

**FACTORS THAT INFLUENCE WOMEN'S CAPACITY TO PROTECT
THEMSELVES FROM CONTRACTING HIV INFECTION IN A
ZAMBIAN COMMUNITY: A CASE STUDY OF NKONKOLA AREA IN
MAZABUKA DISTRICT**

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JUSTINA MUCHAKA MOONGA

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HEALTH**

**DEPARTMENT OF COMMUNITY MEDICINE
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DEDICATION

Dedicated to my mother Mrs. Keresia Muchaka Manyenga and my daughters Jolly, Muka, Mary, Nchimunya and Keresia for many sacrifices they have made during my studies and for their unfailing encouragement and support.

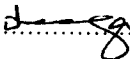
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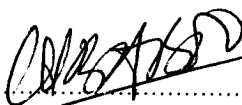
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I, the undersigned have read this dissertation and have approved it for examination.


Dr KS Baboo, MBBS, M.MED, FRSH
Senior Lecturer
Department of Community Medicine
University of Zambia

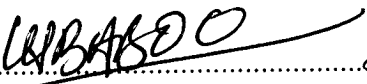
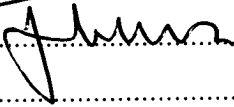
Date: 15/4/99

APPROVAL

This dissertation of **JUSTINA MUCHAKA MOONGA** is approved as fulfilling part of the requirements for the award of the degree of Master of Science in Public Health by the University of Zambia.

Signed:

Date:

	DR. K. S. Baboo	19/4/99
	Dr C. Chumbe	19. 4. 99

ABSTRACT

This study examined factors that lead to high incidence of HIV/AIDS infection among women in order to establish determinants that influence women's protection from contracting HIV/AIDS infection. The exercise was done by investigating the subjects' level of awareness of the existence and seriousness of HIV/AIDS; the subjects' knowledge of how HIV/AIDS is transmitted and how it can be prevented; and the subjects' views on the use of condoms as a preventive measure against the spread of HIV/AIDS in their community.

Data were collected both quantitatively and qualitatively by administering a standardized pre-tested questionnaire to each of the 88 subjects. In addition, focus group discussions were held with men and women outside the study sample. Specific methods of data collection consisted of a cross sectional survey of 88 women in Nkonkola, Mazabuka district. Of the 88 women in the study sample, 38 were members of an NGO called *Women for Change* (WFC) who were selected by systematic random selection, while 50 were non members of WFC. The members of WFC were included in the study to establish the impact of women's economic empowerment on their capacity to protect themselves from HIV/AIDS infection.

The findings show that the subjects have a very high level of knowledge of the existence of HIV/AIDS since $n=88$ and 98.9 percent both WFC and non WFC members have heard of HIV/AIDS. It did not matter as whether they belong to WFC or not, the Knowledge was the same. Tests of statistical significance on Knowledge on HIV made of transmission between WFC and non WFC members confirm that no association exists between Knowing the existence of HIV/AIDS and belonging to WFC. A total of 88 women were interviewed, 38 belong to WFC and 50 are not members of WFC, Knowledge on mosquito bite as a mode of HIV transmission gave $P=.4824$ for WFC and $P=1.00$ for non WFC members, multiple partners as mode of HIV transmission gave $P=1.00$ for WFC and $P=1.00$ for non WFC members. Despite this high level of Knowledge existence of HIV/AIDS, most of the participants in the study were not doing anything to protect themselves from contracting HIV infection. 22.7 percent of the subjects Know at least three persons who have

HIV/AIDS while 54.5 Knew at least three persons who had died of HIV/AIDS. The main sources of information on HIV/AIDS included relatives and friends (36 percent) , doctors /nurses (17 percent) , and the rest heard from other sources . Very few respondents thought they were personally at risk of contracting HIV/AIDS infection.

There is unfortunately a very low level of condom acceptability in the study community . As much as people Know that couples can prevent HIV infection by using condoms , WFC ($P=.0025$) , and non WFC ($p= 1.00$) , they do not actually use them , on responding to a question of ever using condoms , WFC ($P=.5177$) and non WFC ($P=1.00$) They also do not insist to their partners to use condoms WFC ($P=.1599$) and non WFC ($P=1.000$). Opinion on couples using condoms was tested using chi-square test. A statistically significant result was observed on WFC members ($P=.0025$) as opposed to non WFC members ($P=1.00$).

Although there is no statistical significance on talking about sex for both WFC ($P=1.00$) and non WFC ($P=1.00$) , the results suggest that AIDS prevention and control campaigns have not taken into account the cultural, social and economic constraints on women's ability to protect themselves from contracting HIV/AIDS infection. This may be because Zambian cultural practices are still biased towards men who are the major decision makers and prime advocates of dry sex and ritual cleansing. This implies that HIV/AIDS prevention programmes must be set within a broader context of women's status and rights. The interventions must include efforts to raise self confidence and improve communication skills. The interventions should also address body awareness, partner communication and provide opportunities for group support and networking to help women begin the process of adopting risk reduction behaviours. To be effective, the programmes should give more direct attention to the issues of gender and power that provide the social context of sexual decision making.

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Lastly, I would like to thank all the respondents who willingly sacrificed their time to answer the questions. It is my sincere hope that the answers they provided will contribute positively to the fight against HIV/AIDS which is devastating our nation. To all the above and all those whose names have skipped my mind, I say thank you very much.

LIST OF ACRONYMS

AIDS	-	Acquired Immuno Deficiency Syndrome
ARC	-	AIDS related complex
ANC	-	Antenatal clinic
CBoH	-	Central Board of Health
FGDs	-	Focus Group Discussions
GDP	-	Gross Domestic Product
GPA	-	Global Programme on AIDS
HIV	-	Human Immune Virus
I.C N.	-	International Council of Nurses
NASTLP	-	National AIDS/STDs/TB and Leprosy Programme
NGO	-	Non-Governmental Organisation
STDs	-	Sexually Transmitted Diseases
SWAAZ	-	Society for Women and AIDS in Zambia
U.K.	-	United Kingdom
UN	-	United Nations
WFC	-	Women for Change
WHO	-	World Health Organisation
ZARD	-	Zambia Association for Research and Development

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CHAPTER ONE: INTRODUCTION

1. 1. Background Information

The first AIDS case was discovered in the United States of America (USA) in 1981. Since then, the cumulative number of AIDS cases and HIV seroprevalence reported to the World Health Organisation (WHO) in various populations has risen considerably and was estimated at 29.4 million at the end of 1996. WHO further reported that HIV incidence among women had increased to six (6) million at the end of 1994. WHO also estimated that more than thirteen (13) million women will have been infected by HIV by the year 2000 and that about four (4) million of that number will have died from AIDS. Around the world, there are 73 women infected with HIV for every 100 infected men, with Sub-Sahara Africa having more infected women than men. In this region 40 percent of women died of AIDS as compared to 37 percent of men in 1994 (WHO).

Olaitan (1996) reports an increase in prevalence of anonymous antenatal testing of HIV in the London area from 1 in 380 (26%) in 1990 to 1 in 50 (2%) in 1993, showing a dramatic increase in the number of infected women. By 1994, women represented 40 percent of all new AIDS cases world wide (WHO). In Asia, Nyonyo (1995) reports that half of the newly infected adults in Myanmar, Shan State, are women. He points out that 6 to 10 percent of women registered at public Maternal and Child Health Centres were already seropositive.

In Europe, 15.4 percent of new infections in adults in 1993 were due to heterosexual transmission. In France, heterosexual transmission cases increased from 19 percent in 1991 to almost 25 percent in 1993. In 1993, in the USA, AIDS cases in women were almost 10 percent higher than in 1992 (WHO, 1995).

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In Sub-Saharan Africa, HIV has been transmitted predominantly through heterosexual intercourse since the beginning of the epidemic. About 11 to 12 women for every 10 men are newly infected every day (WHO). The rate of HIV infection among women is still increasing rapidly. Dreka-Su-Williams (1993) states that as the HIV/AIDS epidemic deepens, African women are faced with an unprecedented dilemma arising primarily from inability to protect themselves from HIV infection, and the ways in which they would deal or cope with the impact of HIV/AIDS upon their lives. He further reported that approximately 50 percent of the estimated 7.5 million people who are infected with HIV in Africa are women.

In Francistown, Botswana, HIV prevalence in pregnant women rose from 8 percent in 1991 to about 35 percent by 1993. In some countries like Cote d'ivoire, Zaire and Uganda, AIDS has become the leading cause of adult deaths (Decock, et al. 1994).

In 1994, 500 women died of AIDS in Sub-Saharan Africa. By 1 January, 1995, 5,447 adult women were living with HIV/AIDS as compared to 4,952 adult men (Global AIDS Coalition). Parker, R. (1996), reports that by mid 1996, 13.3 million adults were living with HIV in Sub-Saharan Africa, representing 60 percent of the world total. In Kenya, Malawi, Rwanda, Tanzania, Uganda, Zambia, Zimbabwe where HIV began to spread widely in the early 1980s, more than 10 percent of women attending antenatal clinics surveyed in urban areas have been found to be HIV positive with rates which may exceed 40 percent in some surveillance sites.

According to the World Health Organisation, eight to ten million people in Sub-Saharan Africa are estimated to be infected with HIV. Young women are at higher risk of HIV/AIDS infection than men. This is because of early marriages, traditional practices, incest and sugar daddy relationships. Men, some of whom are infected, prefer having sex with virgins in the hope of protecting themselves from infection. In the process, the young women get infected. Erber (1990), identifies women's inability to protect themselves from infection as one of the major factors that predispose them to greater risk of HIV infection.

Erber (1990) further states that in cases where women are already infected, protecting others is negatively influenced by several psychosocial, cultural and legal barriers to decision-making and independent action.

Over the past decade, AIDS has grown from a disease that primarily affected specific subsets of the population of Western countries to a pandemic that directly or indirectly, now affects much of the world's population. As the HIV/AIDS epidemic continues to spread, evidence accumulates that it is by no means confined to the so called "RISK GROUPS" [homosexual men, injecting drug users and prostitute women] (Piot et al 1993).

While HIV/AIDS affects both men and women the economic and social/cultural factors in many societies often prevent women from taking measures that would protect them from HIV infection. The Panos (1990) projects that HIV infection in women is set to become one of the major challenges to public health, health care and social support systems world-wide.

Today, 90 percent of all people living with HIV are in developing countries. In Kenya, of the 200,000 people expected to have died of AIDS by 1995, two thirds were women. In Lesotho, AIDS reports are substantially higher in women than in men, a ratio of 54.5 to 45.5 (SAFAIDS and WHO, 1995).

1.2. The Zambian Situation

Overall, the most conservative estimate of HIV adult prevalence rate (per 100 population aged 15-49 years) in Zambia is not less than 17 percent (WHO, UN, 1996). Of course this figure varies according to different categories of people. In urban areas, the prevalence is estimated at 21 percent while the corresponding figure for rural areas is estimated at 10 percent (Francine Van Borne et al, 1996).

Between 300 and 400 people are newly infected by HIV in Zambia, making it one of the

worst hit countries. It is also estimated that the number of adults who have progressed from HIV infection to AIDS is expected to increase from about 10,000 in 1990 to over 75,000 by the year 2000 (Kalumba, 1997).

Preliminary results from a survey in an urban Zambian population suggest that women are now 1.4 times more likely to become infected than men. According to the 1992 Sentinel Surveillance Survey, infection rates among women attending antenatal care were between 6.8 to 14.5 percent in rural areas and 15 to 17.1 percent in urban areas. Information obtained from the National AIDS/STD/TB and Leprosy Programme (NASTLP) shows that in 1992, between 14.4 percent and 16.5 percent of adult Zambians were HIV infected. NASTLP further forecasts that the prevalence in rural areas will reach an estimated 20 percent in the year 2000 and that the number of AIDS cases among adults will rise from between 33,000 to 38,000 in 1993 to between 62,000 and 72,000 in 1997.

In a study at Monze Hospital in Southern Province Bruve and Foster (1994) observed that about 55 of the new admissions were HIV positive. Other studies on Zambia indicate a higher prevalence of HIV infection in females than in males. The rates for 15-19 year old females is seven times that of males in the same age cohort (Fylkesness, 1995). Sero surveillance data from antenatal clinics from 1994 show a great diversity in the spread of HIV across the country, the range being from 1.6 percent to 31.9 percent (Fylkesness et al, 1995). There is a marked urban/rural differentiation in infection rates. In rural areas the average is around 10 to 15 percent and in urban areas it is higher, at 25 to 30 percent. However, Webb (1994) suggests that rates are still rising in rural areas while they have actually stabilized in urban areas.

These figures, however, do not in any way portray the real situation in Zambia considering the fact that for various reasons HIV/AIDS cases in Zambia like in other African countries are under-reported by as much as 10 percent (UNAIDS, 1996). Kalumba (1997) states that it is not possible to know the current number of HIV positive cases because most of the data collected pertain to AIDS cases rather than still healthy HIV positive individuals.

1.3. Statement of the Problem

The actual total number of AIDS cases in Zambia is unknown. This is because of under diagnosis, incomplete reporting and delays in reporting. The clinical presentation of AIDS and the natural history of HIV infection in women is still not clearly understood. Hence many women are either not diagnosed early enough or are misdiagnosed. Very little information about Zambian women's health status has been documented particularly when not pregnancy related.

In Zambia, HIV is one of the most important public health problems, often accounting for 90 percent of heterosexual transmission. According to WHO (1995) most of these are women, 38 percent of whom transmit the infection to their children.

Most women currently lack the necessary information, tools, and power over their own bodies and lives, to enable them reduce the risk of contracting HIV/AIDS infection. While HIV infection among women is increasing rapidly, public awareness about the mode of infection is limited and the required services for women are not accessible. To match the expanding epidemic there is need for expanded response. Alongside increased and improved action in the health sphere, there is need to find out and do more about the underlying conditions that predispose women to infection. There is also need to strengthen the ability of individuals and communities to deal with HIV/AIDS prevention. It is against this background that the researcher decided to carry out the study on factors that influence women's capacity to protect themselves from contracting HIV infection.

1.4 Rationale

Nkonkola is predominantly a poor rural and polygamous community. All these factors make the area high risk for HIV/AIDS infection. According to MOH/CBoH 1997 prevalence estimates by district, Mazabuka has the highest rural prevalence of 12.5 percent in Southern

Province. It was therefore assumed that such a situation would offer an opportunity to study factors that influence women's capacity to protect themselves from contracting HIV/AIDS infection. Nkonkola is also not over studied as compared to other districts especially those in urban setting like Lusaka, which has been the subject of repeated and intense studies.

It is against this background that a need has been felt to carry out this study to investigate factors that influence women's capacity to protect them from contracting HIV/AIDS infection in Nkonkola. It is hoped that data from Nkonkola would provide 'virgin' ground for exploration. In addition, hosts of Lusaka studies for example would readily yield information, which can be used for comparison. It is also hoped that the information derived from the study will be of assistance to relevant authorities, NGOs, communities and individuals planning and implementing HIV/AIDS programs to improve and/or increase women's capacity to protect themselves from contracting HIV/AIDS infection.

1.5 Hypotheses

The study has two theses and these are:

- H1: Current preventive and protective methods against HIV/AIDS infection are not working for women.
- H2: Cultural factors are responsible for the high incidence of HIV/AIDS infection among women.

1.6 Study Objectives

1.6.1. General objectives

The general objectives of the study are to:

- (I) investigate factors that lead to the high incidence of HIV/AIDS infection among women.
- (ii) determine influencing factors on women's protection from contracting HIV/AIDS infection.
- (iii) determine factors that influence women's knowledge about the mode of spread and prevention of HIV/AIDS infection.

1.6.2. Specific Objectives

The specific objectives of the study are to:

- (I) explore the beliefs/attitudes associated with STDs and HIV/AIDS among women.
- (ii) find out women's knowledge about the mode of spread and prevention of HIV/AIDS infection. Find out the protective methods that women use to protect themselves from contracting HIV/AIDS infection.
- (iii) describe women's perception towards HIV/AIDS infection.
- (iv) find out the social status of the respondents.
- (v) find out the major sources of HIV/AIDS information among the respondents.
- (vi) describe the behaviors that are associated with the spread of HIV/AIDS infection.
- (vii) make recommendations for strategies to increase women's capacity to protect themselves from contracting HIV/AIDS infection.

1.7. Literature Review

Giraldo (1988) notes that there is high HIV prevalence in developing countries due to poor health resources and reduced public health programmes as well as low general public awareness of the disease. Giraldo further stresses the need to understand the pattern of sexual activity in a community in order to effectively implement health education measures.

Ruser (1981) points out that many women who are at risk of HIV infection face formidable obstacles to change their sexual behaviour. These include lack of knowledge, denial of risk status, embarrassment about discussing sex and AIDS, difficulty in asserting themselves, lack of control in relationship with men and lack of partner cooperation.

Surveys in Kenya, Uganda and Zaire record that compared to men, women know less about HIV/AIDS, learn about it later and are less likely to hear about it through the mass media. Women often hear about AIDS from other people, where as men get more information from radio and news papers (NARESA, 1997).

According to Deborah (1996) an analysis of more than 300 television public service announcements (PSAs) from 36 countries, revealed that women are not being given messages on how to protect themselves from HIV infection. She further stated that as the number of women who become HIV-positive through sexual transmission continues to rise alarmingly, PSAs modify their portrayals of women.

The Women and AIDS Research Program conducted in 13 countries by the International Centre for Research on Women identified many obstacles to preventing HIV infection among women. These include sexual norms that limit women's access to information by dictating that they must be ignorant about sexual matters, women's economic dependence on men, violence against women and widespread acceptance of male promiscuity (Rao et al,1995).

Global AIDS Policy Coalition (1995) states that women of all ages and social economic background are now at risk of HIV/AIDS infection due to a variety of factors which influence their ability to protect themselves from infection. This view is shared by Health Action (1996) who observe that women generally have little status or power and depend on men as providers. Health Action (1996) also point out that most women who have become infected with HIV have followed the Ministry of Health messages to the best of their ability-staying with one partner and trying to protect themselves by using condoms. However, because of the physical and sexual power that men have over women, it is difficult for women to insist that men use condoms.

Allen et al (1994), report that the majority of HIV infected women in Kigali are monogamous and at high risk because of the current or previous behavior of their steady sexual partners, yet traditionally, women cannot broach the subject of sex and have little decision-making power in the sexual encounter.

Sunkutu (1994) observes that while men can protect themselves from HIV/AIDS infection because of their dominant role in society, women find it difficult because of their low status within the society and family. She further cites wives' inability to refuse husbands' demands for unprotected sex and commercial sex workers' susceptibility to economic incentives for high risk sex as examples of the dangers women are exposed to. Sunkutu also notes that generally women in Zambia have considerably less control over their own lives because of their subordinate role in society and that this places them at a special disadvantage with regard to their ability to protect themselves from the risk of HIV infection.

WHO (1990) also acknowledge that the impact of AIDS on women is increasing and that millions more women are especially vulnerable to infection because of their subordinate position in the family and society. This low status has the effect of restricting women's ability to protect themselves from sexual transmission of HIV because they often have little

autonomy.

Campbell (1995) observes that the focus of prevention of HIV/AIDS is often on the individual, without attention to the social cultural context in which individuals interact. For example prevention approaches may ignore the reality that women do not always have control over the behaviour of their male partners. Moreover, women are not always aware of the past or present risk behaviour of their partners and so do not perceive themselves at risk.

Traditional norms and attitudes also affect women's protection. It has been observed that women who contract a reproductive tract infection react with the same cultural attitudes that anything having to do with sexuality is dirty and shameful and they try to ignore it as long as possible. Most women think that symptoms such as discharge, discomfort, and even chronic abdominal pain during intercourse and menstruation are part of the female biological make up, and consequently inevitable.

Dooley (1996) states that in Zimbabwe women's low status and lack of power severely limit the extent to which they can protect themselves from both sexual violence and HIV infection, and that women who do attempt to adopt such prevention strategies are vulnerable to abuse. Dooley further reports that substantial numbers of married women are now becoming infected with HIV. Dooley also points out that even when a woman knows that her husband has other partners, her low status in marriage, taboos relating to sex discussion, the fear of violence and rejection and the perception that wives are obliged to provide sex all place immense barriers on married women's ability to protect themselves from sexually transmitted infections including HIV. George (1994), observes that the possession of several key resources, information and skills, money and social support are necessary to having power over one's life and within relationships.

Early marriage and sexual intercourse increase the risk of HIV infection among women. The 1996 Zambia Demographic Health Survey report states that by the age of 16, about 500 of the girls in Zambia already had some sexual experience. The proxy indicators of teenage pregnancies and STDs in this age group support this. This early sexual activity has serious implications in relation to contracting HIV/AIDS infection.

Although literature review has reported some factors, which influence women's ability to protect themselves from contracting HIV/AIDS infection, very little information has been documented about Zambian women's health, particularly when not pregnancy related. No other study has been done to determine women's capacity to protect themselves from contracting HIV/AIDS infection in Zambia.

1.8. Operational Definitions

1. **Dry Sex** is the practice of using herbs to dry the vagina for the purpose of giving the male partner more pleasure by increasing penile-vaginal friction.
2. **Sexual Cleansing** is a common ritual where a widow/widower has sex with a relative of his/her spouse
3. **Polygamy** is the practice of marrying more than one wife at a time.
4. **Poverty** is the state of being characterized by insufficient income and productive resources to ensure sustainable livelihood in major areas such as food, clothing, shelter and access to basic social services (health, education, water and sanitation).
5. **Gender** as used here, refers not only to sex but also to the wide variety of behaviour, expectations and roles attributed by social structures to women and men.
6. **Household** is a group of persons who normally live and eat together.

7. **Pandemic** refers to occurrence of a disease which is widely distributed throughout the world.
8. **Carrier** refers to a person who is infected by HIV. Even if that person does not show signs of sickness he/she will still have the virus in his/her blood and can pass on the virus to others.
9. **Prostitute** in this context refers to those who are either single and engage in promiscuous activities in order to supplement their income or who are, in some instances, married and have extra-marital affairs.

CHAPTER TWO: METHODOLOGY

2.1. Research Design and Study Type

This is a descriptive and qualitative study. In this study, the researcher observed, discovered and has described and analysed the demographic characteristics and other underlying dimensions of women. A qualitative research design was chosen in order to gain an insight into the perceptions of women on HIV/AIDS. The method was appropriate because the study sought to find out people's views about actions, norms and values. 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 factors that influence women's capacity to protect themselves from contracting HIV/AIDS infection. It is hoped that the findings of the study will impact positively on HIV/AIDS prevention and control programmes in Zambia.

2.2. Variables

The independent variables included lack of condom use, low social status of women in society and family, poverty, culture/customs, low levels of literacy for women, inadequate access to health services for diagnosis and treatment, lack of time to go for treatment and other services, multiple partners, lack of information on HIV/AIDS transmission and prevention, low economic and social status and ignorance.

2.3. Study Setting

The study was carried out in Nkonkola area of Mazabuka District in the Southern Province of Zambia. The area is about 48 kilometres from the turn off of Magoye-Lusaka road. It is a village setting in a rural area with typical village activities taking place. The area is about 62559 sq. km² with an estimated population of 5923. It is serviced by Chivuna Rural Health

Centre situated about 10 kilometers from the study site. The centre offers both curative and preventive services. The area has seven schools including a girl's secondary school run by Catholic Missionaries.

2.4. Study Units

Women for Change is a Zambian Non Governmental Organization (NGO) committed to working with and empowering women in remote rural communities through gender analysis. The group uses popular education methodologies to achieve social change. In this study, 50 economically empowered women from *Women for Change* groups and 50 women from non *Women for Change* groups were selected.

2.5. Ethical Considerations

Ethical approval was sought from University of Zambia Research Ethics Committee. Permission was sought from *Women for Change* to use their women groups. Participation in the study was voluntary and consent was obtained from the respondents prior to the study. Confidentiality was also maintained throughout the interviews.

2.6. Pre-testing of Questionnaires

Prior to the formal research study, a small-scale pre-test of the questionnaires and other survey instruments was done. It was conducted in Kalomo district an area with the same socio-cultural setting as Nkonkola, the study area.

2.7. Sample Selection and Data Collection

A random sample of 88 women was selected from *Women for Change* groups and non *Women for Change* groups in Nkonkola using a Systematic Random Sampling (SRS) technique. The data for this study are based on these selected women. In addition, Focus Group Discussions (FGDs) were conducted with both men and women who were not in the sample. Data were collected on the subjects' perception of risk of HIV/AIDS infection, subjects' knowledge of and attitude towards HIV/AIDS, sexual behaviour, communication with partners and use of, access to, and acceptability of condoms. Data on education, marital status, employment and number of children were also collected.

2.8. Data Processing and Analysis

The questionnaires were individually coded by the researcher and data entered into the computer and edited using EPI-INFO soft ware. The Focus Group Discussion (FGD) recordings were also processed by listening to the tapes and noting major points. As stated above, a descriptive approach was used to analyse the data. Simple tables and figures are used in this report to present and interpret the data.

2.9. Limitations

A number of limitations were encountered in this study. Due to insufficient funding to cover the intended 150 respondents only 88 respondents were interviewed. In addition, some sampled subjects had gone out of the area, since the study was done during the rainy season and it was difficult to follow them due to bad roads. In view of the small sample, the results can not be generalised to the whole District and the Province.

CHAPTER THREE: COUNTRY PROFILE

3.1. Geography

Zambia is a Sub-Saharan African country sharing borders with eight countries: Malawi and Mozambique to the east, Zimbabwe, Botswana and Namibia to the south, Angola to the west, and Zaire (Congo-Kinshasa) and Tanzania to the north. Zambia is a landlocked country covering 753,000 square kilometres. Administratively, the country is divided into nine provinces and 72 districts, which include Mazabuka where the study was done.

3.2. Economy

Zambia has a mixed economy consisting of a modern and urban-oriented formal sector confined to the line of rail, and a rural agricultural sector. The poor economic performance which began in the mid 1970s has consequently led to lower Gross Domestic Product (GDP). The income per capita declined from \$350 in 1980 to \$264 in 1994 (World Bank, 1997).

3.3. Politics and Administration

Zambia was a British colony until 24 October, 1964 when she became independent. Since then the country has undergone three major phases of governance. Firstly, the post independence era of multiparty politics up to 1971, followed by one-party rule before reverting back to the multi-party system in October, 1991. The country has a cabinet of 35 ministers of whom two are women.

3.4. Population

The population of Zambia has more than doubled over the past decades. The 1969, 1980 and 1990 national censuses reported a total population of 4.0 million, 5.7 million and 7.8 million respectively, with an average annual growth rate of 2.7 percent between 1980 and 1990. In 1997, the population of Zambia was estimated at 9.7 million ZDHS (1996). Close to 50 percent of the population is in the young age groups. At national level, 63 percent of the population reside in rural areas while 37 percent live in urban areas (LCMS 1996). The population density in Zambia increased from 5.3 people per square kilometre in 1969 to 7.5 in 1980 and 10.4 in 1990. While the urban population has grown by an average of 2.7 percent per annum during the 1980-90 decade, the rural population has increased by 3.5 percent in the same period. Women in the child bearing age account for about 51 percent of the people living in Zambia (ZDHS,1996).

3.5. Education

Zambia's formal education is based on a three-tier system: 7 years primary education, 5 years secondary education (2 years junior secondary and 3 years senior secondary). Graduates from secondary school may then choose to further their education either by attending university for a four to seven year courses leading to a degree or by attending a vocational or technical institute for a two or three year certificate/diploma course (ZDHS 1996, p12).

The 1996 Zambia Demographic Health Survey indicates that in general more men than women have been to school. In every age group of people 10 years and over, the median for the number of years of schooling is consistently higher for males than it is for females. The proportion of females with no education increased from 24 percent in 1992 to 25 percent in 1996, (ZDHS,1996). The ZDHS, 1996 report indicates that rural residents are at a disadvantage in terms of education compared to urban residents. One in five rural women of childbearing age has never been to school, compared to urban women. Access to education is a serious problem. Currently, only two-thirds of the children aged 7 to 13 are in school

(560,000 out of school), UNICEF, (1994). Poor children, and especially the girl-child, are the most deprived of educational opportunities.

Education has been shown to have the strongest and most direct impact on women's health. It has also an impact on women's confidence, status and ability to participate in decision-making, both within their own homes and communities. Unfortunately as mentioned earlier, there are over one million illiterate people in Zambia. Two-thirds of these are women. About 24 percent of all women in Zambia have not received formal education, only one percent have obtained higher education (UNICEF, 1994).

3.6. Poverty

According to Tolosi and Nawiko (1997), some economic indicators show that the economy of Zambia is improving, while social indicators show that the standard of living is declining. According to CSO, 58 percent of the urban population were in 1991 unable to attain a standard of living that is consistent with social standards. The figure increased to 70 percent in 1993 and results of Living Conditions Monitoring Survey LCMS, (1998) show that the figure was above 80 percent in 1996. World Bank (1991) noted that 69 percent of all Zambians lived in households in which basic needs were not being met. Zambia's poverty levels have risen from 75 percent in 1986, to almost 90 percent in 1992. There are more poor women than men. The ratio being 1:12 (Ngenda, 1993).

About 885,000 persons were poor in southern province in 1996, the majority of whom were women, and this accounted for about 76 percent of the total population in the province. Overall population below the poverty line is 70 percent, with more in rural areas as compared to urban areas (UNICEF, 1994). The impact of poverty has mainly fallen on the shoulders of the female section of the population. Low household budget, lack of funds and major burden of domestic care are born by women irrespective of their age, position and condition. These are young teenagers, housewives and old women. This is the most vulnerable section of the population which requires care rather than negligence and

deprivation of their rights. This is one reason why women are found to be helpless and are often found to be in the receiving end with ill health, unregulated fertility and their complications. HIV/AIDS is one of them.

Poverty in many cases contributes to the spread of HIV in that many poor women engage themselves in sexual activities in exchange for money or in polygamous unions with men of higher status within their communities. The 1996 ZDHS report states that exchange of sex for money or gifts is a coping strategy for dealing with poverty. Nearly 11 percent of the women and 24 percent of the men interviewed reported exchanging sex for money or gifts during the 12 months prior to the survey.

3.7. Marriage and Fertility

Marriage is universal in Zambia. By the end of their reproductive years, all but 1 percent of women have been married. However, there are indicators that women who have secondary or higher education marry more than four years later than women with no education. Urban women generally marry about one year later than their rural counterparts (CSO, 1996).

Early marriages as stated earlier expose a lot of the adolescent girls to sexual and reproductive health problems including HIV/AIDS. This is due to their lack of knowledge, negotiating skills, misconceptions and anatomical development. They are quite often abused by older men and negotiating for the use of condoms is almost impossible if at all they have knowledge of condom use. Most of the time they submit easily due to force and poverty, rather than desire or individual consent.

Polygamous marriages are common in Zambia, especially in the southern province. In 1996, 17 percent of currently married women in Zambia were in a polygamous union. It is more common in rural than in urban areas (22 percent compared with 9 percent). Better educated women are less likely to be in a polygamous union than women with less education. Ten percent of women with secondary or higher education are in a polygamous

union, compared with twenty four percent among women who have no formal education (CSO, 1996).

Child bearing begins early in Zambia, with over one-third of women becoming mothers by the time they reach 18 and around two-thirds having had a child by the time they reach 20 years. The median age at first birth falls between 18 and 19 years. Moreover, 31 percent of teenage women (age 15-19) have begun childbearing, with 24 percent having had a child already and 7 percent carrying their first child (CSO, 1996).

Urban women have, on average, two children fewer than rural women (5.1 births compared with 6.9 births, respectively). Comparison of data from the 1992 and 1996 ZDHS reports indicate that the urban rural gap in fertility is widening.

The background information given in the above text clearly shows some indicators of great concern which in most cases perpetuate the spread of HIV infection among women. Despite high numbers of women in the population, women are marginalised in all circles, hence their insubordination to men economically, socially and culturally. Low education level as per 1996 ZDHS predisposes them to lack of knowledge on critical issues in life and this perpetuates their inability to handle some health problems within their families. This, coupled with insubordination, renders them a higher risk of even contracting HIV infection.

CHAPTER FOUR: PRESENTATION OF FINDINGS

4.1. Demographic Characteristics.

Demographic characteristics can indicate an individual's ability to protect herself from contracting HIV/AIDS and to cope with the impact of the disease once infected. For example, individuals with high education and adequate income are better placed to assert themselves and negotiate for safer sex than those with no education and less income. Therefore, this study collected information on some demographic characteristics of women in the study sample.

TABLE 1: AGE DISTRIBUTION OF RESPONDENTS

Age group	Respondents	
	Number	Percent
15 - 19	06	07
20 - 24	12	14
25 - 29	10	11
30 - 34	12	14
35 - 39	18	20
40 - 44	13	15
45 - 49	08	09
50 & over	09	10
Total	88	100

The information presented in Table 1 shows that the majority of the respondents belong to the active reproductive age group (20-39 years). This is the most vulnerable age group to HIV/AIDS infection. The minimum age was 15 years, maximum 57 years, mean 35 years median 35.5, mode 38.00 and standard deviation 10.240. This is not a normal distribution of the population.

Educational Level of Study Subjects

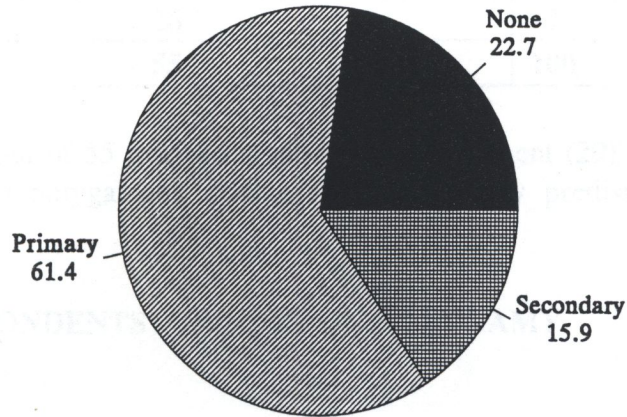


FIGURE 1: EDUCATIONAL LEVEL OF STUDY SUBJECTS

About three-quarters (61.4 percent) received primary education and 15.9 percent reported having received secondary education. The rest had never been to school.

FIGURE 2: MARITAL STATUS OF RESPONDENTS

Marital Status of Respondents

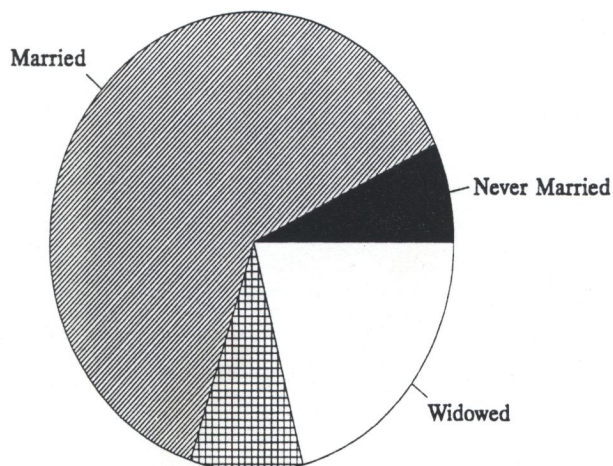


Figure 2 shows that a large proportion (63 percent) of the women in the study were married and only 7 percent had never been in a marital union. Others were, 21 percent widowed and 9 percent divorced.

TABLE 2: MARRIED WOMEN BY TYPE OF MARRIAGE

Type of marriage	Respondents	
	Number	Percent
Monogamous	29	53
Polygamous	26	47
Total married	55	100

Table 2, shows that out of 55 married respondents, 53 percent (29) were in monogamous and the rest were in polygamous marriages. Polygamy predisposes women to HIV infection.

TABLE 3: RESPONDENTS' OPINION ON POLYGAMY

Polygamous marriage	Respondent	
	Number	Percent
Approve	15	16.7
Disapprove	73	83.3
Total married	88	100

Table 3 above shows that 83.3 percent of the respondents did not approve of polygamy for various reasons.

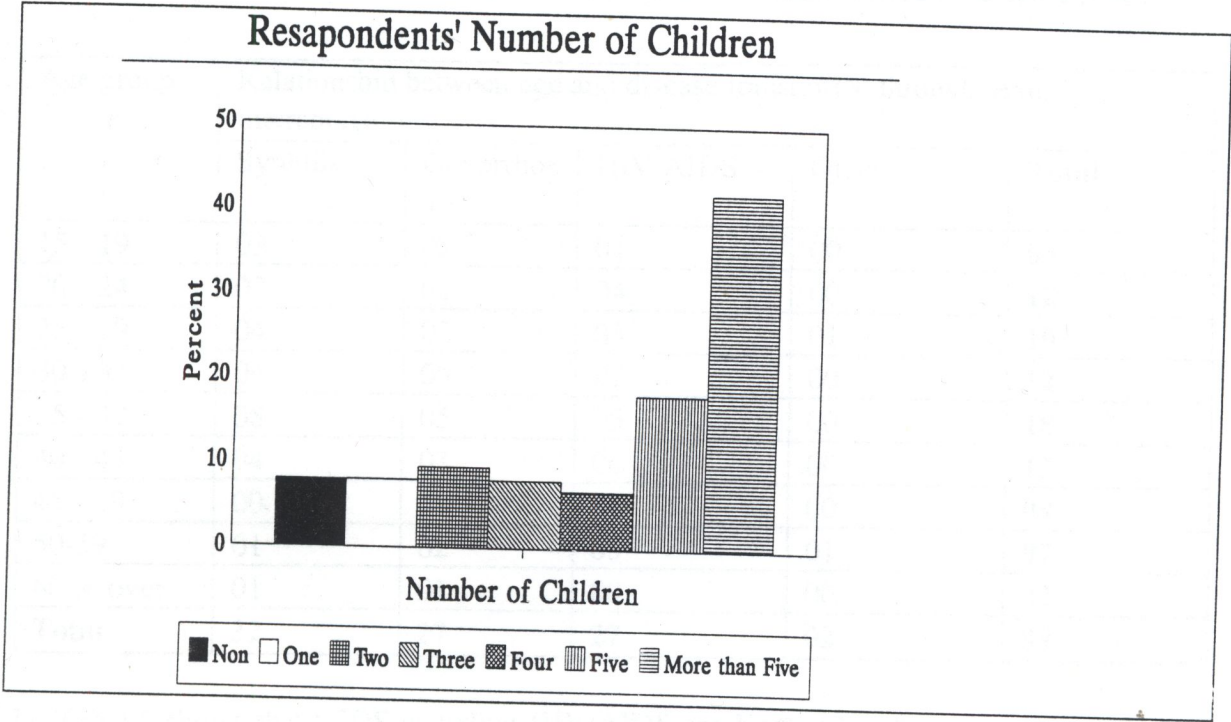


FIGURE 3: RESPONDENTS' NUMBER OF CHILDREN

Figure 3 shows that the majority of the respondents had children while eight percent never had. Of those who had children, 37 (42.0 percent) had more than five children.

TABLE 4: RESPONDENTS' OCCUPATION

OCCUPATION	Respondents	
	Number	Percent
Nothing	05	5.7
Farmer	72	81.8
Regular employment	02	2.3
Casual work	01	1.1
Self employed	08	9.1
Total	88	100

Table 4 shows that the majority (81.8 percent) of the respondents are peasant farmers. Others are self employed (9.0 percent), no occupation (5.6 percent), regular employment (2.27 percent) and casual worker (1.13 percent).

TABLE 5: AGE GROUP BY TYPE OF SEXUALLY TRANSMITTED DISEASES

Age group	Relationship between age and disease transmitted through sexual intercourse				
	Syphilis	Gonorrhoea	HIV/AIDS	Other	Total
15 - 19	03	02	01	00	06
20 - 24	07	01	04	00	12
25 - 29	04	02	03	01	10
30 - 34	04	05	03	00	12
35 - 39	08	05	05	00	18
40 - 44	04	03	06	00	13
45 - 49	00	06	02	00	08
50-59	01	02	03	01	07
60 & over	01	01	00	00	02
Total	32	27	27	02	88

1. Table 5 shows that STDS including HIV/AIDS are Known by all age groups, with the age range 35-44 being the most Knowledgeable . The age range 15-19 has less Knowledge especially in HIV/AIDS. It was further observed that more respondents (32) have Knowledge about syphilis compared to 27 who have Knowledge of HIV/AIDS and Gonorrhoea .
2. The age 40 - 44 did not know about syphilis, while age group 50 and above did not know about HIV/AIDS. This could have been due to chance.
3. There was no statistical difference between age group and type of sexually transmitted disease heard of, p-value was .7267 ch: square 28.66 and df 34.

TABLE 6: RESPONDENTS PERCEPTION OF THE SERIOUSNESS OF HI/AIDS

Social group	Respondents' perception of the seriousness of AIDS/HIV in Zambia			Total
	Not serious	Very serious	Do not know	
Women for Change	13	33	04	50
Non-Women for Change	08	28	02	38
Total	21	61	06	88

Table 6 shows that the majority (61 respondents) perceive HIV/AIDS as a serious disease. Of these, 33 are *Women for Change* members. The rest, (21 respondents) thought HIV/AIDS is not a serious disease and (6 respondents) did not know.

Knowledge of People Suffering from HIV/AIDS

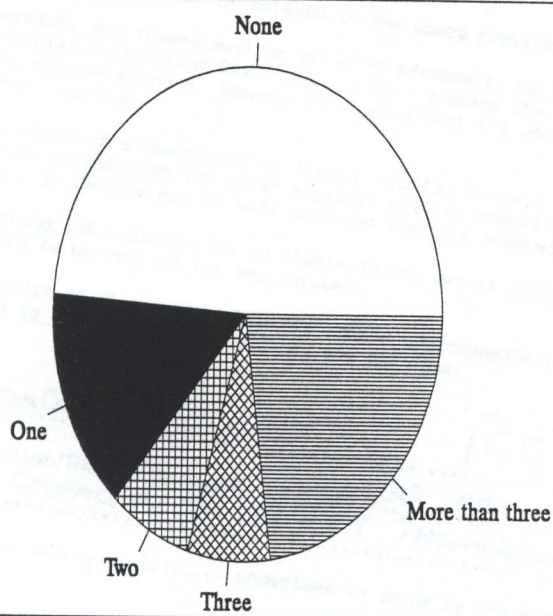


FIGURE 4: KNOWLEDGE OF PEOPLE SUFFERING FROM HIV/AIDS

Figure 4, shows that about 51.1 percent of the respondents knew some people who suffer from HIV/AIDS while 48.8 percent did not know about other people suffering from HIV/AIDS.

Knowledge of People who Died of HIV/AIDS

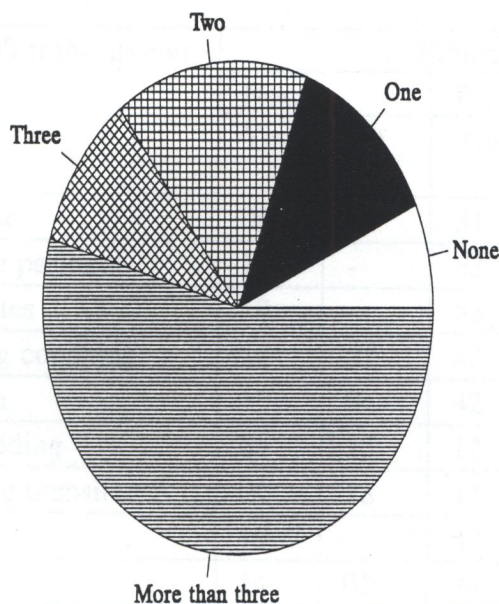


FIGURE 5: KNOWLEDGE OF PEOPLE WHO DIED OF HIV/AIDS

From figure 5, it is quite clear that knowledge of deaths due to HIV/AIDS is extremely high. The majority of the respondents 83.1 percent know some people who died of HIV/AIDS.

TABLE 7: SOURCE OF INFORMATION ON HIV/AIDS

Source of Information	Number	Percent
Live drama	05	5.7
Radio	09	10.2
Poster	04	4.5
Leaflets/Brochures	00	00
Relatives/Friends	32	36.4
Doctor/Nurse	15	17.0
Newspaper/Magazine	01	1.1
Other, specify	22	25
TOTAL	88	100

Table 7 shows that relations and friends (36.4 percent) constitute the main source of HIV/AIDS information. Other sources include doctor/nurse (17.0 percent), radio, (10.0

percent) posters (4.5 percent). The other respondents mentioned different other sources under *other*. Only one person heard of HIV/AIDS from the newspaper/magazine and none heard of it from leaflets/brochures.

TABLE 8: RELATIONSHIP BETWEEN PERCEPTION OF HIV MODE OF TRANSMISSION AND LEVEL OF EDUCATION

Mode of HI/AIDS transmission	Educational level						Total
	None		Primary		Secondary		
	Yes	No	Yes	No	Yes	No	
Sexual intercourse	09	10	31	22	11	03	86
Sex with multiple partners	19	-	53	.	14	.	86
Sex with prostitutes	19	-	53	.	14	.	86
Sex without using condoms	14	05	42	11	14	.	86
Blood transfusion	15	04	42	11	12	02	86
Sharing cloth/bedding	04	15	12	41	.	14	86
Using same eating utensils	01	18	15	38	01	13	86
Injections	19	-	42	11	13	01	86
Mosquito bites	14	05	34	19	10	04	86
Others	08	10	17	35	01	13	86

Table 8 shows that regardless of their educational level most respondents were aware of the modes of HIV/AIDS infection. Perception of the role of selected factors in HIV/AIDS transmission in relation to level of education does not indicate much difference. Two people did not respond to this question.

**TABLE 9: RELATIONSHIP BETWEEN AGE AND PERCEPTION OF HIV/AIDS
AS A NEW DISEASE (PERCENTAGE)**

Age group	Response			Total
	Agree	Disagree	No opinion	
15 - 19	04	02		06
20 - 24	02	09		11
25 - 29	04	06		10
30 - 34	-	11		11
35 - 39	04	13		17
40 - 44	-	12		12
45 - 49	02	06		08
50 & over	01	07		08
Total	17	66		83

From table 9 above most of the respondents (66) perceived HIV/AIDS as a new disease. The table also shows that the majority of the respondents were in the age group 30 - 44. Out of the 88 respondents interviewed, five (5) did not respond to the question.

**TABLE 10: RELATIONSHIP BETWEEN RELIGION AND OPINION IN
COUPLES USING CONDOMS**

Religion	Opinion on the use of condoms			Total
	Approve	Disapprove		
None	06	02	05	13
Catholic	32	09	06	47
Protestant	05	01	00	06
Muslim	01	00	00	01
Others	15	04	02	21
Total	59	16	13	88

Table 10 shows that the majority of the respondents 59 (67 percent) approve of couples using Condoms to avoid HIV/AIDS Infection. Of these 32 (54 percent) are Catholics. The only Moslem in the study sample does not approve.

TABLE 11: RELATIONSHIP BETWEEN AGE AND OPINION ON EXTRA MARITAL AFFAIRS BY A MAN

Age group	Extra marital affairs by a Man		Total
	Tolerated	Not Tolerated	
15 - 19	-	06	06
20 - 24	-	12	12
25 - 29	02	08	10
30 - 34	-	12	12
35 - 39	-	18	18
40 - 44	01	12	13
45 - 49	-	08	08
50 & over	-	08	08
Total	03	84	87

Most of the study subjects especially those in the age range 35-39 did not approve of their spouses having extra marital affairs. Only three individuals, two in the age group 25 - 29 and one in the age group 40 - 44 approved of men's extra marital affairs while one did not respond.

TABLE 12: RELATIONSHIP BETWEEN RELIGION AND OPINION ABOUT DRY SEX INCREASING CHANCES OF HIV/AIDS INFECTION

Religion	Dry sex			Total
	True	Untrue	No opinion	
None	02	02	09	13
Catholic	24	09	14	47
Protestant	01	02	03	06
Muslim	01	00	00	01
Others	11	02	08	24
Total	39	15	34	88

Table 12 show that 39 people approve of the fact that dry sex increases chances of HIV/AIDS infection. 34 respondents had no opinion while 15 said it is not true.

TABLE 13: RELATIONSHIP BETWEEN PROTECTION FROM HIV/AIDS INFECTION AND EDUCATION

What women can do to protect themselves	Educational Level			
	Number	None	Primary	Secondary
Nothing	20	08	12	00
Condoms	18	03	23	05
Abstain	30	02	11	04
One partner	08	02	06	00
Transfusion	00	00	00	00
Injection	00	00	00	00
Mosquitoes	00	00	00	00
Traditional	10	05	02	03
Total	86	20	54	12

In table 13, 13 of those with no education mentioned condom use, 46 with primary education mentioned condom use and 13 with secondary education mentioned condom use as a protective measure from HIV/AIDS infection. Misconceptions about protection from HIV/AIDS were observed even from those with secondary education. Two persons did not respond.

TABLE 14: RELATIONSHIP BETWEEN AGE AND PARENTS ENCOURAGING CHILDREN TO USE CONDOMS

Age group	Opinion on teenagers use of condoms during sexual intercourse			Total
	Approve	Disapprove	No opinion	
15 - 19	04	02	00	06
20 - 24	09	02	01	12
25 - 29	06	04	00	10
30 - 34	06	05	01	12
35 - 39	14	03	01	18
40 - 44	05	06	02	13
45 - 49	04	03	01	08
50 & over	03	05	01	09
Total	51	30	7	88

Table 14 shows that 51 (57 percent) women approve of parents encouraging their children (teenagers) to use condoms. Discouragement of children to use condoms seem to be more pronounced among the age range of 40-44, and higher among the non educated. More of

the respondents in the age 35-39 years approve the encouragement of children to use condoms.

TABLE 15: RELATIONSHIP BETWEEN SOCIAL GROUP AND CONDOM USE

Social group	Response		Total
	Yes	No	
<i>Women for Change</i>	15	35	50
<i>Non Women for Change</i>	11	27	38
Total	26	62	88

In Table 15 more women 62 (70 percent) have not used condoms, only 26 (30 percent) admitted having used condoms. The majority of those who have used condoms (15) are members of *Women for Change*.

TABLE 16: RELATIONSHIP BETWEEN SOCIAL GROUP AND INSISTENCE ON CONDOM USE

Social group	Respondents opinion		Total
	Yes	No	
<i>Women for Change</i>	30	20	50
<i>Non Women for Change</i>	25	13	38
Total	55	33	88

Table 16 shows that of all 88 women interviewed, the majority (55) feel that women should insist on condom use to their husbands/partners, of these 30 are members of *Women for Change*. The rest of the respondents (33) did not believe they had the right to insist on condom use.

TABLE 17: STATISTICAL TEST FOR VARIOUS VARIABLES

VARIABLES 1.HIV MODE OF TRANSMISSION	P-VALUE AND MEMBERSHIP TO WFC	
	WFC= YES	WFC=NO
Mosquito bites	p= .4824	p= 1.00
Multiple partners	p= 1.00	p= 1.00
Prostitution	p= 1.00	p= 1.00
Not using condoms	p= .0535	p= 1.00
Blood transfusion	p= .6555	p= 1.00
Sharing cloths / bedding	p= .0358	p= 1.00
Injections	p= .688	p= 1.00
Using same eating utensils	p= .6243	p= 1.00
Witchcraft	p= .1514	p= 1.00

VARIABLES 2.PREVENTION OF HIV INFECTION	P-VALUE AND MEMBERSHIP TO WFC	
	WFC= YES	WFC=NO
Ever used condom	p= .5177	p= 1.00
Can HIV be prevented	p= .9718	p= 1.00
Insistence on condom use	p= .1599	p= 1.00
Opinion on couples using condoms	p= .0025	p= 1.00
3.CULTURAL PRACTICE Talk about sex	p= 1.00	p= 1.00
4. PROTECTION FROM HIV INFECTION Stick to one partner	p= 1.00	p= 1.00
Use condom	p= 1.00	p= 1.00
Abstain from sexual intercourse	p= 1.00	p= 1.00

Despite the fact that 98.9 percent of the study sample have heard of HIV/AIDS , it seems they are not sure of the HIV mode of transmission . There is statistical significance among WFC members of sharing cloths /bedding as a mode of transmission . There is however , statistical significance among WFC members on Opinion on couples using condoms in order to prevent HIV infection.

4.2. RESULTS FROM THE FOCUS GROUP DISCUSSIONS

Participants in the focus group discussions were asked questions similar to those asked in the interview. In most cases, the pattern of responses were similar to the interview. There was no difference in the age range of the participants in the focus group discussions and those in the interview.

4.2.1. HIV/AIDS knowledge and awareness

The majority of the participants in the focus group discussions were aware about HIV/AIDS and were able to mention some signs and symptoms of the disease. Most of them thought it was a new disease, and they know that currently there is no cure nor vaccine for it. However, there were some misconceptions about the cause and mode of transmission. Some participants said that one can get HIV infection by having sex with a woman who has aborted. Others said that HIV/AIDS originated from Congo Kinshasa (i.e. Kasai businessmen). Some suspected some foods to be responsible for HIV/AIDS infection. Some participants felt that AIDS was found only in urban areas and that foreign truck drivers and prostitutes were some of the sources of infection. A relative low level of awareness of HIV/AIDS was observed in the non members of *Women for Change* in the focus group discussions.

The majority of the participants thought it is was not possible for them to protect themselves from HIV/AIDS infection while some mentioned faithfulness to one sexual partner as the main way of avoiding HIV infection. Others identified abstinence, condom use and drinking some traditional medicine as options. Some men said that it was impossible to avoid HIV infection because of the high rate of promiscuity among women.

4.2.2. Attitudes on condom use

Although the majority of the participants in the focus group discussions had never used condoms, they expressed strong views based on hear say, about the negative aspects of condoms. Some of the comments which came out of the focus group discussions included the view that condoms are responsible for promiscuity; that condoms are for prostitutes; condoms interfere with sexual pleasure; condoms decrease sexual pleasure and affect the man's sexual performance and condoms can not be used on a woman a man loves.

Both members and non members of *Women for Change* believe that use of condoms could prevent them from having children. Women in the focus groups said that they would find it difficult to ask a man to use condoms because as couples, they seldom discuss sexual matters. Men thought it was not acceptable to use condoms with their wives, but that it was alright to use condoms with casual partners.

With reference to some Zambian traditional practices, the majority of the participants were against the practice of widow inheritance and cleansing. It was apparent from the discussions that the majority of the participants correctly recognized these practices as potential risks in the transmission of HIV/AIDS infection.

4.2.3. Other related behaviours and practices

Some participants did not approve discussing sex matters with children. They said that this should be done by traditional initiators, friends and the school. Some said that they would like an HIV test done on them so that they take precautions to live longer and not to infect others. There were also others who said that they would not like the HIV test done on them because they would be worrying and frightened if they were found to be positive. Most participants said they do not discuss sex with their spouses. Some of the reasons cited for this were shyness, traditional norms and fear of being labelled as prostitute.

The cultural and ethical norms of most African countries, Zambia included prohibit random sex talks. Discussions on sex related issues can only take place between persons of the same age or by adults of accepted special standing or relationship to young people (WHO,1990).

Similar views were observed by Bezmalinovic et al (1994) in Guatemala where women at the perinatal and STD clinics said that they had never spoken to their partners about sex. Some Guatemalan men reported that they spoke more freely about sexual matters with sex workers than with their steady partners. These norms that discourage women from being communicative about sex serve as barriers to partner communication, a pre-requisite for the adoption of HIV/AIDS protective behaviours.

In Zambia like in other African countries, men exert greater power and more control over sex related matters. Yet the role of men in sexual decision making has not been emphasized in HIV/AIDS prevention approaches. These findings also confirm the organization of sexuality where in most cultures and societies, the terms of sexuality are essentially determined by men. This leaves women at disadvantage in bargaining for condom use.

Answering another question, participants in the focus group discussions thought it is not right for a woman to also have a man/boy friend if she knows that the husband has a woman/girlfriend. This shows that society has double standards for sexual behaviours between men and women. Fidelity is promoted for both sexes, but male unfaithfulness is more tolerated and unquestioned. The socio-cultural norms encourage men to indulge in sex

and women to be passive and uninformed about sexual matters and this predisposes them to HIV/AIDS infection.

Participants were asked to make comments with regard to protecting women from HIV/AIDS infection. Some of the suggestions made included that there should be provision of information to both women and men on condom use; the government should educate rural communities about the cause, effects and prevention of HIV/AIDS; government should subsidize the available medicines to prolong the lives of those infected with HIV; government should pass a law to stop sexual cleansing of widows/widowers and government should empower women by introducing self help industries for rural women.

CHAPTER FIVE: DISCUSSION OF FINDINGS

Of all the 88 women interviewed, 66 percent were in the active reproductive age group of 25-39 years. This is the age group which is most vulnerable to HIV/AIDS infection and need empowerment to protect them from contracting HIV/AIDS infection. Research in Zambia has shown that women in the early reproductive ages are more likely to contract HIV/AIDS than their male counterparts. According to Kiremire and Luo (1996), women aged 15 and 24 years are 4 times more likely to contract HIV/AIDS than men in the same age group. The youngest age in this study was 15 years and only 6 percent of the respondents were in the age range 15-19 years. This may be because in rural areas, due to distances to schools, children start their education late and this age group could be at primary school.

When the age group was compared with the type of sexually transmitted disease (STD) heard of, it was observed that all age groups in the study were aware of STDs including HIV/AIDS and majority (66) of them perceived HIV/AIDS as a new disease.

All age groups did not tolerate extra marital relations of their spouses. Even though most women in the study rejected extra marital relations of their spouses, it looks like they are powerless because most of the time women's opinions are overruled by their spouses. This was also found by Foster in Zimbabwe. Foster observed that women refused to acknowledge their partners behaviour because they feel powerless to change the situation.

Denial means they are unable to take the first step towards responding to their own risk of infection. AIDS Captions (1996), also observe the belief that "men will be men" and will seek multiple partners for sexual release. This may also be due to the fact that women have little say or control in the extra sexual affairs of their husbands. Women usually have lower bargaining position relative to men because of emotional and economic dependance on men. Therefore there is need to empower women so that they can be liberated from this dependency. One way of doing this is by recognising women as equal partners within their families and communities.

An analysis of the respondents marital status revealed that 55 out of 88 women interviewed were married, another 18 were widowed, 8 divorced and 6 had never married, 26 were in polygamous marriage. Polygamy can be a vehicle of HIV/AIDS transmission. Dossier (1990) also states that women in polygamous marriage tend not to have enough sexual attention and financial support from their husbands, hence the tendency for extra marital affairs. Polygamy also does not appear to prevent a man from seeking casual sex from other women. Nevertheless, of all the women interviewed 83.3 percent did not approve of polygamy for various reasons.

Child bearing is a common phenomenon and most women in the study had children except for 7 who had none. In fulfilling reproductive expectations, women risk their own infection due to unprotected vaginal intercourse. They also risk transmitting the HIV/AIDS to a child if they become pregnant. WHO (1993) also acknowledge that as HIV/AIDS infections in women rise, so do infections in the infants born to them. The traditional norms regarding child bearing favour women having as many children as possible. This makes it difficult for women to consider let alone insist on condom use. Women with low education and income prefer a large number of children because the children provide insurance against divorce and support in old age. It is also a tangible contribution to marriage as it justifies their usefulness. While this is true, it leaves the most vulnerable section of society (mother and child) helpless. This crisis can only be changed by drastic social reforms which would make women and men equal partners.

Respondents' educational level was also investigated. It was found that the majority of the respondents (54) had received primary education, 20 had not been to school and only 14 had secondary education. The 1996 ZDHS report states that rural residents are at a disadvantage with regard to education compared to urban residents. One in five rural women of child bearing age has never been to school. Low levels of female literacy make dissemination of information on HIV/AIDS difficult. A study in India cited low levels of female literacy as a primary obstacle to spreading HIV/AIDS information (Jaswal, 1993).

The majority of the respondents in this study (81.1 percent) were peasant farmers. Only 2.27 percent were in gainful employment. The lack of gainful employment makes women

economically insecure or dependent on men for survival. Even those who are peasant farmers have no ownership to land and other resources. Due to lack of gainful jobs, women engage in unprotected casual sex as means of livelihood despite the risk of HIV/AIDS infection. Living conditions monitoring survey (1997) also observed that the majority of the females 84 percent were peasant farmers.

Most respondents in the study were aware of HIV/AIDS and its mode of transmission regardless their educational level and membership to WFC. This may be attributed to the fact that since 1982, when Zambia established case definition for HIV/AIDS, (Hira et al, 1982), and the government declaring HIV/AIDS as a clear disease, HIV/AIDS campaign programmes were mounted. Twenty years of AIDS education in Zambia has resulted in nearly 90 percent of AIDS awareness in the community as has been shown in this study.

Despite the fact that 98.8 percent of the study sample have heard of HIV/AIDS, it seems they are not sure of the mode of transmission and prevention of HIV infection .As a result these women are not doing anything to protect themselves from contracting HIV/AIDS infection. This may imply that the major sources of information in the study community relay wrong information about the mode of transmission and prevention of HIV infection. However, rural communities have little access to printed information as is shown in this study. Often women get little or incomplete information from friends and relatives. Health services are also highly inadequate.

It is also important to recognize other specific sexual behaviours and traditional Zambian practices that enhance the spread of HIV/AIDS infection among women. These include intercourse with a person who has multiple sex partners, dry sex, widow inheritance and widow cleansing through sexual intercourse. The majority of the women in the study were against the practice of widow inheritance. As many as 80 percent of the respondents either claimed ignorance of the fact that dry sex tends to increase chances of HIV/AIDS or dismissed the fact that it is untrue. These findings underscore the need to mount and intensify public awareness campaigns to educate the public on the actual potential role of

dry sex and other traditional practices in the spread of HIV/AIDS infection.

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, (1991) concluded that women practising dry sex stand a higher risk of contracting HIV infection especially where spouses have other partners. MOH/CBoH (1997) noted that the practice of widow inheritance continues to be prevalent in parts of the country, particularly in rural areas. This is likely to spread HIV infection among women.

Most of the respondents in the study irrespective of their educational background believed that use of condoms and abstinence was the most effective measure of protection against HIV/AIDS infection although there is no statistical significance in the findings as shown on table 17. However, 20 respondents believed that nothing can protect one against the HIV infection and 10 believed that some traditional medicines have protective measure.

This study also found that 51 women out of the 88 in the study sample approve of parents encouraging their children to use condoms as a protective measure against HIV/AIDS infection. Thirty respondents did not approve of their children using condoms. Approval perhaps was given because they could not cope with the impact of fertility and economic situation in the country. Those who did not approve the use of condoms by their children probably believed in the traditional cultural values of Zambia. According to the ancient Zambian traditions, children are not allowed to indulge in sexual activities but pursue knowledge, education and career. Answering another question, 59 respondents approved of couples using condoms to avoid HIV/AIDS infection WFC ($P=0.0025$) and non WFC ($P=1.00$). It is also noted from the study findings that 55 respondents feel that women should insist on condom use to their husbands/partners.

Despite these opinions on condom use, very few women 26 (29.5 Percent) acknowledged ever using condoms. Of these, 15 (17 percent) were members of *Women for Change*. This may be because *Women for Change* members are empowered in decision making. Although it has scientifically been demonstrated that if properly used, condoms provide the second best preventive measure against HIV/AIDS transmission, this study community does not use condoms. This may be due to some cultural perceptions regarding sex and love, how it should be performed and enjoyed. Even if women are aware of the preventive measures, they may, if playing a subordinate role within interpersonal relations, be deprived of the opportunity to put their knowledge into practice.

CHAPTER SIX: CONCLUSION AND RECOMMENDATIONS

6.1. CONCLUSION

This was a small study in which only 88 women were considered. The study set out to investigate factors that lead to the high incidence of HIV/AIDS infection among women. It was also meant to determine factors that influence women's capacity to protect themselves from contracting HIV/AIDS Infection. It looked at some demographic profile and women's attitudes towards HIV/AIDS. Care was taken to see how well the women in the study were equipped to protect themselves from contracting HIV/AIDS infection. However , the identified factors do not seem o have any statistical significance.

The findings have revealed a high level of knowledge about HIV/AIDS among Nkonkola women. However, this knowledge has not been transmitted into behavioral change that would enable them protect themselves from contracting HIV/AIDS infection. There is no statistical association between Knowing about HIV/AIDS is transmitted and prevented for both WFC PV.447 and non WFC P.value 1.000. The women in the study are at risk of HIV/AIDS infection because of various factors which include low levels of condom use, their partners' non monogamous sexual behavior because of polygamy and certain traditional sexual practices all of which are influenced by socio-economic and cultural factors. The lack of gainful employment also makes women economically insecure or dependent on men for their survival. Due to their poor economic position, women engage in unprotected casual sex as a means of livelihood despite the risk of HIV infection. The effect of all these factors restricts women's ability to protect them from the sexual transmission of HIV.

According to the findings of this study, about 54 percent of the respondents have never been to school and the rest have either some primary or secondary education. The people of Nkonkola are highly polygamous and heterosexual. They also have large families, all of

which put them at high risk of contracting HIV infection. However, the majority of the respondents in the study disapproved of polygamy. These women perhaps lacked control over their partner's sexual behavior and did not have any choice but to submit themselves to men's predominance. This predisposes them to HIV/AIDS infection.

It was further found that wives' bargaining power in marriage is low in the area of sex. They generally require their partners' consent to engage in certain behaviours related to sex. As a result, women are in a disadvantaged position to negotiate for safer sex and use of condoms. Irrespective of their educational background, women believed that extra marital sexual relationships are not good and approved of condom use, but this they did not put into practice.

The study illustrates the limitations of current HIV/AIDS intervention programmes which need to address body awareness, perform communication and provide opportunities for group support and networking to help women begin the process of adopting risk reduction behaviour. It is concluded that women's status in the family and society, coupled with some cultural factors contribute to the high incidence of HIV/AIDS infection among women.

The study did not look into the impact of poverty, which could be a major factor towards empowering women and enhancing their capacity to protect themselves from contracting HIV/AIDS infection. In Zambia, the cost of living is very high and available funds do not meet even the basic necessities. Most of the time it is the women who suffer and resort to some means of survival for their livelihood which include exchange of sex for money or material resources.

6.2. IMPLICATIONS

These study findings have the following implications:

- a. Health education methods used in the prevention and control of HIV/AIDS infection have had some impact on women in terms of increased awareness and knowledge about HIV/AIDS.

- b. Despite this knowledge and awareness about HIV/AIDS, women have not changed their behaviour to protect themselves from contracting HIV/AIDS infection. A concerted effort and campaign, which should include socio cultural and traditional sexual practices that increase the risk of HIV/AIDS infection among women, should be designed and implemented in rural communities. Information, education and communication (IEC) strategies about HIV/AIDS should continue through recognized effective channels.
- c. Policy makers need to bridge the inequalities between men and women especially access to education which grossly limit the ability of most women to protect themselves from contracting HIV/AIDS infection.

6.3. RECOMMENDATIONS

HIV/AIDS awareness programmes have been going on from as far back as 1982 when the first case of HIV/AIDS was recorded in Zambia. There has been a lot of donor input to bring down the incidence and prevalence of HIV/AIDS. Zambia even has its own case definition for adult and paediatric HIV/AIDS. The government and most communities are aware about the drastic impact of this dreadful disease. Recently, the Central Board of Health (CBoH) and the Ministry of Health (MOH) suggested that Zambia would have to deal with at least one million orphans due to HIV/AIDS and that nearly 2.1 million people in Zambia would be infected with HIV/AIDS by the year 2005.

It is not surprising but rather true that the majority of these will be young and middle-aged people, 50 percent of whom will be women. Further analysis has shown that women between 15 and 19 years are already with at least two children. It is suggested that by the year 2005, age group 15-19 years and 20-35 years will be missing due to HIV/AIDS (CBoH, 1997). The burden of orphans and workload will fall upon the elderly.

Given the above scenario and the findings of this study, the following are recommended:

The government, donor agencies, nongovernmental organizations, communities and individuals should :

- I Make the goal of decreasing women's vulnerability to HIV/AIDS infection go hand in hand with interventions targeted at broadening societal issues such as improving the status of women in society and targeting men to take responsibility for HIV/AIDS prevention.
- II Promote and support programmes aimed at making women economically independent
- III Promote the use of research findings in policy making, programme design and implementation.
- IV Spearhead social change which might cause communities to change some of their practices such as polygamy and cleansing of widows/widowers through sexual intercourse.
- V Support efforts to bring in the female condom and education campaigns to publicize its use as something the women themselves have control over.
- VI Strengthen the gender component and aim at equity and equality in programme implementation through sensitising and educating of gate keepers such as policy makers, traditional leaders, community leaders, media professionals, religious leaders etc. on stereotype in the perception and representation of women in society.

- VII Equip parents with effective communication skills in addressing sexuality and other sensitive issues with their children especially adolescents.
- VIII Design programmes for adolescent boys and men that go beyond condom literacy to promote sexual and family responsibility. Educating men and boys on the consequences of multiple partnerships and high-risk sexual behaviour.
- IX Enforcement of national legislation and international conventions on gender equity, human rights and reproductive rights of women to fight against sexual violence and HIV/AIDS related stigmatisation, discrimination and exclusion.
- X Penetrate gatherings such as initiation ceremonies so that critical advice on HIV/AIDS infection should be given at the tender age of puberty and earlier.
- XI Alongside the women's economic empowerment WFC should incorporate health issues in their projects.
- XII Spiritual and moral education (SME) should be taught from a tender age in homes, schools and churches.

6.4. SUGGESTIONS FOR FURTHER RESEARCH

The results from this research have highlighted the need for more research on the socio-economic and social-cultural factors underlying the spread of HIV/AIDS infection among women as well as the need for research on the most effective methods for disseminating information on HIV/AIDS.

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APPENDICES

**APPENDIX I: QUESTIONNAIRE ON WOMEN'S CAPACITY TO PROTECT
THEMSELVES FROM CONTRACTING HIV AIDS
INFECTION**

SERIAL NUMBER:.....

PROVINCE:.....

NAME OF VILLAGE:.....

DATE OF INTERVIEW:.....

NAME OF SUPERVISOR:.....

NAME OF RESEARCH ASSISTANT:.....

INSTRUCTIONS TO INTERVIEWER

- 1. No names should appear in this questionnaire.
- 2. Information given in this questionnaire will be kept strictly confidential.
- 3. Circle the appropriate number of the response(s).
- 4. Ask all questions.
- 5. Write the appropriate responses in the space provided.

SECTION A - DEMOGRAPHIC DATA

1. Age (AGE) Date of birth (DOB)

2a. Marital status (MARITAL)

- (1) Single
- (2) Widowed
- (3) Divorced
- (4) Married
- (5) Separated
- (6) Cohabiting

2b. If married, what type of marriage are you in?

- (1) Monogamous
- (2) Polygamous

2c. If you are in polygamous marriage, how many other wives are there?

- (1) One
- (2) Two
- (3) Three
- (4) More than three

2d. Do you approve of polygamy?

- (1) Yes
- (2) No

Explain
.....
.....
.....

3. Level of education (EDU)

- (1) None
- (2) Primary
- (3) Secondary
- (4) College

4. Occupation (OCCUP). What do you do for a living?

- (1) Nothing
- (2) Farmer
- (3) Regular employment
- (4) Casual work
- (5) Self employed

5. Religion (RELIGION)

- (1) Roman Catholic
- (2) Protestant
- (3) Muslim
- (4) None
- (5) Other, specify

.....

.....

.....

6. How many children have you ever had?

- (1) None
- (2) One
- (3) Two
- (4) Three
- (5) Four
- (6) Five
- (7) More than five

**SECTION B - QUESTIONS ON KNOWLEDGE,
ATTITUDES AND PRACTICE**

7. What diseases have you heard of that can be transmitted through sexual intercourse?

- (1) Syphilis**
- (2) Gonorrhoea**
- (3) HIV/AIDS**
- (4) Other, specify**

.....

.....

.....

8. Which of the diseases have you ever contracted?

- (1) Syphilis**
- (2) Gonorrhoea**
- (3) HIV/AIDS**

9. Do you have a friend or relative who has any of these diseases?

- (1) Yes**
- (2) No**

10. Have you ever heard of a disease called HIV/AIDS?

- (1) Yes**
- (2) No**

11. If the answer to question 10 is 'YES', what was the FIRST source of your information?

- (1) Live drama
- (2) Radio
- (3) Poster
- (4) Leaflets/brochures
- (5) Relative/friend
- (6) Doctor/nurse
- (7) Newspaper/magazine
- (8) Other, specify

.....

.....

.....

12. How can a person acquire HIV/AIDS?

- (a) Sexual intercourse (1) Yes (2) No
- (b) Sexual intercourse with multiple partners
(1) Yes (2) No
- (c) Sexual intercourse with prostitutes (1) Yes (2) No
- (d) Not using a condom during sexual intercourse
(1) Yes (2) No
- (e) Blood transfusion (1) Yes (2) No
- (f) Sharing clothes/beddings (1) Yes (2) No
- (g) Using same eating utensils (1) Yes (2) No
- (h) Injections (1) Yes (2) No
- (I) Mosquito bites (1) Yes (2) No
- (j) Witch craft (1) Yes (2) No
- (k) Other,

specify.....

.....

13. What can women do to protect themselves from contracting HIV/AIDS?

- (a) Nothing (1) Yes (2) No
- (b) Abstain from sexual intercourse (1) Yes (2) No
- (c) Use condoms (1) Yes (2) No
- (d) Stick to one sexual partner (1) Yes (2) No
- (e) Avoid blood transfusion (1) Yes (2) No
- (f) Avoid injections (1) Yes (2) No
- (g) Avoid mosquito bites (1) Yes (2) No
- (h) Seek protection from traditional healers
(1) Yes (2) No
- (I) Other, specify

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14. What are the main symptoms of HIV/AIDS?

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15. How many people do you know who have HIV/AIDS?

- (1) None
- (2) One
- (3) Two
- (4) Three
- (5) More than three

16. How many people do you personally know who have died of HIV/AIDS in the past year?

- (1) None
- (2) One
- (3) Two
- (4) Three
- (5) More than three

17. Is it possible for a healthy looking person to have the HIV/AIDS virus?

- (1) Yes
- (2) No
- (3) Don't know

18. Can HIV/AIDS be transmitted from mother to child?

- (1) Yes
- (2) No
- (3) Don't know

19. Can HIV/AIDS be prevented?

- (1) Yes
- (2) No
- (3) Don't know

**20. If your answer to question 19 above is 'yes',
explain.....**

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21. Can HIV/AIDS be cured?

- (1) Yes
- (2) No
- (3) Don't know

22. If the answer to question 21 above is `yes', how?

- (1) By modern medicine
- (2) By traditional medicine
- (3) By both modern and traditional medicine
- (4) One its own
- (5) Other, specify

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23. Who are the people at risk of contracting HIV/AIDS?.....

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24. Some people use condoms during sexual intercourse to avoid contracting or transmitting HIV/AIDS or other sexually transmitted diseases. Have you heard of this?

- (1) Yes
- (2) No

25. What is your opinion on couples using condoms to avoid contracting or spreading HIV/AIDS and other sexually transmitted diseases?

- (1) Approve
- (2) Disapprove
- (3) No opinion

26. How much do you trust in the use of condoms as a means of preventing HIV/AIDS?

- (1) A lot
- (2) Not much
- (3) No at all

27. What is your opinion on parents encouraging their children (teenagers) to use condoms during sexual intercourse to avoid contracting HIV/AIDS and other sexually transmitted diseases?

- (1) Approve**
- (2) Disapprove**
- (3) No opinion**

28. Have you ever used a condom during sex to avoid contracting or transmitting diseases such as HIV/AIDS?

- (1) Yes**
- (2) No**

29. Should a wife insist on the husband using a condom during sexual intercourse if she suspects that the husband has been or is seeing other women?

- (1) Yes**
- (2) No**

30. Do women generally suggest condom use to their sexual partners/husbands in your community?

- (1) Yes**
- (2) No**

31. If your answer to question 30 above is `no', what do you think can be done to improve women's ability to use condoms?

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32. What can women do to influence their husbands/sexual partners to use condoms?

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33. Do you talk about sex with your husband/male partner?

- (1) Yes
- (2) No

34. If your answer to question 33 above is `no', why not?.....

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35. What is your opinion on young people engaging in sex before marriage?

- (1) Approve
- (2) Disapprove
- (3) No opinion

36. Is it common for women in your community to have more than one sexual partner?

- (1) Yes
- (2) No
- (3) Don't know

Explain

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37. How often do you discuss the problem of HIV/AIDS with your

(a) Husband/sexual partner?

- (1) Never
- (2) Sometimes
- (3) Most of the times
- (4) All the time

(b) Children?

- (1) Never
- (2) Sometimes
- (3) Most of the times
- (4) All the time

(c) Relatives?

- (1) Never
- (2) Sometimes
- (3) Most of the times
- (4) All the time

(d) Neighbors/friends?

- (1) Never
- (2) Sometimes
- (3) Most of the times
- (4) All the time

38. What is your opinion on parents discussing sex with their children?

- (1) Approve
- (2) Disapprove
- (3) No opinion

39. If your answer to question 38 is not 1, who do you feel should provide sexual health information to young people?

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40. 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?

- (1) It is true
- (2) It is not true
- (3) Don't know

41. What is your perception of the seriousness of HIV/AIDS in

(a) ZAMBIA?

- (1) Not serious
- (2) Very serious
- (3) Don't know

(b) COMMUNITY?

- (1) Not serious
- (2) Very serious
- (3) Don't know

42. If a wife knows that her husband has a girl or woman friend, is it okay for her to also have a boy or man friend?

- (1) Yes
- (2) No

43. In traditional Zambian society, extra marital affairs by a man was usually tolerated. What do you think about this in our present society?

- (1) It should still be tolerated
- (2) It should not be tolerated
- (3) Don't know

44. In your community, what do women do to protect themselves from contracting HIV/AIDS infection?

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45. What would you do if you suspected your husband/male partner had HIV/AIDS?

- (1) Use a condom**
- (2) Make sure he had a good bath**
- (3) Nothing**
- (4) Other, specify**
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46. What are your expectations of marriage?

- (1) Companionship**
- (2) To have children**
- (3) To have sex**
- (4) Other, specify**
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47. It is a common practice among a number of ethnic groups in Zambia that when a husband or wife dies, the widow or widower is made to have sex with a man or women from the diseased family, in order to be cleansed. What is your opinion on this practice?

- (1) It should be encouraged**
- (2) It should not be encouraged**
- (3) No opinion**

48. Some people contend that with so much HIV/AIDS around, the practice of inheriting widows should be stopped. What is your view on this?

- (1) Agree**
- (2) Disagree**
- (3) No opinion**

49. Some people argue that HIV/AIDS is not a new disease in Zambia, but has been there. What is your opinion on this?

- (1) Agree
- (2) Disagree
- (3) No opinion

50. (a) Would you like an HIV/AIDS test done on you?

- (1) Yes
- (2) No

(b) If your answer to question 50(a) above is 'YES', explain

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(c) If your answer to question 50(a) above is 'NO', explain

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51. What recommendations would you make in relation to women's protection from contracting HIV/AIDS infection to

(a) Government?

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(b) The women?

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THANK THE RESPONDENTS FOR THEIR TIME AND COOPERATION

APPENDIX II: FOCUS GROUP DISCUSSION GUIDE

INSTRUCTIONS TO MODERATOR:

1. Introduce moderator and recorder
2. Explain the purpose of the discussion and topic in general.
3. Give assurance of confidentiality.
4. Encourage participants to discuss subject matter openly.
5. Let participants introduce themselves.
6. Rules: Participants should listen to each other, respect each other's opinion, if possible only one person should talk at a time.
7. Explain the purpose of the tape recorder and obtain consent.

KNOWLEDGE OF HIV/AIDS

1. What health problems do women face in this community?
2. What is HIV/AIDS?
3. What causes HIV/AIDS?
4. How can a person acquire HIV/AIDS?
5. Is it possible for a healthy looking person to have HIV/AIDS?
6. Can HIV/AIDS be transmitted from mother to baby?
7. Can HIV/AIDS be prevented? How?
8. Can HIV/AIDS be cured? How?
9. How can you tell that someone has HIV/AIDS?
10. What is a condom?
11. How is a condom used?
12. How is a condom disposed after use?
13. Do women generally suggest condom use to their sexual partners/husbands?
14. Do women have more than one sexual partners in your community?
15. Do you know of any dangers related to HIV/AIDS?
16. Do you discuss HIV/AIDS with your partner/husband/children/neighbour/friend?
17. What can women do to protect themselves from contracting HIV/AIDS?

PERCEPTION OF HIV/AIDS

18. What is your opinion on the use of condoms?
19. What is your opinion on methods used for cleansing of a widow/widower after the death of a spouse?
20. Do you think people need protection from contracting HIV/AIDS
21. What kind of protection do you think people need to prevent contracting HIV/AIDS?
22. What should be the source of this protection?
23. What other things do you have to say about HIV/AIDS prevention?

APPENDIX III: INFORMED CONSENT

Dear participant,

Please read through the following statement and sign if you wish to participate.

- 1. The objective of the study is to determine factors which influence women’s protection from contracting HIV/AIDS infection.
- 2. Participation in this study is voluntary, hence you are free to withdraw if you wish.
- 3. Benefits to the participants are likely to be long term. Ability for individuals and communities to deal with HIV prevention will be strengthened and they will understand more the mode of HIV infection and prevention
- 4. Policy makers and other stakeholders will ensure improved action in the health sphere and other areas based on the findings and recommendations of the study to increase women’s capacity to protect themselves from contracting HIV infection.
- 5. All information given during the study will be confidential and the interview will be carried out in private.
- 6. Further Information
This study is being conducted as Masters in Public Health student at the University of Zambia, School of Medicine, Department of Community Medicine.

Ihereby called participant, understand the objectives of this study and that I will be observed and interviewed.

I hereby consent to participate

Dated thisday of.....19.....