KNOWLEDGE, ATTITUDES AND SEXUAL BEHAVIOURAL PRACTICES AMONG THE HEARING IMPAIRED PUPILS IN ZAMBIA IN THE ERA OF HIV AND AIDS. *THE CASE OF MAGWERO SCHOOL FOR THE DEAF IN EASTERN PROVINCE OF ZAMBIA*

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BY

REDGES MUNSAKA MULEYA

A dissertation submitted to the University of Zambia,
Gender Department in partial fulfillment of the
requirements for the award of the degree of

MASTER OF GENDER STUDIES

THE UNIVERSITY OF ZAMBIA

JUNE 2010

DECLARATION

I, REDGES MUNSAKA MULEYA declare that this dissertation:

(a) Represents my own work

(b) Has not previously been submitted for a degree at this or any other University; and

(c) Does not incorporate any published work or material from another dissertation.

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APPROVAL

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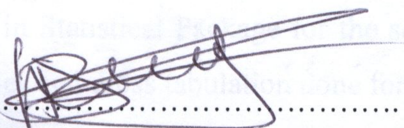
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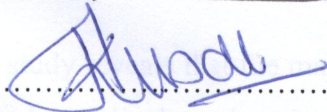
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EXECUTIVE SUMMARY.

This study was carried out to investigate the HIV and AIDS-related knowledge, attitudes, beliefs and sexual behaviors of hearing impaired students at Magwero School for the deaf in eastern province. The level of HIV prevalence in Zambia is at 16 percent for the youth and the young people are being disproportionately affected. The study was targeting the hearing impaired adolescents, knowledge about STDs and HIV transmission and prevention. Another concern was about the condom use and how HIV and AIDS- related attitudes and beliefs could be influencing the sexual behaviors of the deaf teenagers.

Relevant local, regional and international HIV and AIDS literature was reviewed. Data for the study was collected through both quantitative and qualitative approaches. A detailed questionnaire was administered to 75 teenage students selected from Magwero School for the deaf. Three Focus Group Discussions (FGD) were also conducted to gain deeper insights into issues not sufficiently covered by the questionnaire. Data was captured in Statistical Package for the social sciences (SPSS) computer programme and frequencies and cross tabulation done for analysis.

The study reveals that the majority of the deaf pupils at Magwero School for the deaf, in secondary school, are kept by their own parents some of them single while others are kept by their guardians who ranged from uncles, aunties and grandparents. The study also revealed that most of the respondents where in boarding while others are day scholars.

The awareness about HIV and AIDS was almost universal with almost 100% of the respondents having the knowledge on how AIDS is transmitted from one person to another and how they can protect themselves from infection. On STDs, the male participants had comparatively better knowledge on the names and symptoms of various STDs. The majority of the respondents believed the use of condoms reduces sexual pleasure while others stated that prolonged use of condoms has side effects.

This study further revealed that anti-AIDS club at Magwero School for the deaf has played a major role in disseminating HIV and AIDS information. Also it was discovered

that the impact of the country's interactive media such as television, radio and newspapers on HIV and AIDS information has not benefited the deaf pupils compared to their hearing counterparts. The other sources of information revealed in the study are the interpersonal communications about AIDS which was highly common among the respondents.

In terms of access, the study indicates that both male and female respondents have equal access to HIV and AIDS in general, except in isolated incidences such as access to information about STDs and condom use, males had more information. Most respondents did not see their parents as reliable sources of HIV and AIDS information mostly because they saw their parents as too strict and authoritative. Also the traditional beliefs make the discussion with parents of any issue related to sex a taboo in almost all Zambian societies difficult.

The study indicates that despite the HIV and AIDS information that the respondents have acquired many of them still lack the ability to modify their behavior, more so with female respondents who are seen in many ways or being less empowered to make decisions about their sexual health. Indications from the research are that many deaf pupils especially girls become sexually active at a very tender age.

A number of the female respondents who took part in this study first had sex when they were merely ten years. Reasons for having sex ranged from, being forced into it to the fear of loosing their boyfriends. For male respondents one of the main reasons for having sex was to be accepted by their peers in an environment where high expectations are linked to a boy's sexual orientation and performance.

This research has also shown that more hearing impaired adolescents at Magwero have low risk perceptions. On condom use, the study discovered that several misconceptions which have ultimately contributed to negative attitudes related to the usage of condoms among the respondents. Fear of pregnancy was the major reason why many deaf especially girls preferred to use condoms during sex but not the fear of contracting HIV

and AIDs. Surprisingly many female respondents stated that virginity is an out dated concept. Preventive tailored educational HIV and AIDS programme must be intensified and made more comprehensive to bridge the information gap among the hearing impaired pupils.

DEDICATION

I dedicate this work to my loving mother who inspired me to fight for my freedom. Her encouragement to me on issues of life has encouraged me to study Gender issues. May God giver her long life and live to eat the fruits of her labor.

ACKNOWLEDGMENT

I want to express my sincere gratitude to my supervisor, Dr. J. R.S. Malungo, senior lecturer in the Demography Division, Department of Social Development Studies, School of Humanities and Social Sciences, University of Zambia, whose patience, guidance, advice, insightful comments and encouragement gave me the zeal to work hard in preparing the dissertation. I also wish to sincerely thank Dr R. M. Macw'angi, Dr.K.Kusanthan, Dr. F. Gadsden and Dr.T. Rising all lecturers in the Department of Gender Studies, for their assistance whenever I needed them. Sincere thanks also go to Mr. Mandyata, Mr. Jones, Mr. Kani and Miss M. Simalalo for their assistance during my proposal preparation.

Special thanks also goes to management of Magwero School for allowing me to collect data from the school through interviews and administering questionnaires and conducting focus group discussion at the school. I also sincerely thank the participants in the study for their cooperation during the data collection process. Special thanks also go to Mrs. Maboshe Mubanga for being available each time I needed this work to be typed.

Finally, special thanks also go to my family, my husband, Mukendwa, for his guidance and support during my study. My sons, Joe, Lufe, Vivian, my only daughter Sepo Deborah and my nieces Febby and Mama. This is for their support and encouragement during my study. I don't forget my Almighty God who gave me life and strength during this study. Thank you Father. May Your Name be glorified, Amen.

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ACRONTYMS AND ABBREVIATIONS

AIDS	-	Acquire Immune Deficiency Syndrome
CBOs	-	Community Based Organization
CBOH	-	Central Board of Health
FBOs	-	Faith Based Organization
FGD	-	Focus Group Discussions
NGO	-	Non Governmental Organizations
PPAZ	-	Planned Parenthood Association of Zambia
SRH	-	Sexual Reproductive Health
STI	-	Sexually Transmitted Infections
STDs	-	Sexually Transmitted Diseases
HIV	-	Human Immune Virus
UNAIDS	-	United Nations AIDS Agency
UNICEF	-	United Nations Children's Education Fund
WHO	-	World Health Organization
UNESCO	-	United Nations Educational Scientific Cultural Organization

CHAPTER 1: INTRODUCTION AND BACKGROUND TO THE STUDY.

1.1 BACKGROUND TO THE STUDY

Since the early 1980s when the first case was diagnosed in the United States of America (USA), HIV and AIDS have grown into a serious global epidemic. The world health Organization (WHO) (2004), says that HIV and AIDS is a serious threat to mankind and its impact will extend to future generations.

According to the Joint United Nations Programme on HIV and AIDS (UNAIDS) and WHO (2004:2), an estimated 39.4 million adults and children, were living with AIDS. About 2.7 million were recorded in 2002 alone. Young people particularly the female ones are at the centre of the global epidemic. The United Nations populations fund (UNFPA) (2006), indicated that over 1 billion youth (aged 15 to 24 years), and worldwide are living positive. The study also indicated that young females are 1.6 times as likely as young men to be HIV positive. And every day, about 6,000 youth are infected with the virus. Sub- Saharan Africa (SSA), is the most affected region in the world (Jackson 2002; UNAIDS/WHO, 2002; WHO, 2004). For every 12 African adult, one is living with HIV and AIDS (WHO 2004:1). The UNFPA (2006), reported that 63% of the 15 to 24- year- old people living with HIV live in SSA, 21% in the Pacific region and 1% in the industrialized countries of Western Europe and North America.

The prevalence rate of HIV and AIDS among the pregnant antenatal attendees is the largest in Southern Africa and the prevalence gaps are growing wider (UNAIDS/WHO 2004).The Zambian government, civil society and other non-governmental organizations have embarked on anti HIV and AIDS campaign programmes aimed at informing the nation about the negative consequences of HIV and AIDS. Undoubtedly the HIV and AIDS pandemic has affected all sectors of the Zambian societies, although the vulnerability of women and young people especially the deaf requires that they be given special attention in as far as prevention programmes are concerned. The Demographic Health Survey (DHS)

of 2007 indicates that the knowledge of HIV and AIDS in Zambia is almost universal and nearly 100% (CSO, 2007).

There is, however, little known about how much the deaf know about HIV and AIDS. Most of HIV and AIDS messages are in printed materials, television and radio. The information can not reach the deaf because they cannot hear. In addition, most deaf pupils have poor reading skills and therefore very few can benefit from the HIV and AIDS written materials (Kelly, 1991).

In the midst of so much research done on the youth in relation to HIV and AIDS, there has been however no information on the hearing impaired youth in relation to the disease, and yet, globally10% of the world's populations are people living with disability and 8% of these live in developing countries (Hellender, 1999).

Deaf adolescents also go through maturation stages of puberty like any other person without disability (Patton, 1987). During this stage, young people are prone to taking risks by engaging in various experimental behaviors. The deaf adolescents may therefore find themselves engaging in sexual activities without full knowledge of the dangers of HIV and AIDS.

1.2 STATEMENT OF THE PROBLEM

Reaching hearing impaired adolescents with HIV and AIDS messages, clinical care and reproductive health services present a unique challenge. It also appears that lack of adequate and reliable information as well as restrictive traditions and cultural beliefs in many of our societies remain one of the major obstacles to deaf adolescents. Safer sexual practices and attitudes among the deaf have also not been examined.

There are also very few hearing people who are competent in sign language; therefore the deaf adolescents may not be properly sensitized with the messages of HIV and AIDS (UNICEF 1999). Kelly (1991) confirms that even when HIV and AIDS messages are available in print or media, the low literacy rates and limited educational levels,

complicate the comprehension of these messages among the deaf. He goes on to say that, in Zambian schools, sex education programmes are not done in sign language in order to carter for deaf pupils in schools, therefore HIV and AIDS information cannot adequately be presented to the deaf. This can promote misconceptions about AIDS among the deaf pupils.

Most deaf pupils are limited in scientific knowledge and contradictory beliefs about AIDS and STIs may stem from their reliance upon unreliable and interpersonal sources of information and also from traditional beliefs and practices that may place on them gender stereotypes to which they maybe pressured to succumb. This lack of vital information makes them more vulnerable to sexually transmitted infections and subsequent acquisitions of HIV and AIDS.

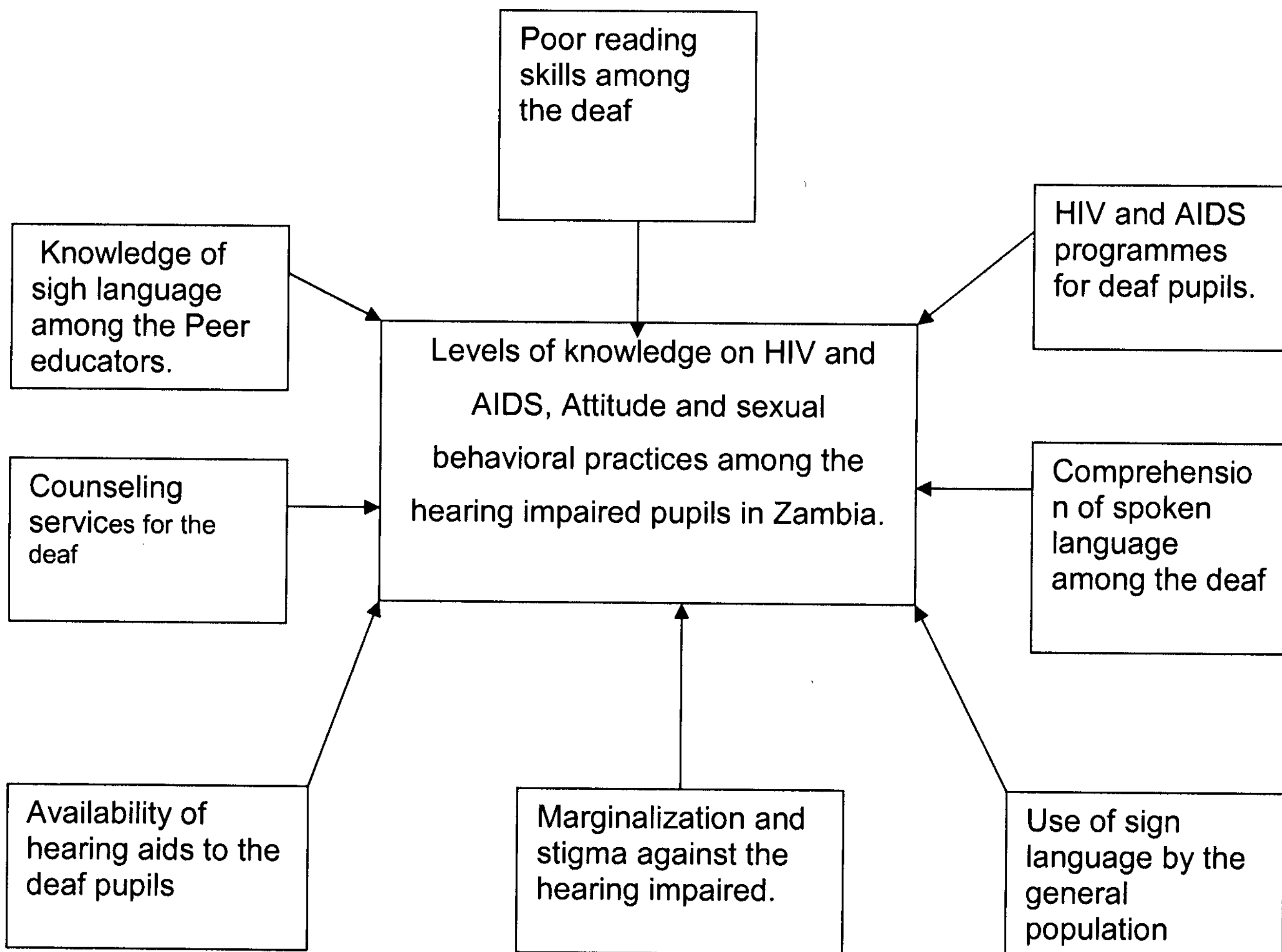
Although many studies have been done on HIV and AIDS in Zambia, little has been done among the deaf communities to assess their HIV and AIDS knowledge levels, attitudes and behavioral practices.

The problem is even more serious for young deaf girls and women who due to many socio-cultural constraints, lack of relevant economic empowerment and skills needed to negotiate for safer sex with their partners. This study therefore attempts to investigate the major sources of the HIV and AIDS information for deaf boys and girls in secondary schools, and the effects of this information on their attitude and sexual behaviors. A case Study at Magwero School for the Deaf, in Eastern Province of Zambia was taken.

1.2.1 PROBLEM ANALYSIS

In our quest to understand better the problems faced by the hearing impaired persons, a number of factors which affect their knowledge have been indentified. These factors include poor reading skills, knowledge of sign language among the peer educators, availability of hearing aids to the deaf pupils, marginalization and stigma against the deaf, HIV and AIDS programme for deaf, counseling services for the deaf, comprehension of spoken language among the hearing impaired.

1.2.1 PROBLEM ANALYSIS DIAGRAM



With all these barriers against proper communication among the deaf, knowledge therefore is affected and thereby influences patterns of sexual behaviors. We can therefore conceptualize the problem to be centered on the variable in the problem analysis diagram on Figure 1.2.1 above.

1.3 SIGNIFICANCE OF THE STUDY

The study will be useful in many ways. Firstly the findings of the study will provide materials for inception of HIV and AIDS and educational awareness campaign programmes to the deaf population to the hearing impaired communities in the country.

Secondly, the study will provide issues to be considered by various stakeholders when generating policy and legislature on HIV and AIDS for the deaf generally and deaf high schools in particular.

1.4 PURPOSE OF THE STUDY

In view of the foregoing concerns and the perceived need to design the appropriate HIV and AIDS programmes for the deaf pupils in high Schools, the purpose of this study was to assess the levels of knowledge, attitude and sexual behavioural practices among the hearing impaired pupils in Secondary Schools in Zambia (A case of Magwero school for the deaf).The study was guided by the questions outlined below.

1.5 RESEARCH QUESTIONS

(i) How much knowledge do the deaf have about HIV and AIDS?

(ii) Are there HIV and AIDS programmes specific for the deaf in the country?

(iii) Are there HIV and AIDS campaign programmes at Magwero School for the Deaf? How do the deaf pupils respond to these programmes?

(iv) Are the deaf pupils sexually active?

(v) How do the deaf use the knowledge about HIV to avoid getting infected?

1.6 OBJECTIVES OF THE STUDY

General objective

Assessing levels of Knowledge, attitude and sexual behavioral practices among the hearing impaired pupils in Secondary Schools in the era of HIV and AIDS.

SPECIFIC OBJECTIVES

(i) To identify the major sources of HIV and AIDS and STIS information for deaf boys and girls at Magwero school for the deaf.

(ii) To find out the gender equality in accessing HIV/AIDS information between deaf boys and girls at Magwero school for the deaf.

(iii) To find out if deaf boys and girls at Magwero school for the deaf are using this information to adopt better attitudes and sexual practices.

(iv) To recommend suitable strategies to reach the deaf pupils with the massage of HIV and AIDS awareness.

1.7 OPERATIONAL DEFINITIONS

Deaf - The partial or total loss of hearing

Impairment - The loss of abnormally of psychological or physiological or Anatomical structure of function

Deaf culture - Traits or characteristics referred to as a learned behavior common to deaf people

Sign language - The natural language used by the deaf people in deaf communities around the world with linguistic structure analogies to, but, completely autonomous from spoken language

Communication - Transfer of information from one person to another.

Attitude - Various ways of thinking or behaving towards some other people or something

Sex - Being male or female.

Sexuality - Fundamental component of personality of human beings manifest at or communication with others, of feeling of expressing and living human love

Knowledge - Information that will help students decide what behaviors are healthy and responsible

AIDS - The letters stand for "Acquired Immune Deficiency Syndrome" a Human body progressively loses its natural ability to fight against infections because the immune system has been weakened by a virus called HIV (Jackson 2002)

Attitude - Fishbein &Ajzen (2004) defines attitude as the general feeling (ranging from positive to negative) a person has towards self, other people, objects or events. This study investigates the feeling or evaluations that respondents have with regard to some related HIV and AIDS related issues.

Behaviour - It is a generic concept that covers, acts, activities, responses and measurable response of an organism.

Belief - An emotional acceptance of some proposition statements or doctrine.

Epidemic Unusual and significant rise in cases of a certain disease or infections in a relatively a short period of time

Knowledge - An accumulation of information that people have internalised.

HIV - The abbreviation stands for Human Immune deficiency virus. HIV is a virus that causes AIDS.

Safer Sex A form of sex that is free of any risk of HIV transmission.

CHAPTER II: LITREARTURE REVIEW

2.1 INTRODUCTION

This chapter looks at various studies that have been conducted in the field of HIV and AIDS and people living with disability, particularly the hearing impaired. The literature reviewed is on published articles and accredited books from computerized data base and libraries.

In this chapter, the literature review is derived from global, regional and national perspectives. However, it must be made very clear right from the outset that the literature specific to Zambia is extremely scanty and scarce and not easily available in the country.

2.2 GLOBAL PESPECTIVE

The issue of disability has a rich and culturally diverse history as far back as human existence. From the time of medieval the people living with disability have continued to suffer from all forms of torture and discrimination in the societies they lived in (Borne *et al,* 2005).

Kevan (2007), states that global survey which was conducted in 2004 was one of the major researches that have been conducted in the World on HIV and AIDS and disability. He states that this research essentially highlighted the fact that people with disabilities were not yet is radar screen on the HIV and AIDS sector despite being vulnerable to all known risk factors. With a growing awareness within this disability sector, people with disability are also vulnerable to HIV, and there arises a need to be included in HIV awareness programmes.

Josselyn (1962), stated that the change that occurs at puberty by causing many young people to perceive the world afresh, through the eyes of those who have nurtured them, may increase the risk of HIV infection among the deaf. Therefore, opportunities for social initiation and education at this stage need to be very rich and varied among the deaf communities.

Bundy (2002) agrees with Josselyn (1962), that it is at puberty stage that the hearing impaired adolescents need more information about HIV and AIDS since they go through the same maturation like their normal counterparts.

Child (1996) explains adolescent stage in details as a transformation or change of physical, mental, psychological and social organization of one's life. King (1986), reiterates that many adolescents learn about themselves by experimenting with their sexual feelings, and because of their many long-held assumptions about behavior, many live good habits and customs and subject them to scrutiny and sometimes completely discard them. Raynest (1972) agrees that many researchers see the years between adolescence and young adult as a period of considerable stress and emotional turbulence.

Mc Candles and Boyd (1991), go on to say that, it is at this stage of development that many boys and girls begin to question and discard parental guidance and societal principles and values that there is the resurgence of the ego demands hence young people's criticism of societal and parental influence means that their previous, super egos are broken up. Child (1996), calls it the adolescent identify crisis.

Because adolescence is a stage when behaviors which have been appropriate in childhood is suddenly overlooked or discarded, and is a period of great sexual stimulation and experimentation, many adolescents are likely to engage in risky sexual activities that may have negative repercussions for their health. Kelly (1998), states that AIDS education, is a pre-requisite for individuals and community survivals.

Groce *et al* (2006), retaliate that the inclusion of people with disabilities into HIV and AIDS programmes cannot wait since the issue is one of basic human rights and public health. They went on to say that the lives of people with disabilities are not less valuable and there can be no justifiable argument to assign them to the bottom of the HIV priority. Since people with disabilities make up to 10% of the global population, the number is

simply too large to ignore and continued exclusion runs the risk of hampering efforts to slow down the spread of the virus.

People living with disabilities have various challenges in terms of accessing HIV and AIDS methods of information (Kempton and Kahn, 1991). Clearly the ability to receive information and methods of providing information differs by impairment, sex, age, location and other factors (Robert, 2005). Inevitably impairment that affects communication, sight, hearing, speech and intellect are the most significant since information is provided on the assumption that they can read and hear.

Another notable research was conducted by Kevan (2007), in India on the exclusion of people with disability from HIV and AIDS progammes. In his report Kevan (2007), strongly states that poverty is recognized as a factor that significantly increased vulnerabilities to HIV. He went on to say that disability is both a cause and consequence of poverty and people with disability are over represented among the poorest of the poor. Coates (1991), agrees with Kevan (2007), that people with disability are part of every social, religious and sexual orientation and that they are found within every high risk and vulnerable group.

It is also becoming increasingly clear from researches conducted by UNFPA/UNICEF and WHO (1997), that adolescence sexual activity, especially in developing countries is closely linked with educational economic opportunities. One of the major concerns of different stakeholders is that sexual relationship for young girls is usually involuntary, (www.UNICEF.or/Pan 98/woman.htm). Lack of economic and educational opportunities force many deaf girls into early sexual activities.

According to Vittillo (2006), sexual abuse is on the increase among the hearing impaired girls raising the levels of sexually transmitted infections (STIs) among the victims. Peter (2004), adds on to say that, prevention of sexually transmitted infections among the deaf is a challenge because they are not able to negotiate for safer sex due to their hearing

impairment. Brisk (2008), retaliates that most deaf persons have not yet been empowered in terms of information on where to get help in case of STIs.

Kevan (2007), reports that in terms of access to information, most of the people living with disability in India had received the information on HIV, citing friends and other people in the community as their primary source of information, with a few government agencies and non governmental organizations working on HIV. The author further states that only 8% of the respondents mentioned TV, radio and newspapers. He also argued that the low number acquiring information from the media illustrates their inaccessibility to people with sensory and communication impairments as well as the low literacy levels of people with disabilities.

However Gopinath, & Patil (2000), reported from their study on the disability and HIV in India that just under half of the respondents did not know who to approach or where to go if they wanted to get more information on HIV, while 81% of the respondents felt that the amount of information on HIV reaching people with disability was less than that reaching the general population. Groce (2004), states that the low number of people with disability asking for information on HIV makes the case of mainstream among HIV organization to be more proactive in insuring the inclusion of people with disabilities in their plans and programme. Particularly as the majority feel they are vulnerable to HIV infections.

2.3 REGIONAL CONTEXT

A report on the first deaf workshop on HIV and AIDS (1997), in Tanzania reported that the hearing impaired are marginalized group and suffer because of their continued risk, vulnerability and lack of access to HIV and AIDS information and services that can help them to have knowledge on HIV and AIDS.

2.3.1 Issues around specific impairment

Clearly the ability to receive information and inform oneself on HIV, and methods of providing information differ by impairments, sex, age, location and other factors (Emasu, 2004). Inevitably impairments that affect communication – sight, hearing, speech and

intellect are the most significant since information is provided on the assumption they can hear. However, every impairment comes with its own set of issues.

2.3.2 Visual Impairment

Nethrajothe in Chennai (2007), reports that one of the social factors observed that make blind men and women vulnerable is that many marry quite late in life because it takes them longer to get established in terms of finding a steady job and saving money. As a consequence many blind men engage in premarital sex.

Further, Engelbrecht (2003), states that many blind and partially sighted people are still schooled in residual institutes and instances of homosexual behavior between adolescent males were reported in several interviews in his research conducted in Uganda.

Translation of HIV materials into Braille has been the most common methods used, in order to reach the blind people with the messages of HIV. There are however, very few blind people who can read Braille. Braille can also be written in different languages such as local languages or official languages such as English or French, but the challenge has been the interpretation of these Braille materials in other languages because very few people are trained to read Braille (Keran, 2007).

Fink (2006) further emphasizes the importance of practical demonstrations, such as how to use a condom which requires detailed descriptions and gives an opportunity for visually impaired people to feel these visual aids. He went on to say that giving a condom to a blind person will be far more effective than simply a description. He said that use of realistic and life size models are helpful. He further states that most people develop their knowledge of what the opposite sex looks like through pictures and photographs. Moore (2007), says that someone who is blind from birth will not have had that opportunity to see, therefore, he / she will need life size models which they can touch and feel.

2.3.3 Hearing Impairment

Piche (2000), stated that, deaf people are generally excluded from everyday life, because people are not aware that they are deaf. He went on to say that you cannot tell by looking.

According to Taylor (2002), ability to communicate is the most important factor in the acquisition of knowledge, therefore particular considerations in terms of hearing impaired people and their vulnerabilities such as communicating to them in sign language or through visual aids should be taken into account.

Obrain (2006) revealed that ability to communicate also depends on when they became deaf. He stated that Someone who became deaf after they learned how to talk (post lingual deafness) will be at a greater advantage in terms of speech skills and the ability to lip-read than someone who was born deaf (pre-lingual deafness).

Charles (2007) adds on to say that, communication also depends upon the degree of deafness. He further states that someone who is hard to hearing (partially deaf) but able to acquire and use a hearing aid will be at a greater advantage than someone who is completely deaf. Gaskia (1999), reports that in general, hearing impaired people have very low levels of body literacy and that this disadvantages them in terms of communication. Jenny (2002), revealed that poor levels of body literacy are a result of the inaccessibility of subjects such as human biology and reproduction within the school curriculum. Although most hearing impaired children do not got to school, those who do, usually attend regular schools where teachers are not given the training time or resources to communicate effectively and as a result, much of the curriculum passes them by.

Rodgers (2005), argues that although some hearing impaired children attend schools with specialist training facilities, these only go up to 7th grade where as subjects such as human biology, reproduction and sex education are not covered.

Lessoni *et al* (2004), establishes that the ability to learn effectively in any subject is depended upon the communication skills between teacher and student. They went on to say that out come of poor communication skills, is high levels of illiteracy among the hearing impaired people. Heuttel K. (2001) adds on to say that inability to communicate makes hearing impaired, particularly women more vulnerable to sexual abuse and exploitation.

Deter man *et al* (1999), declared that although there are no physical barriers to prevent hearing impaired people from attending public sessions on HIV they generally get left out because people cannot tell if someone is hearing impaired by looking at them.

2.3.4 Deaf Blindness

Groce (2003), reveals that according to Sense International and the Helen Keller Institute, deaf-blind people are extremely vulnerable to abuse and exploitation because of the difficulties of communicating and ability to access information. Runner (2001), also reports that abuse does happen, but it is generally unreported. He adds on to say that deaf blind people can only be made aware of the abuse through what is called *"bad touch"* and *'good touch'* methodology. These deaf blind persons are taught that certain kind of touch is abusive while others are good. This is demonstrated by using finger spelling directly on to the palm and tactical sign language.

2.3.5 Issues around Gender and Disability

DFID (2007) stated that gender inequality in disability means that disabled men will be more aware and have more opportunities to socialize than women with disabilities, and therefore in terms of HIV information, there is need to consider the gender dimension rather than impairment.

Grayson (2007), in his research on Gender and disability in South Africa reported that exclusion and marginalization on the basis of sex and impairment are two common forms of discrimination. A disabled woman therefore suffers the double discrimination and multiple impacts of both forms of inequality. The implication of this in terms of HIV is that women with disabilities particularly those without speech, hearing and intellectual impairments are more vulnerable to sexual exploitation and abuse than men with disabilities or nondisabled women.

Baylies and Bujral (2000), established that the fact that many women with disabilities have had sheltered lives, kept at home by families for protection out of embarrassment or

simply their own limited mobility, means that many have not had the opportunity to acquire the social skills to recognize predatory behavior and potentially vulnerable situation.

Because it is assumed that women with disabilities will not be sexually active they are not given information on relationships, how to deter predatory behavior or negotiate safer sex. They further stated that women with disabilities are likely to have fewer opportunities for relationship than non-disabled women. The outcome is that some disabled women are therefore more vulnerable to creatures and with that, reduced negotiating power and increased vulnerability to exploitation.

Baylies (2000) stated that the social imperative to get daughter married, combined with the fact that woman with disabilities are generally considered less eligible as marriage partners means that many are married off to any man willing to accommodate them. In many cases in Africa women with disabilities living in rural areas become second or third wives. The resultant is low self-esteem combined with negligible knowledge of sexual health which severely diminishes their ability to negotiate for safer sex.

A report on the first deaf workshop on HIV and AIDS (1997) agreed with Lezzoni *et al.,* (2004) in that the deaf are marginalized group and they suffer because of their continued risk, vulnerability and lack of access to HIV and AIDS information and services that can be used to impact knowledge and skills. This can also help to protect themselves and their partners and prevent further infections and ensure further treatment in infected persons. Heuttel Rothstein (2001) confirmed that there is little information that reaches the deaf because the majority cannot read and write.

A situational analysis done by Ndhlovu (2007) on the accessibility of HIV and AIDS counseling by pupils with hearing and visual impairment in selected schools in Zambia revealed that 28% of the hearing impaired in these schools have no access to HIV and AIDS counseling user – friendly services.

A survey done by Grace *et al* (2004), in Central Africa revealed that gender imbalances in many African countries have put girls/women with disability at a higher risk of contracting HIV and AIDS than their normal counterparts. These high levels of HIV/ and AIDS infections among persons living with disability are due to a combination of factors which to a large extent are beyond their own control. The survey further revealed that traditional practices, lack of economic and educational opportunities in many African societies still make women and young girls more vulnerable to HIV and AIDS infections.

Ng'weno (1994), has re echoed this by arguing that since they were still considered by African men and boys to be essentially sex objects, it is important that girls and women get to understand their sexual roles in society. He further emphasized that girls need meaningful education about sexuality and their HIV and AIDS vulnerability because many men are now seeking younger girls for sexual relations in the belief that this will reduce their own chances of contracting HIV and AIDS.

Bruce *et al* (1995), in his survey on education and HIV and AIDS recommended that Schools must be ably empowered to carry out the task of bringing HIV and AIDS awareness programmes in order for the present generation of young people to be saved from the HIV and AIDS scourge.

Kelly (1994) has also argued that schools especially secondary schools, possesses an innovative function and is charged with the responsibility of bringing about new values, practices and activities in the community in which they operate.

Sather *et al* (2002) agreed with Kelly (1996) that apart from the HIV and AIDS pandemic, schools have the responsibility to develop skills which equip young people for positive social behavior and for coping with negative sexual pressures. Child (1997), said that changes in sexual behavior are not easy to measure. This is because sexuality is predominately a private matter which many individuals are not ready to freely discuss. But Eaton *et al* (2003) have revealed that to bring about behavioral change, motivation and self reliance are needed in order for one to act according to the information that he/she has

received. They went on to say that many adolescents, therefore acquiring sexual health information becomes the first step in developing positive behavioral attitudes that positively affect their sexual behavior.

2.4 National Perspective

The Zambia Sexual Behavior Survey (2000) indicated that about 50% of the Zambian boys and girls generally have their sexual debut by the time they reach 17 years. This entails that a lot of attention needs to be implored to the adolescents. This is because they constitute a special group that is vulnerable to HIV and AIDS, infections, unwanted pregnancies and unsafe abortions.

The Zambian government through the Ministry of Education has also recognized the need for schools to influence the behaviors and attitudes of young people through HIV and AIDS programmes (Grassley, 2003). However, Zambia unlike other countries in the Sub-region, such as Zimbabwe, Botswana and South Africa, still lack a clear policy on sex education for secondary schools (Bollinger, 1999).

A research by PPAZ (2003), on the Copperbelt province of Zambia, states that most respondents knew very little about the existence of sex education in schools. This is despite the fact that, many adolescents in secondary schools are faced with increased peer pressure. This has forced them into risky sexual behavior. Especially deaf girls are more at risk. This is because one can easily take advantage of their deafness.

Another research done by the Child in Crisis-YWCA (2003) in Lusaka urban showed that out of 45 different cases of girls reported, about 7 girls had babies or they were pregnant as the result of the abuse. Fourteen (14) were confirmed as having STIs, while the biggest problem that had arisen out of the sexuality and the HIV and AIDS pandemic is that the hearing impaired adolescents have not been spared.

Muyenga, (2005), reported that out of 256 690 people with disabilities in Zambia 47.2% were women facing challenges due to impairment functional loss or disability. She went on

to say that 10% women with hearing impairment had no resistance to sexual abuse. Bruce (2004), said that such women were offered nothing except Sexually Transmitted Infections or HIV and AIDS.

The Ministry of education policy on HIV and AIDS does not specifically address the disability challenges among the students living with disability. People with disability have inherent and basic human needs. These rights and needs must be affirmed, defended and respected. Sex education in schools should lead to positive change in behavior modification and social skill development.

CHAPTER 111: RESEARCH METHODOLOGY AND STUDY DESIGN

3.1 INTRODUCTION

This chapter presents the research methodologies used in the study. It discusses the sources of data and the instruments used for data collection. It also outlines some of the limitations encountered during data collection.

3.2 STUDY DESIGN

A research design is a programme to guide the research in collecting, analyzing and interpreting observed objectives (Polit and Hungler, 1996). It is a specification of the most adequate operations to be performed in order to test a specific hypothesis or to answer specific questions under a given condition. In this study qualitative research design was used. This is because it is more concerned with individual situations with incidents or phenomena (Cormack 1987).It also employs a non-numeric data and its aim is to describe in detail, with a view to explaining the objectives of the study (Wilson, 1993).

In a qualitative study, the researcher is also guided by certain ideas, perspectives or hunches in the overall approach to be investigated, but the aim is to allow participants to provide information in a more spontaneous way (Colman 1987). The study chose this research design because it provides detailed information especially for topics that have not been researched. The research used qualitative method because the method allows the respondents discuss their personal experiences in focus group discussion. In addition to the qualitative approach, quantitative data were obtained. These helped measure the levels and patterns of behavior among the study population.

3.3 STUDY SETTING

The study was done at Magwero School for the deaf in Eastern province. Magwero School for the deaf is 28 kilometers from Chipata town which is a provincial Head quarter of Eastern Province of Zambia. The pupils at the school come from all over the country. This is the only school which caters for the deaf from pre-school to high school in the province. The school has a population of 152 pupils with staff of 18 members. Permission was sought from the school administration to carry out the study.

3.4 STUDY POPULATION

The study population is the indentified boundary from within which the investigators will select people to take part in the inquiry. When this boundary is drawn, it depends primarily on the purpose of the inquiry (Thomas *et al* 1998).The target population for this study were grade 8 to 12 deaf pupils at Magwero school for the deaf.

3.5 SAMPLE SELECTION

Sample sizes of 75 participants were selected at the school. Pupils were selected from strata of grades 8, 9, 10, 11 and 12. Class registers were used to obtain details of the pupils. Systematic random procedure was used to come up with the sample size from each class. Eighteen (18) pupils from each class were randomly selected. Permission was sought from Magwero School for the deaf. Informed consent form was availed to the participants who signed it prior to the study. Confidentiality and anonymity was maintained.

3.6 DATA COLLECTION INSTRUMENTS

3.6.1 Questionnaire

In order to collect quantitative data and also to obtain a cross sectional perspective of the problem, structured questionnaire was used. The questionnaire was pre tested at Zambia Association for the Deaf (ZNAD).The pilot study was conducted four months before the actual fieldwork commenced. Questionnaires were tested and the results obtained did not show any serious problems in terms of validity and relevance. Appropriate adjustments were made.

3.6. 2 Interviews

In-depth interviews were used to obtain qualitative data. Dexter (2005), reckons that interviews provides access to the content of a situation and make the researcher reach deeper meaning about the reality being studied. The researcher was able to get information about the behavior, attitude and knowledge of HIV and AIDS among the deaf pupils at the institution.

Hamersley and Atkinson (2004) stressed that the expressive power of interview language provides the most important resource in its capacity to represent descriptions, explanation and evaluation of an almost infinite variety about any aspect of the world. Holstein (2007), argued that in qualitative research, interviews are not restricted to a fixed set of questions, and usually lay between structured and unstructured techniques. Insights into the perceptions of a particular person(s) within the situation are obtained.

3.6.3 Focus Group Discussion

Three (3) focus group discussions were also conducted. The recruitment of the focus group participants was done from pupils in senior classes from grade ten (10) to twelve (12). There were 10 participants in each focus group discussion from each class, bringing the total number of the participants to forty (40).

Focus Group Discussion (FGD) was chosen as data collection tool because it simultaneously solicited for opinions and experiences of respondents. FGD also offered a certain quality control, in that, participants provided checks on each other (member checking); excluding extreme or false views (Polit and Hungler (1996). Discussions were transcribed. A teacher competent in sign language was identified as a researcher assistant and interpreted in sign language during the focus group discussion while the researcher who also understands sign language transcribed.

The focus group discussions were conducted using a discussion guide, which had been pre-tested and adjusted appropriately. The tools covered the following themes:

1. HIV and AIDS and STIs knowledge information.
2. Risk perceptions and effects of HIV and AIDS.
3. Risk behavior and Gender relations.
4. Sexual practices and condom use.
5. HIV and AIDS information and sources.
6. Myths and misconceptions on HIV and AIDS condom use.

To make the participants at ease the discussion were held both in English and sign language, with the help of sign language interpreter. Since all the participants were deaf, they participated, using sign language. The hard of hearing were also able to vocalize either in English, or their own, local language. Each FGD lasted for about one hour with a break of about 10 minutes given to participants in between to have some refreshments.

3.7 Data Collection techniques

Data was collected between 10th to 25th March 2008. There are three main data collecting tools in this study. These are questionnaires, oral interviews, and Focus Group Discussions. A total number of 75 (Seventy five) questionnaires were distributed to the respondents. The respondents answered the questions on the questionnaire individually by filling in the spaces provided on the questionnaire. All the questionnaires were collected from the respondents and secured safely.

The in-depth interview with the key informants, which included house parent, senior teacher and the headmaster, were undertaken individually. Data from the oral interview were transcribed.

Prior to the Focus Group Discussion, the indentified participants were explained to the purpose of the study and the content of the consent form with the help of the sign language interpreter. Those who agreed to participate were requested to sign the consent form.

After all the participants signed the consent forms, the moderator welcomed them and sat in an informal circle. The research assistant sat at an angle where he could not be distracted by the participants as he took notes and his role was explained. Sign language interpreter sat next to the moderator (researcher) for easy of communication.
The climate was set by starting informal conversations and asking non-threatening questions to put the group at ease and encourage them to speak and sign among themselves. The moderator encouraged the participants to speak freely and continued to guide the discussion using a focus discussion guide (see Appendix A) comprising of pre-considered

issues related to each objective. At the end of the discussion, the moderator summarized the discussion and thanked the participants for participating in the discussion.

3.8 Data analysis

Qualitative data was analyzed by themes and subject while quantitative data was analyzed using the computer package; Scientific Package for Social Sciences (SPSS). This helped to generate frequencies showing graphs and percentages presented in this work.

3. 9 Ethical considerations

On the account of the delicate nature of the study which involves people with disabilities as human subjects, it was therefore important that the study took into consideration the research ethics. Firstly, the study was cleared by the University of Zambia Ethics committee. In line with the principal of the informed consent, the participants were informed about the purpose and the focus of the research. The willingness of the respondents was protected and any remarks attributed to their willingness to participate were assured.

The introductory letter to the respondents was designed to meet basic standards by Bailey (1996), Holloway (1997) and Kvale (1996). Consideration also was taken to explain to the respondents that nothing would embarrass them or injure their feelings. The respondents were availed with information regarding direct and indirect benefits from this study both for themselves, their respective institutions and policy makers in the Ministry of Education.

The researcher took special care of the respondents by getting written permission from the school administration before this study was carried out. Confidentiality was ensured by keeping the questionnaire scripts under lock and key for security purposes. When reporting the findings of the study and narratives, the researcher ensured that the names of the respondents were not revealed. Instead codes were used to facilitate the numbering. In this way, it would not be possible for other person to identify the participants with any part of the information given in the study.

Additionally, the responses did not have any uniqueness that jeopardized their anonymity. Absolute confidentiality was communicated to respondents in writing and sign language. The right to decline was explained too.

3.10 Dissemination and utilization of the findings

Findings and recommendations from this study would be made available and accessible to policy makers, particularly the Ministry of Education, the Zambia Agency for people with disability and other stakeholders in the disability movement.

3.11 Limitation of the study

Firstly and foremost nearly all surveys about knowledge, attitude and behaviours towards sensitive issues as HIV and AIDS have limitations in that the respondents base the responses on the self declaration. Case studies are limited by the sensitivity and integrity of the investigator and the possibility for bias to affect the final product (Merriam, 1998).

Furthermore as the narrative indicates, it was possible that respondents did not say what they wanted to say or said what they had not intended to say due to limitations in sign language of the interpreter since sign language is sometimes locally designed. The other limitation was the inadequate financial resources which prevented the study to cover all the deaf schools in Zambia.

Finally it is worth drawing our attention to the limitations of the method used in selecting the key informants-purposive sampling. This method did not cater for the many variables that existed in deaf schools in Zambia. The sample was not totally representative. Based on the fore mentioned facts the findings can not be extended to a wider cohort beyond Magwero School for the deaf.

CHAPTER IV: BACKGROUND CHARACTERISTICS OF THE RESPONDENTS

4.1INTRODUCTION.

There is no doubt that families play an important role in the lives of adolescents because at this stage many of them are still legally and economically dependent upon their parents or guardians for survival. It is also through the family that the socialization process starts and as such the gender norms and attitudes that children adopt in later years are largely dependent upon it.

In this chapter, particular reference to sex, age, respondents' keepers, and parent child relationships will be highlighted in order to describe more precisely adolescents who took part in the study. In first instance respondents were asked to state their age sex and the results are shown in Figure 4.1 and in Table 4.1

Figure 4.1 Sex of the respondents.

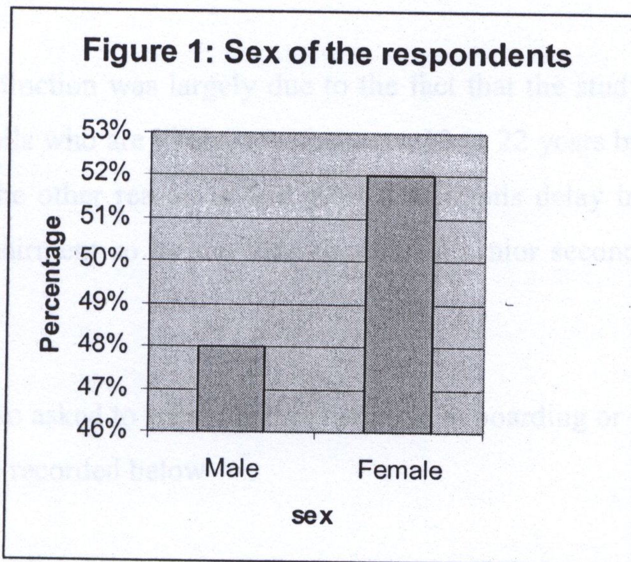


Figure 4.1 show that a total of 75 respondents took part in the study representing 100%. Majority (52%) of the respondents were female. On the sex of the respondents, more deaf girls were in the boarding for security reasons, for most parents felt that their girls are secure in boarding than when they are walking from home. The other reason put across during focus group discussion was that there are few deaf schools in the country so most of

the respondents come from other parts of the country and use the boarding facility at school.

After finding out about the sex of the respondents, the study wanted to establish the age of the respondents, and the results was recorded in Table 4.1 below.

Table 4.1 **Respondents, age, sex.**

Age	Female%	Male%	Total%
13-15	16.3	13.3	29.3
16-19	26.6	20.0	47.6
20-22	6.6	14.6	23.1
Total	38	37	100

A total 29.3% of the respondents were aged between 13 and 15 while the majority (47.6%) were aged between 16 and 19. About (23.1%) of the respondents were aged between 20 to 22 years.

This sex and age distinction was largely due to the fact that the study targeted junior and senior secondary pupils who are likely to be between 13 to 22 years by the time they reach secondary school. The other reason is that most deaf pupils delay in enrolling in school because of their impairment so by the time they reach senior secondary school, they are above 20 years.

Respondents were also asked to state whether they live in boarding or they are day scholars and the responses are recorded below

Table 4.1 **Responses on where they stay**

Place	Female%	Male%	Total %
Boarding	58.6	16.3	74.7
Day schooling	8.0	16.3	25.3
Total	49	26	100

Of all respondents who took part in the study, a total of 13 males (representing 16.3% of the respondents) were day scholars while a total of 44 females (representing 58.6%) of girls were in boarding, 5 females (representing 8%) were day scholars while 13 males (representing 16.1%) were in boarding.

There were evidently more girls than boys because most parents prefer their deaf girls to be boarding school where they feel there is more security compared to day school, because they fill that they can be abused by men on the way to or from school.

Having established where respondents stayed, they were asked to state their respective educational levels in school and the results are shown in the Table 4.2

Table 4.2 Grades of respondents

Grades	No. pupils	Female%	Male%	Total%
8	10	8.0	5.3	13.3
9	17	12.0	10.7	22.7
10	10	4.0	9.3	13.3
11	20	14.6	12.1	26.7
12	18	14.0	10.0	24.0
Total	75	38	37	100

Table 4.2 shows that the majority of the respondents were in grade 11 (26.7%) while those in Grade 12 were 24%.Those in Grade 9 represented 22.7%, in Grade 10 they were 13.3% and those in Grade 8 were 13.3%.

As already stated in Chapter Three the study involved pupils from grades 8 to 12. There were generally more girls than boys in all grades except in grade 10.

4.4. RESPONDENTS' KEEPERS

Several researchers have identified several factors that may cause adolescents to engage in risk behaviors. These include among other things coming from a family with low socio-economic status, not living with parents or living with only one parent or living with parents who have low education levels. Apart from this, adolescents who generally come

from disadvantaged houses tend to start sexual activities early in life. In this study respondents were asked to state the people responsible for their up keep and the results are shown in the Table 4.3

Table 4.3 **Respondents' Keepers.**

Keepers	Females %	Males%	Total %
Both parents	29.4	24.2	53.3
Mother only	10.6	13.3	23.9
Father only	2.6	4	6.6
Guardians	6.6	6.6	13.2
Total	38	37	100

According to the table a larger proportion of the respondents who are kept by both parents were females (29.3%), 24% male reported that they lived with both parents. Some 10.6% of the females and 13.3% of the males were looked after by their mothers only. A mere 6.6% reported that they were looked after by their father only while a 13.2% were looked after by their guardians.

When asked during the focus group discussion whether the living arrangement had any effects on their attitudes and sexual behaviors, many participants were of the view that what was cardinal was whether some one was getting enough attention and support from whoever they were staying with.

One male participant had the following to say."

> *There are some parents who have no time for their children such that they have no idea what goes on in their children's lives. Because of this, many young people especially the girls develop some kind of I don't care attitude and go out to look for people who can give them love and attention and end up with married men(*19 year old grade 11 boy)."

Another female participant had the following to say:

"*When I lost my parents I was brought to stay with my uncle who I hardly knew and being a deaf person I could hardly communicate with any one at home for they did not know how to communicate in sign language. It was a very difficult life for me because no one seemed to care for me and I ended up in the street until a missionary picked me from the street and brought me here at school.*(18 year grade 12 girl).

4.5 PARENTAL ATTITUDE TOWARDS RESPONDENTS

It is no doubt that parents' attitude towards their children play an important role on the kind of people those adolescents become. Having established who keeps the respondents, respondents were asked how they related with their keepers and interaction with them and the results are shown below.

Table 4.4 Percentage distribution of keeper –respondent interaction

Keeper-Respondent	Male%	Female%	Total%
They enjoyed talking to me generally.	20.0	12.6	32.6
Are too authoritative and strict,	6.6	26.6	33.3
Are open to me about sex	5.3	13.3	18.6
Give me some freedom to make decisions.	8.0	6.5	14.5
Total	37	38	100

About 20% of males stated that their parents enjoyed talking to them, while 12.6% of female respondents on the other hand agreed that their parents/ guardians enjoyed talking to them. The study also revealed that 6.6% of male respondents stated that their parents/ guardians were authoritative, against 26.6% of the female respondents. Only 5.3% of the males reported that their keepers were open about sex compared to 13.3% of the female respondents.

This shows that in most families, parents are likely to talk to girls about sex than boys. As far as freedom is concerned more boys (8%) reported that they were given freedom to make independent decisions against 6.6% of girls who are not given such freedom to enjoy.

During the Focus Group Discussion, most respondents alluded to the fact that their parents whether highly educated or not, are usually very strict on them. However, some participants were of the view that in some way a high level of education made some parents or keeper a bit more tolerant and accommodating towards their children compared to those with low levels.

One male participant said the following:

> *both my parents are not very educated my mother*
> *for example only went up to grade nine but they are*
> *always encouraging me to work hard at school.*
> *But as far as social life is concerned, I see my parents*
> *as old fashioned because they are too strict on me*
> *and always want me to dress up in long things like*
> *an old person (*19 year old female in grade twelve)

Another participant had the following to say:

> *I personally wanted to do well at school and I am*
> *encouraged by my parents who are well educated.*
> *Find those a bit more tolerant towards my social life*
> *compared to some of my friends whose parents have*
> *low education levels* (20 year old male in grade twelve).

The above statistics and explanation from the participants is an indication that there are gender imbalances in the way boys and girls are treated in most houses. Ironically boys who are given more freedom to make independent decisions are ones who are talked to less about sex than the girls who are not given such freedom to enjoy.

During FGD, many female participants confirmed that their parents were stricter with them than they were with their brothers or males, one female participant stated:

> *my parents especially my father always wants*
> *me and my sisters to account for our whereabouts*
> *every time but doesn't seem to mind my brothers*
> *coming home late and sometimes I think that it*
> *is really not fair for him to*
> *treat us like this* (16 year old female grade 10).

In response, one participant had the following to say:

> *Parents have the right to be more concerned about*
> *the girls because if they are not, they can become*
> *pregnant and bring problems to their parents who*
> *may be forced to start looking after unwanted babies*
> *. But if their male child makes someone pregnant,*
> *all they have to do is to pay some money and buy few*
> *clothes for the baby because it is not their direct*
> *responsibility to look after the baby*
> *and the mother* (17 year old grade 11 male).

With such perspective by adolescents it becomes very clear that gender biases in the way male and female children are raised have continued despite persistent calls by various stakeholders to have such gender imbalances addressed. This also partly explains why a large number of female respondents indicated that their parents do talk to them about sex compared to the male counterparts.

The study established during the FGD that the fact that most of the conversation pertaining to sex between mothers and their daughters usually gravitate towards the preparation of the girl child for successful future roles as wives and mothers, and warnings

against unwanted pregnancies but not necessarily towards their empowerment, sexual risks and personal independence.

Having information on the interaction between the respondents and their keepers, the respondents were asked if they take their keepers' advice and the responses are recorded below.

Figure 4.2 Table

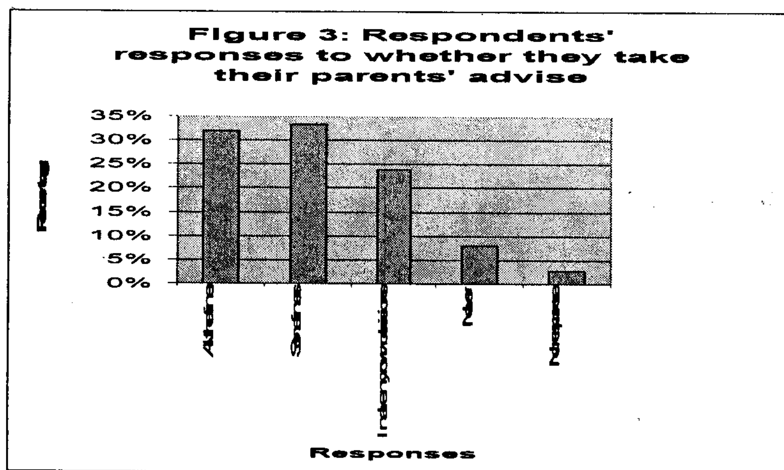


Figure 4.2 show that only 32% of the respondents took their parents' advice. The findings also reviewed that 34% of them sometimes took their parents, advice while 4% of the respondents said they make their own decisions and eight 8% of the pupils said that they never take their parents' advise and 2.5% of the respondents did not respond.

During the focus group discussion most participants complained that some parents do not set a good example to their children because they also do bad things such as drinking beer;

> *Some parents /guardians do not set good example because they drink beer, and sometimes they have extra marital relationships. So as children we also find ourselves doing what our parents do. We find it difficult to take their advice.* (17 year grade 11 boy).

Another participant said; you

> *can't follow everything what parents say other wise you end up not enjoying life. Some parents are too strict and they can make your life difficult, so it's better not to take their advice* (22 year grade twelve boy).

From the above mind set of most of the participants, it's a clear explanation why most young people find themselves in problems because they have discarded parental advice.

CHAPTER V: KNOWLEDGE ON HUMAN IMMUNE VIRUS AND AQUIRED IMMUNE DEFICIENCY SYNDROME AND SEXUALLY TRANSMITTED DISEASES (HIV/AIDS)

5.1 INTRODUCTION

It has been suggested that children should learn about sexual health issues early in life because acquiring knowledge is the first step in developing positive attitude that may lead to healthy behaviors. In this study respondents were asked a series of questions to assess their knowledge of HIV and AIDS. Such information is vital for the formation of HIV and AIDS prevention programmes for the deaf young people.

Also critically important for the prevention programme is the knowledge that HIV and AIDS can be avoided and that the infection can be prevented in the absence of visible symptoms. It therefore follows that, in the face of serious AIDS pandemic being faced in this country, hearing impaired adolescents should learn all they possibly can about HIV and AIDS, not merely for the sake of it but in order for them to develop a deeper appreciation of its implication in their own lives and in the lives of those around them. In this chapter the study establishes and high lights the HIV and AIDS and STIs knowledge.

5.2 KNOWLEDGE ON HIV AND AIDS AND STIs

According to the data obtained from the ZDHS (2007), (CSO, 2007), the general knowledge levels of HIV and AIDS among Zambians is high. This study sought to establish whether hearing impaired students in high schools have knowledge of specific issues related to HIV and AIDS and STDs, such as the difference between HIV and AIDS.

In order to do this, the respondents were asked to state the meaning of AIDS and the difference with HIV. The results are presented in Table 5.1.

Table 5.1.Percentage Distribution of respondents' knowledge of differences between HIV and AIDS

The meaning of HIV and AIDS.	Male%	Female %	Total %
AIDS means-Acquired immune deficiency syndrome	29.3	34.6	63.9
HIV – is a virus while AIDS is the actual disease.	10.6	16..3	26.9
Window period is time between infection with virus and when someone develops AIDS.	5.2	4.0	9.2
Total	37	38	100

As much as the 2007 ZDHS indicates that the general knowledge of HIV and AIDS in Zambia is almost universal, results obtained from the study indicate that both male and female respondents who took part in this study did not have a very good understanding of specific issues related to HIV and AIDS.

Comparatively, however, female respondents had a better understanding of these issues than the males. As could be seen from the table 34.6% of the female respondents knew the definition of HIV and AIDS compared to 29.5% of the males. Only 10.6% of the male respondents knew the difference between HIV and AIDS and 13.3% of the females. About 5.2 % of the male respondents knew the meaning of window period compared to only 4.0 % of the female counterparts.

5.2.2 Respondents' General Understanding of STIs

Owing to the relationship that exists between AIDS and STIs, it is important that deaf adolescents gain considerable knowledge and facts about not only AIDS but various STIs as well. In this study it was endeavored to find out whether or not respondents knew the names of various STIs. The results are presented in Table 5.2 below.

Table 5.2 Percentage of Respondents, who had general knowledge on STIs

Names of common STIs	Male %	Female%	Total %
syphilis	15.6	12.0	27.6
Gonorrehorea	15.3	8.6	23.9
Leaking- locally known as Kanswende	12.0	13.3	25.3
Bolabola	10.0	13.2	23.2
Total	37	38	100

Overall, the respondents' knowledge of names of various STIs was quite low. Comparatively, male respondents tended to be more knowledgeable and accurate about the names of the various STIs than female respondents. Many girls were apparently confused about the names of various STIs. About 15.6% of males against 12 % of the females reportedly knew about syphilis. Some 15.3% of the males knew gonorrehorea, compared to only 8.6% of the females. About 12% of the males reported knowing about kanswende, compared 13, 3% of the female knowing it.

5.1.2 Respondent's Knowledge of Symptoms of STIs

Apart from knowing the names of various STIs it is important for deaf adolescents to know the symptoms of these STIs, so they can be able to identify them, and thus seek medical attention as soon as the need for such araisesTable5.1.3 presents the percentages distribution of the respondents by knowledge of symptoms of STIs.

Table 5.3 Percentages distribution of respondents who knew the symptoms of various STIs

Symptoms of various STIs	Male %	Female%	Total %
Syphilis is swelling of the private parts	16	12.3	28.3
Gonorrehorea-vaginal discharge	14.3	15.2	29.5
Leaking –pain when urinating plus pus.	15.3	8.3	23.6
Body rash	12.2	6.5	18.5
Total	37	38	100

More male respondents knew the symptoms of various STIs than their female counterparts. Despite the low knowledge on the symptoms of STIs, STIs still remain one of the biggest challenges being faced by many developing countries especially in the sub-Sahara region.

Research carried out by the UNFPA (1998), in some developing countries, including Zambia revealed that even when young people do know about various STIs, inexperience; peer pressure as well tradition-cultural expectations usually cause them to take undue risks. As a result, a number of young people are still ignorant of the repetitive nature of the most STIs if not treated and do not seem to understand fully the relationship between STIs and HIV and AIDS.

According to the national health policy frame work of 1998, 53% of all STIs cases at the University Teaching Hospital (UTH) STI clinic were AIDS related and by (2001) the number had gone to 70% (VSU 2005). When asked during the focus group discussion (FGD) most respondents gave an impression that STIs were simple ailment which needed not raise undue alarm because they were not as bad as HIV and AIDS since most of them could be cured.' *AIDS kills and STI does not kill* (grade 12 deaf male) '

This notion by some respondents confirmed what was revealed by PPAZ (2003), that although most young people were worried about getting STDs, they feel more in control of

the situation because they believe that STIs could be cured. Because of this, most of them are seemingly less worried about STIs.

It also became clear from the study and FGD that a number of hearing impaired adolescents in high schools are ignorant of the relationship between STIs and HIV and AIDS. One other important concern that came out of the discussion was the fact that there was too much emphasis being placed on HIV and AIDS at the expense of STIs which many respondents felt was very common among the deaf pupils in high schools;

> *Many of us the deaf pupils suffered from STIs*
> *at one time or another .But it is embarrassing*
> *to go to the hospital, let alone telling your*
> *parents about it*" (19year old grade 12 male).

This view was also echoed by the house parent during the interviews, that they are many incidences of some of these boys and girls having symptoms of STIs

> " *We see a lot of these pupils suffering from STDs*
> *and we assist them by taking them to near by clinic* ".(house parent)

Another respondent narrated that;

> *The problem I had myself, I did even know*
> *what type of STD, it was, but I am lucky,*
> *my uncle found me some herb which*
> *helped me* (20 year old grade 12 boy).

A female respondent said that

> "*I know a certain boy with in the school*
> *who sells capsules for STDs and many*
> *boys go to buy from him.* (Grade 11 18 year old female).

It was very disturbing to learn that most participants did not understand the relationship between STDs and HIV and AIDS even when they knew that the highest mode of

transmission of AIDS is through unprotected sexual intercourse. Many female participants were of the view that males were responsible for the high levels of HIV and AIDS in the country. Male respondents also claimed that girls and women were the ones responsible for the high levels of STIs in Zambia.

> *STDs are caused by women. "When you sleep with a woman who had an abortion, you can get an STI that's why they are called Matenda yabakazi or Diseases obtained from women* (20 year old grade 12 male).

5.2 Knowledge of Modes of HIV and AIDS Transmission:

The are specific facts that young hearing impaired people must know regarding how AIDS is transmitted and how it can be prevented so that they can adopt appropriate attitudes and develop healthy sexual practices.

Table 5.4 Percentage distribution of respondents who knew about the modes HIV and AIDS transmission.

Modes through which HIV can be transmitted.	Male %	Female %	Total%
Un protected sex with an infected person	30.6	27.3	57.9
Unsterilized needles and sharp objects like Razor blades and syringes	10.5	6.4	16.9
Multiple sexual partners	8.0	4.3	12.3
Unsafe blood transfusion.	9.6	3.3	12.9
Total	37	38	100

The knowledge about the modes of transmission of HIV and AIDS transmission was not universal. Less than 60 % of all the respondents know that HIV could be transmitted through unprotected sex with an infected person. Comparatively more male respondents (30.6%) were aware of the transmission of HIV than females (27.3%).

Also, few respondents knew that HIV and AIDS could be transmitted by having multiple sexual partners. About 9.6% of the male respondents and 3.3% of the female respondents were aware that HIV and AIDS can be transmitted through unsafe blood transfusion.

Many participants shared common misconception about transmission through blood transfusion and attributed the likelihood of individuals becoming infected with HIV to the strength of their blood. They explained that individuals with weak blood were more likely to become infected and manifest AIDS symptoms faster than individuals with strong blood.

During a focus group discussion one female participant had this to say in sign language;

> *It all depends on the blood of the person,*
> *if it is strong it can take a person even*
> *10 years to get AIDS, but if it is weak, it*
> *can only take few months* (16 year old grade 10 male).

Such responses were an indication that despite the high levels of knowledge of HIV and AIDS in Zambia, there might still be a number of misconceptions on HIV and AIDS present, at least for deaf adolescents in School.

These misconceptions include sharing toilets, and that utensils would transmit HIV and AIDS. These misconceptions were reiterated by Gaskia S. (1999) when he stated that hearing impaired persons have limited information around them because they cannot benefit from most of the information from the media.

5.3 Knowledge of Methods of Preventing HIV and AIDS

The knowledge on how the transmission of HIV and AIDS can be prevented is important because it shows how young people especially the deaf could reduce their chances of infection.

In order to find out their knowledge on how HIV and AIDS can be prevented, respondents were asked what a person can do to avoid contracting AIDS. Table 5.4 shows the

percentages of respondents who correctly reported what one could do to prevent being infected with HIV.

Table 5.5 percentages of respondents who knew how HIV and AIDS can be prevented

Methods by which HIV and AIDS can be prevented	Male %	Female %	Total %
Correct and consistency use of condoms	20.3	11.3	31.6
Having one sexual partner only	18.2	7.1	25.3
Abstaining from sex	10.4	8.3	18.7
Avoiding casual sex	15.2	9.2	24.4
Total	37	38	100

Both males and females were less knowledgeable about how to prevent HIV and AIDS. About 20 % of males and 11% of females reported that using condoms consistently and correctly could help prevent the spread of HIV and AIDS. Some 18 % of the males and 7% of females agreed that sticking to one sexual partner prevent HIV and AIDS Abstinence was also reported at low levels as a preventive measure.

These findings have shown that both deaf boys and girls at Magwero tend to have a low knowledge of important details related to HIV and AIDS. As could be seen from (Table 5. 2. Page 36) boys seem to have better and more definite understanding of STDs and their symptoms than girls do.

Boys seemed to be more confidence of protecting themselves against HIV and AIDS than girls. From the way most males participants were responding during the focus group discussion the researcher could see clearly that boys felt more in control of the STIs and HIV and AIDS situation than girls;

I know that I can easily protect myself
from STDs and HIV and AIDS because

it is me who can decide whether to sleep
with a girl or not, I can decide to use a
condom or not, but for girls they can't make
these decisions (19 year old grade 11 boy.)

Many girls on the other hand displayed an attitude of fear and ignorant claiming that they are usually the victims of male supremacy because even when they choose to remain virgins men contort them and that men by nature are never satisfied with one girlfriend or wife. It was alleged that men always go for better looking girls or prostitutes and infect innocent wives or girlfriend; *This is why AIDS will never end"* (18 year old grade 12 female). When asked by the researcher what they meant by stating that men were by nature never satisfied with one woman both male and female participants reported that this is how boys or men are made by God;

Men have more sexual feelings than girls.
Girls and women can control themselves
sexually while boys and men can not because
they are made like that by God, (16 year old grade 11 female).

Such responses were an indication of some of the misconceptions among the deaf adolescents that might be causing them to engage in risk sexual practices thus making them more vulnerable to infection.

5.4 Risk Perceptions

Risk perceptions are measured according to how concerned people are about getting infected by HIV and AIDS virus. Since the perception of own risk presumably plays an important role in the practice of safe sex, respondents in this study were asked whether they perceived themselves at risk of getting infected.

Table 5.6 **Percentages on Respondents' risk perception.**

Risk Indicators	Male %	Female %	Total %
I see my self at risk of getting infected with AIDS	26.6	16.0	45.6
It is important for the boys/ girls in sec. school to know their HIV status.	21.1	33.3	54.4
Total	37	38	100

On whether deaf adolescents saw themselves at risk of getting infected with AIDS, about 16% of the female respondents saw themselves at risk compared to 26% of the male respondents. These figures are some how a confirmation that even though boys and girls are generally concerned about the HIV and AIDS and STIs crisis in the country, boys particularly are less worried. When 33% of the female respondents agreed that it was important to know their HIV status, 21% of their male counterpart did. This was another indication that a number of deaf adolescents have a low risk perception.

When asked during the Focus Group Discussion who the participants felt was more at risk of being infected, both male and females participants reportedly felt that girls faced a much higher risk of infection as they are likely to have a number of partners before they can find some one to settle with in life.

This statement was also supported by Baylies and Bujral (2000), who said that people living with disabilities suffer double discrimination and are likely not to get a marriage partner in life and if they get married, they become second or third wife which increases their low self esteem and diminish their ability to negotiate for safer sex.

One male participant during the FGD stated that;

> *biologically girls are more at risk but*
> *sometimes they put themselves at risk.*
> *For example when asked to buy condoms*
> *they feel shy to go to the shop and buy*

condoms, boys take it that they don't want to use condoms" (19 year old grade 12 male).

Many girls claimed that although they were naturally more descent than boys they sometimes find themselves in a very difficult situation where they were unable to say no because their boyfriend especially older boy friends provided them with things they needed. Sometimes girls are given ultimatums to choose between having sex with their boyfriends or risk ending the relationships.

CHAPTER VI: ATTITUDE AND BELIEFS ABOUT SEXUAL BEHAVOIUR AND CONDOM USE

INTRODUCTION

Having established the knowledge of STIs and HIV and AIDS in the preceding chapter, this chapter highlights some beliefs and attitudes, especially those related to sexual behavior such as initiation to first sex and condom use. All this was done in an attempt to determine how respondents' future sexual practices might be affected by what they have done and come to know about HIV and AIDS and STIs.

6.1 Initiation to first Sexual Intercourse

The age at which one becomes sexually active is an important factor in determining one's exposure to the risk of contracting HIV and AIDS and other STIs, including unplanned pregnancies. Some young people might have a number of sexual partners before they finally decide to get married.

At their age, many young people are also not mature enough to make responsible sexual decisions. Because of this, deaf adolescents must be much as possible encouraged to delay the onset of sexual activities. In this study, respondents were asked to state the age at which they first had sex and findings are shown in the Table 6.1

Table 6.1. Percentage Distribution of Respondents at First Sex

Age at First Sex	Male %	Female %	Total %
Below 10	8.3	12.1	20.4
Between 10 and 15	6.3	15.3	21.6
Between 15 and 18	18.6	12.3	30.9
Above 18	10.0	10.0	20
Not Yet	5.0	2.1	7.1
Total	37	38	100

Only less than 9% of the males first had sex when they were below 10 years old. This was against 12 % of the female respondents. About 6 % of the males reported that they first had sex when they were between 10 and 15 years old, against 15.6 % of females in the same age range. About 18.6 % of the males stated that they had first sex when they were between 15 and 18 years old against 12.3 %of the females in the same category.

From these statistics, we observe that girls become sexually active at an earlier age than boys. The largest proportion of deaf girls who took part in the study was between the ages of 10 and 15 years, while for boys it was between the ages of 15 and 18 years old. On a general note, these findings somehow show that greater sexual freedom exists among deaf adolescents in schools.

Other findings from this part of the study are also a confirmation of what has been stated by kings (1995) that although many young people do get the information about the dangers of HIV and AIDS, they do not actively act on the various messages in order to adopt better sexual practices. It might be true to state that once young people start having sex they might find it extremely difficult to change their behavior regardless of what they see and hear around them. In any case the process of behavior change is comparatively easier for young because most of the common behavior patterns adopted by young people are experimented, usually temporal of peer pressure which is very forceful at this stage.

Therefore messages and strategies to prevent and stop high risk sexual behavior should be provided to the youth especially the hearing impaired. Those who are already sexually active should be encouraged to use condoms to prevent any HIV infection.

6.2 Relationship with whom Respondents first had sex

Having established their age at first sex, respondents were asked to state with whom they had first sex and the results are shown in the Table 6.2.

Table 6.2. Relationship with whom Respondents first had sex

With whom had First Sexual act	Male %	Female %	Total %
A relative	8.9	17.7	26.6
A friend	22.3	18.1	40.4
A stranger	10.3	15.6	25.9
Did not at all	5.0	2.1	7.1
Total	37	38	100

From the table above, only 8.9% of the male respondents stated that they had first sex with someone related to them. On the other hand there were about 17.7 % of the female respondents who reported having sex with some one related to them, an indication that deaf girls are more vulnerable to molestation and incest within the home than boys. About 22.3% of the males stated that they had first sex with a friend against 18 % of the female respondents. Only 10.3% of the males admitted having sex with a stranger and 15.6 % for the female respondents, another indication which shows that deaf girls were more susceptible to rape or forced sexual activities by and /or with strangers outside their homes than boys.

Many participants stated that it was more common for girls to be raped especially the deaf girls who cannot be heard when they scream because they are dumb.

During the F.G.D, the researcher also heard that homosexuality is fast becoming a trend among many young deaf boys in high schools. Participants stated that some boys who lost their parents or came from poor families were lured into this by people who claimed to be well-wishers.

One participant stated that:

> *"I have a friend whose parents died and*
> *some rich white man offered to continue*
> *sponsoring him to school. My friend started*
> *coming with nice things to schools such as*

CDs, cell phones and nice clothes .He even went to South Africa for a holiday. But his young brother told me that this white man used to demand sex from both him and his brother (16 year old grade 10 male).

Even though the study could not fully dwell into the details of these claims the fact that some participants reported on them was an indication that this sexual behaviors might slowly be taking root among the high school pupils especially deaf pupils who are most vulnerable.

6.3 Respondents Having Boy friends and Girl friends.

In this study, the researcher was also keen to establish the number of respondents who had either a girl friend or boy friend. The study also wanted to find out how many respondents had had sex with their partners three months prior to the study. Results are shown in the Table 6.3.

Table 6.3.**Percentages distribution of Respondents with Boy friend and Girl friends**

Had boys/ girl friend	Male %	Female %	Total %
Had Boy/Girl Friend	21.3	30.6	51.9
Had Sex three Months prior to the study	15.3	25.7	41.0
Had neither Boy friend nor Sex	5.0	2.1	7.1
Total	37	38	100

About 21.3 % of the male respondents stated that they had girl friends while 30.6% of the females did have boy friends. This shows that girls were more likely to be in relationship with members of the opposite sex in their adolescent stage than boys.

On whether respondents with boy friends and girlfriends had sex in the previous three months, 15.3% of the male respondents and 25.7% of the female respondents said that they

had boy/ girl friend had had sex in the previous three months prior to the study. About 7.1% of the deaf adolescent's reported that they had neither boy friend nor girl friend at the time of study.

The evidence above is a clear indication that a relatively large proportion of both deaf boys and girls in high schools are already sexually active. Because of this even though some respondents might not already be sexually active they are in the position where they could be easily become sexually involved with their boyfriends or girlfriends due to peer pressure.

During focus group discussion a participant stated that it was almost impossible for anyone in boarding school not to have feelings for the opposite sex*; like me, I have a girlfriend and am having fun.*"(A grade 12 twelve male). A grade 11 girl stated that there was a lot of pressure from the boys around the school. *They entice us with nice things, so you're forced to give in*; Grade 11 17 year old female).

The view of having sex was also echoed by the key respondents during the interviews with the senior teacher that these pupils are actually sexually active;

> *These pupils are sexually active;*
> *we have had cases where some*
> *girls have fallen pregnant in*
> *the school* (senior teacher).

Some male participants also claimed that they get encouragement from some male teachers who tell them to learn how to hunt for girls while they still have the strength.

This assertion by some participants shows how gender misconceptions and imbalances are sometimes perpetuated by the very people who are supposed to promote balanced gender relations between boys and girls in high schools such as teachers. This could be due to the fact that some teachers themselves are still very gender unaware and are ignorantly

contributing to the promotion of misconceptions that are responsible for illicit sexual activities which put young people at risk of HIV and AIDS infection.

6.4. Knowledge and usage of Condoms among Respondents

A number of research findings both in Zambia and other parts of the world have shown that apart from abstinence, condoms offer the best form of protection against STIs including HIV and AIDS and unplanned pregnancies.

But whether or not high school deaf pupils are using condoms to protect themselves and whether or not they actually know how these condoms are used are issues which will be discussed in this section. In view of this, respondents were asked to state whether they had used condoms during their first sexual encounter and whether they actually know how to use these condoms are meant to be used. The results are shown in table 6.4, and 6.4 respectively.

Table 6.4.a **Percentage Distribution of respondents who reported that they used condoms during First sex**

Condom use during first sex	Male %	Female %	Total %
Used condoms	25.6	15.4	40
Did not use condoms	23.3	36.7	60
Total	37	38	100

The most knowledgeable age group in as far as the use of condoms is concerned appeared to be those from 16 years and above.

Table 6.4.b. Percentage distribution of respondents who reported knowing how to use condoms

Percentage of respondents who reported knowing how to use condoms	Male %	Female %	Total %
Age			
13-15	8.5	2.0	10.5
16-17	25.0	15.2	40.2
18+	28.4	12.9	9.3
Total	37	38	100

An estimated 25% of the males and 15% females in the study stated that they had used condoms during their first sexual encounter.

Paradoxically the number of deaf pupils who stated that they knew how to use condoms correctly was slightly lower than those who stated that they did not know how to use condoms.

During focus group discussion more male participants looked confident and knowledgeable in the usage of condoms, but said we *are not sure whether we know how to use condoms* (19 year old grade 12 male). Even though many hearing impaired adolescents may have the knowledge on how to use condoms, they might consciously disregard this knowledge as one participant pointed out;

> *Madam Condoms reduce sexual enjoyment,*
> *so sometimes we ignore the condoms even*
> *when you have it in the pockets"* (20 year old grade 12 boy).

As it has been reported in the PPAZ (2000) that quite unlike the adults, most sexual encounter among the young people are not planned and usually happen spontaneously for fear of being caught. Another reason why they may seemingly be more deaf pupils with the knowledge of correct usage of condoms might not necessarily be that they are sexually active, but that young people in high schools acquire knowledge about sex and condom use even before they become sexually active.

Comparatively during the focus group discussion more boys seemed to have used condoms during their first sex than girls. This could be due to the fact that have already established in this report that boys tend to begin their sexual activities when they are much older than most girls. Another reason could be that traditionally it is the man who initiates sex and ultimately decides whether or not to use condoms during sex.

6.5. Reasons for using condoms among the hearing impaired pupils

Various research findings in Zambia and other parts of the world indicate that despite the existing knowledge that condoms are one way through which HIV and AIDS can be prevented, the rate of condom acceptability in many countries especially in Africa is still quite low. At this point respondents who reported being sexually active were asked to state their reasons for using condoms and the results are shown in Table 6.5.1.

Table 6.5. Reasons for using condoms.

Percentages of respondents who reported that they used condoms because:	Male %	Female %	Total %
Of fear of pregnancy	20.2	45.3	65.5
Of fear of STIs	24.5	14	34.5
Total	37	38	100

About 45% of the female respondents cited fear of pregnancy the major reason that had used condoms during sex against 20% of the male respondents. About 24% of the male respondents indicated that they had used condoms for fear of STIs and HIV and AIDS against 14% of the female respondents.

During the Focus Group Discussion the participants were asked why it was important to use condoms. The study found out that boys used condoms to protect them selves from STIs and HIV and AIDS, while girls used condoms to protect themselves against pregnancies.

A pupil stated;

> we *use condoms but sometimes condoms are not there so we use ice-block plastics instead* (a grade 11, 18 years boy).

Another boy in the discussion said that:

> *if you're seen carrying condoms it is a shame so we hide from being seen by teachers, if you're found, you can be punished by the school authorities* (A grade 11 19 year old boy.)

This was also echoed by the deputy Head of the school that

> *"condoms are not allowed to be distributed at school because it's against the African culture. It is against our culture, it's like we are encouraging bad behaviors among the pupils* (Deputy Head Teacher.)

This is a clear sign that cultural believes also hinder the fight against HIV and AIDS. The usage of ice-block plastics is also a sign of lack of information on hygiene and infectious diseases among the pupils at the school, because those ice-block plastic papers could be carrying bacteria.

This is also an indication that there is non availability and access to condoms at school. We also see from the findings that many girls place the protection against the pregnancy as primary concern than protection from STIs and HIV and AIDS. One of the reasons could be that traditionally girls are brought up to believe that unwanted pregnancies are a disgrace to families and to society at large.

Another reason could be that before the affirmative action programmes for girls started, a girl who fell pregnant whilst in school was expelled. However in the wake of serious AIDS

pandemic and with an anti-AIDS campaigns going on, there should be more attention by both boys and especially girls to not only prevent pregnancy but also avoid HIV and AIDS infection by use of condoms.

The respondents should be more worried about contracting HIV and AIDS than the mere natural out come of unprotected sex which is pregnancy because undoubtedly HIV and AIDS has more grave consequences for young people than a pregnancy. This lack of knowledge in this area can also be attributed to lack of enough ant- AIDS campaign programs for the deaf pupils in high schools.

6. 6. Attitude and believes about condom use

When people are positive about condoms they are likely to use them. In this section issues such as the right to sexual negotiation and the empowerment of females were assessed through statements such as only boys not girls have the right to buy and use condoms. Results are shown in Table 6.6.1

Table 6.6. **Percentage Distribution of Respondents, Attitudes and Beliefs about condoms and sexual practices**

Beliefs about condoms and sexual practices.	Male %	Female %	Total %
Use of condoms reduces sexual pleasure	12.2	10.0	22.2
Only boys and not girls have a right to buy and use condoms	5.3	12.6	17.9
When girls say no to a sexual proposal, she indirectly means yes.	8.0	3.3	11.3
The more girlfriends a boy or a man has the more of man he is.	10.3	2.2	12.5
Virginity is an old fashioned and out dated concept.	5.1	10.2	15.3
Prolonged condom use has side effects	15.5	5.3	20.8
Total	37	38	100

More boys than girls indicated that the use of condoms reduces sexual pleasure. About 12.2% of the male respondents compared to a mere 10% of the female respondents reported that use of condoms reduces sexual pleasures. Such misconceptions and negative attitudes

towards condoms by boys may be an indication that they are not keen on using them and that they may not be willing to allow their sexual partners to insist on using them.

This evidently puts girls in a more disadvantaged position:

> *There is a common say among deaf boys in*
> *the school that having a sex with a condom*
> *is like taking a shower whilst wearing a rain*
> *coat and that condoms are for tasting the fruit*
> *first time, meaning that condoms are only*
> *important when you are having sex for the*
> *first time with your girlfriend.* (A 20 year old grade 12 male).

Most of the male respondents were of the view that when a girl turns down a sexual proposal, she indirectly means yes because as one male participants stated,

> *Action speaks louder than words. A decent girl*
> *will not accept your move just like that, she will*
> *keep on saying no or may be next time, but you*
> *can tell by the signs like looking down and smiling,*
> *a sign that she also wants* (A 19 year old grade 12 male).

A number of the female respondents also agreed to the above misconception, showing that most of them lack proper negotiation and /or communication skills because they are brought up to believe that a girl must exhibit some degree of shyness and naivety in sexual maters if she is to be considered innocent.

> *You just can't say yes, when a guy wants*
> *to sleep with you, especially for the first time.*
> *It is embarrassing and it shows the guy that*
> *you're a bitch, so you must just say no,*
> *even when deep down your heart, you're*
> *are saying yes"* (18 year old grade 11 female).

When asked how they felt society had contributed to the high rate of infection among deaf women and girls, many boys argued that it was actually the girls who were at fault because they were always enticing the men and boys by dressing provocatively. *Most girls like to wear tight things so that they can attract us, and since boys are naturally weak, we can't resist the temptation of seeing a beautiful girl.* (18 year old grade 11 male). Female respondents on the other hand were of the view that it is the boys and men who are naturally weak and fail to stick to girlfriends and wives.

It becomes very clear to the researcher at this stage that both boys and girls participants were brushing aside critical gender issues such as having multiple sexual partners and how these are related to the problem of HIV and AIDS.

What most participants referred to as "*naturally weak*" was after all a gender misconception which is perpetuated in many societies. As a result, the hearing impaired pupils have also accepted this notion mainly because of the way they are brought up in various homes and the way the societies in which they live, are organized at large.

6.7 Conception of safer sex among the hearing impaired pupils

In this study respondents were asked to state what they understood by safe sex the findings are shown in table 6.7.

Table 6.7 **Percentage Distribution of the respondents' understanding of safer sex**

Percentage of what safe sex mean	Male %	Female %	Total %
Using condoms during sex	29.5	31.5	61
Masturbation	14.5	6.2	20.7
Having sex during safe days	6	12.3	18.3
Total	37	38	75

About 30% of the male respondents and 37% of the female respondents correctly stated that safe sex meant that having sex using condoms.

However only a few respondents gave an accurate explanation by adding the aspect of correct and consistent use of condoms. This shows that although most deaf pupils may generally be aware of safer sex, some of them are likely to ignore the fact that condoms are only effective when used consistently and correctly. Some reported that safer sex meant having sex during safe days. While others said, it was masturbation.

Overall what seems to be coming out is the fact that hearing impaired pupils are well aware of the role of condoms in as much as protection from STIs and HIV and AIDS and pregnancy are concerned.

Despite the knowledge, many of them continue to display negative attitudes towards condoms.

> *Condoms are okay, the only problem with them*
> *is that you don't feel anything and they also*
> *prolong the game, too much such that you*
> *might be caught. The other problem is that*
> *some people say that condoms can give cancer*

This in some way is a confirmation of what has been stated in PPAZ report from a research conducted in 1998 among young people in Ndola's Chifubu Township. According to the report it was found out that although condoms among the youth are popular "skin to skin sex is the most desirable such that a number of young people usually take advantage of a girl's safe day's period to enjoy unprotected sex.

CHAPTER V11: SOURCES OF HIV AND AIDS INFORMATION

7.1 INTRODUCTION

To many people in Zambia the mass media has been the source of HIV and AIDS information (CSO *et al.,* 2007); these mass media have also shown how best people can protect themselves against HIV and AIDS infection. Apart from the media several other sectors of society, NGOs, CBOs and FBOs have also acted positively in bringing issues of AIDS to the people. This chapter assesses sources of knowledge among the hearing impaired.

7.2 SOURCES OF STIs INFORMATION AND KNOWLEDGE

In this study respondents were asked to state what their sources of information on STIs other than HIV and AIDS were, the results were shown in the Table7.1

Table 7 1. **Percentage Distribution of Respondents" Sources of STDs Information and knowledge**

Sources of information	**Female**	**Male**	**Total %**
Parents	10.6	6.6	18.3
Friends	13.3	16	29.3
T.V	4.0	9.3	13.3
church	2.6	4.0	6.6
Books	2.6	6.6	9.2
Ant-AIDS club	16	7.3	23.3
Total	**38**	**37**	**100**

A large percentage 29.3% of the respondents got their STIs information from their friends. Some 23.1% stated that they got their information from the anti- AIDS club; while a mere 9.2% got their information from the books. That is, more respondents got the STIs information from their friends while a smaller number got it from their churches.

As discussed earlier in Chapter 4, male respondents were more likely to have better knowledge of STIs than girls and were more likely to openly discuss STIs with their friends.

During most focus group discussions many participants bemoaned the lack of information about STIs, which they claimed were more common among the deaf boys and girls than any other disease.

7.3 SURCES OF HIV AND AIDS INFORMATION AND KNOWLEGDE

Among those who had ever seen or heard HIV and AIDS information, the percentage of respondents who reported their sources in relation to their age is shown in Table 7.2.

Table 7.2. Percentage of who obtained HIV and AIDS information in relation to age

Age	Parents%	Teachers%	Friends%	News papers%	TV%	Anti- %Aids club.	Church%	Total%
13-15	14.0	17.6	10.1	5.6	11.8	30.6	10.3	100
16-17	11.8	20.5	15.7	8	13.9	24.1	6	100
18+	2.2	16.8	25.3	12.9	14.5	25.4	2.9	100

Anti-AIDS club provided information to the largest group of respondents in all age groups. About 10.3 % of the respondents aged between 13 -15 .About 15.7 % of those aged between 16 and 17 and 25.3 % of respondents aged between 18 and above were likely to get their HIV and AIDS information from friends.

The table above shows that the levels of parent–child communication decreases with age as the younger adolescents between 13 and 15 were more likely to get AIDS information from their parents compared to older adolescents. On the other hand the levels of peer communication increases with age as older adolescents aged between 16 and 18+ were more likely to receive HIV and AIDS information from their friends.

During focus Group Discussion most respondents stated that they were not really free to talk to their keepers about AIDS because at many times the environment in which they got such information was rarely conducive;

> My *mother talks about AIDS when I have done something wrong may be when I come late home. This makes it hard for me to appreciate what she's saying because I also get upset.* (18 year old grade 12girl).

Churches mostly provide AIDS information to young or adolescents compared to older adolescents. This shows that as young people grow older, they are less likely to be influenced by their religious beliefs.

During FGD, participants argued that because most deaf people do not get what preachers preach at church most of the deaf people do not go to church. This shows that most churches don't have necessary sign language skills to carter for the deaf people in the communities.

The study however revealed that some pastors from a named church come at the school every Sunday to preach to the deaf pupils in sign language. One pupil stated;

> *Pastors tell us to abstain at church, because sex is sin; (Grade* 10 16 year old boy).

In response one male participant said;

> *Even though pastors tell us to abstain, it is difficult to abstain to some of us who have already tested the fruit. Condoms must be encourage*d (A 21 year old Grade 12 male)

In terms of access to information, both males and female respondents seemed to have equal access to HIV and AIDS information. What differed were the sources from which

they were likely to get the information from. These may range from parents, peers, TV, and anti-AIDS club at school which is done in sign language.

In cases where there were gender disparities, there where very minimal, there by providing what has already been established in this research that both girls and boys in high schools have equal access to HIV and AIDS information from various sources especially information pertaining to transmission and prevention.

7.4 HOW RESPONDENTS VIEWED HIV AND AIDS INFORMATION RECEIVED

In order to determine the trusted sources of information, respondents were asked to state how they viewed or perceived the information they received from the various sources and the results are recoded in the Table 7.3

Table 7.3. Percentage Distribution of how Respondents perceived HIV and AIDS information

Found HIV and AIDS information	Male %	Female %	Total %
Embarrassing	8.4	15.6	24.0
Confusing	10.7	16.3	27.0
Boring	6.4	7.0	13.4
Helpful	16.3	18.3	34.6
Total	37	38	100

Comparatively, more female respondents found information they received from various sources embarrassing than their male counterparts. About 6.4% of the males stated that they found the information boring, some 18.3 % of the female respondents found it helpful compared to 16.3 % for males.

Since a large number of both males and female respondents found it either boring, confusing or embarrassing, this means that the information was not well received and might therefore not have the intended out come in so far as influencing young people's sexual behavior.

In one FGD participants complained that there were several contradictions in the information from various sources;

> *Sometimes we are told that abstinence*
> *is the best at other times we are told to*
> *use condoms .so I personally got*
> *confused* (grade 11 19 year old male).

Many respondents complained that those who interpreted in sign language on TV were confusing because they used other signs and sometimes they do not know how to sign proper signs. One pupil indicated that;

> *Sign language is different from place to place*
> *so we can not know certain signs; (*17 year old Grade 11female).

These misconception and negative beliefs about HIV and AIDS among the deaf in high schools may be due to personal unreliable sources of information to which they are exposed to:

> *We need more programmes designed and*
> *presented by deaf youth on the TV. The*
> *sign language must be universal and be*
> *made simple so that we the deaf people*
> *can understand everything about HIV and*
> *AIDS. This will help in reducing the confusion*
> *and the embarrassment faced by a number*
> *of us* (18 year old grade 11 female).

7.5 PREFERED SOURCES OF HIV AND AIDS INFORMATION

Having established the major sources of HIV and AIDS information for the deaf adolescents at Magwero School for the deaf, and how they perceived this information, respondents were asked to state their preferred sources of information. The results are reported below in Table 7.4

Table 7.4 percentages Distribution of respondents who preferred to get information from.

Percentage of respondent who preferred to get information from.	Male %	Female %	Total %
Parents	6.3	8.2	14.5
Anti-AIDS club	12.3	13.6	25.6
Health workers	7.0	8.0	15.0
People living with HIV and AIDS.	10.3	14.0	24.3
Friends	5.0	4.0	9.0
Media	6.0	6.0	12.0
Total	37	38	100

The majority of the respondents 26% stated that they preferred to get HIV and AIDS information from Anti-AIDS club. People living with HIV and AIDS were also a major source of information for both males and female respondents. Despite their previous complaints about parents not talking to them about sex and related issues, however some respondents still preferred to get HIV and AIDS information from their parents.

When asked during the FGD why parents were not the preferred sources of information for many deaf adolescents, participants were of the view that it was embarrassing to discuss such topics with parents;

> *It is a taboo in our culture to talk to your parents about sex, besides our parents can never allow us to have boyfriends/girlfriends or maybe use a condom, even if they were aware that their child was sexually active* (18 year old grade 10 male).

Some participants did however suggest the way to avoid this problem;

> *It is better for mothers to talk to their daughters and fathers to talk to their sons about sex related*

issues and AIDS so that traditions are maintained
and also to avoid embarrassment (18 year grade 11girl.)

This was, however, seen as an indication of gender biases common among deaf adolescents most of which are influenced by their traditions and up bringing.

Some respondents preferred to get information from the people who are living positively with the HIV and AIDS (PLWA).To them these have the experience and actually bearing the burden of the disease. Some participants in the FGD reported how some one came who was HIV and AIDS positive to talk about AIDS. One pupil reported'

He shared with us how he got infected and
how the disease has changed his life; (20 year grade 11 boy).

7.5 MSCONCEPTION RELATED TO INFORMATION ON HIV AND AIDS TRANSMISSION

Information about HIV and AIDS is usually over shadowed by a number of misconceptions. This negatively affects most deaf pupils' perception of the disease. In order to gain some insight about some of the common misconceptions of HIV and AIDS among the hearing impaired pupils in high schools, they were asked about the same.

The study had five statements on misconceptions related to information on how AIDS is transmitted from one person to another and the results are highlighted in the Table 7.5

Table 7.5 **Misconceptions about Modes of AIDS Transmission**

Misconception about modes of Transmission	Male %	Female %	Total %
Mosquito bites	6.0	7.2	13.2
Sharing cup/plates with infected person	10.5	12.6	23.1
Spread through saliva	8.3	10.5	18.8
Sharing toilets/bathroom with infected person	10.3	8.3	18.6
Transmission through witchcraft.	8.9	10.1	20.3
Total	37	38	100

Results from this study indicate that 8.3% of the male and 10.5% of the female respondents reported that AIDS can be spread through saliva.

During the FGD, however this was qualified by stating that this could only happen if the people kissing have open sores in their mouths A male pupil reported that;

I was told that if a person is infected
he has sores in the mouth and kisses a
healthy person, then the healthy person
becomes infected; (16 year grade 10 male.).

Only 6% of the male respondents and 7.2% of he female respondents reported that HIV and AIDS could be transmitted through mosquito bites.

According to the 2003 Zambia Sexual Survey (ZSBS), a belief in mosquito transmission of HIV and AIDS has decreased dramatically among the adolescents since 1998. But it is still high among the deaf adolescents an indication that deaf adolescents are left out in most HIV and AIDS awareness progammes which the government prepares for the youth in the country. Similarly the misconceptions about transmission through witchcraft are notable. About 9 % of the males and 10 % of the female respondents were likely to believe that AIDS could be transmitted through witchcraft.

The misconception about HIV and AIDS transmission through sharing cups, plates, toilets and bathrooms were still common among the deaf at the school. The (2005) Zambia Sexual Behavior Survey (ZSBS), indicated that there had been no major changes about HIV and AIDS misconceptions and beliefs since 2000. In fact a slight rise was observed among the adolescents from 12.7% in 2000 to 12.9% in 2005. (CSO, 2005)

7.6 MISCONCEPTION RELATED TO INFORMATION ON HIV AND AIDS

Despite the high awareness of HIV and AIDS knowledge among the deaf adolescents, the study discovered that many deaf pupils still held a number of hindering beliefs that impacted negatively on their attitude leading to a number of them taking unnecessary risks.

In Chapter 5, misconceptions exclusively related to HIV and AIDS transmissions were discussed.

The ability of female to make decisions about sexual activities had also important implications for HIV and AIDS infections because it showed whether or not they could protect themselves from sexually transmitted diseases such as HIV and AIDS and unwanted pregnancies.

Respondents were therefore asked a series of questions to ascertain the levels of acceptability of certain practices or behaviors related to men and women, the results are presented in the Table 7.6

Table 7.6 Percentage Distribution of Respondents' misconception and beliefs on HIV and AIDS and STDs

Misconception and Beliefs on HIV and AIDS and STIs	Male %	Female %	Total %
Sleeping with a young girl cures aids in a man	12.6	8.0	20.6
Seeking protection from a traditional healer can prevent AIDS	15.3	8.0	23.3
AIDS positive people are getting what they deserve	10.5	14.4	24.9
A boy who has never had an STI isn't man enough	7.4	6	13.4
AIDS is mostly a disease for the rich and famous	9.5	8.3	17.8
Total	37	38	100

Only 12.6 % of the male respondents and 8 % of the female respondents reportedly agreed that sleeping with a young girl or a virgin cures AIDS in the man. This wild misconception has in a recent past led to a rise in a number of children being molested or abused by older men.

Fortunately most of the respondents disapproved of the practice;

> *it is not true that when a man sleeps with a young girl,*
> *he can be cured of AIDS because as we heard AIDS*
> *has no cure* (16 year old grade 9 male).

Another participant had the following;

> *all those men who are molesting young girls and babies must just be sentenced to death because infecting an innocent person with AIDS is as bad as murder. People know that there is no cure for AIDS, but I know that desperate people do desperate things, The best they can do is start taking ARVs* (19 year old grade 12 female).

Findings from this chapter have also shown that a good number of deaf pupils in high schools still hold conflicting beliefs about HIV and AIDS such as "AIDS" is a disease for the rich people, which is likely to affect their sexual behavior negatively.

As stated earlier some of these beliefs may be partly due to the misinformation about HIV and AIDS arising from the unreliable and personal sources such as friends. Some of these issues may also be rising from the indigenous traditions and cultural beliefs about sex, found and practiced in many communities in which these deaf pupils live.

From what many participants stated during FGD held at school, there was clash between modern scientific information such as a girl has a right to protect her self by demanding the use of condoms with her boyfriend, but traditionally, it's a shame for a girl to talk about condoms to her boyfriend.

CHAPTER V111: CONCLUSION AND RECOMMENDATIONS.

8.1 CONCLUSION

This study on knowledge, attitude and sexual behavioral practices among the hearing impaired pupils has demonstrated that deaf pupils in the country are at high risk of getting infected with HIV and AIDS. The reasons for this are weak HIV and AIDS awareness programmes among the deaf pupils in high schools. To obtain the results, several instruments were used which included questionnaire, interview and focus group discussion guide.

It is clear from the findings that the main sources of information for the deaf pupils on HIV and AIDS are their peers who may not have scientific knowledge on issues of HIV and AIDS. The implication of this is that these pupils will get wrong information which will further put them at higher risk of getting infected. In the real sense the information and knowledge that deaf adolescents have acquired from different sources has not substantially affected their willingness to do away with risk activities through which they can be infected with the HIV virus.

Negative gender ideas between boys and girls were also reported when more male participants stated that when girls say no to the sexual proposal, they indirectly mean yes: such views have led to a number of misconceptions about masculinity and femininity to a point where many deaf adolescents have accepted beliefs concerning sexual behaviors. This increases chances of HIV and AIDS infection. What has also clearly come out of this research is the dilemma facing many HIV and AIDS educators; most of them do not know sign language, a language which is used by hearing impaired people. The other challenge with sign language is that it differs from one community to another. This language barrier has for a long time left the deaf people outside most HIV and AIDS awareness programmes. This denied them chances to acquire the most needed knowledge on HIV and AIDS.

The other factor is that despite what the deaf have come to learn about the dangers of HIV and AIDS, they continue to a very large extent to behave in a way that put them at risk as evidenced by a large percentage of respondents who reported not having used condoms during their sexual debut. The explanation of this seems to lie in part to the general practice that many deaf adolescents are at a stage in life when they are likely to be experimenting with their new found feelings by engaging in activities that are likely to put them at risk.

But the traditional gender roles expectations placed on boys and girls may cause them to behave in a way contrary to the information they are getting. For example it is traditionally unacceptable for a girl to buy a condom to use during sexual relationship.

It also seems that most deaf adolescents have not internalized and personalized the risks that HIV and AIDS and STIs poses on them as individuals. This is mostly because many of them are living with a *"self fulfilling prophecy"* where they never see themselves at risk but almost associates AIDS with people who portray certain behaviors like having multiple sexual partners or sleeping with prostitute, not through a mere unprotected sexual act. The findings further showed that few respondents recognize the fact that they are at risk of getting HIV and AIDS.

The failure by most respondents to see the link between HIV and STIs have in a way contributed to their low risk perception as most of them are deceptively comforted by the thought that STIs unlike AIDS can be cured using traditional herbs.

There is also the failure to see gross dangers associated with unprotected sex in general even though they may be aware of the fact that it is one way through which AIDS is transmitted. In other words unprotected sex which only leads to having STIs are not as harmful as the unprotected sex which causes HIV and AIDS, because STIs are curable. It is ironical that many females were more afraid of getting pregnant than they are of acquiring HIV and AIDS.

The research has also shown that some adolescents find the HIV and AIDS information they are receiving from various sources confusing and embarrassing, something which is not likely to bring out desired response to the provided HIV and AIDS message. Most of the confusion may also be as a result of sources of information such as friends who may not necessarily have the right facts about the disease. Such information usually tends to be distorted and saturated with a number of misconceptions.

The fact that different sectors of Zambian societies such as the church have chosen to promote and emphasize different aspects of preventive behavior such as abstinence or condom use also brings about some form of confusion to the adolescents. There is therefore an urgent need to harmonize HIV and AIDS messages for deaf adolescents to lessen unnecessary conflicts.

Other findings from this research have shown that information that explicitly focuses on how HIV and AIDS and other STIs are acquired is not enough to modify the risk behaviors of young deaf people.

Hearing impaired youths should be helped to redefine the nature of their relationships, such as gender imbalances when making decisions in a sex relationship, which promote the subordination of women and girls.

The HIV and AIDS information being given to deaf adolescent in High Schools must therefore address the issues of gender and help girls and boys acquire skills through which they will be able to cope with sexual pressure. Deaf adolescents especially boys, must be taught from a very early stage that gender equality goes beyond the knowledge that girls can also do in mathematics and science in class.

This is only part of the bigger picture. They must be taught to recognize and appreciate girls as equal players in the economic, social and moral spheres of life including choice on safer sex. Girls on the hand must be given information that not only pertains to the problem

of HIV and AIDS in general but more importantly issue, that affect their sexual rights, responsibilities, priorities and risks.

The study also showed that there were gaps in terms of the information flow both to the hearing impaired boys and girls. There must be therefore intensified and deliberate efforts by parents, teachers and communities at large to ensure that they help raise the personal risk perception of the young deaf people so that they stop looking at AIDS with a futuristic approach and begin to appreciate that HIV and AIDS is a disease which also affect young deaf like themselves. This can only be done if they are given the information that is relevant to the different situations in which they find themselves in.

RECOMMENDATIONS

Based on the findings in this report the research makes the following recommendation:

1. HIV and AIDS and sex education should be introduced by the Ministry of Education in all schools for the deaf. This will help produce right information and discard misconceptions and beliefs present among boys and girls in high schools.

2. High school special teachers must be trained to offer HIV and AIDS counseling, sex and gender education to deaf pupils in order to promote the flow of information and knowledge about these issues.

3. High school teachers must be trained in sign language in order to communicate effectively to their deaf pupils on HIV and AIDS related issues.

4. Since peers play an important role in interpersonal communication about sex and HIV and AIDS, peer education among the deaf pupils in high schools must be developed so that there is an exchange of reliable HIV and AIDS information among peers in high schools

5. The Ministry of Education must collaborate with civic and church organizations involved in anti-AIDS campaign programmes for adolescents in general so that they formulate common objectives and goals to avoid confusing young people. This will also help to lessen misconceptions about sex, condoms and HIV and AIDS in general.

6. The government and civil societies should sensitize the public not to discriminate the people living with disabilities especially on HIV and AIDS related issues, but to have an inclusive approach to HIV and AIDS campaign programmes.

7. Since most respondents were seemingly ignorant of cardinal gender issues and the way these relate to the problem of HIV and AIDS, gender sensitization

should be made an integral part of various. HIV and AIDS programmes carried out in schools by various organizations. To this effect the Ministry of Education must work closely with organizations like FAWEZA to ensure that gender sensitization in schools goes beyond the academic promotion of a girl child.

8. Interpersonal skills development must be enhanced in all high schools through activities such as sports, debate and other extra curricular activities to ensure that the deaf pupils develop skills through which they can protect themselves from risky sexual activities.

9. Boy child education that sensitizes boys in high schools to respect girls not only academically but socially as well must be promoted by various organizations in Zambian communities. This would prevent boys from seeing girls as mere objects of their sexual fantasies and gratification, but as human beings who deserve respect in all areas of life. This will lessen the many misconceptions about sex and improve deaf adolescents' attitude and sexual behaviors.

10. There is need to fund new and indigenous HIV and AIDS research undertakings involving deaf pupils in high schools. This would provide new data to be used in addressing the challenges posed by the HIV and AIDS pandemic.

11. Sex education must be introduced in colleges which trains special teachers so that they in turn can teach the deaf pupils in schools where deaf pupils are.

12. Reliable sources of HIV and AIDS information for the deaf must be put in place through awareness programmes tailored for the hearing impaired pupils and HIV and AIDS literature written in sign language.

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APPENDIX I

QUESTIONNAIRES FOR STUDENTS

Personal Data

Instructions

(a) Do not write your name on this paper
(b) Treat this work as contribution.
(c) Put a tick [√] on your choice or circle your answer or fill in the appropriate responses in the space provided.
(d) All answers must be written in the space provided.

---

1. Sex (a) Male [ ]
   (b) Female [ ]
2. What grade are you?
   (a) 8 [ ]
   (b) 9 [ ]
   (c) 10 [ ]
   (d) 11 [ ]
   (e) 12 [ ]
3. How old are you? .... {years}
4. Where do you stay?
   (a) In boarding? [ ]
   (b) Day schooling? [ ]
5. Who looks after you?
   (a) Both parents? [ ]
   (b) Guardians [ ]
   (c) Father only [ ]
   (d) Mother only [ ]
   (e) Mother and Step-Father [ ]
   (f) Father and Step-Mother [ ]
   (g) Any other.. [ ]
6. Do you take alcohol?

(a) Sometimes [ ]
(b) Always [ ]
(c) No [ ]

7. How would you describe your parents/guardians' attitude towards you?
....
....
....
....

8. Do you value your parents/guardians' advice on important issues?
(a) All the time [ ]
(b) Sometimes [ ]
(c) I usually make my own decisions [ ]
(d) Never [ ]

9. Are you a religious person?
(a) Very much [ ]
(b) Fairly [ ]
(c) Not at all [ ]

10. How seriously do you take your religious teaching?
(a) Very seriously [ ]
(b) Fairly seriously [ ]
(c) Not at all seriously [ ]

11. Do you value your friends' advice and opinions on important issues?
(a) Yes [ ]
(b) No [ ]

Knowledge of HIV/AIDS and S.T. Ds

1. Apart from HIV/AIDS, what other STDs do you know?
....
....
....
....

2. What do you think is the best way to treating STDs?
....
....
....
....

3. What is the difference between ordinary STD and HIV/AIDS?
....
....
....
....

Knowledge of Mode of HIV/AIDS Transmission

1. AIDS can be transmitted through sharing unsterilized needles and razor blades.
   (a) True [ ]
   (b) False [ ]
   (c) Not sure [ ]
2. A pregnant girl or woman can transmit HIV/AIDS to her unborn baby.
   (a) True [ ]
   (b) False [ ]
   (c) Not sure

   [ ]
3. HIV/AIDS can be transmitted through mosquito bites.
   (a) True [ ]
   (b) False [ ]
   (c) Not sure [ ]
4. HIV/AIDS can be transmitted through saliva by deep kissing.
   (a) True [ ]
   (b) False [ ]
   (c) Not sure [ ]
5. Breast milk from the mother to the baby can transmit HIV/AIDS.
   (a) True [ ]
   (b) False [ ]
   (c) Not sure [ ]
6. You can get HIV/AIDS by sharing the same toilets and bathrooms facilities with an infected person.
   (a) True [ ]
   (b) False [ ]
   (c) Not sure [ ]
7. You can get HIV/AIDS by sharing cups and plates with an infected person.
   (a) True [ ]
   (b) False [ ]
   (c) Not sure [ ]

Knowledge of HIV/AIDS/STD Prevention

1. Washing off sperms immediately after sex can prevent STD/HIV/AIDS infection.
   (a) True [ ]
   (b) False [ ]
   (c) Not sure [ ]
2. You can prevent HIV/AIDS by not giving or receiving.
   (a) True [ ]
   (b) False [ ]
   (c) Not sure [ ]
3. Having many steady girl friends rather than going for prostitutes can help prevent HIV/AIDS.
   (a) True [ ]
   (b) False [ ]
   (c) Not sure [ ]

4. Seeking protection from a powerful traditional healer can help prevent the spread of HIV/AIDS.
   (a) True [ ]
   (b) False [ ]
   (c) Not sure [ ]

5. Engaging in oral and dry sex can prevent the spread of HIV/AIDS.
   (a) True [ ]
   (b) False [ ]
   (c) Not sure [ ]
6. Avoiding mosquito bites can prevent the spread of HIV/AIDS.
   (a) True [ ]
   (b) False [ ]
   (c) Not sure [ ]
7. Abstinence is the best form of HIV/AIDS prevention.
   (a) True [ ]
   (b) False [ ]
   (c) Not sure [ ]

Sexual Practices and Condom use

1. Do you have a boy/girl friend?
   (a) Yes [ ]
   (b) No [ ]
2. Have you ever had sex with your current or past boy/girl friend?
   (a) Yes [ ]
   (b) No [ ]
3. How old were you when you first had sex?
   ....
4. Was it with the present boy/girl friend?
   (a) Yes [ ]
   (b) No [ ]
5. Did you use a condom during your first sexual encounter?
   (a) Yes [ ]
   (b) No [ ]
   (c) Can't remember [ ]
6. If you answered yes to the above question, why did you use a condom?
   (a) Fear of pregnancy [ ]
   (b) Fear of HIV/AIDS and STDs [ ]
7. If you answered no to condom use, why didn't you use a condom?
   (a) I trusted any girl friend/boy friend [ ]
   (b) I didn't think it was necessary [
   ]
   (c) I was afraid of what my partner would think [ ]
8. What are some of the reasons for your first sex?
   (a) Peer pressure [ ]
   (b) Need to experiment with my feelings [ ]

(c) Need to prove any love for my boy/girl friend [ ]
(d) Need to prove my manhood and be in control of my life [ ]

9. Have you changed your partners in the last 12 months?
(a) Yes [ ]
(b) No [ ]

10. Are you still having sex?
(a) Yes [ ]
(b) No [ ]

11. What are some of the reasons you are still having sex?
(a) Need to keep my boy/girl friend [ ]
(b) Need to show that am a man [ ]
(c) Need to gain experience [ ]
(d) Am being forced [ ]

12. How often do you use condoms during sex presently?
(a) Always [ ]
(b) Sometimes [ ]
(c) Never, we trust each other [ ]

13. If you have never had sex, when do you intend to start?
(a) When I finish grade 12 [ ]
(b) When I go to University/College [ ]
(c) When I meet the right person [ ]
(d) When I get married [ ]

14. Who in a relationship must initiate sex?
(a) Boy [ ]
(b) Girl [ ]
(c) Both [ ]

15. Has anybody ever taught or demonstrated to you how to correctly use a condom?
(a) Yes [ ]
(b) No [ ]

16. The best sex between two young people is;
(a) That which is planned before it happened [ ]
(b) That which happens without planning [ ]
(c) That which happens after they have come to trust each other [ ]

17. How do you rate abstinence for two young people in a relationship?
(a) It is difficult but possible [ ]
(b) It is difficult and impossible [ ]
(c) It makes a relationship boring [ ]

18. Who according to you is responsible for ensuring abstinence in a relationship?
(a) Boy [ ]
(b) Girl [ ]
(c) Both [ ]

19. What do you think about distribution of condoms to girls and boys in secondary schools?
(a) It is immoral in a christen nation like Zambia [ ]
(b) It increases sexual activities between boys and girls in secondary

Schools [ ]
(c) It is a good way of preventing the spread of HIV/AIDS among young People [ ]

Beliefs and Misconceptions about HIV/AIDS/STDs and Condom use

1. AIDS can be treated it detected early
   (a) True [ ]
   (b) False [ ]
   (c) Not sure [ ]
2. Once a person has suffered from an STD, they can not get it again.
   (a) True [ ]
   (b) False [ ]
   (c) Not sure [ ]
3. If an old HIV positive male sleeps with a young girl, they can be cured from HIV/AIDS.
   (a) True [ ]
   (b) False [ ]
   (c) Not sure [ ]
4. Is a boy impregnates a girl and refuses to take responsibility, her relatives can bewitch him with AIDS.
   (a) True [ ]
   (b) False [ ]
   (c) Not sure [ ]
5. When a person has T.B, they certainly have HIV/AIDS.
   (a) True [ ]
   (b) False [ ]
   (c) Not sure [ ]
6. When a person has T.B they certainly have HIV/AIDS.
   (a) True [ ]
   (b) False [ ]
   (c) Almost always [ ]
7. Use of condoms reduces sexual pleasure.
   (a) True [ ]
   (b) False [ ]
   (c) Not sure [ ]
8. Prolonged use of condoms has negative effects on a boys future sexual performance.
   (a) True [ ]
   (b) False [ ]
   (c) Not sure [ ]

Attitude and Beliefs about Sexual Behaviors

1. What do you see as some of the benefits of two young people having sex with their boy/girl friend?
   (a) They learn to trust each other [ ]
   (b) They prove their love for each other [ ]

(c) They gain important knowledge and experience [ ]
(d) They learn to respect each other [ ]

2. People who are HIV positive are getting what they deserve.
   (a) True [ ]
   (b) False [ ]
3. Do you ever see yourself at risk of getting HIV/AIDS at any point in your life?
   (a) Yes [ ]
   (b) No [ ]
   (c) Not sure [ ]
4. When do you think you will be most vulnerable to HIV/AIDS infections?
   (a) Now [ ]
   (b) When I finish school [ ]
   (c) When I get married [ ]

5. It is not necessary for boys and girls in secondary schools to know their HIV/AIDS status because it might disturb their studies.
   (a) True [ ]
   (b) False [ ]
   (c) Not sure [ ]
6. HIV/AIDS is a disease like any other; it does not deserve the attention it is getting
   (a) True [ ]
   (b) False [ ]
7. I can never be friends with a person who is HIV/AIDS positive.
   (a) Yes [ ]
   (b) No [ ]
   (c) Not sure [ ]
8. It really does not matter what I do with my life now, I can still get AIDS anyway.
   (a) True [ ]
   (b) False [ ]
   (c) Maybe [ ]
9. The more sexual experiences one has the easier it becomes to avoid HIV/AIDS.
   (a) True [ ]
   (b) False [ ]
10. Despite what I know about HIV/AIDS, I still see sex as;
   (a) A normal part of growing up [ ]
   (b) A gift from God to enjoy [ ]
   (c) A risk to my own life [ ]
11. STDs are women's diseases (Matenda yabakazi).
   (a) True [ ]
   (b) False [ ]

HIV/AIDS Information and Sources

1. From where have you got most of the information about STDs and HIV/AIDS?

(a) Church [ ]
(b) Teacher [ ]
(c) Parents [ ]
(d) Friends [ ]
(e) Newspaper [ ]
(f) Television [ ]
(g) Radio [ ]
(h) Health worker [ ]
(i) Peer educator [ ]
(g) Any other..

2. How would you describe the information you have received?
(a) Embarrassing [ ]
(b) Boring [ ]
(c) Helpful [ ]
(d) Confusing [ ]

3. If you cited your parents or guardians as your source of HIV/AIDS information, how was this information given to you?
(a) As direct advice [ ]
(b) In form of warning and threats [ ]
(c) Indirectly [ ]

4. Would you trust a traditional healer to give important scientifically correct HIV/AIDS information?
(a) Yes [ ]
(b) No [ ]
(c) Sometimes [ ]

5. Would you trust your friend to give you scientifically correct HIV/AIDS information?
(a) Yes [ ]
(b) No [ ]
(c) Sometimes [ ]

6. Who do you think has more HIV/AIDS information between deaf boys and deaf girls in secondary schools?
(a) Deaf boys [ ]
(b) Deaf girls [ ]
(c) Both of them [ ]

9. With regard to the HIV/AIDS information you have received, do you think boys and girls in your school are;
(i) Using condoms during sex?
(a) Yes (b) No (c) Not sure
(ii) Are still engaging in unprotected sex?
(a) Yes (b) No (c) Not sure
(iii) Abstaining from sexual activities?
(a) Yes (b) No (c) Not sure

(iv) Sticking to one sexual partner?

(a) Yes (b) No (c) Notsure

APPENDIX II

Focus Group Discussion Guide

I welcome you all to this discussion. I want to encourage all of you to feel very free to make contributions about the various issues that will be raised. There are no wrong or right answers. Kindly note that only one speaker will be allowed to speak at any given time, and you are not allowed to make any interjections when one person is speaking. If you want to speak indicate by raising your hand and the facilitator will give you chance to speak.

General Awareness of HIV/AIDS

Some people thing that anyone who suddenly loses weight and has constant diarrhoea and vomiting has AIDS. Please tell us anything you know about AIDS.

Probe:

- Ask what HIV/AIDS stands for?
- Ask about some known symptoms of AIDS.
- Can one tell by looking at a person whether he/she has AIDS or not?
- There are several ways through which AIDS is transmitted from one person to another, what mode of transmission do you know?

Probe:

- Ask for detailed explanations on mode of transmission and probe on those left out.
- Can witches and wizards magically give AIDS to people they do not like?
- Other people think AIDS can be transmitted through handshakes with infected persons. What other misconception and beliefs related to how AIDS is transmitted is common among the deaf? Like yourselves.
- It is believed that people with disabilities cannot be infected with AIDS? Is it true? Is it often said that "prevention is better than cure", and since there is no cure for AIDS, and a lot of emphasis is being put on prevention. Abstinence and condom usage are seen as the best and the most effective ways of preventing HIV/AIDS. What methods of prevention are you aware of?

Probe: Ask about effectiveness of these methods

- Some people say condom use is not good because it reduces the sexual pleasure. What is your comment on this?
- Ask about the need for correct and consistent use of condoms in HIV/AIDS prevention.
- Ask also for opinions on the belief that boys/men are the only ones who should decide whether or not to use condoms during sex.
- Some people believe that it is very difficult for a sexually active young person to control themselves (secondary abstinence) and that only someone who had never had sex can abstain. What does abstinence mean to young people like you?

Probe: What are some of the challenges faced by adolescents in practicing abstinence?

- Who has the responsibility to ensure that a boy and a girl in a relationship abstain from sex?

Appreciation of ....and Risk Perceptions

It has been said "if one is not infected, they are affected". How do you think HIV/AIDS has affected young people like you in our society?

Probe: Why do you think girls find it difficult to move away from circumstances that increase their risk of infection?

- Do you thin there are deaf adolescents who are infected with AIDS?
- Ask how different sectors of society contribute to the high rate of HIV/AIDS infection among girls/women, schools, family, religion etc.

Risk Behaviour and Gender Relations

There are a number of imbalanced gender relations at many levels of society. For example, men and boys are brought up to believe that the more girls/women they have the more of a man they are. Men are allowed to have extra marital relations. Girls and women on the other hand are not expected to leave the confines of their relationship for sexual gratification elsewhere, otherwise they would be branded as prostitutes.

- Do you see or experience any imbalanced cultural and traditional beliefs and practices as young people especially those related to sexual gender roles?

Probe: In which ways have these gender imbalanced between boys and men and girls/women contribute to the high levels of HIV/AIDS in Zambia in general and in your society in particular?

- Ask how women/girls living with disabilities are more vulnerable to HIV/AIDS?
- There are fears that homosexuality is fast becoming a trend in Zambia, young boys are lured into this practice by promises of money and material wealth.

HIV/AIDS Information

One of the main interventions that has been used in the fight against AIDS is the dissemination of information to educate people about its dangers and how they can protect themselves against infection. The media through television, radio and newspapers, has been a major source of information for many people in Zambia. Other NGOs and the church have also played major role in this fight. Please tell us of other sources of HIV/AIDS information that you know about. Are there any sources that specifically target the deaf young people like you?

Probe: What important messages have you obtained from the various sources?

- Why do you think young people should be given special attention in the fight against HIV/AIDS?
- Do you think deaf girls and deaf boys have the same access to HIV/AIDS information?
- Do you think they should be given the same type of information?
- What is the best means to disseminate HIV/AIDS information to the deaf adolescents and why?

APPENDIX III

University of Zambia
School of Humanities and Social Sciences
Gender Studies Department
P O Box 32379
Lusaka

The Head
Magwero School for the deaf,
P O Box
Chipata.

Dear Sir/Madam,

RE: RESEARCH STUDY: KNOWLEDGE, ATTITUDE AND SEXUAL BEHAVIUORAL PRACTICES AMONG THE HEARING IMPAIRED STUDENTS IN ZAMBIA IN THE ERA OF HIV AND AIDS: (A CASE OF MAGWERO SCHOOL FOR THE DEAF.

I am a student at the University of Zambia, School of Humanities ad Social Sciences, Department of Gender Studies. As part of the requirements for this course, I am required to conduct a research study. I want to conduct focus group discussions with grades 8 to 12. The results of this study will help identify best strategy to reach the deaf with the message of HIV and AIDS and with regards to their sexuality and will assist the Ministry of Education to map up programmes which will be tailored towards the deaf pupils in high schools.

I am hereby seeking permission to carry out the study at your institution.

Yours faithfully,
Redges, Munsaka, Muleya.

APPENDIX 1V

CONSENT FORM FOR RESPONDENTS AT MAGWERO SCHOOL FOR THE DEAF

My name is Redges Munsaka Muleya. I am a student in gender studies at the University of Zambia. I am collecting information at your school in connection with HIV and AIDS. The information is for both academic purposes and for the Ministry of Education who may provide HIV and AIDS awareness programmes in school for the deaf in Zambia

Your participation in this research is entirely voluntary. You, re free to take part or not. If you decide to take part, you are still free to withdraw at any time without penalty or loss of service and without reason.

You may also choose to answer particular questions and leave out those which you do not wish to answer.

Any information you share in this research is completely confidential and your name will not be shared with anyone or attached to the information you give.

....

I consent voluntarily to be a participant in this research.

Participant name..
Participant signature..
Consent date..
Researcher name...
Signature of researcher...
Date...

APPENDIX V

IN-DEPTH INTERVIEW TO THE PUPILS

- Do you engage sexual relationship?
- Do you use a condom when having sex?
- When did you start having sexual relationships?
- How many boy girls have you slept with?
- What do you know about HIV/AIDS?
- How can one avoid contraction of HIV/STDS?