WOMEN'S PARTICIPATION ON HIV/AIDS ISSUES: A CASE OF MISISI COMPOUND LUSAKA DISTRICT

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DECLARATION

I, Beatrice Muchimba Kanyamuna, declare that this report has been composed and compiled by me and that the work recorded here is my own. All the diagrams and maps have been constructed by me and the sources of all materials referred to have been specially acknowledged. This project report has not been previously accepted for any academic award.

Signed:---------- Date:1/11/04----------

DEDICATION

To my Late Dad(Mr. Kanyamuna , T.), my Late sweetheart(Mr. Mutakai, J.) who never lived long enough to see me realize this dream, my mum, sister and my children(Milimo and Kubilwa).

AKNOWLEDGEMENTS

My heartfelt gratitude go to the University of Zambia (UNZA) for according me this memorable opportunity of experience especially in my young life. I particularly thank my supervisor Mrs. E.N.S, Imasiku who worked so tirelessly in guiding me through out the project. Indeeded your efforts 'madam' are genuinely appreciated. May God continue guiding you.

I'm further thankful to the course coordinator Mrs. M, Muzyamba who offered overall guidance throughout the course. Surely your way of approach to things discouraged me from being lazy and a failure in life.

My special thanks also go to Dr. M, Mulenga (Head of Department), Dr. G.P.A, Banda, Mr.G.M, Kajoba, Mr. G, Hampwaye, Mr. J, Volk, Mr. E, Kapungwe, Mrs. W.S, Nchito, and Mrs.S, Sinyibulula(Secretary) who spared their time to share with me some ideas on how to go about with my report.

Further thanks go to my friends like Mr. W. Hamoonga, Mr. L. Buleya, Mr. F. Siakabeya, and Mr. F. Mwenda, for the moral support and criticisms. I am so deeply indebted to thank my GEO 474 course mates for their companionship.

Finally, to all the persons above and many others not named, I say, God richly bless them (you). I thank God through his son Jesus for granting me the comfort I have enjoyed on campus.

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ACRONYMS.

ARV - Anti-Retroviral

CSO - Central Statistics Office

ECA - Economic Commission for Africa

GRZ - Government Republic of Zambia

MAWD- Ministry of Agriculture and Water Development

MOH- Ministry of Health

CBOH- Central Board of Health

PRB - Population Reference Bureau

SADC- Southern African Development Community

SG - Surveyor General

UN - United Nations

UNAIDS- Joint United Nations Programme on HIV/AIDS

UNECA- United Nations Economic Commission for Africa

UNO - United Nations Organisation

UNFPA- United Nations Population Fund

ZARD- Zambia Association for Research and Development

CBD - Central Business District

ABSTRACT

Urban poor women play key roles in the development of the health sector especially in issues of HIV/AIDS. Meanwhile, Zambian women have for a long time been marginalized in this sector. Women are marginalized in the sense that access to health and education facilities is not as easy for them as it is in the case of their male counterparts. Therefore, one tends to wonder whether women really play a key role in the health sector. Is their potential being realized?

HIV/AIDS has reached alarming levels in all corners of life. It is now infecting people in all age-groups but the most infected are women, (GRZ, 2002). Hence the study's general objective was to investigate women's participation in HIV/AIDS issues. The specific objectives were: to find out if women in Misisi compound had any knowledge on HIV/AIDS; the methods that they use to prevent themselves from being infected with HIV; whether HIV/AIDS patients and orphans are taken care by women in Misisi compound; and if these women do discuss HIV/AIDS issues with their families.

Out of 7,000 households found in Misisi Compound, 40 were sampled at random. The interval sampling method was used to get a sample of 40 respondents.

Among other things, this study has revealed that women in Misisi Compound have the knowledge about HIV/AIDS and how to prevent it, though not all of them use the known methods to prevent themselves from being infected. Some women are involved in taking care of HIV/AIDS orphans and patients. There are also organizations that deal with issues of HIV/AIDS in terms of treatment and care to infected persons.

In view of the above findings, recommendations made are that there is need to empower women education wise and economically for them not to engage themselves in sexual activities in exchange for money to sustain their livelihoods. Gender roles should be explained properly to the people and women should be sensitized very much on what is right for them.

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CHAPTER ONE

1.0 INTRODUCTION

This chapter consists of back ground to the study, statement of the problem, aim and the specific objectives. The research questions, rationale of the study and definition of the key words are incorporated as well.

1.1 Background to the Study

There has been a high prevalence and incidence of HIV/AIDS that has reached alarming levels in Zambia. It is estimated that 16% of the adult population is currently infected with HIV, (Population Reference Bureau, 2003). Due to this, life expectancy of Zambians is at 41 years for males and 40 years for females, (PRB, 2004). This life expectancy figure is far below of other countries such as Senegal which has 52 years for males and 55 years for females. This low life expectancy in Zambia is below the average years for sub-Saharan Africa of 50.1 years, (Government of the Republic of Zambia and United Nations Organizations (GRZ/UNFPA), 1996). This low life expectancy is due to factors such as high mortality rates, poverty, and difficulties in accessing medical services especially among the rural and urban poor. The high mortality rates are as a result of the high prevalence of HIV/AIDS.

The human toll of AIDS is a tragic reality being experienced by families, communities, and the nation at large. There is no aspect of life that has not been directly or indirectly negatively influenced by the AIDS epidemic. AIDS has become a major cause of illness and death depriving households and society of a critical human resource base and thereby reversing the social and economic gains made since independence. The manifestations of HIV/AIDS have led to poverty, and the state of poverty directly or indirectly creates vulnerability to HIV/AIDS. HIV/AIDS leads to poverty by eliminating the productive loss of human capital. Economic growth and prosperity hinge on a healthy human resource base and this is currently threatened by the HIV/AIDS epidemic.

Although women constitute about half of Zambia's population, they are disproportionately affected by HIV/AIDS pandemic, in the sense that women are culturally relatively weaker to protect themselves against a spouse suspected to be infected, (Ministry of Health and Central Board of Health (MOH/CboH), 1999). It is estimated that about 1.2 times as many women are afflicted with AIDS as are men. Women are thought to be 2 to 4 times as susceptible to infection with HIV during unprotected intercourse and more vulnerable to other STDs (GRZ, 2002). Generally, women lack complete control over their lives and are taught from early childhood to be obedient and submissive to males, particularly males who command power such as a father, uncle, husband, elder brother or guardian.

According to Zambia Demographic Health Surveys (ZDHS, 2001-2002) of CSO (2003) analysis, Lusaka had a prevalence rate of 22%, Copperbelt 20%, Southern 18%, Northern 8%, while North-Western had 9%. The studies in Ndola revealed a prevalence rate of 32% among females and 25% among males. About 8% of males and 17% of females aged 15-24 were living with HIV. In June 2000, there were 830,000 people over the age of 15 years living with AIDS and of these, 450,000 were women while 380,000 were men, (GRZ, 2002).

Misisi compound being one of the first compounds to be established in Lusaka is prone to this deadly disease, HIV/AIDS. The area is near the Central Business District (CBD) and is densely populated with people having less or no education and involved in businesses like: local beer brewing, stone crushing, vending, sand mining, among others. These businesses are low paying jobs and hence the need to research as to whether women in Misisi compound have the time to participate in issues of HIV/AIDS or not.

1.2 Problem Statement

Women are the key players in most of Zambia's economic activities such as agriculture in which women contribute about 67% of the rural labour; commerce related activities such as business and other related ventures (ZARD, 1997). However, despite this important analysis, women's contribution to development in the country has for a long time not been well recognized despite being key players. They are in most cases side

lined even in issues such as those concerning mortality, fertility, family planning and home decision making processes which affect them directly. Due to this, resources are just wasted in issues that are supposed to involve women but are just done by men. These resources are just used without yielding any fruitful results. Because of this, there is need to have integrated decision making processes which involve both men and women so that each category of sex concerns are heard and upheld.

Therefore, the study was carried out in Misisi compound to see how women have participated in issues related to HIV/AIDS.

1.3. Aim

To investigate women's participation in matters of HIV/AIDS in Misisi compound.

1.4. Objectives

The following were the specific objectives of the study:-

i To find out if women in Misisi compound have any knowledge about HIV/AIDS,

ii To find out the methods women in Misisi compound use to protect themselves from being infected by the HIV/AIDS,

iii To investigate whether women in Misisi compound take care of HIV/AIDS Patients and orphans,

iv. To find out if women in Misisi compound discuss HIVAIDS issues with their family members,

v. To establish whether there are organizations that deal with matters related to HIV/AIDS in Misisi compound.

1. 5 Research questions

The data investigated is not quantitative but qualitative; hence, research questions instead of hypotheses were used. The research questions that were incorporated in this study are:-

i. Do women in Misisi compound have any knowledge on HIV/AIDS?

ii. What methods of protection against HIV/AIDS do women in Misisi compound use?

iii. Do women in Misisi Compound take care of the HIV/AIDS patients and orphans?

iv. Do women in Misisi compound discuss HIV/AIDS issues with their family members?

v Are there any women's organizations that deal with matters related to HIV/AIDS issues in Misisi compound?

1.6 Definition of terms

i. **Participation**: according to Longman (1987), the word participate means taking part or having a share in an activity or event. Participation in this study is used to refer to taking part in HIV/AIDS activities or events.

ii. **HIV/AIDS issues**: Longman (1987) defines the word 'issue' as a subject to be talked about, argued about, or decided. Hence, HIV/AIDS issues in this study are matters on HIV/AIDS to be talked about.

iii. **HIV**: means Human Immunodeficiency virus that causes AIDS.

iv. **AIDS**: stands for Acquired Immune Deficiency Syndrome which is defined in terms of how much deterioration of the immune system has

taken place as seen by the presence of opportunistic infections (MOH/CBOH, 1997).

1.7 Rationale

This study was concerned with investigating the role of women in HIV/AIDS issues bearing in mind that the results can be used by planners and policy-makers in the development of high density residential areas when formulating policies and programs such as HIV/AIDS awareness and mitigation measures, prevention strategies, health promotion programs among others. The results can also be used as the starting point for further studies on women's involvement in HIV/AIDS in other parts of the country. The findings to this research can help HIV/AIDS education on how to address the communities on issues concerning HIV/AIDS.

1.8 Organization of the Report

The study has been organized in the following chapters. The first chapter has given the back ground to the study by considering the following:- brief back ground of the study, statement of the problem, aim, specific objectives, research questions, definition of terms, and rationale. Chapter two reviews the literature related to the study, while chapter three presents information on the study area. Chapter four gives information on the methodology and chapter five presents the research findings/results, chapter six presents discussion of findings. The last chapter (seven) gives the conclusion and recommendations.

CHAPTER TWO

2.0 LITERATURE REVIEW

2.1 Introduction

The chapter consists of sections dealing with HIV/AIDS as a global epidemic, HIV/AIDS in African situation, Zambian HIV and AIDS situation, and finally, women's profile in development in Zambia.

2.2 HIV and AIDS: The Global Epidemic

The report from UNAIDS (1996) estimated that globally 22.6 million people were living with HIV infection or AIDS. Of these 21.8 million were adults and 830, 000 were children. Approximately, 42% of the total number of people infected were women; the majority (90%) was from developing countries. Sub-Saharan Africa and the Caribbean had the highest national rates of adult HIV prevalence. Considering the scenario, HIV/AIDS has become a major development challenge in the world, rolling back hard-won social gains in human development, including life expectancy, income and education. For example, the life expectancy in Southern Africa which rose from 44 years in 1950s to 59 years in early 1990s had dropped to 45 years in 2000. Before the HIV/AIDS pandemic, life expectancy in Botswana was estimated at 69 years, but with the pandemic it is at 44 years (ECA, 2002). Three quarters of people with HIV/AIDS have been buried from the 22.6 million world wide since the epidemic began. World wide, for every 100 HIV infections, between 75 and 85 have been transmitted through unprotected sexual intercourse (ECA, 2000). Women are the most vulnerable for some are ashamed to say 'No' to sex even when they know that their partners are unfaithful and have the virus.

2.3 HIV/AIDS: African Situation

According to SADC (2004), HIV and AIDS continue to be the biggest health challenge in the region with corresponding adverse impacts on socio-economic development. Furthermore, the HIV/AIDS pandemic and other communicable diseases undermine Africa's development efforts. For example, in 2000, 2.4 million Africans succumbed to AIDS and there were 3.8 million new infections, (ECA, 2000). These developments are

looked at in terms of peace, security and democracy which need to be upheld and promoted, (SADC, 2004).

In addition, young African women have higher infection rates than young men. For the teenage girls in some countries, the infection rate is five times higher than teenage boys. On the other hand, young people in their 20s have an infection rate which is 3 times higher in females than males. Because of this, in Africa, women's peak infection rates occur at earlier ages than men's. This basically, explains why there is an estimation of 12 women living with HIV for every 10 men in Africa (UNPF, 1996).

Because of this picture, African countries, has been adversely affected in terms of man-power provision in agriculture, industries and other sectors of development (SADC 2004). This problem have been fuelled up by male economic and social dominance, poverty, unfaithful partners, and lack of education amongst the majority of women and limited access and choices to resources.

Hence, SADC and other stakeholders in the region recognize the effects of the HIV and AIDS and have committed themselves to main streaming HIV and AIDS into its policies and programs response to the scourge's multifaceted nature and implications on the social, economic and political outcomes at households, community, national and regional levels (SADC, 2004). This mainstreaming is aimed at alleviating poverty in general, ensuring food security in particular since they are the major causes of HIV/AIDS. In July 2003, SADC and African Leaders signed the Maseru Declaration on the HIV and AIDS. This was done to demonstrate their commitment to addressing a number of issues related to the HIV/AIDS such as causes, prevention and social mobilization, improving care, access to counselling and testing services, treatments and support, accelerating development and mitigating the impact of HIV and AIDS, intensifying resource mobilization and strengthening institutional, monitoring and evaluation mechanisms (SADC, 2004). The other issue concerns the procurement of ant-retroviral (ARVS) drugs. This programme was sort to be achieved in Southern Africa through the Southern Africa HIV and information dissemination services (SAFAIDS). The other policy framework which the African leaders forwarded to be looked at are

enhancing of human health and mitigation of HIV/AIDS and other chronic diseases. These were aimed to be estimated through mainstream policies and programmes to promote human health, combat HIV and AIDS in agriculture and enhance natural resources development. Finally, it aimed at promoting research, production and utilization of traditional foods that strengthen the immune system.

Because of these policies and programmes, in Botswana, out of a population of 1.7 million, 16 000 adults and 1500 children are on anti-retroviral treatment. Due to this, 85% of the patients have improved their health and productivity while 90% of those on treatment have adhered to the treatment (SADC, 2004). In Malawi, South Africa and Zimbabwe, ARV roll out programmes have also been started. The initiation of these policies and programmes are due to the Pan African Treatment Access Movement (PATAM) Conference held in Harare, Zimbabwe in March 2004 to explore regional strategies for scaling up access to ARV therapy and treatment of opportunistic infections (SADC, 2004).

Eventually, considering these policy strategies and programmes, it is hoped that the mainstreaming measures of the HIV/AIDS and infectious diseases will be combated. Hence, there will be promotion of needed manpower to enhance economic growth and development. Lastly, health status and standard of the African people will be enhanced which will be followed by high life expectancy.

2.4 Women's Profile in Development in Zambia.

Women empowerment is an important component of a country's development for it occupies a crucial position in the forward and backward linkages in national development. For example, it is estimated that women account for 60 – 80% of agriculture labour force on the continent, (UNECA,1996). Although women constitute 51% of Zambia's population, they have not benefited from the development process in comparison with men due to the gender imbalances in the social, economic and political spheres (ZARD, 1998). Women are relegated to lower levels of the expanding public sector and service and industries such as sales ladies (Mwenda, 1992). Women in the

informal sector tend to be concentrated in food, textile, beer brewing and street-vending activities which require less capital and yield lower income.

In general, women are more vulnerable to poverty than men for several reasons. Firstly, women have lower levels of education than men. For example in 1998, 29% of the female population had no education at all, while only 24% of the male population had no education at all. While 15.6% of the male population had completed grade 10 or higher, the corresponding percentage for female was only 8.5% (GRZ : 2002).

Educational institutions, school curriculum and career guidance, accord boys more and better prospects. In such a situation girls acquire attitudes and aspirations which place them second best. Available indicators show that the girl child is discriminated against from the earliest stages of life, through her childhood and into adulthood. Girls are often treated as inferior and are undermining their self-esteem. Secondly, women have a very small share in formal employment which is generally more rewarding than informal employment. There were only 12% of women in formal employment in 1996 for example, while the remaining 88% was for males. Further, 39% of women as opposed to only 16% of the men were employed as unpaid family workers in 1998 (GRZ :2002).

According to ZARD (1987), women are the main producers, providers and traditional managers of food production at family and national levels. Although this is the case, women's productivity is constrained by lack of access to productive resources such as credit, improved technology and extension services. Though they are pillars of subsistence farming, their role and contribution are not recognized or supported by government policies, (Saito, 1992).

Land, which should be the major factor of production, is prominently controlled by men, even though women are the most active participants in agriculture and environmental activities. The statutory and customary laws and practices are biased against women, preventing them from owning and inheriting land on an equal basis (MAWD, 1985). For example, under traditional tenure, land is usually granted to and inherited by males following kinships pattern, leaving women with no say.

Insufficient decision making power by women in commerce, trade and industry along with gender biases contribute to the unfair situations women experience as they strike to engage in business. This contributes extensively to women engaging in petty trading and other marginalized ventures in the informal sector where most female labour is concentrated.

Every human being is entitled to accessible and affordable health facilities. In Zambia, this is not the case. The poor cannot access and afford health facilities and this consists of mainly women and children (MOH/CBOH, 1999). Several factors including ill equipped Health Centres, poor quality services, inadequately trained staff, long distances to services, user fees, place health services out of reach of many women. Various factors have contributed to this situation. The largest cause being the decline in the Zambian economy during the last decade and the rapid fall in rates of per capita income.

Women are vulnerable to the infection because of their subordinate position in sexual relations. This subordination means that it is difficult for women to insist on using condoms in order to protect themselves from HIV infection even when they know the sexual partner has been promiscuous. In this way, AIDS has sent many faithful wives to their grave (ZARD, 1987). Lusaka and the Copperbelt provinces recorded consistently the highest number of STDs (Gonorrhoea, syphilis and chancroid) cases from 1990 to 1994 (MOH/CBOH, 1995). Taking Lusaka district as a study area for example, Seshamani (2000) shows that, the district had 29.5% cases of HIV.

2.5 Zambian HIV and AIDS Situation

The HIV/AIDS epidemic is certainly not a new phenomenon in Zambia. There is evidence that HIV prevalence was already at significant levels in the mid-1980s and at high levels by the early 1990s (Fyikesnesi. et al 1994). This means that the rate of new people infected was very high.

In 1998, the estimated HIV prevalence rate for the entire country was at 19.7%. In urban areas, the prevalence rate among 15 – 49 years olds was more than 28%, in rural areas it

was 13.6%. Currently the HIV prevalence rate for the entire country is at 16% which is still very high (CSO, 2003).

Generally, women lack complete control over their lives and are taught to be submissive and obedient to males. Hence, dominance on male interest and lack of self-assertiveness on the part of women puts them at risk. In order to enhance male pleasure, a number of women continue practicing dry sex, which can increase vulnerability to infection through exposing genital organs to bruising and laceration (MOH, 1994).

Lusaka population has been hit by the deadly disease as shown by statistics given earlier on. (This is sometime due to men wanting to have many girlfriends and women wanting money from man-friends). Sexual satisfaction and prostitution which are regarded as a way of living are often the origins of HIV infection. Women being the most infected and affected victims of the disease in society still have limited knowledge and ability to come out in the open to exercise their capability to reduce the spread of the disease. Having eluded to the prevailing situation it is therefore important that the study investigates on how women participate in issues of HIV/AIDS.

CHAPTER THREE

3.0 STUDY AREA

3.1 Introduction

This chapter discusses the study area by highlighting the basic facts about the area. In this way there is enhancement of not only understanding but also being focused in the study. It looks at the location of the study area, population size, economic activities and the factors influencing the selection of the study area.

3.2 Location

Fig 3.1 is showing the location of Zambia in Africa. Zambia lies between latitude 6° South and 18°S and longitude 24°E and 36°E. Fig 3.2 shows the nine provinces of Zambia in which the study area (Lusaka Province) falls. Lusaka province has four districts namely: Luangwa, Kafue, Chongwe and Lusaka itself. The study area is in Lusaka District. Lusaka is the capital and the largest city in Zambia. It lies along the altitude of about 1 265 meters above sea level on the mid-tertiary plateau surface (Davies, 1971). Lusaka is centrally placed and on the line of rail, with road links to western, northern, southern and eastern provinces.

Misisi compound, which is the study area in Lusaka District is approximately 1 kilometre from the Central Business District (CBD) as shown in figure 3.3. It is approximately found within longitude 28°15′E and Latitude 15° 25′S. It is found between the great North Road and the line of railway, running from Livingstone to Kitwe.

3.3 Population

Lusaka is a leading single financial, commercial and industrial centre in Zambia. Its location originated in 1905 as a siding on the single-track railway built to serve the new broken hill mine (Kabwe). Its name was derived from Lusaaka, the headman of a nearby village (Davis, 1971). Misisi compound, being one of the oldest compounds in Lusaka, emerged in 1942 and now has 7000 households. It has a population of about 15571 males and 15030 females (CSO, 2003).

3.4 Economic Activities

The understanding of socio-economic activities in a place is so vital to make correct references. Those covered under this category are occupation, division of labour in house holds and how women and men participate in the labour force.

3.4.1 Division of Labour in Households

Two thirds to three quarters of households work is performed by women. Women spend 30 hours or more on housework each week while men spend around 10 – 15hours per week, (UN, 1995). Among household tasks the division of labour remains firm in most countries. Most men do not do the laundry, clean the house, make the beds or iron clothes, and most women do little household repair and maintenance. Even when they are in formal employment women do most of the housework.

3.4.2 Occupation

Misisi compound comprises of different tribes/languages from different parts of the country. Hence the kind of life found in the compound is of mixed cultures. They lead a subsistence kind of life and their major occupation is small-scale business. There are various activities towards income generation most of which hinge on sale of products such as those from farms, gardens and building materials (crushed stones and building sand). Women, who happen to be mainly responsible in providing food in homes, do most of the activities like brewing beer and collection of farm products and building materials. However, participation in development tends to be under the control of men. Besides the above, Misisi residents also cultivate along the line of rail and the road as well and grow crops like maize, sweet potato, pumpkin leaves and beans to supplement on their diets. Additionally these crops can be sold for cash hence being a source of income. Women in particular are used for labour in cultivation.

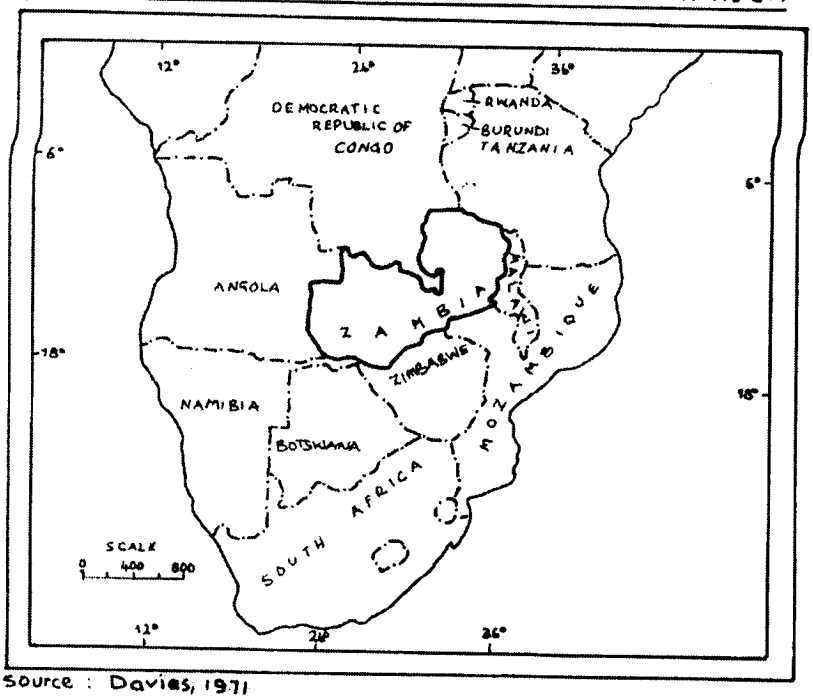
3.5 Factors which Influenced the Selection of the Study Area.

Misisi compound is situated approximately a kilometre away from the CBD, and this makes it prone to activities such as trading, prostitution and beer parties which tend to

make people be sexually active. The compound being not legalized at first by the government attracted a lot of people (mainly not educated) who came to look for employment in the industries but with the closure of some of the industries, many people were left jobless but decided to remain in the compound. It is this lack of education and employment that has led people to be involved in miscellaneous activities and this has prompted the researcher to carry out a study in the compound for these activities lead to high risks of contracting HIV.

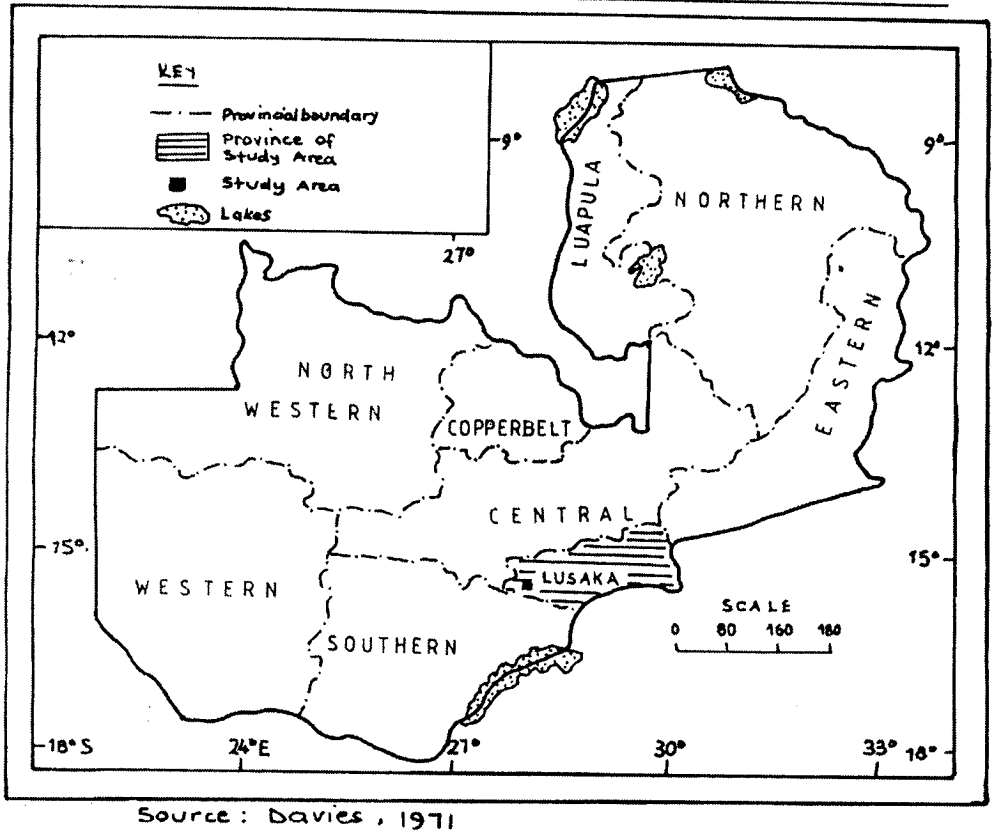
The researcher was also made to choose on Misisi compound for she spent her holiday in Lusaka, hence time and transport costs were cut-off., since it is a walking distance from the CBD to Misisi. The factors mentioned above it merited the selection of Misisi compound as a study area.

Fig.3.1 LOCATION OF ZAMBIA IN SOUTHERN AFRICA



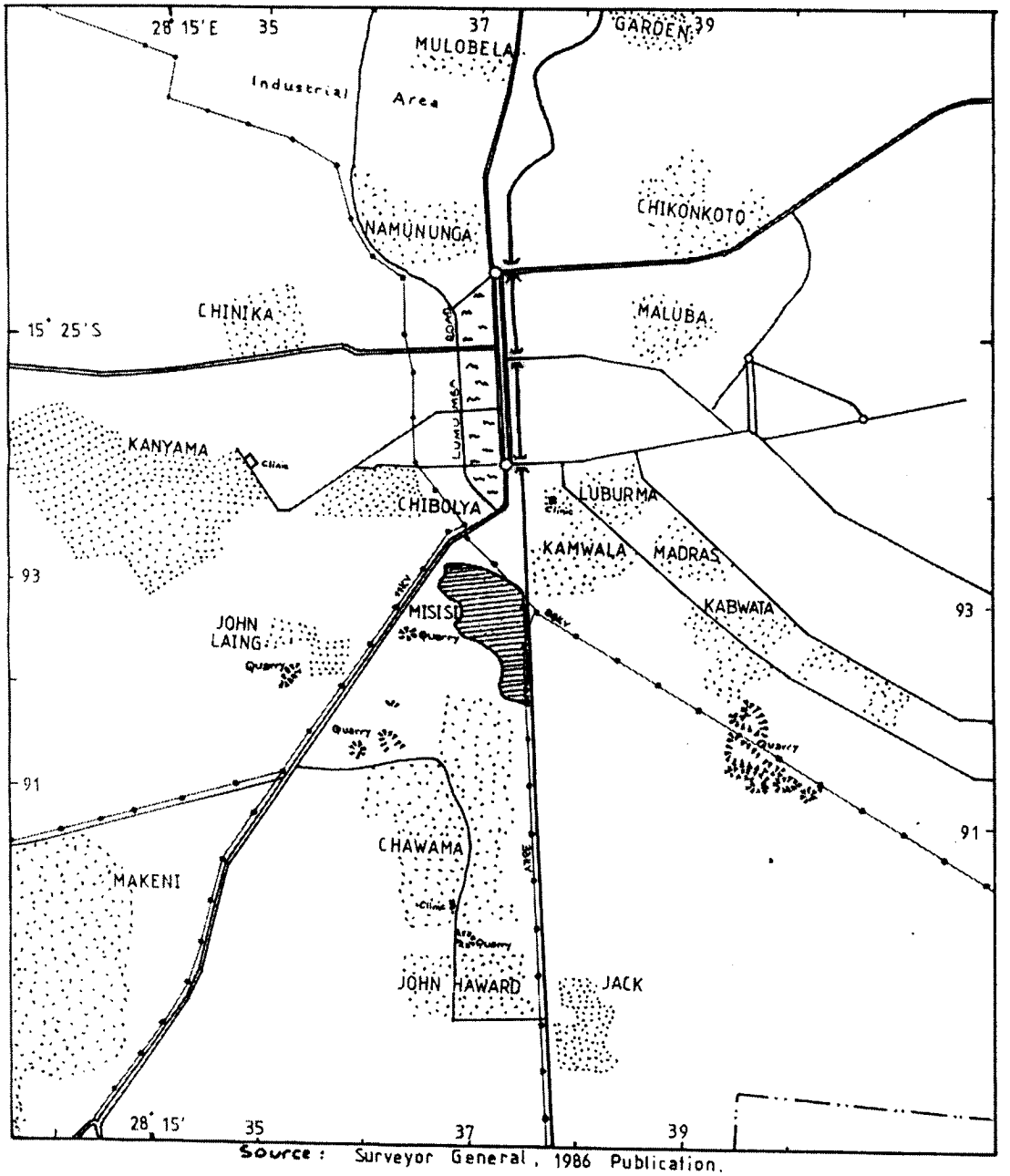
Source : Davies, 1971

Fig.3.2 LOCATION OF LUSAKA PROVINCE IN ZAMBIA



Source : Davies , 1971

Fig. 3.3. LOCATION OF MISISI COMPOUND IN LUSAKA DISTRICT - LUSAKA PROVINCE.



CHAPTER FOUR

4.0 METHODOLOGY

4.1 Introduction

The chapter discusses the sources of data, data collection methods, sample size and the sampling procedure, data analysis and presentation, as well as problems encountered during the research.

4.2 Sources of Data

The data sources were both primary and secondary. With due consideration that the majority of the urban poor women in developing countries have a low education background, questionnaires were administered in direct contact with the respondents in order to get proper information. In addition to this, data was sourced from libraries.

4.2.1 Primary Source of Data

Under this category, two groups of people were targeted as sources of data. These were, the women in Misisi compound and the leaders of the organizations involved in HIV/AIDS issues. The other primary source of data was direct observation by the researcher.

4.2.2 Questionnaires

These were administered in direct contact with sampled women of Misisi compound (See Appendix 1). The data collected was pertaining to women's knowledge about HIV/AIDS and women's involvement in caring for HIV/AIDS orphans and patients among other things.

4.2.3 Interviews

An interview was conducted with the coordinators for the Kara Counselling and St Lawrence Home based care project run by the Catholic (see Appendix II). The information collected included: when the organization started, what led to the formation of the projects, the projects involvement in the issues of HIV/AIDS in terms of what is offered, general performance of not only women but also men in the compound on HIV/AIDS programmes, and the projects future prospects with regards to women's participation in HIV/AIDS activities.

4.2.4 Direct Observation

Direct observation was equally another primary method used. With regards to this, not only what would be seen mattered, but also what was heard. Through mingling with various women in the compound, a lot of information was collected in terms of the attitudes and commitments of women in the health sector. These were vital for comparisons sake with data obtained through questionnaires.

4.2.5 Secondary Sources of Data

This involved the use of literature regarding the roles of women in the health sector. Books, journals and reports from libraries such as those at the University of Zambia and other resource centres were made use of. While reviewing literature, the main focus was on those dealing with urban poor women and their involvement in the health sector, particularly HIV/AIDS issues.

4.3 Sampling Frame

The total number of households in Misisi compound was got from CSO who provided the total number of males, females and households. Misisi has a total number of 7000 households, with 15571 males and 15030 females.

4.4 Sampling Size

A reasonable sample size of 40 households was chosen out of the 7000. This was due to resource and time constraints. This sample is reasonable because it exceeds the minimum required sample size of 30 in carrying out statistical tests. The obtained information was generalized across the number of women found in Misisi compound.

4.4.1 Sampling Procedure

A probability sampling method, which was most suitable, was used. With regards to this, the interval or systematic sampling method was employed. This was done in order to ensure that there is a representative sample of women across the compound in all sections.

The interval sampling was calculated using the following formula:

$K = N/n$ where K is the interval

N is the population size (i.e. 7000 in this case)

n is the number of respondents to be interviewed (i.e. 40 in this case)

Hence $K = 7000/40$

: - $K = 175$

The first woman to be interviewed was picked from houses numbered between 1 and 175 using simple random tables. Therefore, every 175 household was sampled and included in the research.

4.5 Data Analysis and Presentation/Processing

Data was processed manually through the evaluation of the questionnaires. This is because the data collected was qualitative nature. The data was then analysed and the percentages of the various responses were worked out and presented in either pie charts or tables.

4.6 Limitations to the Study

There were two major limitations, that is, time and resources and/or money. The time to carry out the research was relatively short. The factor was compounded by the fact that resources and /or money were or was not enough. For one to spend a lot of time collecting the data, it required reasonable resources and /or money which were not available.

Some respondents were difficult to interview as they said they were too busy with other things i.e. selling on the streets, and others thought the researcher was from a satanic church, hence could not accept to be interviewed.

CHAPTER FIVE

5.0 RESEARCH FINDINGS

5.1 Introduction

This chapter presents the research findings to the study. The issues covered include: the characteristics of the sample, the knowledge of the respondents on HIV/AIDS issues, and women's participation in HIV/AIDS programmes among other things.

5.2 Characteristics of the Sample

The sample size consisted of 40 respondents who were all women. Hence it was biased towards women. The main aim was therefore to investigate on the participation of women in HIV/AIDS issues.

5.2.1 Age of the Respondents

Table 5.1 shows the age distribution of the respondents. The majority of the respondents were between the age of 21 – 30 which accounted for 17 (42.5%) of the sample. Those between the ages of 31 – 40 accounted for 30%. Those between the age of 10 – 20 accounted for 12.5% and those with the age above 41 accounted for 15%.

Table 5.1 Age of the Respondents

Age in Years	No. of Respondents	%
10 – 20	5	12.5
21 – 30	17	42.5
31 – 40	12	30.0
41+	6	15.0
Total	**40**	**100.0**

Source: Field Data (2004)

5.2.2 Marital Status of the Sample

The respondents fell into four (4) groups with respect to their marital status: Single, married, widowed and separated. Table 5.2 shows that 20 (50%) of the

sample were married, 13(32.5%) were single, 5(12.5%) were widowed, and 2(5%) separated.

Table 5.2: Marital Status of the Sample

Marital Status	No. of Respondents	%
Single	13	32.5
Married	20	50.0
Widowed	5	12.5
Divorced/Separated	2	5.0
Total	**40**	**100.0**

Source: Field Data (2004)

5.2.3 Household Size

Table 5.3 shows that the respondents with the household size ranging from 1 to 5 were 19 (47.5%) and those ranging from 6 to 10 were 19 (47.5%). Those ranging from 11 to 15 accounted for 1 (2.5%), and those with 16 and above accounted for 1 (2.5%).

Table 5.3 Household Size

Size of Household	No. of Respondents	%
1 – 5	19	47.5
6 – 10	19	47.5
11 – 16	1	2.5
16+	1	2.5
Total	**40**	**100.0**

Source: Field data (2004)

5.2.4 Educational level of the respondents

Table 5.4 shows the educational level of the respondents. More than half of the women 22(55%) had attained secondary education, 13 (32.5%) had primary education, 2 (5%) had post secondary education and 3 (7.5%) had no education at all.

Table 5.4 Respondent's Highest Educational Attainment

Level of Education	No. of Respondents	%
No education	3	7.5
Primary	13	32.5
Secondary	22	55.0
Post-Secondary	2	5.0
Total	**40**	**100.0**

Source: Field data (2004)

5.2.5 Spouses' Highest Educational Attainment

Table 5.5 shows the spouses' highest educational attainment. From the study, it was found that of the 20 respondents who were married, 11(27.5%) of them had spouses with no secondary education, 3(7.5%) had primary education, 4(10%) had post-secondary education, and 2(5%) had no education at all.

Table 5.5 Spouses' Highest Educational Attainment

Level of education	No. of Respondents	%
No education	2	10.0
Primary	3	15.0
Secondary	11	55.0
Post-secondary	4	20.0
Total	**20**	**100.0**

Source: Field data (2004)

5.2.6 Occupation of Respondents

All the 40 respondents had something to do to sustain their livelihood. Home makers accounted for 13 (32.5%) of the sample, business persons accounted for 10 (25%), maids accounted for 3 (7.5%), casual workers accounted 2 (5%), tailors accounted for 2 (2.5%), sex workers accounted for 5 (12.5%), and nurses, teachers, office orderlies and students accounted for 4 (10%). Table 5.6 shows the various kinds of jobs which the respondents in the study area were involved in.

Table 5.6 **Occupation of Respondents**

Job Description	No. of Respondents	%
Nurse Assistant	1	2.5
Nurse	1	2.5
Teacher	1	2.5
Office Orderly	1	2.5
Business	10	25.0
Maid	3	7.5
Casual Worker	2	5.0
Tailor	2	5.0
Home maker	13	32.5
Student	1	2.5
Sex Worker	5	12.5
Total	**40**	**100.0**

Source: Field data (2004)

5.2.7 Occupation of Household Head.

Some households were headed by men who were husbands to the respondents, while others were headed by females (meaning the households had no male heads). Table 5.7 shows the occupation of the heads of the households. The field data reveals that only 15% of the household heads were employed in the formal sector, while 85% of them were in informal employment.

Table 5.7 **Occupation of the Head of the Household**

Job Description	Type	No. of Respondents	%
Nurse Assistant	Formal	1	2.5
Nurse	Formal	1	2.5
Teacher	Formal	1	2.5
Police Officer	Formal	1	2.5
Driver	Formal	3	7.5
Clerk	Formal	1	2.5
Shopkeeper	Informal	2	5.0
Maid	Informal	3	7.5
Tailor	Informal	2	5.0
Carpenter	Informal	1	2.5
Casual worker	Informal	5	12.5
Self	Informal	1	2.5
Students	Informal	1	2.5
Business	Informal	10	25.0
Sex worker	Informal	5	12.5
Total		**40**	**100.0**

Source: Field Data (2004)

5.3 Women's Perception of HIV/AIDS Issues

The survey showed that most respondents knew that AIDS is a killer disease. This is because most of their relatives are suspected to have died from AIDS. Of the 40 respondents, 24 (60%) said they had their relatives who died from suspected AIDS. Among those who died were their parents, spouses, uncles, to mention but a few.

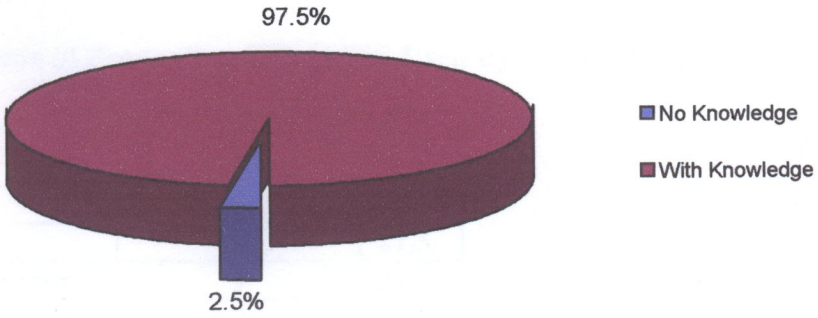
5.4 Women's Participation in HIV/AIDS Issues

The survey showed that the respondents participated in a number of activities attached to HIV/AIDS. These are activities such as keeping AIDS orphaned children, giving care and medication to the infected persons, giving food to the sick, counselling, and carrying out sensitization programmes on HIV/AIDS through drama and music. Of the 40 respondents, 18 (45%) were keeping orphans. The community AIDS activities were carried out by 15 (37%) from the sample.

5.5 Respondents Knowledge on HIV/AIDS Issues

Almost all the respondents had knowledge on HIV/AIDS. The survey shows that out of the 40 respondents, 39(97.5%) had the knowledge concerning HIV/AIDS, while only 1 (2.5%) had no knowledge of HIV/AIDS. Fig. 5.1 shows these distributions by percentage.

Fig 5.1 Respondents Knowledge on HIV/AIDS



Source : Field data (2004)

5.6 Knowledge of Organizations Dealing in HIV/AIDS

The survey shows that 43% of the respondents had knowledge on organizations dealing in HIV/AIDS issues while 57% of them had no knowledge of these Organizations mentioned were: the Kara Counselling and Testing, and St. Lawrence Home Based Care.

5.7 Methods of HIV/AIDS Prevention which the Respondents Knew.

With the little or no education that women in Misisi Compound had, the survey showed that the methods known for HIV/AIDS prevention were: condoms, abstinence, having one sexual partner, and using sterilized razor blades and sharp utensils. It shows that 39 (97.5%) of the respondents knew these preventive measures, while only 1 (2.5%) did not know of any method.

5.8 Respondents' Protective Methods against HIV/AIDS Infection

Table 5.8 shows the methods of prevention against HIV/AIDS infection that are used by the respondents. It shows that those who abstained from sex as a way of preventing HIV/AIDS infection were 11(27.5%), those who use condoms were 11 (27.5%), those who have one sexual partner were 9(22.5%), and those who do not use any method of prevention were 9 (22.5%).

Table 5.8 Methods of Preventing HIV/AIDS Used by Respondents

Method	No. of Respondents	%
Abstinence	11	27.5
Condoms	11	27.5
One sexual partner	9	22.5
No method	9	22.5
Total	**40**	**100.0**

Source: Field data (2004)

5.8 Ways of Infection

Different respondents knew different ways of infection with HIV. Table 5.9 shows that almost all the respondents 39 (97.5%) knew that HIV virus is got through having sexual intercourse with an infected person. While others said the virus was got through the use of unsterilised razor blades, syringes, needles, and etcetera. These accounted for 27 (67.5%). Those who argued that the virus is got through blood transfusion accounted for 15 (37.5%) and those who said it was through kissing accounted for 5(12.5%). Lastly, 1 (2.5%) said it was through hand shaking.

Table 5.9 Ways of Infection

Way	Number of respondents
Sexual intercourse with infected person	39
Blood transfussion	15
kissing	5
handshaking	1
Unsterilised razor blades, syringes, needles	27

Source: Field Data (2004)

5.9 Respondents' Family Discussions on HIV/AIDS Issues

The survey showed that 28 (70%) did discuss HV/AIDS issues while 12 (30%) did not discuss with their families. Their discussions were based on preventive measures and the effects of AIDS. Of the 28 who discussed HIV/AIDS issues with their families, those who were free to do so accounted for 96.4% while only 3.6% were not free to do so.

5.10 Willingness to Open up to the Public if Discovered HIV Positive.

The survey showed that some respondents were for the idea of publicizing their HIV status while others were not. Those who were willing to publicize their status if found HIV positive accounted for 45%, while those who were not willing accounted for 55%.

5.11 Acceptance of Leadership in an Organization Dealing in HIV/AIDS Issues

When asked as to whether they would accept leadership, 30% of the respondents said they would not accept leadership while 70% said they would. The reasons given by those who would not accept are shown in table 5.10.

Table 5.10 Reasons for Refusing to Accept Leadership in an HIV/AIDS Organization

Reason	No. of Respondents	%
Not allowed by husbands	1	2.5
No time/busy	6	15.0
No qualifications	5	12.0
Total	**12**	**30.0**

Source: Field data (2004)

CHAPTER SIX

6.0 DISCUSSION OF RESEARCH FINDINGS

6.1 Introduction

This chapter will discuss the findings of the research which was carried out on women in Misisi compound. The discussion will try to answer the research questions used in the study. The areas that will be tackled are: the respondents' knowledge about HIV/AIDS, methods used by respondents to protect themselves from being infected by HIV and respondents' care-taking of HIV/AIDS patients and orphans among other things.

6.2 Knowledge about HIV/AIDS

People's knowledge about HIV/AIDS is one of the important present-day solution pertaining to HIV/AIDS prevention. According to the survey data shown in fig.5.1, 39(97.5%) out of the 40 respondents had knowledge concerning HIV/AIDS. The respondents also know that AIDS is a killer disease due to its devastating impact on the community. Furthermore, they are either infected or affected by the pandemic. Because of this, they are very much sure that HIV does not choose who to infect. Those who where affected had lost some of their relatives through AIDS and were keeping AIDS orphaned children.

According to MOH/CBOH (1999), knowledge concerning HIV/AIDS is virtually universal among Zambian adults, as most of them understand that it is a fatal disease and that no cure is available. Moreover, more than four out of every five adults know that people can take positive actions to avoid transmission of the virus. Similarly, more than 80% of adults know that even health looking people can be HIV positive while 70% of adults know some one who has died from AIDS.

6.3 Methods used by Respondents to Protect themselves from Being Infected by HIV/AIDS

Misisi residents use different methods to protect themselves against HIV/AIDS as shown in table 5.8. The mentioned methods are condoms, abstinence, having one sexual partner, and use of sterilized sharp utensils. However, although 39(97.5%) of the respondents knew these preventive measures of HIV infection, 9(22.5%) of them were not using any of the methods. There were a number of reasons given by the respondents as why they were not using the methods of being AIDS free and the following are some of the reasons: spouses' refusal to accept the idea of using any safer sex method and traditional values prevalence. These can therefore be considered to be factors that have contributed to high HIV prevalence in Zambia. These have resulted in a raging and pervasive HIV/AIDS epidemic that has left no corner of Zambia untouched. It is therefore evident that basing on the findings from the survey, it can be deduced that most of the people in Misisi compound are aware of the HIV/AIDS pandemic and ways of staying safe.

6.4 Care-taking of HIV/AIDS Patients and Orphans

According to the research findings, there are a number of respondents who are taking care of HIV/AIDS patients and orphans. Those who were taking care of HIV/AIDS patients were 5(12.5%) and 18(45%) of the respondents were taking care of AIDS orphans. It can therefore be argued that since these women are already under privileged in terms of resources, the additional burden of keeping the sick as well as orphans can make them be involved in miscellaneous activities leading to HIV/AIDS risks.

6.5 Family Discussion on HIV/AIDS Issues

It is important for people to discuss HIV/AIDS issues so that the nature of the disease, consequences of being infected and the prevention measures are known to all people. According to the survey, 28(70%) of the respondents discussed HIV/AIDS with their families. The discussion had to do with the preventive measures on HIV/AIDS. Such discussions help the family members to know that HIV can be transmitted through having sexual intercourse with an infected person among other things. Such knowledge helps

people to make informed decisions in their lives. The organizations dealing with HIV/AIDS issues have also helped in sensitizing the public on HIV/AIDS.

However, one of the biggest problems in addressing the HIV/AIDS pandemic is that people have often avoided admitting being infected with the virus. This is because of the fear of stigmatization and discrimination attached to it. Therefore, as shown in section 5.10 only 18 (45%) out of 40 respondents were willing to publicize their HIV status if found positive while 22 (55%) argued that they would not. Unwillingness to publicize one's status and how one is coping with it, limits the diffusion of more knowledge concerning HIV/AIDS to the general public. This increases the risk of transmission of HIV to others. Therefore, parents or guardians should be encouraged to discuss HIV/AIDS issues with the household members to make them pioneers of information dissemination to the community.

6.6 Organizations Involved in HIV/AIDS Issues

There are two organizations dealing with HIV/AIDS issues in Misisi compound. These are Kara Counselling and St Lawrence Home Based Care. The activities which they are involved in are counselling, giving food and medication to the sick, sensitization programmes through drama and music and keeping HIV/AIDS orphans. The HIV/AIDS patients are visited in their homes by care givers from both organizations. The organizations carryout these activities hand in hand with Misisi community. These organizations have contributed a lot to Misisi community because apart from caring for the sick and orphans, they have also created employment especially to those who congregate with the Catholic Church. The organizations are also sensitizing the community on HIV/AIDS dangers and how to remain safe from HIV infection.

The 47% of the respondents who are not aware of these organizations seem to have closed their eyes to social activities. This could be because of their low educational status and their unwillingness to engage themselves in developmental activities. This state of affairs has also led them into poverty. This conforms to GRZ (2002) which states that women are more vulnerable to poverty as they have lower education attainment levels.

Education reduces vulnerability to a variety of factors such as streetism, prostitution and dependence especially of women on men which are a breeding ground for HIV infection.

6.7 Employment Status

Lack of economic growth is one of the factors leading to deprivation of women's participation in HIV/AIDS issues. There are increased income inequalities between males and females leading to persistent discrimination against women and the girl child, insufficient investment in economic and social infrastructure to keep pace with requirements for rapid economic growth, and the HIV/AIDS pandemic. As shown in table 5.1, most of the residents in Misisi compound are in informal employment and thus this can not empower them to get high incomes to support them economically and hence can not afford to monitor their health status. Most of them are thus involved in promiscuous activities of either beer drinking or prostitution leading to high risks of contracting HIV.

Efforts of poverty reduction cannot bear sufficient fruits unless complimented by simultaneous efforts to address the problem of HIV/AIDS. Slow economic growth is therefore one factor that leads to low participation of women in HIV/AIDS issues. This is because they are forced to engage themselves in other ventures to supplement their small incomes.

Poverty affects men and women differently, hence the terminology 'feminization of poverty'. According to the survey data, table 5.1 shows that 85% of household heads were involved in informal employment but of these, at least those with assurance of a salary were male headed house heads. According to (CSO: 1998), the incidence of poverty by sex of household head showed that female headed households were more likely to be extremely poor than those in the male headed household. The records show that 77% of all persons with female headed households were poor compared to 72% of male headed household.

6.8 Acceptance of Leadership

According to the survey as shown in table 5.10, not all respondents would accept leadership if any organization dealing with HIV/AIDS issues was to be introduced in the compound. Of those who would not accept leadership, one of them said she was not allowed by her husband, six were busy with house chores and others businesses and the other five said they were not fit as they had no qualifications for leadership. Women have no control over their husbands and hence cannot easily access health facilities (MOH/CBOH: 1998). The most prominent factor in such situations is lack of education. Women will have no voice in the home, be overloaded with housework and even refuse to do what is right for their lives. Hence women should be empowered education wise and economically. There should be no intimidation from men.

CHAPTER SEVEN

7.0 CONCLUSIONS AND RECOMMENDATIONS

7.1 Introduction

The purpose of this chapter is twofold. On one hand, it summarizes the major findings of this study while on the other hand, it offers recommendations not only for future interventions but also research related to this subject.

7.2 Conclusions

The overall intention of this study was to find out the participation of women in HIV/AIDS issues. Particularly, the focus was on women in Misisi Compound in Lusaka. The following are some conclusions on the objectives of the study:

- Firstly, the knowledge about HIV/AIDS by women in Misisi Compound was looked at and was found out that 39(97.5%) of the respondents knew about HIV/AIDS. This knowledge was got through the media, clinics, and organizations and also through personal experience from their relatives who died of suspected AIDS.
- With the issue of preventive methods from getting HIV, the women knew of preventive methods such as; condoms, abstinence, one sexual partner and using sterilized needles. Almost all respondents knew these methods except for one. Of the 40 respondents, 31 practiced these methods while 9 of them did not. This entails that the women who do not use any of the methods are at a high risk of contracting the HIV, and this will affect manpower levels country wide.
- Special attention was paid to the participation of women as well as their performance in activities of HIV/AIDS. The specific objective was to investigate if at all women participated in taking care of HIV/AIDS orphans and patients. It was discovered that women in Misisi participated in caring for the sick and looking after orphans.
- Women in Misisi Compound did discuss issues on HIV/AIDS with their family members and the issues were: how one gets infected; effects of HIV/AIDS and the preventive measures (see section 5.9). The more people discuss the

HIV/AIDS pandemic, the more people become aware of the disease, and the more they become careful with their sexual behaviours.

- There are two organizations that deal with matters related to HIV/AIDS in Misisi Compound namely: Kara Counselling and St.Lawrence Home Based Care. The organizations offer services such as: care giving to the sick, medication, education to HIV/AIDS orphans, sensitization programmes on HIV/AIDS through drama and music. Consequently, these women are able to know about HIV/AIDS and how to care for the sick, among other things.

7.3 Recommendations

Having considered the role that women play in HIV/AIDS issues, the following recommendations have been made:

1. The government should give special attention to rural and urban poor women in the informal sectors. All barriers that hinder progress in this respect should be removed. Such barriers include customary laws or culturally and socially ascribed gender roles. These should be repealed not theoretically but practically. It is no time to engage in unprofitable political debates. All that is needed is to practically level the playing field. Then the fruits will tell.
2. Non-Governmental Organizations (NGOs) and the government need to take the challenge of sensitizing the urban women on their social, political, and cultural rights. Hand in hand with this, there is need to sensitize more on gender issues as this has misled a lot of people especially men who think that women are now taking over their roles. However, men should not be sidelined in these sessions as most of them misunderstand the concept. Sidelining men can even cause more harm than good. Hence, there is need for proper approach lest the situation worsens. Probably men should address their fellow men.
3. There is need to reduce social – economic impact of HIV/AIDS and the main focus should be individuals and families, at the workplace, in homes, and on the whole Zambian society. The government should promote positive and healthy living among the asymptomatic HIV positive people by expanding the voluntary counselling and testing (VCT) services through funding the organizations

involved in issues of HIV/AIDS. Accessibility to VCT services should be expanded even to the poor. The ARVs should also be made available to everyone.

4. The government should further empower women educationally by providing or re-introducing adult literacy where the less educated and those women who did not go to school at all can learn to read and write because this can empower women with the right decision making.

7.4 Suggestion for Future Research

Despite the fact that the results from this study can serve as a basis for more detailed research, it has not been able to consider men's viewpoints. Therefore, there is need for future researchers to balance up men's viewpoints with those of women. For instance, the role of men and women in the health sector can be looked at from both view points. Mapping these viewpoints would be beneficial to planners, more especially if the areas to be studied were many. The future research should also look at how effective ARVs can be distributed to HIV/AIDS patients to benefit everyone who is infected.

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APPENDIX I

QUESTIONNAIRE ON WOMEN'S PARTICIPATION IN HIV/AIDS ISSUES IN MISISI COMPOUND- LUSAKA

Dear Respondent,

I am Kanyamuna Beatrice a third year student at the University of Zambia in the School of Education carrying out a research on women's participation in HIV/AIDS issues. This is in partial fulfilment in the award of Bachelor of Arts Degree with Education. Hence, be assured that the information you will give will be treated as confidential and is purely for academic purposes only.

Please feel free to answer the questionnaire.

SECTION A- BASIC INFORMATION

1. What is your age? .....
2. What is your marital status? Please tick
   - Single ☐
   - Married ☐
   - Widowed ☐
   - Divorced ☐
   - Separated ☐
3. What is the size of your household? .....
4. What is your occupation? .....
5. What is the occupation of the head of the household?
6. What is your highest educational attainment? .....
7. What is your spouse's highest educational attainment?

SECTION B GENERAL INFORMATION

8. Do you have any knowledge of HIV/AIDS? Please tick

   Yes ☐ No ☐

9. How is HIV/AIDS acquired? Tick correct answers
   - (a) Through Kissing ☐
   - (b) Through shaking hands ☐
   - (c) Sexual intercourse with an infected partner ☐
   - (d) Use of razor blade, syringes already used by infected people ☐
   - (e) Blood transfusion ☐
   - (f) Sharing the same bed with an infected person. ☐
10. Where did/do you get information on HIV/AIDS issues? Please list

    .....

11. Have you lost any of your family members through HIV/AIDS? Please tick

    Yes ☐ No ☐

    If 'Yes' proceed to question 12 above, if 'No' go to question 15

12. Which of the following family members have you lost? Please tick,

(a) Father ☐ (e) Child ☐

(b) Mother ☐ (f) Uncle ☐

(c) Brother/s ☐ (g) Aunt ☐

(d) Sister/s ☐ (h) Any other specify .....

13. Are you keeping any of the orphans form the person/s mentioned in question 5? Please tick

Yes ☐ No ☐

If 'yes' proceed to question 14, if 'No' go to question 15

14. How many are you keeping? .....

15. Are you keeping any HIV/AIDS patients?

Yes _____ No _____

16. Do you know of an organization that deals with HIV/AIDS issues in Misisi compound? Please tick

Yes ☐ No ☐

If 'yes' proceed to question 17, if 'No' go to question 18.

17. What programmes do the organizations offer to the community in as far as HIV/AIDS issues are concerned?

.....

.....

.....

18. Are you as an individual involved in some activities, which are tailored to assist the community in the area of HIV/AIDS? Please tick.

Yes ☐ No ☐

If 'yes' proceed to question 19, If 'No' go to question 20

19. Which activities are you involved in?

.....

.....

20. What methods of preventing HIV/AIDS do you know? Please list.

a. .....

b. .....

c. .....

d. .....

21. Which of the above methods mentioned do you use to prevent HIV?

Please specify .....

22. How often do you use the method mentioned above? Please specify

.....

23. How do you regard the traditional teaching that woman must be available for Sex whenever the partner asks for it? Please specify

.....

.....

24. Do you practice dry sex with your partner? Please tick?

Yes ☐ No ☐

If 'yes' proceed to question 25, if 'No' go to question 26.

25. Why do you do that? .....

.....

26. Suppose you were tested positive for HIV, would you come out in the open or would you be free to tell others about your status? Please tick

Yes ☐ No ☐

If 'yes' proceed to question 27, if 'No' go question 28

27. Give reason as to why you will not do so.

.....

.....

28. Do you discuss AIDS issues with your family? Please tick

Yes ☐ No ☐

29. What do you discuss? .....

.....

30. How free are you in doing this? .....

.....

31. If chosen to be a leader in an AIDS organization, would you accept the appointment? Please tick

Yes ☐ No ☐

If 'No' proceed to question 32.

32. Why would you refuse to accept the offer?

.....

.....

Thank you very much for your time

END

APPENDIX II

Questionnaire for Organizations Dealing with HIV/AIDS Issues

SECTION A

Background Information

Section A looks at the background information of the organizations' co-coordinators.

Sex_____
What is your position in this organization? _____
How long have you worked for this organization? _____

SECTION B

Organization's background information and services

Section B looks at the background information of the organizations and the services offered.

What is the name of the organization? _____
When was the organization formed? _____
How many members of staff do you have in this organization?
Men _____ Women _____
What factors influenced the formation of the organization?_____
_____
Who are the targeted persons in this organization? _____
_____
What services do you offer as an organization to the community? _____
_____
Do you have any projects dealing with HIV/AIDS activities? _____
Are there any women that participate in these activities and how active are they?
_____
From the services that are offered by the organization, how many people have you identified living with HIV/AIDS? _____
Apart from your own initiative on funds, do you receive any funding from any other organizations found in Zambia? If any is it sufficient to for your requirements?
_____
What challenges do you face in the provision of the services to the community as an organization? _____
What are they prospects of this organization concerning HIV/AIDS issues?
_____

THE END