sample Size

A purposive sample was recruited from pupils at high schools in Chingola. The schools were Chingola, Maiteneke and Sekela High Schools. The sample consisted of 3(2 Ladies and 1 Male) patrons and 245 pupils. Of these, 128 were females and 117 males and they were aged between 15 years and 19 years. They were divided into groups of those that are members of Anti Aids clubs and those that are not, who acted as a comparison group. The target consisted of pupils that fell into the description of "adolescent" and are in High School. All peer educators at the schools were also part of the sample. The Anti-AIDS club members and Peer educators are all involved in Anti-AIDS activities at the schools. This is a club which is open to all pupils at the school. Its main activities are HIV/AIDS sensitization, one to one discussion with other pupils and drama performances, including debates. The Peer educators are those that are trained by CHEP and act as facilitators in the clubs.

3.4 Sampling Procedure

Purposive sampling was used to select the sample. The Class registers and Members' books were used as a guide. Only pupils that fitted the description of 'adolescent' and in a High School, in Chingola were eligible to take part in the study. Initially the researcher carried out naturalistic observation during Anti-AIDS club meetings. Five days' observation was allotted to each School. A comparison group of pupils matched for demographic characteristics and attending the same schools as the Anti-AIDS club members and peer educators were included in the study sample. Since this group of children was matched for age, sex and place of residence, purposive sampling was also used to recruit them. These children were asked screening questions to ensure that they were not and had never been involved in any Anti-AIDS activities, at school or in the community. They were asked the activities they engaged

in at home before and after school, and if they did any Anti-AIDS activities, how often and for how long. Only those pupils that did not fulfil the inclusion criteria for Anti-AIDS club members or peer educators were included in this group.

3.5 Measures

A combination of three methods was applied to collect data. These three included questionnaires for all the three categories, Members of Anti-AIDS, Peer Educators and Non-Members, in-depth interview for the Patrons of the Anti-AIDS Clubs and focus group discussions (FGDs). A combination of these methods facilitated the collection of adequate information relating to the research topic as they complimented each other's strengths and compensated for each other's weaknesses.

Topic guide for Focus Group Discussions: The topics for the focus group discussion were generated from the preliminary interviews held with the pupils before administering the questionnaires and from the quantitative data analysis results. The focus group discussions were guided by the following topics

(i) Does belonging to an Anti-AIDS club have any relationship with reduction in risky sexual behavior?

(ii) Does information from peer educators help in reducing risky sexual behavior?

(iii) Do approaches used by peer educators succeed in reducing risky sexual behavior? (v) Do members of the Anti-AIDS club/Peer educators play their roles as outlined in the manual?

(vi) Are the Peer educators regarded as role models by their peers?

The questionnaires had been used in a study by Ntombela (1990) in South Africa and the objective of the study was to determine learners' awareness of HIV/AIDS and their attitude towards peer educators. These questionnaires were used in this study to get information on the

relationship between belonging to an anti-AIDS club/Peer educator and risky sexual behavior. The analysis of the responses also assisted in answering my research questions.

3.6 Data Collection Methods

All the participants were interviewed at their various schools. Prior to this, consent for the pupils to participate in the study was obtained from the head teachers of the schools.

The researcher was involved in the Anti-AIDS club activities at the schools and attended their meeting and also performed roles of the Patron. There was also full participation in one of the in- house Peer educators training as a facilitator. For the purpose of achieving results of this study, the researcher utilized semi structured, in-depth face-to-face interviews, Questionnaires and Focus Group Discussion as a method of data collection. The researcher administered the questionnaires to all the groups at different times. As most of the participants had difficulties in reading, the researcher had to read the questions one by one. This approach was used because the pilot study revealed that it was appropriate method for this sample. The Patrons of the clubs were also interviewed. The Teacher completed version of this interview was used to obtain the Patrons' rating of general risky sexual behaviour of pupils that were actively involved in Anti-AIDS Club activities and those that weren't. Qualitative data was collected through focus group discussions.

(i) Questionnaires: These were used to find out how peer educators were perceived, how HIV/AIDS messages are received from the peer educators and whether their peers considered them as role models. The researcher got samples of questions used in similar studies and aligned them to her areas of focus which assisted in answering the research questions. The main themes in the questionnaire were those related to peer pressure influence, behavior change due to sensitization by peer educators and members of the Anti-AIDS Clubs,

level of information and/or training which peer educators received and whether they were competent enough to disseminate the required information.

The questions were based on components of the Diffusion model.

This theory has three major components which are as follows:

a) The communication channels which are used for dispensing an idea or new message.
b) Opinion leaders who should stand out, in terms of morals, who are able to dispense the message in a simple and straightforward way.
c) Time and Process – required to reach community or group. People receive/accept messages at different time intervals.

(ii)Focus Group Discussions: The discussions addressed how Anti-AIDS Club members and peer educators were perceived, how HIV/AIDS messages were received from them and whether they were considered as role models or not. The researcher got samples of questions used in the study by Ntombela (2009) and aligned them to her areas of focus which assisted in answering the research questions. The main themes in the questionnaire were those related to peer education influence, behavior change due to sensitization by peers, level of information and /or training which peer educators receive and whether they were competent enough to disseminate the required information. The questions were based on components of the Diffusion model.

(iii)Key Informant interviews: Primary Bio-data and information was collected from the key informants, who were the patrons of the Anti-AIDS club. The interview schedule had both open ended and closed questions and was conducted on a one-to-one basis. This was in order to help verify questions and responses with ambiguities.

Ethical Consideration

Each participant in the study was asked to give their own consent before information was collected from them. The pupils and the school administration were assured that no harm was to come to them as a result of participation in the study and that every care would be taken to keep the information obtained confidential. Only those children who gave consent by reading and signing the consent form participated in the study.

3.7 Data Analysis Procedure

Data for the final study was collected and analyzed. The Chi-square, a non-parametric test, was used to analyze the nominal data. Chi-square was used as it tested frequencies, mostly percentages and proportions. The Chi square, test-of-independence was also used to compare frequencies of the two main variables for in the two hypothesis, which were as follows:

H1 Members of Anti-AIDS clubs are less likely to engage in risky sexual behavior than those who are not.

H2. Members of Anti-AIDS clubs/Peer educators are more likely to be regarded as role models, by their peers.

CHAPTER FOUR

PRESENTATION OF RESEARCH FINDINGS

4.0 Introduction

This chapter provides results of the present study and addresses each of the research objectives and hypothesis. These results were arrived at by using the data analysis procedure discussed in Chapter Three. The results are presented separately for the two hypotheses. Initially the risky sexual behavior of the pupils that are members of Anti-AIDS clubs was compared with the risky sexual behavior of those pupils that are not members of these clubs. Questions relating to risky sexual behaviors were asked to both groups and the responses were compared to determine which group engaged less in such behaviors.

4.1 Analyses

Table 1: Perception of sex involvement among adolescents at high schools in Chingola

TEST ITEM	OPTIONS	PUPIL STATUS	
How common is it for young people at your school to have sex?		Members of Anti AIDS	Members of Non Anti-AIDS
	Very common	19(52.8%)	34 (94.4%)
	Common	17 (47.2%)	2(5.6%)
Total		36 [100%]	36 [100%]
Test Item	Value	Df	Sig
Pearson Chi-Square Continuity	16.087(b)	1	.000
Correlation	14.014	1	.000
Likelihood Ratio	17.857	1	.000
Not valid cases	72	1	.000

Table one above indicates how easy or common it is for pupils to engage in sexual behavior. The results indicate that 94.4 percent of the non-members indicated that it was very common for young people to engage in sex acts while 52.8 percent who belonged to an Anti-AIDS club felt that it was very common.

To determine whether the percentage difference was significant, a chi-square test was done. The results indicate that a higher percentage of non-members of Anti-AIDS club (94.4 %) felt that it was common for non-members to have unprotected sex than members of Anti-AIDS club (52.8%), $\chi 2$ (1, N = 36) = 16.087, p = .001:

Table 2: Comparison of perceptions of sex involvement between Members and Non Members of Anti-AIDS Clubs

			PUPIL STATUS		
	Optional answers		Members of Anti AIDS	Non Members of Anti-AIDS	TOTAL
Have any of your friends had sex before?	No	% within pupil status count	26(74.3%)	36 (100%)	62 (87.3%)
	Yes	% within pupil status count	5 (14.3%)	0 (0%)	5 (7.0%)
	I do not know	% within pupil status count	4 (11.4%)	0 (0%)	4 (5.6%)
Total		% within pupil status count	35 (100%)	36 (100%)	71 (100%)
Chi-Square Test	Value	Df	Asymp. Sig (2-sided)		
Pearson Chi-Square	10.601	2	.005		

Table two above shows that both groups indicated that their friends have had sex before. But all the pupils from the non-members group said all their friends have had sex before compared to 74.3 percent of those pupils who belonged to an Anti-AIDS club. This result also showed a significant difference between the two groups as indicated in table four below, $\chi 2$ (1, N = 71) = 10.601, p = .005. The percent difference was significant.

Table 3: Pupil's Risky sexual behavior

			PUPIL STATUS		
	Optional answers		**Members of Anti-AIDS**	**Non Members of Anti-AIDS**	**TOTAL**
Have you ever had sex?	Yes	% within pupil status count	13(36.1%)	31 (86.1%)	44 (61.1%)
	No	% within pupil status count	23(63.9%)	5 (13.9%)	28 (38.9%)
Total		% within pupil status count	36 (100%)	36 (100%)	72 (100%)
Chi-Square Test	**Value**	**Df**	**Asymp. Sig (2-sided)**		
Pearson Chi-Square	18.935	1	.000		

The Table above shows that 36.1 percent of the participants who were members of the anti-AIDS club had had sex before, but 86.1 percent of the non-members had engaged in sex before The percentages or the two groups were compared in a Chi-square test to determine if the difference between the two groups was significant, the results show that there was a statistically significant difference in the percentage of pupils who have had sex before, between members of anti-AIDS and non- members, $\chi 2$ (1, N = 72) = 18.935, p = .001.

Table 4: Risky sexual behavior and membership of the Anti-AIDS club

	Options			
Have you had sex before you became a member of the Anti AIDS club?	Yes		No	
	N	%	N	%
Pupil status Members of anti-AIDS	13	36.1%	23	63.9%
Have you had sex since you became a member of the Anti AIDS club?	yes		No	
	Count	Row %	Count	Row %
pupil status members of anti AIDS	5	15.2%	28	84.8%

Table 4 shows that belonging to an anti-AIDS club significantly improved pupils' attitude towards risky sexual behavior. Only 15.2 percent showed that they engaged in risky sexual behavior after joining the anti-AIDS club. The table also indicates that members of the Anti-AIDS Clubs are more likely than non-members, to regard peer educators as their role models. A focus group discussion was used to analyze this hypothesis. Nine pupils from the Anti-AIDS club and nine pupils from pupils who were not members of the club were organized into two focus group discussion the discussions were done separately for each group. The results of the FGDs indicate that the hypothesis went in the expected direction. Pupils who were not members of the Anti AIDS club did not consider peer educators as their role models and Anti- AIDS club members thought that peer educators had a positive influence with regard to reduction of risky sexual behaviors amongst their peers. The comparison results in above analyses indicate that when involved in HIV and AIDS activities, adolescents are able to change their behavior. It further confirms that when used accurately the Diffusion of Innovation Model is able to achieve positive behavioral results, attitudes and perceptions.

4.2 FOCUS GROUP DISCUSSION (VERBATIVES)

TOPIC 1: Since Anti-AIDS club members have learnt about risky sexual behaviors, they inform others about its dangers. The members responded**:** *Emukwai. We have a program in which we have outlined our weekly sensitizations for the school. We usually conduct these during break time, at assemblies and anywhere in the school; premises. We do this on Wednesdays, every week*. The Non-*Members responded**:** Chachine. The Anti-AIDS club members inform us about the dangers of involving ourselves in unprotected sex. They offer us advice and encourage us to abstain. Some of our friends think it's a waste of time listening to their talks and mock them.*

TOPIC 2: Anti-AIDS club members receive support from all teachers in the school

The Members responded: *Madam we do this work as volunteers. We have to use our own transport to come back from Debates with other schools. The Patron, in most times uses her money to assist. The school administration assists with lunch for us although we would appreciate some pocket money. Most pupils appreciated their work and gave them support during the sensitization activities. The* Non Members responded*: The Anti-AIDS club members are fully supported by the school. This is because they are allowed to perform during assemblies and are free to walk into other classes, and discuss HIV and AIDS. They are even allowed to enter the staff room when other pupils are not allowed.*

TOPIC 3: Anti-AIDS club members mix well with other pupils and can therefore influence them. The Members responded: *We mixed freely with the other pupils that is why at this school, we do not have many 'mothers'. If you check our records you will find out that this is*

true. The Non Members responded: These are our friends and they usually have updated information, so we mix freely with them and listen to what they have to say about HIV and AIDS. They even have charts so this makes it very scary to think of getting involved in sex.

TOPIC 4:**Anti-AIDS club members are friendly to other pupils at school hence pupils feel free to ask them about risky sexual behaviors**

The Members responded: *Yes. They are our friend and apart from being at the same school, we stay in the same neighborhood. The Non Members responded: Most of them are friendly, except some girls that want to show off. We are free to ask any question about HIV and AIDS.*

TOPIC 5: Anti-AIDS club members can express themselves well and are therefore listened to by fellow pupils.

The Members responded: *We try but most of the materials we have is in English and it is at times difficult to interpret in Icibenba. If only they can be more manuals in vernacular.*

The Non Members responded: Madam this is where they fail mostly. They have manuals, charts and booklets but are unable to read correctly, apart from a few. That is why it is important for someone to who has good reading skills to be in the Anti-AIDS Club. They fail to speak in English and we laugh at them so some even avoid speaking during assembly.

TOPIC 6: Anti-AIDS club members at my school are good role models and their behavior has positive influence on other pupils

The Members responded: *We are role models because our friends at this school are able to see from our behavior which is not just at school but also when we get back to our homes. We know the dangers of AIDS and so we do not engage in any risky sexual behaviors*

One group of Non Members responded: Awe. These guys just pretend. They have relationships amongst themselves so it is their secret. We have not seen any of them get pregnant but maybe they use condoms since they are the ones that even distribute them in the toilets. The other 2 groups responded: They are role models. This is because none of those girls has been pregnant and we do not see them in pairs after school, but in groups. A few that we knew had relationships have changed since they joined the club. They are very good people now and even counsel others.

TOPIC 7: Anti-AIDS club members are regarded by other pupils as more knowledgeable

The Members responded: We truly have the knowledge that is required but the peer educators have the most updated one because they usually attend meetings at CHEP. The *Non Members responded: Within that club there are those peer educators who are at a higher level than just the ordinary members. Generally, the members of the Anti-AIDS clubs have latest knowledge because they even attend meetings on HIV and AIDS.*

Focus Group Discussion Summary

TOPIC 1: Since Anti-AIDS club members have learnt about Risky sexual behaviors, they inform others about its dangers.

Pupils who were not members of the Anti-AIDS club however were divided on this issue. Of the nine in the FGD five felt that members of the Anti-AIDS club were not adequately equipped to inform others about risky sexual behavior.

TOPIC 2: Anti-AIDS club members receive support from all teachers in the school.

The discussion groups were ambivalent on this issue they explained that since they were not members they could not tell whether Anti-AIDS club members received support from teachers but they claimed that most pupils did give them adequate support.

TOPIC 3: Anti-AIDS club members mix well with other pupils and can therefore influence them.

All agreed that they mixed well and that to some extent they also listened to what the Anti-AIDS club members and Peer educators told them about risky sexual behavior.

TOPIC 4: Anti-AIDS Club members are friendly to other pupils at school hence pupils feel free to ask them about risky sexual behaviors.

All groups responded in the affirmative but stated that at times the Anti-AIDS club members showed off.

TOPIC 5: Anti-AIDS club members can express themselves well and are therefore listened to by fellow pupils.

All groups stated that most of the Anti-AIDS Club members could not express themselves well, unless in vernacular. Some words were like insults in the vernacular making it difficult to explain.

TOPIC 6: Anti-AIDS club members at my school are good role models and their behavior has positive influence on other pupils.

Most groups were divided on this issue. Of the nine in the FDG, six felt that only a few of them were role models and claimed that the Anti-AIDS club members and Peer educators had affairs amongst themselves.

TOPIC 7: Anti-AIDS club members are regarded by other pupils as more knowledgeable.

Of the nine FGDs, five agreed that both Peer educators and Anti-AIDS club were knowledgeable, three indicated that only the Peer educators while one group disagreed.

CHAPTER FIVE
DISCUSSION AND FINDINGS

5.0 Introduction

This chapter discusses the findings, relating them to previous research and makes recommendations. The discussion of the study is presented in the major themes as follows:

a) Perception of sex involvement among adolescents at high schools in Chingola
b) Comparison of perceptions of sex involvement between Members and Non Members of Anti-
c) AIDS Clubs
d) Pupil's Risky sexual behavior
e) Risky sexual behavior and membership of the anti-AIDS club
f) Discussion on Focus Group discussion results
g) Patron's general views

5.1 FINDINGS

5.1.1 Perception of sex involvement among adolescents at high schools in Chingola

The results of the present study indicated how easy or common it was for pupils to engage in sexual behavior. The results indicated that most of the non-members indicated that it was very common for young people to engage in sex acts while 52.8 percent who belonged to an Anti AIDS club felt that it was very common. The results indicate that a higher percentage of nonmembers of Anti-AIDS club felt that it was common for non-members to have unprotected sex than members of Anti-AIDS club. This finding is in line with earlier research by Strunin and Hingson (1987) that indicated that of 860 adolescents, 16 to 19 years of age;

70% were sexually active. The study by Buysse, 1996, Gray & Saracino, (1989) also confirms the findings that indicated that there was still high engagement in unsafe sexual behaviors such as sex with multiple partners, sex with unknown persons, as well as negative views about condom use, and a low rate of behavior change even after learning about HIV/AIDS. This finding is also in agreement with the Guttmacher Institute study which discovered that adolescents aged between 15 -19 years, engaged in vaginal sex and that the prevalence has remained steady over the past decade.

5.1.2 Comparison on perceptions of sex involvement between Members and Non Members of Anti-AIDS Clubs

Both groups of sex involvement between Members and Non Members of Anti-AIDS Clubs indicated that their friends have had sex before. But all the pupils from the non-members group said all their friends have had sex before compared to 74.3 percent of those pupils who belonged to an Anti-AIDS club. The finding of this study is in line with previous findings by William Ocran and Maclean Yaw Danso (2009), which concluded that Behavioral change was the responsibility of the individual and not the community. This indicates that an individual had to make a decision to refrain from bad practices, they should have an inner conviction. These finding also confirm the several prominent studies, including those conducted in Zambia by Mukoma (2001), Rasing (2003) and the Zambia Country Biennial Report (2010) which showed that adolescents were still engaging in risky sexual behaviors such as sex with multiple partners, as well as having negative views about condom use, and a low rate of behavior change even after learning about HIV/AIDS.

5.1.3 Pupil's Risky sexual behavior

Thirty six percent (36%) of the participants who were members of the anti- AIDS club had had sex before, but 86.1 percent of the non-members had engaged in sex before. The percentages or the two groups were compared in a Chi-square test to determine if the difference between the two groups was significant, the results show that there was a statistically significant difference in the percentage of pupils who have had sex before, between members of anti-AIDS and non- members. These findings that adolescents that were non-members of the Anti AIDS club still engaged in unprotected sex, collaborates with the research by Kalichman, et al., (2007), who discovered that it was still common in Zambia for young people, to have unprotected sex, and this facilitated the transmission of HIV. Campbell & Mac Phail (2002) found that adolescents did not practice protected sex and this exposed them to unwanted pregnancies and HIV infections. The confirmation that those that were members of the Anti-AIDS club engaged less in unprotected sex has also been supported by other findings by Volk & Koopman (2001) that suggest that perceived susceptibility must be accompanied with accurate knowledge in order to bring about behavioral change.

5.1.4 Risky sexual behavior and members of the Anti-AIDS club

Belonging to an anti-AIDS club significantly improved pupils' attitude towards risky sexual behavior. Only 15.2 percent showed that they engaged in risky sexual behavior after joining the anti-AIDS club. This indicates that members of the Anti-AIDS Clubs are more likely than nonmembers, to regard peer educators as their role models. A focus group discussion was used to analyze this hypothesis. Nine pupils from the Anti-AIDS club and nine pupils from pupils who were not members of the club were organized into two focus group discussion the discussions were done separately for each group. The results of the FGDs indicate that the

hypothesis went in the expected direction. Pupils who were not members of the Anti-AIDS club did not consider peer educators as role models and Anti- AIDS club members thought that peer educators had a positive influence with regard to reduction of risky sexual behaviors among school going children. The comparison results in above analyses indicate that when involved in HIV and AIDS activities, adolescents are able to change their behavior. It further confirms that when used accurately the Diffusion of Innovation Model is able to achieve positive behavioral results, attitudes and perceptions.

5.1.5 Discussion on FG results

There is clear indication that the clubs are functioning according to plans. The Anti-AIDS club members freely discuss topics related to HIV and AIDS effectively. They overcome the challenge of vocabulary by speaking in *IciBemba* with their peers. They are not easily discouraged by negative statements. During these discussions, it was clear that the Diffusion of Innovation Theory was at play.

Communication: The Anti-AIDS club members had several channels of disseminating the message to their peers. This was done during assemblies, class debates and during lunch break.

Opinion Leaders: The Anti-AIDS club members stood out as opinion leaders. Their peers considered them to have good morals and they were able to dispense the HIV and AIDS messages clearly. Most times, the messages were disseminated in *Icibemba*, a Zambian language which all their peers were familiar with.

Time and Process: The members had a weekly plan of all their activities. These activities went on throughout the year.

5.1.6 Patrons' general views

Interviews with all the 3 patrons from the 3 High Schools brought the need for the Anti-AIDS Clubs in schools to be supported more. They were also able to demonstrate that some of the pupils had become very good champions of the HIV/AIDS drive. The majority were the girls that had been readmitted after giving birth. There was clear demonstration of significant of change of risky behaviour and attitude towards HIV prevention measures. The girls that were either Peer educators or members of the Anti-AIDS had a positive attitude towards which their peer that were not members had no knowledge, very little knowledge on how to use them.

At one of the schools, there was a group of 3 girls that had actually been involved in sex work and had briefly left school and settled in Solwezi. According to the Patron of that school, the girls had now reformed and were very active members of the Anti-AIDS. They attributed this positive change to the one–to-one discussions that Anti-AIDS club members usually had with their peers. This researcher had a chance to talk to them, in confidence and they confirmed this assertion and attributed their reformation to the discussion they had had with the Anti-AIDS Cub members.

CHAPTER SIX
CONCLUSION AND RECOMMENDATIONS

6.0 Introduction

The overall goal of this research was to compare risky sexual behavior between adolescents that were actively involved in HIV and AIDS activities and those that weren't. This research explored the activities that members of the Anti-AIDS clubs were carrying out at the three High Schools. Adolescence is a time when peer group influences are particularly significant to a young person's development and since the advent of HIV/AIDS in the early 1980s; peer education has become an increasingly popular tool to reach adolescents

6.1 CONCLUSIONS

The following conclusions can be drawn from the research findings:

6.1.2 Anti-AIDS club members and risky sexual behavior

From the results analyses, it is sadly evident that our adolescents are still indulging in risky sexual behaviors. These results are in line with the study conducted by Kiirya (2004), in Uganda, which suggested that HIV-risk sexual behaviors vary with sex, age, residence and educational status of adolescents. This study also found that despite the change in cultural beliefs and realignment to Christian life styles, adolescents are still engaging in sex. The fact as to whether they are using protected or unprotect sex is not easy to establish. Although these adolescents are still engaging in sex, they have the appropriate knowledge, attitudes and beliefs about HIV and AIDS. There is a paradigm shift in believe now compared to the UNICEF Survey results of 2007 carried out in Botswana, Zimbabwe, Namibia and Zambia, that found that young girls, between 19 and 24, were often preferred by older men who believed that unprotected sex was less likely to lead to infection, and that sexual intercourse

with a virgin would cure a sexually transmitted disease, including AIDS. The adolescent are having consensual sex with their peers or older people, in the case of girls.

6.1.3 Anti-AIDS Club members and Risky sexual behavior

The findings if this research has established that adolescents that are actively involved in HIV and AIDS activities are able to refrain from indulgence into risky sexual behaviors. An assumption could be that either they were scared or that they inertly changed their behavior because of the knowledge, attitudes and perceptions they have acquired, as members of the Anti-AIDS club. This is in line with the study by Maclean Yaw Danso (2009) that stated that Behavioral change was the responsibility of the individual and not the community". It's further explained that 'The latter could provide enabling environment within which the former can effect behavioral change'. These Anti-AIDS club members are also regarded as role models by their peers and because of this, able to disseminate the message to their peers easily. They are also an example to their peers and this in some way influences them to refrain from indulgence in risky sexual behaviors.

6.2 RECOMMENDATIONS

6.2.1 District HIV and AIDS Centers

This research has given an in depth understanding of the need for a facility specifically to handle adolescent relates sexual issues. As earlier indicated in this report, adolescents represent an important population that deserves special attention and in an attempt to prevent or reduce the spread of HIV/AIDS among adolescents in Africa, School-based HIV/AIDS prevention programs are the most effective, in terms of disseminating sexual reproductive health information.

There are some HIV and AIDS centers, under Ministry of Health in the Districts, but the fact that there are managed by adults is a hindrance to the adolescents as it does not allow them the openness that they require. These Centers would even organize seminars and refresher training for all the members of the Anti-AIDS clubs in the District. At the moment these are very erratic and pupils depend on their patrons to get this information.

6.2.2 School Curriculum Enhancement

There is need for the curriculum to be enhanced in such a way that HIV and AIDS is taught fully and in a practical way. At the moment it is a topic and incorporated in subjects like Life Skills and Science. A recommendation by. Kaaya et al., (2002) and Malambo (2002) state that initiating these programs when children are at a young age and developing the appropriate message before they leave school will assist in preventing risky sexual behavior even later in life. A study by Mouli (1991), cited in Malambo (2002), indicated that most teachers thought HIV/AIDS prevention programs should be done at an early age, before children started experimenting with sexual behavior. However, some teachers, at the time of the study, were hesitant to talk about sex, but only wished to do this if incorporated in other programs, such as human biology, religious education or behavioral science.

6.2.3 Encouraging peer education in the school

There is need for this to be encouraged at National, Regional and District level of the Ministry of Education in collaboration with Ministry of Health. This need to be included in the Policy because as at now the HIV and AIDS Policy does not clearly indicate the inclusion of peers counseling each other or Anti-AIDS clubs.

A study by Turner and Shepherd recommends this approach and stated that it was the most cost effective than any other methods. They recommend that Peers as a credible source of information and empowering for those involved. Peers are more successful than professionals in passing on information because people identify with their peers. Peers can reinforce learning through constant interaction and contact because adolescence is a period when peers tend to have more influence than authority figures such as parents and teachers, peer leaders can model positive patterns of behavior.

6.3 LIMITATIONS OF THE STUDY

One of the major problems encountered was that of recruiting participants for the study. This was because the research was done for a period of 2 years. This was for the data to be realistic, the new Grade 10 members of the Anti-AIDS club had to be given time (first term) to be trained. The Grade 12 had to be on and off club activities, especially towards Mock exams and when preparing for exams in the third term. The other challenge was that the data collection and participant observation activities had to be done only when schools were open. It was later during data analysis when it was recommended that the sample size be increased. The researcher had to re conduct the research and by this time, pupils were writing their end of year final exams for Grade 12s and had to wait for the following year.

The naturalistic observation also took two weeks in each of the High schools so as to establish that the respondents were those being sought for, as outlined in the definitions. After explaining the purpose of the exercise the researcher was allowed to conduct the observation, but when it came to recruiting the participants, it was found that most Peer educators were in Grade 12 and had written their last paper and left. Only a few of them who were still clearing

and willing to participate in the study. This was particularly the case at Chingola High School. In addition, some of the pupils were above the required age. The pupils and teachers complained that they were being inconvenienced; as a result the researcher had to buy lunch for all respondents and teachers. Even though the study took long, there were still some areas that were left unexplored. One of the questions that remain unresolved is whether the adolescents that are still involved in risky sexual behavior are using protected sex or not. The Social economic status and type of households these adolescents were coming from was also not explored.

REFERENCES

Agyei-Mensah, S. 2001.Twelve Years of HIV/AIDS in Ghana: Puzzles of Interpretation. Canadian Journal of African Studies 35(3):441-472. 03.03.2008

AIDS Care (2008). *"The epidemiology of HIV infection in Zambia*. Central Board of Health.

Adimora et al. (2006). HIV and African Americans in the Southern United States: Sexual Networks and Social Context. Sexually Transmitted Diseases 2006: 33 *(7 supplement): S39-45.*

Africa Recovery (2003). *"Famine and AIDS batter Southern Africa', News release*.

Badcock-Walters P., Kelly M., and Görgens M., (2004). Does knowledge equal change? HIV/AIDS Education and Behaviour Change? *Centers for Disease Control and Prevention. Oral Abstract D4a – Prevalence of Sexually Transmitted Infections and Bacterial Vaginosis among Female Adolescents in the United States: Data from the National Health and Nutritional Examination Survey (NHANES) 2003-2004. 2008 National STD Prevention Conference (March2008).*

Central Statistics Office (CSO) (2003). *Zambia Demographic and Health Survey 2001– 2002.*

Calverton, Maryland, USA, Central Statistics Office, Central Board of Health: Zambia, and ORC Macro.

Ghosh, J and Kalipeni, E (2005). Women in Chinsapo, Malawi: Vulnerability and risk to HIV/AIDS. *Social Aspects of HIV/AIDS Research Alliance journal, 2(3), pp.320-332.*

Georges Guiella and Nyovani Janet Madise (2007). HIV/AIDS and Sexual-Risk Behaviors among Adolescents: Factors influencing the use of condoms in Burkina Faso. *African Journal of Reproductive Health Vol. 11 No.3 December, 2007.*

Glanz, K., Rimer, B.K. & Lewis, F.M. (2002). Health Behavior and Health Education. Theory, Research and Practice. San Fransisco: Wiley & Sons.

Jayson, Sharon (2007-02-15). "What's up with hookups? USA Today.

Kalunde, Kabwe, Wendy (1997). HIV/AIDS and sexual behavior among youth in Zambia, UNZA, Lusaka.

Kiirya, L. (2004). Culture and Gender-Related Factors Predicting HIV-Risk Sexual Behaviors Among Adolescents and Young Adults in Iganga District, Makerere Institute of Social Research, Uganda.

Koula Merakou and Jenny Kourea-Kremastinou (2006) Peer education in HIV prevention: *An evaluation in schools,* Makerere University.

Lewis, Benoit Denizet (2005). Friends with Benefits (windows media). *National Public Radio. Retrieved on 2008-04-15.*

Malambo Rosah Moonga (2000). Teach Them While They Are Young, They Will Live to Remember. The views of teachers and pupils on the teaching of HIV/AIDS in basic education: *A case study of Zambia's Lusaka and Southern Provinces*, University of Oslo.

Millennium Development goals -Progress Report Zambia (2013). Lusaka, Zambia.

Mmari, K.N. & Magnani, R.J. (2003). Does making clinic-based reproductive health services more youth-friendly increase service use by adolescents? Evidence from Lusaka, Zambia. *Journal of Adolescent Health 33, pp. 259–270.*

Morris, M. et al. (2006) Concurrent partnerships and the spread of HIV and AIDS 11(5), pp. 641–648.

Mukoma, W. (2001). Rethinking school-based HIV/AIDS interventions in South Africa. Southern African Journal of Child and Adolescent Mental Health, 13(1), 55-66.

Mukuka, L. and V. Slonim-Nevo. (2006)AIDS-related knowledge, attitude, and behavior among adolescents in Zambia, *Ethnicity and Disease* 16(2): 488–494.

Nshindano Chama and Pranitha Maharaj (2008) Reasons for multiple sexual partnerships: *Perspectives of young people in Zambia*, Lusaka, Zambia.

Ntombela Olivia Zanokuhle Nokuthula (2009) Learners awareness of HIV & AIDS and their attitudes towards peer educators in secondary schools, Pretoria, South Africa.

Pierson, Ntata et al (2008). *Gender differences in university students' HIV/AIDS related knowledge and sexual behaviors in Malawi: A pilot study.*

Panafrican New Agency (2001) "Controversial Testing Produces Unexpected Results.

PEPFAR (2008) "The Power of Partnerships: The U.S. President's Emergency Plan for AIDS relief. *2008 Annual Report to congress.*

Rasing, L. (2003) HIV/AIDS and sex education among the youth in Zambia: *Towards behavioral change.* Hamburg/Leiden: Lit Verlag/ASC.

Ryan, S. Manlove, J. and Franzetta, K. (2003): *First Time: Characteristics of Teens' First Sexual Relationships. Child Trends Research Brief. Child Trends*, 4301 Connecticut Ave NW, Suite 350, Washington, DC 20008.

Society for Family Health Report (2007), Lusaka, Zambia.

Stepp S. Laura (9/16/2005). *Study: Half of All Teens Have Had Oral Sex, Washington Post*

Sexually Transmitted Infections Report (2004) "Monitoring trends in sexual behavior in Zambia, 1996-2003", E Slaymaker and B Buckner, 80 (Suppl II)

The Lancet (2008) *'Zambia's health-worker crisis', Pp 639, Vol 371.*

Torimiro et.al. 2007, Sexual Risk Behavior: *A gender perceptional analysis of HIV/AIDS prevention strategies among the Nigerian rural youth*. Obafemi Awolowo University Ile-Ife, Nigeria.

Toroitich-Ruto, C. (2000). The Effect of HIV/AIDS on Sexual Behavior of Young People in Kenya, Family Health International, Nairobi, Kenya.

UNAIDS (2006). Sub-Saharan Africa. 2006 Epidemic Update. Available from: *URL: http;//www.unaids.org/en/HIV*

UNAIDS/WHO, (2008) *Report on the AIDS epidemic*, Geneva.

Underwood, C (2001) "Impact of the HEART Campaign, *Findings from the Youth Surveys, 1999 to 2000.*

UNDP Report (2007) Preventing HIV/AIDS among adolescents through integrated communication programming. Geneva.

UNICEF (2006). A Framework for the Protection, Care and Support of Orphans and Vulnerable Children Living in a World of HIV and AIDS. New York.

U.S. HIV/AIDS Surveillance: *General Epidemiology (Through 2006). Centers for Disease Control and Prevention, 2008. Available from; URL: http://www.cdc.gov/hiv/topics/surveillance/resources/slides/general/slides/general*

Van Dyk, 2003). HIV/AIDS: Care and Counseling- A Multidisciplinary Approach. CTP Book Printers; Cape Town

WHO (2006). 'The Health of Youth: Facts for Action', *Technical Discussion Paper, No. 5, Geneva*

WHO (2008) 'Towards Universal Access: Scaling up priority HIV/AIDS interventions in the health sector: *Progress report 2008*

Wilson, B. D. M., Miller. 2003. "Examining strategies for culturally grounded HIV prevention: a review." *AIDS Education and Prevention, 15 (2): 184-202.*

Zambia Country report (2012) *Monitoring the Declaration of Commitment on HIV and AIDS and the Universal Access, Biennial Report.* Lusaka.

Zambia Demographic and Health Survey (2005) Central Statistical Office, CBoH, ORC Macro.

Zambia Demographic and Health Survey (2007) – *Key Findings*. Lusaka.

Zambia Sexual Behavior Survey 2005, Central Statistical Office, CBoH. Lusaka.

APPENDIX 1: QUESTIONNAIRES

(a) QUESTIONNAIRE FOR NON-MEMBERS

School …….
Grade……..
Date ……..

STATEMENT OF CONFIDENTIALITY

This questionnaire is basically for Academic purposes only. There are a few questions that I would like you to answer. Some of them ask about personal and sensitive subjects, so I want to remind you that nobody here will see your answers. Several students like you will be asked to complete this questionnaire. All information collected will be used strictly for purposes of this study and will not be disclosed or released for any other purpose without prior consent.

PLEASE DO NOT WRITE YOUR NAME ON THIS QUESTIONNAIRE.

SECTION A: BIOGRAPHICAL DATA
Please provide the information below:

1. Please indicate whether you are a boy or a girl

   (a) Boy …….. (b) Girl ……

2. How old are you?

   (a) 15 years (b) 16 years (c) 17 years

   (d) 18 -19 years

3. Which Religious denomination/place of worship do you belong to?

   (a) Pentecostal (b) Roman Catholic (c) United Church of Zambia

   (d) Anglican (e) Methodist (f) Reformed (f) Other…… (Please specify)

   3.1 How often do you go to church/place of worship?

   (a) More than once a week

   (b) Once a week

   (c) Once every two weeks

   (d) Once a month

   (e) Once a year

   (f) Other …….

4. What church/religious activities are you involved in?

(a) Choir
(b) Sunday school/Children's church
(c) Youth group e.g.
(d) Usher
(e) Evangelism
(f) Intercession
(g) None
(h) Other

SECTION B:

Please answer the questions that follow as best as you can. There is no right or wrong answer.

Example:

1. What is sex?

(a) Playing with boys/girls (b) Having a boy/girls friend (c) Sexual Intercourse (d) Other

If my answer is 'c', I will put a circle around 'c' like this (c)

Part 1: Risky Sexual Behavior

5. How common is it for young people to have sex?

(a) Very common
(b) Common
(c) Not common
(d) I don't know

6. Have any of your friends had sex before?

(a) Yes (b) No (c) I don't know

7. Have you ever had sex?"

(a) Yes (b) No. If "No", skip to Q 8.

7.1 How old were you when you first had sex?

……

7.2 How long had you known this person before you had you had sex with him/her?

……..

7.3 What are some of the reasons that influenced you to have sex?

(a) Financial gain (b) to prove that I love him/her (c) To know how it feels (d) I was forced

(e) Its being done by every one of my age (f) for fun (g) other

7.4 Did you use any protection?

(a) Yes (b) No (c) I don't remember.

7.5 If yes, what protection did you use?

(a) Male condom (b) Female condom (c) Gel (d) Vaseline (c) Other

7.6 Why did you use this method?

(a) To avoid pregnancy (b) To prevent infection (c) To know how it feels with this method (d) Other

7.7 How did you learn about this method?

(a) From friends (b) From my boy/girlfriend (c) From the teachers (d) From the Peer Educators (e) From the Television and Newspapers (f) From the Anti-AIDS Club members (g) Other

How many people have you had sex with?

(a) One (b) two (c) Three (d) More than Three times (e) Other

7.8 When was the last time you had sex?

(a) This week (b) Last week (c) 2 weeks ago (d) Last Month (e) Some months ago

(f) Other

Section 2: Knowledge

8. What do you regard as risky sexual behavior? Tick all that you think are answers.

(a) Someone who has unprotected sex.

(b) Someone who has many sexual partners and does not use protection.

(c) Someone who like playing with girls/boys

(d) Someone who has sex but uses condoms

(e) Someone who has several partners and uses condoms (f) someone who does not have any sex at all.

(g) Other

8.1 Where did you get this information from?

(a) Friends (b) Teachers (c) Anti-AIDS club members (d) Television and Newspapers (e) Other

8.2 What can be done to reduce risky sexual behavior among young people?

(a) Use condoms at times

(b) Not to have sex at all

(c) Punish those that have sex

(d) Use condoms at all times when having sex

(e) Other

9. Is there an Anti-AIDS Club at this school?

(a) Yes (b) No (c) I don't know

9.1 Tick what you think members of the Anti-AIDS Club do.

Involved in HIV & AIDS Awareness Programs	Know how to Teach HIV & AIDS issues	They are able to explain properly HIV & AIDS issues	Do what they teach others

9.2 What information do Anti-AIDS Club members tell you about?

(a) Dangers of having sex (b) About how to use condoms (c) Abstinence, Being faithful and Condom Use (d) HIV & AIDS (d) Alcohol and Drug abuse (e) Other

9.3 How do they tell you this information?

(a) Pamphlets (b) During Assembly (c) Through one-to-one talks at break and lunch hour

(d) Other

9.4 Do they do it well or not?

(a) Very well (b) Not very well (c) A bit well

10. Do you want them to do more? (a) Yes (b) No

11. If your answer No, why do you say so?

……..

……

12. What information have you received from Anti-AIDS Club Members on risky sexual behavior?

(a) Nothing (b) That it can end into pregnancies (c) That it can lead to HIV & AIDS

13. How helpful has this information been to you?

(a) Very helpful

(b) Helpful

(c) Not helpful

(d) Not helpful at all

14. How often do the Anti-AIDS Club members hold each of the following activities shown in the table which follows?

	Once a week	Once a month	Once a term	Once a year	Never
(a) Competitions					
(b) Drama					
(c) Debates					
(d) Poems					
(e) Songs					

15. Is this enough according to you?

(a) Yes (b) No

16. If your answer is 'No', tick how often you would like these activities to be held.

(a) Weekly (b) Twice a month (c) Every Month (d) Every Term (e) Other

17. How common is it for children at this school to involve themselves in risky sexual behaviors?

(a) Very common (b) Common

(c) Not common (d) Not common at all

18. What do members of the Anti-AIDS Club do to reduce risky sexual behaviors among school children at this school?

(a) Hold writing competitions (b) Talk to us during break and lunch time (c) Perform plays about dangers of risky sexual behaviors (d) Nothing (e) Other

19. What effects have the activities of Anti/AIDS Club members' messages had on risky sexual behaviors among school children at this school?

(a) Very effective (b) Effective (c) Very little effect (d) Nothing (e) Other

20. What differences are there between members of the Anti-AIDS Club and other school children in terms of risky sexual behavior?

(a) Members of Anti-AIDS Club engage less in risky sexual behaviors than non-members

(b) Members of Anti AIDS Club engage more in risky sexual behaviors than nonmembers

(c) There is no difference between Members of Anti-AIDS Club and non-members in terms of engaging themselves in risky sexual behaviors

21. From what you know, are there any Anti-AIDS Club members who engage themselves in risky sexual behaviors?

(a) Yes (b) No. (c) I don't know

If your answer is 'b' or 'c', go to Question 21.1.

21.1 Why do you think they have involved themselves in risky sexual behavior?

(a) Financial gain (b) to prove that they love their partners (c) To know how it feels
(d) it's being done by every one of my age (f) for fun (g) other

22. How helpful has this information been to you?

(a) Very helpful

(b) Helpful

(c) Not helpful

(d) Not helpful at all

SECTIONC

Below are some statements relating to the work of Anti-AIDS Club Members in your school? You are also provided with the scale that runs from '0 to 5' next to each statement. In the rating scale, '0' means *never*, '1' means *rarely*, '2' means *sometimes*, '3' means *often*, '4' means *most often* and '5' means *always*.

State the number which best describes your rating about each statement.
For Example:

		Never	Rarely	Sometimes	Often	Most Often	Always
	There are plays by Anti-AIDS Club Members at this school.	0	1	2 **X**	3	4	5

If the answer is *Sometimes, I will put 'X' in the box.*

		Never	Rarely	Sometimes	Often	Most Often	Always
23	Since Anti-AIDS Club Members have learnt about Risky Sexual Behaviors, they inform others about its dangers.	0	1	2	3	4	5
24	Anti-AIDS Club Members should be provided with information regarding Risky Sexual Behavior.	0	1	2	3	4	5
25	Anti-AIDS Club Members have discussed information on Risky Sexual Behaviors with their fellow pupils	0	1	2	3	4	5

26	Anti-AIDS Club Members receive support from all teachers in the school	0	1	2	3	4	5
27	Anti-AIDS Club Members are supported by their fellow pupils	0	1	2	3	4	5

The following questions refer to the attitude pupils have about Anti-AIDS Club Members. Please answer, 'Not true', 'Not sure' or 'True'.

28	Anti-AIDS Club Members mix well with other pupils and can therefore influence them	**NOT TRUE**	**NOT SURE**	**TRUE**
29	Anti-AIDS Club Members are friendly to other pupils at school hence pupils feel free to ask about Risky Sexual Behaviors	**NOT TRUE**	**NOT SURE**	**TRUE**
30	Anti-AIDS Club Members share information with other pupils with regard to Risky Sexual Behaviors.	**NOT TRUE**	**NOT SURE**	**TRUE**
31	Anti-AIDS Club Members can express themselves well and are therefore listened to by fellow pupils.	**NOT TRUE**	**NOT SURE**	**TRUE**
32	Anti-AIDS Club Members are respected by other pupils	**NOT TRUE**	**NOT SURE**	**TRUE**
33	Anti-AIDS Club Members at my school are good role models and their behavioral pattern is positively influential to other pupils	**NOT TRUE**	**NOT SURE**	**TRUE**
34	Anti-AIDS Club Members are regarded by other pupils as more knowledgeable	**NOT TRUE**	**NOT SURE**	**TRUE**

35	Anti-AIDS Club Members offer advice to other pupils	**NOT TRUE**	**NOT SURE**	**TRUE**
36	Anti-AIDS Club Members also have sex with their partners	**NOT TRUE**	**NOT SURE**	**TRUE**

(Adapted from a study by ZanokuleNokuthula Olivia Ntobela)

<u>THANK YOU VERY MUCH FOR YOUR PARTICIPATION.</u>

(b) QUESTIONNAIRE FOR ANTI-AIDS CLUB MEMBERS

School …….
Grade……..
Date ……..

STATEMENT OF CONFIDENTIALITY

This questionnaire is basically for Academic purposes only. There are a few questions that I would like you to answer. Some of them ask about personal and sensitive subjects, so I want to remind you that nobody here will see your answers. Several students like you will be asked to complete this questionnaire. All information collected will be used strictly for purposes of this study and will not be disclosed or released for any other purpose without prior consent.

PLEASE DO NOT WRITE YOUR NAME ON THIS QUESTIONNAIRE.

SECTION A: BIOGRAPHICAL DATA

Please provide the information below:

1. Please indicate whether you are a boy or a girl

   (a) Boy …….. (b) Girl ……

2. How old are you?

   (a) 15 years (b) 16 years (c) 17 years

   (d) 18 -19 years

3. Which Religious denomination do you belong to?

   (a) Pentecostal (b) Roman Catholic (c) United Church of Zambia

   (d) Anglican (e) Methodist (f) Reformed (f) Other…… (Please specify)

4. How often do you go to church/place of worship?

   (a) More than once a week

   (b) Once a week

   (c) Once every two weeks

   (d) Once a month

   (e) Once a year

   (f) Other …….

5. What church/religious activities are you involved in?

(a) Choir
(b) Sunday school/Children's church
(c) Youth group e.g.
(d) Usher
(e) Evangelism
(f) Intercession
(g) None
(h) Other

6. How common is it for young people who come to your school to have sex?

(a) Very common
(b) Common
(c) Not common
(d) I don't know

7. Have any of your friends had sex before?

(a) Yes (b) No (c) I don't know

8. Have you ever had sex?"

(a) Yes (b) No. If "No", skip to Q 9.

8.1. How old were you when you first had sex?

……

8.2. How long had you known this person before you had you had sex with him/her?

……..

8.3. What are some of the reasons that forced you to have sex?

(a) Financial gain (b) to prove that I love him/her (c) To know how it feels (d) I was forced (e) Its being done by every one of my age (f) for fun (g) other

8.4. Did you use any protection? (a) Yes (b) No (c) I don't remember.

If answer is (b) skip to 8.8

8.5. What protection did you use?

(a) Male condom (b) Female condom (c) Gel (d) Vaseline (c) Other

8.6. Why did you use this method?

(a) To avoid pregnancy (b) To prevent infection (c) To know how it feels with this method (d) Other

8.7. How did you learn about this method?

(a) From friends (b) From my boy/girlfriend (c) From the teachers (d) From the Television and Newspapers (e) From the Anti-AIDS Club members (f) other

8.8. How many people have you had sex with?

(a) One (b) Two (c) Three (d) more than three times (e) Other 8.9 when was the last time you had sex?

(a) This week (b) Last week (c) 2 weeks ago (d) Last Month (e) Some months ago (f) Other

8.10. How many people have you had sex with?

(a) One (b) two (c) Three (d) I cannot remember (e) None (f) Other

SECTION B: The following questions relate to Risky Sexual Behavior Knowledge, Training and as a role model to others

Part 1: Risky Sexual Behavior

9. Are there any members of your club who are engaging in Risky Sexual Behaviors? (a) Yes (b) No.

If No go to Q 11.

10. Why do you think they are doing this?

(a) To buy food (b) to prove that they love their partner (c) To know how it feels (d) They are forced (e) it's being done by everyone (f) For fun (g) Other

11. Have you had sex before you became a member of the Anti-AIDS club? (a) Yes (b) No

If No go to Q 12.

11.1. When was this?

(a) This week (b) Last Month (c) Last Year (d) Other

11.2. What caused you do so?

(a) To buy food (b) to prove that I love my partner (c) To know how it feels (d) I was forced (e) it's being done by everyone (f) For fun (g) Other

12. Have you had sex since you became a member of the Anti-AIDS club? (a) Yes (b) No.

If No go to Q 13

12.1. When was this?

(b) This week (b) Last Month (c) Last Year (d) other

12.2. What forced you to do so?

(a) To buy food (b) to prove that I love my partner (c) To know how it feels (d) I was forced (e) It's being done by everyone (f) For fun (g) Other

13. When did you become a member of the Anti-AIDS club? Since Grade……..

(a) 8 (b) 9 (c) 7 (d) 10 (e) This Year

14. What is your role as a member of the Anti-AIDS club?

(a) To talk about the dangers of Risky Sexual Behavior with other pupils

(b) To distribute pamphlets to pupils on Abstinence and condom use

(c) To have competitions with other schools

(d) Other

15. Have you had any training to enable you carry out your work?

(a) No (b) Yes

If No, go to Q 16

15.1. How often do you have this training?

(a) Monthly (b) Termly (c) Twice a year (d) Once a year (e) Other

15.2. Who conducts the training?

(a) Our Patron (b) Other older members (c) The Teachers (c)Other

15.3. How good is the training that you have received?

(a) Very good (b) Good (c) Average (d) Poor (e) Other

16. Are you able to talk to your friends about Risky Sexual behaviors?

(a) Yes (b) No

If No, go to Q 17.

16.1. Which age of students do you find easy to discuss sexual issues with?

(a) Those younger than me (b) My age mates (c) Both older and younger than me (d) None

(e) Other

16.2. Why do you say so?

(a) Because I do not feel comfortable to talk about such topics.

(b) I have not been trained

(c) I don't know the topics very well

(d) Because it is easier for me

(e) Other

16.3. Which gender do you find easy to discuss sexual issues with?

(a) boys (b) girls (c) both boys and girls (d) None (e) Other

17. Why do you say so?

(a) Because I do not feel comfortable to talk about such topics.

(b) I have not been trained

(c) I don't know the topics very well

(d) Because it is easier for me

(e) Other

18. Which of the following do you do in order to try and reduce risky sexual behavior amongst your friends, at this school? Tick any of the answers below

(a) Drama

(b) Competitions

(c) Debates

(d) Poems

(e) During parade

19. How often is this done?

	Once a week	Once a month	Once a term	Once a year	Never
Competitions					
Drama					
Debates					
Poems					
At parade					

20. How often is it supposed to be done?

(a) Once a week (b) Once a month (c) Once a term (d) Once a Year

21. How do you reach out to every pupil at this school?

(a) One-to-One talks (b) Debates (c) Drama (d) Poems (e) Other

22. Which topics about Risky Sexual behavior do you find difficult to discuss with your school mates? Tick any of the answers below

(a) Use of condoms (b) Sex (c) Abstinence (c) Having partners (d) Other

23. Why?

(a) I do not feel comfortable to talk about such topics.

(b) I have not been trained

(c) I don't know the topics very well

(d) Other

24. Which topics are you able to discuss easily?

(a) Use of condoms (b) Sex (c) Abstinence (c) Having partners (d) Other

25. Why?

(a) I feel comfortable to talk about such topics.

(b) I have been trained

(c) I know the topics very well

(d) Other

Part 3: Role Model

26. What benefit has the Anti-AIDS Club activities been to your fellow pupils at this School?

(a) Very beneficial (b) Good (c) Average (d) Poor (e) Other

27. How common is it for children at this school to involve themselves in risky sexual behaviors? (a) Very common (b) Common (c) Not common (d) Not common at all

28. What do members of the Anti-AIDS Club do to reduce risky sexual behaviors among school children?

(a) One-to-One talks (b) Debates (c) Drama (d) Poems (e) Other

29. What effects have the activities of Anti-AIDS Club members had on risky sexual behaviors among school children at this school?

(a) Very effective (b) Effective (c) Average (d) Not effective (e) Other

30. What differences are there between members of the Anti-AIDS Club and other school children in terms of risky sexual behavior?

(a) Members of Anti-AIDS Club engage less in risky sexual behaviors than nonmembers

(b) Members of Anti-AIDS Club engage more in risky sexual behaviors than nonmembers

(c) There is no difference between Members of Anti-AIDS Club and non-members in terms of engaging themselves in risky sexual behaviors

31. Are there any Anti-AIDS Club members who engage themselves in risky sexual behaviors?

(a) Yes (b) No (c) I'm not sure

If No go to Q 32

31.1. Why do you think they are still practicing risky sexual behavior?

(a) Because of poverty (b) to prove that they love their partner (c) To know how it feels

(d) They are forced (e) it's being done by everyone (f) for fun (g) other

32. When pupils at this School have questions about risky sexual behavior where do they go for clarifications?

(a) Teachers (b) The Head Teacher (c) Anti-AIDS Club members (d) other

32.1. Why do you think so?

.....

……..

33. What suggestions to you have which can help to reduce risky sexual behavior amongst adolescents?

……

SECTION C

Below are some statements relating to the work of Anti-AIDS Club Members in your school? You are also provided with the scale that runs from '0 to 5' next to each statement. In the rating scale, '0' means *never*, '1' means *rarely*, '2' means *sometimes*, '3' means *often*, '4' means *most often* and '5' means *always*.

State the number which best describes your rating about each statement.

For Example:

		Never	Rarely	Sometimes	Often	Most Often	Always
	There are plays by Anti-AIDS Club Members at this school.	0	1	2 **X**	3	4	5

If the answer is *Sometimes, I will put 'X' in the box.*

		Never	Rarely	Sometimes	Often	Most Often	Always
34	Since Anti-AIDS Club Members have learnt about Risky Sexual Behaviors, they inform others about its dangers.	0	1	2	3	4	5
35	Anti-AIDS Club Members should be provided with information regarding Risky Sexual Behavior.	0	1	2	3	4	5
36	Anti-AIDS Club Members have discussed information on Risky Sexual Behaviors with their fellow pupils	0	1	2	3	4	5

37	Anti-AIDS Club Members receive support from all teachers in the school	0	1	2	3	4	5
38	Anti-AIDS Club Members are supported by their fellow pupils	0	1	2	3	4	5

The following questions refer to the attitude pupils have about Anti-AIDS Club Members. Please answer, 'Not true', 'Not sure' or 'True'.

39	Anti-AIDS Club Members mix well with other pupils and can therefore influence them	**NOT TRUE**	**NOT SURE**	**TRUE**
40	Anti-AIDS Club Members are friendly to other pupils at school hence pupils feel free to ask about Risky Sexual Behaviors	**NOT TRUE**	**NOT SURE**	**TRUE**
41	Anti-AIDS Club Members share information with other pupils with regard to Risky Sexual Behaviors.	**NOT TRUE**	**NOT SURE**	**TRUE**
42	Anti-AIDS Club Members can express themselves well and are therefore listened to by fellow pupils.	**NOT TRUE**	**NOT SURE**	**TRUE**
43	Anti-AIDS Club Members are respected by other pupils	**NOT TRUE**	**NOT SURE**	**TRUE**
44	Anti-AIDS Club Members at my school are good role models and their behavioral pattern is positively influential to other pupils	**NOT TRUE**	**NOT SURE**	**TRUE**
45	Anti-AIDS Club Members are regarded by other pupils as more knowledgeable	**NOT TRUE**	**NOT SURE**	**TRUE**

46	Anti-AIDS Club Members offer advice to other pupils	**NOT TRUE**	**NOT SURE**	**TRUE**
47	Anti-AIDS Club Members also have sex with their partners	**NOT TRUE**	**NOT SURE**	**TRUE**

(Adapted from a study by ZanokuleNokuthula Olivia Ntobela)

THANK YOU VERY MUCH FOR YOUR PARTICIPATION.

(c) QUESTIONNAIRE FOR PEER EDUCATORS

School …….
Grade……
Date ……..

STATEMENT OF CONFIDENTIALITY

This questionnaire is basically for Academic purposes only. There are a few questions that I would like you to answer. Some of them ask about personal and sensitive subjects, so I want to remind you that nobody here will see your answers. Several students like you will be asked to complete this questionnaire. All information collected will be used strictly for purposes of this study and will not be disclosed or released for any other purpose without prior consent.

PLEASE DO NOT WRITE YOUR NAME ON THIS QUESTIONNAIRE.

SECTION A: BIOGRAPHICAL DATA
Please provide the information below:

1. Please indicate whether you are a boy or a girl

   (a) Boy …….. (b) Girl ……

2. How old are you?

   (a) 15 years (b) 16 years (c) 17 years

   (d) 18 -19 years

3. Which Religious denomination do you belong to?

   (a) Pentecostal (b) Roman Catholic (c) United Church of Zambia

   (d) Anglican (e) Methodist (f) Reformed (f) Other…… (Please specify)

4. How often do you go to church/place of worship?

   (a) More than once a week

   (b) Once a week

   (c) Once every two weeks

   (d) Once a month

   (e) Once a year

   (f) Other …….

5. What church/religious activities are you involved in?

(a) Choir
(b) Sunday school/Children's church
(c) Youth group e.g.
(d) Usher
(e) Evangelism
(f) Intercession
(g) None
(h) Other

6. How common is it for young people who come to your school to have sex?

(a) Very common
(b) Common
(c) Not common
(d) I don't know

7. Have any of your friends had sex before?

(a) Yes (b) No (c) I don't know

8. Have you ever had sex?"

(a) Yes (b) No. If "No", skip to Q 9.

8.1. How old were you when you first had sex?

……

8.2. How long had you known this person before you had you had sex with him/her?

……..

8.3. What are some of the reasons that influenced you to have sex?

(a) Financial gain (b) to prove that I love him/her (c) To know how it feels (d) I was forced (e) Its being done by every one of my age (f) for fun (g) other

8.4. Did you use any protection? (a) Yes (b) No (c) I don't remember. If answer is (b) skip to 8.8

8.5. What protection did you use?

(a) Male condom (b) Female condom (c) Gel (d) Vaseline (c) Other

8.6. Why did you use this method?

(a) To avoid pregnancy (b) To prevent infection (c) To know how it feels with this method (d) Other

8.7. How did you learn about this method?

(a) From friends (b) From my boy/girlfriend (c) From the teachers (d) From the Television and Newspapers (e) From the Anti-AIDS Club members (f) Other

8.8. How many people have you had sex with?

(a) One (b) Two (c) Three (d) More than Three times (e) Other

8.9. When was the last time you had sex?

(a) This week (b) Last week (c) 2 weeks ago (d) Last Month (e) Some months ago (f) Other

8.10. How many people have you had sex with?

(a) One (b) Two (c) Three (d) I cannot remember (e) None (f) Other

SECTION B:

The following questions relate to Risky Sexual Behavior Knowledge, Training and as a role model to others

Part 1: Risky Sexual Behavior

9. Are there any members of your club who are engaging in Risky Sexual Behaviors? (a) Yes (b) No. (c) I don't know If No go to Q 11.

10. Why do you think they are doing this?

(a) To buy food (b) to prove that they love their partner (c) To know how it feels (d) They are forced (e) it's being done by everyone (f) For fun (g) Other

11. Have you had sex before you became a member of the Anti-AIDS club? (a) Yes (b) No

If No go to Q 12.

11.1. When was this?

(c) This week (b) Last Month (c) Last Year (d) other

11.2. What caused you do so?

(a) To buy food (b) to prove that I love my partner (c) To know how it feels (d) I was forced (e) it's being done by everyone (f) For fun (g) Other

12. Have you had sex since you became a member of the Anti-AIDS club? (a) Yes (b) No.

If your answer is 'No' go to Q 13

12.1. When was this?

(d) This week (b) Last Month (c) Last Year (d) other

12.2. What caused you do so?

(a) To buy food (b) to prove that I love my partner (c) To know how it feels (d) I was forced (e) It's being done by everyone (f) For fun (g) Other

13. When did you become a member of the Anti-AIDS club? Since Grade……..

(a) 8 (b) 9 (c) 10 (d) 10 (e) This Year

14. What is your role as a member of the Anti-AIDS club

(a) To talk about the dangers of Risky Sexual Behavior with other pupils

(b) To distribute pamphlets to pupils on Abstinence and condom use

(c) To have competitions with other schools

(d) Other

15. Have you had any training to enable you carry out your work?

(a) No (b) Yes

If the answer is 'No', go to Q 16

15.1. How often do you have this training?

(a) Monthly (b) Termly (c) Twice a year (d) Once a year (e) Other

15.2. Who conducts the training?

(a) Our Patron (b) The Peer Educators (c) The CHEP Coordinator (c)Other

15.3. How good is the training that you have received?

(a) Very good (b) Good (c) Average (d) Poor (e) Other

16 Are you able to explain topics about Risky Sexual behaviors to your peers?

(a) Yes (b) No (c) At times

16.1 Which age of students do find easy to discuss sexual issues with?

(a) Those younger than me (b) My age mates (c) Both older and younger than me

(d) None

(e) Other

17 Why do you say so?

(a) I do not feel comfortable to talk about such topics.

(b) I have not been trained

(c) I don't know the topics very well

(d) Because it is easier for me

(e) Other

18. Which gender do find easy to discuss sexual issues with?

(a) Boys (b) girls (c) both boys and girls (d) None (e) Other

19. Why do you say so?

(a) I do not feel comfortable to talk about such topics.

(b) I have not been trained

(c) I don't know the topics very well

(d) Because it is easier for me

(e) Other

20. Which of the following do you do in order to try and reduce risky sexual behavior amongst your peers, at this school?

(a) Drama

(b) Competitions

(c) Debates

(d) Poems

(e) Assembly talks

21. How often is this done?

	Once a week	Once a month	Once a term	Once a year	Never
Competitions					
Drama					
Debates					
Poems					
Assembly Talks					

22. How often is it supposed to be done?

(a) Once a week (b) Once a month (c) Once a term (d) Once a Year

23. How do you reach out to every pupil at this school?

(a) One-to-One talks (b) Debates (c) Drama (d) Poems (e) Other

24. Which topics about Risky Sexual behavior do you find difficult to discuss with your school mates?

(a) Use of condoms (b) Sex (c) Abstinence (c) Having partners (d) All of them

25. Why?

(a) I do not feel comfortable to talk about such topics.

(b) I have not been trained

(c) I don't know the topics very well

(d) Other

26. Which topics are you able to discuss with ease?

(a) Use of condoms (b) Sex (c) Abstinence (c) Having partners (d) Other

27. Why?

(a) I feel comfortable to talk about such topics.

(b) I have been trained

(c) I know the topics very well

(d) Other

Part 3: Role Model

28. What benefit has the Anti-AIDS Club activities been to your fellow pupils at this School?

(a) Very beneficial (b) Good (c) Average (d) Poor (e) Other

29. How common is it for children at this school to involve themselves in risky sexual behaviors? (a) Very common (b) Common (c) Not common (d) Not common at all

30. What do members of the Anti-AIDS Club do to reduce risky sexual behaviors among school children?

(a) One-to-One talks (b) Debates (c) Drama (d) Poetry (e) Other

31. What effects have the activities of Anti-AIDS Club members had on risky sexual behaviors among school children at this school?

(a) Very effective (b) Effective (c) Average (d) Not effective (e) Other

32. What differences are there between members of the Anti-AIDS Club and other school children in terms of risky sexual behavior?

(a) Members of Anti-AIDS Club engage less in risky sexual behaviors than non-Members

(b) Members of Anti-AIDS Club engage more in risky sexual behaviors than non-Members

(c) There is no difference between Members of Anti-AIDS Club and non-members in terms of engaging themselves in risky sexual behaviors

33.1. What differences are there between peer educators and nonmembers of the Antacid's club in terms of risky sexual behavior?

(a) Peer Educators do not engage themselves in risky sexual behaviors than non-Members

(b) Peer educators engage more in risky sexual behaviors than non-Members

(c) They all engage themselves in risky sexual behaviors

33.2. What differences are there between peer educators and members of the Anti-AIDS club in terms of risky sexual behavior?

(a) Peer Educators do not engage themselves in risky sexual behaviors.

(b) Peer educators engage more in risky sexual behaviors than non-members

(c) They all engage themselves in risky sexual behaviors

(d) They both do not engage themselves in risky sexual behavior

34. From what you know, are there any Anti-AIDS Club members who engage themselves in risky sexual behaviors?

(a) Yes (b) No

If No go to Q 35

34.1

34.2

34.3 Why do you think so?

(a) Because of poverty (b) to prove that they love their partner (c) To know how it feels

(d) They are forced (e) it's being done by everyone (f) for fun (g) other

35. Are there any Peer educators who engage themselves in risky sexual behaviors?

(a) Yes (b) No

If No go to Q 36

35. 1 why do you think so?

(a) Because of poverty (b) to prove that they love their partner (c) To know how it feels

(d) They are forced (e) it's being done by everyone (f) for fun (g) other

36. When pupils at this School have questions about risky sexual behavior where do they go for explanations?

(a) Teachers (b) The Head Teacher (c) Peer educators (d) Anti-AIDS Club members (d) other

36.1 Why do you think so?

……
……

36.2 When you have questions about risky sexual behavior where do you go for explanations?

(a) Teachers (b) The Head Teacher (c) Peer educators (d) Anti-AIDS Club members (d) other

36.3 Why do you do so?

……..

37. Are you able to educate your friends who you know are involved in risky sexual behavior?

(a) Yes (b) No(c) At times

If the answer is 'Yes', how do you do it.

……

If the answer is 'No', why?

……

38. What ideas do you have which can help to reduce risky sexual behavior amongst young People? ……

SECTION C

Below are 10 statements relating to the work of peer education in your school? You are also provided with the scale that runs from '0 to 5' next to each statement. In the rating scale, '0' means never, '1' means rarely, '2' means sometimes, '3' means often, '4' means most often and '5' means always.

State the number which best describes your rating about each statement.

For Example:

		Never	Rarely	Sometimes	Often	Most Often	Always
	There are trained peer educators at this school.	0	1	2 X	3	4	5

If my answer is 'Sometimes', then I will put an 'X' in the box as written above.

		Never	Rarely	Sometimes	Often	Most Often	Always

39	The school has continued with peer education to bring about awareness on Risky Sexual Behaviors	0	1	2	3	4	5
40	The peer education sessions are good to attend	0	1	2	3	4	5
41	Since peer educators have learnt about Risky Sexual Behaviors, they inform others about its dangers.	0	1	2	3	4	5
43	Peer educators should be provided with information regarding Risky Sexual Behavior.	0	1	2	3	4	5
44	Peer educators have discussed information on Risky Sexual Behaviors with their fellow pupils	0	1	2	3	4	5
45	Some people have been protected from getting infected with the HIV virus by learning about dangers of Risky sexual behaviors	0	1	2	3	4	5
46	Peer educators must be given the opportunity to address their fellow pupils whenever they	0	1	2	3	4	5

	have attended training						
47	Peer education receives support from all teachers in the school	0	1	2	3	4	5
48	Pupils who are peer educators are supported by their fellow pupils	0	1	2	3	4	5

The following questions refer to the attitude pupils have about peer educators.

Please answer, 'Not true', 'Not sure' or 'True'.

49	Peer educators mix well with other pupils and can therefore influence them	NOT TRUE	NOT SURE	TRUE
49	Peer educators are friendly to other pupils at school hence pupils feel free to ask about Risky Sexual Behaviors	NOT TRUE	NOT SURE	TRUE
50	Peer educators share information with other pupils with regard to Risky Sexual Behaviors.	NOT TRUE	NOT SURE	TRUE
51	Peer educators can express themselves well and are therefore listened to by fellow pupils.	NOT TRUE	NOT SURE	TRUE
52	Peer educators are respected by other pupils	NOT TRUE	NOT SURE	TRUE
53	Peer educators at my school are good role models and their behavioral pattern is positively influential to other pupils	NOT TRUE	NOT SURE	TRUE

54	Peer educators have outstanding performance in class	NOT TRUE	NOT SURE	TRUE
55	Peer educators are regarded by other pupils as more knowledgeable about Risky Sexual Behavior.	NOT TRUE	NOT SURE	TRUE
56	Peer educators offer advice to other pupils	NOT TRUE	NOT SURE	TRUE
57	Peer educators discriminate other pupils at school	NOT TRUE	NOT SURE	TRUE
58	Peer educators are hypocrites	NOT TRUE	NOT SURE	TRUE

(Adapted from a study by ZanokuleNokuthula Olivia Ntobela)

THANK YOU VERY MUCH FOR YOUR PARTICIPATION.

(d) INTERVIEW QUESTIONS FOR ANTI-AIDS CLUB PATRONS

School …….
Questionnaire Number……..
Date ……..

STATEMENT OF CONFIDENTIALITY

This questionnaire is basically for Academic purposes only. There are a few questions that I would like you to answer. Some of them ask about personal and sensitive subjects, so I want to remind you that nobody here will see your answers. Several students like you will be asked to complete this questionnaire. All information collected will be used strictly for purposes of this study and will not be disclosed or released for any other purpose without prior consent.

PLEASE DO NOT WRITE YOUR NAME ON THIS QUESTIONNAIRE.

SECTION A: BIOGRAPHICAL DATA

Please provide the information below:

1. Gender (a) Male (1) (b)Female (2)
2. Age: 25-30 years (1) 31-40 years (2) 41years and above (3)
3. For how long have you worked as a teacher? 5 -10 years (1)

   11-15 years (2)

   16-21 Years (3)

   22 years or more (4)
4. For how long have you been a patron? 1 - 3 years (1)

   3 - 6 years (2)

   7 – 10 Years (3)

   10 years or more (4)
5. What other clubs are you a patron of?
6. What is your main role? …….....

   ……

7. How do members disseminate information about HIV/AIDS to peers?

……

8. What gender is in the majority?
9. Why do you think so?

……

10. What do you think has motivated pupils to join the Anti-AIDS club?

……

11. Of what benefit has the information to the members of the club? ……..

……

12. How is the information pupils get from the Anti-AIDS members consolidated in class lessons?

……..

……

13 What is the difference between members of Anti-AIDS clubs, Peer educators and nonmembers, in terms of?

A)

Knowledge……

……

b) Attitudes ……..

……

c)Practice ……

……

d) Behavior change……

……

14. How is the sexual behavior of adolescents at this school?

……

……..

15. Why do you think this is so? ……..

……

16. Do you integrate HIV/AIDS information in your subjects and interaction with the pupils of this school?

17. How?

……

……

……

18. Why?

……

……

19. What challenges do you face? ……

(a) As a Patron.....

……

……

(b) As a Teacher…….

……

20. What do you suggest?

.....

.....

.....

THANKYOU FOR YOUR TIME

FOCUS GROUP DISCUSSION POINTS

1. Since Anti-AIDS club members have learnt about risky sexual behaviors, they inform others about its dangers.
2. Anti-AIDS club members receive support from all teachers in the school
3. Anti-AIDS club members mix well with other pupils and can therefore influence them
4. Anti-AIDS club members are friendly to other pupils at school hence pupils feel free to ask them about risky sexual behaviors
5. Anti-AIDS club members can express themselves well and are therefore listened to by fellow pupils.
6. Anti-AIDS club members at my school are good role models and their behavior has positive influence on other pupils
7. Anti-AIDS club members are regarded by other pupils as more knowledgeable