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THE UNIVERSITY OF ZAMBIA

SCHOOL OF MEDICINE

DEPARTMENT OF POST BASIC NURSING

HIV/AIDS AMONG THE YOUTH: KNOWLEDGE, ATTITUDES, SEXUAL PRACTICE AND HEALTH SEEKING BEHAVIOUR IN KAPIRI-MPOSHI

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AIDS -	Acquired Immune Deficiency Syndrome.
ARC -	AIDS Related Complex.
GPA -	Global Programme on AIDS.
HIV -	Human Immuno - Deficiency Virus.
ICRW -	International Center for Research on Women.
M .O. H -	Ministry of Health.
STD -	Sexually Transmitted Disease
SAFAIDS-	Southern African Aids Information Dessemination Service
U T H -	University Teaching Hospital
UNAIDS-	United Nations Agency for AIDS
WHO -	World Health Organisation
WHA -	World Health Assembly
R P R -	Rapid Plasma Reagent
Z D H S-	Zambia Demographic and Health Survey

DECLARATION

I hereby declare that the work presented in this study for a Bachelor of Science Degree in Nursing has not been presented either wholly or in part for any other degree, and is not being currently submitted for any other degree

Signed:..
Candidate

Signed:...Dec 8th '97
Lecturer

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STATEMENT

I hereby certify that, this study is entirely the result of my own independent investigation. The various sources to which I am indebted are clearly indicated in the text and in the references.

Signed:........Abenns....8th December, 1997.........

Candidate

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Lastly but not the least, my great appreciation and thanks to my God, the Lord Jesus Christ who gave me the strength to go on. (Philipians 4:13, "I can do all things through Christ who strengthens me").

DEDICATION

This study is dedicated to my beloved Children, Saka, Chama and Mutinta for enduring mum's absence from home, to my brother Borniface and sisters Priscila and Angela, whose patience, love and care made me be where I am today.

ABSTRACT

The main objective of this study was to determine the knowledge, attitudes, sexual practices, and health seeking behaviour of the youth concerning HIV/AIDS.

The study was conducted at Kapiri Mposhi urban. The data was collected from 50 in-school -youth and 50 out-school-youth. Systematic sampling method was used. A structured interview questionnare for 60 youths, and a total of four focus group discussions comprising 10 participants each were held. A descriptive non-experimental type of study was undertaken.

Literature review was based on historical perspectives of HIV/AIDS.; Global, Regional, and Zambian perspective of HIV/AIDS, and its impact on the general population and the youth; and on past and current aspects of knowledge, attitudes sexual practices and health-seeking behaviour concerning HIV/AIDS.

Results of the study revealed the following:-

- though the majority of the youth had moderate, followed by high knowledge about HIV/AIDS, very few indicated that they had changed their sexual behaviour;

- there was a high rate of sexual practice with multiple sexual partners, especially in the age range15-19 years, often without use of condoms;

- Though the youth indulged in unsafe sexual practices they neither perceived themselves to be at risk of contracting HIV infection, nor did they view STD as a risk factor to HIV;

- Knowledge about HIV/AIDS does not change their attitudes towards HIV/AIDS but real life experience with someone who is HIV positive or has died from the illness did influence change in attitude;

- The church was found to play a role in shaping morals as the majority of those who were regular at going to church had none or few sexual partners.

CONCLUSION: HIV/AIDS has and will become an increasingly important problem among the youth, in Kapiri Mposhi. Knowledge about HIV/AIDS alone cannot change sexual practices of the youth. The problem in general is multifaceted and need to be dealt with by combining forces of all stake holders.

1.0. INTRODUCTION

1.1 BACKGROUND INFORMATION

Zambia is a land locked Central African Country in the Sub-Saharan Africa. The country is bordered by Zimbabwe, Botswana, Namibia, Malawi, Angola, the Democratic Republic of Congo, Tanzania, and Mozambique. It covers an area of 752,614 square kilometres and consists of 2.5 percent of the area of Africa.

The country is divided into 9 provinces and 72 districts. Each provincial Head-quarters is linked to the national capital Lusaka by an all weather road. An improved transport network makes the mobility of people from rural to urban areas and vice versa much easier. Urbanisation has increased from 30% in 1964 to 42% in 1990 (Strategic Plan 1994-1998). The increased mobility and migration of people in search of greener pastures, are key factors in the spread of the Human Immune Deficiency Virus (HIV) in the general population in Zambia.

There are seventy - two officially recognised ethnic groups of which the major languages are Luvale, Bemba, Tonga , Nyanja , Lozi and Lunda. The various ethnic groups represent diversities of cultural beliefs and traditions some of which may influence the spread of HIV in Zambia.

The 1969, 1980, and 1990 national census reported total populations of 4.0 million, 5,7 million and 7.8 million respectively implying growth rates of 3.1 in both intercensal periods (Dzedzeke, 1997). He further reported that the fertility level remained virtually constant during the 1969-1980 period. There was a decline in fertility rates in the 80s and 90s. The fertility rates were estimated at 6.7 in 1990, 6.5 in 1992 and 1996.

The life expectancy at birth increased from 43 years in 1969 to 51 years in 1980 and then declined to 48.9 in 1996. The observed decline in fertility rate in the 80s and early 90s have been precipitated by the difficult socio-economic situation in the country. The advent of the acquired immune deficiency syndrome has also contributed greatly to the decline. The HIV epidemic will affect population growth in future, which is primarily determined by the fertility rate and the age-sex structure of the population.

Two thirds of Zambia's population figures are children and young adults while the adult population 35-60 years constitute one third (MOH, 1993). It is in this view that the Zambian government has targeted the youth in prevention and control programmes as they are regarded as the' window of hope' in containing the epidemic.

HIV is transmitted in semen, vaginal fluid and blood. Infection with HIV can only be spread through the following ways:-

- Through unprotected vaginal or anal intercourse with an infected person (70-75%) for heterosexual transmission. A few cases have been attributed to oral intercourse;

- Through infected blood - in transfusion, blood products (3-5%), the use of contaminated needles, syringes, or other skin piercing instruments, injecting drug use (5-10%), medical and quasi medical use;

- From an infected mother to her baby before or during birth (5-10%); the risk of transmission is estimated at 30% with transmission taking place during delivery. Breast feeding has also been attributed to as a route of transmission (Dossier 6, 1997).

High - risk behaviour is sexual or drug - injecting behaviour which allows HIV to be transmitted from an infected person to an uninfected person. Several studies carried out show that HIV - infection cannot be transmitted through casual contact, kissing or mosquito bites. This has helped to quell irrational fears of casual contact even among health personnel.

Young people are more vulnerable to contracting HIV infection during adolescence. According to the World Health Organisation (WHO), the period of adolescence is defined as" the progression from the appearance of secondary sex characteristics to sexual and reproductive maturity, the development of adult mental processes, and adult identity, and the transition from total socio - economic dependence to relative independence" (WHO, 1975). As the definition implies, adolescents are no longer fully under control of adults, but not yet entrusted with adults rights and responsibilities. As they enter a new world of social relationships, they are challenged with reconciling social and familial norms of behaviour with emerging sexual feelings and desires.

Early unprotected sexual activities exposes the youth to the risk of contracting sexually transmitted diseases (STD), including HIV infection. In many developing and developed countries, more than half of young people have unprotected penetrative sex by the age of 16. Aggleton and Warwick (1992) reported that 50% of young people in Britain will have experienced sex by the time they are 16. They further reported that by the end of 1991, there had been 27 reported cases of AIDS and 530 reported cases of HIV infection amongst young people aged 15 - 19; and 229 reported cases of AIDS, and 2, 672 reported cases of HIV infection amongst those aged 20-24.

Zambia faces a similar trend of HIV/STD. Studies conducted at the University Teaching Hospital, Lusaka in 1990, revealed that 54% attending for the first time were sero-positive. The majority were in the sexually active group, either single or married. Most of these were in ages less than 26 years (MOH, 1993).

Review of other literature for instance the World Health Assembly held in May 1989 reported that, nearly one and half to two million of those infected with HIV were under the age of 25. About 20% of all people who had H I V / A I D S were in their twenties (Beverns et al, 1989).

Girls and women are especially vulnerable to HIV infection. They marry or have sexual intercourse with older and more sexually experienced men. Globally, they have less access to education, have less power to refuse unwanted sex and to negotiate safer sex, and may be unaware of having an STD. STD increase the risk of transmission of HIV infection. Sexual abuse is common in many countries. Any forced intercourse is likely to cause tears in the genital tissue, which makes it easier for HIV to enter the body. In Africa women aged 15 to 24 are more likely to be HIV-infected than men of the same age for biological and socio-economic reasons (WHO, UNICEF 1995).

Young people have limited information about sex and sexual development, and no access to counselling and advice. Lack of confidentiality and disapproving staff attitudes are quite common when young people seek help for STD at health facilities.

Some young people are more vulnerable than others. Poverty, unemployment, or homelessness are often linked with lack of education, alcohol and drug abuse, gender inequalities, and rapid changes in family and social structures. Moreover, young people who become HIV positive are often discriminated against or they have their needs ignored.

Street children may engage in commercial sex as the only means of survival. As more street children become infected with HIV, they may suffer greater abuse and discrimination. They may not even seek medical advise for fear of being harassed or questioned by medical personnel. They may not be able to pay for their medical care as well.

HIV/AIDS is a disease which knows no boundaries, does not discriminate between races, economic status or religion. Most of the disease epidemics kill mainly the weakest especially the very young and the old. HIV is no respecter of the fittest as it affects everyone equally, as Tinker (1992) put it, "since HIV hits active young adults the hardest, it could be described as the killer of the fittest. The population it leaves behind is less able to cope because it has lost its most productive sector"

It is for this reason that many countries the world over are concerned about this disease. African countries including Zambia have drawn up a national policy on HIV/AIDS which include prevention and control programmes. The Zambian government through the Ministry of Health as well as a wide range of donor agencies, have committed themselves to the collection of data on the extent of the epidemic, including information on knowledge, attitudes, sexual practices and health -seeking behaviour. Results are used to develop effective intervention programmes.

The Zambia national programme for AIDS prevention and control was drawn up in 1987. Its primary objectives were to monitor the HIV/AIDS epidemic, disease transmission by all known routes, and to improve management of HIV infected and AIDS patients. Health education is thus of paramount importance in the control and prevention.

Nation wide campaigns which have sought through the media, hospital counselling centres and other channels to increase awareness and understanding of HIV/AIDS have been embarked. WHO believes that, though a cure or vaccine is not yet available, the spread could be contained through intensive health education campaigns to encourage necessary behavioural changes specifically sexual behaviour.

Interventions for HIV/AIDS prevention and control in Zambia have been enhanced by the Health Reforms Programmes. Health Reforms have been characterised by real movement from an excessively centralised system to a decentralised system of health care delivery. The centre provides support and national guidance to the districts to effectively respond to their health needs within the confines of their catchment areas. The focus of this reform is to provide equity of access to cost effective quality health care as close to the family as possible. In order to operationalise these ideals, the Government has developed a National Strategic Plan which recognises the various levels of care with the household playing the critical role in the production of health.

Kapiri Mposhi is one of the districts in Zambia where epidemiological studies on HIV/AIDS have been conducted. According to the population based survey of 1995/96, the HIV prevalence in Kapiri Mposhi has increased from 13.5% in 1994 to 31.4% (Cl:28.4 - 34.4), as compared to Lusaka urban which has 26.2% (Cl: 24.4 - 28.1) and the rural 15.5% (Cl: 13.4 - 17.7), (Fylkesnes et al, 1997). These statistics coincide with the District Action Plan report of 1996 which rated STDs and HIV second to malaria in prevalence rates, as compared to previous years. Moreover, the hospital alone has documented 94 HIV/AIDS cases under the Home Based Care Unit. This in itself has great implication on the health care delivery system regarding the inadequate health facilities available at the hospital, whose bed capacity is only 35.

Kapiri Mposhi District is located in Central Province. The district is centrally located enroute to the Copperbelt, Lusaka and Northern provinces. The district is served by a major railway line - Tazara, which connects land locked Zambia with the port of Dar-es-salaam. Both the Zambia railway line, copperbelt and great north roads dissect the district. The good roads and railway networks makes the mobility of people from various places possible. The district's central location with international routes make it susceptible to high rates of promiscuity and commercial sex is common.

Traders and truck drivers converge at Kapiri Mposhi Central, making the under privileged to trade in sex as the main source of income. The major industry is Kapiri Mposhi Glass products which has since been closed.

The district has a total population of 210,645 with a growth rate of 4.2% (District Action Plan, 1997). It has 21 rural health centres of which 16 are run by Government, 4 by missionaries and one by ZCCM. The district is densely populated in Kapiri Mposhi township, fishing areas in the Lukanga swamps and Kafue river. Subsistance farming is the main source of income for the majority of the rural population. Commercial farming is done to a smaller extent. In Kapiri Mposhi town, the majority of people are street vendors, marketeers while a small population of people own shops. Restaurants, motels, bars, and markets do exist. The closure of the Kapiri Glass Products being the major employer has great implications. This will influence further spread of HIV infection as many families have no extra source of income. If the situation is left unchecked, more people will be infected with HIV as they begin to engage themselves in high risk behaviour for economic gain.

1.2 STATEMENT OF THE PROBLEM

AIDS has become a permanent challenge to human ingenuity and solidarity since its recognition in the late 1970s. It is a long, often painful, and fatal disease that develops in people up to a decade or more after they have been infected by HIV. Approximately, half of all HIV infections so far have occurred in men and women younger than 25 years. In many developing countries, recent data indicate that up to 50% of all new infections are among 15-24 year olds with females out numbering males by a ratio of two to one. (Weish et al, 1996).

Within the sexually active population, HIV prevalence is highest in 20-30 year old women and 30 - 40 year old men. This indicates high levels of sexual mixing and transmission between these groups; symptomatic of the sugar daddy scenario. In younger age cohorts, HIV prevalence is far higher in females; HIV infection rates for 15-19 year older females are seven times that of males in the same age cohort, indicating the high incidence of inter-age cohort sexual mixing and the fact that the highest number of new infections is in adolescent girls (Mulenga, 1996).

Adolescence being a period of profound physical, mental and emotional change, young people often experiment with hidden behaviour that increases the probability of HIV infection. Early unprotected sexual intercourse, the use of alcohol and drugs that impair judgement, and the sharing of needles to inject drugs predisposes young people to the virus.

The Zambian society is faced with an alarming increase of STDs including HIV, pregnancies and abortions among not only teenagers but even those who have not reached their teens.

As Cremis (1984) emphasised, ''the root cause of the problem is that, for every girl who gets pregnant or contracts an STD, there is a man or boy who has committed adultery or fornication with her and each of these couples, there are 30/100 others whose intercourse has not been revealed because it did not result in either pregnancy or serious disease." Sexual activity is a private matter and only the individuals involved become aware of it. What makes changing AIDS-related behaviours so complex is that the risk behaviours associated with HIV transmission are based predominantly on interpersonal relations.

The number of HIV/AIDS cases among the youth is increasing inspite of the efforts by the Zambian government and Non-governmental organisations to curb the spread of the disease. Since the first AIDS case in Zambia was diagnosed in 1984 and officially recognised in 1985, the cumulative total number of notified persons with AIDS and AIDS related complex (ARC) increased to 29,734 as of October 1993 with 1592 deaths. By December 1996 there was a cumulative total of 42, 447 cases of which 4 ,010 were adolescents (Fylsknes et al, 1993, Zambia National Health Policies (1992). Authorities in the National AIDS /STD/ TB and Leprosy Programme agree that figures reflect a significant under reporting.

In Kapiri Mposhi district, the number of HIV/AIDS cases are also increasing. The number of STDs had increased in 1995 - January to June, 1411 as compared to 841 in 1994, but increased to 130 by June 1996 (District Action Plan, 1996). The district hospital alone documented 94 cases of HIV/AIDS, under the Home Based Care Unit by January 1997. Out of these, 68 were under the age of 35. These statistics are indicative of how serious HIV/AIDS is among the Kapiri Mposhi youth. Taking into consideration the long incubation period, most of the infected people may have been infected as adolescents.

Assuming that measures to prevent further transmission are not intensified the figures indicate that more young people will be infected over the next decade, due to its multiplier effect. STDs increase the risk of transmission of HIV. As Fylkesnes et al (1992) stated, "the likelihood or odds in favour of HIV infection for women with a positive Rapid Plasma Reagent (RPR) test was found to be 1:8 times as large as that of women not testing positive".

HIV infection may also have a negative impact on, on-going health programmes. The national history of endemic diseases for example tuberculosis may be modified by concomitant HIV infection, so that patients would experience more fulminant disease relapses. These lead to increased rates of transmission of endemic diseases in the population. Consequently the standard management of common diseases may become less effective.

The provision of health and social services is a major cost to any health delivery system. More so to developing economies such as Zambia with inadequate financial means to sustain the system. A study by Hira et al, (199 3) indicate that the daily professional cost per patient is $3.49, while annual cost of clinical Care for AIDS patients is $27.1 million, and that for HIV related disease is $27.3 million. With hyper-inflation affecting the country, the costs are likely to increase in the near future. The demands for care will increasingly fall on poorly equipped and under funded rural services such as Kapiri Mposhi District hospital with only a bed capacity of 35, but catering for a large population of 36,006 people. This implies that there will be 1 000 people competing for one bed. The quality of care will seriously be affected as in-patient days will be reduced to create space for others.

Already, about 50% of hospital beds in our major hospitals in Zambia are occupied by people with opportunistic infections, due to AIDS. In such a case consequences of over crowding and under staffing will affect the quality of care for the terminally ill AIDS patients. As Howie (1987) stated, "it is obvious that existing hospitals would not cope with the sheer number of cases even if reality falls considerably short of the worst case scenario."

The impact of HIV/AIDS among the youth will have a lot of implications. The social and economic development may be very critical in view of the fact that the youth are the most reproductive of all age groups. The mortality rates among the economically and socially most reproductive age groups especially 20-45 year olds, may rise several fold as a result of AIDS.

This has prompted the researcher to find out what the Kapiri Mposhi youth know about HIV/AIDS and measures they are taking to prevent the spread of the disease among them. As the future lies in the preserving the youth, the focus must be in this age group to promote good health related behaviour.

The following could be attributed as factors influencing the knowledge, attitude sexual practices, and health -seeking behaviour among the youth in Kapiri Mposhi concerning HIV/AIDS.

Inadequate health education campaigns on HIV/AIDS affects understanding and perception of dangers of unprotected sex. Lack of outreach programmes for out-of-school youth deprives this segment of the population with knowledge required to bring about behavioural change. Outreach programmes for in-school - youth mostly cover immunisation and omits important topics on HIV/AIDS regarding the fact that most pupils are sexually active and suffer its consequences. Literature on HIV/AIDS for those able to read is also not available.

Unavailability of youth friendly services discourages the youth from seeking medical advice for fear of stigmatisation especially when suffering from an STD. Disapproving staff attitudes are quite common making the youth to eskew medical care and opt for alternative approaches such as self-care or traditional healers. The efficiency of such type of care may be inadequate and lead to disease progression. It also deprives the youth from getting adequate health care from professional experts . All this leads to poor quality of service.

Age and sex are demographic variables that can affect knowledge, attitudes, sexual practices and health-seeking behaviour among the youth. A very young person may not perceive a susceptibility to HIV infection. Comprehension of seriousness of the disease will be at stake leading to negative attitudes towards prevention of HIV/AIDS transmission.

Males feel that sex and having many sexual partners is a sign of virility or manhood. From an early age, a boy learns that being masculine is crucial to his identity and self-esteem. If a boy does not have sex at an early age, friends and family may question his masculinity. For example in a study in Thailand, some girls said that a boy who does not visit prostitutes must be a homosexual (Xenos et al, 1993).

Women on the other hand are socialised to be submissive to men. They may have little or no choice about whether, and with whom they have sex. Very often, women are not in position to either say no or influence their partner's sexual behaviour, including whether or not condoms are used. The growing HIV/AIDS threat to women and children will not diminish until women have the power to say no to sex, to choose their own partners and influence sexual behaviour. This can only be achieved when women are empowered so that their dependence syndrome on men is reduced.

Educational level enables individuals to appreciate and value health services available, especially screening procedures like HIV testing. It also helps to understand the consequences of the disease better, resulting in behavioural change. The illiterate youth may not value the available health services probably visiting the health centre only on event of serious illness. Lack of education also leads to unemployment and eventually poverty. There is a high correlation that exists between poverty and vulnerability to the virus, a correlation that has lead to high rates of infection in the most economically deprived populations.

A large number of youths drop out of school as a result of lack of secondary school in the district. There are only two primary schools in Kapiri Mposhi Central where basic schools for secondary education has been established only up to grade 9 in one school, and grade 8 in the other. This leaves a substantial number of youth out of school. Such kind of youths may end up in the streets predisposing themselves to unhealthy practices which may lead to HIV infection.

Recreational facilities are not available in the area except few football and netball pitches in schools. No youth clubs are available to keep the out-of-school youths busy. Most often the youth end up engaging in beer drinking, drug abuse, or loittering in the streets. As the saying goes , 'an idle mind is the devils workshop', the youth may end up indulging in unsafe sexual practices especially under the influence of drugs and alcohol.

Cultural traditions, fear and other barriers prevent the youth from learning about the sexual transmission and other forms of HIV transmission, or acting on the knowledge they have. Matters of sexuality are not discussed openly between parents and their children but left to grandparents, uncles and aunties who may not take time to counsel the youth.

Strong cultural attachments do not permit or support communication about sexual matters because most often leaders and parents do not admit that their children could be sexually active. Infact, many youths are out of touch with traditionalists.

The family constitutes the primary unit in society and consequently plays a major role in early socialisation of a human being, and what eventually individuals turn out to be in real life. With disintergration in family structure, the process of socialisation may be inadequate leading to poor personality development . This affects attitudes towards health promotion and maintenance. Properly socialised individuals tend to have a positive attitude towards life, while poorly socialised individuals tend to be reckless.

Very often reckless individuals or those lacking parental control tend to leave home, may suffer assault and abuse. They experience poverty leading to malnutrition, depression, and become susceptible to all sorts of infections including HIV. They don't normally care what happens to them and their main concern would be to get their basic needs. Such kind of youth may not regard an anti-AIDS message as important because they don't see it as a problem of now., but tomorrow. As Dr. Banda of the Churches Medical Association of Zambia pointed out. "There is a feeling that life is already hard. There are other priorities like getting the next meal which press on people much more than AIDS. They just want to secure food and housing before they can think of AIDS. And the long incubation period makes them think of it as a problem of tomorrow, not today."

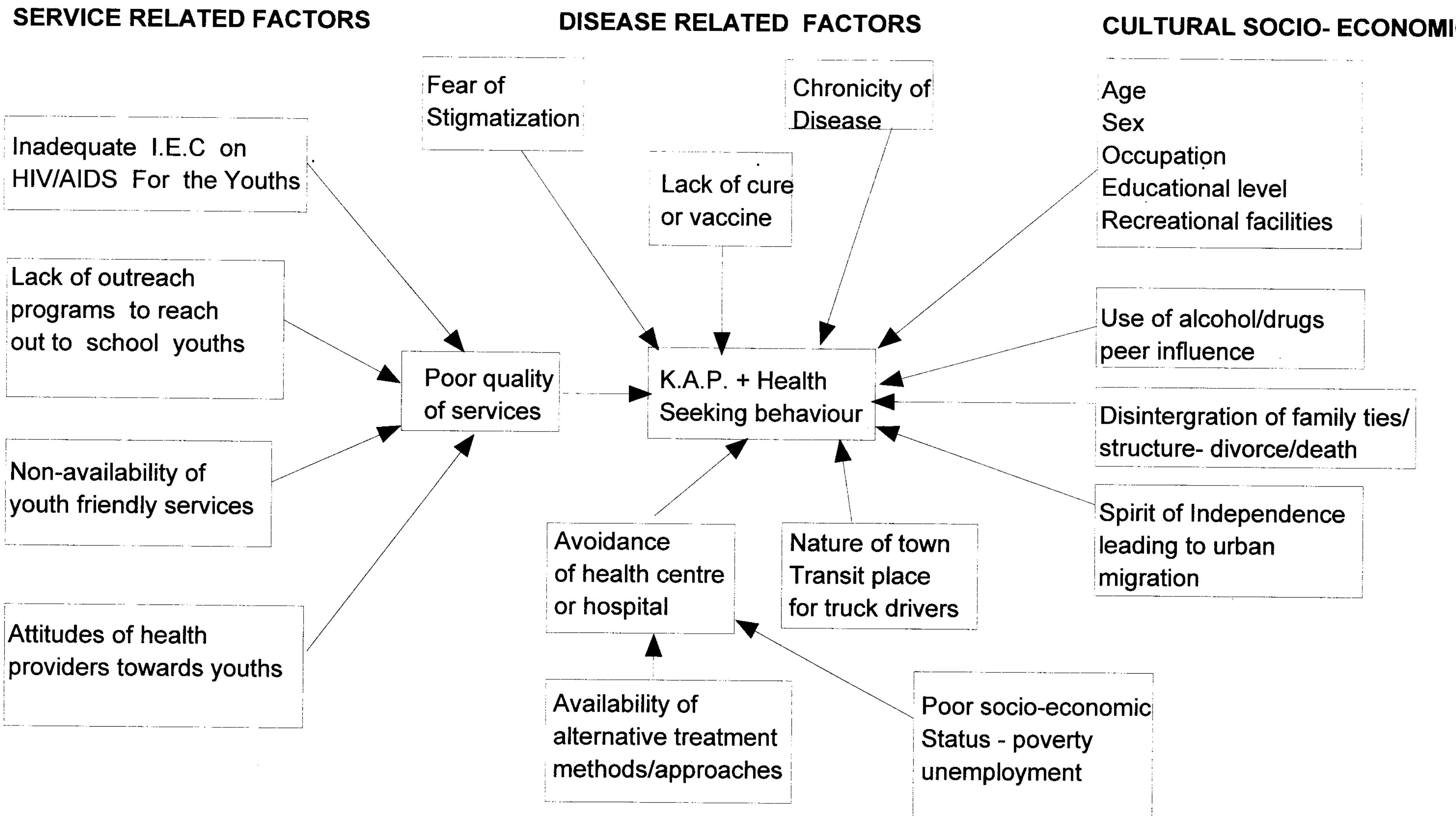
Non utilisation of health services for treatment of STDs is attributed to availability of alternative approaches such as traditional healers, chemists and private doctors. This deprives the youth from getting proper screening procedures and adequate health education on dangers of unsafe sexual practices. Their continued ignorance will affect their knowledge, attitude and practices.

Peer influence encourages the youth to indulge in alcohol and drug abuse leading to unhealthy sexual practices. Throughout the world and in every culture, young people experiment alcohol, drugs and sex. This combination can be partially deadly in an age of HIV. Many sero-positive individuals in their twenties were probably infected during adolescence as a result of behaviour experimentation.

The spirit of independence among the youth makes them leave home at an early age. Young people tend to be more concentrated in the urban areas than the population as a whole. They often move to urban areas to find better opportunities for jobs and education. Kapiri Mposhi is experiencing a very rapid growth due to influx of young immigrants from the country side. Many of them rely on friends for advice which may grossly be misleading .

Chronicity of the HIV infection gives false hope that the individual is healthy leading to continued ignorance and unprotected sex, hence the spread of the disease to sexual partners. The window period on average takes about 10 years for an infected person to develop AIDS. During the incubation period, the infected person will show few if any symptoms, but will be able to infect other people. Lack of cure also complicates the epidemic. Wreckless individuals may spread the disease knowingly. This is why the epidemic should be taken seriously to ensure that people. Especially the youth get the right message about HIV/AIDS and make necessary behavioural change.

'FACTORS ANALYSIS DIAGRAM



1.3 STUDY JUSTIFICATION

Although most studies have been carried out on HIV/AIDS among the youth in relation to their knowledge, attitudes, sexual practices and health seeking behaviour in either urban or rural, very few have covered both.

Kapiri Mposhi being an upcoming urban amidst village community, coupled with its highly accessible geographic position, provides a fluid social transition in which no one seem to be in control to take the lead in HIV/AIDS prevention. The rapid urbanisation of young people has led to mushrooming of squatter compounds within the urban setting making the HIV/AIDS prevention and control much more difficult due to high rates of prostitution. The youth are attracted to try themselves out with their newly acquired independence to indulge in sexual matters, while at the same time trying to reconcile with traditional norms and culture.

Boys and girls between ages 12 - 19 years, are sexually active making them more vulnerable to HIV infection and other STDs. In the homes, sexual instructions are characterised by taboos and not by reason, which, when found to be fake, is discarded with loss of face of the instructor. The youth are therefore, misinformed and get limited information from friends, pornographic materials and other sources. This lack of proper sex education for the youth has resulted in unsafe sexual practices which will have an impact on HIV/AIDS prevention and control.

In the absence of a cure and the high cost of care for HIV/AIDS patients, the only cheap and effective means to reduce the impact are intensive prevention and control measures, if the underlying factors are identified. While the incident of HIV is high, and is clearly on the increase in Kapiri Mposhi, little is known about attitudes behind the sexual behaviour, nor, is there much information about the extent and accuracy of knowledge about how HIV is, and is not transmitted.

Because of the need for depth in understanding factors behind sexual behaviour, as well as the need to cover a broad range of issues, and understand inter-relationships, the researcher utilised both quantitative and qualitative research approaches. It is hoped that the findings will be sufficient to warrant mobilisation of resources into the project by all stake holders.

1.4 OBJECTIVES OF THE STUDY

1.4.1 GENERAL OBJECTIVE

To determine the knowledge, attitudes sexual practices and health seeking behaviour concerning HIV/AIDS among the youth in Kapiri Mposhi district, with a view to evaluate the impact of the HIV/AIDS prevention/control programmes.

1.4.2 SPECIFIC OBJECTIVES

a). To establish the youth's knowledge on cause, mode of transmission and prevention of HIV/AIDS.

b). To determine the level of practice of unsafe sexual behaviour among the youth.

c). To determine the attitudes of the youth towards HIV/AIDS.

d). To establish the factors that influence prevention and control of HIV transmission among the youth.

e). To identify factors that are involved in health seeking behaviour.

f). To identify health motivators which could be used as a basis for strengthening behavioural change.

g). To make recommendations to all stake holders in the prevention and control of HIV/AIDS such as Government and Non-Governmental organisations.

1.5. DEFINITION OF TERMS

YOUTH: For the purpose of this study, the terms adolescents, young people and young adults are used interchangeably, reflecting the adoption by the World Health Organisation of the United Nations definition of adolescent age category as those individuals aged 10 to 24.

KNOWLEDGE: understanding; that which is known or familiarity with information about something.

ATTITUDE: A manner of feeling and behaviour, a settled mode of thinking.

POSITIVE ATTITUDE: When the youth perceive AIDS as a deadly disease and if one is willing to apply preventive measures or able to assist AIDS patients.

NEGATIVE ATTITUDE: When the youth perceive AIDS like any other disease which has always been there and if one is not willing to apply any preventative measures, or assisting AIDS sufferers.

SEXUAL PRACTICES:

NOT RISKY: The youth has none, or, one sexual partner, and using condoms for prevention of HIV infection.

RISK: The youth is having multiple sexual partners; is having unprotected sex and not refraining from sexual intercourse.

HEALTH SEEKING BEHAVIOUR: What the youth do individually or collectively in order to maintain, and or, return to health. This includes specific steps taken by the youth, such as self-care, asking relatives/ friends, use of pharmacy, health care centre/hospital.

1.6 HYPOTHESIS:

1.6.1 There is little knowledge among Kapiri Mposhi youth on transmission, consequences and HIV/AIDS prevention.

1.6.2 The youth practice unsafe sex due to inadequate knowledge on HIV transmission and its impact on human life.

1.6.3 Lack of health motivators among the youth leads to non-compliance behaviour to prevention programmes.

CHAPTER II

2.0 LITERATURE REVIEW

2.1 INTRODUCTION

The Acquired Immune Deficiency Syndrome (AIDS) was first recognised in 1981 when unusual clusters of pneumocystis carinii pneumonia and Kaposis sarcoma were reported in young, previously health homosexual men in New York City, Los Angeles, and San Francisco. Within the next few years, additional AIDS cases were identified in other cities in the United States and in Europe, the Caribbean, and Africa . (Quinn, 1995).

Cases of these and other opportunistic infections associated with unexplained immune suppression were subsequently reported among persons with haemophilia, recipients of blood and blood products, injecting drug users and their homosexual partners, and children with similar opportunistic conditions (Gary, 1996).

By mid 1980s, AIDS was recognised as a global pandemic, and the cause, the human immune deficiency virus (HIV) was identified. There are two strains of HIV namely, HIV-1 and HIV-2. Both viruses reproduce by using the genetic materials of cells they invade, gradually disabling the immune system, making an individual susceptible to various infections. HIV-1 is more virulent and prevalent in Sub-Saharan Africa. HIV-2 is mostly prevalent in West Africa, some countries in the Americas and Europe (Dossier 6, 1992).

When people are said to be HIV positive, it means that they have the virus in their blood without showing signs and symptoms of being sick. Gradually, the person's body will no longer be able to defend itself from common infections because the virus destroys the body's defence cells leading to AIDS. Common symptoms of AIDS are marked weight loss, chronic diarrhoea, fever, tuberculosis not responding to anti-tuberculous drugs, generalised lymphadenopathy and Kaposis sarcoma - a form of cancer that commonly affects the skin.

It is evident that the epidemic will continue to grow with continued transmission from asymptomatic pool of HIV infected individuals. WHO, estimates that for each reported case, there might be between 50-100 healthy carriers. This gives 10-20 million infected people. Between 10 and 30% of these will have developed full blown AIDS in the next 5-10 years while 20-50% will develop ARC which will eventually lead to full blown AIDS as well (Sibien, 1994)

2.2 GLOBAL OVERVIEW

AIDS emerged as a threat to the health, development and survival of millions of individuals, families and communities throughout the world during the mid 1980. By early 1992, it was estimated that world-wide, infection rates reached more than one in ten adults in some communities (Dossier 6, 1992).

The global cumulative total number of HIV infection has more than doubled in the last decade increasing from 12 million in 1992, to 29.4 million by 1997. According to the UNAIDS 1997 report, submitted to SAFAIDS news, the cumulative figures have increased world-wide as follows:-

- 22.6 million cumulative infections;
- 22.6 million people living with HIV/AIDS including 830 000 children;
- 400 000 new infections in children in 1996 alone, mostly infected at birth;
- 90% of people with HIV/AIDS living in developing countries;
- 14 million people living with HIV/AIDS in Sub-Saharan Africa, 63% of the world's total;
- 2.7 million new infections, nearly 50% in women;
- 8.4 million cumulative AIDS cases;
- 1.5 million HIV/AIDS related deaths in 1996 alone;

Cumulative HIV cases- 6.4 million of which 5.0 million are adults and 1.4 million children. More deaths occurred among male adults, 2.9 million as compared to 2.1 million women as of December 1996 {UNAID fact sheet ,1996}. WHO further estimates that by the year 2000, 30-40 million HIV infections will have occurred in men, women and children, with 50% of all HIV infections occurring among people aged 15-24 years (Kallings, 1994).

Although the largest number of people infected with AIDS are in Sub-Saharan Africa, the most rapid growth of HIV infection during the 1990s has been in South East Asia with transmission escalating to epidemic proportions in Thailand, Indonesia and India (Quinn, 1995)

The infection rate is attributed to activities the young people engage in. HIV is transmitted among young people mainly through sexual intercourse. The young people who inject drugs, transmission is through sharing of contaminated injecting equipment. HIV infection in drug users has been reported by over 50 countries, many of which are in Asia, Eastern Europe and South America.

Transmission from an infected mother to the baby around the time of birth is also increasing; young women often discover they are infected with HIV only when their babies become sick and are diagnosed with AIDS (Quinn, 1995, Dossier 6, 1996).

A Houston study conducted by Sugarman et al, (1991) among homeless youth revealed that, 25% had injected drugs, 20% had shared needles for other purposes, 16% had had anal intercourse, 19% had engaged in prostitution, and 67% of all subjects reported having four or more sexual partners. Only 20% reported that they always used condoms.

Around the world, poverty coerces many young people of both sexes into early sexual activity for money. These young people usually have little bargaining power in their sexual relationships and may be unable to protect themselves from pregnancy and STD.

In Thailand an estimated 800 000 girls under 20 earn money as prostitutes (Xenos et al, 1993). Hughes, (1994) in a Brazilian study also reported that street kids are initiated into sex at an early age, often without their consent, and they are subject to a range of sexual practices that often leave them perplexed about their own sexual identities. Street kids of both sexes are frequently raped by older boys and sometimes used for passive anal intercourse. Most young girls opted for the cult of the behind-anal intercourse for fear of pregnancy and without losing their virginity. Such practices predisposes the youth to HIV infection.

As more people get the HIV infection, it will impact on economies of most communities as the disease affects mostly the sexually active populations in their reproductive years. By contracting AIDS, their productivity decreases and finally it disappears. Instead of bearing the driving force in productivity, they become an economic burden to their families and society as a whole.

2.3 REGIONAL PERSPECTIVE

Although AIDS has had an enormous impact medically, culturally and economically on all countries, Sub-Saharan Africa is bearing the main brunt of the AIDS pandemic.

Heterosexual transmission has predominated since the beginning of the pandemic accounting for 90% of all current HIV infections in adults and adolescents in Africa. More than 10% of women attending ante-natal clinics surveyed in many countries have been found to be HIV infected, with rates exceeding 40% in some areas. The rates of newly acquired HIV infections are highest in the 15-24 year old group among both females and males in most Sub-Saharan Africa. The peak of new infections occurs several years earlier in young women than in young men due to early onset of sexual activity. Uganda's HIV prevalence in 13-19 year old females is over 20 times higher than males of the same age. (The status and trends of the Global HIV/AIDS pandemic, 1996).

Vijana ,(1997) reported that the number of 15-24 year olds expected to be HIV positive by the year 2000 in Sub-Saharan Africa is 571 000, while the total reported AIDS cases in April 1993 was 56,575. Authorities agree that these numbers greatly underestimate actual AIDS cases and deaths. Adolescents are a group of particular concern in the rapidly growing HIV/AIDS epidemic in most Sub-Saharan Africa.

In Kenya, Mohammed ,(1996) reported that national data indicate an alarming increase in HIV/AIDS prevalence among 15-19 and 20-40 age groups. For example, 70% of AIDS cases in Kenya are below the age of 24 years which is similar in many developing countries. Most often, this is because of lack of information about sexual activity and unprotected sex which leads to increased risk to STD including HIV/AIDS. He further reported that 33% had laboratory evidence of gonococcal infection. Another study showed that out of 406 found with STD, 44.1% were aged between 15-25 years.

The age at 1st sexual intercourse in Kenya has dropped from 17 years to 12 years with a mean age at first coitus being 13 years for boys and 14 years for girls (Vijana, 1997) The trend is almost the same in most of the countries in the Sub-Saharan Africa.

In a number of countries in the region, the spread of HIV has been spurred by population movements due to situations of conflict, poverty and powerlessness in which the majority of populations live. There is a high correlation that exists between poverty and vulnerability to the virus, a correlation that has led to high rates of infection in the most economically deprived populations.

The poor socio-economic situation particularly for women, and the underlying cultural expectations that men may have multiple partners influence the spread greatly. As a result, AIDS is systematically undermining the health, economic and social infrastructure of countries throughout Sub-Saharan Africa. The health cost of the epidemic are already substantial and constantly rising.
As young people and middle aged adults fall ill, and eventually die, children are orphaned, elderly relatives are left without support, households and communities are impoverished. The national and global economy loses managers producers and consumers.

2.4. ZAMBIAN PERSPECTIVE

It is estimated that HIV has been endemic in Zambia since the late 1970s. During mid 1980s, Zambia, like any other African country was still in a stage of denial of AIDS as a real problem.

In the face of scores of media stories especially in Europe and North America, blaming Africa for the AIDS pandemic, virtually all African governments reacted defensively by denying that AIDS was a problem in their countries. This led to official inactivity and loss of precious time allowing the epidemic to spread unabated (Chandra, 1992).

However, Zambia took the case seriously and by 1987, health education campaigns were intensified and strategies to curb the incidence were set up. Zambia is one of the hardest hit countries in the Sub-Saharan Africa. Cumulative figures have been increasing since 1984. The following table shows the cumulative AIDS and ARC cases from 1984 to December 1996.

TABLE 1: TOTAL AIDS AND ARC CASES REPORTED ALL ZAMBIA BY YEAR: 1984 - 1996 (DEC. 1996).

YEAR	CUM. TOTAL	CUM. TOTALS	CUM. TOTALS
1984	0	1	1
1985	1	3	4
1986	241	1347	1588
1987	709	4741	5450
1988	1693	8234	9927
1989	2808	11757	14565
1990	4201	15066	19367
1991	5847	18684	24531
1992	7123	20784	27907
1993	8304	22497	30801
1994	9406	23358	32764
1995	12741	25973	38714
1996	14566	27881	42447

SOURCE: M. O. H. (NASTLP)

TABLE 2: AIDS REPORTED CASES: CUMULATIVE TOTALS BY AGE GROUP AND SEX: (DEC. 1996)

AGE-GROUP IN YEARS	MALES	FEMALES	UNKNOWN	TOTAL
0-4	379	359	5	743
5-14	85	70	0	155
15-19	112	542	1	655
20-29	2730	2376	4	5110
30-39	1192	639	2	1833
50-59	368	127	0	495
60+	97	26	0	123
NOT STATED	**317**	**358**	**2**	**677**

SOURCE : M. O. H. (NASTLP)

The majority of reported AIDS cases is in the ages 20-39 years with females out numbering males. This indicates high levels of sexual mixing and transition between these groups where elderly men seek the young girls believed to be AIDS free.

High infection rates for 15-19 year old females are seven times that of males in the same age group, and the rate of new infections is highest among adolescent girls. However, the 1996 survey shows a drop in infection rate among this age group. Sero -positivity is associated with women with over twelve years of education than those with none. This relates to sexual networking of thes women, whose partners are more likely to be affluent, in formal employment, and have access to other sexual partners. Incidence rates are generally still rising, over the estimated 500 new infections per day (Mulenga, 1996).

Sero-prevalence data from ant-natal clinics from 1994 show a great rural/urban difference across the country ranging from 1.6 to 31.6%. Average infection rates for 1995 show average rates of 10-15 in rural areas, while in urban areas it is higher between 25-30%. Evidence shows that in rural areas incidence rates are still rising while in urban areas they have actually stabilised.

PREVENTION OF HIV/AIDS IN THE GENERAL POPULATION

Throughout the 1980s and into the 1990s, HIV prevention has been closely associated with the protection of individual human rights. Public health measures such as compulsory testing and isolation have largely been rejected as inefficient in public health terms and inappropriate in the context of human rights protection HIV prevention has been based chiefly on elective measures such as Information, Education, and Communication, (I.E.C) counselling, and voluntary testing. The proper use of condoms will substantially reduce the risk of transmission of HIV. Individuals need to take their own precautions to avoid infection.

2.5 KNOWLEDGE ABOUT HIV/AIDS AMONG THE YOUTH

Almost all studies reviewed report a very high awareness of the existence of HIV/AIDS with the WHO and G P A surveys recording that over 9 out of 10 people know the disease everywhere except a few countries (WHO/GPA Surveys, 1996).

A study conducted by Adrian et al ,(1993) among adolescents in Haiti revealed that women were found to have better knowledge of AIDS than men. 38.1% of the 1118 sexually active male survey respondents were found to engage in high risk behaviour. AIDS was believed to come by fate which explained the tendency to persist in high risk behaviour.

The trend is not very different from that of Sub-Saharan Africa. The lowest awareness recorded in any study was in Togo where just under two-thirds of respondents had heard of AIDS and the sexual differential in knowledge was also great. Despite awareness campaigns in Senegal through the media and health workers,10% of men and women in the study, most of them uneducated had never heard of HIV/AIDS. Moreover, misconceptions about transmission were common among those who knew of it. Most of them have never heard of condoms including those who had higher education level.

In the study conducted in Malawi, reported by Weish , (1996) , indicated that adolescents were generally knowledgeable about AIDS. Males and females knew how the disease was transmitted and that it was fatal. However, young people did not think they were at risk for HIV/AIDS. For example, quoting Helitzer, (1994), she reported that 86% of 300 girls surveyed in the Malawi study said it was not likely they would get AIDS despite the fact that 56% of the sample reported being sexually experienced.

In Zambia, several studies have been conducted among the youth concerning HIV/AIDS. A study by Macwangi, (1993) among young people with AIDS in Lusaka revealed that knowledge about HIV/AIDS was very high among the youth although it was not accompanied by behavioural change. Condom use was also very low. Misconceptions and stereotypes about causes, prevention and treatment of AIDS were common. Communication about sexuality and HIV/AIDS in general, and between family members was lacking due to various socio-cultural factors. In general correlation between knowledge and sexual practice was very low.

2.6 ATTITUDES TOWARDS AIDS

Attitudes may be viewed broadly as specific responses to particular objects. These responses determine the likes and dislikes, and the differential values which a person attaches to different objects or phenomena. They have therefore a significant role in regulating the behavioural patterns of individuals. The attitude is regarded as determining the general character of the act. Fontana, (1988) describes attitudes as the relatively enduring orientation that individuals develop towards objects and issues they encounter during their lives.

Attitudes therefore clearly contain elements of values and beliefs as well as varying degrees of factual knowledge. The concept of attitude helps us understand the direction of behaviour and action. A change in behaviour is usually preceded by a change in thought patterns of individuals.

Attitudes develop from childhood. They are usually taken from parents and others through verbal contacts rather than from experience. Lack of trust in an informant lead to development of negative attitudes. Once attitudes are formed, they may be very difficult to change, hence the need for health education to start at an early age. Attitudes are wrapped up with a person's feelings, needs and self concept. They are easy to maintain because a person sees what he wants to see and may distort reality as to find evidence to support any position he wants. (Blair et al ,1969, Bhatnager, 1972).

A study conducted in Kansas City by Mc Elreath et al, (1992) to assess perceptions of AIDS in school-aged children and their parents attitude towards persons with AIDS were found to be significant predictors of a child's attitudes towards persons with AIDS, but were not significant predictors of a child' knowledge of AIDS. The child's own knowledge level served as a significant predictor of the child's attitudes and visa-versa.

A study done by Brown, (1992) among middle aged school sexually active and abstinent adolescents in Rhodes Island found that the sexually active boys compared with their partners were less knowledgeable about HIV, less fearful of HIV, less tolerant of people with AIDS, riskier in non HIV related attitudes, and had a greater history of other risk behaviours. A similar but less marked pattern was found for girls.

Such societal reactions to AIDS are same in other developed and developing countries. Attitudes towards sex and sex education have been of much debate with parents and community leaders arguing that sex education can increase sexual experimentation among the youth. However, the youth's attitudes towards sex are mainly influenced by peers which has great impact on sexual lives of many young people.

Interviews conducted by Maker, (1996) among rural and urban South African youth reveal several beliefs about sex. One village boy stated, "other boys look at your face and find you have pimples, then they say that sperms are in your face. Therefore, you try hard to get rid of them through having sex". Other youths believed that love is worth nothing if there is no sex. Having one sexual partner was said to be boring because it is like playing a video cassette and keep rewinding and playing the same thing, which meant that it could be boring.

Although young men in most countries believe that having multiple sexual partners is a sign of manhood, they do very little to protect themselves from the risk of HIV infection. Attitudes such as these put young people at risk of contracting STDs including HIV.

Attitudes towards condom use are also varied and quite low among youth groups. Schensul et al, (1994) quoted by Weish, (1996) revealed that condom use among sexually active women in a Mauritius study was reportedly low. For example, only one out of the 90 women interviewed reported using condoms despite the fact that 20% of the samples reported having had sexual intercourse.

Several studies carried out in Zambia reveal both positive and negative attitude towards people with AIDS. A study carried out by Mkumba and Edwards,(1992) among college students in Zambia revealed that, students attitudes were generally poor with 19.9% saying that people with AIDS should be isolated, 16.8% said, they deserve to suffer and only 50.3% said they should be given same opportunities as everyone else in life. These attitudes were regardless of previous HIV/AIDS education given. Therefore, intensive health education about sex and facts about AIDS need to be intensified to ensure the youth develop good attitudes towards people with AIDS.

2.7 SEXUAL PRACTICES OF THE YOUTH

Sexual, specifically heterosexual intercourse is the predominant mode of HIV transmission. Behavioural risk factors include the number of sexual partners, the frequency of unprotected sexual contact, anal intercourse, prostitution, sex with a prostitute, and a history of STD.

Of all factors mentioned, the most discussed and studied is the association between STD and HIV, frequently referred to as the epidemiological synergy. Under this theory, coinfection with HIV and other STD prolongs or auguments the infectiousness of the person with respect to an STD. The STD in turn, facilitates HIV transmission, and consequently, the two infections mutually reinforce one another in terms of transmission.

In America, there has been continued rise in AIDS cases among those individuals reporting heterosexual contact and among women. The increase in cases in 1993 was greater among women (151%) than among men (105%). Proportional increases were greater among blacks and Hispanics than whites. The largest increase in case reporting was among persons aged 13 to 19 years and 20 to 24 years with majority of infections occurring in women (Quinn, 1995)

The association of HIV and STDs is relevant for most countries where STDs continue to increase in incidence. Spread in the developing world can be attributed to inadequate health services leading to STDs remaining untreated. The rate of infection in women in particular is difficult to document, since women with STD often have few or no symptoms.

Serological studies have been conducted in several STD clinics and selected hospitals world-wide. Otten et al, (1992) stated that in Miami, the incidence of HIV was higher (4.8%) for women than males (2.7%) among 5164 persons with repeated visits to STD clinics. This sero conversion rate was highest in 15 to 19 year old black women (7.1%), and for those with primary or secondary syphilis (12.8%), during the time of sero conversion. In most STD clinics in America, high rates of HIV sero-conversion have been documented among heterosexual teenagers with concurrent infections with either chancroid, syphilis or herpes.

Several studies reviewed show that sexual initiation for both girls and boys occur quite early in life before marriage e.g. in Kenya the age at first sexual intercourse has dropped from 17 to 12 years with a mean age at first coitus being 13 years for boys and 14 years for girls, and that some girls, have sex before menarche.

In Malawi, 56% of 300 female adolescents surveyed in 10 villages reported being sexually experienced, and 58% had sex before menarche. The mean age for sexual intercourse was 13.6 years. However, 59% had sex before attending a traditional ceremony (Mohammed, 1996, Helitzer, 1994).

Love and desire only partially explain young womens sexual experiences. Several studies found that economic gain was a motivating factor in some girls sexual activity. Young women in a Zimbabwe study, conducted by Bassett and Sherman (1994), acknowledged the existence of sugar daddies in their communities who seek adolescent school girls for sex in exchange for money or gifts.

The Zambian scenario is not any different as young people initiate sex at an early age about 16 years (DHS, 1992). The hard socio-economic situation for many, leads to high risk behaviour such as sex for monetary gains, and support from resourceful people in society. The 1992 sentinel surveillance data shows that 22.7% ante-natals in urban areas in the age group 15-19 years were HIV positive as compared to 15.2% of the same age group in rural areas (Strategic Plan 1994 - 1998).

Young people engage in sexual activities and yet do not feel at risk of contracting HIV. A study conducted by Mulapo, (1992) among street adolescents in Lusaka revealed that although the adolescents had moderate knowledge about HIV/AIDS they practised unsafe sex. They also felt that they were not at risk of acquiring HIV because they were not prostitutes. Although most of them were aware of free condom distribution in their areas, they said that they do not use them because they interfere with sexual pleasure .Males had more sexual partners than females; with heterosexual contact accounting for 39% of female adolescents compared with 29 female adults. Consequently, 20% of the respondents gave a history of STD.

2.8 HEALTH SEEKING BEHAVIOUR

With increasing rates of HIV infection among high risk groups, increased numbers of individuals infected with HIV are seeking health care.Within cities of America primary Health Care is provided by emergency department at nearby hospitals and has helped to document numbers of people infected with HIV/AIDS. In Baltimore, HIV sero prevalence increased from 6% to 11.3% between 1988 and 1992 in patients attending the hospitals emergency dept. (Quinn & Cales, 1992).

Logically, abstinence, partner reduction, condom use and seeking treatment for STD should be embraced as beneficial actions because they reduce risk of HIV and STD's as well as pregnancy for adolescents. However, they have an ability to see life choices in terms of long term consequences, the costs of HIV/STD prevention may be too high in terms of peer and partner relationships and emerging sexual desires.

Vasconcelos et al, (1995) reported that some young women and men in Brazil indicated that carrying condoms can make a girl appear promiscuous. According one Brazilian girl, "people will think she must be having sex with the whole world." Similarly a male factory worker from Chiang Mai, Thailand commented, "If a girl carried a condom in her purse, I would think she is very bad" (Thongkrajai et al,1994, Vasconcelos et al ,1995).

Voluntary HIV counselling and Testing has been carried out in Zambia in various places. A study conducted in Lusaka by Kelly et al, (1994) indicated that 70 percent of those attending were men . The common reason for wanting to be tested was to be able to make plans for the future (23%) including specific plans for marriage (10%), planning a pregnancy (1), plans for overseas study (3%) or entering holy orders (1%). Current illnesses and worries about health particularly amongst men , was a common trigger factor for wanting to be tested.

Men wanted to be tested for previous sexual behaviour while women frequently stated the illness or death of their husband. Those with sero-positivity said it would help them cope with the illness.

The comparison of findings from the two population - based surveys in Lusaka 1990 - 1995 indicates significant changes in terms of more condom use and reduced number of different sexual partners. The majority of respondents stated that condoms are safe to prevent HIV/STD, and that condom use shows responsibility. Condom protection was more common among urban and rural residents, and among groups with higher education than those with lower education (Fylkenes et al, 1996).

For example, 46% of the urban men reported to have used a condom when last having casual sex compared to 21% among rural men. The data may indicate low availability as a serious barrier to condom use in rural areas. Further more religions beliefs related to the use of condoms is an additional significant barrier. Self perceived risk and worry of being infected motivated them to change behaviour.

2.9 CONCLUSION

Youth sexuality is a reality and continues to hound many countries world wide. Early sexual activity among young people lead to risk of STDs and HIV infection. As infection rates continue to increase among young people, the figures will continue to rise and more severe impacts will be felt in every part of society. Perception of risk to HIV infection is also deficient among the youth.

Sex education beginning in early childhood is an essential part in preserving the future generations. Several studies have disapproved that sex education enhances sexual activity but infact delays its onset. In North America, studies conducted by Wellings et al (1994) examined the impact on sexual behaviour of sex education or HIV education programmes in schools and non - school settings. Results suggests that such programmes do not hasten the onset of intercourse or increase its frequency, but infact delays its onset and frequency.

Hence, sex education is a useful tool for the youth in changing attitudes towards sex amidst the age of HIV/AIDS. This will consequently lead to responsible behaviour among youth groups.

CHAPTER III

3.0 RESEARCH METHODOLOGY

3.1 RESEARCH DESIGN

The research was designed to determine knowledge, attitudes, sexual practices and health - seeking behaviour concerning HIV/AIDS among Kapiri Mposhi youth.

STUDY TYPE

The researcher conducted a non-intervention descriptive study using both qualitative and quantitative methodologies. Qualitative research involves identification and explanation of a number of other mutually related variables that give insight in the nature and causes of a certain problem or situation, and in the consequences of the problem for those affected. Quantitative research aims at quantifying the size, distribution and association of certain variables among a study population.

This type of the study was chosen to identify and explore variables responsible for the level of knowledge, attitudes, sexual practices and health seeking behaviour. This design helps to describe the phenomena and allows for data collection from the existing resources to show the association between the dependent and the independent variables.

A variable is a characteristic of a person, object or phenomenon which is measurable and can take different values. (Health systems Research Module P.8.2). The variables are tabled and listed below:

FRAME WORK FOR DEFINING VARIABLES

VARIABLE	OPERATIONAL DEFINITION	SCALE OF MEASUREMENT, INDICATORS AND CUT OFF POINTS
Knowledge Attitude towards aids	Response to questions on knowledge Response to questions on attitudes	Ordinal (i) High - 5 or 6 correct answers (ii) Moderate - 3 or 4 correct answers (iii) Low - 0 to 2 Ordinal (i) Positive responses (ii) Negative responses
Sexual practices	Response to questions on sexual practices	Ordinal (a) Risky/unsafe (i) Risky-more than one sexual partner (ii) Suffered from STD (iii) Non use of condoms (b) Not risky/safe (i) One or no sexual partner (ii) No STD (iii) Use of condoms
Health seeking behaviour	Readiness to seek professional health care.	Ordinal (i) Good - attends clinic/hospitals (ii) poor-avoids clinic

LIST OF INDEPENDENT VARIABLES

1. Age
2. Sex
3. Educational level
4. Occupation
5. Peer pressure
6. Traditional/cultural beliefs
7. Familystructures/Living arrangements
8. Recreational facilities
9. Information, education and Communication

3.3 RESEARCH SETTING

The study was conducted in Kapiri Mposhi in Central Province, as a follow up of epidemiological studies for HIV/AIDS in 1994 and 1996 respectively. This research setting was chosen because the setting harbours a lot of migrant youths from all walks of life the area being popularly known as good trade area for all sorts of business including commercial sex.

3.4 SAMPLING SELECTION AND APPROACH

3.4.1 STUDY POPULATION:

The study population comprised both the in-school and the out-of-school youth qualifying in the age group 10-24 years.

The in-school youth were drawn from the two basic schools - Lukanda Basic comprising grade 8 only and Kapiri Basic with grades 8 and 9. The out-of-school youth were drawn from major streets of Kapiri Mposhi Central, and old and new markets, town centre bus stop, and Tazara railway station. These places were chosen because they are heavily patronised by the youth. Four compounds also were randomly selected from a total of 14 compounds. Those selected were, Ndeke, Material, Soweto, and Zambia compound.

3.4.2 SAMPLE SIZE:

A sample of 100 youths was selected of which fifty were from schools while the other fifty were out of school youth. A total of 60 youths were for structured interview while the remainder formed a total of four focus groups comprising of 10 participants.

3.4.3 SAMPLING FRAME:

This consisted of In-school-youth from a sample frame of 400 pupils. Out- -of - school youth from sampling frame of 14 compounds and other target areas mentioned earlier.

3.4.4 SAMPLING PROCEDURE:

A systematic sampling method was used from a sampling frame of 400 students. A total of 50 respondents from schools were required. Therefore, the sampling interval was 8. The number of the first pupil to be chosen was picked blindly out of the 8 pieces of paper numbered 1 to 8. The number 4 was picked and every following eighth student was included in the sample until a sample of 50 students was reached. The same random figure was used for out-of-school youth since their numbers were not known.

3.5 DATA COLLECTION, TECHNIQUES AND TOOLS

3.5.1 DATA COLLECTION TOOLS

1. STRUCTURED INTERVIEW QUESTIONNAIRE

The researcher picked this technique because it allowed illiterate respondents to participate in the study. The same was used for in-school-youths to create unforminity. This method made it easier for the researcher to make observations on the environment as well as pick both non-verbal and verbal cues.

Verbal discussion made it easier for the researcher to clarify or rephrase questions without changing the meaning. Both open ended and closed ended questions were asked - the former to elicit the respondent's own opinions in their own words.

ADVANTAGES OF THIS METHOD

The interview method is flexible and the interviewer can explore responses and tailor the interview to the situation.

- Response rate is quite high since the respondent may find it difficult to refuse to talk once consent has been obtained. Response rate is about 80 -90%.

- The interviewer is able to observe both verbal and non-verbal ones including respondent's level of understanding.

- Ambiguous and confusing questions can be rephrased without changing the meaning.

- The interview allows more opportunity to appraise the validity of the report because it makes on spot observation of what is happening.

- There's increased contact with respondents making it easier to develop rapport between interviewer and the respondents.

DISADVANTAGES

- Time consuming especially for the researcher conducting the interview alone.
- The respondent may lose trend of thought while waiting for the researcher to finish writing the responses for the question.
- Recording errors may occur as the interviewer tries to record the information quickly.

- Interviews may not ensure complete anonymity.

- Personal/sensitive questions may not be answered honestly by the respondents. This was offset by developing rapport early during the interview and reassuring the respondents of confidentiality.

2. **FOCUS GROUP DISCUSSION**: This is a qualitative research method that offers specialised techniques for obtaining in-depth responses about what people think and how they feel. It enables the researcher to gain insight into attitudes, beliefs, motives, and behaviours of the target population. Qualitative research is conducted to answer the question 'why' whereas quantitative research addresses the questions of 'how many' or how often. The qualitative research process is one of discovery as well as being interpretative. There are both conceptial and practical reasons for using qualitative research.

The primary conceptual reason is that it provides greater depth of responses, and therefore, greater understanding of issues under study such as issues of sexuality. The general, focus group discussions can be executed and analysed quickly in the absence of data processing capabilities or computers. Because of its flexibility the study design can be modified while it is in progress. It also provides a direct link with the respondents. FGD generate interraction between the researcher and the respondents by allowing new and valuable ideas to emerge.

A total of 4 focus groups were conducted, two groups of girls in-school and out-of-school youths within same age group. There was no difficult for the researcher in interviewing male participants.

3.6 ETHICAL CONSIDERATION

Regarding ethical considerations for the study, permission from the District Council and District Health Management was obtained prior to the interviews with respondents. Privacy, anonymity and confidentiality among respondents was ensured,permission from respondents was obtained before the interview.

3.7 PILOT STUDY

The data gathering instrument was tested prior to actual data collection. This was carried out at the University Teaching Hospital bus stop for out-of-school youth and Libala secondary for in school youth. The field test enabled the researcher to assess the reliability and validity of data collection tool. Duration of interview, appropriateness of language used and sequencing of the questions were also assessed. Inappropriate questions were altogether eliminated while others were modified. Some open ended questions were changed to closed questions.

3.8 UTILISATION OF FINDINGS

The research findings will be used to make recommendations to relevant authorities to formulate strategies that will facilitate the effective planning and implementation of prevention and control programmes. The identified strategies will eventually lead to behavioural changes in the control and prevention of the HIV epidemic among the Kapiri Mposhi youth.

3.9 LIMITATIONS OF THE STUDY

The major limitations of this study was the limited resources such as funds and the time frame-work in which the data collection was supposed to be completed. As a result, it was very difficult to conduct the study on a large scale, hence ,the selected sample size had to be one which could easily be managed within the given resources and time-frame. The sample size was too small to make generalisations.

CHAPTER FOUR

4.0 PRESENTATION OF FINDINGS

4.1 INTRODUCTION

Data Analysis is a process by which the researcher summarizes and describes data.Inferences can possibly be made from the study sample to the population from which the sample was drawn. Data can be only be useful when arranged in a meaningful manner in order to be able to derive patterns of relationships. The data presented in this study was obtained from 60 youths in Kapiri Mposhi and their age in years ranged from 10 - 24. Four focus group discussions were also analyzed and summarized.

4.2 DATA ANALYSIS

Data from questionnaires was checked for completenesses before being put on the master sheet. Frequencies were made by simple talling. Questions to certain variables were cross-tabulated to show the relationship between them in numerical terms. Responses from open ended questions were categorized, coded, and entered on the master sheet. A pocket size scientific calculator was used for data analysis.

4.3 PRESENTATION AND INTEREPRETATION OF FINDINGS

Tables were used to present findings. Each table has a prose to highlight the main findings. The tables are presented under categories as shown in the interview.

A. DEMOGRAPHIC DATA

TABLE 1: AGE RANGES IN RELATION TO SEX OF RESPONDENTS

AGE IN YEARS	SEX		TOTAL
	MALE	FEMALE	
10 - 14	4 (7%)	4 (7%)	8 (13%)
15 - 19	18 (30%)	18 (30%)	36 (60%)
20 - 24	12 (20%)	4 (7%)	16 (27%)
TOTAL	34 (56%)	26 (44%)	60 (100%)

The majority of the youth, 36 (60%) were aged between 15 - 19 years. Males 34 (56%) were more than females 26 (44%).

TABLE 2: AGE RANGE OF RESPONDENTS IN RELATION TO MARITAL STATUS

AGE RANGE	MARITAL STATUS		TOTAL
	MARRIED	SINGLE	
10 - 14	0	8 (13%)	8 (13%)
15 - 19	0	36 (60%)	36 (60%)
20 - 24	7 (12%)	9 (15%)	16 (27%)
TOTAL	7 (12%)	53 (88%)	60 (100%)

The majority of the youth were single 53 (88%) except a few who were married 7 (12%) from the age group of 20 - 24.

TABLE 3: AGE RANGE OF RESPONDENTS IN RELATION TO LEVEL OF EDUCATION.

AGE RANGE	LEVEL OF EDUCATION			TOTAL
	NONE	PRIMARY	SECONDARY	
10 - 14	1 (2%)	5 (8%)	2 (3%)	8 (13%)
15 - 19	2 (3%)	7 (12%)	27 (45%)	36 (60%)
20 - 24	0	9 (15%)	7 (12%)	16 (27%)
TOTAL	3 (5%)	21 (35%)	36 (60%)	60 (100%)

Most of the respondents have attained secondary school education 36 (60%) and only 3 (5%) have never been to school.

TABLE 4: AGE RANGE OF RESPONDENTS IN RELATION TO OCCUPATION.

AGE RANGE	OCCUPATION OF RESPONDENTS				TOTAL
	IN SCHOOL	UN-EMPLOYED	FORMAL EMPLOYMENT	SELF EMPLOYED	
10 - 14	5 (8%)	1 (2%)	1 (2%)	1 (2%)	8 (13%)
15 - 19	25(42%)	8 (13%)	1 (2%)	2 (3%)	36 (60%)
20 - 24	0	5 (8%)	2 (3%)	9 (15%)	16 (27%)
TOTAL	30(50%)	14 (23%)	4 (7%)	12 (20%)	60 (100%)

Most youths 30 (50%) are in school, while others are either unemployed 14 (23%) or self employed 12 (20%) and only 4 (7%) were in formal employment.

TABLE 5: RESPONDENTS RELIGION

RELIGION	FREQUENCY	PERCENTAGE SCORE
CHRISTIAN	56	93%
AETHEIST	4	7 %
TOTAL	60	100%

The majority of respondents 93% are Christians while 4 (7% do not believe the existence of God).

TABLE 6 (a): RESPONDENTS LIVING ARRANGEMENT IN RELATION TO SEX

LIVING ARRANGEMENT	SEX		TOTAL
	MALE	FEMALE	
Both parents	11 (18%)	12 (20%)	23 (38%)
One parent	3 (5%)	7 (12%)	10 (17%)
Other relatives	2 (3%)	3 (5%)	5 (8%)
Living alone/friends	18 (30%)	4 (7%)	22 (37%)
Total	34 (57%)	26 (44%)	60 (100%)

The table shows that 23 (38%) of respondents lived with both parents while 22 (37%) lived with either by themselves or with friends.

TABLE 6(b): RESPONDENTS LIVING ARRANGEMENT IN RELATION TO SEXUAL PRACTICE

LIVING ARRANGEMENT	SEXUAL PRACTICE		TOTAL
	YES	NO	
Both parents	10 (17%)	13 (22%)	23 (38%)
One parent	7 (12%)	3 (5%)	10 (17%)
Other relatives	0	5 (8%)	5 (8%)
Living alone/friends	22 (37%)	0	22 (37%)
TOTAL	39 (65%)	21 (35%)	60 (100%)

The Majority 22 (37%) of respondents who lived alone or with friends, and 10 (17%) with both parents were more sexually active.

B. **KNOWLEDGE ABOUT HIV/AIDS**

TABLE 7 (a): AGE RANGE OF RESPONDENTS IN RELATION TO KNOWLEDGE ABOUT HIV/AIDS

AGE RANGE	KNOWLEDGE ABOUT HIV/AIDS			TOTAL
	HIGH	MODERATE	LOW	
10 -14	4 (7%)	3 (5%)	1 (2%)	8 (13%)
15 - 19	13 (22%)	21 (33%)	2 (3%)	36 (60%)
20 - 24	8 (13%)	8 (13%)	0	16 (27%)
TOTAL	25 (42%)	32 (53%)	3 (5%)	60 (100%)

The level of knowledge is largely moderate 32 (53%) followed by high 25 (42%). Age range 15 - 19 had highest scores on both moderate 35% and high 22%.

TABLE 7 (b) RESPONDENTS LEVEL OF KNOWLEDGE IN RELATION TO SEXUAL PRACTICE

LEVEL OF KNOWLEDGE	SEXUAL PRACTICE		TOTAL
	YES	NO	
HIGH	17 (28%)	8 (13%)	25 (42%)
MODERATE	21 (35%)	11 (18%)	32 (53%)
LOW	1 (2%)	2 (3%)	3 (5%)
TOTAL	39 (65%)	21 (35%)	60 (100%)

The majority of respondents 21 (35%) with moderate knowledge and 17 (28%) with high knowledge were sexually active.

TABLE 8 : SEX OF RESPONDENTS IN RELATION TO THEIR UNDERSTANDING OF CAUSE OF HIV/AIDS

SEX	UNDERSTANDING OF HIV/AIDS			TOTAL
	DO NOT KNOW	WITCH CRAFT	VIRUS	
MALE	9 (15%)	**2 (3%)**	**23 (38%)**	**34 (57%)**
FEMALE	**6 (10%)**	**3 (5%)**	**17 (28%)**	**26 (43%)**
TOTAL	**15(25%)**	**5 (8%)**	**40(67%)**	60 (100%)

Most of the respondents know the cause of HIV/AIDS to be the virus, 40 (67%) and 5 (8%) attributed it to witch craft while the remainder 15 (25%) did not know.

TABLE 9 : MEANS OF PROTECTING ONESELF FROM HIV/AIDS IN RELATION TO SEX OF RESPONDENTS

MEANS OF PROTECTING ONE SELF FROM HIV/AIDS	SEX		TOTAL
	MALE	FEMALE	
DO NOT KNOW	2 (3%)	2 (3%)	4 (6%)
USE OF CONDOM	17 (28%)	2 (3%)	19 (29%)
ABSTENANCE/AVOIDANCE OF SEX	10 (16%)	13 (22%)	23 (38%)
FAITHFULNESS TO PARTNER	5 (8%)	9 (15%)	14 (23%)
TOTAL	34 (57%)	26 (43%)	60 (100%)

Condom use as a means of preventing HIV/AIDS is male favourite 17 (28%), while abstinence/avoidance of sex, 13 (22%), and faithfulness to partner, 9 (15%) is mostly preferred by females.

TABLE 10: RANGE OF HIV/AIDS TRANSMISSION MODES BY RESPONDENTS

MODE	SCORE
SEXUAL PRACTICE	60
MOTHER TO BABY	23
CASUAL CONTACT	15
BLOOD TRANSFUSION	13
PIERCING INSTRUMENTS/TATTOOS	13
KISSING	06
MOSQUITO BITE	03

The sexual route of transmission is generally known as the commonest route of HIV transmission by all respondents.

TABLE 11: SEX OF RESPONDENTS IN RELATION TO SOURCE OF INFORMATION ABOUT HIV/AIDS

SEX OF RESPONDENTS	SOURCE OF INFORMATION ABOUT HIV/AIDS					
	FRIENDS	RADIO	TELEVISION	HEALTH WORKER	BOOKS/ NEWS PAPERS	DRAMA
MALE	18	12	11	10	3	2
FEMALE	14	7	7	6	3	0
TOTAL	31	19	18	16	6	2

The commonest source of information on HIV/AIDS is from friends (31), radio (19), Television (18), health workers (16) and books/newspapers (6) for both sexes.

TABLE 12: AGE RANGE OF RESPONDENTS IN RELATION TO SOURCE OF INFORMATION ABOUT HIV/AIDS

AGE RANGE	SOURCE OF INFORMATION ABOUT HIV/AIDS					
	FRIENDS	RADIO	TELEVISION	HEALTH WORKER	BOOKS /NEWS PAPERS	DRAMA
10 - 14	2	2	4	4	0	0
15 - 19	17	8	7	8	3	2
20 - 24	12	9	7	4	3	0
TOTAL	31	19	18	16	6	2

The age range of 15 - 19 and 20 - 24 years (17 and 12) have friends as source of information about HIV/AIDS. The age range 10 - 14 had only 2 under the same category.

TABLE 13: SEX OF RESPONDENTS IN RELATION TO PERCEIVED RISK OF CONTRACTING HIV/AIDS THROUGH SEXUAL PRACTICE

SEX	PERCEIVED RISK OF CONTRACTING HIV/AIDS		TOTAL
	RISK	NOT RISK	
MALE	8 (13%)	26 (43%)	34 (57%)
FEMALE	2 (3%)	24 (40%)	26 (43%)
TOTAL	10 (16%)	50 (84%)	60 (100%)

The majority of male respondents 26 (43%) and females 24 (40%) do not think of being at risk of contracting HIV/AIDS from sexual practice.

TABLE 14: AGE RANGE OF RESPONDENTS IN RELATION TO PERCEIVED RISK OF CONTRACTING HIV/AIDS THROUGH SEXUAL PRACTICE

AGE RANGE	PERCEIVED RISK OF CONTRACTING HIV/AIDS		TOTAL
	RISKY	NOT RISKY	
10 - 14	0	8 (13%)	8 (13%)
15 - 19	6 (10%)	30 (50%)	36 (60%)
20 - 24	4 (7%)	12 (20%)	16 (27%)
TOTAL	10 (17%)	50 (83%)	60 (100%)

The majority 50 (83%) of respondents did not perceive risk of contracting HIV/AIDS of which 30 (50%) were in the age range 15 - 19 years.

C. ATTITUDES TOWARDS HIV/AIDS

TABLE 15: SEX OF RESPONDENTS IN RELATION TO ATTITUDE TOWARDS HIV/AIDS

SEX	ATTITUDES OF RESPONDENTS TOWARDS AIDS		TOTAL
	POSITIVE	NEGATIVE	
MALE	26 (44%)	8 (13%)	34 (56%)
FEMALE	12 (20%)	14 (23%)	26 (44%)
TOTAL	38 (64%)	22 (36%)	60 (100%)

Males 26 (44%) have positive attitudes towards HIV/AiDS while 14 (23%) females have negative attitudes.

TABLE 16: AGE RANGE OF RESPONDENTS IN RELATION TO ATTITUDE TOWARDS AIDS

AGE RANGE	ATTITUDES OF RESPONDENTS		TOTAL
	POSITIVE	NEGATIVE	
10 - 14	5 (8%)	3 (5%)	8 (13%)
15 - 19	24 (40%)	12 (20%)	36 (60%)
20 - 24	9 (15%)	7 (12%)	16 (27%)
TOTAL	38 (63%)	22 (37%)	60 (100%)

Majority of respondents 24 (40%) in the age range 15-19 have a positive attitude towards HIV/AIDS while the same age range has highest number 12 (20%) of those with negative attitude.

TABLE 17: RESPONDENTS' HIV/AIDS EXPERIENCE IN RELATION TO ATTITUDE TOWARDS HIV/AIDS.

HIV/AIDS EXPERIENCE	ATTITUDES TOWARDS HIV/AIDS		TOTAL
	POSITIVE	NEGATIVE	
RELATIVE HIV +VE	1 (2%)	2 (3%)	3 (5%)
RELATIVE DIED FROM AIDS	13 (22%)	3 (5%)	16 (27%)
FRIENDS HIV +VE	2 (3%)	3 (5%)	5 (8%)
NONE	22 (37%)	14 (23%)	36 (60%)
TOTAL	38 (64%)	22 (36%)	60 (100%)

The majority 22 (37%) of those with no experience with HIV/AIDS had a positive attitude while the same group had the largest number 14 (23%) of negative attitude. Majority 13 (22%) out of 16 (27%) with relatives who died from AIDS had a positive attitude.

TABLE 18: SEX OF RESPONDENTS IN RELATION TO BEHAVIOUR DISPLAYED IF FOUND HIV +VE

SEX	BEHAVIOUR WHEN HIV POSITIVE					TOTAL
	SPREAD DISEASE	USE A CONDOM	BOTHERE-D OR HIDE	ABSTAIN	STICK TO PARTNER	
MALE	7 (12%)	14 (23%)	0	12 (20%)	1 (2%)	34 (57%)
FEMALE	6 (10%)	8 (13%)	2 (3%)	10 (17%)	0	26 (43%)
TOTAL	13 (22%)	22 (36 %)	2 (3%)	22 (37%)	1 (2%)	60 (100%)

The majority of respondents 22 (36%) would use condoms, 22 (37%) would abstain from sexual intercourse while 13 (22%) would spread the disease.

TABLE 19: INCIDENCE OF SEXUALLY TRANSMITTED DISEASE AMONG RESPONDENTS IN RELATION TO PERCEIVED RISK OF CONTRACTING HIV/AIDS

INCIDENCE OF STDs	PERCEIVED RISK OF CONTRACTING HIV/AIDS		TOTAL
	RISKY	NOT RISKY	
SYPHILIS	1 (2%)	4 (6%)	5 (8%)
GONORRHOEA	2 (3%)	5 (8%)	7 (12%)
CHANCROID	1 (2%)	3 (5%)	4 (6%)
NONE	6 (10%)	38 (64%)	44 (74%)
TOTAL	10 (17%)	50 (83%)	60 (100%)

The table shows that 50 (83%) of the respondents did not perceive risk of contracting HIV/AIDS through STD, the majority being those who had no STD 38 (64%).

TABLE 20: RESPONDENT' NUMBER OF SEXUAL PARTNERS IN PAST YEAR IN RELATION TO PERCEIVED RISK OF CONTRACTING HIV/AIDS

NO. OF SEXUAL PARTNERS IN PAST YEAR	PERCEIVED RISK OF CONTRACTING HIV/AIDS		TOTAL
	RISKY	NOT RISKY	
NONE	0	21 (35%)	21 (35%)
1 - 2	6 (10%)	13 (22%)	19 (32%)
3 - 4	3 (5%)	9 (15%)	12 (22%)
5+	1 (2%)	7 (12%)	8 (13%)
TOTAL	10 (17%)	50 (83%)	60 (100%)

The table shows that 12 (22%) of respondents with 3 - 4 sexual partners 9 (15%) did not perceive multiple sexual partners as risky, while 3 (5%) did.

D. SEXUAL PRACTICE

TABLE 21 (a): AGE RANGE OF RESPONDENTS IN RELATION TO NUMBER OF SEXUAL PARTNERS IN PAST YEAR

AGE RANGE	NO. OF SEXUAL PARTNERS IN PAST YEAR				TOTAL
	NONE	1 - 2	3 - 4	5+	
10 - 14	6 10%)	2 (3%)	0	0	8 (13%)
15 - 19	13 (22%)	11 (18%)	8 (13%)	4 (7%)	36 (60%)
20 - 24	2 (3%)	6 (10%)	4 (7%)	4 (7%)	16 (27%)
TOTAL	21 (35%)	19 (31%)	12 (20%)	8 (14%)	60 (100%)

Age group 15 - 19 had highest number of sex partiners 8 (13%) (3 - 4 partners), 4 (7%) for 5 or more partners in the same age group.

TABLE 21 (b): RESPONDENTS LEVEL OF KNOWLEDGE IN RELATION TO NUMBER OF SEXUAL PARTNERS

NO. OF SEXUAL PARTNERS	LEVEL OF KNOWLEDGE			TOTAL
	HIGH	MODERATE	LOW	
NONE	9 (15%)	10 (17%)	2 (3%)	21 (35%)
1 - 2	5 (8%)	14 (23%)	0	19 (31%)
3 - 4	6 (10%)	5 (8%)	1 (2%)	12 (20%)
5+	5 (8%)	3 (5%)	0	8 (15%)
TOTAL	25 (42%)	32 (53%)	3 (5%)	60 (100%)

The table shows that 11 (18%) of respondents with high knowledge had multiple sexual partiners followed by those with moderate knowledge 8 (15%).

TABLE 22: AGE RANGE OF RESPONDENTS AT FIRST SEXUAL INTERCOURSE IN RELATION TO NUMBER OF SEXUAL PARTNERS

AGE RANGE AT FIRST S.I.	NO. OF SEXUAL PARTNERS				TOTAL
	NONE	1 - 2	3 - 4	5+	
9 - 11	0	5 (8%)	2 (3%)	1 (2%)	8 (13%)
12 - 14	0	9 (15%)	2 (3%)	3 (5%)	14 (23%)
15 - 17	0	4 (7%)	5 (8%)	4 (7%)	13 (22%)
18 - 20	0	1 (2%)	3 (5%)	0	4 (7%)
VIRGINS	21 (35%)	0	0	0	21 (35%)
TOTAL	21 (35%)	19 (32%)	12 (20%)	8 (13%)	60 (100%)

Majority of respondents had their first sexual intercourse between the ages 12 - 14, 14 (23%), and between ages 15 - 20, 13 (22%). Mean age at first sexual intercourse was 13 - 14 years.

TABLE 23: SEX OF RESPONDENTS IN RELATION TO NUMBER OF SEXUAL PARTNERS IN PAST YEAR

SEX OF RESPONDENTS	NO. OF SEXUAL PARTNERS IN PAST YEAR				TOTAL
	NONE	1 - 2	3 - 4	5+	
MALE	7 (12%)	9 (15%)	10 (17%)	8 (13%)	34 (57%)
FEMALE	14 (23%)	10 (17%)	2 (3%)	0	26 (43%)
TOTAL	21 (35%)	19 (32%)	12 (20%)	8 (13%)	60 (100%)

Males, 27 (45%) had more sexual partners than their female counterparts, 12 (20%).

TABLE 24: SEX OF RESPONDENTS IN RELATION TO WHAT /WHO INFLUENCES SEXUAL RELATIONS

SEX	WHO/WHAT INFLUENCES SEXUAL PRACTICE					TOTAL
	NONE	GIRL FRIEND	BOY FRIEND	FRIENDS	POVERTY	
MALE	11 (18%)	3 (5%)	0	20 (33%)	0	34 (56%)
FEMALE	6 (10%)	0	5 (8%)	10 (17%)	5 (8%)	26 (44%)
TOTAL	17 (28%)	3 (5%)	5 (8%)	30 (50%)	5 (8%)	60 (100%)

The majority 30 (50%) of the respondent's sexual activity is influenced by friends.

TABLE 25: AGE RANGE OF RESPONDENTS IN RELATION TO INCIDENCE OF STD

AGE RANGE	INCIDENCE OF STD				TOTAL
	NONE	SYPHILIS	GONORRHOEA	CHANCROID	
10-14	8 (13%)	0	0	0	8(13%)
15-19	9 (15%)	3 (5%)	4 (7%)	0	36(60%)
20-24	7 (12%)	2 (3%)	3 (5%)	4 (7%)	16(27%)
TOTAL	44 (73%)	5 (8%)	7 (12%)	4 (7%)	60(100%)

Age range 20 - 24 had the highest number of STDs, 9 (15%) followed by age group 15 - 19, 7 (12%).

TABLE 26: SEX OF RESPONDENTS IN RELATION TO INCIDENCE OF STD

SEX	INCIDENCE OF STD				TOTAL
	NONE	SYPHILI S	GONORRHOEA	CHANCROID	
MALE	24 (40%)	3 (5%)	4 (7%)	3 (7%)	34 (57%)
FEMALE	20 (33%)	2 (3%)	3 (7%)	1 (2%)	26 (43%)
TOTAL	44(73%)	5(8%)	7 (12%)	4 (7%)	60 (100%)

Males 10 (17%) have highest incidence of STD as compared to females, 6 (12%).

TABLE 27: RESPONDENTS NUMBER OF SEXUAL PARTNERS IN RELATION TO INCIDENCE OF STD

NO. OF SEXUAL PARTNERS	INCIDENCE OF STD				TOTAL
	NONE	SYPHILIS	GONORRHOEA	CHANCROID	
NONE	21(35%)	0	0	0	21(35%)
1-2	14(23%)	1(2%)	3(5%)	2(3%)	19(32%)
3-4	5(8%)	2(3%)	3(5%)	2(3%)	12(20%)
5+	4(7%)	2(3%)	1(2%)	1(2%)	8(13%)
TOTAL	44(73%)	5(8%)	7(12%)	4(7%)	60(100%)

The table shows that 16 (27%) of respondents with multiple sexual partners had STD. Highest I ncidence was among those with 3-4 partners, 7 out of 12 (58%) and 5+ partners, 4 out of 8 (50%).

TABLE 28: RESPONDENTS FREQUENCY OF GOING TO CHURCH IN RELATION TO INCIDENCE OF STDs

FREQUENCY OF GOING TO CHURCH	INCIDENCE OF STD				TOTAL
	NONE	SYPHILIS	GONORRHOEA	CHANCROID	
REGULAR	25(42%)	2(3%)	1(2%)	1(2%)	29(48%)
OCCASSIONAL	15(25%)	3(5%)	4(7%)	3(5%)	25(42%)
NEVER	4(7%)	0	2(3%)	0	6(10%)
TOTAL	44(73%)	5 (8%)	7(12%)	4(7%)	60(100%)

The majority of respondents 25 (42%) who regularly attend church have never contracted STD, only 4 (7%) out of 29 (48%) had contracted an STD.

TABLE 29 : RESPONDENT'S NUMBER OF SEXUAL PARTNERS IN PAST YEAR IN RELATION TO FREQUENCY OF GOING TO CHURCH

NO. OF SEXUAL PARTNERS IN PAST YEAR	FREQUENCY OF GOING TO CHURCH			TOTAL
	REGULAR	OCCASIONAL	NEVER	
NONE	13 (22%)	8 (13%)	0	21 (35%)
1 - 2	9 (15%)	9 (15%)	1 (2%)	19 (32%)
3 - 4	5 (8%)	5 (8%)	2 (3%)	12 (20%)
5+	2 (3%)	3 (5%)	3 (5%)	8 (13%)
TOTAL	29 (48%)	25 (42%)	6 (10%)	60 (100%)

The table shows that 13 (22%) of the regular church goers had no sexual partners while 7 (12%) had multiple sexual partners.

TABLE 30 : SEXUAL PRACTICE OF RESPONDENTS IN RELATION TO OCCUPATIONAL STATUS

SEXUAL PRACTICE	OCCUPATIONAL STATUS				TOTAL
	PUPIL	FORMAL EMPLOYMENT	SELF EMPLOYMENT	UNEMPLOYED	
YES	12(20%)	4 (7%)	10 (17%)	13 (22%)	39(65%)
NO	18(30%)	0	2 (3%)	1 (2%)	21(35%)
TOTAL	30(50%)	4 (7%)	12 (20%)	14 (23%)	60(100%)

27 (45%) out of 30 (60%) out -of -school youth were sexually active as compared to 12 (20%) of pupils.

TABLE 31: CONDOM USE AMONG RESPONDENTS IN RELATION TO INCIDENCE OF STD

CONDOM USE	INCIDENT OF STD		TOTAL
	YES	NO	
YES	12 (20%)	8 (13%)	20 (33%)
NO	4 (7%)	36 (60%)	40 (67%)
TOTAL	16 (27%)	44 (73%)	60 (100%)

The table shows that 20 (33%) of the respondents used the condom of which 12 (20%) had STD previously.

TABLE 32: CONDOM USE AMONG RESPONDENTS IN RELATION TO NUMBER OF SEXUAL PARTNERS IN PAST YEAR

CONDOM USE	SEXUAL PARTNERS IN PAST YEARS				TOTAL
	NONE	1-2	3-4	5+	
YES	1 (1.6%)	10 (17%)	8 (13%)	1 (1.6%)	20 (33%)
NO	20 (33%)	9 (15%)	4 (7%)	7 (12%)	40 (67%)
TOTAL	21 (35%)	19 (32%)	12 (20%)	8 (14%)	60 (100%)

Most respondents used condoms 20 (33%) while a similar number, 20 (33%) with sexual partners did not use condoms.

TABLE 33: CONDOM USE AMONG RESPONDENTS IN RELATION TO SEX

CONDOM USE	SEX		TOTAL
	MALE	FEMALE	
YES	14 (23%)	6 (10%)	20 (33%)
NO	20 (33%)	20 (33%)	40 (66%)
TOTAL	34 (56%)	26 (43%)	60 (100%)

More male respondents used condoms 14 (23%) than females (6 (10%). A similar no 20 (33%) of both sexes never used condoms.

TABLE 34: CONDOM USE AMONG RESPONDENTS IN RELATION TO OCCUPATIONAL STATUS

CONDOM USE	OCCUPATIONAL STATUS				TOTAL
	PUPIL	FROMAL EMPLOYMEN T	SELF EMPLOYED	UNEMPLOYED	
YES	2 (4%)	4 (7%)	5 (8%)	9 (15%)	20 (33%)
NO	28(46%)	0	7 (12%)	5 (8%)	40 (67%)
TOTAL	30 (50%)	4 (7%)	12 (20%)	14 (23%)	60 (100%)

Condom use was more common for those out-of-school, unemployed 9 (15%), self employed 5 (8%), and formal employment 4 (7%), 20 (33%) as compared to in school 2 (4%).

TABLE 35: HEALTH SEEKING BEHAVIOUR IN RELATION TO INCIDENCE OF STD

INCIDENCE OF STD	HEALTH SEEKING BEHAVIOUR			TOTAL
	H.C/HOSPITAL	PRIVATE CLINIC	TRADITIONAL HEALER	
SYPHILIS	2 (13%)	1(6%)	2 (13%)	5 (31%)
GONORRHOREA	4 (25%)	2 (13%)	1 (6%)	7 (43%)
CHANCROID	2 (13%)	1 (6%)	1 (6%)	4 (25%)
TOTAL	8 (50%)	4 (25%)	4 (25%)	16 (100%)

The table shows that 8 (50%) of respondents seek hospital/health centre treatment, while the rest go to private doctor or traditional healer.

TABLE 36: RESPONDENTS' PREFERENCE ON WHO TO TALK TO ON MATTERS OF SEXUALITY IN RELATION TO SEX

PREFERENCE ON WHO TO TALK TO ON SEXUALITY	SEX		TOTAL
	MALE	FEMALE	
FRIENDS	22 (37%)	16 (27%)	38 (63%)
CHURCH LEADERS	2 (3%)	0	2 (3%)
HEALTH WORKERS	6 (10%)	4 (7%)	10 (17%)
PARENTS	1 (2%)	2 (3%)	3 (5%)
UNCLES	0	0	0
AUNTIES	1 (2%)	0	1 (2%)
GRANNIES	2 (3%)	4 (7%)	6 (10%)
TOTAL	34 (57%)	26 (43%)	60 (100%)

The table shows that 38 (63%) of respondents preferred to discuss sexual issue with their friends of which 22 (37%) were males while 16 (27%) were females. 10 (17%) of respondents preferred to talk to health workers.

TABLE 37: RESPONDENTS WILLINGNESS TO HAVE HIV TEST IN RELATION TO THEIR SEX

WILLINGNESS TO HAVE HIV TEST	SEX		TOTAL
	MALE	FEMALE	
YES	15(25%)	6 (10%)	21 (35%)
NO	19 (32%)	20 (33%)	39 (65%)
TOTAL	34 (57%)	26 (42%)	60 (100%)

The majority 39 (65%) of respondents were not willing to have an HIV test out of which 20 (33%) were females while 19 (32%) were males. 21 (35%) of respondents were willing to have an HIV test majority being males 15 (25%).

4.4 REPORT ON FOCUS GROUP DISCUSSION

PROFILE OF RESPONDENTS

There was an over-whelming response of young people to participate in the focus group discussions. A total of four focus group discussions were held. Both in-school and out-of -school youth participated categorized according to gender. Age range of participants was 15-24. Level of educational attainment ranged from none attendance to about grade 9. The majority of them dropped out of school at grade seven level, either due to lack of sponsorship or failure to proceed.

Few of the participants lived with both parents while the majority either lived with a single parent, other relatives or with friends. Occupation of respondents ranged from being a pupil to informal income generation ventures. Most of the participants were christians. All christian denominations were represented with the catholics topping the list.

COMMON HEALTH PROBLEMS

This section was intended to prepare participants for the discussion centred on HIV/AIDS. Malaria, diarrhoea and respiratory diseases were mentioned by pupils in order of priority, while out -of-school youth commonly mentioned STDs and HIV/AIDS. The council was blamed for poor water supply and lack of formation of proper drainage system in the area. STDS and HIV/AIDS were said to be due to poverty which has led many people to go into prostitution. An 18 year old female out-of-school youth echoed, "we are forced to engage in prostitution to make ends meet otherwise there is no way we can survive. Males mentioned stealing from travellers as means of survival. Others said they helped bus commuters to get passengers, getting an amount ranging from K500.00 to K1 000.00 per bus load. There is need to engage youth in fruitful economic ventures to lift their standards of living.

WHAT YOUNG PEOPLE DO IN THEIR SPARE TIME

Lack of recreational activities was echoed by many. ''Our favouraite pass time is drinking beer or smoking dagga since there is nothing else to do. With hard economic times, one just has to drink beer to get by," a fifteen year old boy s tated. Drug and alcohol abuse leads to unsafe sexual practices due to impaired judgement that occurs. There's need to counsel young people so that they can utilize the little money they get into fruitful ventures than buying drugs and alcohol.

Young girls are sent into the streets to sell groundnuts, cassava and other items to suppliment family income, most of whom come from single parent families. They are usually lured into sex by men who promise to buy all their merchandise. Though this is a form of income generation, parents should be told that they are abusing their children and making them vulnerable to the risk of HIV infection.

KNOWLEDGE ABOUT HIV/AIDS

AIDS is commonly known as Kaliyonde-yonde (losing weight) or Kalaye noko (Go and say bye to your mother). Virtually, all participants had heard about HIV/AIDS. The sexual route of transmission was known by all respondents and that the disease was caused by a virus . Arguments arose in all groups when few participants mentioned transmission through shaking hands, kissing, mosquito bites and witchcraft. Eventually all respondents agreed that the disease was transmitted; through blood tranfusion, sexual activity, sharing injecting equipment or other sharp piercing instruments. Mother to unborn baby was known by few respondents.

However, STDS were not viewed by majority of respondents as a risk factor to HIV infection. Various beliefs were held about HIV/AIDS. Young people in both groups stated that contracting HIV/AIDS was seen more or less as part of a misfortune and accepted as an almost inevitable consequence of being an adult, a status which presupposes being sexually active. It was compared to some childhood disease like measles where others would suffer while others do not suffer from it.

Others viewed the disease as a form of punishment from God. "There's too much immorality, and God is punishing people because man has become disobedient to God", This belief was re-forced by others who said that population explosion with inadequate resources has caused God to destroy people because they have failed to be self-reliant". Such beliefs should be offset by intensive health education to let people know the facts about AIDS.

The majority of respondents were confused about the difference between HIV/AIDS. Most of them believed they could identify a person with HIV which can lead to risk of infection, especially where choice of sexual partiners is concerned. The main source of AIDS information is through friends who can grossly mislead their friends unless they are trained to be peer educators.

Although majority of respondents agreed that there was no cure, others believed traditional healers had the remedy and that the government is suppressing their practice. There's need for health educators to work with traditional healers to ensure masses are not misled.

ATTITUDES TOWARDS AIDS

Youths felt that AIDS was only for prostitutes, truck drivers and others. Most of the youth deny that AIDS has any relevance to their lives. Despite knowing about HIV/AIDS, the majority felt AIDS did not concern them. Most youths did not connect sex with disease . Sex was believed to be part of life, and meant to be enjoyed. "You can get mad if you dont have sex. Elders told us sex is bad, but once I got into it, it was extremely exciting, and I looked forward to it again," a seventeen year old girl stated.

The youth have a myriad of defences which allow them to think they are off the AIDS register. The tendency for the youth both to assert knowledge of HIV and deny their potential risk of infection suggests deeply ambivalent feelings. Educational strategies for the youth should concentrate on emotional engagement with the issues and more personal follow up and through group discussions.

Most participants were sympathetic and felt pity for people with AIDS. Others indicated that though they were sympathetic with them, they could not stay in the same house with them. Such feelings could be avoided by telling people that AIDS cannot be transmitted through casual contact, and that AIDS patients are like any other people able to lead productive lives. Attitudinal change among the general population and health workers need to be embarked in the reduction of stigma.

SEXUAL PRACTICES OF THE YOUTH

Both boys and girls were said to be initiators of sexual relationships. Participants stated that it is possible for one to have a reliable sexual partner for love, and another for socio-economic support. An 18 year old girl stated that, "it is better to have two or more boyfriends so that you can be supported or have a shoulder to cry on when one lets you down." However, multiple sexual partners was said to be more common among males since females wait to be proposed.

Self-proclaimed virgins were of the view that sexual urge could be controlled or suppressed by occupying themselves with spiritual values which demands sex only in the context of marriage. They urged others who had no self-control to walk in the spirit in order to conquer the desires of the flesh. None of the intervewed youth admitted to anal or oral sex but masturbation mutually or alone was common.

Peer pressure had a great influence in activities of young people. They encouraged one another to take alcohol and drugs which enabled them to engage in sex without feeling ashamed. Boys and girls especially the out-of-school youth roam bars and disco houses where they end up in sexual encounters. Truck drivers are targeted by females as they are believed to give them gifts and money and sometimes take them on travel tours. A girl was capable of getting two or more partners, most often without use of condoms because they were both drunk. In the words of a 22 year old girl, "I sometimes find two or more partners by changing bars after which I clean myself with urine or mosi before going after another client". Herbal insertions to contract the vagina are also used. Girls are given up to K10 000 per round but residents were said to be stinge.

Such behaviours often put these young girls at risk of contracting HIV/AIDS. Measures need to be taken to get them off the streets so that they can do something more profitable. Without much support, it would be difficult to stop them from engaging in sex and the spread of AIDS will continue. As Bowser et al, (1990) indicated, "In communities where the 'crack man' appears to have the only employment and the only source of income and mobility, what reason would a young person have for believing an ANTI-AIDS mess For sure, it is self defeating to give health education to people and expect behaviour change without dealing with the root cause of the problem. age? The danger would not become apparent until friends began to die from AIDS".

Condoms are used but not consistently by majority of participants. Condoms were said to be a male contraceptive or used mostly for masturbation. The few who used condoms said they used them with people they did not trust. A 19 year old school boy stated that Kapiri Mposhi girls are like a minibus where people get in and out and therefore, you have to use double condoms to protect yourself from STD. Besides, girls enjoy B.B.C - meaning' body to body' contact and will use their nails to break the condom so that they feel the 'soup' - semen." This means that the use of condoms was not fully understood and need attention.

Girls with multiple sexual partiners relied on their male counterparts to suggest use of condoms for fear of being termed disease carriers if they offered a condom to a man. There's need to develop tools to increase gender sensitivity in the development of programmes.

Parents and guardians were accused of not teaching the growing children the truth about sex. According to a 16 year old girl,"my mother's tummy would bulge for a certain period, after which she would go to hospital and come back with a baby saying she bought it from the market or hospital. I did'nt know until my friend told me she had sex with a boy and got pregnant and gave birth to a baby boy later." Lack of information on sexual issues leads to continued ignorance among the youth groups. Parents or entrusted adults need to openly discuss the pros and cons of sex without reservation so that the youth can make the right choices to protect themselves.

HEALTH SEEKING BEHAVIOUR
WHAT YOUNG PEOPLE DO WHEN THEY ARE SICK

Majority of the youth seek health care freely for other diseases apart from STDs. Self medication with herbal concotions and antibiotics bought from friends, hawkers or chemists was common. Herbs were obtained from traditional healers for long term protection against HIV/AIDS including STDs. This could grossly mislead the young people into engaging in unsafe sexual practices, hence the need to intergrate traditional healers actively in the prevention and control of HIV/AIDS.

Fear of victimization and lack of confidentiality by hospital staff were expressed. Females resented being examined by males often without privacy. Others feared being tested for HIV when sent to the laboratory for RPR. As a result, they ended up going away to seek self-medication. User fees and shortage of drugs were other barriers mentioned. The youth complained that after payment they ended up being given prescriptions to buy drugs. The policy of taking their sexual partners along for treatment was condemed by the youth as most of thier partners were hit and run.

To offset such barriers, there must be improvements on drug supplies, and staff attitudes. A review of user fees especially for the vulnerable groups like the youth should be reviewed and clients treated immediately before they are sent off to get their partners because some genuinely do not know the whereabouts of their partners. Youth friendly services can also be established for the youth to be free to verbalize their concerns. Female patients can also be examined by their female counterparts.

Most of the youth did not favour the idea of being tested for HIV as it was viewed as like signing a death sentence for oneself. There's need to have open discussions with the youth for them to value this service so that they can appreciate the need for positive living. Others who wanted to know their sero- status said they feared payments as they did'nt know that HIV test or condom distribution were free services. Referral was made for those who seriously considered to be tested, for further counselling. Health workers need to sell their services.

It was quite evident that the youths shared much of thier general health problems with guardians while sharing with friends sicknesses pertaining to the reproductive system. The following were recomendations by the youth on how best they can be taught about HIV/AIDS

- through drama groups and role plays.
- encooperating teachers and parents in teaching about sexuality. Health workers were also recomended by those who had no adults they could trust.
- showing of video tapes pertaining to HIV/AIDS.
- formation of anti AIDS clubs where the youth could be actively involved.
- enco-operating sex education in school curriculum and training pupils to be peer educators.
- encouraging net working of people with AIDS (PWAS).

CHAPTER FIVE

5.0 DISCUSSION OF FINDINGS AND IMPLICATIONS TO THE HEALTH CARE SYSTEM

5.1 INTRODUCTION

The study was designed to determine the knowledge attitudes, sexual practices, and health seeking behaviour among Kapiri Mposhi youth, in view of making recommendation to relevant authorities for action. The assumptions of the study were that the Kapiri Mposhi youth had little knowledge on HIV transmission its consequences and prevention. They practice unsafe sex due to inadequate knowledge on transmission and its impact on human life, and that lack of social support for the youth leads to non-compliance behaviour. The discussion is based on the data collected and analysed.

5.2 SOCIO-DEMOGRAPHIC DATA OF RESPONDENTS

The study population comprised of 60 youths, of which the majority 36(60%) were aged between 15-19 years. There were more males 34(56%) than females 26(44%) (Table 1), A total of 4 focus group discussions, comprising of 10 participants were also held. Most youths 53 (88%) were single while the other few (12%) were married (Table 2).

The educational level of respondents was satisfactory as most of them 36 (60%) had attended secondary education except for a few 3 (5%) with no formal education (Table 3). Half of the respondents 30(50%) are in school while the other half 30(50%) are either unemployed 14 (23%), self-employed 12 (20%) or in formal employment 4 (7%), (Table 4). Problems of unemployment are diverse among Kapiri Mposhi youths and need interventions by Government and Non-Governmental Organisations to bring up support projects to prevent the youth from indulging into unsafe sexual practices.

Qualitative findings revealed that urbanisation is increasing in Kapiri Mposhi as many youths travel from various places in Zambia to Kapiri Mposhi without any form of support from anyone. They end up in squatter compounds where they find friends from similar backgrounds to stay with and plan strategies for their survival.

The majority 56(93%) of the respondents were Christians while a few 4(7%) did not believe in the existence of God. (Table 5). Most of the respondents 23 (38%) lived with both parents while 22 (37%) lived with friends or by themselves (Table 6a). Table 6b also reflects that those who lived with friends or alone were sexually active.

Peer influence and spirit of independence will lead the youth to continue engaging in unsafe sexual practices as a means of survival as they receive no proper counselling or guidance from a trusted person. Friends may not be reliable source of information on matters of sexuality and their knowledge may be grossly misleading and endangering the lives of their friends as far as HIV infection is concerned. Hence the need for constant dissemination of HIV/AIDS information by experts so that the youth can adopt safe sexual behaviour in the prevention and control of HIV infection.

5.3 KNOWLEDGE ABOUT HIV/AIDS

The majority of respondents 32 (53%) had moderate knowledge, followed by high 25 (42%) and low 3 (5%) (Table 7). The majority 40 (67%) of respondents knew that the disease was caused by a virus while 15 (25%) did not know the cause, and a few 5(8%) attributed it to witchcraft, (Table 8). Transmission modes were generally known to be sexual (60), mother to baby (23) and blood transfusion (13).

However, there were still important gaps where some people still believe that HIV can be transmitted through casual contact (15), mosquito bites (3) and kissing (6) (Table 10). The level of knowledge was not related as those who had high and moderate knowledge engaged in sexual practice (Table 7b).

The above misconceptions could encourage fatalism and reduce motivation to avoid infection through un-protected sexual intercourse. The ignorance on transmission of the virus implies that health education campaigns against HIV/AIDS need to be intensified. These beliefs underscore the urgent need for prevention programmes tailored to both in-school and out-of-school youth.

Qualitative findings revealed that some respondents believed that they could recognise a person with HIV infection. The difference between HIV/AIDS was not clear. Initially all respondents believed that there was no AIDS cure, but still others believed the traditional healers had the remedy. This means that health educators need to work with traditional healers to ensure that people in general are given facts about HIV/AIDS.

Means of protecting oneself from HIV varied. Condom use was mostly preferred by males 17 (28%) while females 13(22%) predominantly preferred abstinence or avoidance of sex (Table 9). Only 2 (3%) of females used condoms. The reasons would be that females are unable to demand or negotiate for safe sex with their partners thereby increasing their risk to HIV infection. Men should be made to change their views on women's submissive nature especially where HIV/AIDS is concerned.

Information about HIV/AIDS is commonly obtained from friends (31) radio (19), television (18) and health workers (16) respectively (Table 11). Health workers seem not to be in the lead to disseminate information about HIV/AIDS and need to revisit their strategies in the prevention and control of HIV.

The youths in the age group 15-24 years share information with each other more than the young ones (29) as compared to (2) in the age group 10-14 years (Table 12). This implies that peer education can readily be acceptable in the prevention and control of HIV in Kapiri Mposhi.

The majority 50(83%) of respondents did not consider themselves to be at risk of contracting HIV/AIDS of which 30 (50%) were in the age range 15 - 19 years (Table 13). More males 20 (43%) and females 24 (40%) do not think of being at risk of contracting HIV and are therefore likely to continue indulging in unsafe sexual practices . Health education needs to be intensified stressing the fact that everyone who practices unsafe sex is at risk.

5.4 ATTITUDES OF RESPONDENTS TOWARDS HIV/AIDS

The majority of respondents had a positive attitude towards HIV/AIDS 38(64%), especially among males 26(44%) than females 12(20%), (Table 15). The age range 15-19 have a positive attitude towards HIV/AIDS, 24(40%) while the same age range had highest number 12(20%) with negative attitudes. (Table 16). The majority of those who knew someone with AIDS or had died from the illness had positive attitudes towards people with AIDS (Table 17). This implies that they will be more willing to help those who are affected by HIV/AIDS.

The incidence of STD, 12 (20%) of respondents, and multiple sexual partners 16 (27%) was not perceived as a risk factor to HIV/ AIDS (Tables 19 and 20). This implies that the youth will continue practising unsafe sex thereby increasing their vulnerability to contracting HIV/AIDS. Health education need to be intensified, stressing the fact that multiple sexual partners and incidence of STD are risk factors to contracting HIV infection.

The focus group discussions revealed that despite high levels of knowledge, respondents clearly felt confused about HIV/AIDS and how to respond to it. Both sexes would react differently if they were told that they were HIV positive. Some said they would hide due to a feeling of shame while others would keep silent and not tell anyone at all. Majority said there was nothing much one could do to protect themselves particularly females.

Most youths 22 (37%) preferred either to use condoms or abstinence from sex 22 (37%). The other 13 (22%) felt they would revenge the disease so as to lose life with a large following (Table 18). The former attitudes need to be encouraged while the latter need urgent attention as the youth may spread the disease knowingly. Similar sentiments were expressed by Zulu speaking youth in South Africa during interview with Madlala. Having an HIV sero-positive status confirmed was believed to be a most horrible thing which could cause the sufferer to do awful things. As one 24 year old informant put it, "you lose hope, you know you are going to die. All you can do is go off and spread it. It's your only hope knowing that you won't die alone." By spreading the virus, the youth feel they are sharing the burden, the anger, the hopelessness and, ultimately the death -what the Zulu youth called "Ubuntu" (meaning they must share each other's burdens " (Madlala, 1995).

Attitudes such as these suggest that respondents harbour negative attitudes which inhibit the implementation of behaviours designed to reduce the spread of AIDS. Therefore, there is need to embark on group discussion and individual counselling to ensure that the youth can change their attitudes towards prevention programmes.

Attitudes towards condom use were generally ambivalent, with few respondents inherently against them especially the in-school-youth, who mostly used condoms only for masturbation when sexual partners were not available.

Condoms were believed to interfere with sexual pleasure. Females were ashamed to carry condoms for fear of being termed prostitutes or disease carriers. This entails that women have no say in decision making about use of condoms.

In many cases, positive attitudes about the use of condoms coincided with negative feelings about the role of women in condom initiation and use . Sacco et al, (1993), in their study reported that men engaged in preliminary condom use behaviours - carrying and keeping condoms at home more often than the women did. Their results were interpreted from the perspective of Eagly's, (1987) gender role theory, which suggest that although females may indirectly influence condom use decisions, providing condoms is the expected role of males, infusing them with greater control over the interpersonal process.

Qualitative findings revealed that although the majority of the respondents viewed AIDS as a deadly disease, they could not inform their sexual partners if found to be HIV positive. Such attitudes imply that the youth would continue to spread the disease to their partners. This was related to fear of being stigmatised or abandoned by relatives or partners. The few who stated that they would tell their partners wanted support and make plans on how to live with the disease without infecting their partners. Concerning such attitudes, attention should be devoted to telling others that people with HIV can live productive lives.
Therefore, there's no reason to isolate them, and that HIV cannot be transmitted through casual contact.

The power imbalance characteristic of gender relations among adults can be shaped by family and household dynamics that occur during childhood and adolescence. Differences in household roles and responsibilities ascribed to girls and boys have implications for women's ability to communicate, make decisions on sexual matters or concerning their health. In the African context the submissive role of the woman makes them not to speak for their rights.

Decision making on sexual matters is entirely left to the men and they may not refuse sexual advances making them at risk of contracting HIV infection. These issues should be addressed to ensure that women become more assertive and responsible in the control of the epidemic than feeling helpless.

5.5 SEXUAL PRACTICES OF THE YOUTH

The study revealed that males 27 (45%) had more sexual partners than their female counterparts 12 (20%) (Table 23). A study carried out in Uganda also support the finding that males had more sexual partners than females (Konde - Lule 1989). Age range 15-19 years had the highest number of sexual partners 8(13%), (3-4) partners, 4 (7%) for 5 or more partners in the same age range (Table 21). This in itself has been found to predispose an individual to contract HIV infection. The number of sexual partners had no correlation with knowledge as respondents with high knowledge 11 (18%) were also found to have multiple sexual partners (Table 21b).

Sexual activity was increased in the late teens and early 20s (15-24 years) when youths have 3 or more sexual partners in a year (Table 21). Mean age at first sexual intercourse is 13-14 years (Table 22) which is much lower than the national average (16 years) stated by the Zambia Demographic and Health survey (1992) implying that sexual intercourse begins at an early age among Kapiri Mposhi youth. The lowest age at 1st sexual contact was 9 years, and the highest being 20 years (Table 22). This implies that the lower the age at first sexual contact, the higher the chances of having multiple sexual partners thereby increasing the risk of acquiring HIV infection.

Sexual activity among the out-of-school was greater 27(45%) as compared to pupils 12 (20%) who were sexually active (Table 30). The researcher attributed this to lack of recreation and other constructive social amenities to divert their minds from engaging in sex. Focus group discussions revealed that there is nothing much the youth do apart from drinking alcohol and smoking dagga for some, which predisposes them to indulge in sex. Hence the need to involve the youth in projects that can keep them busy.

Peer pressure plays a major role in influencing sexual behaviour. The study revealed that males 20(33%) and females 10 (17%) were influenced by friends (Table 24). Sexual issues are discussed among friends and experiences shared. It was evident that parents and other relatives had a minor role to play in youth sexuality as most youths relied on friends for information which could grossly mislead them 38 (63%) discussed with friends, 10 (17%) with health workers and a few 3(5%) discussed with parents (Table 36). Parents' lack of involvement in teaching their young about sexual issues make the youth to live in ignorance and take on individualistic approaches. Children should be taught about consequences of engaging in unsafe sexual practices so that they can face such challenges with informed decisions. What a child learns in early childhood helps to build up his personality and self image especially when good morals are imparted.

Sexual practice was associated with exchange of money and gifts as highlighted in the focus group discussion, especially for girls where they sought eligible men for financial support. Few boys also admitted that some advantaged girls and women offered them money and gifts for sex. These findings are supported by a study by Bassett and Sherman (1994) who stated that young women in a Zimbabwe school-based study acknowledged the existence of "Sugar Daddies" in their communities. Several respondents mentioned being approached by these men for sex in exchange for money to pay school fees and other essentials.

These sugar daddies may already be infected thereby increasing the young people's vulnerability to HIV infection. The youth should be cautioned and counselled to say no to sex outside marriage. The socio-economic status of the youth should be uplifted by providing financial support for income generation activities. All stake holders in the control of the epidemic should be involved.

The role of the church is shaping morals cannot be over emphasised. The majority of regular church goers 13(22%) had no sexual partners (Table 29). The majority 25 (42%) who regularly attend church have never contracted STDs. Only 4 (7%) of them contracted an STD as compared to 10 (17%) of occasional attenders (Table 28). Therefore the church plays a major role in imparting morals.

The incidence of STD was common with 15-24 year olds and affected males more than females (Table 25, 26) Age range 20-24 had highest incidence of STD 9 (15%) followed by 15 - 19, 7 (12%) while age range 10-14 had none. These findings are similar to a UNICEF report which stated that STDs are the commonest group of communicable diseases reported in most countries. The higher rates for STDs are usually found in the 20-24 year old age group, followed by the 15-19 year old age group.

The low numbers of STD in females as compared to males is attributed to the fact that biologically, STD in women are not readily diagnosed. Signs and symptoms may not readily be experienced, and possibly disappear when medications such as antibiotics are given for other diseases . Women should therefore be taught how to recognise STD or attend the hospital/health centre when their partners are diagnosed with STD. There is an increased risk of HIV infection in those with STD Quinn (1995) states that there is a strong association between STD and HIV infection.

Condom use for prevention of STD including HIV is high among those who had previous history of STD (Table 31). 20 (33%) of respondents used the condom of which 12 (20%) had an STD before. Therefore, experience with STD led to behavioural change. Condom use with multiple sexual partners was not very common. 20 (33%) of respondents with multiple sexual partners did not use condoms (Table 32). This explains why incidence of STD among those with multiple sexual partners was high especially among those with 3-4 partners (7 out of 12) and 5+ partners) (4 out of 8) (Table 32). This increases the probability of contracting HIV infection among the youth.

Qualitative findings suggest that condoms are mostly used as a male contraceptive and for masturbation. Pupils felt that condoms were not necessary because they only had one sexual partner at a time. This may put them at risk as that partner could be the one to give them HIV infection. It was also apparent that the youth did not know that condoms were freely distributed at government health centres, but relied on buying them from hawkers or bars. This could explain the inconsistency in using condoms as many could not readily obtain them. Health workers should inform the youths of availability of free condoms at family planning clinics as well as STD clinics.

5.6 HEALTH SEEKING BEHAVIOUR

The study revealed that the hospital was commonly used as the first contact for treatment of STDs followed by private doctors (4) and traditional healers (4) equally (Table 35) . Qualitative findings brought up details as to when the hospital/health centres are visited. The majority of participants stated that STDs were highly stigmatised in their communities. As such, they preferred to discuss their ordeals with friends and institute self-care remedies from traditional healers or buy antibiotics from vendors or chemists.

Very often , the regime was inappropriate or not completed. Unscrupulous use of antibiotics could lead to resistance as the drugs may be rendered ineffective against certain infections. Consultation with adults was only done on other health issues apart from STD as parents or relatives never discuss issues of sexuality with their children/dependants. Most of them infact, had no choice because they had none to discuss with as they stayed by themselves. Majority desired to discuss such issues with entrusted adults and urged health workers to take up the role since most youths lived alone or with friends. In Khon Kaen, Thailand, a school based study also found that adolescents wanted access to trusted adults (Thongkrajai et al, 1994). Attitudes of the youth towards HIV testing was negative as only 21 (35%) were willing to take an HIV test while, 39 (65%) were not willing (Table 37).

Assessing sexual partners sero-status was basically based on physical appearance, which is quite dangerous as HIV carriers remain health and pose as a potential danger in disseminating the virus to others. Condoms were also avoided when a partner appeared to be health. Health education need to be intensified in this area.

Behavioural change was reported by a few respondents from focus groups who stated that messages and video shows by the Family Health Trust they had previously watched were frightening. As such, most youths would begin using condoms and lessen casual sex. This claim was not as a result of independent measures, but it is suggested that the youths ' behaviour was beginning to change as a result of publicity. Therefore, the health personnel could use this measure (video shows) to help change the perception of youths about HIV/AIDS, and bring about behavioural change.

5.7 IMPLICATIONS ON HEALTH CARE.

The high rates of sexual activity/practice among the youth in Kapiri Mposhi are frightening in view of the consequences that occur with high risk sexual behaviours. This calls for urgent measures to be instituted in order to preserve the youth who are tomorrow's leaders and productive work force.

The concept of the youth being the 'window of Hope' for an AIDS-FREE Zambia may be an illusion because the sexual activity of young people start as early as 9 years in Kapiri. Therefore, knowledge about HIV/AIDS prevention and control should start earlier in childhood if positive change in attitude and sexual behaviour is to be seen. The knowledge of reality about HIV/AIDS help them appreciate that anyone is at risk and therefore need to modify or change their sexual behaviour.

Those influenced into having multiple sexual partners due to economic pressures could be more than what the study reflects and there is need to address this issue in prevention and control of HIV/AIDS.

Generally, the problem cannot be solved by one group of the community but will need the interaction and intervention of all the key players like families, the clergy, teachers, politicians, chiefs, NGOS and notable personalities in the community in order to address problems like :-

- high risk sexual practices
- abstinence or use of condoms
- urbanisation and its economic and socio-cultural consequences
- empowerment of the youth including women in order to reduce their dependency on men.

CHAPTER SIX

6.0 CONCLUSION

The research study has revealed a lot on the knowledge, attitudes, sexual practices and health seeking behaviour among youths in Kapiri Mposhi namely:-

- The high rate of sexual practice with multiple sexual partners often done without use of condoms;
- lack of appreciation on the risk of contracting HIV/AIDS if they indulge in unsafe sexual practices;
- knowledge about HIV/AIDS does not change their attitude but real life experience with someone who is HIV positive or has died from the illness did influence change in attitude;
- The church was found to play a role in shaping morals as the majority of those who were regular at going to church had non or few sexual partners.

The problems in general is multifaceted and need to be dealt with by combining forces of all stake holders or interested parties. Knowledge about HIV/AIDS alone cannot change the sexual practices of the youth.

6.1 RECOMMENDATIONS

These findings were delivered from the findings as well as views of respondents. In order to revamp the control and prevention programmes on HIV/AIDS, the following measures need to be taken:-

1. Mobilise a multi-disciplinary team to co-ordinate the HIV/AIDS education and monitoring. The team should include community members, the clergy, teachers, headmen, and any other significant personalities. Bar owners to co-operate by closing bars early.

2. Non-governmental organisations such as Family Health Trust, Thasinta, CINDI and others could come in to initiate projects which could involve the youth especially out of school youth to help in income generation and teaching of skills.

3. Conduct workshops for teachers, so that they can comfortably include HIV/AIDS prevention and control in the school curriculum in both primary and secondary schools. Introduction of sex education in schools will have a great impact on knowledge, change of unsafe sexual practices, and attitudes towards HIV/AIDS.

4. Emphasis must be made on promotion of safer sexual behaviour, for example abstinence, sticking to one partner, increased use of condom, and promotion of mutual faithfulness in marriage. Counselling sessions for both in and out-of-school youth should be encouraged, including marriage counselling.

5. Peer educators should be trained and given support by the HIV prevention and Control programme officers. Peer education will have a great impact since most respondents felt free to discuss sexuality with friends.

6. Provide intensive information, education and communication (IEC) using posters, discussions, role plays, drama groups and video shows.

7. Develop and produce appropriate messages for separate groups in terms of sex, age group, secio- economic status and marital status.

8. Empower women to be self supporting economically and to be assertive on demanding condom use and making decisions on when, and when not to have sex .

9. Improve access to condoms either freely or at a nominal fee and should be as close to the youth as possible through community based distributors.

10. Improve youths' access to health facilities by providing a youth corner, or a day/days can be set aside to answer or discuss issues pertaining to HIV/AIDS on individual basis.

11. Lobby for community support for the sustenance of the projects to be formed such as anti AIDS clubs, Tasinta and others. Bar owners to participate in this support group.

12. There is need to build a secondary school to help the youth continue their education as lack of progress leads to early marriages and increased risk to HIV infection

13. Expand the hospital as it has purely standards of a rural health centre.. The expansion will create more room for counselling patients as well as delivery of quality care to the clientelle.

14. Encourage people with HIV/AIDS to come in the open to motivate other people.

15. Clinic personnel need special training to treat young clients in a supportive, non judgmental way and to help them choose appropriate methods of STD and HIV prevention.

16. Community leaders and politicians in Kapiri Mposhi should advocate for an Agricultural College to provide skills for the youths to promote agricultural industry since the land is good for farming.

17. The church organisations need to work together in strengthening the morals of the youth so that they can have a positive outlook towards life situations inspite of the hard socio-economic situation in the country. They can organize youth groups which could discuss issues about HIV/AIDS.

18. There is need to conduct further research similar to this one in a purely urban and rural area to elicit any differences from this study.

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University of Zambia
School of Medicine
Department of Post Basic Nursing
P.O. Box 50110
LUSAKA.

30th July, 1997

The District Secretary
Kapiri Mposhi District Council
P.O. Box 810006
KAPIRI MPOSHI

ufs The Head of Department
Post Basic Nursing Dept
P.O. Box 50110
LUSAKA.

Dear Sir,

Re: RESEARCH PROJECT NR 420

I am a fourth year student undertaking the Bachelor of Science Degree in Nursing at the above mentioned institution. In partial fulfillment of the course requirements, I am required to submit a research study in the area of my interest. My research topic is entitled, "HIV/AIDS among the youth: Knowledge, Attitudes, Sexual practices and health seeking behaviour.

The purppse of this letter is to seek permission to collect the required data from Kapiri Mposhi Central. I intend to collect data using a self-administered questionaire to the in-shhool youth, interview schedule for community leaders and focus groups for the out-of-school youth-street vendors, the N'gwanigwazi as well as marketeers. If permission is granted data collection will commence during the 3rd week of August, 1997.

I will be very grateful if my request will be granted the results of my study will be available to the District.

Yours faithfully,

Hamukwala Grace

THE UNIVERSITY OF ZAMBIA

SCHOOL OF MEDICINE

DEPARTMENT OF POST BASIC NURSING

1st April, 1997.

Dear Sir/Madam

This is to introduce...HAMUKWALA GRACE...................... a Fourth Year BScN student in the School of Medicine, Department of Post Basic Nursing. This student is carrying out a Research study in partial fillfulment of the Degree requirement. The name of the Research Topic is .HIV/AIDS AMONG THE YOUTH: KNOWLEDGE, ATTITUDES, SEXUAL PRACTICES AND HEALTH SEEKING BEHAVIOUR.

We shall be most grateful if you could access the student to information on the subject, clients or interviews and any other assistance the student may require.

Yours faithfully,

Patricia M. Ndele (Mrs)
ACTING HEAD/RESEARCH LECTURER

/emc

KAPIRI MPOSHI DISTRICT COUNCIL

Telephones: 271031/271244/5

All correspondence to be addressed to the District Secretary

In reply please quote:
Ref. No KMDC/51/5/14

Civic Centre
Independence Avenue
P.O. Box 810006
KAPIRI MPOSHI

..............................19......

22nd November, 1997

Miss Hamukwala Grace,
University of Zambia,
School of Medicine,
Department of Post Nursing,
P.O. Box 50110,
LUSAKA.

Dear Madam,

RE: RESEARCH PROJECT NR.420

I refer to your letter dated 30th July, 1997 in connection with the above stated subject matter.

You wrote seeking permission to collect the Data from Kapiri Mposhi Central in which you are required to submit a Research Study in the area of your interest your Research Topic entitled "HIV AIDS among the Youth": knowledge, attitudes, sexual practices and Health seeking behaviour.

I write to inform you that this Council has no objection to your Academic pursuint. The Results of your study should also be made available to the District.

I wish you a success in your research study.

Yours faithfully
KAPIRI MPOSHI DISTRICT COUNCIL

J. Mumba
ASSISTANT CLERICAL OFFICER
for/ACTING COUNCIL SECRETARY

c.c. The Head of Department,
Post Basic Nursing Department,
P.O. Box 50110,
LUSAKA.

JM/ljsc*

Telephone: 271192, 271188

Fax: 271192

In reply please quote:

No.............................

REPUBLIC OF ZAMBIA

MINISTRY OF HEALTH

OFFICE OF THE DISTRICT HEALTH DIRECTOR
P.O. BOX 810093
KAPIRI-MPOSHI

10th SEPTember, 1997

Ms Grace Hamukwala
University of Zambia
Basic Nursing
LUSAKA

U.F.S.: The Head
Department of Post Basic Nursing
P.O. Box 50110
LUSAKA

Dear Madam,

RE: RESEARCH PROJECT NR 420

Thank you very much for your letter dated 29th August, 1997 on the above subject, Iam pleased to let you know that, permission to collect data on HIV/AIDS in Kapiri-Mposhi on school youths, community leaders, marketers and street vendors has been granted.

You may start the exercise at your convenient time.

Thank you,

Dr. V. M. Daka
DISTRICT DIRECTOR OF HEALTH
KAPIRI-MPOSHI DISTRICT.

THE UNIVERSITY OF ZAMBIA

SCHOOL OF MEDICINE

DEPARTMENT OF POST BASIC NURSING

NURSING RESEARCH

TOPIC: HIV / AIDS AMONG THE YOUTH: KNOWLEDGE, ATTITUDE, SEXUAL PRACTICE, AND HEALTH SEEKING BEHAVIOUR IN KAPIRI MPOSHI DISTRICT.

STRUCTURED INTERVIEW SCHEDULE   QUESTIONNAIRE NO: ....

DATE : ....

TIME : ....

PLACE: ....

INSTRUCTIONS TO THE INTERVIEWERS

1. Introduce yourself to the respondent and explain the purpose of your visit.

2. Assure the respondent of confidentiality and anonymity by explaining that all the information will be treated confidential.

3. Ask questions as phrased; only clarity where necessary should be given without changing the meaning of the question.

4. Tick and fill responses in appropriate spaces provided. Some questions have more than one response.

5. Thank the respondent at the end of each interview for sparing his/her time for the interview.

SECTION A **BACKGROUND INFORMATION**

FOR OFFICIAL USE ONLY

1. What is your age?
   (a) 10 - 14 yrs
   (b) 15 - 19 yrs
   (c) 20 - 24 yrs

2. Marital Status
   (a) Single
   (b) Married
   (c) Divorced
   (d) Widower/widow

3. Sex
   (a) Female
   (b) Male

4. Educational Level
   (a) None
   (b) Primary
   (c) Secondary
   (d) College
   (e) University

5. Occupation
   (a) Employed
   (b) Unemployed
   (c) Self-employed
   (d) Student

6. Religion
   (a) Christian
   (b) Hindu
   (c) Muslim
   (d) Atheist

7. Church Attendances
   (a) Regular
   (b) Occasional
   (c) Never

8. With whom do you live?

(a) Both parents
(b) One parent
(c) Alone
(d) Friends
(e) Sister/brother
(f) Grand parents

9. Do you drink beer?

(a) Yes
(b) No

10. If Yes, what type of beer?

(a) Mosi
(b) Chibuku
(c) kachasu
(d) Spirits

11. Do you smoke?

(a) Yes
(b) No

12. If Yes, what type of Cigarette?

(a) Rothmans
(b) Balani
(c) Consulate
(d) Dagga (Marijuana)

13. What is the commonest health problem in your area?

(a) Malaria
(b) Diarrhoea
(c) AIDS
(d) Tuberculosis
(e) Sexually Transmitted diseases
(f) Others, specify ________________

SECTION B. QUESTIONS ON KNOWLEDGE

14. Have you ever heard about HIV/AIDS?

    (a) Yes

    (b) No

15. If Yes, where did you hear it from?

    (a) Radio

    (b) Television

    (c) Friends

    (d) Newspapers/books

    (e) Health Wrkers

16. What is your understanding of HIV/AIDS

    (a) A disease caused by witchcraft

    (b) Disease caused by evil spirits

    (c) Incurable disease caused by a virus

    (d) I don't know

    (e) others, Specify ____________________

17. In which ways can HIV be transmitted?

    (a) Sexual intercourse

    (b) Mosquito bite

    (c) Casual contact

    (d) Blood transfusion

    (e) Mother to unborn baby

    (f) Tattoos caused by traditional healers

    (g) Kissing

    (h) Use of contaminated piercing instruments

18. Is there an cure for HIV/AIDS

    (a) Yes

    (b) No

    (c) I don't know

19. How can you protect yourself from getting HIV infection?

(a) I don't know

(b) Abstinence from sexual intercourse

(c) Through use of condoms

(d) Avoidance of sex before marriage

(e) By having one faithful partner

20. Can you tell by merely looking at a person that he/she is HIV positive?

(a) Yes

(b) No

21. Explain your answer to question 20

____

____

____

22. If the answer to question 20 is No, how can a person know if he/she is infected with HIV?

(a) Blood test

(b) I don't know

(c) Suspicion of signs and symptoms such as persistent swelling in neck, armpits, groin

23. Have you had any experience with HIV/AIDS?

(a) I have a relative who has the illness

(b) I have a relative who had died from the illness

(c) I know a friend who is HIV positive or have died from the illness

(d) I don't know anyone who has the illness

SECTION C. QUESTIONS ON ATTITUDES

24. Do you think AIDS is a deadly disease?

    (a) Yes
    (b) No

25. Would you tell your partner that you are infected with HIV?

    (a) Yes
    (b) No

26. Explain your answer to question 25

    ____
    ____
    ____

27 What does your culture say about AIDS?

    ____
    ____
    ____

28. What are people's feelings about AIDS patients in your community?

    (a) They are sympathetic with them
    (b) They should be given equal opportunities like any other person.
    (c) They deserve to die
    (d) They are being punished by God

29. Can you stay in the same house with someone with AIDS

    (a) Yes
    (b) No

30. What would you do if you were found to be HIV positive

    (a) Infect as many partners as possible
    (b) Use a condom

30. (c) Tell my partner to be tested as well
(d) Keep it as a secret
(e) Abstain from sex

SECTION D. QUESTIONS OF SEXUAL PRACTICE

31. Do you have a regular sexual partner?
(a) Yes
(b) No

32. At what age was your first Sexual intercourse?

____

33. How many sexual partners do you have
(a) None
(b) 1 - 2
(c) 3 - 4
(d) More than 4

34. How many sexual partners have you had in the past year?
(a) None
(b) 1 - 2
(c) 3 - 4
(d) More than 4

35. Did someone/something influence you to have sexual intercourse?
(a) Yes
(b) No

36. If Yes, who/what influenced you?
(a) Friends
(b) Sugar daddy
(c) Other, specify ______________

37. Have you ever used a condom during your sexual relations?
(a) Yes
(b) No

38. Have you had any of the following difficulties in using condoms?

(a) Not available for young people

(b) Not available for married people

(c) Find too embarrassing to get condoms from clinic

(d) Partner refuses to use condoms

39. Have you ever suffered from any sexually transmitted disease in the past year?

(a) Yes

(b) No

40. If Yes, which ones

(a) Syphilis

(b) Gonorrhoea

(c) Chancroid

(d) Herpes Genetalis

SECTION E. HEALTH SEEKING BEHAVIOUR

41. Have you ever attended a health service in the past year?

(a) Yes

(b) No

42. If Yes, which ones?

(a) Rural health centre

(b) Hospital

(c) Traditional healers

(d) Private doctor

43. Who do you think is in the best position to talk to young people about HIV/AIDS and other issues of sexuality?

(a) Friends

(b) Teachers

(c) Grand parents

43. (d) Aunties/Uncles
(e) Church leaders
(f) Health workers
(g) Others, specify ______________

44. Do you feel at risk from HIV
(a) No
(b) Yes
(c) I don't know

45. Do you worry about being HIV positive?
(a) No
(b) Sometimes
(c) Very worried

47. Have you had any HIV test before?
(a) Yes
(b) No - I don't want one
(c) No, but would have one if available today
(d) No, but would have one at a future date

48. What is the best way to teach young people about AIDS?

____
____
____

FOCUS GROUP DISCUSSION FOR THE YOUNG: AGED BETWEEN 15 - 24

STREET VENDORS, N'GWAN'GWAZI AND IN-SCHOOL YOUTH

INTRODUCTION:

Greetings and welcoming remarks to participants: Introduce self and recorder

B. PURPOSE OF DISCUSSION

I am here to find out and learn from you what you know about HIV/AIDS. I feel you are the right people who can help in the prevention and control of the spread of the HIV Infection if you had the knowledge of the disease. Prevention is indeed better than cure when one utilizes the knowledge he/she has for any disease such as HIV/AIDS. Feel free to contribute during the discussion as all your contributions are important.

DISCUSSION TOPICS

HEALTH: General warm up question

1. What are some of the commonest health problems in your area?

2. What factors do you think contribute to these health problems?

3. What do you think could be done to improve the situation?

4. What do you do in your spare time?

CAUSES OF HIV/AIDS AND TRANSMISSION

5. Have you heard about HIV/AIDS? Where did you hear it from? What have you heard about HIV/AIDS?

6. In which ways can a person get AIDS?

7. How can you tell that someone has HIV/AIDS

8. Is there any cure for AIDS?

9. How can the HIV infection be prevented?

10. Are you aware of counselling services offered for HIV/AIDS?

ATTITUDES TOWARDS AIDS

11. Do you think HIV/AIDS is a deadly disease?

12. What are your feelings towards people with AIDS?

SEXUAL PRACTICES

- Who initiates sexual activity?
- Do people have sex with more than one sex partner in your community
- Do people engage in any other sexual practice other than vaginal intercourse?
- Have you ever used a condom during sexual relationships?

HEALTH SEEKING BEHAVIOUR

21. What do young people do when they are sick?

22. Are you free to utilize the health services offered by Government?

23. Where do you prefer to get health education from?

24. Have you had an HIV test before?

25. What do you think are the best ways of teaching young people about HIV/AIDS and issues of sexuality