NCHELENGE DISTRICT HIV/AIDS TASK FORCE

FINAL REPORT ON HIV/AIDS AND REPRODUCTIVE HEALTH SURVEY IN THE SCHOOLS OF NCHELENGE DISTRICT 2006

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FUNDED BY:

Ministry of Education
DEBS Office
Nchelenge

DATF
Nchelenge

MSF – Holland
Nchelenge

November 2006

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ABBREVIATIONS/ACRONYMS

ABC	Abstinence, Be faithful and Condom use.
AIDS	Acquired Immune Deficiency Syndrome
ARV	Ant-Retro-Viral
ART	Anti-Retro Therapy
CATF	Community HIV/AIDS Task Force
CHAZ	Churches Health Association of Zambia
CSO	Central Statistical Office
CSW	Commercial Sex Workers
DAO	District Administrative Officer
DATF	District HIV/AIDS Task Force
DC	District Commissioner
DEBS	District Education Board Secretary
DFT	District Facilitation Team
DHMT	District Health Management Team
DTF	District Task Force on HIV/AIDS
FBO	Faith Based Organisation
HBC	Home Based Care
HIV	Human Immunodeficiency Virus
IEC	Information, Education and Communication
IGA	Income Generating Activity
KAB	Knowledge, Attitude & Behavior
M&E	Monitoring and Evaluation
MoE	Ministry of Education
MoH	Ministry of Health
MSF-H	Medicine San-Frontier Holland
NAC	National HIV/AIDS/STI/TB Council
NZP+	Network of Zambian People Living with HIV/AIDS
OVC	Orphans and Vulnerable Children
PCI	Project Concern International
PLWHA	People Living With HIV/AIDS
PTA	Parents Teachers Association
RHC	Rural Health Centre
STD	Sexual Transmitted Diseases
STI	Sexual Transmitted Infections

Acknowledgements

The author of this report is grateful to MSF Project Coordinator Vera Zwaga, whose encouragements and moral support was an inspiration to the whole team, Lilit Poghosyan MSF Mental Health Officer who assisted in the survey sampling and result analysis, and the entire District Facilitation Team for the tireless work they put in to enable this exercise be concluded successfully. The Nchelenge DEBS and his Staff including all Teachers in the Schools were this survey was conducted are also commended for having availed resources as well as their unreserved cooperation during the implementation of the survey.

Special thanks are extended to all the pupils that participated in the exercise for having given the information to the team in order to have a spring board to implement activities in the schools.

We also wish to thank the DATF Chairperson Dr. Davis Mwewa and his entire District DATF Executive Committee for having given the team authority to implement the questioner in schools.

This report would not be completed without acknowledging the District Commissioner Mr. Kasoloko and the District Administration Officer Mr. Nsamba. N. E for having created an enabling environment in the district for the team to be able to conduct this survey without any huddles.

Acknowledgments are also due to the following people who contributed to this report:

- Mwakapushi Brady -Africare RAPIDS Nchelenge
- Enos Mwape – Forum for Youth Organisations in Zambia
- Musonda Ernest - Forestry Department
- Kunda Alex - Medicines Sans Frontiers Holland Nchelenge
- Mulenga Douglas - Ministry of Education
- Mumba Jedediah Medicines Sans Frontiers Holland Nchelenge

These made the teams that implemented the survey in all the Schools.

To all we say please do not tire but keep it up may the good Lord bless you all abundantly.

1.0 EXECUTIVE SURMARY

- **Background**

  Since DATF come into being in 1996, HIV/AIDS interventions in Schools were primarily left to the Ministry of Education as a sole implementing partner. The Ministry has disseminated information on HIV/AIDS in Schools through the Anti AIDS Clubs in spearheaded by the Guidance Teachers who have been given the responsibility of overseeing School HIV/AIDS Programs/activities.

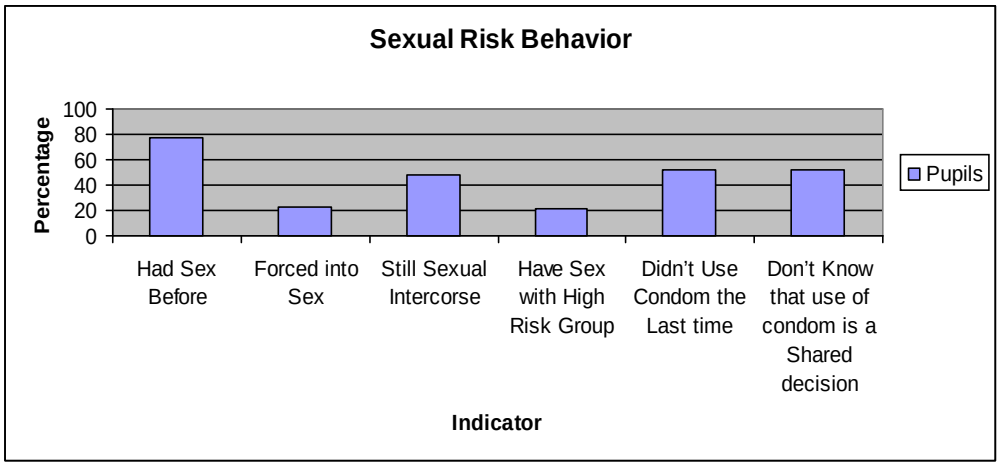
Information dissemination methodologies have been basically through distribution of information leaflets, Drama, Debates, Poetry, Peer Education, Cultural Dances etc.

During the June 2006 Annual General Meeting, the District Lobby and Advocacy Team gave a report in which levels of abortions, Child defilements, STIs and Child abuse among youths were highlighted. This prompted the Assembly to instruct the District Facilitation Team to institute a Knowledge Attitude and Behavior Survey in Schools so as to come up with strategies to use in HIV/AIDS interventions; as Support to the initiatives put in place by the Ministry of Education in the spirit of Multi sectoralism.

- **Preview**

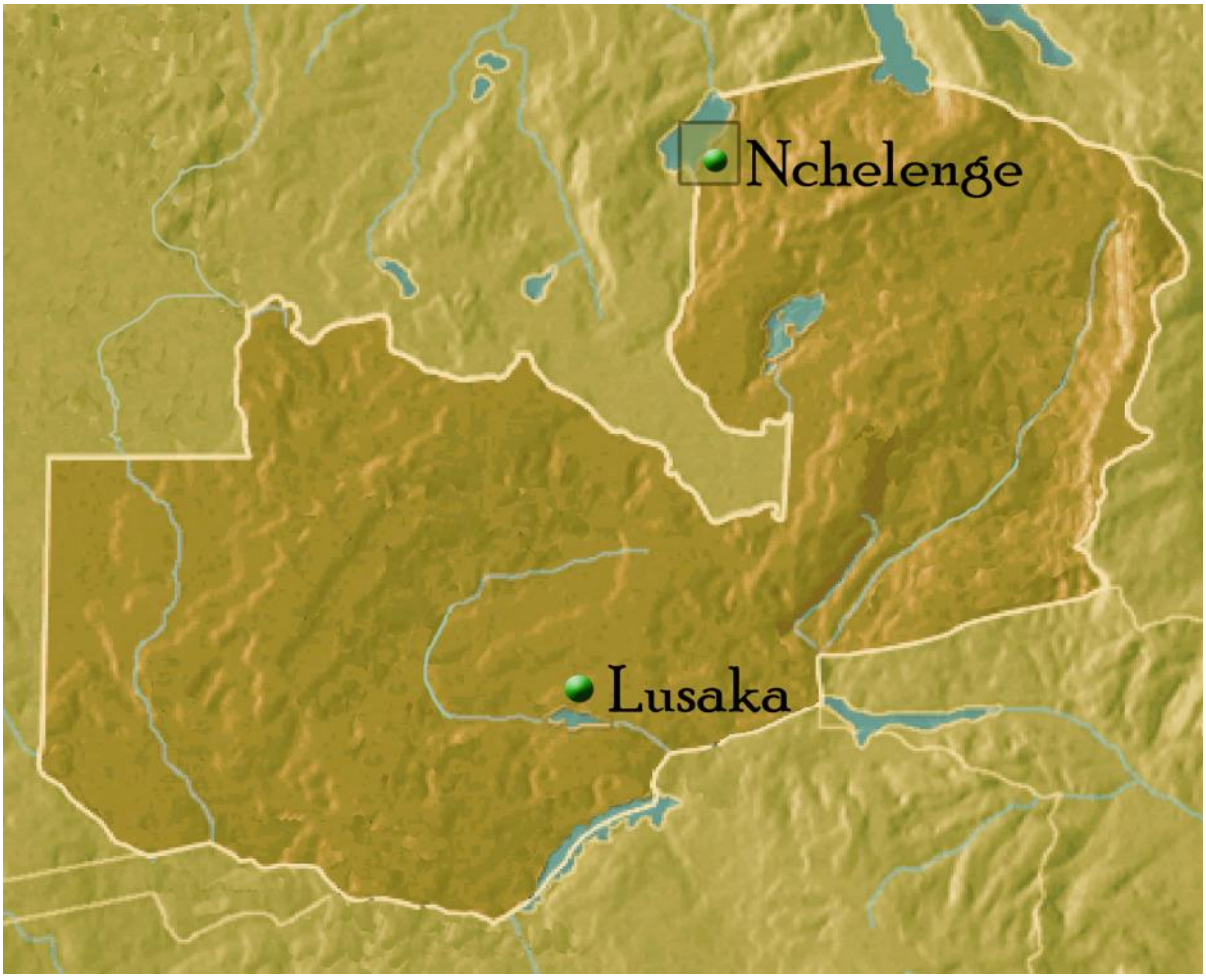
With the total number of 658 questioners filled in 13 schools sampled out of the 38 Schools in Nchelenge, 76.8% pupils of which 88.8% are boys and 62.7% are girls had had sexual intercourse before. Of these, 12% boys and 44% girls were forced into the act the first time they had it. 52% o boys and 39% of girls are still sexually active with 26% of the girls having sex with people in the high risk group whilst for boys in this category its 18.2%. 40.9% of boys and62.1% of girls did not use condoms the last time they had sexual intercourse.

51% of boys and 53.8% of girls do not know that use of a condom is a shred decision and 58% of boys and 69% of girls believe that a girl can never say no to having sexual intercourse if asked by a boy or man.
IT was however discovered that pupils knowledge on HIV/AIDS were high and most of this knowledge was acquired within the boundaries of the school.



1. INTRODUCTION

Where are we found?



- Population served: 135,880 **(CSO figures estimate from 2000 Census of population)**
    - 24% peri-urban 75% rural
    - Fishing population

Nchelenge district is one of the districts in Zambia that is hardest hit by the HIV/AIDS epidemic. This could be attributed to the high mobility of the population that is due to mainly two major economic activities that are fishing and mining.

HIV/AIDS pandemic has been around for over two decades now, with a devastating effect in virtually all sectors of human endeavor. This has continued to pose a great threat to human development.

Like any other part of the country, Nchelenge has not been spared with the scourge. Current District statistics ***(January 2005 Zambia ART Centre Directory*)** show that the district has a prevalence of 11.2% with the mostly affected age group being the economically productive 15 – 49 years. There has been a steady reduction in the prevalence rates from 1996 which was 24% and in 2000 it was at 16.8% **(HIV/AIDS in Zambia 2004 publication)**.

In responding to the problem, a multi-sectoral District HIV/AIDS Task Force (DTF) was constituted in the last quarter of 1996, with financial and material support from Project Concern International Zambia.

The DTF's *modus operandi* was to rationalize resource allocation and supplement DHMT's effort in mitigating HIV/AIDS impact through broad-based collaborative/ strengthening effort.
From onset, the broad aims of DTF were set to ensure **Up-holding the dignity of those infected and affected by HIV/AIDS** and **reduce further of the spread of the disease.**

Activities carried out to-date are focused on: -

- **Education for prevention & control (IEC)** of HIV mainly through popular theatre **(drama),** distribution of literature and sensitization workshops for various groups in the community.
- Proper **identification and treatment of Sexually Transmitted Infections**
- Community Based care of the chronically ill
- **Condom availability & access (antecedent for use)**
- Education **support to the Orphans & Vulnerable children**.

Towards the end of the year 2001, a **Building Effective AIDS Coalitions Organizations Networks** (BEACON) assessment was done aimed at Building Effective AIDS Coalitions Organizations Networks. This was done with support from PCI **(Z)**. This opened up the arena of Capacity areas that require improvements. These were considered in the Organization's capacity improvement. Later, in 2004, following a Human Capacity Development workshop organised by a National Facilitation Team , through CHAZ, the DATF re-organised its management and came up with a desired outcome in this task of mitigating HIV/AIDS intervention.

As mentioned to earlier, DATF through the District Facilitation Team saw the need of taking interventions in schools after a report from the District Lobby and Advocacy Team revealed that there were many cases of abortions and STIs in Schools which was itself an indication that the Pupils were practicing unsafe sex. In order to take appropriate interventions, there was need to know the Sexual Behaviors, Knowledge on HIV/AIDS and Attitudes towards HIV/AIDS among the pupils in Schools. Thus DATF together with MoE and MSF initiated and conducted a Knowledge, Attitude and Behavior (KAB) Survey in sampled Schools in Nchelenge District.

11. OBJECTIVES

The KAB survey of a sexual behaviors, attitudes and knowledge activities among the youths is a fundamental activity required for an effective behavior change prevention and control program. Survey is defined as the "ongoing systematic collection, collation analysis of data and the dissemination of information to those

who need to know in order that action may be taken." In other words, survey provides information that leads to action being taken to respond to the felt needs of the target group.

The main goal of the survey was to obtain quantitative data on sexual behaviors, attitudes and knowledge of youths towards HIV/AIDS issues so as to be able to develop appropriate messages and intervention in HIV/AIDS programs in Schools. This goal can be divided into five objectives which are:

i. Establish a system to monitor the implementation of HIV/AIDS in School Communities and their surrounding communities;
ii. Provision of information on sexual behavior of Youths
iii. Provision of information to help guide School HIV/AIDS program planning;
iv. Provision of evidence of success of current HIV/AIDS intervention programs in Schools and subsequently the levels of knowledge of youths towards HIV/AIDS issues;
v. Determine Pupils the attitudes trends of towards issues of HIV/AIDS.

12. METHODOLOGY

The survey on HIV/AIDS and reproductive health issues in the schools of Nchelenge district is a quantitative study with probability cluster sampling method. The target population consists of 12-19 year old school children.

School going youths were picked as an entry point to the program because of the strategic positioning of schools in the communities as the interventions would easily spill over to non school going youths in the communities. It is also hoped that schools would be used as springboards to DATF activities in Zones.

The Ministry of Education also provided the enabling environment for the survey to take place through their good will as well as provision of the counterpart funding to the activity.

Sample size, sampling and survey procedures

Sampling size

The target population consists of 12-19 year old school children. This means that pupils in grades six and seven were picked in lower basic schools, grades eight and nine in upper basic schools, and pupils in grade eight to twelve at the High School.

Sampling Procedure

According to the data obtained from MoE there are 38 schools in the district with 26433 total numbers of pupils. The number of clusters was decided to be 13 (1/3 of 38). As to determine the sampling interval, the total number of students was divided in the number of clusters: 26433/13=2033. The first number was selected randomly, had the same number of digits **(4)** as the sampling interval **(2033)** and was less or equal to it. That number was 1120, so the first school was Chandwe basic (it was the second school which had the corresponding cumulative number of students more or equal to the random number chosen).The rest of the clusters were chosen by adding the sampling interval to the previous number.

As a result the following schools were chosen, each school consisting of one cluster.

Clusters	**Schools**
1	Chandwe Basic
2	Chisenga Basic
3	Kabuta Basic
4	Kambwali Basic
5	Kanakashi Basic
6	Kashikishi Basic
7	Kenani Basic
8	Lukwesa Basic
9	Lushiba Basic
10	Mubamba Basic
11	Mwatishi Basic
12	Ntoto Basic
13	Nchelenge High

Survey Procedure

The team members, who were collecting the information from the pupils in selected schools, had to sit and divide themselves into four **(4)** groups of two. At school the teams were paying a courtesy call to the school managers and explain the purpose of the survey. After explaining the purpose of the survey, school managers were left with the responsibility of appointing patrons/matron to help the teams to select respondent pupils using random sampling from upper basic classes. After the selections were done pupils who were selected were isolated from the rest of the pupils and team members allocated to the school had to explain the idea of the survey to the selected respondent.

The guidelines laid down to the survey were as follows:

- No names to be written on the questionnaire so that no one will know the respondent to maintain the highest standard of confidentiality.
- Questions to be given honest answers
- Respondents were not allowed to talk to each other during the exercise and all questions on how to fill questions through were to be answered by the facilitators who kept all respondents in sight by moving around.

The questionnaire was explained to respondents going by question by question. After all was done respondent were asked to fill the questionnaire and after finishing they were asked to fold the questionnaire and return to the responsible personnel/teams members to that school.

Data Processing and Analysis

I. Plan for data collection

Each cluster consisted of 50 questionnaires. At the schools the target population was defined using random number table. The instructor picked a random number from one to five, then went to the class and asks the students to count from one to five. Then he offered every person with the number he picked to be included in the survey there by having the ten participants. This was in those classes with about fifty pupils. Those classes with less pupils, the number intervals reduced by dividing ten into the number of pupils in a class.

II. Plan for data processing and analysis

After the completion of all 650 questionnaires (13x50), the database was then created and the data was entered and analyzed with SPSS programme.

III. Ethical consideration

It was clearly stated in the questionnaire and explained to the pupils that the information they put in the questionnaire was anonymous and confidential and was needed for HIV/AIDS programme planning purposes in schools only.

IV. Pre-testing

The Pre-testing of the 30 questionnaires was done in 2 schools. Based on the pretest results there were changes made in the structure of the questionnaires. The questionnaires were also translated into Bemba giving the opportunity for students to fill up with the language they feel more comfortable with.

V. Data analysis/interpretation

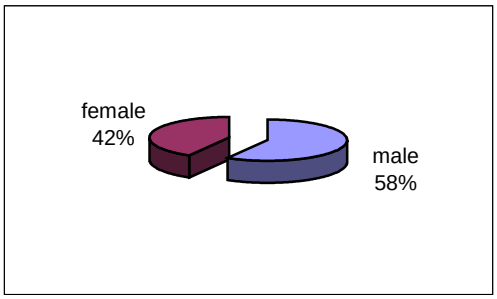
The analysis and the interpretation of the data were to give information on the knowledge level, sexual risk behavior and attitude towards HIV/AIDS and reproductive health issues among teenage school children. The results would considerably help in the designing of a relevant HIV/AIDS programme in schools

13. RESULTS

Demographic information

A total of 658 questionnaires were completed in 13 sampled schools in Nchelenge district from 18th-22nd Sep 2006. Of the 658 pupils interviewed 383(58.2%) were male and 274(41.6%) were female. Despite close adherence to random selection procedure, the number of male students interviewed was higher then female. This was mainly due to the fact that the survey was conducted at schools where the number of male students explicitly exceeds the number of female students. Given that the survey targeted adolescents as an age group, around 87% of the respondents of both sexes were in between ages of 13 and 19. The mean age of the respondents was 16.91.

Chart 1



Knowledge on HIV / AIDS, Transmission and Prevention

The vast majority of respondents know about the existence of HIV/AIDS (90.4%), but boys are slightly better informed and had more correct knowledge than girls. The overall percentage of correct knowledge on HIV transmission is almost 80%. However, 8.7% of students think that they can get HIV/AIDS through kissing, 5.1%, through mosquito bites, 2.9%, by shaking hands. Almost 3% also think that they can get the virus by drinking from the same bottle and by swimming in the lake together with HIV positive people. All above mentioned misconceptions are more common among girls then among boys (22.5% versus 17.9%). 72.3% of both boys and girls know that healthy looking person can be HIV positive and 81.3% knows that there is no cure for HIV/AIDS.

Almost 83% of boys and 78% of girls believe that they can protect themselves from HIV/AIDS. The most common way of protection is condom use: 34.9% (37.5% among boys, 31% among girls), closely followed by abstinence 33.4% (32.2% among boys, 35.2% among girls).Around 12% of both boys and girls prefer to protect themselves by having sex with one partner. The misconception that one can be protected from HIV by having sex with a virgin is common among 3.3% of respondents and 9.4% believe that they can be protected by avoiding people with HIV infection. This last figure indicates the discriminatory attitude and stigma among schoolchildren towards HIV positive people.

Table 3

Variable	Male		Female		Total	
	N°	%	N°	%	N°	%
Has heard of HIV/AIDS:						
1. yes	352	92.6	233	87.3	585	90.4
2. no	28	7.4	34	12.7	62	9.6
How can you get HIV:						
1. kissing	53	7.9	46	10.0	99	8.7
2. drinking from the same bottle	8	1.2	12	2.6	20	1.8
3. having unprotected sex	327	48.6	215	46.7	542	47.8
4. shaking hands	19	2.8	14	3.0	33	2.9
5. from mosquito bites	34	5.1	24	5.2	58	5.1
6. sharing sharp, cutting object	226	33.6	141	30.7	367	32.4
7. simmering in the lake	6	0.9	8	1.7	14	1.2
Can a healthy looking person have HIV:						
1. yes	274	72.3	194	72.4	468	72.3
2. no	72	19.0	43	16.0	115	17.8
3. don't know	33	8.7	31	11.6	64	9.9
Is there a cure for HIV/AIDS:						
1. yes	37	9.9	30	11.4	67	10.5
2. no	311	83.4	206	78.3	517	81.3
3. don't know	25	6.7	27	10.3	52	8.2
Can you protect yourself from HIV:						
1. yes	316	82.9	205	77.7	521	80.8
2. no	51	13.4	31	11.7	82	12.7
3. don't know	14	3.7	28	10.6	42	6.5
How can you protect yourself from HIV:						
1. use condom	255	37.5	141	31.0	396	34.9
2. abstain	219	32.2	160	35.2	379	33.4
3. have sex with a virgin	20	2.9	17	3.7	37	3.3
4. have sex with one partner	83	12.2	57	12.5	140	12.3
5. avoid meeting people with HIV/AIDS	57	8.4	50	11.0	107	9.4
6. don't know	15	2.2	10	2.2	25	2.2
7. other	31	4.6	20	4.4	51	4.5

Stigma

The core indicator showing the existence of stigma among schoolchildren is the question whether they are willing to be friends with HIV positive students to which 57% of answered negatively. Interestingly, more boys (41.7%) than girls (35.2%) expressed willingness to be friends with HIV positive student.

Table 4

Variable	Male		Female		Total	
	N°	%	N°	%	N°	%
Willing to be friends with HIV positive student:						
1. yes	158	41.7	95	35.2	253	39.0
2. no	211	55.7	159	58.9	370	57.0
3. don't know	10	2.6	16	5.9	26	4.0

Sources of information about HIV/AIDS

The most commonly mentioned source of information on HIV/AIDS was teachers/Ant AIDS Clubs (42.7%). Next was literature (19.3%) and parents/siblings (17.4%). Surprisingly, friends and fellow students were the least common source of information on HIV/AIDS.

Table 5

Variable	Male		Female		Total	
	N°	%	N°	%	N°	%
Where got information on HIV/AIDS:						
1. parents/siblings	96	15.3	90	20.2	186	17.4
2. friends/fellow students	87	13.9	69	15.5	156	14.6
3. teachers/Anti/Aids clubs	276	44.0	182	40.9	458	42.7
4. literature	127	20.3	80	18.0	207	19.3
5. other	41	6.5	24	5.4	65	6.1

Sexual Risk Behavior

76.8% of interviewed students (86.8% of boys and 62.7% of girls) indicated that they have had sexual intercourse in their life. Mean age at first sexual experience for both sexes was 13.6 (13.3 for boys, 14.2 for girls). While the vast majority of either boys (81.8%) or girls (73.4%) had their first sexual experience with a fellow peer, 16 % of girls had their first sexual contact with an older person while 6.2% of boys, with commercial sex worker. Around 12% of boys and 44% of girls reported of having their

first sexual intercourse by force which might indicate that the sexual abuse of minors is widespread in the community although there is need for further investigation with qualitative survey. The difference between boys and girls shows a clear gender imbalance. Of those who were sexually active 47.4 % noticed that they are presently in sexual relationship and 55.3% had sexual intercourse in last 12 months.

Table 1

Variable	Male		Female		Total	
	N°	**%**	**N°**	**%**	**N°**	**%**
Had sexual intercourse:						
1. yes	329	86.8	168	62.7	479	76.8
2. no	50	13.2	100	37.3	150	23.2
When first had sex, was it						
1. by force	39	11.9	76	44.2	115	23.0
2. willingly	289	88.1	96	55.8	385	77.0
Partner during first sexual intercourse:						
1. fellow peer	265	81.8	124	73.4	389	78.9
2. older person	14	4.3	27	16.0	41	8.3
3. commercial sex worker	20	6.2	6	3.6	26	5.3
4. other	25	7.7	12	7.1	37	7.5
Presently have sexual relationship:						
1. yes	168	51.9	69	39.2	237	47.4
2. no	156	48.1	107	60.8	263	52.6
Sexual intercourse in last 12 months:						
1. yes	196	59.9	81	46.6	277	55.3
2. no	131	40.1	93	53.4	224	44.7

Condom Use

Around 48% of students reported condom use during last sexual intercourse with boys having used condom less then girls (40.9% versus 62.1%). On the question who should be proposing condom use, more then half of the respondents (52.3%) answered that it should be shared decision, though 25.5% thought it should be man to propose while 14.6% considered that it should be woman. Interestingly, boys were twice more likely than girls to mention that its man's responsibility to propose condom use (32.2% versus 16.2%), while girls where twice more likely to state that it is the women who should propose condom use (21% versus 10%). This finding demonstrates that although gender biasness in decisions on sex is there, girls feel that they are able to propose condom use. This However, it is encouraging that more then half of both sexes (51.2% boys, 53.9% girls) agreed that proposal of condom use should be shared decision. On the question whether a girl can refuse to have sex, only 58.3 % of boys and 69.4% of girls answered yes. It is interesting to mention also that only half of the students agreed with the possibility for a girl to get pregnant from the first sexual intercourse which indicates the low knowledge level on reproductive health issues.

Table 2.

Variable	Male		Female		Total	
	N°	**%**	**N°**	**%**	**N°**	**%**
Used condom during last sex:						
1. yes	131	40.9	100	62.1	231	48.0
2. no	189	59.1	61	37.9	250	52.0
Who should propose condom use:						
1. man	122	32.2	44	16.2	166	25.5
2. women	38	10.0	57	21.0	95	14.6
3. shared decision	194	51.2	146	53.9	340	52.3
4. don't know	25	6.6	24	8.9	49	7.5
Can a girl refuse to have sex:						
1. yes	217	58.3	186	69.4	403	63.0
2. no	106	28.5	47	17.5	153	23.9
3. don't know	49	13.2	35	13.1	84	13.1
Can a girl become pregnant with the first sex?						
1. yes	203	53.4	115	42.6	318	48.9
2. no	135	35.5	113	41.9	248	38.2
3. don't know	42	11.1	42	15.6	84	12.9

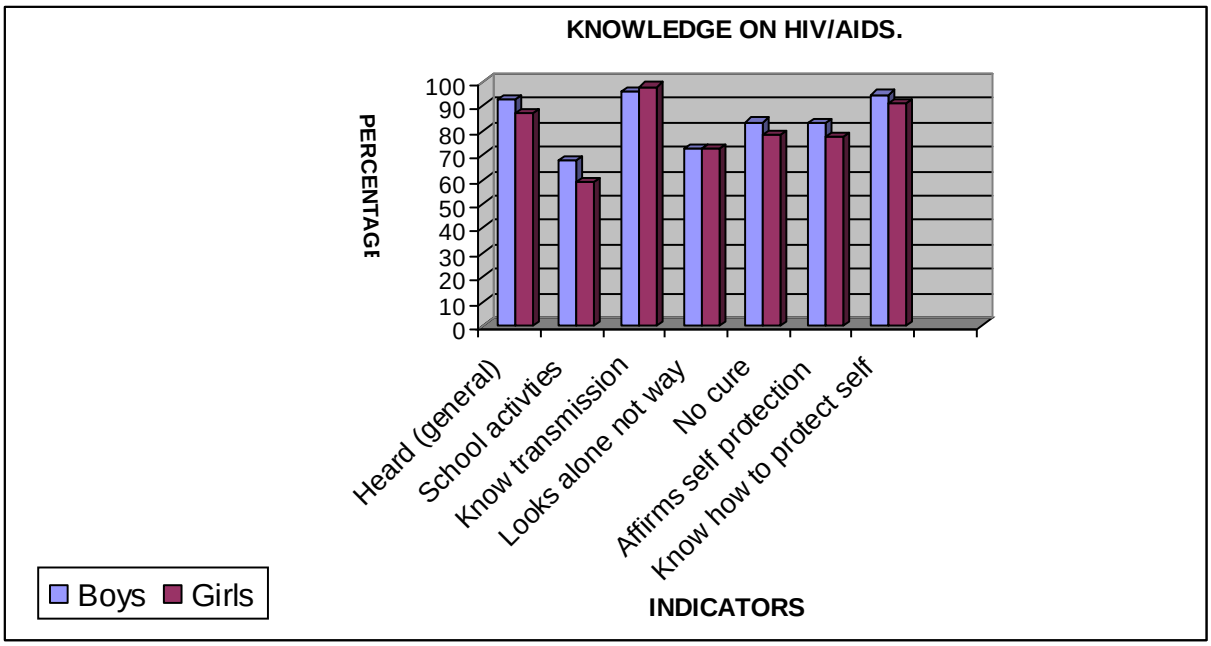
14. DISCUSSION

With the above result analysis, knowledge, attitude and behavior issues can be analyzed so as to try and generate discussion points which would then result into a yard stick to map up effective and efficient strategies for interventions amongst our youths, so as to generate a sustainable response to HIV/AIDS.

Knowledge on HIV / AIDS, Transmission and Prevention

The table below shows the discussion points as translated into percentages:

OBJECTIVE	ACTIVITY	BOYS	GIRLS	TOTAL %
HIV/AIDS KNOWLEDGE ANALYSIS	% of pupils that have heard about HIV/AIDS	92.6	87.3	90.4
	% of pupils that heard about HIV/AIDS from the School activities	67.8	58.7	63.9
	% of pupils that know how they can get HIV/AIDS	96	97.9	97.2
	% of pupils that know that a healthy looking person can have HIV	72.3	72.4	72.3
	% of pupils who know that there is no cure for HIV/AIDS	83.4	78.3	81.3
	% of pupils who know that they can protect themselves from HIV	82.9	77.6	80.8
	% of pupils that know what to do to protect themselves from HIV	94.6	90.9	93.1



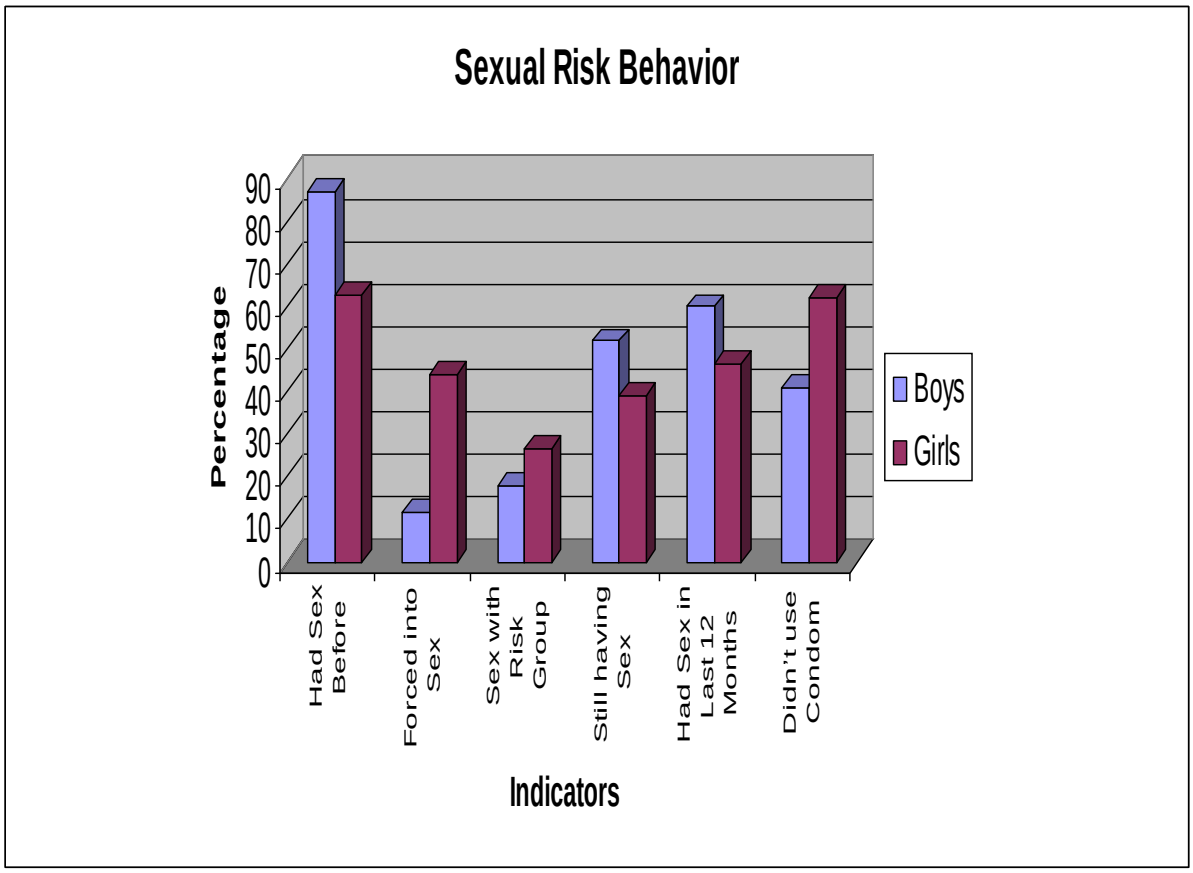
It goes without saying that a high percentage of pupils have some knowledge on HIV/AIDS, the mode of transmission and how to prevent it. It is also evident from the results that most of this knowledge was got from within the boundaries of the school premises. This shows that the interventions being put in place by the School Authorities in as far as information dissemination on HIV/AIDS are working.

It is therefore prudent that the information dissemination techniques used in Schools are encouraged and scaled up as there is always a continuous in and out flow of pupils in Schools. It must be noted that at the end of the day these pupils find themselves in communities which in itself makes a good entry point of information dissemination to youths in communities.

Sexual Risk Behavior

As discussed above in the result analysis, it is very clear that a high percentage of the pupils are involved in high risk behavior and a lot needs to be done in addressing the issues that make pupils engage in such acts regardless of the high levels of knowledge they have on HIV/AIDS. One School of thought would be that the mode the information is given to the pupils is not in the form they understand it and hence the needs to find methods that are tailored to the needs of the youths.

OBJECTIVE	ACTIVITY	BOYS	GIRLS	TOTAL %
SEXUAL BEHAVIOUR ANALYSIS	% of pupils who have had sexual intercourse before.	86.8	62.7	76.8
	% of pupils that were forced into sex the first time they had sex	11.9	44.2	23
	% of pupils that had sex with people of the high risk group the first time they had sex	18.2	26.6	21.1
	% of pupils that are presently having sexual relationship	51.8	39.2	47.4
	% of pupils that have had sexual intercourse in the last 12 months	59.9	46.5	55.3
	% of pupils that didn't use condoms the last time they had sexual intercourse	41	62.1	51.5

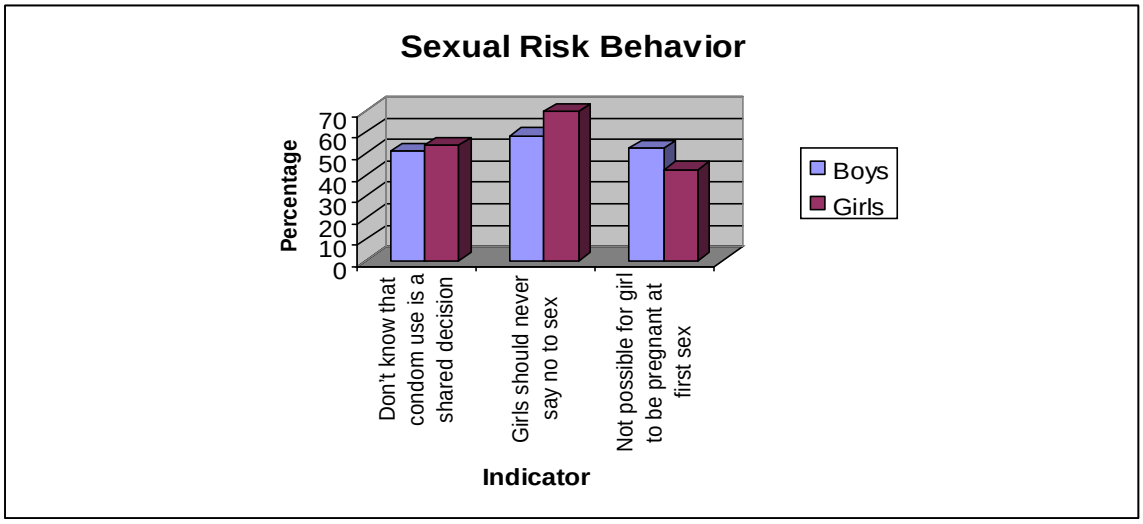


In as much as we have seen that a high percentage of our pupils are sexually active, we must not forget that the policy as at now is that we have to promote abstinence in Schools as far as sexual intercourse is concerned. Abstinence on the other hand doesn't seem to work in our schools as such there is need to sensitize the pupils on other alternative methods of safer sex.

Attitude Towards HIV/AIDS And Reproductive Health Issues

There is also need to address pupils' perception to issues in HIV/AIDS. More information needs to be given to our youths in Reproductive Health and in the rights of a girl child to make a choice and informed decisions. Most of the pupils in schools think that a girl has no right to say no to sex. This is a dangerous state of affair as it put or girls at high risk of being infected.

OBJECTIVE	ACTIVITY	BOYS	GIRLS	TOTAL %
ATTITUDE TOWARDS HIV/AIDS ANALYSIS	% of pupils who do not know that use of a condom is a shared decision	51.2	53.9	52.3
	% of pupils that believe that girls should never say no to sex	58.3	69.4	63
	% of pupils that think its not possible for a girl to became pregnant the first time she has sex	53.4	42.6	48.9



15. CONCLUSION

Recommendation

Develop HIV/AIDS program interventions tailored to the needs of each School depending on the felt needs of the particular school. This will Promote School program ownership and School management will take the program beyond the research phase and hence promote sustainability and continuity. Instrumental to this process is identifying opportunities and strategies for partnership and integration of youth care and support activities into existing or planned programs.

Involve school managers to promote youth peer educators, generate school support, reduce stigma, and enhance access to existing community services that provide HIV/AIDS services.

Care and Support Interventions

- Institute ongoing monitoring and training to strengthen capacity and improve services provided by matrons and patrons. Support for ongoing monitoring and training can be enhanced by local partnership. These would include DATF implementing partners working in the in neighborhood communities.
- Provide HIV and Sexual Health library in school to help youth in remote areas to have access to information. Use and ownership of and maintenance responsibilities for the library must be clearly defined and agreed upon before they are supplied with Information Education and Communication materials.
- The Guidance Teachers must be trained in management of Ant AIDS club so as to enhance positive outputs of these clubs. They must also be capacity belt on how to handle issues of ABC including Reproductive and Sexual Health in Schools.
- School Managers at every School shall provide space for counseling activities to be conducted.
- Replenish consumable supplies in the IEC materials on a regular basis. Meeting this need reaffirms the value of advocacy activities and builds their confidence.
- MoE together with cooperating partners shall develop monitoring tools to truck the performance of the program.

Prevention and Intervention

- Help young people to appropriately determine their personal risk of HIV and AIDS. Programs working with young people often focus on ensuring that they are aware of HIV and AIDS and know the facts about transmission, without necessarily ascertaining that they understand how these facts relate to their own lives. Even young people who are well informed about the general facts of HIV prevention can believe that they are personally immune from infection when it comes to assessing individual risk. Effective strategies are required to enable young people to appropriately determine their personal risks of HI V infection and to sustain protective behaviors, in ways that recognize gender vulnerability and cultural realities, Increase understanding of the social context of vulnerability of young people.

- Programs targeting school going youth need to go beyond increasing knowledge about transmission routes, to increasing youths awareness of how social and cultural factors increase their vulnerability or limit their ability to adopt protective behaviors. Recognition and discussion of difficult issues such as intergenerational sex, exchange of gifts and money for sex, and forced sex are also important in ensuring that programs for school going youths address all aspects of their vulnerability.

- Address gender stereotypes and mistrust in relationships. Young people of both sexes often blame each other for the spread of HIV because of a general feeling of mistrust in relationships. Gender stereotypes, which particularly prevent girls from taking greater initiative to protect them selves, need to be addressed. There is an urgent need to find ways of building trust and responsibility for HIV prevention between young people in a relationship.

- Ensure youth are able to care for people living with HIV and AIDS safely, even as part of .prevention efforts. Young people who are well informed about HIV and AIDS know that they cannot contract HIV by casual contact. However, there is a gap between this knowledge and the reality of caring for someone who has AIDS. Stigma levels among the youths are still high. While many youth programs focus on prevention alone, the reality is that many young people are caring for people living with HIV and AIDS in their own homes and communities, and questions of safety cannot be ignored. It is important that youth prevention programs in high endemic areas combine prevention and care to ensure that youth caregivers are not at risk of contracting HIV or other infections.

Other issues identified that need to be addressed;

Need to extend the program beyond the classroom was identified. There is great need to include the whole School community if the benefits of the programs implemented have to yield intended results. PTA must be included in the program. The following would be areas to be tackled to involve the whole school community;

- Create information dissemination forums for PTA. There is need to identify workable approaches to this activity as some approaches may work in some areas but may not work in others.
- Establish formal and informal collaborations and partnerships to improve access to treatment for clients seeking medical attention and for others seeking VCT, and improve caregiver knowledge of when and how to make referrals. Partnerships with local institutions, including youth and OVCs programs, can help to address the range of needs of clients and their families. This Intel strengthening the link between schools and CATFs and RHCs
- Involve people living with HIV and AIDS in the design of care and support programs, offering individuals the opportunity to articulate their own priorities and needs to thus increase the acceptance and coverage of community care and support activities. PLHA involvement is feasible in isolated rural areas, even where community stigma is high.

- In as much as increase access to condoms for sexually active youth in rural areas would be an ideal approach to reduce risk levels, abstinence promotion still remains the preferred method of intervention to youths than condom promotion in schools. This is in line with the Zambian policy which promotes abstinence among youths. However, alternative safer sex methodologies must be shared with pupils in schools. The interventions should go beyond ABC to include Reproductive and Sexual Health Education.

Annex 1.

Questionnaire

This survey will help us understand what you know and how you feel about HIV/AIDS and reproductive health. **Your answers are very important for the quality of the HIV/AIDS programme at schools. Please answer each question carefully and honestly. You DON'T need to put your name on the questionnaire, so no one will know how you answered this survey.**

Sex: 1. Boy 2. Girl Date: _____
Age_____ School: _____

1. Have you ever had sexual intercourse?

1. Yes
2. No (go to question 9)

If yes

2. How old were you when you first had sex? _____ years

3. When you had sex for the first time was it

1. By force
2. Willingly

4. With whom did you have it?

1. With fellow peer/boy or girl friend
2. With older person
3. With commercial sex worker
4. Other _____

5. Are you presently having a sexual relationship?

1. Yes
2. No

6. Have you had sexual intercourse in the last 12 months?

1. Yes
2. No

7. Did you use a condom when you last had sex?

1. Yes (go to question 9)
2. No

8. **If no**, reasons for not using_____
_____

9. Who, in your opinion, should propose condom use?

1. Man
2. Women
3. Shared decision
4. Don't know

10. Can a girl refuse to have sex?

1. Yes
2. No
3. Don't know

11. Is it possible for a girl to get pregnant the first time she has sexual intercourse?

1. Yes
2. No
3. Don't know

12. Have you heard of HIV/AIDS?

1. Yes
2. No

13. **If yes**, where did you get the information on HIV/ADS?
(More then one answer is possible)

1. Parents /Siblings
2. Friends /fellow students
3. Teachers / Anti AIDS Clubs
4. Literature (leaflets, books & magazines, etc)
5. Other_____

14. How can a person get HIV?
(More then one answer is possible)

1. Kissing someone who has HIV/AIDS
2. Drinking from the same bottle as infected person
3. Having sex with infected person without condom
4. Shaking hands with infected person
5. Being bitten by mosquitoes or other insects
6. Sharing razors, needles, blood sucking horns
7. Swimming in the lake/river with an infected person

15. Can a healthy looking person be infected with HIV?

1. Yes
2. No
3. Don't know

16. Is there a cure for HIV/AIDS?

1. Yes
2. No
3. Don't know

17. Can you protect yourself from becoming infected with HIV?

1. Yes
2. No
3. Don't know

18. What can you do to protect yourself from HIV?
(More then one answer is possible)

1. Use condom
2. Don't have sex/abstain
3. Have sex with a virgin
4. Have sex only with one partner
5. Avoid meeting people with HIV/AIDS
6. Don't know
7. Other_____

19. Would you be willing to be a friend with a student who has AIDS or is infected with HIV?

1. Yes
2. No
3. Don't know