

**TEACHERS' VULNERABILITY TO HIV/AIDS
INFECTION: THE CASE OF LUSAKA DISTRICT.**

BY

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DEDICATION


This piece of work is dedicated to my late parents, my wife and children. It is also dedicated to those People Living With HIV/AIDS (PLWHAs), teachers in particular.

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DECLARATION

I, the undersigned, declare that this dissertation represents my own work; that it has not previously been submitted for a degree at the University of Zambia or at any other University and that it does not incorporate any published work or material from other theses.

Signed 

Date 12/04/06

APPROVAL

The University of Zambia approves this dissertation by Jonathan Chankabalala Munachaka as fulfilling part of the requirements of the degree of Master of Educational Psychology.

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ABSTRACT

The sexual transmission of HIV continues at an alarming rate in sub-Saharan Africa despite high knowledge levels of HIV/AIDS. Some factors such as socio-economic, culture, attitudes, communication and perception of risk to HIV may be responsible for engaging in risk sexual behaviors.

A cross sectional descriptive qualitative study of "Teachers' Vulnerability to HIV/AIDS Infection: The Case of Lusaka District", involving 300 government school teachers, was carried out. This study was carried out in Lusaka District from October to December 2003. Questionnaires, FGDs, interview and observations were used to collect data. For the purpose of this study a convenient sample of 300 teachers was used to select the teachers from 14 schools situated in the Lusaka District.

The study sought to determine the factors that make teachers vulnerable to HIV/AIDS infection; establish the gender difference to HIV/AIDS infection; and suggest interventions on how to fight, prevent and control it.

The findings show that the subjects had high level of knowledge on HIV/AIDS, though this did not motivate behaviour change as evidenced by low use of condoms by the subjects. For instance, only 27.7% used condoms. Only 10.3% of those who used condoms used them consistently. Some could not *use them because of their religious beliefs and lack of enjoyment during their use*. Almost one-half (47%) of the respondents believed that condoms were

porous and could allow the virus to pass and infect the sexual partner. Others believed that AIDS could be cured by herbal medicine and prayers. Misconceptions about the mode of transmission of HIV were also reported by the respondents such as that HIV is spread by mosquito bites, witchcraft, use of the same cup with the infected and condom lubricant.

There were no significant workplace programmes for teachers found at schools. Apart from the teacher co-ordinators of pupils' Anti-AIDS clubs, there was no teacher involvement in such clubs. Condoms (male) were only dispersed at one school by a head teacher and most of the teachers reported that they were mostly and usually shy to collect them from their boss. Teachers' AIDS awareness workshops and seminars were irregular and often conducted by the NGOs to very few selected teachers due to high costs involved in organising such trainings. Those teachers who were suspected of suffering from AIDS were not likely to be promoted or recommended because they were seen not to perform.

The study revealed that multiple partnership and sex with non-regular partners, including pupils (72%), prevailed among teachers thereby exposing them, both teachers and pupils, to the risk of HIV infection. The fact that almost one-quarter of teachers were single raised concern of their increased risk of HIV infection as they would be in unsteady sexual relationships.

The majority (63%) of the respondents did not know their HIV status. Despite the fact that 32% of the respondents claimed that they were negative, no one

reported to be positive while 42% and 49.3% reported that they were neither afraid nor at risk of acquiring HIV/AIDS, respectively. Another 32% of the respondents were not willing to have an HIV test for fear of dying early or being stigmatised and discriminated if the results were positive. This was so despite the government's effort, through the MoH, of supplying free ARVs to sick teachers. This study finding demonstrated the need for strong VCT campaign among the teachers.

More female than male teachers were either widowed, divorced or in polygamous marriages. In addition, 9.5% of women also used herbs before sex with their partners to increase sexual arousal, warm vagina and body or contract vagina, among other reasons. Others used ditto, salt solution, vagina douching and tissue paper. The study showed that female teachers were at high risk for HIV infection due to laceration of mucosa. It revealed that the imbalance of power between men and women constrained women's choices with regard to safer sex and continued to affect their decisions. There were several interrelated factors to account for this including social, economic and cultural status of women.

Raising knowledge through exposure to information did not lead to optimal behaviour change if risk perception was not also increased. Increases in knowledge must occur concurrent with increases in risk perception for optimal reduction in risk taking behaviour to result. Expectation that attitudes predicted or influenced behaviour was often violated. The prediction of

behaviour from attitudes could be improved if situational variables were considered.

Innovative sex and reproductive health education and human rights sensitisation were proposed to continuously be offered to teachers, with special emphasis to women. Mass media campaigns should also systematically be designed and mounted in communication about HIV/AIDS.

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LIST OF ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ARRM	AIDS Risk Reduction Model
ARV	Antiretroviral
AU	African Union
BESSIP	Basic Education Sub- Sector Implementation Programme
CBoH	Central Board of Health
COMESA	Common Market for Eastern and Southern Africa
CSW	Commercial Sex Worker
EFA	Education For All
FGD	Focus Group Discussion
GDP	Gross Domestic Product
HBM	Health Belief Model
HIPIC	Highly Indebted Poor Country
HIV	Human Immune Virus
MDG	Millennium Development Goals
MoE	Ministry of Education
MoH	Ministry of Health
NASTLP	National AIDS STIs and Leprosy Programme
PLC	Public Limited Company
PLWHA	People Living With HIV/AIDS
SAfAIDS	Southern Africa AIDS Focus
STI	Sexually Transmitted Infections
THPAZ	Traditional Health Practitioners Association of Zambia.
UNAIDS	Joint United Nations Programme on HIV/ AIDS

UNICEF	United Nations Children's Fund
UNDP	United Nations Development Programme
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation
ZSBS	Zambia Sexual Behaviour Survey

CHAPTER 1

INTRODUCTION

Acquired immune deficiency syndrome (AIDS) is a condition caused by a virus called human Immune-deficiency virus (HIV) that affects the body's immune system and leads to fatal health problems. It is transmitted from an infected person to another person through exchange of body fluids, mostly during sexual contact through unprotected sex. The majorities of infected individuals look healthy and feel well for many years after infection. They may not even suspect they harbour the virus, though they can transmit it to others. UNAIDS estimates are that 90% of all HIV infected people worldwide do not know they have the virus (UNAIDS, 1998). A laboratory blood or saliva test is the only certain way to determine whether an individual is HIV positive. Once they have an established HIV infection, individuals are infected for life and will succumb to opportunistic infections caused by the weakening of their immune systems. Treatment with antiretroviral (ARV) drugs can slow the progression of HIV infection but these expensive medications are not readily available to most people in the developing world, who often lack access even to drugs that combat opportunistic diseases.

HIV infection is caused by HIV-1 and HIV-2, the two main types of the virus (Mertens and Piot, 1997). Globally, HIV-1 accounts for most HIV infections and HIV- 2 appears largely confined in West Africa, with foci in Angola and Mozambique and some cases reported in Europe, the Americas and India. The prevalence of HIV-2 is lower than that of HIV-1 where the two types coexist, with the exception of Guinea- Bissau, where HIV-2 predominates. Compared with

HIV-1, HIV-2 appears less transmissible through sexual intercourse, its spread is slower and the disease it causes progresses more slowly. In contrast to HIV-1, HIV-2 prevalence increases steadily with age. Throughout this paper, the abbreviation HIV refers to HIV-1.

The global scale of the AIDS epidemic is enormous. By the end of 2003, about 37.8 million people were living with HIV/AIDS, of which 25 million were found in sub-Saharan Africa and about 4.8 million became newly infected and 2.9 million died from AIDS (UNAIDS, 2004). Since the beginning of the epidemic more than 50 million people have been infected with HIV and during 1999, 5.4 million people contracted HIV and 2.8 million people died from the disease (UNAIDS, 2000). Over 5 million were being infected annually, half of them young people between the ages of 15-24. Of those infected 30-50% were expected to die within 5-10 years of acquiring the disease. Due to high fatality rate and lack of curative treatment or vaccine, this cumulative toll is expected to double by 2010.

Sub-Saharan Africa, despite having just over 10% of the world's population, has more than 60% (25.4 million) people living with HIV (UNAIDS, 2005). In 2004, 3.1 million people in the region became newly infected while 2.3 million died of AIDS. Among young people aged 15-24 years, about 6.9% of women and 2.1% of men (with average 36 young women, for every 10 young men) were living with HIV at the end of 2003. According to UNAIDS (2005) report, women are disproportionately affected by HIV and they (women and girls) comprise 57% of adults living with HIV in sub-Saharan Africa.

Within the Sub-Saharan Africa, the Common Market for Eastern and Southern Africa (COMESA) region has one of the highest rates of infection, as high as 30 percent of the population in some countries and consequently, life expectancy in many countries has dropped by as much as 30% in the last five years (COMESA, 2000). Human capital flight (brain drain), conflicts and debt burden are other critical challenges facing the regional economy other than HIV/AIDS pandemic.

South Africa, with prevalence rate of 21.5% has the highest (after India and Nigeria) number of people living with HIV in the world. By the end of 2003, 5.3 million, 2.9 million of them women, were living with HIV in South Africa (UNAIDS, 2005). Botswana has one of the highest recorded HIV prevalence levels in the world, estimated at 37.3% of the adult seroprevalence among its 1.7 million people (UNAIDS, 2004). One in eight babies is born HIV-positive and 66,000 children have been orphaned by the epidemic (UNAIDS, 2004).

In Zimbabwe, with prevalence rate of 24.6% of HIV/AIDS infection (UNAIDS / WHO, 2005), 1,200 people die from AIDS each week (UNAIDS, 2001). Almost 13,000 people in Namibia, with prevalence rate of 21.3% (UNAIDS/WHO, 2005) were diagnosed with HIV in 1998. 23% of all deaths that occur in hospitals in that country are AIDS related. In urban areas one in every four pregnant women is HIV- positive. According to UNICEF report almost one third of the population of Swaziland is HIV positive (UNAIDS, 2001).

Some countries in East and West Africa show signs of declines in HIV infection levels. The steepest drop has been in Uganda and Senegal. In Uganda, national prevalence fell from 13% in the early 1990s to 4.1% by the end of 2003 (UNAIDS, 2005). Senegal has a prevalence rate of 0.8%. This does not seem to suggest that the fight against HIV/AIDS has been won. There is still an enormous work to be done to prevent newly infections and complacency should be avoided at all cost.

HIV/AIDS is a problem that cuts across all segments of society and impacts a wide range of sectors. It is intrinsically linked to core technical areas of development work and poses a threat to sustainable development and exacerbates poverty (World Bank, 1996). In human development terms, the epidemic dramatically increases mortality rates, thereby reducing life expectancy and causing distortions in population structures of severely affected countries (UNDP, 1996).

The epidemic is devastating families, increasing health care costs, weakening economies and reversing many of the development gains of the last decades. AIDS is now one of the world's leading killers among infectious diseases (WHO, 1998). The impact of the epidemic extends throughout the economy and forces nations to make choices between today and future lives and between health and other important investments for development.

AIDS is slowing the growth of national economies by reducing the size and productivity of the labour force, diverting savings to medical and funeral expenses and decreasing public spending on health and welfare services. The microeconomic effects of AIDS such as absenteeism, decline in skilled workforce, higher payments for sickness and death benefits are already having an impact on national production and income in parts of sub-Saharan Africa. It is estimated, for example, that by 2005 Kenya's Gross Domestic Product (GDP) will be 15% smaller than it would have been without AIDS (UNDP, 1999).

One World Bank study attempted to quantify the effects of AIDS on the school system. The study found that under the worst- case scenario of the AIDS epidemic in Tanzania, by the year 2020, the cohort size would shrink by 22% for primary school - aged children and 14% for secondary school - aged children relative to an AIDS- free scenario (World Bank, 1992). The study also predicted that by 2010, Tanzania would have lost 14,460 teachers to AIDS. By 2020, some 27,000 teachers will have died. Training replacement teachers for the year 2020 will cost about \$37.8 million (in 1991 dollars) in recurrent costs. HIV/AIDS epidemic has, by large, increased the cost of achieving Education for All (EFA) and the Millennium Development Goals (MDG) by 2015 (World Bank, 2002).

The Zambian Situation

The first AIDS case in Zambia was identified in 1984 (Stover and Johnston, 1999). An estimated 16% of the adult population is currently infected with the HIV and most of these people do not even know they are infected (NAC, 2004).

ZDHS of 2001/2002 reported that the proportion of women and men who tested HIV- positive was 18% and 13%, respectively (CSO, 2003). One in six adults in Zambia is living with HIV. HIV prevalence is highest in Lusaka (22%) and Copperbelt (20%) Provinces with one out of every five adults infected with HIV (NAC, 2004; UNFPA, 2004). Southern and Central Provinces are next highest with prevalence rate of 18% and 15%, respectively. Eastern and Western Provinces have 14% and 13%, respectively, followed by Luapula (11%), North-Western (9%) and Northern (8%).

The number of annual new AIDS cases in Zambia was about 13,700 in 1990 but rose to 82,300 in 2000 and it would rise to 95,800 in 2005 and drop to 93,100 in 2010 (NAC, 2004). It is estimated that 260 people in Zambia develop AIDS every day. According to NAC (2004) in 1990 10,600 people died from AIDS and rose to 76,700 in 2000, 95,400 by 2005 and 94,100 in 2010. In 2004 over 255 Zambians were dying from AIDS every day. Since the beginning of the epidemic 1.4 million people will have cumulatively died by 2010 (CSO, 2003). Based on current projections, national prevalence rates should drop to 6% by 2025 if the government targets are reached (UNFP, 2004).

Early government responses to the epidemic focused on the prevention of blood supplies and the dissemination of information to the public on how to prevent HIV infection. A broader partnership or multi-Sectoral approach (NAC, 2004) with multi-level understanding later replaced the initial biomedical response. The holistic multi- Sectoral approach involves linkages with government ministries at

all levels, local and international NGOs, CBOs, FBOs, the private sector, UN, multilateral and bilateral co-operating partners. All these are empowered to develop and implement HIV/AIDS policies, strategies and interventions using their different comparative advantages.

The overall vision of the Zambian response, as stated in the *National HIV/AIDS Policy*, is to have a nation free from HIV/AIDS (NAC, 2004). The Zambian response involves interventions to mitigate the spread of HIV, provide care and support to the infected and affected. This has been made possible through the formulation of the *National HIV/AIDS/STI/TB Policy*, the *National HIV/AIDS Intervention Strategic Plan 2002-2005*, partnerships, increased funding for HIV/AIDS programmes, gender balancing, fighting stigma and discrimination and respecting human rights and dignity of HIV infected people (NAC, 2004). Some of the interventional responses include behaviour change communication (BCC), use of the ABC model, social marketing of condoms (condom promotion), VCT, controlling STIs and PMTCT. Others are care and support for PLWHA and OVCs, provision of ARVs and ART and collaborating with groups with high-risk behaviours.

AIDS related illnesses and deaths among employees have affected firms by increasing expenditures and reducing revenues. According to Baggley et al (1994) in Zambia, the crude mortality rate for employees of 33 factories and other businesses soared from 2.5 deaths per 1000 persons in 1987 to 183 in 1993, an increase virtually wholly attributed to HIV-related disease. At Chilanga Cement

PLC, the number of hours lost to illness and funerals increased by three times from 13380 hours in 1992/93 to 43,370 in 1994/95 because of the growing epidemic. For Indeni Petroleum Refinery, the cost of medical care, salary compensation for the families of the deceased employees and funeral grants more than doubled between 1991 and 1993 and had exceeded profits by 1996. Medical expenses and training costs increased while person/man hours reduced (MoH/CBoH, 1999; NAC, 2000). Long distance truckers are also at risk of getting infected with HIV. Dar Farms International, one of the largest trucking companies in Zambia, lost 39 out of 144 drivers to AIDS between 1996 and 1999 and yet it takes at least three years to train such a driver (NAC, 2000). According to NAC (2000) uninformed personnel are vulnerable to HIV infection, in part, as a result of their high mobility, which keeps them away from their partners for extended periods of time. This group includes soldiers, police, nurses, airmen, and national service personnel.

Within the education sector most teachers fall in age groups that are most vulnerable to HIV infection. Earlier evidence indicates that teachers in Zambia are a very high-risk group (Fylkesnes, Brunbory and Msiska, 1994). The teaching profession has already lost many of its members to AIDS and may lose many more (MoE, 1999). Such losses have made it increasingly difficult to fully staff existing schools by qualified teachers and to provide education to all eligible children. On the other hand, training costs for teachers rise to replace those lost to the epidemic and public finance is increasingly becoming less available for

education sector because of, in part, diversion of public funds to address HIV/AIDS epidemic (MoH/CBoH, 1999).

Investment in education is vital because it promotes achievement of several of the MDGs, adopted unanimously by 189 countries in September 2000, which include reducing poverty and hunger, achieving universal primary education, improving gender equality and empowering women, reducing infant and child mortality, improving maternal health, lowering the prevalence of HIV/AIDS, ensuring environmental sustainability and developing a global partnership for development (World Bank, 2002). In addition, the endorsement of the EFA at the World Education Forum in Dakar, Senegal, in April 2000 by 155 countries will be a catalyst to reaching MDGs. EFA partnership is committed to ensuring that by 2015 all children, especially girls, children in difficult circumstances and those from ethnic minorities, have access to and complete free and compulsory education of good quality (World Bank, 2000). In addition, it commits the partnership to eliminating gender disparities in primary and secondary education. Fighting HIV/AIDS infection among teachers is seen to be critical and imperative in order to achieve both Millennium Development Goals (MDGs) and Education for All (EFA) goals.

Statement of the Problem

HIV/AIDS increases education sector costs. On the supply side, budgets have to accommodate higher teacher hiring and training costs to replace teachers who have died of AIDS, as well as the payment of full salaries to sick teachers who

are absent and additional salary costs for substitute teachers (NAC, 2000 and 2004). Deheneffe, Carael, and Noubissi (1998) estimated that out of approximately 31,600 primary school teachers in 1996/97, 6,300 (20%) were HIV positive. There is also earlier Zambian evidence that teachers are a very high-risk group (Fylkesnes, Brunborg and Msiska, 1994). Furthermore, studies have reported an HIV prevalence of up to 40% among teachers in Zambia, (Klonda, 1997; NAC, 2000). The infections are now resulting in deaths. MoE data show that 680 teachers died in 1996, 624 in 1997, and 1,331 in the first ten months of 1998. This means that the number of teacher deaths increased from less than two per day in 1996 to more than four per day in 1998. The number of teachers who died in 1998 was more than one-fifth of the number estimated to be HIV positive. While one cannot attribute all of these deaths to AIDS, the 1998 teacher deaths represented a mortality rate of 39 per thousand, which is about 70% higher than the mortality rate of 23 per thousand for the 15 - 49 year old age group in the general population (MoH, 1999). For the education system, the 1998 deaths alone were equivalent to the loss of about two - thirds of the annual output of newly trained teachers from all training institutions combined. This projection does not even take into account expansions that are required under a universal education scheme, the EFA goals (World Bank, 2002).

According to MoH (1999) and NAC (2000) the highly HIV/AIDS infected populations in Zambia are Commercial Sex Workers (CSW), truck drivers, uninformed personnel and teachers. The high death rate among teachers has been associated with HIV/AIDS infection (MoE, 1999). The need to encourage

behaviour change among teachers is critical. Unfortunately, little is currently known about the factors that may make teachers vulnerable to HIV/AIDS infection.

Aim of the Study

The aim of the study was to investigate the factors that make teachers vulnerable to HIV/AIDS infection in Lusaka District and suggested suitable interventions of preventing and controlling it.

Specific Objectives of the Study

The specific objectives of the study were to:

- (i) determine the factors that make teachers vulnerable to HIV/AIDS infection.
- (ii) establish gender differences in teachers' vulnerability to HIV/AIDS infection.
- (iii) recommend interventions of fighting HIV/AIDS infection among teachers.

Research Questions

- (i) What are the factors that make teachers vulnerable to HIV/AIDS infection?
- (ii) Which gender of teachers is more vulnerable than the other to HIV/AIDS infection?
- (iii) What could be done to fight HIV/AIDS infection among teachers?

Justification of the Study

The study was important because once factors that make teachers vulnerable to HIV/AIDS infection were established, intervention might be possible. The findings might/ also benefit the policy developers, HIV/AIDS activists and co-operating partners in education provision. The findings would also contribute to the body of knowledge and might stimulate further inquiry.

Delimitation of the Study

The study of the vulnerability of teachers to HIV/AIDS infection was done in Lusaka District in Lusaka Province at the 14 sampled government schools. Lusaka District was chosen because it has high population of about 2 million and many people come and mingle from all over the country. Apart from that, Lusaka has one of the highest HIV prevalence rates in the country. The other reason is that schools are close to one another and as such teachers were more accessible than in other districts and provinces. Because of this the objectives of the study could easily be achieved. Therefore, it was seen to be an ideal district from which the study of vulnerability of teachers to HIV/AIDS infection could be done.

Limitations of the Study

The study was done in Lusaka District that has an urban setting. In view of this, the results cannot be generalised to other parts of the country, especially rural areas. The other limitation was that vulnerability of teachers to HIV/AIDS infection is generic and may change over time on the same teachers as new

views and behaviours come in. Vulnerability also changes according to the age of the participants. As participants grow, their behaviours and views are also likely to change. The stakeholders in education are many but the study only involved and concentrated on the teachers. Since the vulnerability of the teachers to HIV/AIDS infection vary along several dimensions and that there are also variations over time, the results of the study cannot be used for a long period of time. The other limitation was that the study confined itself in determining the causes of teachers' vulnerability to HIV/AIDS infection.

Operational Definitions of Terms

- Adult: A person aged between 15 and 49.
- AIDS: Acquired Immune Deficiency Syndrome. It is a contagious disease which is caused by HIV and has no known cure as yet.
- Alangizi: Women who offer traditional guidance and marriage counseling to other women who are in marriage.
- Alcohol: Intoxicating liquid such as beer, wine and whisky.
- Antiretrovirals: Drugs that suppress the replication of of HIV in a person's body, delaying the onset of full- blown AIDS and prolonging life. They do not kill or eliminate the virus.
- Attitude: Learned predisposition to respond in a favourable or unfavourable manner to a particular person, behaviour, belief or object.
- Bana chimbusa: Women who offer traditional training and information about sex

and other related matters to the bride.

Behaviour: Way of conduct.

Counselling: Helping someone to manage his/her problems.

Discrimination: Segregatory tendencies at work place and homes (communities).

Dry sex: Use of drying agents during sexual intercourse that create lesions or sores that facilitate the transfer of the HIV.

Gender: Gender identifies the social differences between men and women that are learned, are changeable over time, and have wide variations within and between cultures.

Heterosexual: Sexual intercourse involving male and female persons.

HIV: Stands for Human Immune-deficiency Virus. It is a virus that causes AIDS.

HIV prevalence: The percentage of persons ages 15 to 49 in a population who are HIV- infected. It is determined by dividing the number of 15 to 49 year olds who are HIV- infected by the total number of 15 to 49 year olds in a population.

Human rights: Fundamental freedoms and basic human entitlements to which every Zambian is entitled by virtue of the Constitution of Zambia or international agreements to which Zambia is a signatory. UNAIDS lists examples of human rights of PLHWAs including the right to non-discrimination, equal protection and equity before the law, privacy, liberty of movement, work and equal access to education, housing, health and among others others.

Life expectancy: The number of years from birth that an individual on average can expect to live .

Mortality: Number of people who die each year per 1000 people.

Multi-sectoral approach: An approach that actively involves different government sectors (for example, education, agriculture, health) as well as private sector ,NGOs, churches, community groups and others.

Non-cohabiting or non-regular partner: Sexual partners who are not married to or living with one another.

Poverty: The state of being poor.

Sexual cleansing: Sexual act which involves a deceased's relative and the surviving spouse meant to cast out a deceased's evil spirit.

Sub-Saharan Africa: Area south of the Equator in Africa.

Unprotected sex: Having sexual intercourse without a barrier such as a condom.

CHAPTER 2

LITERATURE REVIEW

Exposure to HIV/AIDS Information

Exposure to AIDS information increases knowledge of how HIV is transmitted and may result in a reduction of behaviours that lead to HIV transmission. Little is currently known about exposure to public health AIDS information campaigns, especially in developing countries. The research that has been conducted has focused primarily on evaluating single programmes or populations, or only address content or outcomes of the programmes and not who is most likely to be exposed to them (Pierce, Macaskill and Hill, 1990; Stoller and Rutherford, 1989). Understanding these issues is important if programmes are to be properly prioritised appropriately designed to address the needs of target populations and sensitive to target groups' cultural values.

Knowledge of HIV/AIDS

In cross-sectional survey in 1997 and 1998, over 99% of secondary school pupils and 99 percent of sex workers in Senegal knew about AIDS and could name at least two correct ways of preventing it. High proportions also knew about more complex issues such as a symptomatic infection. Close to 70% of sex workers knew that someone who looks perfectly healthy could transmit HIV (UNAIDS, 1999). Knowledge about HIV/AIDS is virtually universal among Zambian adults, most of whom understand that it is a fatal disease and that no cure. More than four out of every five adults know how to prevent it. Similarly, more than 80

percent of adults know that a healthy person can be HIV infected and 70 percent of adults know someone who has died of AIDS (MoH/CBoH, 1999).

Misconceptions about the cause of HIV/AIDS are still common. Up to a third of the various population groups questioned about the knowledge and behaviour in 1997 and 1998 in Senegal thought they could get HIV/AIDS from a mosquito bite or from sharing a toilet with someone who had AIDS (UNAIDS, 1999). According to 1998 Zambia Sexual Behaviour Survey (ZSBS), 33% of males and 27% of females believe that HIV infection is spread by mosquito bites. More than one in five males and the females alike believe that HIV can be caused by witchcraft. 76% of males and 71% of females reported that having one faithful sex partner was one way of avoiding HIV. 70% of males and 51% of females reported that consistent condom use was another way of avoiding HIV. At least 25% of males and females alike reported that there was no way to avoid HIV (NAC, 2000). There is also a belief that condoms are so porous that the virus can pass through.

Attitude to HIV/AIDS

Attitudes follow ABC model of attitudes (Rajecki, 1989), which has three components: affect, behaviour and cognition. The affect component encompasses positive or negative emotions or feelings about something, the actions constitute the behavioural component and the beliefs constitute cognitive component. Surveys on the level of knowledge about HIV/AIDS in Zambia have yielded mixed results. Mkumba and Edwards (1993) reported that 73% of

university students had received some previous HIV/AIDS education. Knowledge was generally good regarding transmission routes but attitudes to prevention were generally negative. Mulwila et al (1993) report that 75.9% of an urban population is knowledgeable about HIV/AIDS yet continue to engage in unprotected penetrative sex. Ayiga, Ntozi, Ahimbisibwe, Odwee and Okurut (1999) examined changes in attitude towards death, HIV testing and sexual behaviour as a result of AIDS in northern Uganda. 87.1 % of the respondents reported that their attitudes towards death had changed because of too many deaths, AIDS and the death of many youths unlike before. Generally, males (88%) were more willing than females (84%) to be tested. Most respondents were willing to be tested in order to know their HIV status and plan for the future. They reported that 68.4% noted sexual behaviour change as a result of AIDS in their communities.

Mode of Transmission of HIV

The major mode of HIV transmission is heterosexual, accounting for 71% of global infections (Ekpo, 1994). Other modes of transmission are perinatal or mother to child, intravenous drug use and skin piercing activities including blood transfusions. In Zambia, heterosexual contact and perinatal transmission account for most HIV infections (MoH/CBoH, 1999) and other mechanisms of transmission such as contaminated blood and reuse of needles are insignificant but nonetheless important.

Prevalence of other STIs

Heterosexual transmission of HIV in Zambia is increased by the presence of the sexually transmitted infections (STIs) such as syphilis and gonorrhea by the partner during unprotected sex. A recent study in Ndola indicated that 11.3% of men and 14.0% of women were infected with syphilis and two of every three sex workers in the Ndola commercial sex worker study were infected with an STI (MoH/CBoH, 1999).

Condom Use

When condoms are used consistently and correctly, they are a highly effective means of preventing the transmission of HIV and other STIs. Though the use of condoms is on the increase in Zambia recently, it is still inadequate. The SBS 1998 indicates that 33% of men and 24% of women used a condom in the last sexual encounter with non-regular partners (CSO, 1999). The use of condoms rose to 39% in 2000 and 42% in 2003 for men while it increased to 33% in 2000 and 35% in 2003 (CSO, 2002 and 2003). The Ndola CSW Survey reported that only one out of four sex workers used a condom with their last clients and less than one out of seven used condoms with all clients (MoH/CBoH, 1999). The studies show low condom use during casual sex encounters.

Alcohol Drinking

Alcohol and other drugs can affect sexual behaviour and increase people's risk of becoming infected with HIV or other STDs. Excessive drinking, for example, diminishes inhibitions, increases aggression, diminishes the ability to use

important information learnt about AIDS prevention and impairs the capacity to make decisions about protection. As alcohol concentration rises in the body, information processing, judgment, memory, sensory perception and motor coordination are progressively impaired. In Senegal, a country with very low HIV prevalence, alcohol consumption is uncommon, in accordance with Islamic Tradition. In the behavioural study in Dakar in 1997, just three percent of women and four percent of men reported having any alcoholic drink in the previous month (UNAIDS, 1999).

Social Mobility

Many people, especially men, are at risk of HIV infection because their work involves spending long periods away from their families. For many women in Zimbabwe, their greatest risk of becoming infected with HIV comes from their husbands' sexual activities while working away from home (Williams and Ray, 1993). Sales representatives, railway workers, long distance truck drivers and soldiers are separated from their families for long periods, sometimes for six months, in case of soldiers on active service. Many men in these situations seek company and sex from girlfriends or female sex workers, exposing themselves and their sexual partners - including their spouses - to the risk of HIV infection.

People on the move are especially likely to be exposed to HIV infection. According to a recent survey in 1998 10 percent of Zambians had lived in their present location for less than a year and nearly 40 percent had lived in their present location for less than five years (MoH/CBoH, 1999). These types of

movement increase the likelihood that sexual activity with non-regular partners will occur exposing themselves and their sexual partners, including their wives, to the risk of HIV infection. Teachers and other government employees are often posted to remote parts of the country separated from their spouses for most of the year. Schaeffer (1994) suggests that many teachers will die from AIDS due to their mobile and elite status.

Teacher-Pupil Relations,

Although the code of conduct of the teaching profession prohibits teachers from engaging in sexual relations with their pupils, it is widely acknowledged that some teachers do have sex with pupils. According to Klonda (1997) such behaviour by teachers is of great concern in the light of a recent study that found that 40% of teachers in the study group were infected by HIV.

Poverty

The link between poverty and HIV through lack of access to health, poor nutrition, lack of education and prostitution is well documented. The World Bank Poverty Assessment reports that about two-thirds (69%) of the Zambian population lives below the poverty level where households do not meet the basic needs (MoE, 1999). For example, list of food basket of commodities for six people in Lusaka, (including only foodstuffs, charcoal and soap) increased from K6, 365.00 in April 1991 to K194, 550.00 in March 1995 and yet the wages of average Zambian workers have remained relatively low (Henriot, 1996). This does not include rentals, electricity, water, health and education expenses. Data

from the CSO indicate that 70% of Zambians fell below the poverty level in 1996. Per capita dropped by 40% from \$ 600 in 1970 - 75 to \$360 in 1990-96. By 1998, Zambia's debt burden remained astromically high at \$6.5 billion and later worsened to \$6.9 billion by the year 2000. Zambia decided to seek exceptional debt relief under the Heavily Indebted Poor Countries (HIPC) initiative and debt swap. These are essential to the government's overall ability to amount an effective and sustainable response to current HIV/AIDS epidemic. Widespread poverty, high rates of unemployment and generally low returns from informal sector-income generating activities have been associated with high-risk sexual behaviour and the spread of HIV/AIDS (MoH/CBoH, 1997; 1999).

The 1998 SBS survey found that 57 percent of women who had sexual intercourse in non-regular partnerships did so in exchange for payment (NAC, 2000Q). The 1996 ZDHS found that 38 percent of sexually active unmarried females had been involved in sex for money, gifts or favours in the last 12 months. To further substantiate these figures, 39 percent of sexually active unmarried men aged 15 to 19 also reported that they had sexual intercourse in exchange for money, gifts or favours in the last 12 months.

Stigma

In many places, people who are thought to have HIV are feared and discriminated against. Stigma can be so strong that it can hamper successful planning for adherence to medication and preventing HIV/AIDS. In many cases, adherence or prevention will require that others learn that the person either has

or is at high risk for HIV infection. For example, the presence of the medication or the prevention materials such as condoms will serve as signs of HIV infection or risk for HIV infection. Given the social stigmatisation of HIV infection, the loss of confidentiality is very likely to lead to negative consequences for the individual.

Furthermore, because HIV/AIDS is viewed in many communities as the outcome of reprehensible behaviour, there is often unwillingness both to seek help by those affected and negative responses often by those able to provide assistance (UNAIDS, 1999).

Gender and HIV/AIDS

The virus (that causes AIDS) is firmly embedded in the general population among women whose only risk behaviour is having sex with their own husbands. The Zambia Demographic and Health Survey, 2001/2002 (CSO, 2003) indicate that women (18%) are 1.4 times more likely to be infected than men (14%). In the 1997 Dakar study, 99% of married women said they had not had sex with anyone except their husbands in the preceding 12 months. Among men the proportion was 12 percent who said they had sexual partners other than their wives in the preceding year (UNAIDS, 1999).

Individuals younger than 24 years old account for more than half of new HIV infections in Africa. Most of these infections are in young women who report having only one sexual partner (husband). Thus, it is depleting the strength and energy of women upon whom their extended families and communities rely to

collect water, farm the fields, raise the children and care for the sick including other AIDS patients (UNAIDS 1998). In another study of nearly 400 women attending STD clinics, 93% were married and 91% had never had sex with anyone but their husbands. All of these women were infected with a sexually transmitted disease and a shocking 13.6% of them tested positive for HIV (UNAIDS/AIDS, 1998).

In sub - Saharan Africa where over 70% of the world's HIV positive people live, women made up about 55% of those living with the virus at the end of 1999, according to UNAIDS (1999), young women in the hardest hit countries were up to three times more likely to be infected than males of the same age.

Initiation ceremonies and practices that prepare the girl-child for marriage are *common and wide spread in both rural and urban Zambia*. Some of these practices may increase risks associated with STI and HIV transmission. For example, among the Tonga and Bemba people of Southern and Northern Provinces instructions include lessons on how to use corrosive herbs and ingredients to dry out the vagina in order to increase male sexual pleasure (MoH/CBoH, 1999). In areas of Zambia where extramarital sexual relationships by women are culturally condoned, the probability of women acquiring HIV is increased.

Human Rights and HIV/AIDS Infection

Violations of human rights have occurred against persons infected with HIV and persons living with AIDS. It is evident that lack of respect for human rights and dignity has exacerbated the epidemic. Nakazibwe (1999) reported that a woman was harassed in the elders' court at Kawangware, Uganda, for denying her husband his conjugal rights even when she knew he was unfaithful. Today, condom access and use is part and parcel of the right to health and even potential right to life. Health workers recommend condom use but the religious groups usually discourage it. No law exists to prevent any agent from advising against condom use. When the prevention triad is sensitively and creatively implemented, HIV prevention can be very effective. Elias and Heise (1993) demonstrated how the prevention objectives are out of touch with the realities of women 's lives. The prevention recommendation to reduce the number of sexual partners fails for women on three levels. First, women's risk is highly dependant on their partners ' sexual behaviour. In Sao Paulo, Brazil, one half of new AIDS cases among women are married, monogamous women. Second, having multiple sexual partners often give women with resources, including education, and jobs in developing countries. Third, women are often unable to exercise control over their sexual activity, principally because of the threats of violence or divorce. The threat of divorce may be sufficient to lead a woman to have unwanted or unprotected sexual intercourse, even if both know he is HIV infected.

Workplace HIV/AIDS Programmes

For many, but not enough, innovative workplace programmes among private industries reflect a strong commitment to educating employees on prevention and ensuring adequate care for those infected (Rosemary and Paul, 1999). Some companies like the Nakambala Sugar Company that have greatly been affected by the AIDS pandemic have since started in-house workshops on AIDS. Condoms are also being distributed at places of work (NAC, 2000). For millions of people in Zimbabwe, the nature of and location of their work, or that of their spouse, is the most important factor in their chances of becoming infected with HIV (William and Ray, 1993). Female domestic workers, for example, are vulnerable to sexual exploitation in the course of their work, and are at risk of HIV infection. Sex workers are at high risk of becoming infected with HIV every time they have unprotected sex with a client. In schools, the Anti-AIDS clubs mainly cater for pupils and teacher involvement is negligible and non-existent in some cases and there is general absence of school clinics. In the public sector, the ministerial HIV/AIDS focal point persons have been instrumental in creating and implementing HIV/AIDS workplace programmes nationally and in provincial administration offices. On the other hand, Ministry of Education has a larger contingent of teachers and lecturers but does not have a workplace programme or a plan of action with some of the problem caused by a large number of sick teachers (Siamwiza, 1999).

HIV/AIDS Based Curriculum

The national policy on education, “Educating Our Future” of 1996 states that the MoE will introduce HIV/AIDS counselling for teachers and integrate HIV/AIDS awareness into its in-service training programmes (MoE, 1996). The Ministry intends to develop comprehensive training programmes for education managers, lecturers, teachers and headteachers so as to help in attitude and behaviour formation and behaviour change. Among other things, the programme will focus on interactive teaching which will enable teachers deal confidently with HIV/AIDS issues and practices which foster self esteem and decision making in their students (MoE, 1999), but Siamwiza (1999) argues that far too many teachers find themselves in a situation where they are embarrassed to teach about HIV/AIDS because of their own status or vulnerable situation.

According to the MoE (1999), HIV/AIDS education programmes will be implemented through the relevant line departments and the BESSIP structures such as the Teacher Deployment and Compensation, Curriculum Development, School Health and Nutrition and Equity and Gender Components

Voluntary Counselling and Testing (VCT) and HIV/AIDS

VCT has many benefits such as behaviour change and prevention of HIV transmission, improved health and medical treatment, informed decision making and psychosocial support. Others are reduction of stigma and access to other services, for instance, PMTCT. Despite the importance of VCT, most adult

Zambians have never been tested for HIV (NAC, 2004). The *Demographic and Health Survey, 2001/2002* reported that 12% of all adults (9% of men and 14% of women) had ever been tested. 69% of women and 64% of men (66% of all adults) wanted to be tested but had not done so. 14% of women and 17% of men were tested in urban areas as compared to 6% of women and 12% of men in rural areas (CSO, 2003). UNAIDS now estimates that nine out of ten people living with HIV do not know they have the virus and therefore cannot seek care or plan ahead for themselves and their families. New research shows that, apart from its other benefits, voluntary testing and counselling can cut the risk of transmission (UNAIDS 1997). Studies carried out by UNAIDS and the USAID in Kenya, Tanzania and Trinidad in 1996 provide conclusive evidence that volunteers who receive an HIV test and counseling go on to have a fewer sexual partners and less unprotected sex. In 1992, a study in Rwanda examined the impact of preventive counselling. It was shown that for the women whose partners were also tested and counselled, the annual incidence of new HIV infections decreased from 4.1% to 1.8%. Among women who were HIV positive, the prevalence of gonorrhoea decreased from 13% to 6%, with the greatest reduction in those using condoms (UNAIDS, 1999). As a result of these findings, counselling was recognised as a mainstream intervention in curtailing the spread of HIV/AIDS.

The Church and HIV/AIDS

Since condoms are not 100% safe, telling people that with a condom one can have safe sex is highly irresponsible since HIV/AIDS is an issue of life and death.

In issues of life and death people should not take or recommend such a risk of using condoms to other people either on a regular basis or even on for a single occasion (Slattery, 2002). Bases on such arguments from the church fraternity, UNAIDS (1999) notes that one of the greatest obstacles to AIDS prevention activities in many countries has been opposition from religious authorities. The tendency for religious leaders to prescribe abstinence and monogamy in the face of overwhelming evidence that these behaviours are not always the norm has been seen in almost every corner of the world. Although initially hostile to condom promotion, a conservative Islamic organisation, Jamra, became an important partner in a dialogue between public health officials and religious leaders in Senegal. They express reservations about what they are prepared to support. For example, Christians are reluctant to support condom use between unmarried people, but are prepared to support it within marriages when transmission of HIV is eminent from an unfaithful partner, though even then the risk remains real though minimised (Slattery, 2002). Christians usually are opposed to the use of any contraception, condoms inclusive and their opposition may have a profound influence, in view of HIV/AIDS in the community.

Political Will

AIDS policy risks being irrelevant if it does not take into account of dynamics of the epidemic. It must also provide a positive framework for action backed by political will and commitment. This must lead to the mobilisation and provision of human and material resources as well as commitment to action on the part of the government. This political commitment has been elusive in many African

countries (SAfAIDS, 1999). Many speakers at the XI International Conference on AIDS and STDs in Africa (ICASA) in September, 1999 noted the absence of any African leaders (RATN, 1999) and questioned how the continent can tackle the epidemic if there continues to be a lack of high-level will and policy to confront what most believe to be the most significant health and development challenge facing the continent.

The active involvement of politicians in HIV/AIDS prevention and control programmes elsewhere in Africa has been seen to be a powerful stimulus for the mobilisation of resources (NAC, 2000). The Senegalese government was the driving force behind a declaration on AIDS made by the heads of state of members of the African Union (AU) in 1992. In association with international donors, the government has invested close to US\$20 million in AIDS prevention programmes between 1992 and 1996 (UNAIDS, 1999). It also tackled obstacles to programme success. For example, an excise tax which quadrupled the price of condoms to Senegalese consumers was dropped to help condom promotion campaigns. In 1996, the first parliamentary meeting on AIDS was held where parliamentarians were to start mobilising their constituents to fight HIV/AIDS scourge.

Polygamy

Polygamy, which is more common in rural than in urban areas, has also been implicated in women's vulnerability to HIV. According to MoH/CBoH (1997) in 1996, 17 percent of married women were in polygamous unions. The highest

rate of reported polygamous relationships is in Southern Province (32%), followed by Northern Province (25%).

Dry Sex and HIV infection

Heterosexual intercourse accounts for over 80% of HIV transmission in Sub-Saharan Africa. Factors facilitating cross-infection may include sexual practices such as the vaginal use of herbs/substances to dry, contract and heat the vagina in order to arouse sexual pleasure. Women prepare for sexual intercourse. Some douche with water, antiseptic solutions and or chemicals and absorbents such as tissue papers and newsprint (Runganga and Kasule, 1995). The use of drying agents can create lesions or sores that facilitate the transmission of the virus. The 1998 Sexual Behaviour Survey revealed that four percent of men and 18 percent of women reported engaging in dry sex in their last encounter with a non-regular partner while two percent of adolescent men and 15 percent of adolescent women said they engaged in dry sex (MoH, 1999).

Sexual Cleansing, Widow Inheritance and Property Grabbing

The traditional practice of widow/widower cleansing is still very common and prevalent, especially in Southern province (NASTLP, 1999). To be purged of the evil spirits assumed to have caused the death of a spouse, the widow or widower is cleansed through the act of sexual intercourse with a relative of the deceased. Closely related to the issue of ritual cleansing is the notion of wife /widow or widower inheritance. Both practices are insisted on irrespective of the HIV status of the person appointed to perform these rituals.

Vulnerability also arises from the deprivation and disposition of property including household goods, land, clothes and other assets due to the common practice of grabbing and sharing the estates of the deceased by the relatives. In general, the loss of property and household goods worsens the social and economic problems faced by widows. Some of them are forced to enter into sex centered relationships in exchange for cash.

Multiple Sexual Partners and HIV Infection

Another factor that contributes to the heterosexual spread of HIV is unprotected sex involving multiple sexual relationships, especially when these sexual partners occur at the same time in a person's life. The 1998 Zambia Sexual Behaviour Survey reported 39 percent of sexually active men and 17% sexually active women had a non-cohabiting partner within the past 12 months (MoH/CBoH, 1999). The percentage of sexually active men who reported sex with a non-cohabiting partner in the past 12 months declined from 39% in 1998 to 29% in 2000 and remained stable up to 2003. For sexually active women, the percentage remained steady at 17% in 1998, 16% in 2000, and 16% again in 2003. But the proportion with married men with extra-marital partners dropped from 21% in 1998 to 13% in 2000 and 9% in 2003, while for married women with extra-marital partners fell from 4% to 2% between 1998 and 2000 and remained at 2% in 2003 (ZSBS, 1998, 2000 and 2003).

Theoretical Framework

There are many behavioural intervention models that have been developed to explain determinants of human behaviour change. Some of these are the Health

Belief Model, the Social Cognitive Theory, the Theory of Reasoned Action, the Communication-Behaviour Change Model and the AIDS Risk Reduction Model. These models all have in common the theory that perceived risks and benefits of behavioural change predict the likelihood of behaviour change as well as guide the approach to behavioural interventions.

Adopting the Health Belief Model (HBM) requires a person to feel personally threatened by a disease (Becker, 1974) with serious negative consequences and must feel that the benefits of making the behaviour will outweigh the costs of not changing. One of the main goals of AIDS prevention campaigns is to convince people that they are at risk, so they will be motivated to take precautions to prevent AIDS.

The Social Cognitive Theory lays emphasis on self-efficacy as cornerstone to behaviour change (Bandura, 1993). Self-efficacy is belief in one's ability or competence to perform the behaviour. Lichtenstein (1982) asked smokers who had just completed a smoking cessation programme about their confidence in the length of time they could stay abstinent and their confidence to abstain in a number of situations. The subjects' confidence or self-efficacy ratings predicted well not only how long they actually stayed off cigarettes but also in what situations they were most likely to return to smoking. Some smokers anticipated that they would have a hard time refraining from smoking when under stress, while others identified being with smokers as a high-risk situation.

The theory of reasoned action (Fisbein, 1999) states that intentions are the most immediate influence on behaviour. Intentions are influenced by positive or negative attitudes and subjective norms. Thus, the theory predicts that a person is most likely to perform behaviour when he or she feels good about performing the behaviour and feels social pressure to perform the behaviour. It is only the most easily remembered consequences that really affect attitudes (Ajzen and Fishbein, 1980). Therefore, if a person's first thought when they see someone smoking is 'smoking makes you look cool', then this is the belief that will determine their attitude about smoking. It does not matter so much that they also believe smoking will cause cancer and heart diseases. That belief may not come to mind easily and the person may believe that it is 'other people' who will get those diseases if they smoke. Similarly, if a person thinks and believes that sex is nice and makes one great, it is then this same belief which will drive them into having sex, including unprotected one. The fact that one will catch the fatal AIDS would be very remote.

The communication-behaviour change model (McGuire, 1981) is based on communication inputs and outputs. The input factors are source, message, channel, receiver and destination. The input factors are manipulated in the public communication campaign in order to have the desired effect on the audience's health attitudes and behaviour. The gender, age, attractiveness of the source of the message can all influence dramatically how the audience responds to the campaign. Message factors include what is said as well as how it is said. Speed of delivery, length of message and tone of voice can all affect the receiver. The

channel is the medium through which the message is transmitted. What is to be considered is not only the cost and number of people reached say by television versus newspapers but also the fact that some channels are more effective for simple rather than complex messages. The communicators need to know the age, likes, dislikes and habits of the target group/audience or the receiver. The destination is the intended long-term outcome of the communication.

The output factors describe a progression of information processing steps that occur in a person who receives a communication that leads to attitude and behaviour change. The output factors include the target population which must be exposed to the message, must pay attention to it, must become involved enough in it to understand what the message is and the change must be reinforced so that it is maintained.

The Health Belief Model, the Social Cognitive Theory, the Theory of Reasoned Action and the Communication- Behaviour Change Model were the four theories found suitable and used in this study of teachers' vulnerability to HIV/AIDS infection in Lusaka District. All the four theories were found to be useful. The Health Belief Model blended well with the topic at hand because it motivates people at risk of HIV to take precautions to prevent it. The Social Cognitive Theory was used because it helps an individual to discover his / her self-efficacy or competence to perform the behaviour, for instance, protecting oneself from acquiring HIV. The Theory of Reasoned Action helps to understand that people would only perform the behaviour when they feel good about performing it and

that they would not easily remember the negative consequences which may later occur, such as fatal AIDS. The Communication– Behaviour Change Model assists the designer of a public communication in maximising the effectiveness of the communication. All in all, all the four theories helped in guiding the study.

From the literature reviewed, it is evident that there are many factors that make people vulnerable to HIV infection. It clearly shows some indicators of great concern that in most cases perpetuate the spread of HIV infection. There have been some inconsistencies with the findings in the reviewed literature. Some studies have shown significant behavioural change while others have not, among others, in the use of condoms. Furthermore, very little information has been documented about teachers' vulnerability. It is, therefore, important to find out in this study to what extent teachers are vulnerable to HIV/AIDS infection in Lusaka District.

CHAPTER 3

METHODOLOGY

Research Design and Study Type

This was a qualitative study. In this study, the researcher observed, described and analysed the demographic characteristics and other underlying dimensions of teachers' vulnerability to HIV/AIDS infection. A qualitative research design was chosen in order to gain an insight into the perceptions of teachers on HIV/AIDS. The method was appropriate because the study sought to find out teachers' views about their practices, norms and values in relation to HIV/AIDS infection. This method was also used because of its capacity to yield in-depth and holistic insights into phenomena being investigated particularly since the study involved the factors that could make them vulnerable to HIV/AIDS infection.

Study Setting

The study was carried out in Lusaka District in Lusaka Province. It was a town setting in an urban area with typical town activities taking place. At the time of the study, Lusaka District had a total of 106 government schools: 53 Middle Basic, 39 Basic and 14 High schools. There were also many private schools that catered for pupils either from early childhood or grade one to nine or twelve. These were not variables for the study. It was served by several Health Centres with one referral hospital, the University Teaching Hospital (UTH).

Target Population

According to the records at the Lusaka District Education Board Secretary's Office, there were 3313 serving government middle basic, basic and high school

teachers in Lusaka District at the time of the study. All these were the study's target population.

The Sample and the Study Units

The sample of the study was 300 serving government school teachers from the sampled high, basic and middle basic schools.

Sampling and Data Collection Procedure

Convenient sampling was used to select 300 teachers from 14 sampled Lusaka District schools. These were Libala and Kamwala High Schools. Some were Mumuni, Burma Road, Jacaranda, Lusaka Boys and Lusaka Girls Basic Schools. Others were Chisengalumbwe, Lusakasa, Mkandawire, State Lodge, Edwin Mulongoti, Twalumba and Desai Middle Basic Schools.

Participants were surveyed by self-administered English language questionnaire. Informed consent was obtained from study participants. However, at a school setting it was likely that some potential participants perceived pressure from school authorities. To mitigate the perception of pressure to participate, the researcher clearly communicated to participants that they were free to decline enrollment in the study. Though, probably by coincidence, most seemingly ill participants declined. In addition to questionnaires, two phases of Focus Group Discussions (FGDs) were conducted in English using a semi-structured format with 30 (15 male and 15 female) teachers selected from the study population but not in the sample. Each sex formed a group discussion

separately. Topics for discussion were predetermined, yet the researcher was free to follow up on responses, and pursue issues that arose naturally during the discussions. Subjects' knowledge, beliefs, attitudes, perception of risk of HIV/AIDS infection, sexual behaviour and social behaviour were gathered.

Ethical Considerations

Ethical approval was sought from the University of Zambia Directorate of Research and Graduate Studies through the School of Medicine. Permission was sought and granted from the MoE to enrol their teachers as participants in the study. Participation in the study was voluntary and informed consent was obtained from the respondents prior to the study. Confidentiality was maintained throughout the study.

Pilot Study

Prior to the formal research study, a small-scale pre-test of the questionnaires was done. It was done with teachers in an area with similar socio-cultural setting of teachers under study. The research instruments were cleaned of ambiguity.

Data Processing and Analysis

The questionnaires were individually coded and entered into the computer by the researcher and edited using Microsoft Excel Software. The FGDs were processed by listening to the audio cassette recorder. Verbal, non-verbal and major responses from the respondents were noted and recorded into themes. A descriptive approach was used to analyse the data. Through EPI- INFO Version

6 software, simple tables and charts were generated and used to present and interpret the data.

CHAPTER 4

PRESENTATION OF FINDINGS

This chapter is a presentation of findings as obtained from the field. The findings are mainly presented in form of tables and figures, using percentages. The study was carried out at 14 schools in Lusaka District between October and December 2003 from which 300 school teachers participated. The 300 teachers were from Libala and Kamwala High Schools, Mumuni, Burma Road, Jacaranda, Long Acres (then Lusaka Boys) and Lusaka Girls Basic Schools. Others teachers were from Chisengalumbwe, Lusakasa, Mkandawire, State Lodge, Edwin Mulongoti, Twalumba and Desai Middle Basic Schools. The additional 30 teachers from Lotus Basic School participated in the FGD to supplement the information from teachers who answered the questionnaire.

Table 1: Socio - Demographic Data

Factor	Male n=110	Female n=190	Total N=300
Age			
20 - 24	7(6.3%)	10(5.3%)	17(5.6%)
25 - 29	12 (11%)	36(19%)	48(16%)
30 - 34	28(25.5%)	26(13.7%)	54(18%)
35 - 39	12(11%)	18(9.5%)	30(10%)
40 - 44	14(12.7%)	24(12.6%)	38(12.7%)
45 - 49	4(3.6%)	26(13.6%)	30(10%)
50 and above	6(5.4%)	12(6.3%)	18(6%)

other	27(24.5%)	38(20%)	65(21.7%)
Total	110(100%)0	190(100%)	300(100%)
Marital Status			
Single	37(33.6%)	28(14.7%)	65(21.7%)
Married	46(41.8%)	129(67.9%)	175(58.3%)
Widowed	4(3.6%)	19(10%)	23(7.7%)
Separated	0(0%)	0(%)	0(0%)
Divorced	0(%)	7(3.7%)	7(2.3%)
Cohabiting	0(%)	0(%)	0(0%)
Other	23(21%)	7(3.7%)	30(10%)
Total	110(100%)	190(100%)	300(100%)
Type of Marriage			
Monogamous	44(40%)	114(60%)	158(52.7%)
Polygamous	0	7(3.7%)	7(2.3%)
Religion			
Christianity	92(83.6%)	176(92.6%)	268(89.3%)
Muslim	0(0%)	0(0%)	0(0%)
Hindu	0(0%)	0(0%)	0(0%)
Atheist	1(0.9%)	0(0%)	1(0.3%)
Other	17(15.5%)	14(7.4%)	31(10.3%)
Total	110(100%)	190(100%)	300(100%)

Religious Denomination			
Catholic	25(22.7%)	48(25.2%)	73(24.3%)
Seventh Day Adventist	16(14.5%)	21(11%)	37(12.3%)
Pentecostal	12(10.9%)	63(33%)	75(25%)
Other	57(51.8%)	58(31%)	115(38.3%)
Total	110(100%)	190(100%)	300(100%)
Educational Level			
Secondary Education	0(%)	8(4.2%)	8(2.7%)
College	66(60%)	124(65.3%)	190(63.3%)
University	32(29.1%)	8(4.2%)	40(13.3%)
Other	12(10.9%)	50(26.3%)	62(20.7%)
Total	110(100%)	190(100%)	300(100%)

Table 1 above shows the demographic information of the respondents. There were 110 (36.7%) male and 190 (63.3%) female teachers who participated in this study. The majority (149) belonged to the active reproductive age group of 20-39 years of age. This is the age group that was found to be most vulnerable to HIV/AIDS infection. Another 86 of the teachers were above this age group of 40 years. 41.8% of the male and 58.3% of female teachers were married. However, 37.3% of male and 28.4% of female teachers were single and some of these were also either widowed or divorced.

89.3% said that they were Christians and 0.3% reported that they were atheists. Among the Christians, the majority reported that they were Pentecostals (25%). Catholics were 24% while Seventh Day Adventists (SDA) were 12.3%.

The educational levels of the respondents were also analysed. 63.3% of the respondents said that they attained college education. Almost a quarter (13.3%) of the respondents had university education. 2.7% reported that they only had secondary education.

Table 2: Respondents' Sources of Information about HIV/AIDS

Articles in newspapers	77%
Conversations with friends	77%
Discussions with health professionals	83.7%
Radios	86%
Televisions	85.3%
Posters and billboards	77%
Magazines	79.7%
Schools	75.7%
Booklets and pamphlets and books	76%
Politicians and community leaders	58.7%
Employers	60.7%
Family members	73.3%
Fellow teachers	75.7%

Singers and actors	73.7%
Prostitutes	35%
Church leaders	80.3%

Table 2 above shows the respondents' sources of information about HIV/AIDS. It was noted that major source of information about HIV/AIDS was through the media. It was also noted that 35% of these teachers got their information from prostitutes or sex workers. This clearly demonstrates that perhaps some of the teachers had partnership with sex workers and therefore were vulnerable to HIV infection.

Figure 1: Mode of HIV Transmission

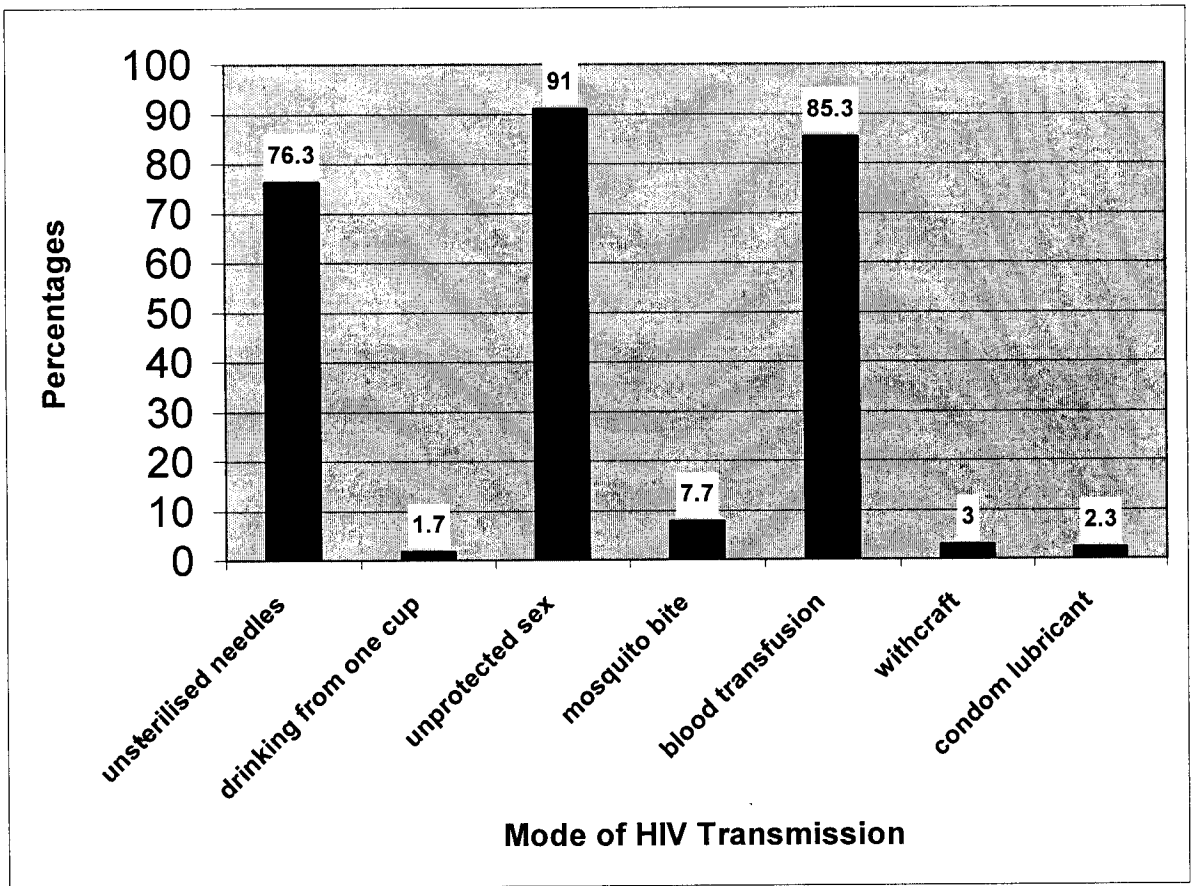


Figure 1 above shows the modes of transmission of HIV. When the teachers were asked about the mode of transmission of HIV, 91 % said that it was transmitted through having unprotected sex with an HIV infected person. 85.3 % reported that it is transmitted through transfusion of unscreened infected blood while 76.3 % reported that it is transmitted through use of unsterilised needles for injections. However, misunderstandings persisted about the mode of transmission. For example, 7.7 % believed that being bitten by a mosquito that has bitten an infected person could transmit HIV. 3 % of teachers said that it could be transmitted through witchcraft while 1.7 % reported that people could get AIDS through condom lubricant and drinking from the same cup, respectively.

Despite having a wide and varied information sources about HIV/AIDS, they (sources of information about HIV/AIDS) appear to be less predictive of knowledge about HIV.

Figure 2: Respondents' Knowledge of People Who Can Contract HIV

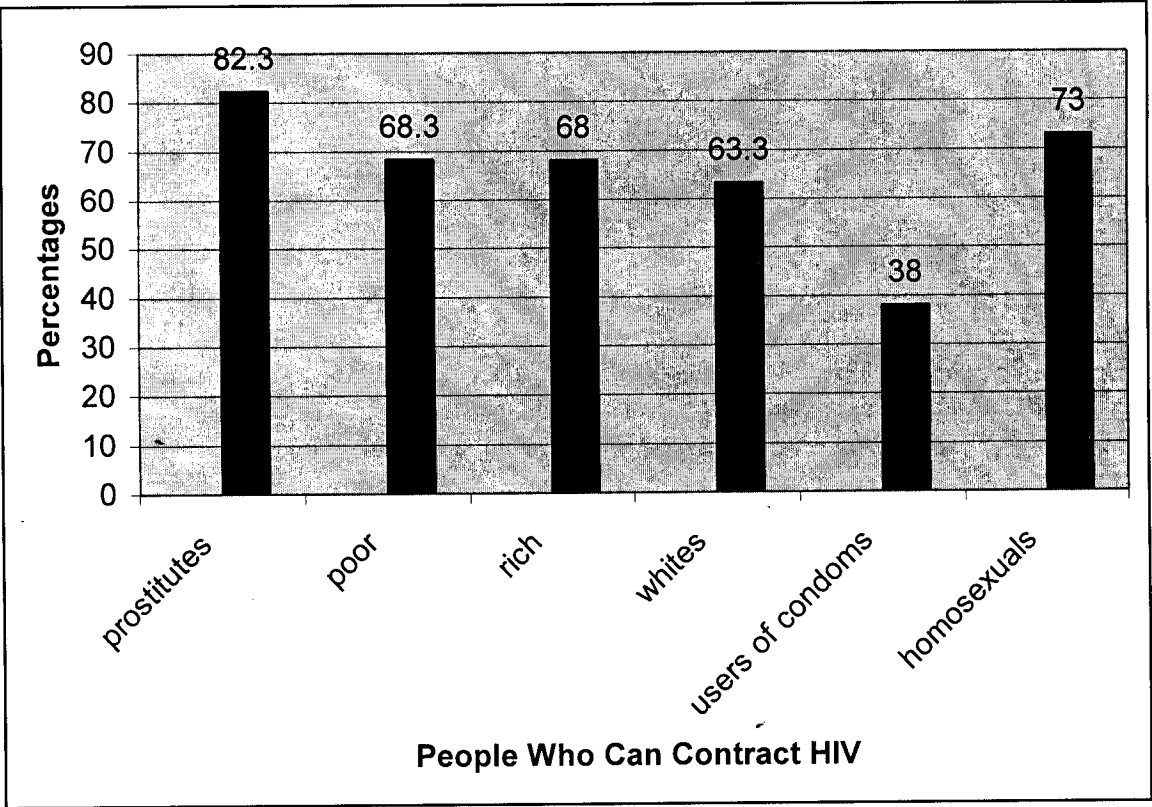


Figure 2 above indicates the people who could contract HIV. 82.3 % and 73 % of the teachers reported that HIV could be contracted by prostitutes and homosexuals, respectively. Those who said that HIV could be contracted by the poor and the rich were 68.3 % and 68 %, respectively. 63.3 % reported that HIV could be contracted by the whites. Only 38 % of them reported that HIV could be contracted by users of condoms.

Figure 3: Respondents' Views on Dry Sex

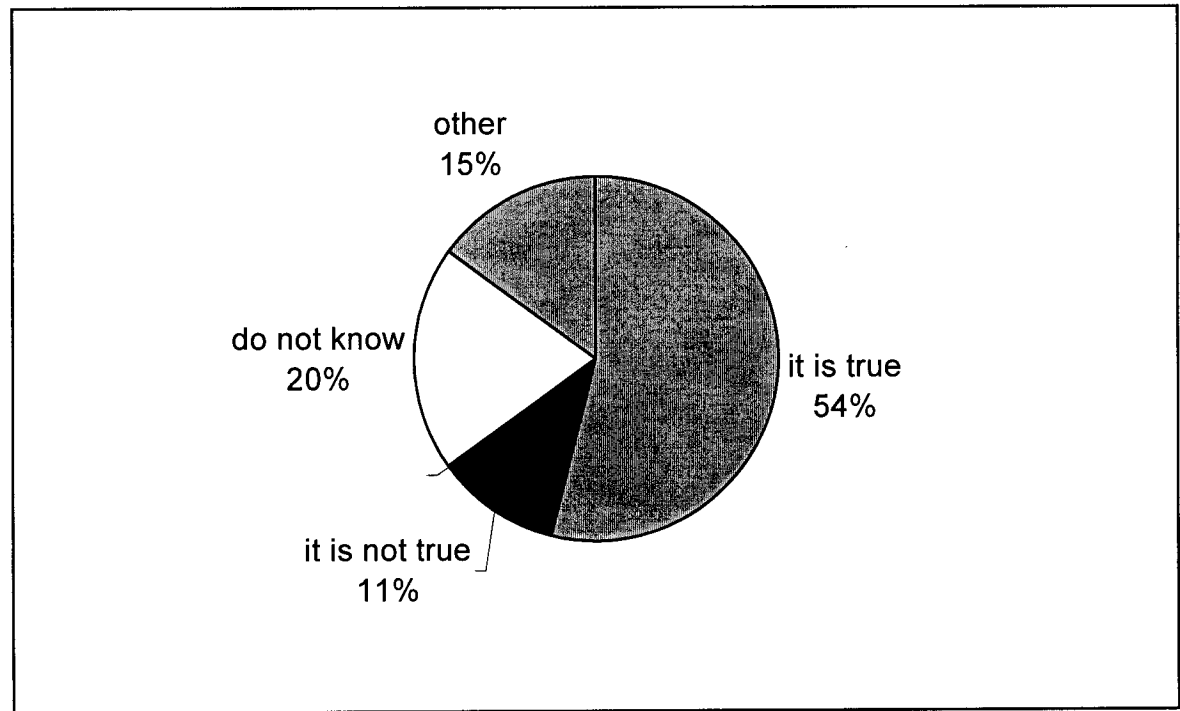


Figure 3 above shows the number of respondents' level of knowledge on dry sex. More than one half (54%) of the respondents said that dry sex could increase the chance of contracting HIV. 20 percent did not know whether it increased or not while 11% said it could not. 15% refrained from answering.

Figure 4: HIV Status of Teachers

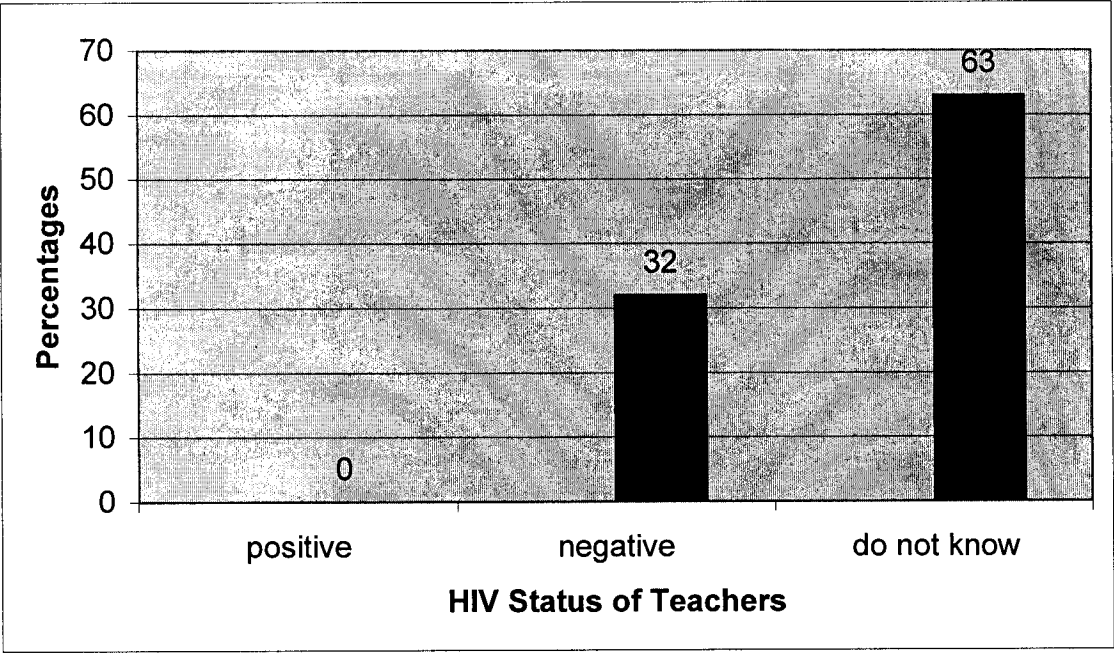


Figure 4 above indicates that almost two thirds (63 %) of the teachers revealed that they did not know their HIV status. About one third (32 %) reported that they were HIV negative. Surprisingly, none said was HIV positive.

Beliefs

The analysis of beliefs about HIV/AIDS held by people is very important because some of the risks of contracting HIV could be embedded in such beliefs.

Figure 5: Analysis of the Belief that Condoms Have Pores

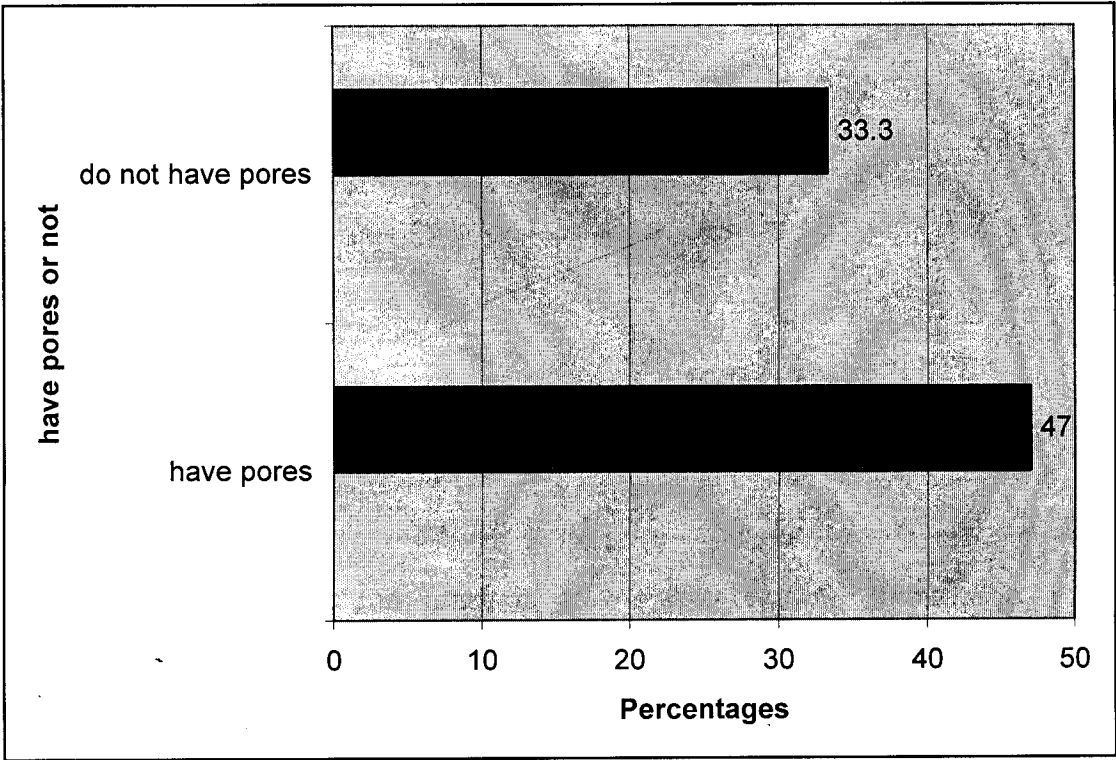


Figure 5 above shows respondents' belief that condoms have spaces small enough to allow the virus to pass through. Nearly one half (47 %) of the teachers believed that condoms have very small pores that can allow the AIDS virus to pass through. Only 33.3 % said they do not have.

Figure 6: Analysis of Whether AIDS Has a Cure or Not.

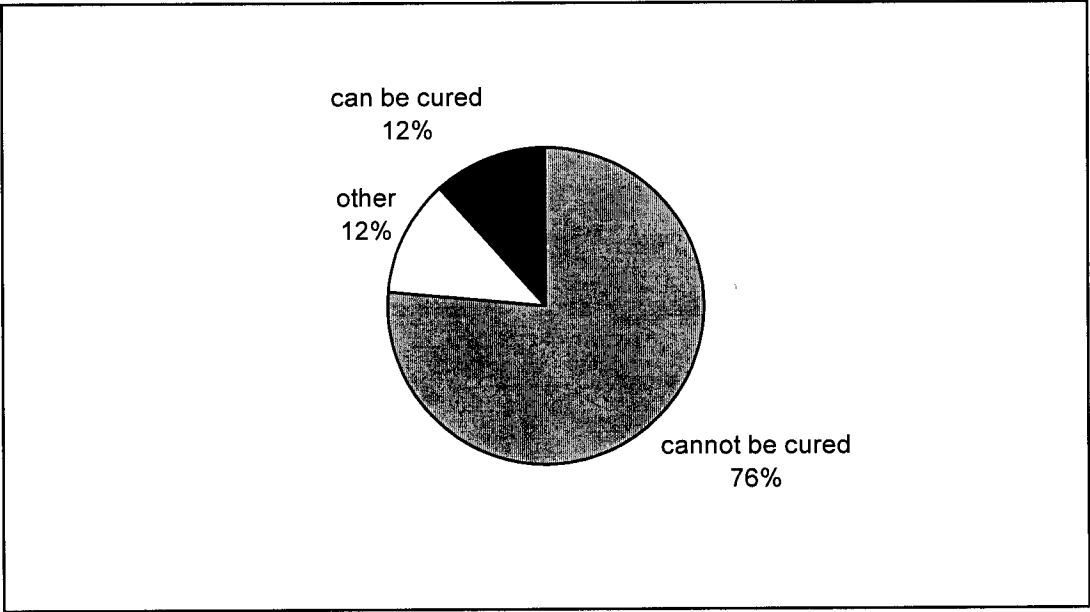


Figure 6 above shows the analysis of the respondents' knowledge on the availability of AIDS cure. Three- quarters (76 %) of the respondents knew that AIDS did not have a cure and 12 % believed that AIDS had a cure. The other 12 % skipped the question.

Table 3 below shows attitudes of respondents on various issues about HIV/AIDS. Attitude to HIV testing is an indicator of willingness to establish one's serostatus that has implications for sexual behaviour change. To find attitudes to HIV testing, respondents were asked whether they would go for an HIV test if it were possible to have one. About one half (52%) of the teachers were willing and prepared to take an HIV test as compared to 32 % who were not. Meanwhile, 16 % avoided responding to this question. Over 89% of teachers suggested that HIV/AIDS should be taught in schools although they said they needed training (51.7%). Almost the same number disclosed that if found HIV positive, they

Table 3: Analysis of Attitudes of Teachers on HIV/AIDS

Factor	Yes	No
Afraid that a family member may get HIV	216(72%)	40(13.3%)
Could talk freely about HIV/AIDS to your children	266(88.7%)	3(1%)
HIV/AIDS should be taught in schools	267(89%)	5(1.7%)
Teachers need training in HIV/AIDS	155(51.7%)	74(24.7%)
Want an HIV test	156(52%)	96(32%)
If positive, would go public	117(39%)	118(39.3%)
Afraid of AIDS	175(58%)	125(42%)
At risk of AIDS	152 (50.7%)	115(49.3%)

would go public (39%) as those who would not (39.3%). 72% were afraid that one of the family members might get HIV as compared to 13.3% who were not afraid. 58% of the teachers expressed fear that they might get AIDS while 42% were not afraid. 50.7% of the respondents reported that they were at risk of acquiring HIV while 49.3% said they were not. Teachers seemed to have a good understanding of HIV/AIDS as a social problem, but not as an issue in their personal lives.

Sexual Behaviours

The sexual behaviour of an individual greatly affects the chances of getting infected with an STI including AIDS. In this section, number of sexual partners, sex with non - regular partners and use of condoms are presented.

Figure 7 below shows that at least 67 % of teachers were sexually active with 64 % of them having one sexual partner while 3.3 % had more than one sexual partners. 13 % had none.

Figure 7: Number of Sexual Partners

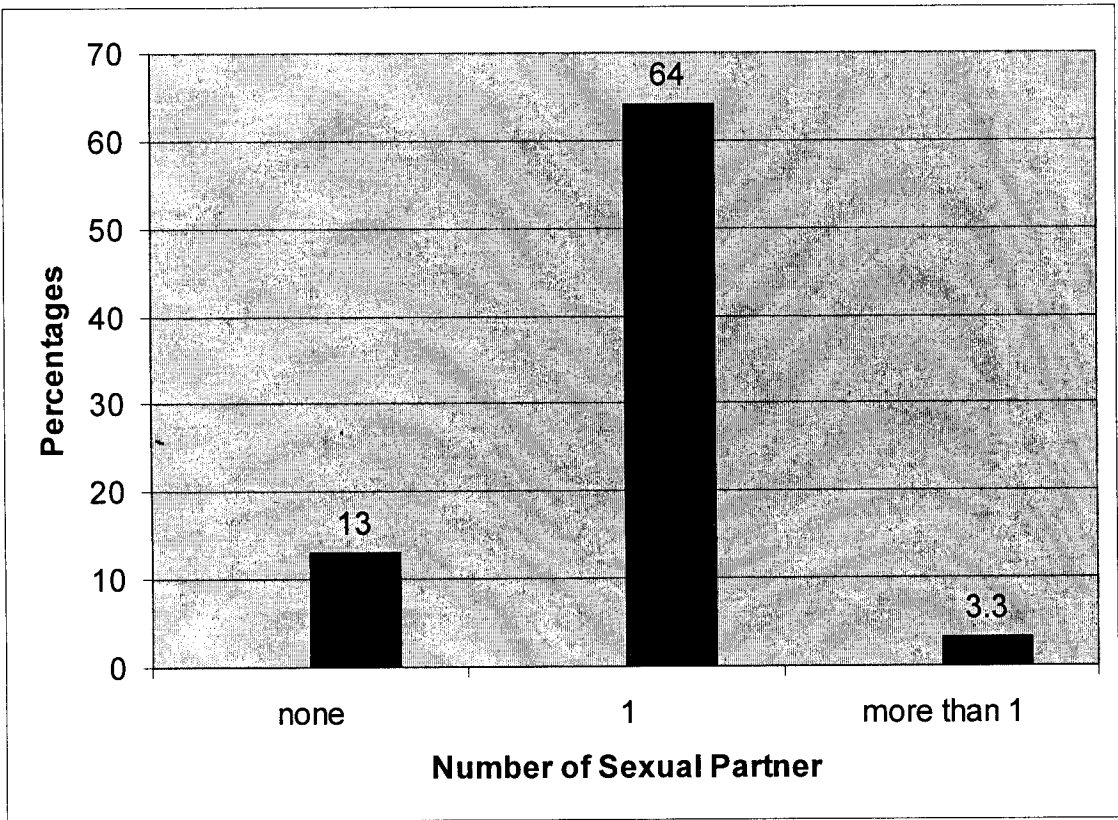


Figure 8 below shows that 6.3 % of the respondents had sex with non - regular partner in the past 12 months while 80 % did not.



Figure 8: Respondents who had Sex with Non – Regular Partners

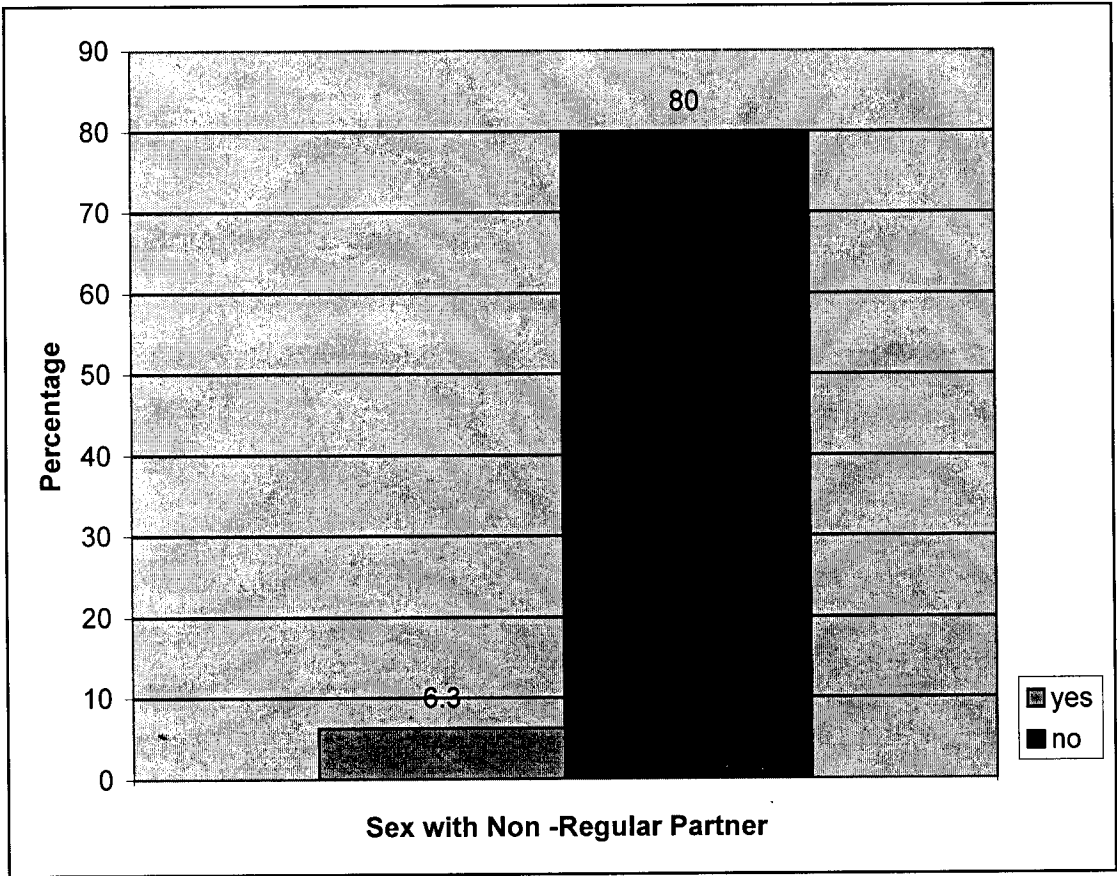


Table 4: Analysis of Condom Use

Factor	Yes	No
Used condoms	83(27.7%)	144(48%)
Used condoms	Always	Sometimes
	31(10.3%)	42(14%)

Table 4 above shows the analysis of the condom use among the respondents. Approximately, one half (48%) of the respondents revealed that they never used condoms and only 27.7% had. 24.3% skipped the question. Out of those who

used condoms, only 10.3% used them consistently. 14% used them inconsistently. 3.3% of those who used condoms did not specify how often they used them.

Figure 9: Sources of Condoms

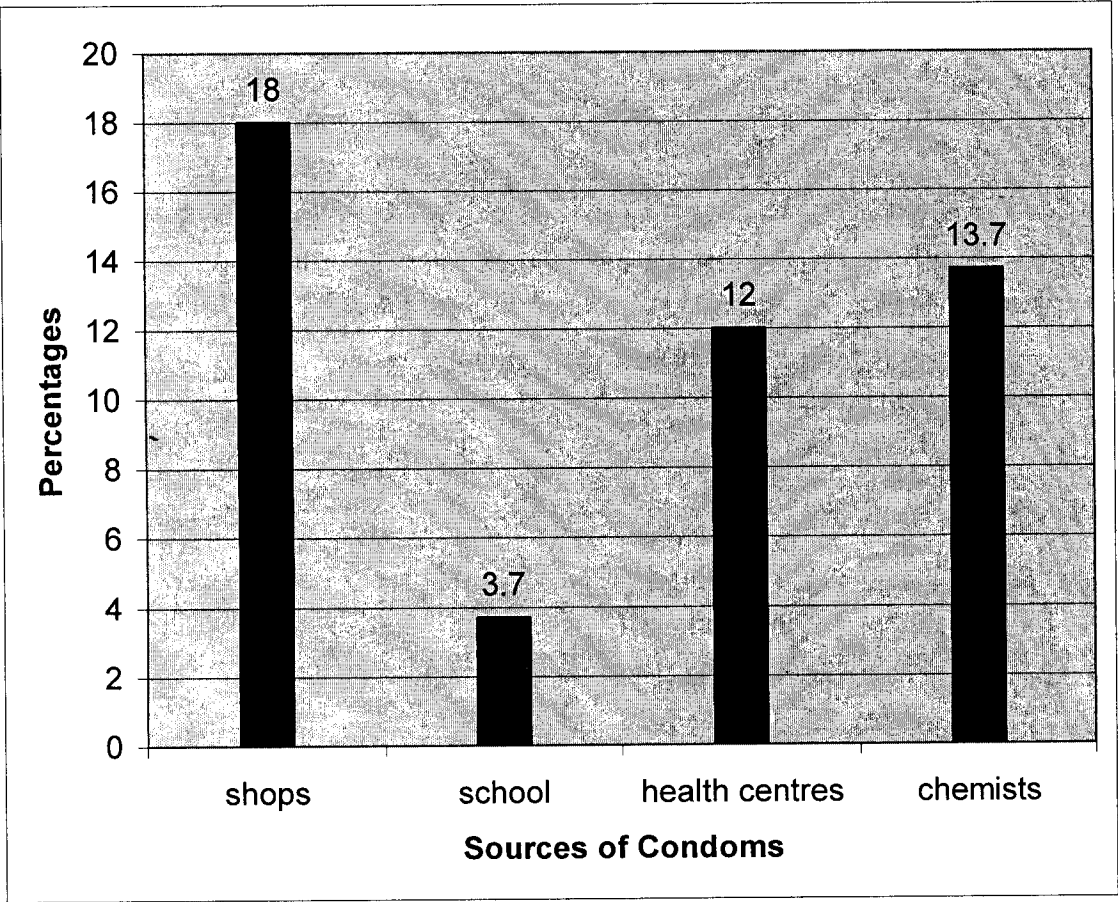


Figure 9 above indicates the sources of condoms for teachers. 18 percent and 13.7 % of teachers got condoms from shops and chemists, respectively. 12 % said they got them from health centres. Few (3.7 %) teachers accessed them from schools.

Figure10: Reasons for Using Condoms

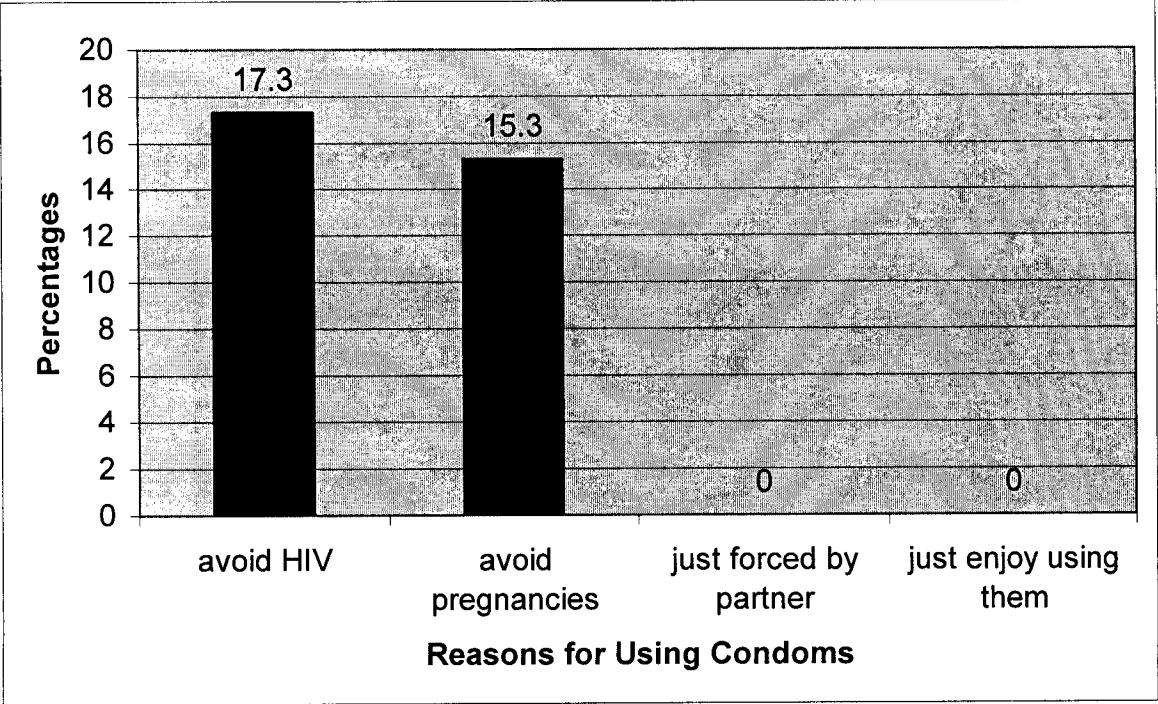
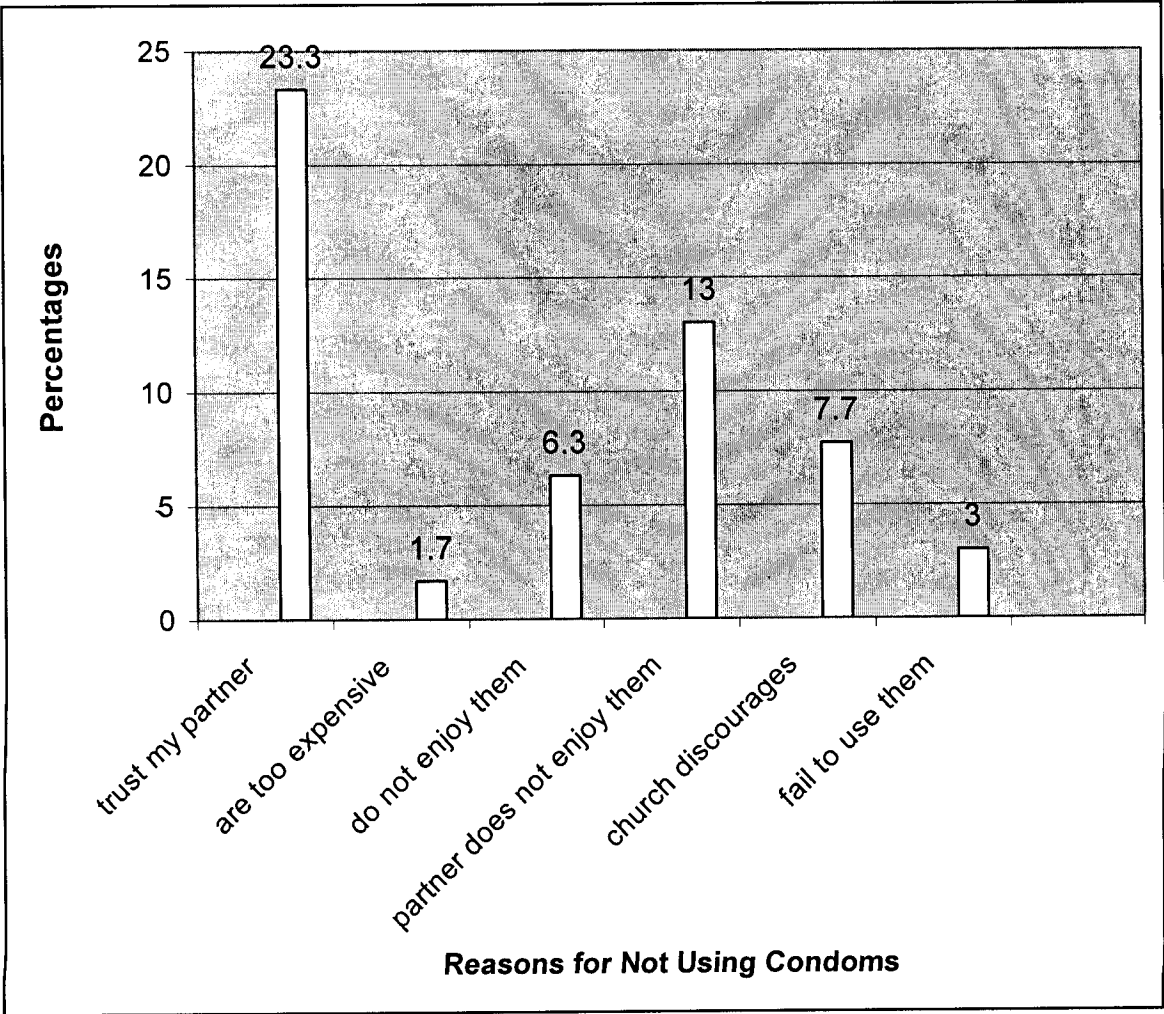


Figure 10 above depicts that 17.3 % of the teachers said that they used condoms to avoid HIV while 15.3 % of them used them to avoid pregnancies. None reported that they used them because their partners either forced them or they just enjoyed using them. There were more teachers who used condoms to avoid HIV than to avoid pregnancies.

Figure 11 below shows the reasons teachers gave for anti- condom use. Nearly one quarter (23.3 %) of teachers did not use condoms because they trusted their partners while 13 % did not use them because their partners did not enjoy them. 7.7 % reported that their church discouraged their use, as 6.3 % believed that condoms reduce the sensation of romantic sex. Some (3 %) said that they just

failed to use them while others (1.7 %) reported that condoms were too expensive.

Figure 11: Reasons for Not Using Condoms



Social habits

An analysis of social habits such as alcohol drinking, social mobility and discrimination of teachers suspected of suffering from AIDS was also done.

Figure 12 below show that 70 percent of the respondents did not drink alcohol. 23 % did while 7 % never responded.

Figure 12: Analysis of Alcohol Drinking Among the Respondents

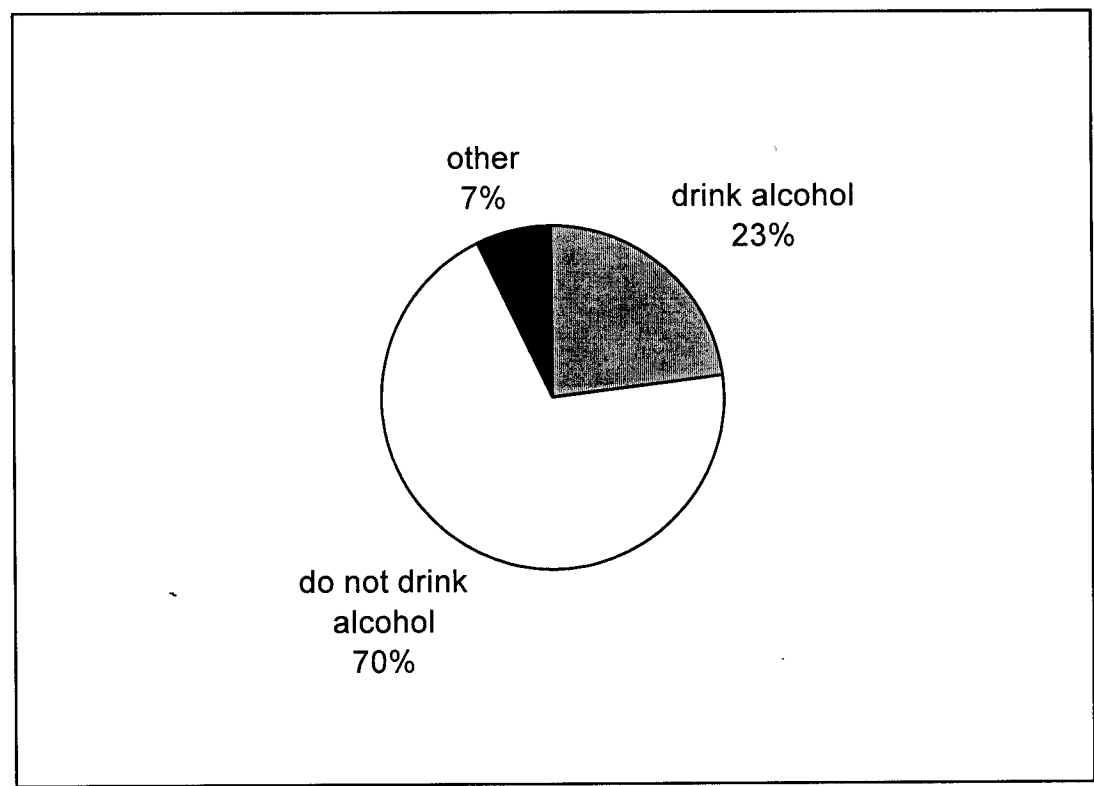


Table 5: Social Mobility of Respondents

Duration	n (%)
Less than 1 year	48(16.7)
1 to 3 years	68(22.7)
3 to 5 years	26(8.7)
More than 5 years	150(50)
Other	8(2.6)
Total	300(100)

Table 5 above shows the duration the respondents have been living in their locations. 16% of teachers had lived in their present locations for less than a year and 48.1 % for not more than 5 years.

Figure 13: Discrimination of Teachers

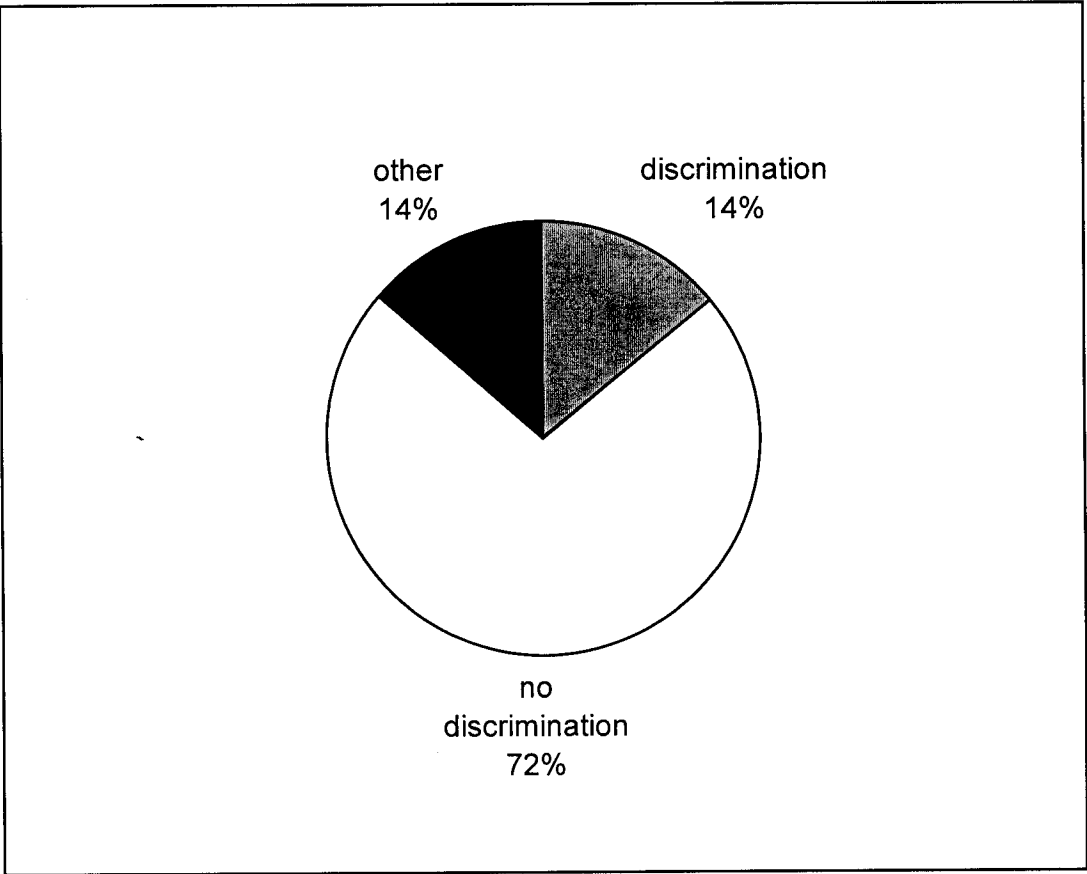


Figure 13 above shows that 72 % of the respondents said they never noted any form of discrimination from either fellow teachers or supervisors against teachers suspected of suffering from AIDS while 14 % did and the other 14 % never answered the question.

Gender Vulnerability to HIV/AIDS Infection

In order to appreciate and understand the dynamics of HIV/AIDS, gender vulnerability to HIV/AIDS among teachers was analysed.

Figure 14: Mode of HIV Transmission by Gender

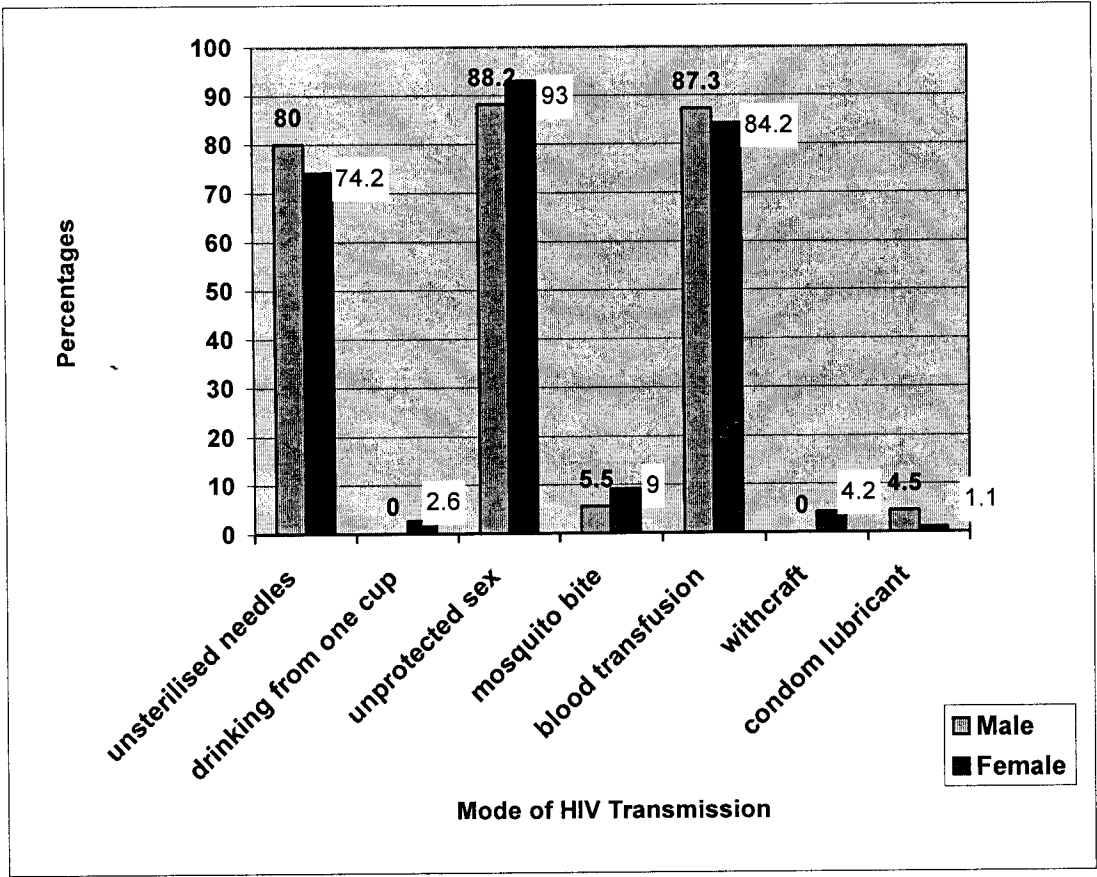


Figure 14 indicates that 88.2% of male and 93% female respondents said that HIV was transmitted through having unprotected sex with an infected person. 87.3% of male and 84.2% of female teachers reported that HIV was transmitted through transfusion of unscreened infected blood. 80 % of male and 74.2% of

female teachers said that it was transmitted through using unsterilised needles for injections.

Nevertheless, misconceptions about the mode of transmission of HIV were noticeable. For example, 5.5 % of male and 9 % of female respondents said that HIV could be transmitted through being bitten by a mosquito. 4.2 % of female respondents believed that HIV was transmitted through witchcraft, 4.5 % and 1.1 % of male and female respondents reported that HIV was transmitted through condom lubricant, respectively. 2.6 % of female teachers believed that HIV could be transmitted through drinking from the same cup as an infected person.

Figure 15 below shows that 85.5 % of male and 81 % of female respondents said that HIV could be contracted by prostitutes. 77.3% of male and 71% female respondents believed that HIV could be contracted by homosexuals. 73% of male and 68% of female believed that HIV could be contracted by the poor while 73% of male and 65.3% of female reported that it could be contracted by the rich. 73% of male and 58% of female thought that it could be contracted by whites. Few (36.4% of male and 39% of female) thought it could be contracted by the users of condoms.

Figure 15: Knowledge Levels of Respondents on Who Can Contract HIV by Gender

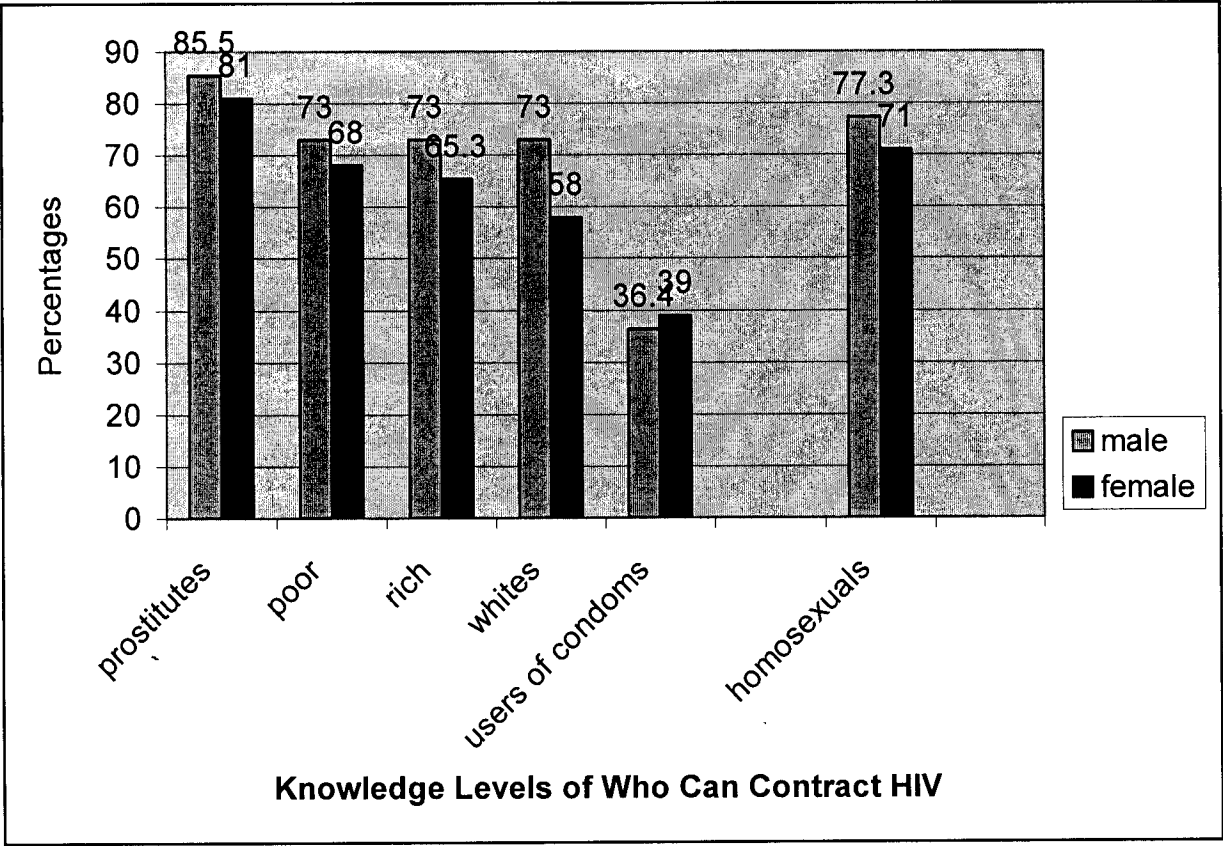


Figure 16 below indicates that 65 percent of male and 62 percent of female teachers reported that they did not know their HIV status, respectively. Approximately one third (31 %) of male and 33 % of female teachers said they were negative. None said was positive.

Figure16: HIV Status of Respondents by Gender

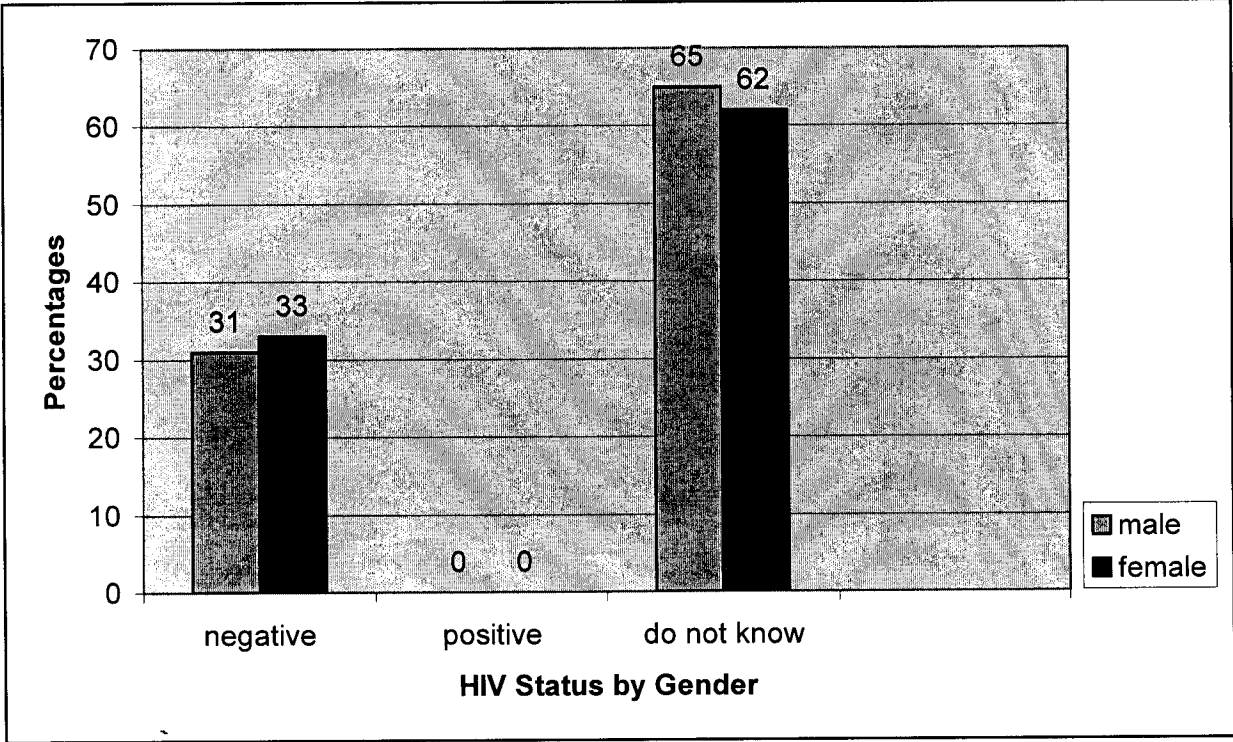


Figure 17: Analysis of Whether Condoms Have Pores or Not by Gender

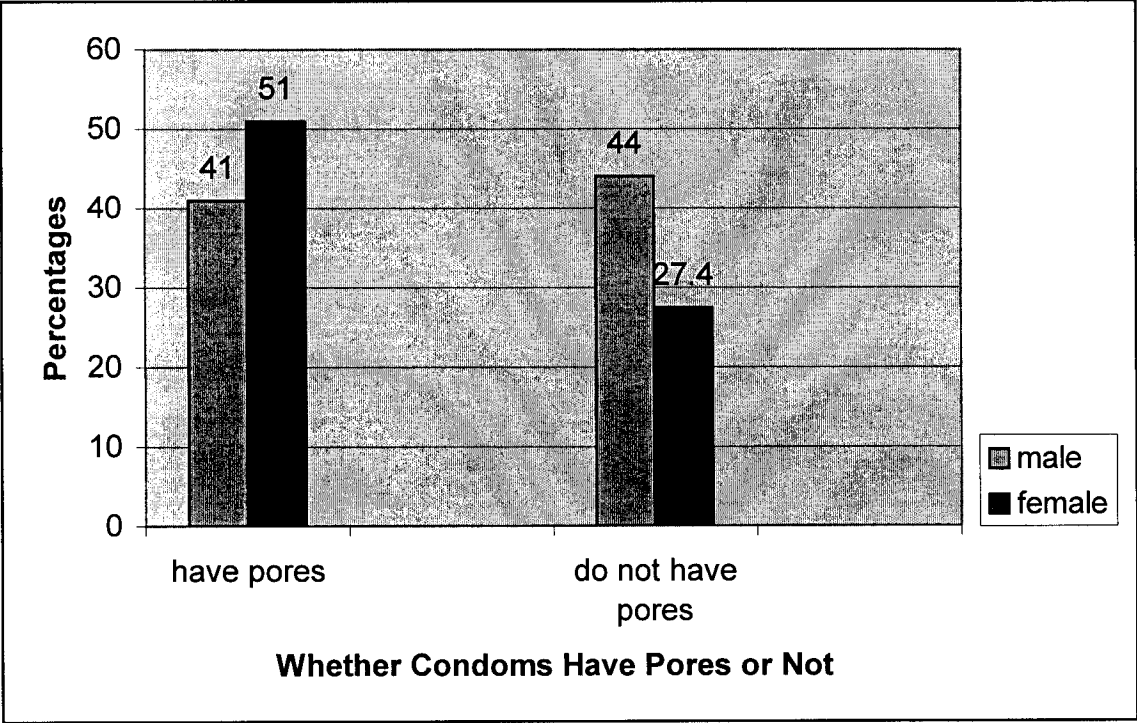


Figure 17 above indicates that 41% of male and 51% of female respondents believed that condoms have pores small enough to allow the HIV to pass. 44% of male and 27.4% of female said they did not.

Figure 18 below shows that 7.3% and 14.2% of male and female believed that AIDS could be cured, respectively. 77.3% of male and 76% of female reported that AIDS could not be cured.

Figure 18: Respondents' Views on whether AIDS is Curable by Gender

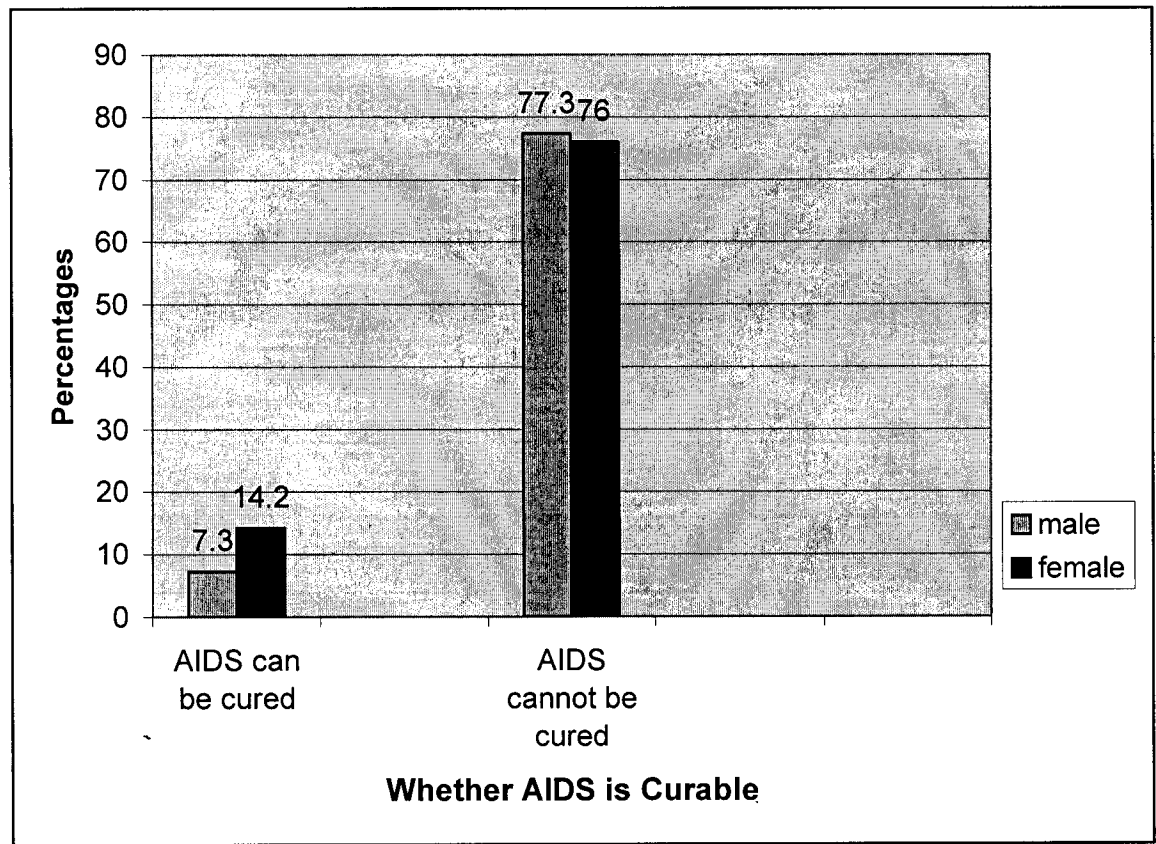


Table 6: Analysis of Respondents' Perceived Risk and Fear of AIDS by Gender

Sex	Afraid of AIDS	Not afraid of AIDS	At risk of AIDS	Not at risk of AIDS
Male	53%	17.3%	49.1%	32%
Female	62%	11%	52%	42%

Table 6 above shows that 17.3% of male and 11% of female reported that they were not afraid of contracting HIV. 32% and 42% of male and female, respectively, said they were not at risk of contracting AIDS.

Table 7: Analysis of Respondents' Attitude on HIV/AIDS by Gender.

Afraid family member may get AIDS	Male (%)	Female (%)	Total (%)
Yes	65.5	76	72
No	18	11	13.3
Other	16.5	13	14.7
Total	100	100	100
Would talk freely about AIDS to children			
Yes	84	92	88.7
No	1.8	0	1
Other	14.2	8	10.3
Total	100	100	100
AIDS should be taught in schools			
Yes	85	92	89
No	1.8	2	1.7
Other	13.2	6	9.3
Total	100	100	100
Teachers need training in AIDS			
Yes	27.3	66	51.7
No	29.1	22.1	24.7

Other	43.6	11.9	23.6
Total	100	100	100
Want an HIV test			
Yes	55	51	52
No	27.3	35	32
Other	17.7	14	16
Total	100	100	100
If positive, would go public			
Yes	40	38.4	39
No	40	39	39.3
Other	20	22.6	21.7
Total	100	100	100

Table 7 above shows attitudes of respondents on various issues about HIV/AIDS. Generally, males (55%) were more willing than females (51%) to be tested. Meanwhile, 16 % avoided responding to this question. Over 85% of male and 92% of female teachers suggested that HIV/AIDS should be taught in schools although they said they needed training (27.3% of male and 66% of female). Almost the same number disclosed that if found HIV positive, they would go public (40 % male and 38.4% female) as those who would not (40% of male and 39% of female). 65.5% of male and 76% of female were afraid that one of the family members might get HIV as compared to 18% of male and 11% of female who were not afraid. Teachers seemed to have a good understanding of HIV/AIDS as a social problem, but not as an issue in their personal lives.

Figure 19: Sex with Non - Regular Partner by Gender

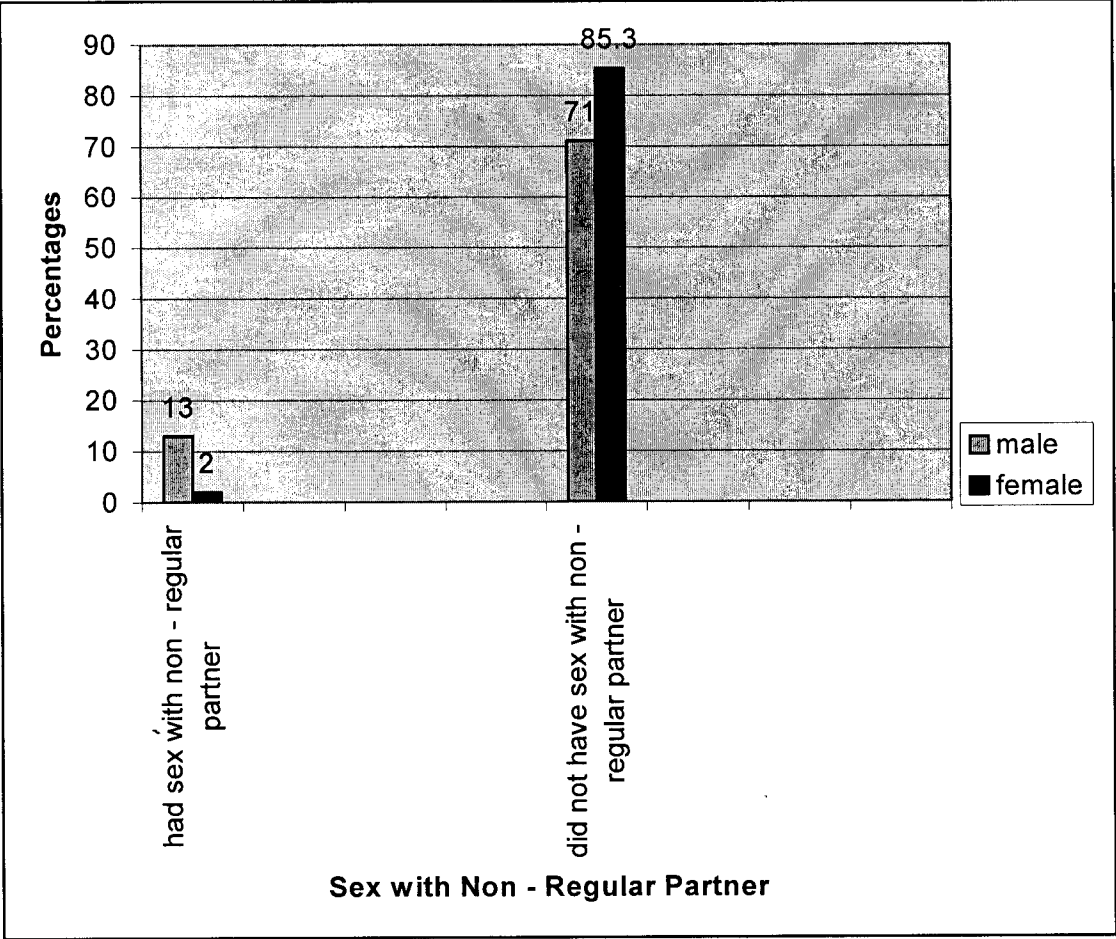


Figure 19 above shows that 13% of male and 2 % of female respondents reported that they had sex with non - regular partner in the last 12 months. 71% of male and 86.3% of female said they did not.

Figure 20 below indicates that 63.3% of male and 66% of female respondents were sexually active with one tenth (9.1%) of male teachers having more than 1 sexual partners. 60 percent of them had one sexual partner. All the 66% of the female sexually active female teachers had only 1 sexual partner. 11% of male and 15% of female did not have any sexual partners.



Figure 20: Number of Sexual Partners by Gender

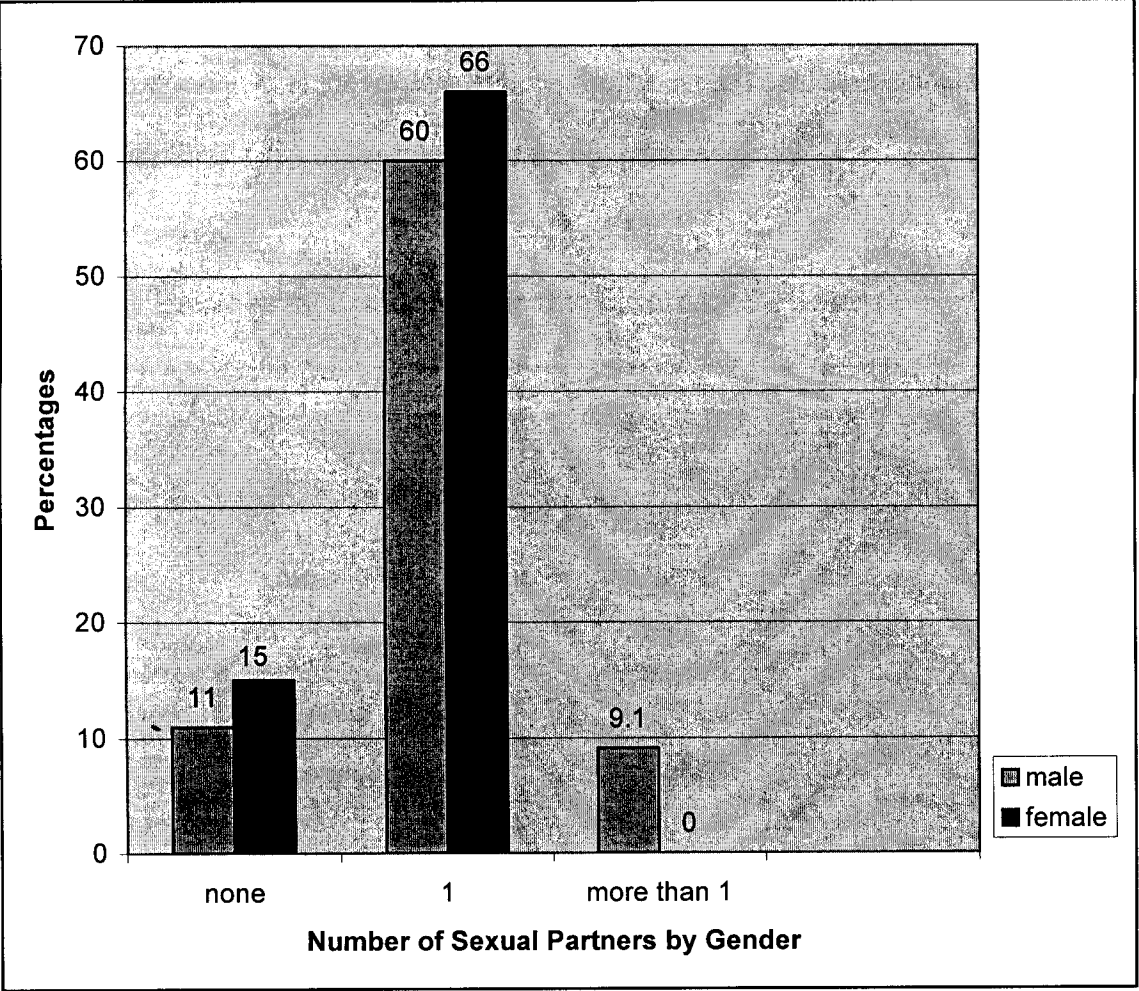


Table 8: Use of Condoms by Gender

Used Condoms	Male	Female	Total
Yes	43%	19%	27.7%
No	33.3%	57%	48%
Always	25.5%	2%	10.3%
Sometimes	16.4%	13%	14%

Table 8 above shows that 43 % and 19 % of male and female teachers reported that they used condoms during sexual intercourse, respectively. Of these, 5.5 % of male and only 2 % of female respondents used condoms consistently while 13% of male and 14% of female used them inconsistently.

Figure 21: Sources of Condoms for the Teachers by Gender

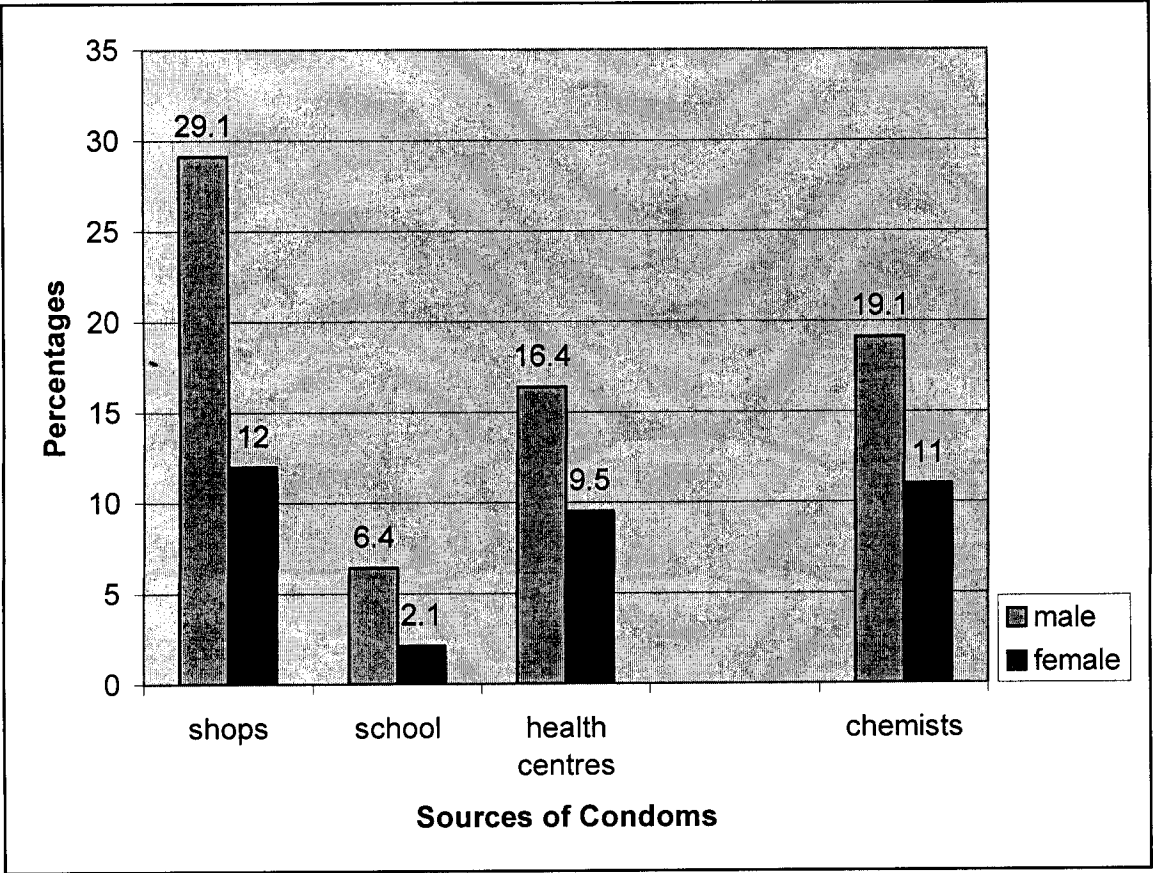


Figure 21 above shows the different sources of condoms for teachers. One third (29.1 %) and 12 % of male and female teachers got condoms from shops, respectively. 19.1 % of male and 11 % of female respondents reported that they got condoms from chemists. 16.4% male and 9.5% of female respondents got

them from health centres. 4 % and 2.1 % of male and female teachers accessed condoms from schools, respectively.

Figure 22: Reasons for Using Condoms by Gender

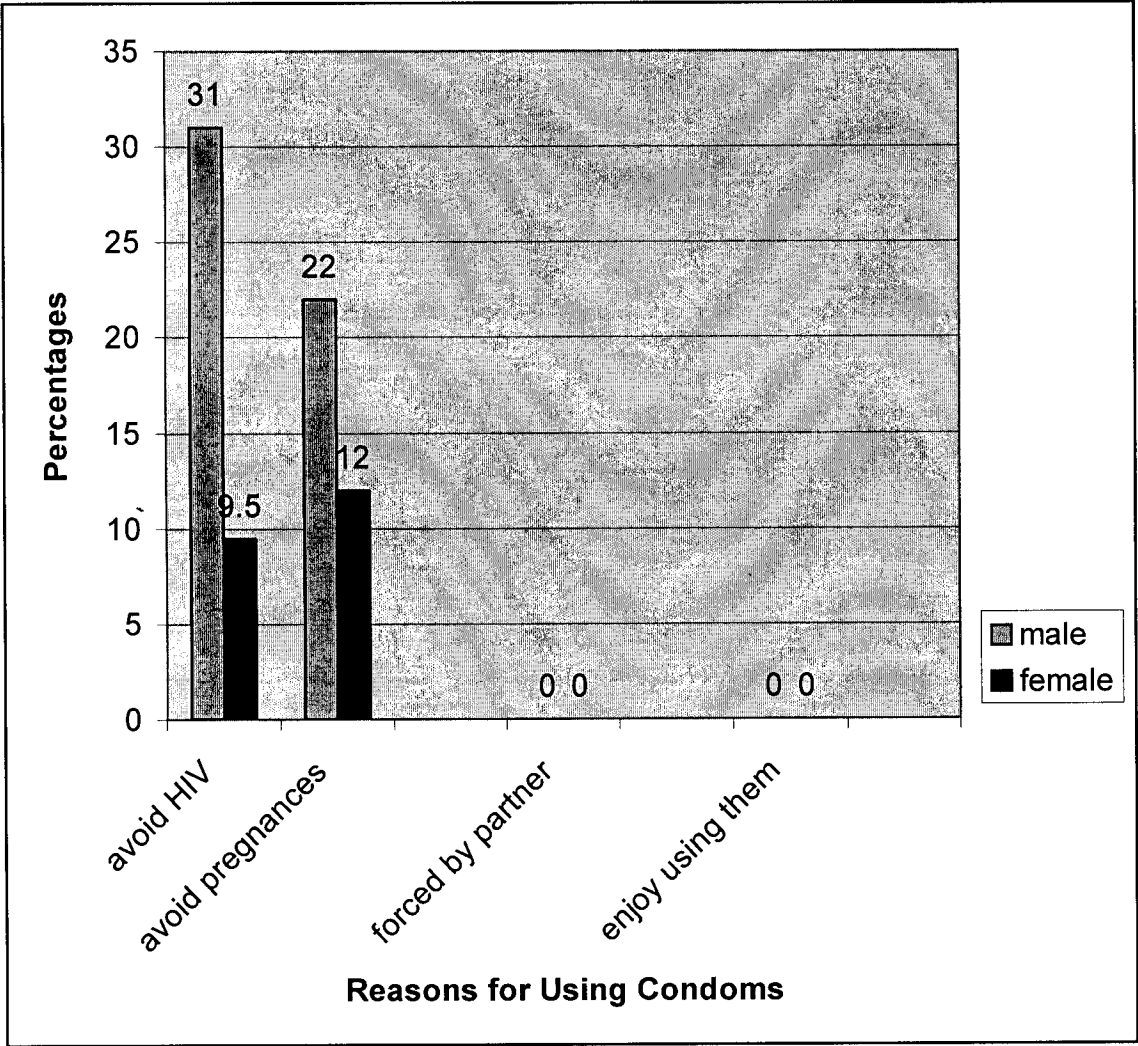


Figure 22 above shows that one third (31 %) and one tenth (9.5 %) of male and female teachers said that they used condoms to avoid HIV, respectively. 22 % of male and 12 % of female respondents reported that they used condoms to avoid pregnancies. None used condoms because of either being forced by partner or just enjoying using them.

Figure 23: Reasons for Not Using Condoms by Gender

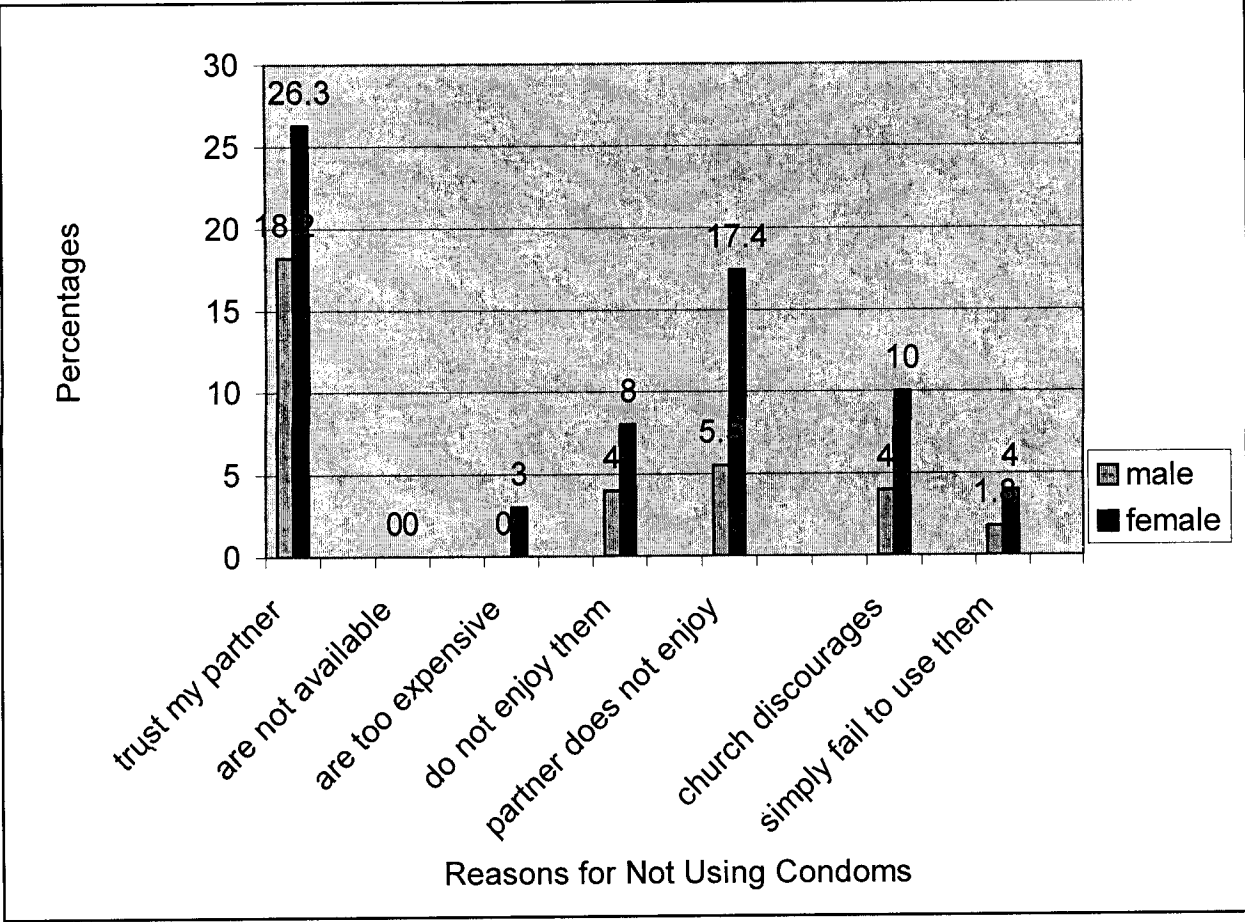


Figure 23 above indicates reasons why some teachers never used condoms. 18.2 % and 26.3 % of male and female teacher respondents reported that they trusted their partners, respectively. Some 5.5 % of male and 17.4 % of female teachers said that their partners did not enjoy using them. 4 % of male and one tenth (10 %) of the female teachers said that their churches discouraged their use. 1.8 % of male and 4 % of female teachers said that they simply failed to use them. Others (4 % of male and 8 % of female teachers) reported that they did not enjoy using them.

Table 9: Alcohol Consumption by Gender

DRINK ALCOHOL	Male	Female	Total
Yes	45%	11%	23%
No	42%	86%	69%
Other	13%	3%	8%
Total	100%	100%	100%

Table 9 above shows the number of teachers who consumed alcohol. 45% of male and 11% of female reported that they drunk alcohol. 42% of male and 86% of female said they did not. 13% did not answer the question.

Figure 24 below shows that 22% of male and 14 % of female teachers had lived in their present locations for less than a year. More than half (59.4%) of male and 42.4% of female respondents had lived in their present locations for not more than 5 years. 36.4% of male and 58% of female had lived in their present locations for more than 5 years.

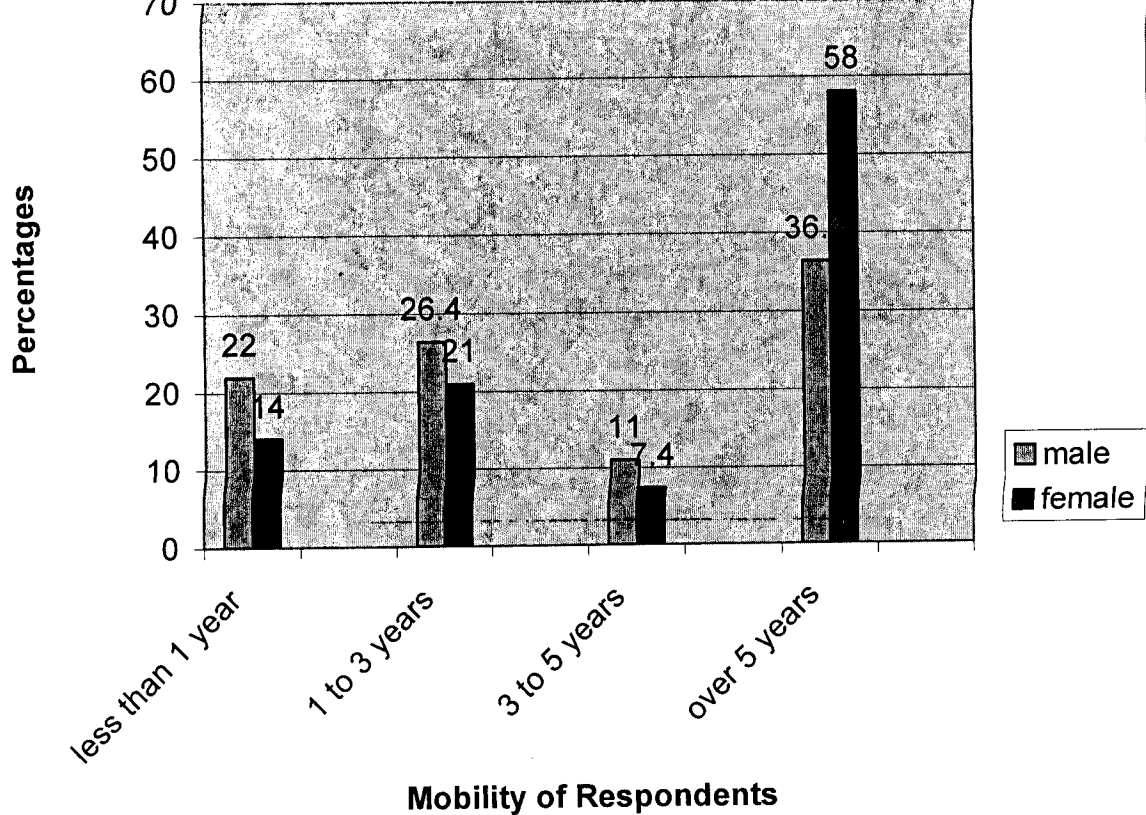


Table 10: Use of Herbs

Use Herbs	n(%)
Yes	18(9.5)
No	136(71.6)
Other	36(18.9)
Total	190(100)

Table 10 above shows the number of female teachers who used herbs before sex with their partners. About one tenth (9.5%) reported that they used herbs while 71.6% did not. 18.9% avoided the question.

Figure 25 below indicates reasons for using herbs. 7.9 % used them to warm vagina and body. 6.8 % used them to contract vagina and 4.7 % just to increase sexual arousal. Some (4.2 %) said that they used herbs to dry vagina. Others (2.1%) said they did so to remove dirty from vagina while 1.1% to strengthen the body against ill health.

Figure 25: Reasons for Using Herbs

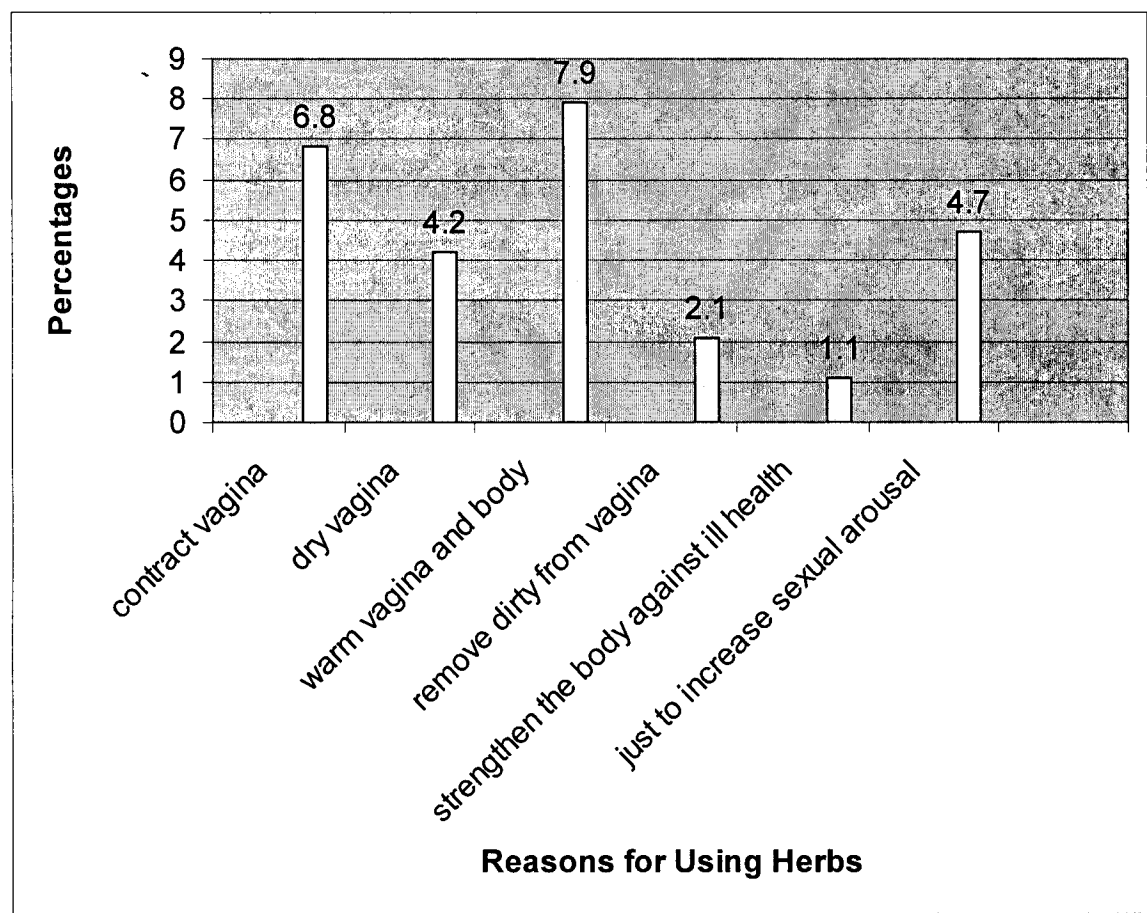


Figure 26: Substances Used by Women before Sex

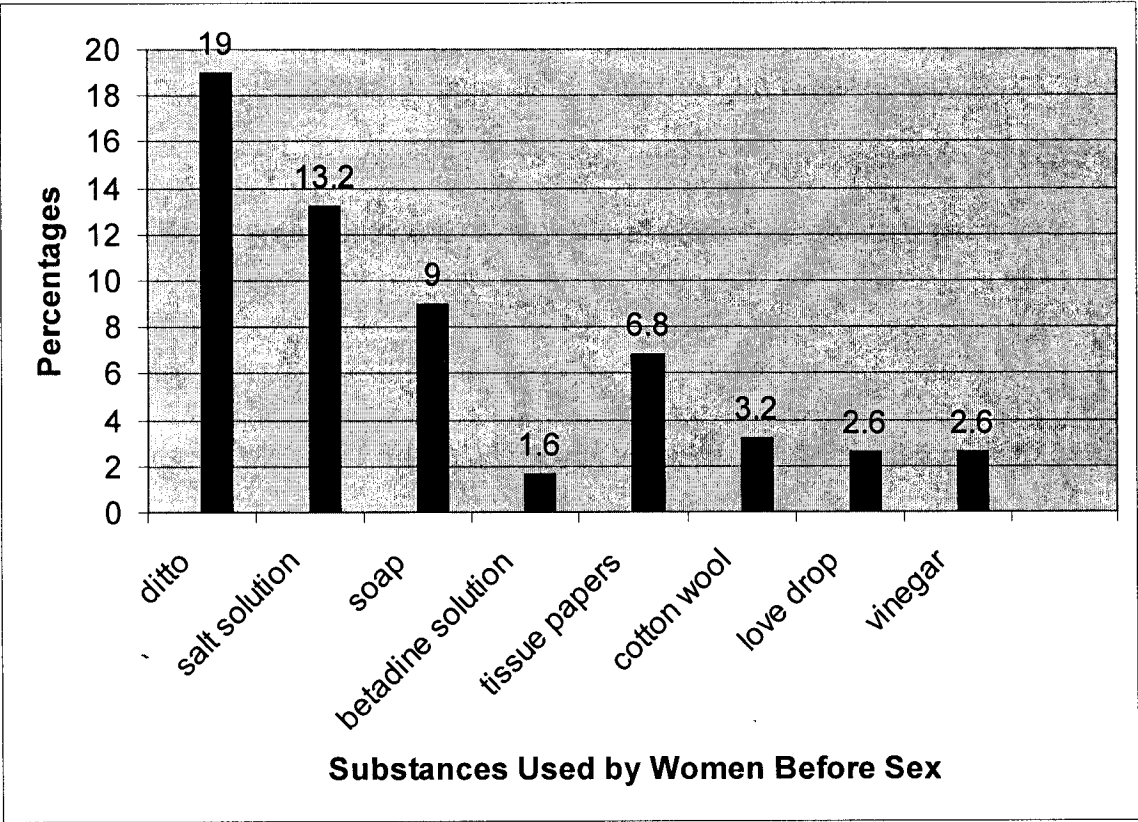


Figure 26 above shows substances female teachers used before sex with their partners. 19 % used ditto, 13.2% salt solution, 9% soap, 6.8% tissue papers and 3.2 % cotton wool. 2.6% used both love drop and vinegar. 1.6 % used beta dine solution.

FINDINGS FROM FOCUS GROUP DISCUSSIONS (FGDs)

Polygamy

The majority of the respondents did not approve of the polygamy. They said it was unchristian. They also said that women in polygamous marriage tend not to have enough sexual attention and financial support from their husbands, hence

extra marital affairs that exposed them to the risk of acquiring HIV/AIDS. On the other hand, some women said that polygamy also does not appear to prevent a man from seeking casual sex from other women. The few who approved, mostly men, said marriage (including polygamy) was a legal human right issue. They also reported that it was convenient for easy and quick multiplication of children. Others said that it was tradition that could cage sexually insatiable men.

Cure of AIDS

The respondents who said that AIDS could be cured attributed the cure to herbal medicine from traditional healers. Others believed that God could cure it through prayer. One 37 year-old woman said, "... there is nothing which is impossible with God so long one accepts Jesus Christ as the personal saviour..."

Alcohol Consumption

Among those who drank alcohol, some, mostly men, reported that alcohol increased their sexual drive and said it gave them impetus and desire for sex. Very few said it reduced it.

Condom Use

Those who used the condoms during sexual intercourse said they used them primarily to avoid STIs including HIV and to avoid unplanned pregnancies. The respondents who did not use condoms had varied reasons. They said they were married so there was no need of using condoms. Some said they (condoms) reacted with skin thereby causing rash. Others said they did not enjoy using them

and that the use of condoms contributes to increased infection levels as HIV is found in condom lubricants / chemicals.

Several other men who intended to use condoms reported that they did not use them when sex happened suddenly and was not planned or they did not expect the partner (to visit) at that time and so on. One 36-year old single teacher said:

“... one woman was difficult to handle, she kept changing her mind, so when she finally agreed, there was no time to go and get a condom, so I had sex with her without a condom...”

Many men said that they want to use condoms with non- regular partners but not with regular partners. One male teacher had a regular partner whom he intended to marry and they had been in a sexual relationship for two years and they relied on safe periods to avoid pregnancy. He discussed sexual encounters with non-regular partners and said, “... I always use condoms because I do not trust them ...”

He further said he would not agree if his partner of two years demanded condom use, “... because she is my regular partner. I trust her...”

There were also some who said condoms had pores small enough to allow the AIDS virus to pass through. One male teacher said, “...there is no need of using condoms since they have small holes which can allow HIV to pass through...”

HIV Test

The majority of the respondents were willing to be tested. Respondents were asked why they would be willing to take the HIV test. Most respondents reported that they wanted to know their HIV status so that they could plan for the future. Some teachers did not want to be tested. They said they were afraid and would die early if found HIV positive. Others said that it was not necessary and could only take the test if they were sick and if there was a cure for AIDS. They said:

“... you can only choose to take a test for curable diseases such as malaria and TB...and it is better not to know the HIV status because one can die faster if found positive...”

Going Public

Some respondents said that they would go public if found HIV positive. They said they wanted to sensitise the community about the pandemic. The majority said they would not go public. They said that they would be stigmatised and discriminated by the community. They said it is dehumanising and degrading and people would think that one was promiscuous. One 27 year - old female teacher queried the essence of going public:

“...why should I go public yet many people suffering from other diseases such as malaria, tuberculosis (TB), etc. do not go public?...”

Discrimination

Some teachers reported that there was discrimination against those teachers suspected of suffering from AIDS. They said the school management rarely promoted (even when one rightly qualifies) or appointed such people into areas of responsibility. They were rarely given scholarships. Sometimes, management

also suggested when such a teacher should stop teaching and re-allocated classes, including Academic Production Unit (APU), where they earned extra income.

On the other hand, the respondents said that they (such teachers) were also discriminated by fellow teachers through indirect comments targeted at them. They said that they also felt discriminated through songs. Some teachers did not use the cups that such teachers used in staff rooms. When there was AIDS talk, they felt ashamed to contribute effectively.

CHAPTER 5

DISCUSSION

This was a cross sectional descriptive study carried out in the schools of city of Lusaka. A convenient sample was used to select 300 school teachers at 14 schools from a total of 3313 who were serving in the schools at the time of this survey. All necessary data to determine the vulnerability of teachers to HIV/AIDS were collected by administering structured open-ended questionnaire. Care was taken to have their consent to participate in the study before administering any questionnaire. Confidentiality was maintained. Those teachers who refused to participate or answer any question were not forced.

The findings of this research have both basic science and applied significance. Understanding the process by which exposure to information, knowledge, attitude, practices, risk perception, and cultural norms and values influence risk reduction is an important part of the research agenda for investigators interested in effective ways to reduce high- risk behaviour. Content of mass media educational efforts to raise knowledge levels is an important component of effective programmes, as several studies of health related mass media have shown (Hormic, 1989). The effect of AIDS related mass media on risk perception, knowledge and behaviour change is still unclear and subject to controversy. Poor results in effecting large-scale changes in risk behaviours have been reported by researchers (Judson, 1989).

The study found that exposure to information significantly raised knowledge of how HIV is transmitted and thus may result in a reduction of behaviours that lead to HIV transmission. Knowledge of HIV alone does not motivate change. For example, despite wide knowledge about the adverse effects of eating fatty foods, weight reduction and diet modification adherence are notoriously difficult. Sexual behaviour is very much influenced by the social- cultural norms.

A heightened perception of risk for acquiring HIV infection may reduce risk-taking behaviour. Douglas and Wildavsky (1982) noted that people often emphasise obscure risks, for instance, polygamy, while ignoring others that are important such as unprotected sex or dry sex. They argue that risks are chosen based on beliefs about values, social institutions, nature and moral behaviour. Risks are, therefore, emphasised or avoided according to the cultural, moral and social acceptability of the underlying activities upon which a particular risk is based. Perception of risk for illness or infection is a major component in most theories of health behaviour. There is evidence that increased perception of risk does lead to behaviour change on the short term, but such changes are believed to diminish over time if not periodically reinforced (Allard, 1989).

This implies that intervention programmes that only stress increasing risk perception will not be as successful as those that also include informational components that provide technical information about HIV. For example, despite being educated, significant misconceptions persisted among teachers such as beliefs that mosquito, witchcraft, condom lubricant and drinking from the same

cup with an infected person could transmit HIV. Such misconceptions could be common and wide spread in the less educated and enlightened populations. Thus, social marketing of desirable behaviours should be complemented with technical education about AIDS for an optimal reduction in risk behaviour. This explains why creating behaviour change through the media is so difficult. Even after attracting the receiver's attention there are several more changes that must be accomplished before the final outcome of a stable new behaviour is achieved.

To reduce the risk of HIV infection, condom use has been advocated because condoms seem to be effective in preventing sexually transmitted HIV (Weller, 1993). Although condoms are being advocated for prevention of HIV infection, there are problems facing condom promotion in Africa. In this study, low condom use was noted. Only 27.7% of teachers had used condoms during sex. 6.5% of the teachers reported that they did not enjoy their use. More female (8%) than male (4%) of respondents reported that they did not use condoms because they did not enjoy using them during sex. These results are in support of the earlier studies done in Nigeria and Cameroon. Stewart, Deforge, Hartmann and Kaminski (1991) reported that 27.5% of the participants of the study conducted in Nigeria stated that they were opposed to the use of condoms because condoms interfered with the sexual enjoyment. More female (17.4%) than male (5.5%) respondents reported they did not use condoms because their partners did not enjoy them. Similar observations have been reported from women attending family planning clinics in Dar es Salaam where it was found that 57.5% reported

having never used condoms because their male sexual partners did not like them (Kapiga, Lwihula, Shao and Hunter, 1993).

In this study, there were more male respondents who used condoms to either avoid HIV or pregnancies. Although condoms were available and affordable, only a very small portion of the respondents reported having used them. The study results indicated a variation in the perceived functions of the condoms in this population. However, the perceived function of condoms was not related to regular condom use. Some participants said they used condoms in sexual relationships for protection against HIV, but it became apparent during discussions that this use was often sporadic and short lived. The people used condoms for contraception said their use in these instances was more systematic, but they were often discarded at 'safe' times of the month, or intercourse commenced unprotected and condoms were later put on for ejaculation.

The fact that 47% of teachers believed that condoms were porous and could allow the AIDS virus to pass through during sex makes it more likely for them not to use condoms as this would not be seen to be a preventative measure against acquisition of HIV. When condoms (male and female) are used correctly and consistently, they are a highly effective means of preventing the transmission of HIV and other STIs (NAC, 2004). Latex condoms offer physical and impermeable barrier against HIV (Perre de Van, et al., 1987). In addition, the respondents who said that AIDS was curable through prayer and herbal medicine were also less

likely to take precautions such as protected sex as it was apparent that they would get cured of it if infected. At the moment there is no cure for HIV and AIDS although the Traditional Health Practitioners Association of Zambia (THPAZ) and the Zambia National Council of N'ganga claim that more than 150 plant materials and herbal preparations are in current use in the treatment / management of HIV and AIDS in Zambia on purely empirical basis

(NAC, 2004 c). National Conference on the integration of traditional and alternative remedies in the management of HIV and AIDS was held in Zambia in July 2004. Preliminary examinations were carried out on the efficacy of some of the samples and further tests are still under way to determine toxicity of these samples.

Condom use in long-term relationship was also problematic. The difficulties of practising safer sex in long-term relationships present a particular risk. Few respondents said that they had used condoms for protection against HIV, but it became apparent during discussions that this use was often sporadic and short lived. The risks are compounded because of not continuing to practise safer sex once a relationship has become established. The discarding of condoms would appear to happen alarmingly quickly and once this step has been taken it seems extremely difficult to return to safer sexual practices. Even when trust has been violated and risk is apparent, a return to safer sex is unlikely. Difficulties in changing established behaviours are also particularly pertinent to people who established their sexual behaviours when condoms had been superseded by the pill and HIV was not an issue.

Furthermore, the church was also seen to be a stumbling block in as far as use of condoms was concerned as 10% of female and 4% male respondents did not use condoms because their churches were against their use. Today, condom access and use is part and parcel of the right to health and even potential right to life. Health workers recommend condom use but the religious groups usually discourage it. No law exists to prevent any agent from advising or advertising against condom use.

The study revealed that condoms were not available for distribution to teachers at all but one-surveyed schools. Even at that particular school teachers found it difficult to access them since they were stored and issued by the Head teacher. All the stocked condoms were male condoms and female condoms were not in supply. Very few teachers had at one time got condoms from their schools despite the opportunity of them (condoms) being available.

Since appropriate condom use reduces the risk of HIV infection and unwanted pregnancies, the findings seemed to be favourable for developing specific health education strategies for condom promotion. In developing an intensive condom promotion programme, specific information on perceptions of condom use is required. Furthermore, the study demonstrated the need for health educators to emphasise consistent condom use for any sexual contact because quite often sex is not for conception but for satisfaction of physiological sexual desires.

The study finding of almost one-quarter (21.7%) of the single respondents pauses a likelihood that they could be in non-regular relationships which puts them at a great risk of contracting HIV. The other implication was that they could fear or rather not be willing to raise families as their living standards and working conditions were too low and poor to add a burden of a family, respectively.

Deliberate workplace programmes that take comparative advantage of the already existing infrastructure and people (teachers and pupils), among others, were weak, not harnessed and almost non-existent. The workplace is a particularly powerful influence on people's social attitudes, values and sexual behaviour. Schools are not simply places where people earn a living. They are also places of social interaction, where people chat, gossip, banter, exchange information and experiences and influence one another's opinion and behaviour. Peer group pressure at work is a key factor in how people think and behave, not just on the job but also in their social attitudes and sexual behaviour outside the workplace. However, the fact that sick teachers are discriminated and stigmatised at school institutions as observed in this study, even the best designed AIDS education programmes are unlikely to be successful in such workplaces.

Although Anti-AIDS clubs do exist in schools, teacher participation, apart from the co-ordinators, was non-existent. The club membership was exclusively for pupils. Social marketing of condoms also does not exist. This is because it is viewed as a taboo and may cause moral decay to the pupils in schools. Very few

Anti-AIDS co-ordinators were invited for seminars and workshops. Moreover, due to partnership with some NGOs, MoE conducted relatively few workshops for teachers. Teachers complained that the MoE did not supply them with enough IEC materials including T-shirts. They said T-shirts were mostly given to non-teaching staff at administrative offices. Information dissemination about HIV/AIDS to teachers is limited because of stigma. The few teachers who attended seminars and workshops were too shy to share information with other teachers partly because of their own known vulnerability by the peers.

It appears that teachers have increased vulnerability as 72% of them reported that teachers were also involved in sexual relations with their pupils. This finding has a bearing on the vulnerability of both teachers and pupils. On the other hand, male teachers could have thought of school girls to be young and, therefore, relatively low risk group. During the FGDs, it was said that female pupils entered into these relations due to peer pressure, as they mainly wanted to earn more marks and have pocket money at school. In addition, multiple partnerships, especially where one does not use a condom, increases vulnerability to HIV infection. The findings show that more men than women had more than one sexual partners in the last 12 months.

Fear of acquiring HIV is not very common, especially among men. Reardon (1989) discussed how fear appeals might best be used in communication about AIDS to people who typically perceive the threat of death as remote. Mass media messages aimed at adolescents emphasise the more immediate consequences

of the disease, including mental problems, skin rushes, sores and a negative effect on a teenager's social life.

Studies were carried out on the effectiveness of fear appeals in condom advertisements which stress the prevention of AIDS. Subjects had more positive attitudes toward a moderate fear appeal commercial (stating that sex can be a risky business) than either a non- fear commercial (stressing the sensitivity of a condom and saying nothing about AIDS) or high fear appeals mentioning the possibility of death (Hill, 1992). A non- fear appeal may appear inappropriate in an AIDS environment and a high fear appeal may be viewed as too threatening to an individual's AIDS - related anxiety. If the fear aroused is too strong, messages may invoke people's defence mechanisms and may be ignored. Fear appeals are attempting to bring about changes in people's motivations, a tricky enterprise at best.

Feldman (1996) argues that fear producing messages ("If you don't practice safer sex, you'll get AIDS") are generally effective, although not always. In such cases, fear appeals work best if they include precise recommendations for actions to avoid danger (Leventhal, 1970; Bolster and Mongeau, 1985). The media campaigns should combine with interpersonal question- and- answer sessions in which discussions can bring out information regarding methods for avoiding the problems described or depicted in the media messages. One- sided arguments in which only the communicator's side is presented, are probably the best if the audience already views the communicator's message favourably. But if the

audience receives a message presenting an unpopular viewpoint, two - sided messages, which include both the communicator's position and the one he or she is arguing against, are more effective, probably because they are seen more precise and thoughtful (Karlins and Abelson, 1979).

The attitudes of society may affect the speed of response to the HIV epidemic. The initial perception of society (which may still persist) was that AIDS was a disease that only infected people who engaged in illegal or immoral activities. This misperception drew attention away from the behaviours that are responsible for the spread of HIV, falsely reassuring the majority of the population that they were not in danger of contracting the disease and making it difficult to convince people to modify their behaviours.

Katz (1960) argues that both attitude formation and change must be understood in terms of the functions that attitude serves for the personality. Some attitudes are held because people are striving to maximise the rewards and minimise the penalties while others are held because they protect people's egos from unacceptable impulses. Some are held because they allow a person to give positive expression to central values yet other attitudes are held because they satisfy a desire for knowledge or provide structure and meaning in what would otherwise be chaotic world. Many religious beliefs serve this function, as do other attitudes as the shared norms of a culture. According to Katz (1960), an attempt to change an attitude may backfire if it is not based on an understanding of the functions the attitude is serving.

A major reason for studying attitudes is the expectation that they enable us to predict behaviour. In some cases, the assumption of attitude - behaviour consistency appears to be violated. Richard LaPiere travelled in the early 1930s around the USA with a young Chinese couple. At that time, prejudice against Asians was quite strong, and no laws against racial discrimination in public accommodations existed. They made 251 visits to hotels and restaurants, and in only one case were they refused service. Six months later, LaPiere sent a questionnaire to each establishment visited asking them whether or not they accept members of Chinese race as guests in their establishments. Of the 128 replies received, 92% said they would not. This classic study then provided some evidence that people's verbal attitudes may not predict their actual behaviour (LaPiere, 1934, in Feldman, 1996).

Prediction of behaviour from attitudes could be improved if other crucial variables were considered. For instance, in certain cases, the situations can have a greater role in determining behaviour than a person's attitude. One of the examples is the presence of the mob, which can make people to behave unpredictably. The situation itself can play an important role in influencing behaviour. Perhaps the prediction of behaviour from attitudes could be improved if situational variables could also be taken into account. For example, one would be tempted to engage in unprotected sex if the condoms are not available. Nonetheless, Ajzen and Fishbein (1980), in the theory of reasoned action, state that it is only the easily remembered consequences that really affect attitudes. Therefore, if a person's

audience receives a message presenting an unpopular viewpoint, two - sided messages, which include both the communicator's position and the one he or she is arguing against, are more effective, probably because they are seen more precise and thoughtful (Karlins and Abelson, 1979).

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thought about sex is 'sex makes you feel good', then this is the belief that will determine their attitude about sex. It does not matter so much that they also believe sex can lead to acquisition of HIV which causes fatal AIDS. That belief may appear remote and not come to mind so easily and the person may think it is 'other people' who can be infected with HIV if they had sex.

These results suggest that raising knowledge through exposure to information will not lead to optimal behaviour change if risk perception is not also increased. Increases on knowledge must occur concurrent with increase in risk perception for optimal reduction in risk taking behaviour to result. Moreover, in order to stimulate self- protective behaviour, it is necessary to address the specific cultural values and beliefs that make those at risk not perceiving that they are engaging in dangerous behaviour. Therefore, intervention programmes should recognise what motivates risk behaviour and promote alternative expressions of masculinity that do not place these people at risk. Messages that integrate values of masculinity with AIDS prevention are likely to be successful at reducing the risk. For example, messages that stress that 'strong men use condoms' or that 'real men have one sexual partner' could promote reduced risk behaviour through addressing those social forces that promote risk behaviour.

Although we cannot exclude the possibility of socially desirable responses being more prominent in the study, there was no teacher who revealed that he/she was HIV- positive. Counselling and testing are important because it helps encourage behaviour change and partner notification (McNeill and Anderson, 1998), which

can help to reduce further transmissions and possibly reduce the vulnerability of monogamous partners who may otherwise have been unaware of the need to take preventive measures. This is especially helpful in countries like Zambia that have policies to supply ARV therapy to PLWHA. It also gives chance to refer PLWHA to support groups that are an essential part of any care programme. Improved quality of life of PLWHA will influence families' economic and social well-being and potentially reduce the social vulnerability (Guzman, 2001). Counselling for PLWHA caregivers is also very important in helping them cope with the stress of caring for relatives and friends and getting external assistance when necessary. HIV counselling and testing can increase community awareness and discussion of HIV and AIDS and can lead to a change in social norms, help redress stigma and lead to more social support for PLWA . This increased community sensitivity can reduce discrimination and mobilise the communities to address the threat of HIV/AIDS and thus reduce risks for socially vulnerable groups.

It is seen from this research that female teachers were at higher risk to HIV infection than their male counter parts because of the complex interaction of socio-economic factors, cultural factors, psychosocial factors and their status and position of women in Zambia. Younger women were especially vulnerable because older men, including male teachers in this case, consider it safer to have unprotected sex with sexually inexperienced women. Age and power seem to be factors in ability to negotiate safer sex. There are many limited

effectiveness of prevention efforts that have not considered the societal and contextual factors that lead to increased vulnerability to HIV infection.

Condom use is not high among women. In this study, more women than men reported that they were at risk of acquiring HIV mainly through their husbands. Despite knowing they were at risk, they were less likely to protect themselves from this risk mainly due to subordinate positions to their sexual partners, the men. For example, 3.2% had used condoms and only 2% had used them consistently during sex. A project in Nigeria found that although the women interviewed understood condoms were their best protection, they could not negotiate condom use with their husbands (Irvin, 1997). A study done in Uganda found that in couples where the husband was HIV negative and the wife HIV positive, condom use was higher than if the man was HIV positive and the woman HIV negative or both individuals were negative. This was as a result of unequal decision-making power, greater awareness among men of risky behaviour, and the cultural pressure for women to bear children (Serwadda et al, 1995). In this study, women appeared also to be less enlightened on HIV/AIDS issues as 51% of them as compared to 41% of men believed that condoms were porous hence posed the risk of contracting HIV even when they were used. In addition, 14.2% of women reported that AIDS could be cured as compared to 7.3% of men.

The women who used herbs before sex held more traditional beliefs about the practice of health. The use of other substances before sex such as ditto, salt

solution, beta dine solution, vagina douching and tissue paper may facilitate transmission of HIV due to laceration of mucosa. Expectations of a dry and contracted vagina in sexual intercourse are incompatible with use of male and female condoms. Male condoms are likely to tear, while fitting of the female condom could be problematic. Studies conducted in various parts of Africa and Zambia have demonstrated a link between dry sex and increased HIV/AIDS transmission. For example, Hira et al (1990) found that the practice of dry sex was associated with increased HIV seropositivity. In another study, Nyirenda (1990) concluded that women practising dry sex stand a higher risk of contracting HIV infection especially where spouses have other partners. Furthermore, beliefs about enhancement of sexual pleasure through using various agents are a cognitive barrier to the use of AIDS prevention device such as micobicides and male and female condoms.

Strengthening of the body against ill health and removing of dirt from the vagina are two main traditional beliefs about health noted, highlighting the need for health education on reproductive health that is based on scientific knowledge. Substitute behaviours such as pelvic- floor muscle exercises can be offered as alternatives.

The needs of teachers are many. They need information and assistance to protect themselves from infection, support to live positively as PLWHAs, help to fulfil their roles as guardian of children, both in the classroom and their homes and they need training and support to perform their professional duties. Kelly

(1999) pointed out that despite these being the major needs for teachers, they have received only very little support.

CHAPTER 6

SUMMARY, CONCLUSION AND RECOMMENDATIONS

Summary

The study revealed some of the factors that lead to the vulnerability of teachers to HIV/AIDS infection.

The findings of this study suggest that vulnerability of teachers to HIV/AIDS infection in Lusaka is principally determined by personal characteristics of the teachers and conditioned by their knowledge, attitudes and practices.

The findings have revealed that exposure to information significantly raised knowledge of HIV/AIDS. However, this knowledge has not been transmitted into behaviour change that would protect them from contracting HIV.

The teachers in the study were at risk of HIV/AIDS infection because of various factors such as low levels of condom use, unwillingness to establish their HIV status, belief that condoms were porous, poverty, low perception that they were at risk of contracting HIV, multiple partnership, misconceptions on the condoms and mode of transmission of HIV, use of herbs and other substances before sex, alcohol, mobility of teachers, stigma and discrimination, poor attitudes toward HIV/AIDS, belief that AIDS can be cured through herbs and prayer and lack of viable institutional workplace HIV/AIDS initiatives or programmes. These, among others, were found to be the major impediments to teachers' ability to fight the pandemic.

Conclusion

The HIV pandemic has its origins in the vulnerability of people and unless and until vulnerability is reduced there will be little progress either with reducing transmission of the virus or enhanced capacity to cope with its socio-economic consequences. While the HIV epidemic makes sustained human development more and more unattainable, and actually leads to poverty, it also destroys the human resource capacities essential for an effective response.

Simple answers to this problem do not exist, but recognition of its existence is a step towards its solution. The development of policies and programmes that address the factors that make teachers vulnerable to HIV infection is imperative if the HIV/AIDS fight is to be won. This entails that the MoE should utilise the comparative advantage potential and opportunities in a much more proactive and genuine manner through closer collaboration and co-ordination with other stakeholders in education so that more positive results could be achieved in much shorter timeframe.

Recommendations

Based on the findings of the study, the government, through the MoE, and other stake holders in education sector should:

1. mount a vigorous campaign to encourage and persuade teachers to go for VCT since the majority of teachers did not know their HIV status as has been observed in this study. Personal testimonies of HIV infected peer teacher educators and mass media programmes that feature HIV infected

persons should be encouraged. However, having HIV infected give personal testimonies would need to be very carefully implemented to ensure that discrimination and stigma do not occur. Participatory workshops that bring teachers together should be organised to identify their vulnerability and to take up measures that address their vulnerability. Teachers should be empowered by identifying and reducing working conditions that contribute to the spread of HIV.

2. train teachers, not only in HIV/AIDS but, in human rights in order to reduce or eliminate the rudimentary knowledge of the subject since it (human rights) is not a subject usually taught in teachers' training colleges or schools. This training should involve midwives, traditional healers, traditional birth attendants and other health workers and caregivers. Trained or trainable volunteer school HIV/AIDS focal point persons to coordinate activities at a school level should be established and encouraged and they should as well be swapping, visiting and having discussions with teachers from other different schools other than theirs. The *Bana chimbusa* and the *Alangizi* should also be trained and sensitised to incorporate HIV/AIDS awareness in their teachings to the brides and married women, respectively. Incorporation of innovative sex education to teachers, especially women, at kitchen parties should be encouraged. These are traditionally women-only events attended by married and unmarried women offer an ideal platform and forum in which information and education about HIV could be given. Females should be discouraged from using herbs before sex with obvious corrosive effects as this may facilitate the transmission of HIV.

3. assemble relevant factual IEC materials stressing, among others, that condoms are not porous thereby cannot leak the HIV and that AIDS cannot be cured through herbs and conventional medicines. Misconceptions among teachers about the mode of transmission of HIV/AIDS should as well be eliminated as this would fuel HIV infection since they would not seek and take proper treatment and correct steps to prevent or avoid it, respectively.
4. commit to the principles of empowerment and mobilisations for teachers and address the factors of vulnerability. Socio-cultural and traditional sexual practice campaign that reduce the risk of HIV/AIDS infection among teachers, especially females, should be designed and implemented. Existing laws that prevent women from being stripped of their belongings after the death of their husband (property grabbing) should be further strengthened.
5. monitor and evaluate existing HIV/AIDS programmes in the MoE and facilitate the incorporation of the accrued experiences of behaviour or change programmes into any existing initiative or new initiatives. A condom dispensary (for both male and female condoms) should be installed, especially in the staff toilets, and condoms should be provided free of charge and information on their proper usage and disposal should be provided.
6. help HIV infected teachers with ARVs to improve their quality of life so that they live longer and continue being productive. Teachers and their supervisors should also avoid provocative behaviour towards teachers who are seen or suspected of being AIDS patients. They should adopt positive life styles which reduce or eliminate discrimination and stigma.

7. educate teachers to refrain from unprotected sex as they visit the prostitutes.
Use of condom or safer sex practice is very poor as has been observed in this study. Therefore, there is need for teachers to adopt safe life styles. They should also be guided against risky behaviours like indiscriminate unprotected sex and multiple partnerships. Teachers should also be educated to remove any misconception about the use of condoms and mode of transmission of HIV through mosquitoes and blood transfusion. This is because the 2005 Blood Bank report shows transmission of HIV through transfusion is at zero level. Again, according to NAC (2004) report, major mode of transmission of HIV is through heterosexuality with unprotected sex and not through mosquito bites, witchcraft, condom lubricant and drinking from the same cup with the infected person. If misconceptions among teachers were not eliminated, the infection levels among them would escalate as they may not be seeking proper treatment and taking correct steps to prevent or avoid HIV/AIDS.
8. develop and demonstrate cultural values and morals among teachers and educational institutions which help in reducing the chances of individuals of acquiring HIV. Therefore, these interventions should recognise what motivates risk behaviour and promote alternative behaviours that do not place these people at risk. This is so because one of the main goals of AIDS prevention campaigns is to convince people that they are at risk, so they will be motivated to take precautions to prevent AIDS.
9. strengthen institutions of the anti-AIDS clubs and support groups in the schools with proper infrastructure and knowledge so that confidential

information like HIV/AIDS can be shared with the counsellors during the dialogue process. In addition, anti-AIDS clubs and other HIV/AIDS workplace programmes should not be left to co-ordinating teachers alone but all other teachers should actively participate and be involved. There is also extensive need for both male and specifically female teachers to be counselled against unprotected sex. There is need to refrain themselves from indiscriminate sex either with pupils or partners outside the school. This is immoral behaviour and teachers should live and lead exemplary lives and as role models to pupils.

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APPENDICES

APPENDIX 1: Consent Form

Dear Respondent,

My name is I am conducting a study of
“Teachers’ Vulnerability to HIV/AIDS Infection: The Case of Lusaka District.”

The objectives of the study are to:

- 1. determine the factors that make teachers vulnerable to HIV/AIDS infection
- 2. establish gender difference to HIV/AIDS infection
- 3. recommend interventions of fighting HIV/AIDS infection among teachers.

The benefits of the study are that:

- 1. The study shall assist in establishing whether teachers are high HIV/AIDS risk group.
- 2. An intervention strategy may be found and designed to fight HIV infection among the teachers.

Be further informed that:

- a) your participation is voluntary and therefore you are free to withdraw from the study at any time you want to.
- b) whatever information you give us, including your HIV status, will be kept strictly confidential.
- c) you should not write your name.

Your participation will highly be appreciated.

Thanking you in advance.

I accept participation.

Signed or	Signed
(Thumbprint)	

Date	Date
(Respondent)	(Researcher)

INSTRUCTIONS: EITHER TICK OR FILL IN WHERE APPROPRIATE

9. If your religion is Christianity, what is your church denomination?

- A) Catholic
- B) Adventist
- C) Pentecostal
- D) Other, specify

10. What is your highest level of education?

- A) Secondary education B) College C) University

11. How do people get HIV? (Tick those that apply).

- A) Using unsterilised needles for injection
- B) Drinking from the same cup as the infected
- C) Having an unprotected sex with an infected person
- D) Being bitten by a mosquito that has bitten an infected person
- E) Transfusion of unscreened infected blood
- F) Witchcraft
- G) Condom lubricant
- H) Other, specify

12. Can HIV transmission be preventable?

- A) Yes B) No

13. If Yes to Question 12, how?

- A) Abstinence
- B) Sticking to one sexual partner
- C) Prevention of mosquito bite
- D) Use of condom during sexual intercourse
- E) Having sex with a virgin

F) Washing the genitals immediately after sex with soda, water,
alcohol and other chemicals.

G) Other, specify

14. Condoms have very small pores which can allow the AIDS virus to pass
through.

A) True

B) False

15. Who can contract HIV?

A) The poor

B) The rich

C) The prostitutes

D) The whites

E) The users of condoms

F) The Homosexuals

G) Other, specify

16. Can AIDS be cured?

A) Yes

B) No

17. If Yes to Question 16, how?
.....

18. Where have you learned about AIDS? (Tick those that apply).

A) Articles in the newspapers

B) Conversations with friends

C) Health educational talks by health professionals

D) Radios

E) Television

- F) Posters and billboards
- G) Magazines
- H) Schools
- I) Booklets, pamphlets or books
- J) Politicians and community leaders
- K) Employers
- L) Family members
- M) Fellow teachers
- N) Singers and actors
- O) Prostitutes
- P) Church leaders
- Q) Other, specify

19. Are you afraid of getting AIDS?

- A) Yes
- B) No

20. Do you think you are at risk of acquiring HIV/AIDS?

- A) Yes
- B) No

21. Are you afraid that someone in your family may get AIDS?

- A) Yes
- B) No

22. Sexual relationships between teachers and pupils do exist in schools.

- A) I agree
- B) I disagree

23. Does the nature of your job take you away from your spouse / partner for a long period of time?

- A) Yes
- B) No



24. In case you miss your sexual partner while away, what do you do?
- A) Abstain
 - B) Masturbate
 - C) Look for another sexual partner
 - D) Other, specify
25. Do you drink alcohol?
- A) Yes
 - B) No
26. If Yes to Question 22, does your alcohol consumption have an effect on your sexual drive?
- A) Yes
 - C) No
27. If Yes to Question 25, in which way?
-
28. How many sexual partners do you have?
- A) 1
 - B) More than 1
29. Have you ever had sex with a non-regular partner in the last 12 months?
- A) Yes
 - B) No
30. Do you use condoms during sexual intercourse?
- A) Yes
 - B) No (Go to question 34).
31. If Yes to Question 30, how often?
- A) Always
 - B) Sometimes
 - B) Other, specify
32. If you use condoms, why do you use them?
- A) To avoid getting AIDS

- B) To avoid pregnancies
- C) I am just forced by my partner
- D) I just enjoy using them
- E) Other, specify

33. If you use condoms, do you find with them enjoyable

- A) Yes
- B) No

34. If you use condoms, who decides you should use them?

- A) Myself
- B) My partner
- C) Both of us

35. Have you ever attended any workshop on HIV/AIDS?

- A) Yes
- B) No

36. Does the school have an anti-AIDS?

- A) Yes
- B) No

37. If Yes to Question 35, what is its role?

- A) Sensitising pupils about HIV/AIDS
- B) Sensitising teachers about HIV/AIDS
- C) Other, specify
-

38. Do you think HIV/AIDS has to be taught in schools?

- A) Yes
- B) No

39. Do you think teachers need specialised training before they could teach on HIV/AIDS?

- A) Yes
- B) No

40. What is your HIV status?

- A) Positive
- B) Negative
- C) Do not know

41. If you were HIV positive, would you go public?

- A) Yes
- B) No

42. Give reasons to your answer to question 40.

.....

43. Would you like an HIV test done on you?

- A) Yes
- B) No

44. Give reasons for your answer to Question 40.

.....

45. If you were HIV positive would you go public?

- A) Yes
- B) No

46. Give reasons for your answer to question 43.

47. It has been argued that dry sex should be avoided because it increases the chance of contracting or spreading HIV/AIDS. What do you think about this?

- A) It is true
- B) It is not true

48. Are there some discrimination tendencies or practices by either fellow teachers or supervisors against those teachers suspected of suffering from AIDS?

- A) Yes
- B) No

49. If Yes to Question 47, explain how?
.....

Questions 50 to 52 only apply to female respondents

50. Do you use herbs and other substances before sex?

A) Yes

B) No

51. If Yes to Question 50, give reasons for using them (Tick as many as applicable to you).

A) Contract vagina

B) Dry vagina

C) Warm vagina and body

D) Remove dirty from vagina

E) Strengthen the body against ill health

F) Prevent entry of air through vagina

G) Prevent diseases of reproductive organs

H) Strengthen pelvic floor muscles

I) Just to increase sexual arousal

J) Other, specify
.....

52. The list below consists of other substances some women use before having sex with their partners. Tick those that apply to you.

A) Ditto

B) Salt solution

C) Soap

D) Beta dine solution

E) Tissue papers

F) Newspapers

G) Cotton wool

H) Cotton cloth

I) Love drop

J) Colgate

K) Washing paste

L) Methylated spirit

M) Vinegar

N) Copper sulphate

O) Human urine

P) Other, specify

THE END

Thank you for your participation.



THE UNIVERSITY OF ZAMBIA
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Dean's Office
P.O. Box 50110
Lusaka, Zambia
Your Ref:
Our Ref:

27th January 2006

Dear Dr Kunkhuli,

Please be notified that Mr. Munachaka's thesis approval by the Ethics Committee has been waved because it does not involve human subjects directly.

He can now finalise his dissertation.

Thank you.


Prof. K. S. Baboo

APPENDIX 4: REQUEST TO VISIT SAMPLE SCHOOLS AND AUTHORISATION.



THE UNIVERSITY OF ZAMBIA
SCHOOL OF EDUCATION

Telephone: 291381
Telegrams: UNZA LUSAKA
Telex: UNZALU ZA 44370
Your Ref:

P O BOX 32379
Lusaka, Zambia
Fax: + 260-1-253952

9th March, 2001.

The District Education Officer
Lusaka Urban District
LUSAKA

Our Ref:

[Signature] ADEBS
Permission granted.

Dear Sir / Madam,

RE: PERMISSION FOR MASTERS STUDENT TO RESEARCH IN LUSAKA
SCHOOLS

Mr. Munachaka Jonathan is a full-time M. Ed. (Educational Psychology) student of this University. He has successfully completed Part I consisting of course work. He is now doing Part II consisting of research on an approved topic leading to the preparation of a dissertation under the Supervision of Professor K.S. Baboo.

For the research, he has chosen to probe into "Teachers' Vulnerability to HIV / AIDS Infection: The Case of Lusaka District".

I would be grateful if your office authorised him to access Schools in the District.

Yours sincerely,

[Signature]
J.T. Phiri
HEAD OF EPSSE DEPARTMENT

c.c The Dean - School of Education