FACTORS ASSOCIATED WITH RISKY SEXUAL BEHAVIOUR IN REGARD TO HIV PREVENTION AMONG PERSONS ATTENDING STD CLINIC AT THE UNIVERSITY TEACHING HOSPITAL, LUSAKA

BY

GRACE S. K. MWANGALA

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University of Zambia
School of Medicine
Department of Community Medicine
LUSAKA

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DECLARATION

I, Grace Sibeso Mwangala, so hereby solemnly declare that this dissertation represents my own and that it has not previously been submitted for any degree at this or indeed any other University.

Sign: G.S. mwangala
(Grace Sibeso Mwangala)

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We have read this dissertation and have approved it for examination.

Date: 24-12-02 **Signature:**

Date: 26/12/02 **Signature:**

Supervisors

Professor K.S Baboo, *MBBS, MD, FRSH, DATBM*

Dr. C. Michelo, *MBChB, MPH*

APPROVAL

The University of Zambia approves the dissertation of Grace Sibeso Mwangala as fulfillment in part of the requirements for the award of the degree of Masters of Publich Health (MPH).

Signature	Date	Designation
	21/12/02	
	26/12/02	

DEDICATION

This work is dedicated to my husband Duff for the support and love throughout the period of study.

To my late mother, Florence Monde Mukena and my late son, Chuubo Kopakopa.

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ABSTRACT

The sexual transmission of human immunodeficiency virus (HV) continues at an alarming rate in Sub-Saharan Africa despite high knowledge levels of HIV. Some factors such as socioeconomic, culture, communication skills and perception of risk to HIV may be responsible for engaging in risky sexual behaviours.

A cross sectional study of 200 persons who attended a clinic for sexually transmitted diseases (STD) with genital ulcer disease and gonorrhea was carried out between February and June 2001. This study was done at STD clinic at the University Teaching Hospital in Lusaka, Zambia. Interviews were carried out using a semi-structured questionnaire.

The study sought to; determine the knowledge of HIV and STD among patients with STD; establish the sexual patterns of patients with STD; determine perception of risk to HIV infection among STD patients; determine factors independently associated with risky sexual behaviour.

Knowledge of HIV transmission and prevention was high(84.0%). A relationship existed between knowledge of STD before the current one and knowledge of relationship between STD and HIV [(OR 68.79, 95% CI (9.57, 140.75)]. A total of 159 (98.0%) patients reported having one sexual partner. Condom use was not associated with the number of sexual partners ($p = 0.350$). Results using a logistic regression analysis showed that patients with multiple partnership were more likely to be male, [OR 1.79, 95% CI (1.21, 2.66] and were more likely to drink alcohol [OR 1.88, 95% CI (1.25, 2.81]. Ninety-five (48.0%) of patients reported that they discussed sex with their partners. Discussion of sex among couples was

independently associated with gender. Males were more likely to discuss sex, [OR 1.72, 95% CI (1.26, 2.35)]. Marital status- the single were less likely to discuss sex [OR 0.54, 95% CI (0.33, 0.90)]; while the married were 2.20 times more likely to discuss sex, [OR 2.20, 95% CI (1.44, 3.36)]. Educational status – those with primary education were less likely to discuss sex [OR 0.42, 95% CI (0.26,0.67)]; while those with secondary education were 1.26 times more likely to discuss sex, [OR 1.26, 95% CI (0.82, 193)]. One hundred and eighty nine (95.0%) of the patients were not aware of their HIV status. The factors independently associated with perception of risk to HIV infection were knowledge of relationship between HIV and STD, [OR 8.78, 95% CI(3.86, 19.97)] and positive history of STD, [OR 4.58, 95% CI (1.90, 11.06)].

High knowledge of HIV and perception of self as being at risk of contracting HIV does not necessarily translate into safer sex practices. Promoting a level ground in communication skills especially discussion of sex in various strata.

LIST OF ABBREVIATIONS

AIDS	-	Acquired Immuno deficiency Syndrome
CI	-	Confidence Interval
DANIDA	-	Danish International Development Agency
DHS	-	Demographic and Health Survey
HIV	-	Human Immuno deficiency Virus
IEC	-	Information, Education and Communication
MoH	-	Ministry of Health
OR	-	Odds Ratio
ZSBS	-	Zambia Sexual Behaviour Survey
STD	-	Sexually Transmitted Disease
UNAIDS	-	United Nations Programme on AIDS
USAID	-	United States Agency for International Development
WHO	-	World Health Organisation

CHAPTER ONE

1.0 BACKGROUND INFORMATION

1.1 GLOBAL EPIDEMIOLOGY OF HIV/AIDS

Acquired Immunodeficiency Syndrome (AIDS) is a disease caused by infection with Human Immunodeficiency Virus (HIV), which prevents the human immune system from functioning properly. HIV/AIDS was first recognised in 1981 among gay and drug abusers in USA[1], where thirty-one (31) cases were reported. Data from HIV sentinel surveillance system (SSS) shows that 47.3 million people had been infected with HIV world-wide since the beginning of the epidemic, of these 33.4 million are still living and 13.9 million died [2].The World Population Data Sheet [3] shows that more people died of AIDS in 1999 than in any previous years. About 2.9 million deaths from HIV/AIDS were reported in 1999 alone, bringing the estimated total of deaths to 16.3 million since the beginning of the epidemic. A total of 5.6 million people became infected with HIV in 1999 alone, approximately 15,000 new infections per day[4]. United Nations Programme on AIDS (UNAIDS_ estimates that by 2010, AIDS will increase infant mortality by as much as 75% in the hardest hit regions of the world[5].

REGIONAL PICTURE

The distribution of the rates of infection is not equal around the globe. Ninety-five percent (95%) of the people who are infected with HIV live in developing

countries[1]. The highest concentration of people with the HIV infection is in Africa, which accounts for 69% of the cases of HIV infection.

The sub-Saharan Africa has the highest infection rates of HIV in Africa. One in every 30 people is infected with HIV[3]. Since the start of the epidemic an estimated 34 million people in the region have been infected with HIV and of these 11.5 million have died. The hardest hit countries in the sub-Saharan Africa are Burkina Faso, Burundi, Central African Republic, Congo, Ivory Coast, Kenya, Malawi, Rwanda, Swaziland, South Africa, Tanzania, Uganda, Zambia and Zimbabwe. Current surveys from some African countries show that the prevalence of infection is high among prostitutes (50- 90%) and those attending departments for sexually transmitted diseases (60-70%) [1]. UNAIDS estimated that by the end of 1999 the epidemic would have left behind a cumulative total of 13.2 million AIDS orphans at family level. Traditional family structures and extended families are breaking down under the strain of HIV. Life expectancy in the hardest hit countries in the region was expected to see an average reduction of 17 years by 2010 – 2015. Young highly productive adults die at the peak of their output resulting in a considerable impact on a country's economy.

ZAMBIAN SITUATION

HIV/AIDS was officially reported in Zambia in 1984 and by July 1997, 45,000 cases of HIV/AIDS had been reported to Ministry of Health (MoH)[1]. Cases of HIV have continued to rise. By 1999, HIV had already infected an estimated 1,009,000 persons, i.e. about 923,000 adults aged 15 to 49 years, and nearly

87,000 children. It was also estimated that about 25,000 children become infected every year and that by the year 2000, there would be 500,000 orphans due to HIV/AIDS in Zambia. By 1999, HIV prevalence in Zambia among adults aged 15 to 49 years was 19.9%. Lusaka, the capital city of Zambia, has an HIV prevalence of 27.3%, the highest in the country[6]. The HIV prevalence in adults has been relatively stable between 1994 and 1998. This means that the number of people who become newly infected is about equal to the number who die from AIDS each year.

MODE OF TRANSMISSION OF HIV

HIV spreads in different ways in different parts of the world. In developed countries, spread has largely occurred through homosexual intercourse, intravenous drug use and transfusion of blood products. In developing countries, spread is primarily through heterosexual intercourse and from mother to baby[1]. In the world as a whole, most transmission occurs through sexual intercourse[7]. The probability of transmitting and acquiring HIV during unprotected sex rises dramatically if either partner is infected with an STD, such as syphilis or gonorrhoea[6]. A person with untreated STD is up to 6 to 10 times more likely to pass or acquire HIV during sex. Most of those infected are young adults and people in early middle age who are also parents, workers, and leaders of society[4].

1.2 STATEMENT OF THE PROBLEM

HIV epidemic is an extremely serious public health problem in Zambia. The HIV situation in Zambia dates as far back as early 1980s when Professor Anne Bayley noticed changes in the characteristics of Kaposis sarcoma in fourty-one of her patients[36]. By 1992, 27,901 cases were reported based on hospital notifications and sentinel surveillance. The number of cases rose to 45,000 in 1997. The HIV prevalence rate for the entire population in Zambia has also risen from 14.4% in 1992 to 19.9% in 1999. Sentinel surveys have shown that one out of every five adult Zambian is infected.

The government's response to this scenario through the MoH was to spearhead various strategies to contain and limit the spread of HIV infection. The strategies ranged from protection of the blood supply to information dissemination and campaigns to change social attitudes and behaviour. Its goals were to reduce HIV and STD transmission; reduce social economic impact of HIV/AIDS and STDs; and mobilisation of local and external resources. International organisations such as United States Agency for International Development (USAID), funded programmes in providing interventions to facilitate behaviour change since 1986[8]. They trained HIV/AIDS educators; worked with private voluntary organisations and non-governmental organisations to expand prevention services, improve sexually transmitted disease programmes and distribution of condoms. The main HIV prevention efforts have involved promotion of condom use, delay of age at first sex, and encouragement of mutual faithfulness.

In Zambia, as in other parts of the world, the general approach to the control of HIV/AIDS has been to promote awareness of HIV/AIDS with the expectation that well-informed individuals will choose to engage less in sexual behaviours that lead to transmission of HIV. Such expectations have generally fallen far short of the desired effects of changing high risk sexual behaviours. Despite the vast knowledge about HIV transmission and its prevention[6,9], surveys have documented no change in sexual behaviour and protective measures through safer sex practices[6,9]. The HIV and STD prevalence rates are also high, being 19.9% and 17% respectively. The design and implementation of appropriate interventions for changing high-risk sexual behaviours may be complicated by perception of risk regarding HIV infection and diverse cultural, economic and social environment in Zambian society.

1.3 JUSTIFICATION OF THE STUDY

Much of the research from Africa has focused on members of special core groups, such as commercial sex workers and long distance truck drivers [10]. Less is known about sexual behaviours of individuals outside these groups, and the socio-economic and cultural situations that create this kind of vulnerability in Zambia.

This study seek to document sexual practices, perception of risk and situations that create this kind of vulnerability among persons attending STD clinic at the University Teaching Hospital (UTH), Lusaka, Zambia.

1.4 OPERATIONAL DEFINITIONS

1. **Safe Sex:** HIV/STD preventive measures such as sticking to one faithful sexual partner, abstinence or use of condom during sexual intercourse

2. **Protected Sex:** Use of condom during sexual intercourse

3. **Risky Sexual Behaviour:** Not practicing safe sex

4. **Prostitute**: A woman or man who received money or material goods in exchange for sex.

5. **Casual Sex Partner:** A woman or man who was previously unknown to the participant and who did not receive payment in exchange for sex

6. **Regular Sexual Partner:** Steady sexual partner (e.g. girlfriend, boyfriend, spouse)

CHAPTER TWO

2.0 LITERATURE REVIEW

Infection with human immunodeficiency virus continues to spread rapidly in sub-Saharan African [3,11] and heterosexual intercourse accounts for an estimated 80% of new HIV infections [6,3,7]. According to UNAIDS and World Health Organisation (WHO), over 30 million people were infected with HIV, and 11.7 million people around the world had already lost their lives to the disease by the beginning of 1998. During 1997 alone, about 5.8 million new infections were estimated worldwide. This accounts for approximately 16,000 new infections a day. The general approach to the control of HIV/AIDS has been to promote awareness of HIV/AIDS through various ways. Options for practising safer sex have been offered, for example, abstinence, being faithful to one sexual partner for life, and masturbation. Condom use has been encouraged. STD control has been implemented.

Sexual behaviour is a major determinant factor in the fight against HIV transmission. However, sexual behaviour may be influenced by various factors. Among these are:

1. Awareness and knowledge of HIV transmission and prevention [9,12];
2. Gender inequalities both socially and economically[13];
3. Social habits and cultural beliefs that predispose to risky sexual practices such as alcohol consumption and male dominance over female [13,14];

4. Mobility due to nature of employment, natural and man made calamities, search for education and employment[15,16];

5. Perception of risk to HIV infection[17]

Surveys have been carried out mostly in Africa on the above factors

AWARENESS AND KNOWLEDGE OF HIV TRANSMISSION AND PREVENTION

Worldwide, there is vast awareness and knowledge of HIV transmission and prevention[9,18]. However, surveys have shown that sexual behaviours do not correlate with the knowledge levels. A study done among urban black mothers in Durban to explore sexual behaviours and knowledge of AIDS revealed that knowledge was high while their sexual behaviours was characterised by a high pregnancy rate and a high proportion had children by more than one consort[18]. In Zambia, awareness of transmission and prevention of HIV is high, although many have misconceptions about HIV transmission[9]. Generally knowledge of HIV prevention among men and women aged 15 to 49 years in Zambia is just below 100%[9,12]. However some misconceptions about HIV transmission have been recorded in the 1998 Zambia sexual behaviour survey. The ways of transmission cited among others were mosquito bite and witchcraft.

The attitudes and sexual behaviour among Zambian adults leave a lot to be desired. Although the majority of adults in Zambia disapprove of extra marital sex, about a third of women do not think that men can be satisfied with only one partner[9]. A similar idea was found in studies done in Uganda, Ghana and

Nigeria[16]. It focused on male sexual behaviour and its limited change during the AIDS epidemic. They found that changing male sexual behaviour was difficult because community believed that males have a biological need for more than one woman as a sexual partner[16]. This study included commercial sex relationships, the use of condoms, beliefs and practices with regard to the cause and treatment of HIV/AIDS, attitudes to risk taking as some of the factors responsible for limited change during the AIDS epidemic. Another study that aimed at determining the knowledge and attitude towards HIV/AIDS among women attending STD clinic in Uganda[32] found out that nearly all women heard of HIV/AIDS but the quality of knowledge was low, two-third though they were at risk of contracting HIV from their regular partners and 10% of the women distrusted their partners. Women may be at risk of contracting HIV not because they lack knowledge but because they are powerless, poor and lack education[30]. World over, women find themselves at special risk of HIV infection because they lack power to determine where, when and how sex takes place. Also cultural beliefs and expectations that make this the case heighten men's own vulnerability[35].

GENDER INEQUALITIES

The socio-economic inequalities can lead to lack of access to sexual health information and services, including condom use by some people. Negative cultural or religious ideas about sex and services can make safer sex difficult[13]. A study on gender perception on issues in safer sex and couple negotiation identified

problems such as denial of AIDS, misconception about AIDS origins and transmission, resistance to condom use, polygamy, economic dependence of women on men and labour migrant which lead to unprotected sex. Other factors were peer pressure for boys and economic incentives for girls[19].

Improving communication skills and assertiveness can help people feel more comfortable talking to partners about sex and what safer sex practices they would enjoy. Research in South Africa showed that adolescent sexual relationships are often violent, that girls may be hit, beaten with objects to force them into sex[13,14]. A study conducted by the Musasa project in Zimbabwe also showed that women in abusive relationships are at risk of infection, mainly because they do not have enough confidence to talk about sex. It also showed that a married woman might know of her partner's extra marital affairs but may be too afraid to raise the issue of safer sex, because she risks being beaten. This state of affairs was also reported by UNAIDS/WHO 1998[2] from a study done in India on women attending STD clinics. The results showed that 91% of the married women had sex with their husbands only, but all of them were infected with STD, while 13.6% of them tested HIV positive. It suggested that poverty, discrimination, lack of educational opportunity, and subordination of women puts young females at greater risk than males. In Uganda, a study[16] was done to investigate the structural problems and rural settings, which predispose people to risks of HIV/AIDS infection despite the fact that the level of awareness and knowledge was very high. They found that risks were created not by lack of awareness and knowledge, but by structural and communication problems. In this study age,

gender, level of education and socio-economic status stratified the parameters. Another study[34] that aimed at describing sexual interaction and HIV related communication in Rwandan couples and also to examine their relationship to HIV testing and condom use was done. They found out that men control sexual decision-making. They also found that condom use was more common if women were reportedly discussing or negotiating condom use.

Worldwide more than half of the people living with HIV infection are under 25 years of age. Young women are more likely to be infected than men because their sex partners are often older men who may already have HIV infection. Biologically women are more vulnerable to infection and often have less power to refuse sex or insist on condom use[15]. Studies done in Malawi, Rwanda, Tanzania and Congo found that socio-economic status and high educational attainments are associated with high rates of infection. Also low income, unemployment or low levels of education leading to poverty and gender inequality appear to influence frequency of risky sexual behaviour[20]. They also suggested that at risk people were sex workers, truck drivers, migrants, military and police, the never married, separated/widowed/ divorced, non-educated, non-farmers and unemployed.

Unprotected sex may be due to resistance to the condom itself. An explanatory qualitative study by Abdool 1993[19] to identify barriers to condom use among high school students in Natal revealed that condom limited sexual pleasure, indicated lack of trust in the partner's faithfulness, challenged the male ego, and was associated with STD. Condom use was not sufficiently understood and not

accessible or available when required. A study by Peltzer K[33], on factors affecting condom use among South African university students also came up with similar finding. However, young people adopt safer sex behaviour provided they have information, skills and means to do so[2].

SOCIAL HABITS AND CULTURAL BELIEFS THAT PREDISPOSE TO RISKY SEXUAL PRACTICES

Alcohol Consumption

UNAIDS/WHO[2] reports that under the educated and under employed, the young people are easy targets for adults wanting sex but are unwilling to pay for it, especially in homes. They also reported that excessive beer drinking, for example, reduces the ability to use important information learnt about AIDS prevention, and impairs the capacity to make decisions about protection.

Mobility

Worldwide, about 125 million people are migrant workers, immigrants or refugees living outside the country where they were born. Many more people move within their country, often from rural to urban areas, in search for education, employment or safety, some as prisoners or students. Some make a living along the roads, railways as traders or transport workers. Such displaced people can be particularly vulnerable to sexually transmitted infections including HIV, because it is often harder to practice safer sex if one is living in difficult circumstances[15]. Also, the fact that one is separated from their partner is a risk

factor. Women in difficult circumstances may be pressurised to exchange sex for food, water or basic needs for themselves and their children. A study[30] to determine factors that influence sex workers' ability to reduce their risk of HIV was carried our at a popular truck shop in South Africa. It was found that sex workers lacked social, legal and economic power and that insisting on condom use reduced their earnings, loss of clients and caused physical abuse. Similar findings from a study in Ghana[31] also stated that women were poor, had poor education and poor nutrition. This made them vulnerable to HIV.

In Zambia, a study to compare associations between mobility and sexual behaviour, and to identify characteristic of trips that are associated with having non-regular partnership while away from home was done. The study concluded that mobile men tended to declare non-regular partnerships more often than non-mobile populations[16].

There is no current literature on situations that lead to risky sexual behaviour in regard to HIV prevention among persons with STD.

CHAPTER THREE

3.0 OBJECTIVES

3.1 *GENERAL OBJECTIVE*

To determine the factors associated with risky sexual behaviours in regard to HIV prevention among persons attending STD clinic at the University Teaching Hospital in Lusaka.

3.2 *SPECIFIC OBJECTIVES*

1. To determine the knowledge of HIV and STD among STD patients at UTH
2. To establish the sexual patterns of patients with STD
3. To determine the perception of risk to HIV infection among STD patients
4. To determine the factors associated with risky sexual behaviours.
5. To make recommendations to all parties concerned, on the factors that expose to risky sexual behaviours.

CHAPTER FOUR

4.0 METHODOLOGY

4.1 DESIGN AND SETTING

This cross-sectional study was conducted between February and June 2001 at the Dermato-Venereology Clinic at the University Teaching Hospital, Lusaka, Zambia. It is a Government referral clinic for sexually transmitted diseases (STDs) and skin infections. The clinic provided free counseling and treatment services for STD clients at the time of study. The clinic had laboratory services, although syndromic approach was mainly used for diagnosis.

4.2 SAMPLE SIZE DETERMINATION

The sample size was calculated at 5% significant level using Epi-Info statcalct program. P = 50%, d = 5%.

The sample size was 168

50% was the maximum sample size since the proportion of patients with genital ulcer disease and multiple partnerships was not known before hand.

4.3 SAMPLING

All clients who presented to the STD clinic at UTH with either a genital ulcer disease or gonorrhea were enrolled into the study because the flow of patients was not adequate. There was an average of 2 clients per day. Data collection was only done from Mondays to Friday when the clinic was operational.

4.4 ENROLLMENT PROCEDURE

Persons who presented to the clinic with genital ulcer disease and discharge were eligible for enrollment in the study. The participants had to be residents of Lusaka for not less than six months from the beginning of the study. All 200 persons referred to the study agreed to participate. Trained, experienced and skilled clinical officers performed a general physical examination, which included a detailed genital examination. Blood was drawn for RPR and film for those with a discharge. Appropriate ant microbial treatment was provided. Information regarding transmission of HIV and STD was discussed during a brief counseling session, and condoms were distributed to those willing after the interview.

4.5 ETHICAL CONSIDERATION

The University of Zambia Research and Ethics Committee, and the directorate of Research and Graduate Studies approved the study. A verbal consent (witnessed) was obtained from each participant

4.6 DATA COLLECTION

The information from the participants was collected with the use of a semi-structured questionnaire. The sections addressing demographic characteristics, sexual behaviour, condom use and perception of risk to HIV/AIDS were developed in collaboration with workers at STD clinic and had been previously pre-tested on thirty patients attending STD clinic with genital ulcer disease and discharge. The researcher and a B.Sc., MPH holder with five years experience at the clinic, who is also a psychosocial counselor and experienced in behavioural

research, conducted the interview. The questions were asked in English, Bemba, Lozi, Tonga and Nyanja, the language commonly used in Lusaka. The occasional client who was unable to communicate in the mentioned languages was not enrolled into the study. Interviews were done in a room with no interruptions. Only the interviewer and the interviewee were allowed in the interview room. Despite the sensitive nature of the questions on sexual behaviour, all participants answered the questions.

4.7 DATA ANALYSIS

Bivariate analysis was performed on selected variables with the use of chi-square tests and odds ratios. Multivariate analysis was performed with use of logistic regression on the SPSS-PC programme on variables that were significant at 5%. The significant level for the results of multivariate analysis was set at 5%.

4.8 STUDY LIMITATIONS

Sampling Method: Probability sampling was not feasible due to the scanty in flow of clients. There was an average of two clients per day; therefore, all clients with genital ulcer disease and gonorrhoea who presented themselves at the STD clinic were interviewed.

CHAPTER FIVE

5.0 PRESENTATION OF FINDINGS AND DATA ANALYSIS

This chapter is a presentation of findings as obtained from the field and is divided into the following sections: Demographic data, analysis of specific variables and analysis of factors independently associated with risky sexual behaviour.

5.1 SOCIO-DEMOGRAPHIC DATA

Table 1 shows the socio-demographic characteristics of the respondents. The respondents aged between 25 years and 34 years were the majority (44.5%). Females accounted for 54.0% of respondents. Most of the respondents were married (50.5%). The majority of the respondents had secondary level of education (48.8%). Most (77.0%) of the respondents were Protestants. A large proportion (54.0%) of respondents lived in high-density residential areas. The respondents whose household income was below K200, 000 were the majority (39.0%).

Table 1: socio-demographic characteristic (total = 200)

FACTOR	n	(%)
Age		
< 25 years	74	(37.0)
25 –34 years	89	(44.5)
> 34 years	37	(18.5)
Gender		
Male	92	(46.0)
Female	108	(54.0)
Marital status		
Single	56	(28.0)
Married	101	(50.5)
Separated *	43	(21.5)
Education		
Primary	74	(37.0)
Secondary	96	(48.0)
College/university	30	(15.0)
Denomination		
Catholic	46	(23.0)
Protestant	154	(77.0)
Residence		
High density	108	(54.0)
Medium density	70	(35.0)
Low density	22	(11.0)
Household income		
< K200, 000	79	(39.5)
K200, 000 – K400, 000	66	(33.0)
>K400, 000	35	(17.5)
No income	20	(10.0)

* The respondents regarded as separated were either divorced or widowed.

5.2 ANALYSIS OF SPECIFIC VARIABLES

1. Knowledge of HIV transmission

Table 2

FACTOR	Not knowledgeable Total = 32 n	(%)	Knowledgeable Total = 168 n	(%)	P value
Age					
< 35 years	11	(34.4)	63	(37.5)	
25 – 34 years	15	(46.9)	74	(44.0)	0.942
35 years +	6	(18.7)	31	(18.5)	
Gender					
Male	14	(43.8)	78	(46.4)	
Female	18	(56.2)	90	(53.6)	0.781
Education					
Primary	16	(50.0)	58	(34.5)	
Secondary	13	(40.6)	83	(49.4)	0.226
College/university	3	(9.4)	27	(16.1)	

Table 2 shows the knowledge of HIV transmission in relation to age, gender, and educational status. Generally, knowledge of HIV transmission 168(84%) among respondents was high regardless of age ($p = 0.942$), gender ($p = 0.781$) and educational status ($p = 0.226$).

Table 3: Analysis of knowledge of who can be infected by HIV and whether cure is available (Total = 200)

Knowledge of who can be infected by HIV	**n**	**(%)**
Anyone who has sex	188	(94.0)
Other	7	(3.5)
Don't know	5	(2.5)
Is AIDS curable		
Cure available	9	(4.5)
Cure not available	178	(89.0)
Don't know	13	(6.5)

Table 3 shows respondents' knowledge of who HIV can infect, and whether AIDS has a cure or not. The majority of the respondents (94.0%) knew that anyone who had unprotected sex could contract HIV infection and 3.5% had misconceptions about HIV transmission. These included: that the educated cannot be infected; only the poor can be infected and that the chances of being infected depended on the goodness of one's blood. Most (89.0%) of the respondents mentioned that there was no cure available. As for nine (9) who said that there was a cure for AIDS, three said that they were not sure of the exact cure. Another three mentioned conventional drugs; one (1) mentioned God and two (2) said that AIDS could be cured through going to hospital frequently whenever one is ill and having no sex for two months after abortion.

Table 4:
Prior knowledge of STD before current one and knowledge of relationship between STD and HIV

	Relationship between STD and HIV			
Prior knowledge of STD Before the current one	**Knowledgeable**		**Not knowledgeable**	
	n	**(%)**	**n**	**(%)**
Had knowledge	107	(99.1)	56	(60.9)
Had no knowledge	1	(0.9)	36	(39.1)
Total	**108**	**(100)**	**92**	**(100)**

An association was tested between prior knowledge of STD before the current one and knowledge of relationship between STD and HIV (Table 4). A relationship existed between prior knowledge of STD before the current one and knowledge of relationship between STD and HIV ($p < 0.001$). Significantly more persons who had knowledge (99.1%) of the relationship between STD and HIV had prior knowledge of STD compared to 60.9% of persons not knowledgeable who had prior knowledge of STD.

Sexual patterns

Sexual patterns of respondents were also analysed by looking at the number of sexual partners and the circumstances associated with them.

Table 5: Number of sexual partner by socio-demographic characteristics

Factor	Multiple Partner Total = 41		One Partner Total = 159		P value
	n	(9 %)	n	(%)	
Age					
< 25 years	15	(36.6)	59	(37.1)	
25 34 years	16	(39.0)	73	(45.9)	0.518
> 34 years	10	(24.4)	27	(17.0)	
Gender					
Male	30	(73.2)	62	(39.0)	< 0.001
Female	11	(26.8)	97	(61.0)	
Marital status					
Single	14	(34.1)	42	(26.4)	
Married	23	(56.1)	78	(49.1)	0.115
Separated	4	(9.8)	39	(24.5)	
Educational status					
Primary	13	(31.7)	61	(38.4)	
Secondary	23	(56.1)	73	(45.9)	0.505
College/university	5	(12.2)	25	(15.7)	
Residence					
High density	26	(63.0)	82	(51.6)	
Medium density	8	(19.5)	62	(40.0)	0.047
Low density	7	(17.1)	15	(9.4)	
Household income					
< K200, 000	15	(36.6)	64	(40.3)	
K200, 000 – K400, 000	12	(29.3)	54	(33.9)	0.670
> K400, 000	8	(19.5)	27	(17.0)	
Don't know	6	(14.6)	14	(8.8)	
Religion					
Catholic	12	(29.3)	34	(21.4)	
Protestant	29	(70.3)	125	(78.6)	0.138
Past history of STD					
Had STD	20	(48.8)	60	(37.7)	
Had no STD	21	(61.2)	99	(62.3)	0.114

Table 5 shows the respondents' number of sexual partners in relation to socio-demographic characteristics. A large proportion of the respondents reported having one sexual partner 159(79.5%). An association was found between gender and the number of sexual partners ($p < 0.001$). An association was also found between the number of sexual partners and residence ($p = 0.047$). The number of sexual partners was not associated with age, marital status, educational status, household income, religion, and past history of STD ($p = 0.114$) table 5.

Table 6: Mobility and number of sexual partners

Mobility	**Multiple partners**		**One partner**	
	n	**(%)**	**n**	**(%)**
Mobile	25	(80.6)	92	(70.2)
Not mobile	6	(19.4)	39	(29.2)
Total	**31**	**(100)**	**131**	**(100)**

Table 7: Length of absence from regular partner with number of sexual partners

Length of absence	**Multiple partners** **Total = 25**		**One partner** **Total = 92**	
	n	**(%)**	**n**	**(%)**
< 1 month	18	(72.0)	71	(77.2)
1 – 6 months	6	(24.0)	10	(10.9)
> 6 months	1	(4.0)	11	(11.9)

Tables 6 and 7 show the sexual patterns of respondents who had regular sexual partners in relation to mobility and length of absence. An association between mobility and number of sexual partners existed ($p = 0.024$). However, length of absence from regular sexual partner was not associated with number of sexual partners ($p = 0.288$).

Social habits

An analysis of social habits such as alcohol intake, condom use, and communication between couples in relation to sexual behavior was done.

Majority of the respondents 129(64.5%) had used a condom during sexual intercourse in their lifetime and of these, 73(56.6%) were still using condom, while 56(43.4%)reported having stopped using condom at the time of study. None of the condom users used condoms every time they had sex, 56(76.7%) used condom occasionally (i.e. less than 50% of the time) while 17(23.3%) used condoms regularly (more than 50% of the time).

Table 8: Alcohol consumption and number of sexual partners

Alcohol consumption	**Multiple partners**		**One partner**	
	n	**(%)**	**n**	**(%)**
Drinks alcohol	31	(75.6)	64	(40.3)
Do not drink	10	(24.4)	95	(59.7)
Total	**41**	**(100)**	**159**	**(100)**

Table 8 shows alcohol consumption in relation to number of sexual partners. Alcohol intake was associated with the number of sexual partners ($p < 0.001$).

Tables 9: Respondents who ever used condoms during sex and number of sexual partners.

Ever used condoms	**Multiple partner**		**One partner**	
	n	**(%)**	**n**	**(%)**
Used	29	(70.7)	100	(62.9)
Never used	12	(29.3)	59	(37.1)
Total	**41**	**(100)**	**159**	**(100)**

Use of condom was not associated with the number of sexual partners ($p = 0.350$) as shown in Table 9.

Table 10: Alcohol consumption with current use of condom.

Alcohol consumption	Used condom		Did not use condom	
	n	(%)	n	(%)
Drinks alcohol	46	(63.0)	27	(48.2)
Do not drink	27	(37.0)	29	(51.8)
Total	**73**	**(100)**	**56**	**(100)**

The majority of respondents who still used condoms also drunk alcohol 46(63.0%), however, there was no association between use of condom and alcohol consumption ($p = 0.093$) as shown in table 10.

Table 11: Current use of condom in relation to past history of STD and prior knowledge of STD before the current one.

Characteristic	Used condom Total = 73		Did not use condom Total = 56	
	n	(%)	n	(%)
Prior knowledge of STD				
Had knowledge	63	(86.3)	46	(82.1)
Had no knowledge	10	(13.7)	10	(17.9)
Past history of STD				
Had STD	30	(41.1)	19	(33.9)
Had no STD	43	(56.2)	37	(62.5)

Table 11 shows the sexual behaviour of the respondents and their ability to have protected sex. Out of the total number of respondents who did not currently use a condom, 82.1% had knowledge of STD before the current STD. Current use of condom was not associated with knowledge of STD before the current one ($p = 0.518$), and past history of STD ($p = 0.699$). The most common reason given for non-use of condom, table 12, was not having multiple sexual partners (39.4%).

Table 12: Reasons for none use of condoms.

Reason	n	(%)
No reason	8	(6.3)
Partner refuses	54	(14.2)
No multiple partnership	50	(39.4)
Other	15	(40.1)
Total	**127**	**(100)**

These were; condom reduces sexual pleasure; it is not reliable; it is cumbersome to use; it reduces reproduction and is a sign of infidelity.

As for the circumstances under which they acquired STD, table 13, the majority 81(40.5%) were not sure of where they acquired the disease since some had sex with more than one sexual partner within a short period of time, and their partners did not complain of an STD.

Table 13: circumstance under which STD was acquired.

Circumstance	**n**	**(%)**
Sex in exchange for money or goods	21	(10.5)
Casual sexual contact	47	(23.5)
Regular sexual partner	51	(25.5)
Not sure	81	(40.5)
Total	**200**	**(100)**

Table 14: Discussion of sex by socio-demographic characteristics.

Factor	Discuss sex Total = 95		Do not discuss sex Total = 105		P value
	n	(%)	n	(%)	
Age					
< 25 years	26	(27.4)	48	(45.7)	
25 –34 years	49	(51.6)	40	(38.1)	0.027
> 34 years	20	(21.1)	17	(16.2)	
Gender					
Male	57	(60.0)	35	(33.3)	< 0.001
Female	38	(40.0)	70	(66.7)	
Marital status					
Single	20	(21.1)	36	(34.5)	
Married	60	(63.2)	41	(39.1)	0.002
Separated	15	(15.8)	28	(26.6)	
Educational status					
Primary	23	(24.2)	51	(48.6)	
Secondary	54	(56.8)	42	(40.0)	0.002
College/university	18	(19.0)	12	(11.4)	
Religion					
Catholic	17	(17.9)	29	(27.6)	
Protestants	78	(82.1)	76	(72.3)	0.103

Table 14 shows discussion of sex by socio-demographic characteristics. A large proportion of the respondents 105 (52.5%) did not discuss sex. Age ($p = 0.027$), gender ($p < 0.001$), marital status ($p = 0.002$), and educational level ($p = 0.002$) were all found to be associated with discussion of sex. Discussion of sex was not associated

with the number of sexual partners (p = 0.868). No association was found between initiator of discussion of sex and gender (p = 0.052).

Table 15: Discussion of sex in relation to current use of condom.

Discussion of sex	**Used condom**		**Did not use condom**	
	n	**(%)**	**n**	**(%)**
Discuss sex	49	(67.1)	26	(46.4)
Do not discuss sex	24	(32.9)	30	(56.6)
Total	**73**	**(100)**	**56**	**(100)**

Condom use was associated with discussion of sex (p = 0.018, Table 15. More persons who currently use condom (67.1%) discussed sex with their partners compared to 46.6% of persons who did not currently use a condom. An association was also found between initiator of condom use and gender (p = 0.007). More males (73.3%) than females (26.7%) initiated condom use.

Perception of risk

Analysis of perception of risk was done on those respondents who did not know their HIV status (table 16). The HIV positive respondents, 11(5.5%), were not included in this analysis.

A large proportion of respondents 134(79.9%) thought that they were personally at risk of contracting HIV, table 16. The factors associated with being at risk of contracting HIV were past history of STD (p < 0.001), knowledge of relationship between STD and HIV (p < 0.001) and knowledge of transmission of HIV (p = 0.031). Number of sexual partners, availability of AIDS cure, use of condom, gender, age, and marital status were not associated with feeling of being at risk.

Table 16: perception of risk to HIV infection with selected variables

CHARACTERISITIC	AT RISK TOTAL = 34 n	(%)	NOT AT RISK TOTAL = 55 n	(%)	P-VALUE
KNOWLEDGE OF TRANSMISSION OF HIV					
Knowledgeable	117	(87.3)	41	(74.5)	0.031
Not knowledgeable	17	(12.7)	14	(25.5)	
KNOWLEDGE OF RELATIONSHIP BETWEEN STD & HIV					
Knowledgeable	89	(66.4)	9	(16.4)	
Not knowledgeable	45	(83.6)	46	(83.6)	<0.001
PAST HISTORY OF STD					
Had STD	66	(49.3)	8	(14.5)	0.001
No past history	68	(50.7)	47	(85.5)	
NUMBER OF SEXUAL PARTNERS					
One	108	(80.6)	41	(74.5)	
More than one	26	(19.4)	14	(25.5)	0.345
AVAILABILITY OF AIDS					
Cure available	5	(3.7)	3	(5.5)	0.212
Cure not available	129	(96.3)	52	(94.5)	
EVER USED CONDOM					
Ever used	87	(64.9)	37	(67.3)	0.758
Never used	47	(35.1)	18	(32.7)	
AGE					
12 – 19 (adolescents)	43	(32.1)	27	(49.1)	
20 – 29 (youths)	66	(49.3)	20	(36.4)	0.088
30 – 55 (adults)	25	(18.7)	8	(14.5)	
MARITAL STATUS					
Single	38	(28.4)	18	(32.7)	
Married	66	(49.3)	27	(49.1)	0.749
Separated	30	(22.4)	10	(18.2)	

5.2 FACTORS INDEPENDENTLY ASSOCIATED WITH RISKY SEXUAL BEHAVIOURS

All factors that were significant at 5% on bivariate analysis were considered on multivariate analysis at 5% level of significance.

TABLE 17

MULTIPARTNERSHIP

CHARACTERISTIC	OR (95% CI)
GENDER	
Male	1.79 (1.21, 2.66)
Female	1
ALCOHOL CONSUMPTION	
Drink alcohol	
Do not drink alcohol	1.88 (1.25, 2.81)
	1

Among the factors considered in multivariate analysis only gender ($p = 0.004$) and alcohol consumption ($p = 0.002$) were significantly associated with multi-partnership. Males were 1.79 times more likely to have had multiple partners than females. The persons who consumed alcohol were 1.88 times more likely to have had multiple partners than those who did not drink,

DISCUSSION OF SEX

CHARACTERISTIC	OR (95% CI)
GENDER	
Male	1.72 (1.26, 2.35)
Female	1
MARITAL STATUS	
Single	0.54 (0.33, 0.90)
Married	2.20 (1.44, 3.36)
Separated	1
EDUCATIONAL STATUS	
Primary	0.42 (0.26, 0.67)
Secondary	1.26 (0.82, 1.93)
College/university	1

Gender ($p < 0.001$), marital status ($p < 0.001$), and educational status ($p = 0.002$) were significantly associated with discussion of sex. Males were 1.72 times, the married were 2.20 times, and those who attained secondary education were 1.26 times more likely to have had discussed sex than the females, separated, and those who attained college or university education respectively.

AT RISK OF CONTRACTING HIV

CHARACTERISTIC	OR (95% CI)
RELATIONSHIP BETWEEN HIV AND STD	
Knowledgeable	8.78 (3.86, 19.97)
Not knowledgeable	1
PAST HISTORY OF STD	
Had STD	4.58 (1.90, 11.06)
Had no STD	1

The feeling of being at risk of contracting HIV was significantly associated with knowledge of relationship between STD and HIV ($p < 0.001$) and past history of STD ($p < 0.001$). Those with knowledge of the relationship between HIV and STD were 8.78 times more likely to feel at risk of contracting STD than those who had no knowledge. Respondents who had a past history of STD were 4.58 times more likely to feel at risk of contracting HIV than respondents with no past history of STD.

CHAPTER SIX

6.0 DISCUSSION OF FINDINGS

This chapter discusses the main findings of the study. The study identified factors associated with risky sexual behaviour in regard to HIV infection among persons attending STD clinic for genital ulcer disease and /or gonorrhea.

The STD patients were preferred because they were particularly at high risk of contracting HIV. The presence of an STD raises chances of acquiring HIV infection.[21] The majority of the respondents were in the reproductive age group. This is the most economically productive segment of the population. They could actually be living with HIV without them knowing and could be a potential risk to about 80% of Zambians who are not yet infected with HIV. The deaths of these persons due to HIV constitute an important economic burden as many productive years and investment in education and training will be lost. Significant family consequences may also be encountered since most people in this age group are raising young children.

The male-female ratio of the respondents was almost 1:1. The females were slightly (54%) more than males (46%). The Zambia demographic and health survey of 1996 also found that among clients attending STD clinics 59% were female. This represents the almost equal likelihood of both genders to contract the deadly HIV infection. A large proportion of respondents resided in high-density residential areas. Most of those who lived in low –density residential areas were either dependants or house servants. In turn, those whose household income was

below K200, 000 were the majority and those whose income was above K400, 000 were the minority. This could mean that the majority of the poor lived in high –density residential areas and therefore attended the government hospitals where they paid a minimum amount of money for the services. On the other hand, those who lived in low-density residential area earned more and could probably afford to seek services from private clinics or buy drugs from chemists. This finding is supported by a report in the Zambia sexual behaviour survey that about 41% of the patients with STDs bought drugs from chemists. The majority of the respondents were married. This shows that marriage in itself is not a safety device to prevention of STD/HIV. Other factors are at play.

It was evident from the results of the study that knowledge of HIV transmission and prevention (84%) was high. This knowledge was independent of age, gender, and educational status. This finding agrees with those of Zambia sexual behaviour survey of 1998 and Zambia demographic and health survey of 1996, which reported that knowledge of transmission was high (82% and just below 100% respectively). Misconceptions about HIV transmission could affect the ability of people to protect themselves from contracting HIV as they may feel helplessly out of control. Knowledge of STDs was also found to be high (81.5%) among the respondents, but the knowledge of the relationship between STD and HIV was average (54%). This gap in knowledge raises concern as it diminishes the perception of risk to HIV infection among the respondents[29] and poses a vulnerability of these people to HIV infection.

Despite the high levels of knowledge of STD and HIV, the subjects still came with STD and 99.1% of those who knew the relationship between STD and HIV also had the knowledge of STD before the current STD. The level of knowledge of HIV and sexual behaviours did not correlate; for instance, there was no difference in the number of sexual partners between those who had an STD in the past and those who did not have. All the respondents had an STD. The majority 159(79.5%) reported having one sexual partner. This gives an impression that unfaithful sexual partners who may have contracted the disease from other sexual partners may characterize their relationships. This scenario is a reflection in the change of policy on STD management. Previously, STD patients were not attended to unless they brought their sexual partners. At present, STD patients are given treatment whether or not they bring their sexual partners. The current notification process is mainly patient referral, where the STD patients are encouraged to inform all his sexual partners to seek treatment[22,28].

An analysis of factors independently associated with having multiple sexual partners revealed that males were more likely to have multiple sexual relations. This finding could be due to the beliefs that one sexual partner cannot sexually satisfy men[9,16,23]. The same analysis revealed that those who drunk beer were more likely to have had multiple sexual relations. This agrees with the UNAIDS report of December 1998 which said that beer drinking diminishes inhibition and reduces the ability to use important information learnt about AIDS prevention[5]. Alcohol consumption was however not associated with the use of condom during

sexual intercourse. This is contrary to a UNAIDS (1998) report which stated that beer impairs the capacity to make decisions about protection[24].

The study results also revealed that mobility was associated with the number of sexual partners. Respondents (80.6%) with multiple sexual relationships were also mobile. However, the length of absence from the regular sexual partner was not associated with the number of sexual partners. Similar findings were reported in a study carried out in Ndola, Zambia[16].

The capacity to protect oneself from STD/HIV was assessed by asking respondents about use of condom in relation to number of sexual partners, knowledge of STD before the current STD and past history of STD. All respondents felt that condoms were not reliable. This could be the major reason why a large proportion of respondents were not using condoms because neither the knowledge of STD before the current one nor past history of STD could influence them into using condoms. None of the condom users used condoms consistently, for similar reasons as the non-users. Studies of why condoms fail have found that inconsistent or incorrect condom use more likely causes failure than impaired judgment from alcohol or drug use[21,25]. Also an exploratory study by Abdool[19], found similar findings such as use of condom indicated lack of trust in the partner's faithfulness, challenged male ego, associated with STD and limited sexual pleasure.

Other reasons given for non-use of condoms such as not having multiple sexual partners indicate that these respondents had trust in their partners who

unfortunately were not faithful to them. Because the condom is the only contraceptive method at the moment that clearly prevents transmission of STDs,[26] the AIDS epidemic has brought urgency and new attention to issues of condom use involving trust, negotiation, and communication between sex partners. The results from this study showed that more males than females initiated condom use and that those who used condoms were more likely to discuss sex. People need to learn to talk about sex directly. Although some couples discuss sex and cooperate in the decision to use condoms, much communication is indirect. Communicating indirectly however, leaves more room for misinterpretation than does talking.

An analysis of factors independently associated with discussion of sex among couples revealed that males were more likely to discuss sex. However, for those respondents who discussed sex with their partners, there was no association found between the initiators of discussion of sex and gender. This implies that women can also feel free to discuss sex with their partners once they develop communication skills. This could enhance the ability to protect oneself with the use of condom, as shown by this study.

The singles were found to be less likely to discuss sex than the married. This could be because the single did not feel committed to their sexual partners since it was not a legal relationship. Educational status was also associated with discussion of sex. Respondents with primary education were less likely to discuss sex than those who attained secondary, college and university education. This implies that education about sexuality, communication and negotiation skills

should start early in life whether one is in school or not. Traditional folks as well as schools should take this responsibility. Because poor communication among couples may lead to risky sexual behaviour, improving communication skills and assertiveness could help people, especially women, feel more comfortable talking to partners about sex and what safer sex practices they would enjoy. A study on communication about sex revealed that "non-talkers" face greater risk for STDs than "talkers" because lack of communication often prevents effective preventive behaviors that require condom use[21]. A similar finding was also reported by the Musasa Project in Zimbabwe[15], which indicated that women in abusive relationships are at risk of infection, mainly because they do not have enough confidence to talk about sex.

Low and high levels of education were found to be less likely to discuss sex. This finding is supported by the results of studies done in Malawi, Rwanda, Tanzania and Congo that found an association between risky sexual behaviour and high educational attainments and low levels of education[27].

The majority of the respondents 134(70.9%) thought that they were personally at risk of contracting HIV. The factors that were independently associated with being at risk of contracting HIV were knowledge of relationship between STD and HIV and with past history of STD. Those with knowledge of relationship between STD and HIV and those with past history of STD were more likely to think that they were at risk of contracting HIV. This finding is contrary to the finding of Carter and Harry et al (1997)[17] who indicated that many people who are

at risk of contracting HIV or STD think they face little risk and not motivated to adopt safe sex.

CHAPTER SEVEN

7.0 CONCLUSION

The findings of this study are important as they give an insight into the factors associated with risky sexual behaviour. This study illustrates that educational programs for controlling the transmission of HIV have succeeded in promoting awareness and knowledge of HIV/AIDS. However, this knowledge has not prevented persons in this study from engaging in high-risk sexual behaviours. The problem of HIV/STD cuts across all sectors that is, gender, marital status, economic status, religion, and educational status. A leisure activity such as beer drinking stimulates sexual desire, which predispose people to engage themselves into casual sex. It also seemed that women and the single were less likely to discuss sex with their sexual partners. This situation may have some cultural origins. Fear of stigmatization may deter persons from going for voluntary counseling and testing. Ignorance to one's HIV status is the worst enemy to fighting the spread of HIV.

It is also evident from the results of this study that decisions to adopt safer sexual behaviours are complex and extends beyond the question of personal vulnerability.

7.1 RECOMMENDATIONS

In view of the findings of the study, the following recommendations are made:

1. Information, Education and Communication for STD patients should include the relationship between HIV and STD.

2. People's perception of condom should be improved if it is to be used successfully and consistently to prevent spread of HIV.

3. Issues of trust, negotiation and communication between partners that are important to condom use and essential to safe sexual relationships therefore, they should be encouraged.

4. An in-depth qualitative study should be undertaken on a large scale to gain insight into cultural and social influences, which promote risky sexual behaviour. This could be a starting point in fighting the HIV epidemic.

5. Other forms of leisure activities other than beer drinking should be encouraged. Permanent sexual partners should be encouraged to go drinking together if they cannot do without beer. This lessens chances of engaging in casual sex.

6. People should be encouraged to go for voluntary counseling and testing so that they become aware of their HIV status.

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APPENDIX 1

INTERVIEW SCHEDULE

FACTORS ASSOCIATED WITH RISKY SEXUAL BEHAVIOUR IN REGARD TO HIV/AIDS PREVENTION AMONG PERSONS ATTENDING STD CLINIC AT THE UNIVERSITY TEACHING HOSPITAL IN LUSAKA

*Interviewer code no.*_____ *Serial no.*_____

*Clinic*_____ *Date*_____

INSTRUCTIONS

1. Interviewer to ask questions and write the responses in the spaces provided or tick the appropriate response in the space provided

2. Interviewers to read out the questions or phrase exactly the way they appear in the text.

1. What is your age (at last birthday)? _____

   Year of Birth: _____

2. Sex

   1. Male
   2. Female

3. What is your residential address? (name of compound)

   _____

4. What is your marital status?

   1. Single
   2. Married
   3. Separated
   4. Widowed
   5. Other (specify) _____

5. What is your religion?

   1. Catholic
   2. UCZ
   3. SDA
   4. Pentecostal
   5. Other (specify) _____

6. What is your highest level of education?

   1. Never gone to School
   2. Primary education
   3. Secondary education
   4. College
   5. University

7. What is your occupation? _____

8. How much is your household income per month?

   1. Below K200,000
   2. K200,000 – K400,000
   3. Above K400,000
   4. Don't know

9. If income is below K200,000, explain your alternative source of income.

   _____

   _____

SEXUAL HISTORY

10. Do you or your sexual partner stay apart for a period of time?

    1. Yes
    2. No

11. If yes to question 10, for how long?

    _____

12. In case you miss your partner while apart, what do you do?

    1. Abstain
    2. Look for another sexual partner
    3. Other (specify) _____

13. Do you drink alcohol?

    1. Yes
    2. No

14. Does your alcohol consumption have an effect on your sexual drive?

    1. Yes
    2. No

15. If yes to question 14, in which way?

    _____

    _____

16. How many sexual partners have had during the:

    1. Last three (3) months? _____
    2. Last six (6) months? _____

17. Where do you get your sexual partners?

    1. Streets
    2. Hotels
    3. Bars/taverns
    4. Other (specify) _____

CONDOM USE AND CULTURAL FACTORS

18. Have you ever used a condom during sexual intercourse?

    1. Yes
    2. No

19. If yes to question 18, for what purpose?

    1. Family planning
    2. To avoid STDs
    3. Either reason

20. Do you still use condoms?

    Yes

    No

21. If yes to question 20 how often do you use condoms?

    1. Occasionally (< 50% of the time)
    2. Regularly (> 50% of the time)
    3. Other (specify) _____

22. Who initiates condom use between you and your sexual partner?

    1. Always me
    2. Always my sexual partner
    3. Either of us

23. If no to question 20, explain why not.

_____

_____

24. Do you discuss sex with your sexual partner(s)?

1. Yes
2. No

25. If yes to question 24, who initiates the discussion?

1. Always my partner
2. Always myself
3. Either of us

26. If no to question 24 explain why not

_____

_____

27. What type of sex do you practice? (tick whichever apples)

1. Oral
2. Vaginal
3. Anal

28. How is HIV/AIDS transmitted? (tick as many as possible)

1. Unprotected sexual intercourse with an infected partner
2. Mosquito bite
3. Sharing spoons, cups, plates
4. Sharing toilets
5. Use of condom
6. Transfusion of unsafe blood
7. Prick from contaminated sharps
8. From infected pregnant woman to her unborn child
9. Other (specify) _____

29. Who can be infected by HIV? (tick as many as possible)

1. Anyone who has unprotected sex with infected partner
2. Homosexuals
3. The rich
4. The poor

5. Users of condoms
6. Injectable drug abusers
7. Others (specify) _____

30. Is AIDS curable?
    1. Yes
    2. No
    3. Don't know

31. If yes to question 28, explain how?

_____

_____

32. Can HIV transmission be prevented?
    1. Yes
    2. No
    3. Don't know

33. If yes to question 32, how? (tick as many as possible?
    1. Abstinence
    2. Sticking to one faithful sexual partner
    3. Use of condom during sexual intercourse
    4. Not using condom during sexual intercourse
    5. Prevention of mosquito bite
    6. Having sex with a virgin
    7. Not sharing plates, spoons, cups
    8. Not sharing toilets
    9. Not sharing needles
    10. Other (specify) _____

34. Who makes decisions in your home?
    1. Myself
    2. My sexual partner
    3. Guardian/parent

35. What prompted you to come to this clinic (tick all that apply)

1. STD screening
2. STD treatment
3. medical exam
4. STD review
5. Other (specify) _____

36. Did you know about STD before the current one?

1. Yes
2. No

37. Under what circumstances do you think you acquired the current STD?

1. Sex with prostitute
2. Casual sex contact
3. Regular sexual partner
4. Other (specify) _____

38. Have you ever had an STD in the past?

1. Yes
2. No

39. If yes to question 38, how often? _____

40. What is the relationship between STD and HIV?

41. Did you Do you think you could get HIV/AIDS yourself?

1. Yes
2. No

42. If yes to question 35, what makes you think so?

_____

_____

THANK YOU FOR YOUR PARTICIPATION

APPENDIX 2

INFORMED CONSENT

TITLE *"FACTORS ASSOCIATED WITH RISKY SEXUAL BEHAVIOUR IN REGARD TO HIV PREVENTION AMONG PERSONS ATTENDING STD CLINIC AT THE UNIVERSITY TEACHING HOSPITAL, LUSAKA"*

Dear Participant,

I am from the University of Zambia. I am carrying out a study on "factors associated with risky sexual behaviour in relation to HIV prevention".

In order to collect information for the work I will be asking you questions about your knowledge on contributing factors associated with risky behaviour. Some of the questions are sensitive and you may not want to answer them.

Please be informed that:

1. Participation is on voluntary basis.
2. You are free to withdraw at any stage during the interview.
3. All information given will be treated with strict confidentiality.
4. There is no direct benefit to you but the information will be very helpful for prevention of HIV disease.
5. If you have any questions or would want any clarifications please call Grace Mwangala on Telephone number 251837 or Cell number 096-756858.

Your participation will be greatly appreciated.

Thank you.

I accept participation.

Signature or thumbprint ..... **Signed**.....
(Participant) (Researcher)

Witnessed by: .....

THE UNIVERSITY OF ZAMBIA

RESEARCH ETHICS COMMITTEE

Telephone: 252641
211440 (UTH) 254824 (Pre-Clinical) Ridgeway Campus
Telegrams: UNZA, LUSAKA.
Telex: UNZALU ZA 44370

Fax: + 260-1-250753

DEAN'S OFFICE
P.O. Box 50110
Lusaka, Zambia.

Your Ref.:

Our Ref.:

28 September 2000

Ms Grace K Mwangala
Community Medicine Department
LUSAKA

Dear Ms Mwangala,

The following research proposal presented to the Research Ethics Committee on 26th July 2000 was approved. Congratulations!

Title of research proposal: **".Behaviour change, a missing link in prevention of HIV/AIDS".**

Please keep the Committee informed on the progress of your research.

Yours sincerely,

Signed:.....

Prof: KS Baboo MBBS MMED FRSH DABTM
CHAIRPERSON, RESEARCH ETHICS COMMITTEE

The University of Zambia
School of Medicine
Department of Community Medicine
P.O Box 50110
Lusaka

12th September, 2000

The Managing Director
UTH Board
P.O Box 50001
Lusaka

u.f.s: Head of Department
Community Medicine
Lusaka

Dear Madam,

Re: PERMISSION TO CARRY OUT A STUDY ON "BEHAVIOUR CHANGE: A MISSING LINK IN PREVENTION OF HIV/AIDS IN LUSAKA URBAN"

I am a postgraduate student in Masters of Public Health Programme at the University of Zambia. I wish to seek permission to carry out a study on the above mentioned topic, in partial fulfillment of the course.

I hope to carry out the study in STD clinic at UTH. The research will entail interviewing clients visiting the clinic.

Thanking you in anticipation of your favourable response.

Grace S.K Mwangala
MPH STUDENT