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Young Men's Sexuality and Sexually Transmitted Infections in Zambia

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ABSTRACT

Aim: To describe and analyse young Zambian men's sexuality and implications for sexually transmitted infections (STIs) including HIV/AIDS in Chiawa rural community and Lusaka urban compound of Misisi.

Methods: Over a period of eight years, 402 men between 16 and 26 years old have participated in the studies; 205 from Chiawa and 197 from Misisi. Random and purposive sampling techniques were used to select the men. Fifty-nine traditional healers were also included in the study. Twenty-three of the traditional healers came from Chiawa and 36 from Misisi. Thirty-seven women in Misisi were included in one of the studies. Data was collected using semi-structured questionnaires, focus group discussions, in-depth interviews, and observations. The questionnaires were administered to the young men twice in Chiawa in 1993 (n=98) and 2001 (n= 79); and once in Misisi in 2001(n=153).

Results: The mean age of the young men was 21 in Chiawa and 20 in Misisi. The majority of the men were not married. Almost all the men in Chiawa and Misisi had attended formal schooling. In 1993, and 2001, 39% and 44%, respectively, were formally employed in Chiawa and only 14% were employed in Misisi.

A real man was considered to be one who was married, had children, had a decent job, cared for the family, and could sexually satisfy his wife. In Chiawa, 97% and in Misisi 76% of them considered themselves to be real men. Four children were considered to be the ideal number during one's life time due to economic hardships.

Forty-three percent and 25% of the men had current pre- or extra sexual marital relationships in 1993 and 2001, respectively. In Misisi, 40% had current pre-or extra marital relationships. Qualitative data revealed that the main reason for these relationships was the need to prove that they were real men. In Chiawa, one-fourth of the men in the two surveys said they had suffered from an STI in the past and most of those in the second survey had sought treatment from the local health facility. In Misisi, 26% had suffered from an STI and many of them had gone to the private clinics for treatment. Majority (91%) of the men in Chiawa, compared with less than half in Misisi (41%) said they considered themselves to be at risk of contracting HIV infection. In Chiawa, they considered themselves to be at risk because of what they believed to be their inability as men to control sexual desires; their lack of trust in the sexual partner; and, unreliability of the condom. In 1993, only six percent said they used a condom all the time they had sex whilst 27% said so during the 2001 survey. In Misisi, 19% said they used condoms all the time. Qualitative data showed that there were misconceptions surrounding the use of condoms. In Chiawa, the healers reported using up to 19 different species of medicinal plants to treat STIs. Both in Chiawa and Misisi, the healers were treating impotency and infertility.

Conclusions: Male sexuality is given prominence mainly because of its role in fertility. Multiple sexual relationships, misconceptions regarding HIV/AIDS, lack of adequate information, and ambiguities about and inconsistent use of condoms, all combine to pose major challenges on the fight against AIDS. The data from Chiawa indicates that sexual behaviour could be changing. The young men in Chiawa are more self-asserting. In Misisi the men's confidence is undermined by unemployment and other social difficulties characteristic of poor urban settlements. In designing interventions to target men's sexual health, we must consider their expressed concerns. Notions about real man that encourage risky behaviours must be targeted. Information, education and communication remain the most effective strategies. The young men's economic plight must also be addressed.

ORIGINAL PAPERS

This thesis is based on the following papers:

- I. Ndubani P. and Höjer B. Sexual behaviour and sexually transmitted diseases among young men in Zambia. *Health Policy and Planning* 2001; **16** (1): 107-112.
- II. Ndubani P. and Höjer B. Traditional healers and sexually transmitted illnesses in rural Zambia. *Journal of Ethnopharmacology* 1999; **67**: 15-25.
- III. Ndubani P. Bond VA. Liljeström R. Hojer B. Young men's construction of male sexuality and implications for HIV/AIDS in Lusaka urban, Zambia. *Journal of Culture, Health and Sexuality*, Revised and re-submitted, August, 2002.
- IV. Ndubani P. Bond VA. Liljeström R. Hojer B. Young Zambian men's sexual health dilemmas and the central role of traditional healers in the context of HIV/AIDS, poverty and urban density. Manuscript 2002.
- V. Ndubani P. Bond VA. Liljeström R. Hojer B. Understanding young men's sexual health and prospects for sexual behaviour change in rural Zambia. *Scandinavian Journal of Public Health*, Accepted, 2002.

The papers will be referred to by their Roman Numerals I-V.

The original articles have been printed in this thesis with permission from the publishers.

ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
ARRM	AIDS Risk Reduction Model
CBoH	Central Board of Health
CHEP	Copperbelt Health Education Project
CO	Clinical Officer
CSO	Central Statistical Office
EHT	Environmental Health Technician
FHT	Family Health Trust
GDP	Gross Domestic Product
GRZ	Government of the Republic of Zambia
HBM	Health Belief Model
HIV	Human Immunodeficiency Virus
HPV	Human Papilloma virus
HSP	Herpes Simplex virus
IHCAR	Division of International Health, Department of Public Health Sciences, Karolinska Institutet
IMF	International Monetary Fund
INESOR	Institute of Economic and Social Research
LUDC	Lusaka Urban District Council
MOH	Ministry of Health
NAC	National AIDS Council
NASTLP	National AIDS/STD/TB/Leprosy Control Programme
NCN	National council of <i>N'ganga</i>
NGO	Non-Governmental Organization
PHC	Primary Health Care
PLWHA	People Living With HIV/AIDS
SAREC	Department for Research Cooperation at Sida
SCLT	Social Cognitive Learning Theory
SBS	Sexual Behaviour Survey
Sida	Swedish International Development Cooperation Agency
STDs	Sexually Transmitted Diseases
STIs	Sexually Transmitted Infections ¹
THPAZ	Traditional Health Practitioners Association of Zambia
UK	United Kingdom
UNICEF	United Nation's Children's Fund
UNAIDS	United Nations Joint Programme on AIDS
UNZA	University of Zambia
UTH	University Teaching Hospital
WHO	World Health Organisation

¹ Sexually Transmitted Infections (STIs) will be used throughout this thesis

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PREFACE

When I first started work in Chiawa, I did not think that men's sexuality would be my main focus of research. But as the work progressed and as I interacted with the community, specifically the male youths at football matches, it occurred to me that some attention needed to be paid to young men's sexual health concerns.

In 1991, I was employed by the Institute of Economic and Social Research (INESOR)-IHCAR Project as a Field Research Officer to be based in a rural community called Chiawa in the Kafue district of Zambia. I lived in Chiawa with my family from April 1991 to September 1993, after which I left for studies in the UK. Whilst away, my family moved to live in Lusaka. Upon my return in 1994, I visited Chiawa regularly—at least once a month, during which data collection for the studies described in this thesis continued. Our project was nicknamed “UNZA Anti-AIDS research”, and occasionally, some of the boys and young men would ask me questions about STIs and eventually end up requesting for ‘red and yellow capsules’ (Tetracycline Capsule is an antibiotic). When I asked why they needed antibiotics, and if they were sick, why would they not go to the health centre, their common response was that they were not comfortable with the staff at the health centre. It was from here that an interest to explore the young men's sexuality started. Initially, I dealt with their understanding of STIs, including the local terminologies for STIs (Bond and Ndubani 1997). This exploration revealed to me that, due to many factors including limited access to the formal health facility, the young men utilised herbal remedies. I followed this up with a further exploration of their knowledge of herbal medicines for treating STIs (Ndubani 1997). The studies in this thesis have their beginning in this work. Later on I decided to complement my rural experience with the urban area and chose Misisi compound in Lusaka as my second research site.

The studies have been a big challenge to me mainly in two ways: firstly, as a Zambian man, studying male sexuality in Zambia, to a very large extent, entailed studying my own sexuality. Although this could be a plus, it could also be a minus, as one has to always separate personal experiences from the data; secondly, working in an interdisciplinary atmosphere, especially one dominated by anthropologists, called for broad-mindedness as well as a sharpening of my sensitivity to cultural issues. This, I had to do mainly by quickly picking up cues from the local language. Therefore, the question that begs an answer is; how different are the Chiawa or Misisi male sexual norms from the ones I have personally known or held? In addressing this simple question during these studies, I tried as much as possible to stick to the empirical data and avoided clouting interpretation with my own subjectivity. I also opened my eyes to see what was new and different.

Friends and enthusiasts have always asked; why men only? The focus on men emanates from the very beginning of these studies. At that time, being new in the area, we did not think it was polite for a man to engage in sexual discourses with women. During the first household survey in the area, we learnt that it was sometimes not easy for male interviewers to freely talk to women. To avoid being unnecessarily insensitive to the local situations, female colleagues of mine dealt with the women while I concentrated on the men.

1. INTRODUCTION TO THE PROBLEM

This thesis is part of an Interdisciplinary Research Project into HIV/AIDS Prevention in Zambia². The Interdisciplinary Research Project started in 1991. The studies described in the thesis were conducted in two Zambian settings: Chiawa, a rural community and Misisi, an urban compound in Lusaka. The Chiawa studies provide a long-term analysis of the young men's sexuality. The data collection spanned over a period of eight years (1993-2001). On the other hand, Misisi provides a cross-sectional view of the young men's perspectives in an urban setting. The data from Misisi was collected during the first four months of 2001. Whilst the main aim of the thesis is to describe young men's sexuality and their interaction with traditional healers, comparisons over time within Chiawa as well as between Chiawa and Misisi are attempted.

The focus on young men was motivated by a number of factors and these include: my own background as a public health professional; a personal commitment towards fighting the HIV/AIDS epidemic; and, a clear lack of adequate information on young men's sexuality due to limited research in the Zambian setting. Whilst there are currently a number of projects working with men, there were obviously few at the time these studies were being conceived. My observations suggest that most projects working with male involvement in reproductive health lack detailed conceptual understanding of issues surrounding men's sexuality. This thesis attempts to provide both a conceptual and an empirical understanding of young men's sexuality so that it may be of some assistance to those projects targeting men.

The acquired immunodeficiency syndrome (AIDS) pandemic is one of the most devastating and catastrophic diseases of our times and a constant threat to the lives of many people all over the world. The pandemic is extensive in sub-Saharan Africa. In 1999, UNAIDS statistics showed that there were approximately 33.5 million people infected with HIV in the world, and close to 70 percent of these were in the sub-Saharan Africa (UNAIDS 1999). Zambia has one of the highest prevalence rates for HIV. The 2001 estimates indicated that 21.5 percent of Zambians aged between 15 and 49 years were infected with HIV (UNAIDS/WHO 2002).

Young people in general are vulnerable to HIV/AIDS. However, young men in particular are more likely to suffer due to their risk taking behaviours. They know less about sexuality and, even though their knowledge of HIV/AIDS may be good, they can be highly variable in their adoption of safer sex (Lemma and Hassan 1994, NZioka 2001). Hence when looking at the issues of men there is a need to be clear from the onset which men we are talking about. Although there are studies on adolescent boys in Zambia, to the best of my knowledge, very few of them target male youths, a group that embraces both adolescents and young men. In order to be useful in enhancing the understanding of male sexuality, the studies in this thesis have attempted to address four fundamental research questions: How do young men behave and why do they behave the way they do?; What does it mean to be a real man?; How do men view illnesses and conditions that threaten their sexuality or sexual functioning?; To what extent does the young men's sexuality impact on STIs including HIV/AIDS?

² For details of the project, see Community Capacity to Prevent, Manage and Survive HIV/AIDS. IHCAR/Hull/INESOR , Working Paper Series.

2. GENERAL BACKGROUND

2.1 Zambia's Location and History

Zambia is situated across the heart of the Great Central African interior plateau with an average altitude ranging between 1,000 and 1,300 metres. In the east (particularly on the Muchinga Escarpment), the land rises to the height of about 2,000 metres above sea level. Broad depressions are found on the edges of the plateau which form Lakes Tanganyika, Mweru, and Bangweulu in the North, the Luangwa river in the east, Kafue basin and the alluvial planes of the Zambezi river in the Western province. The Kariba dam, one of the largest man-made lakes in the World and the Victoria Falls, both on the Zambezi river, are some of the greatest tourist attractions. Zambia is a landlocked country covering a land area of 753,000 square kilometres.

Archaeological evidence suggests that human habitation dates back over two hundred thousand years ago. The earliest known inhabitants were the Bushmen who are believed to have occupied the central African plateau over one hundred thousand years ago (Roberts 1976). Rock paintings in the Zambezi valley indicate occupation by the Bushmen from Stone Age times. The Bantu migration into the present Zambia started around the 1500. The migration was sparked off by the expansion of the *Lunda-Luba* Empire in the Congo Basin, forcing some of the Bantu groups to migrate southwards. The arrival of the Bantu into the interior plateau drove the Bushmen further southward into the Kalahari Desert in Namibia. Today Zambia has a diversity of Bantu ethnicities that can be grouped into 15 main national languages with 72 dialects.

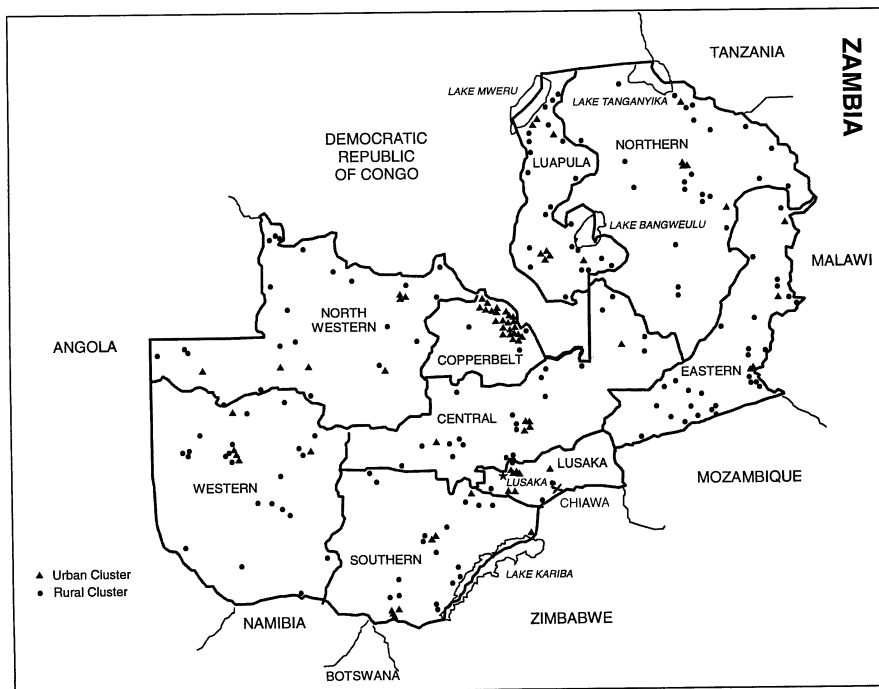


Figure 1: The Map of Zambia

2.2 Demography

Zambia's population currently stands at 10 million people. The sex distribution of the population is 51 percent females and 49 percent males (CSO 2001). The population density is 14 persons per sq km. The crude death rate is 20.2 per 1,000 population whilst crude birth rate is 55.2 per 1,000 population (CSO 1999). The population is growing at 3.3 percent per annum (CSO 1999). Like most of sub-Saharan Africa, the population is extremely young. Demographic projections indicate that, at the current rate of population growth, Zambia's population will continue to be younger for a long time to come. With close to 50 percent of the population under the age of 15 and about 3 percent over the age of 64, there is about one dependent person for each adult in the population. However, a recent demographic development is that fertility levels are falling. Current fertility levels are at 6.1, a moderate decline from 6.5 in the late 1980s and early 1990s (CSO 1997a).

2.3 Social and Economic Situation

Zambia's geographical and economic situations make it extremely difficult to provide and sustain the infrastructure and essential services. Not only is Zambia a landlocked country, but its economic strength has considerably depended on a single product-copper, which has always accounted for 95 percent of export earnings. The landlocked position and geographical shape has implications for communication and transportation networks. During the 1960s, Zambia's economy was rated among the wealthiest in southern Africa because of its vast natural resources. The Gross Domestic Product (GDP) per capita grew fast during the first few years after independence, reaching the peak towards the end of the 1970s. The consequences of combined effects of the oil shocks of the 1970s and the fall in copper prices adversely affected Zambia's economic performance. During the 1980s GDP (at constant 1977 prices) declined from US\$350 to US\$264 in 1994 (CSO 1997b).

The economic decline of the 1970s and 1980s forced Zambia to start borrowing heavily from the multilateral lending agencies-the International Monetary Fund (IMF)- and the World Bank. Attempts to improve the economic performance through the Economic Structural Adjustment Programmes (ESAP), prescribed by these multilateral agencies, did not yield any meaningful economic results. During the 1990s, the process of economic restructuring has impacted negatively on Zambia's social life and structure. In the last 10 years, Zambia has pursued one of the rapid economic liberalisation policies that have seen all the national and parastatal companies privatised. Consequently, tens of thousands of workers have been retrenched from formal employment. In 1998, the proportion of employed persons aged 12 years and above who were in the informal sector was 79 percent whilst that of formal sector employment as percentage of total labour force was 11 percent (CSO 1999). As a result, poverty has peaked during the turn of the millennium and despite Zambia's immense copper and cobalt wealth and huge tracts of arable land, 80 percent of her people live below the World Bank poverty threshold of \$1 a day. The poor economic situation has serious ramifications for HIV/AIDS and the provision of health services in the country.

2.4 Modern Public Health Services

Establishment of health infrastructure

Zambia has come a long way in improving health services since independence. However, one of the drawbacks of the health system has been its emphasis on providing services by way of hospitals, clinics and health centres and thus placing over-reliance on the curative rather than preventive services (CSO 1984). Soon after independence there was a massive development of the health infrastructure; hospitals and health centres were built in all the districts. In order to boost the levels of local health manpower, medical and paramedical schools were also established. By 1964, Chainama College was already training Environmental Health Technicians (EHT) and Clinical Officer (CO)³. In 1965, a training course for another health cadre, the Health Inspectors, was started in the paramedical department of the Evelyn Hone College in Lusaka. Nursing schools were built in all the provincial towns. In 1969 the University of Zambia was established and the medical school was opened at the University Teaching Hospital (UTH).

Although, in the late 1970s, the government wished to implement the Primary Health Care (PHC) strategy as adopted after the Alma-Ata Declaration in 1978 (WHO 1978), the health sector was not able to attain this goal because of infrastructural and financial resource constraints. The effective implementation of PHC was also hampered by the structure of the health services that was not only skewed towards curative but also towards the urban areas. This resulted in inequitable distribution of the meagre health resources including medical and nursing personnel. For example, in the 1980s, 76 percent of the doctors and 80 percent of the nurses were working in towns and provincial centres (Twumasi and Warren 1986), a situation which has persisted to date.

Environmental health and control of Communicable diseases

Zambia has continued to face serious public health problems that the health care sector has not been able to deal with adequately. There is a very high prevalence of death and illness caused by behavioural and environmental factors. Seventy percent of the national disease burden is due to communicable diseases. Because of the bias towards curative, prevention of communicable diseases has been sidelined. Morbidity and mortality profiles reveal high proportions of death and illnesses from Malaria, diarrhoea, respiratory tract infections, malnutrition, and HIV/AIDS related illnesses which continue to pose a major public health concern (CSO 1984, Hansson 1995). Currently only 33 percent of the Zambian population has access to piped water whilst about 50 percent draw their domestic water from a well or bore-hole. Nineteen percent have no access to any form of toilet facility and only three percent of the population have their garbage collected (CSO 1999). These figures suggest that the role of environmental health has been less emphasised and disease prevention has not been strongly supported in the country. This general lack of emphasis on environmental health, hygiene and disease prevention aspects has made it difficult for the Zambian public to appreciate prevention and thus to properly deal with behavioural-related diseases such as STIs, especially at primary prevention levels.

³ Clinical Officers receive a three-year medical training whilst EHT also undergo a three-year training in environmental health at a sub-university Health Science College.

Zambia health reforms

The budgetary allocation to the health sector has been declining over the years. For example, there has been a decline from 12 percent in 1994 to 9 percent in 1999 (University of Zambia 1996, GRZ 1999). In 1991, Zambia introduced the health reforms. The reforms were intended to: foster a spirit of cost-sharing by introducing user fees; improve staff competence through training and effective supervision; improve the infrastructure needed to support the delivery of essential health care package; and, introduce a new Health Management Information System (HMIS) that should monitor the health status of the population (CBoH 1997).

From 1993, a reduction in government spending through the removal of subsidies on almost all the essential goods and services was introduced. The reduction in government spending necessitated the introduction of cost sharing on education and health services. The 'pay-for-yourself' policy has reduced access to health care for many Zambians. At the grass-root level, the reforms are viewed negatively because, despite people paying for the services, drugs are never available (van der Geest 2000). The overall quality of care in government health facilities has deteriorated whilst staff moral is at its lowest ebb. The already deplorable situation in the health sector is being compounded by the brain drain as many health professionals are migrating to neighbouring countries for 'greener pasture'. Although, the high attrition rate among the health professionals is mainly due to the brain drain, deaths due to HIV/AIDS epidemic have significantly contributed.

2.5 Traditional Medicine

Like elsewhere in sub-Saharan Africa, the public health situation in Zambia warrants favourable arguments in support of traditional medicine by all the key players in health. Because of the numerous problems facing modern public health sectors in many low income countries, there has been advocacy for the recognition and promotion of traditional medicine mainly by WHO (WHO 1978, WHO 2000). Traditional healers can offer a viable supplement due to their cultural appropriateness, availability and ease of accessibility for the majority of the communities. Globally, it is estimated that about 80 percent of the populations of low-income countries rely mainly on traditional medicine for their primary health care needs (WHO 1993; Akerela 1994). More specifically, there is a growing recognition that traditional healers have a potentially major role to play in the fight against HIV/AIDS (Green et al. 1995, Nyambo 2001, Ndubani and Höjer 1999). However, it is clear that the Ministries of Health (MOH) have not been fully committed to incorporating and utilising traditional medicine. As Good (1980) observed, the majority of health ministries in Africa are ignoring the several alternative forms of health care that coexist with the scarce biomedical resources. In Zambia, with the high levels of morbidity, the inequitable rural share of national health resources, and the declining per capita spending on health, it is just prudent that the Ministry of Health takes the contribution of the traditional healers seriously.

It is estimated that there are over 50,000 traditional healers in Zambia. About 40,000 are registered with the Traditional Health Practitioners Association of Zambia (THPAZ), the major association for healers in the country (Nyambo 2001). Many more traditional healers operate outside this association whilst others belong to the National Council of *N'ganga* (NCN) and other smaller organisations. The Zambian

traditional healers, locally known as *n'ganga*, can be grouped into four categories; herbalists, diviners, faith healers and traditional birth attendants [TBAs] (Kekelwa 2001).

World Health Organisation (WHO) has defined traditional healer as:

“a group of persons recognised by their community in which they live as being competent to provide health by using vegetable, animal and mineral substances and other methods based on social, cultural and religious backgrounds as well as on the knowledge of, attitudes and beliefs that are prevalent in the community regarding physical, mental and social well-being and the causation of disease and disability” (WHO 1978:14).

2.6 Medical pluralism

Good (1980) has suggested that one of the possible ways to expanding the availability of low-cost primary health care is for health officials to acknowledge their people's medical pluralism and radically redefine existing resources to permit them to be used in a more efficient manner. The understanding of the determinants of care-seeking between western and traditional health sectors is essential for designing effective health services. Health care-seeking behaviour is a topic that has received considerable attention in recent years, with important studies in a number of socio-cultural settings throughout the world (Foster 1997, Kleinman 1980). Some research on the subject has also been carried out in Zambia (Leeson and Frankenberg 1977, Bond and Ndubani 1997, Ndubani 1997, Ndubani et al 1998, Msiska et al 1997). People in many parts of the world today are presented with numerous treatment options when ill and in search of health care. This is indeed the case in Zambia, where a pluralistic medical setting provides a variety of health care alternatives of both indigenous (home-based and traditional) and western (public and private) nature. Although, often people make a distinction between diseases suitable for western treatment and diseases best treated by traditional healers, the combined use of both is common (Ndubani et al 1998). The weight of empirical evidence suggests that regardless of cultural beliefs, people use both traditional and western medicine without giving up traditional explanations of illness (Pelto and Pelto 1997). Multiplicity of cultural, social, economic and geographical factors have been found to determine treatment-seeking behaviour (Kleinman 1980, Foster 1997).

2.7 Sexually Transmitted Infections

Significance of STI control

Globally, the field of STIs has been a dynamic area of public health. During the past two decades, this field has evolved from one emphasising the traditional venereal diseases of gonorrhoea and syphilis, to one concerned with the bacterial and viral syndromes associated with *Chlamydia trachomatis*, herpes simplex virus (HSV), human papilloma virus (HPV), and the HIV. Over 20 organisms and many syndromes are now recognised as being sexually transmitted. All these STIs are historically, biologically, behaviourally, economically, and programmatically interrelated (Cates and King 1998). Long-term health consequences make controlling these infections a crucial public health priority. The role of both ulcerative and non-

ulcerative STIs in facilitating the HIV epidemic has been confirmed through both epidemiological and intervention trials (Plummer et al. 1991, Laga et al. 1991, Grosskurth et al 1995). High rates of HIV seropositivity have been found in populations that already suffer high rates of STIs (Laga et al 1991). In Zambia, in 1991, 60 percent of males and 69 percent of females attending STI treatment in Lusaka tested positive for HIV (UNAIDS 2002). Thus, controlling STIs should become high priority and a cost-effective investment in preventing the spread of HIV. At Cairo in 1994, STIs became an integral part of the global reproductive health agenda (United Nations 1994).

Since one way to slow down the transmission of HIV is to prevent and control STIs through effective cure, in the STI arena cure is part of prevention. Proper treatment of persons infected with curable STI serves several preventive functions, as follows:

- ◆ The reservoirs of sexual transmission are eliminated-this represents primary prevention;
- ◆ The more severe complications are prevented-this represents secondary prevention;
- ◆ Patients can be counselled to reduce high-risk sexual behaviour and to refer sexual partners for treatment-primary and secondary prevention; and,
- ◆ Treatment of curable STI may reduce concurrent transmission of HIV.

For these reasons, STI prevention strategies employ approaches such as diagnosis and treatment that are typically considered to be in the domain of the clinician rather than public health or community health practitioner. Thus curative and preventive efforts are complementary in STI control.

STIs in Zambia

STIs have long been a major public health problem in Africa (Osaba 1981). In Zambia, reports on STIs date back to 1910. Callahan and Bond (1997) report that in the early 1900s the colonial government medical officers noted a high incidence of "venereal diseases" in communities around or close to the urban centres. Reports from the western region of the territory indicated that syphilis was assuming epidemic proportions during the same period. Between 1973 and 1978, the number of STI patients attending government health facilities nearly doubled and in 1978, 75,000 cases of syphilis and gonorrhoea were reported (Callahan and Bond 1997).

Concerted efforts to curb the spread of STIs began in the early 1980s when the MOH established the National STI Control Programme (NASLTCP). The aims of the programme were: to improve management through specialised STI clinics at provincial and district levels; to train personnel in STI management; to conduct health education to increase public awareness; and, to coordinate STI Research. The patterns of infections are often measured through sample populations attending STI and antenatal clinics. These samples, however, are not necessarily representative of the total population. Nevertheless, these data have been useful in providing an overview of the patterns of infections. The data, particularly those of pregnant women attending antenatal clinics, show that the incidences of STI have steadily increased in the last 10 years. Data from 1987 from 6 urban health centres showed that eight percent of pregnant women attending antenatal clinic were found with syphilis (Hira et al. 1990) whilst data from 1994 showed that 17.5 percent of pregnant women attending clinics

in Lusaka were found with syphilis (UNICEF 1995). Estimates show that the national incidence rate for STIs among people older than 15 years attending public health care facilities is 101 per 10000 (Zambia CBoH/MOH 1999). Within the Zambia health reforms, STIs are identified as one of the six thrusts that together contribute 90 percent of diseases burden in the country (CboH 1997).

Zambia has adopted the WHO/UNAIDS management guidelines. Both syndromic and aetiological STI management approaches are applied (UNAIDS/WHO 1999). Unfortunately, well-designed studies to evaluate standard STI management are few and never comprehensive. Allocation of resources for specific STI control activities is not clear. Inadequate diagnostic and laboratory equipment as well as the erratic supply of the recommended drugs has hampered the effective implementation of syndromic and aetiological management of STIs as recommended by WHO/UNAIDS (Ndubani et al 2001). At both community and health facility levels, STIs are highly stigmatised. Stigmatising infected individuals by widespread social disapproval hinder effective STI control through delayed care or increasing denial of high-risk behaviours.

2.8 The HIV/AIDS Situation

HIV/AIDS and its socio-economic effects

In Zambia, the first AIDS case was diagnosed and reported in 1985 and over the years, the magnitude has increased considerably. UNAIDS indicate that 120,000 people died of AIDS in 2001 (UNAIDS, 2002). In 1998, the urban prevalence rate was more than 28 percent and the rural rate was 13.6 percent (Zambia CBoH/MOH, 1999). As elsewhere in the sub-Saharan region, the predominant mode of transmission is heterosexual (Barnett and Blaikie 1992). Mother-to-child transmission is second with 30 - 40 percent of children born to HIV- positive mothers acquiring the infection (Zambia CBoH/MOH 1999). The spread of HIV continues to be exacerbated by a number of socio-economic factors including the high levels of poverty. Several researchers have come to the conclusion that there is a clear link between AIDS and poverty throughout the world (Ankrah 1991, Schoepf 1991, Farmer et al 1995, Aggleton 1996). Estimates show that 80 percent of Zambians live in absolute poverty (CSO 1997b), a situation that makes them highly vulnerable to HIV. Since the advent of the epidemic, life expectancy has declined from 54 in the mid-1980s to an estimated 37 years today. The rising mortality in the adult population is leading to an increase in the number of orphans and street kids. There are currently 570,000 children who have lost their mother or father or both parents to AIDS and who were under the age of 15 years at the end of 2001 (UNAIDS 2002).

The role of the government in HIV/AIDS prevention

Initially the response to HIV/AIDS epidemic was slow partly due to denial and partly due to fears that discussions about AIDS and safer sex or other sensitive subjects would quickly erode the moral fabrics of the Zambian society. Indeed the history of HIV/AIDS raises difficult questions about culture, sex, death and social patterns of behaviour (Standing 1992, Gausset 2001). Prevention efforts in Zambia, as in other countries, have experienced some difficulties. Some of the factors hampering effective prevention include limited health resources, misconceptions about HIV and AIDS, and the social and cultural context of HIV and AIDS (Venier 1998). Because of the long incubation period between HIV infection and the clinical manifestation of AIDS, risky behaviours are not easily perceived as associated with HIV infection.

Consequently, witchcraft beliefs and accusations take the centre stage (Yamba 1997, Dover 2001).

Although rather coming late, the Zambian government's commitment to addressing the issue of HIV/AIDS using multi-sectoral approach has been reflected in the establishment of focal points persons in every government ministry. Government ministries appointed focal points persons to co-ordinate HIV/AIDS activities. The establishment of the National AIDS Council (NAC) reaffirms the government's commitment to a realistic and workable response to HIV/AIDS in the country. In order to have a much more structured and consolidated national response to the HIV/AIDS epidemic, Zambia produced and adopted a national AIDS Strategic Framework for the period from 2001 to 2003 to guide the multi-sectoral response (NAC 2000).

The role of Non-Governmental Organisations (NGOs)

In supplementing government efforts, several NGOs rededicated their efforts by becoming directly involved in all areas of the response to HIV/AIDS. Among the pioneer NGOs were Kara Counselling and Training Trust, Family Health Trust (FHT) and Copperbelt Health Education Project (CHEP). These NGOs and many others, provided a number of services including counselling and testing, HIV/AIDS awareness activities, work with commercial sex workers, training youths and other vulnerable groups in income generating skills. Home-based care is one activity in which NGOs and churches have played a pivotal role. The Network of Zambian People Living with HIV/AIDS (NZPLWHA) has helped to raise awareness about the disease among the general public in order to lessen the problem of stigma. Many other organisations at national, provincial and local levels have provided similar services, educating people about HIV and caring for people with the virus. Intensive efforts by NGOs and the government to raise awareness about the epidemic and to encourage people to change their behaviour have yielded some success. Recent studies show that there has been a decline in the HIV prevalence among women aged between 15 and 19 years (Fylkesnes et al 2001). There has been a decline from 28 percent in 1993 to 15 percent in 1998 in this age group. As in other parts of sub-Saharan Africa, this has been attributed to behavioural change among both men and women (Ng'weshemi et al 1996, Kilian et al 1999, Kamali et al 2000, Fylkesnes et al 2001, Agah 2002).

Future challenges

Zambia still faces many challenges in the fight against the HIV/AIDS epidemic. One of the serious challenges is the adverse macro-economic situation. Anti-retroviral drugs could alleviate the suffering of thousand of people who become infected and go on to develop AIDS. During the 2002, the government has pledged to increase access to and availability of anti-retroviral drugs. A sum of K12.5 billion (US\$2.7 million) has been allocated for the purchase of the drugs for 10,000 PLWHA. Nevertheless, Zambia will continue to face the task of mobilising adequate financial and human resources to mount an effective response against a largely poverty-driven HIV/AIDS epidemic. The numbers of people already infected with HIV point to enormous future care and support requirements. Risky sexual practices, misconceptions and stigma that still surround HIV/AIDS suggest that attitudes and behaviour are not changing rapidly in response to the epidemic. As others have noted, the enormous and complex task of preventing HIV on a community wide level requires not only medical but also social scientists such as anthropologists, sociologists and economists (Freudenthal 2000).

Thus any attempt to control the spread of HIV cannot focus only on the search for a vaccine or an effective cure. It must also take into account the complex social, cultural, political and economic contexts in which the disease occurs. The only realistic approach for years to come is to slow down the spread by influencing behavioural change and effective management of STIs.



Figure 2: A traditional healer showing some of his medicines.
The researcher is standing next to him.

3. CONCEPTUAL FRAMEWORK

A discussion on the prevention of STIs cannot be adequate without examining, in some depth, a conceptual understanding of sexuality. The serious threat of the HIV/AIDS epidemic has opened up a discourse on sexuality, and with it a discussion of men's roles and responsibilities. Two key areas of relevant literature will guide the conceptual framework of this thesis: namely, the study of sexuality; and, the understanding of sexual health-related behaviours and risks.

3.1 The Study of Sexuality

In analysing sexuality, a social constructionist perspective will be adopted in this thesis. Since the intellectual history of social constructionism is wide and complex, the discussion presented here provides a synoptic rather than a comprehensive review.

Dedefining masculinity and male sexuality

The definition of sexuality as provided by Gagnon and Parker (1995) is used. Gagnon and Parker (1995) define sexuality as “culture bound conventions, roles, and behaviours involving expressions of sexual desire, power, and diverse emotions mediated by gender and other aspects of social position”. Schwartz and Rutter (1998) also identify sexual identity, sexual behaviour, and sexual desire as the distinct components of sexuality. The cultural attributes of male sexuality may include diverse notions and ideas about manhood or “real man”. These notions, ideas and actions that reflect manhood or real man exemplify masculinity. Gilmore (1990) defines manhood as the approved way of being an adult male in any given society. More specifically, he argues that, it is about why people in many places regard the state of being a “real man” as uncertain or precarious, a prize to be won or achieved through struggle and living up to expectations.

The constructionist perspective of sexuality

Social construction theory drew on developments in several disciplines. It was, however, largely influenced by the North American tradition of symbolic interactionism and the interpretative strategies found in the sociology of knowledge (Vance 1991). In sexuality research, the first step was the reformulation of the general body of knowledge about sexuality within the constructionist framework. This body of knowledge emphasised the culturally and historically specific character of sexual conduct. The constructionist view was that sexuality is not based *primarily* on internal drives but it is elicited in specific historical and social circumstances. The general theory of sexual scripting emerged as a specific way of analysing cultural, interpersonal and mental aspects of sexuality (Kimmel 1990). Thus, sexuality was seen as a socially constructed assemblage of meanings and behaviours deriving from the values, norms, traditions and prescriptions within a particular culture (Vance 1991). If sexuality is socially constructed, it changes and it can be changed. The range of sexual behaviours available to women and men can be expanded and re-evaluated. Of course, such a process takes time, but the social constructionist perspective opened us to the possibilities of transformation and the responsibility to account for our own sexuality.

In Africa, anthropological evidence suggests *great* variability in sexual regimes and practices. Historically, the African reproductive order (family patterns, marriage forms, sexual regulation etc) differed from the Euroasian family systems.

In an article in "Africa" (1994) Caldwell, implicitly comparing Africa with a Euroasiatic model, suggests that there exists a distinct "African Sexuality" characterized by lack of moral restrictions and religious values. The greatest difference is the glaring sexual freedom of African women.

Obviously Caldwell, as many other Western observers, are not aware of the extent that the sexual and reproductive orders in Africa have been eroded in the confrontation with the West. In the past, in the pre-colonial Africa sexuality was embedded in a coherent social and symbolic order (religious beliefs or cosmologies explaining the meaning of sexuality and fertility). For example, the Kikuyu in the past were very open and explicit about sexuality, keeping it under strict regulation, while today sexuality is hidden in privacy under compact silence (Ahlberg 1994).

As the African moral order deviated from the European settings, the African cultures were wrongly understood. They were regarded as inferior and primitive and became objects of a "civilizing mission" that even alienated the educated African elites from their own history. Gausset (2001) has observed that, from the beginning, Western studies on sexuality in Africa focused mainly on the exotic aspects of sexuality (polygamy, adultery, circumcision, dry sex, levirate, sexual pollution, sexual cleansing various beliefs and taboos). He points out that, during the 19th century and early parts of the 20th century, studies of African sexuality written by missionaries and anthropologists espoused an ethnocentric point of view. These studies tended to describe all local customs as primitive. De-contextualised data by missionaries and colonial administrators focused on polygamy, sexuality outside marriage, inheritance of widows, circumcision and dry sex etc. These taboos and beliefs were described as irrational, and little effort was made to understand the broader socio-cultural contexts in which they were embedded.

In the Western world since the 19th century, sexuality has been cut loose from its yoke of reproduction and the family, so that today the pursuit of sexual pleasure, independent of marriage, is possible. The de-linking of sex from reproduction has been propelled by many social factors. Some of the factors were: urbanisation, which provides the possibility of sexual encounters with strangers; medical advances such as reliable birth control; and, technological innovations like the automobile which provides an opportunity to get away from the family to engage in sex. It is important to underline differences in the de-linking of sexuality from reproduction and family when one is viewing it from an African and not a European perspective. While the forces that brought about the change could be similar, the timing, the meaning and impact of the forces took place in different contexts and consequently, they bring different consequences. In comparison, these forces have far reaching outcomes for Africa than the West.

Even in the West an old moral regime was overturned when sexuality underwent medicalization from the nineteenth century on. A scientific regime replaced the old one (Foucault 1976). It meant a transfer of power from the church to the clinic. According to Foucault, something called sexuality was installed in terms of biomedicine and the biology of reproduction. There was a gradual progression away from the social body of relationships towards the physical body of sensation and pleasure. This move towards the human body, either in the name of reproductive health or sexual desire, paved the way for the individualisation of sexuality, i.e. de-linking sexuality from family obligations. Similarly, in Africa, the medicalisation of

sexuality was enforced under the banner of "sexual and reproductive health" and fostered by international organisations who mainly targeted women while the men were neglected until recently (Mbizvo and Basset 1996).

The next decisive step took place in 1960s and 1970s when controversial ethical issues were solved by biotechnological means (Contraceptives). The separation of sexuality and procreation opened for the "sexual revolution", a permissive sexual culture where old restrictions had lost their validity. The institution of marriage was weakened. Childless sex increased individual freedom. Women were declared sexually equal to men and women became sexually more accessible to men. If intercourse rarely aims at procreation, does the gender of the individuals involved matter at all? Globally, the gay and lesbian movements have called heterosexuality into question. Thus, a new "sexual-revolution in the making" has been introduced by movements that challenge heterosexuality. According to Manuel Castells (1997), the current challenge is characterised by de-linking of marriage, family, heterosexuality, and sexual expression of desire. In Africa, colonial experience, labour migration, urbanization, global trade restrictions, poverty - have all played an important role in the de-linking process. Many countries in the West saw to it that contraceptives; the pill, the IUDs and condoms were generally available and that the schools provided sexual education and contraceptive advice. In most of Africa there was resistance because of the way these technologies were being introduced. They were being forced onto the people without taking into account the local values, resulting in many family planning programmes failing.

The emphasis of research is shifting from sexual practices to the cultural rules and power relationships that construct them. The focus is moving towards the social organisation of sexual interactions, circumstances that influence men's and women's interpretations of their sexual experience. In the contemporary Western societies, sexual categories tend to be defined in terms of sexual preferences. In most of Africa, notions of gender and power play a dominant role in shaping sexual lives and sexual identities. In talking about men, sexuality and masculinity, it is particularly important to continually conceptualise the discussion in power and power relations. This includes power relations with women, children, young people and other men. In the analysis of men and masculinity, we should see men as existing and persisting in the material bases of society, with reference to particular social relations of production and reproduction (Hearn and Collinson 1994). In this case, 'men' refer to the category of people who benefit from particular gendered material relations around reproduction, housework, sexuality or emotional care (Hanmer 1990, Kimmel 1990). In comparison, masculinity is a conglomeration of attributes that are based on models of individual actions and which differ according to culture but which also have central cross-cultural aspects. In theorising about men and masculinity, Hearn and Collinson (1994), have argued for the socially constructed nature of these models and for pluralising of the term masculinity such that we talk of 'masculinities'. This means that there are different models of masculinities (Hearn 1990). Hegemonic masculinity is the idealised form of masculinity at a given place and time (Connell 1995). It is a model of male behaviour and an ideology of male superiority. It is the socially dominant gender construction that subordinates femininities as well as other forms of masculinity, and reflects and shapes men's social relationships with women and other men (Courtenay 2000). Notions of hegemonic masculinities are thus bound up with hegemonic sexualities. This implies that within societies that are male dominated,

some men experience subordination, stigmatisation or marginalisation as a consequence of their sexuality (Courtenay 2000).

Socialisation, gender and male sexuality

From a constructionist perspective, gender consideration is critical. Women and men think and act in the ways that they do because of concepts about femininity and masculinity that they adopt from their culture (Courtenay 2000). Gender is a "set of socially constructed relationships which are produced and reproduced through people's actions" (Gerson and Peiss, 1985). Gender is constructed by dialectical relationships (Connell 1995) and it is something that one does, and does recurrently, in interaction with others. Understanding gender differences contributes to a more complete picture of how sexual relationships and negotiations are enacted (Lear 1995).

In African societies, the family, through the process of socialisation, remains a crucial institution that defines both gender and sexual relations. Socialisation is a process by which members of a group learn and internalise the values and norms of the society (Piel 1985). This can be formal or non-formal but both serve the purpose of initiating boys and girls into adulthood. Zambian boys and girls go through a process of socialisation in which they are moulded into men or women (Ngulube 1989). In most rural settings of Zambia, traditional upbringing entails a separation between the way boys and girls are socialised into adult members. Boys begin to assume masculine tasks such as house construction, herding cattle, hunting and fishing, all of which are perceived to be heavy and sometimes hazardous. These tasks are considered fit for boys and not for girls and are seen as creating real men out of the boys (Ngulube, 1989, Dover 2001). During interaction with the adult males, any sexual abnormality in the boys or young men is identified. If a boy is perceived to be weak physically, he is doubted whether he is strong to able to marry and keep a wife. Being physically strong is important for the protection and feeding of the family (Ndubani 1998). For individuals perceived to be sexually weak, aphrodisiacs would be given to strengthen their sexual potency. When a young man is given potency medicines, he certainly is expected to ascertain whether the medicine has worked and the only way to do that is by engaging in sex. Setel (1996) describes how the Chagga people of Tanzania socialise the young men. He noted that, traditionally, undergoing initiation, entering an age grade, establishing a new home, and concluding a bride wealth marriage were key to establishing adult status for a man. These activities formed the transition from youth to adulthood, shaped men's entry into reproductive life and inculcated values of responsible manhood. There are certain things that a man should and should not do. Men are not supposed to wash clothes, bath babies or work in the kitchen - which is women's domain. These stereotypes, although slowly changing in most of Africa, they provide collective and organised meanings to gender. Men are encouraged to conform to these stereotypes that promote dominant masculine norms. Research indicates that men and boys experience comparatively greater social pressure than women and girls to endorse gendered societal prescriptions. Such as strongly held beliefs that men are supposed to be physically strong, they should be brave and should never cry, all convey deep rooted views about manhood (Ngulube 1989, Courtenay 2000).

In urban Zambian settings, the male adults such as grandfathers and uncles, whose traditional role is to initiate the boys, may not be available. Other forms of socialising

the boys have emerged and have become significant. These include the peer, the school, the media and the church. The socio-cultural values inculcated into the boys during growing up can have much influence on risk taking behaviour. Certain kinds of behaviours, which are in part expressions of masculinity, elevate the young men's risks for STDs including HIV transmission. Reciprocally, conforming to such masculine values and behaviours also victimizes women. It is ironic that in most of sub-Saharan Africa, in spite of pervasive dominance in many spheres of life, the men were for a long time, not a target for most health programmes (Mbizvo and Basset 1996).

Sexuality research and HIV/AIDS

The need for a robust constructionist sexual theory building became important over the course of the 1980s and 1990s as a direct consequence of the HIV/AIDS epidemic. As the relationship between sexual conduct and HIV infection became apparent, a fundamental lack of understanding of sexuality and sexual conduct cross-culturally became increasingly evident. Owing to the HIV/AIDS epidemic, the understanding of sexuality as a social construct has refocused its attention. Emphasis on the social organisation of sexual interaction; the contexts within which sexual practice occur; and the complex relations between meaning and power in the constitution of the sexual experience; have increasingly shifted attention from sexual behaviour, in and of itself, to the cultural rules which organise it (Frudenthal 2001).

Although great concern about AIDS has generally increased the interest in conducting and funding sexuality research, it has also encouraged the resurgence of biomedical approaches to sexuality research through the association of sexuality with disease (Vance 1991, Lear 1995). The medicalisation of sexuality is intensifying, as the public turns to medical authorities for sexual information and advice. However, these biomedical approaches have been criticised. Their approaches to sexuality often regard sexuality as a derivative from physiology and a supposedly universal functioning of the body. These models tend to be the most unreflective about the influence of culture in constructing categories about the body and health. Social construction approaches are virtually unknown, and the concept that sexuality varies with culture and history is expressed through primitive cultural influences (Vance 1991). There is a limited recognition that sexuality has a history and that its definitions and meanings change over time and within populations.

The influence of the biomedical models on sexuality research has also been clearly visible in Africa. Studies focusing on African sexuality became rare after the 1950s. This was because of the accusations labelled against earlier scholars of African sexuality for being Eurocentric (Gausset 2000). Any subsequent research on sexuality was strongly influenced by and conducted within the realm of family planning studies. They focused on gender and on the negotiation of sex roles rather than sexual practices. For decades anthropologists avoided the subject of sexuality. AIDS made it legitimate again to study sexuality in Africa. In the early years of the HIV/AIDS epidemic, biomedical research on AIDS dominated as researchers focused on trying to understand the epidemiology of AIDS. The research mainly concentrated on understanding why the epidemic in Africa was different from that of Europe and North America (Schoepf 1995). One suggestion advanced to explain the heterosexual transmission of HIV in Africa focused on African sexuality. It postulated that the rapid spread of HIV was as a result of high levels of sexual promiscuity among

Africans (Pakard and Epstein 1991). Because this assumption defined AIDS as a purely individual behavioural problem, the role of social scientists was not seen to be central but merely supplementing biomedical knowledge. Therefore, early AIDS research came to largely focus on individual risk behaviour, rather than social and cultural contexts within which HIV transmission occurred (Schoepf 1995, Aggleton 1996).

Drawing heavily on the insights of social constructionism, by the early 1990s it had become apparent that if sexuality research was to make an important contribution to the fight against HIV/AIDS, it would have to focus not only on the incidence of particular attitudes and practices, but on the social and cultural contexts in which sexual activity is shaped and constituted. Research attention would have to be drawn not merely to the calculations of behavioural frequencies, but to the relations of power and social inequality within which behaviour takes place, and to the cultural systems in which it becomes meaningful (Vance 1991). This marked the way forward for AIDS research and social scientists took up the challenge to enhance HIV/AIDS research discourse towards that direction.

3.2 Men's Sexual Health-Related Behaviours and Risks

Perceptions of risk

Over the past two decades, risk behaviour has become one of the most fundamental points of concern for public health scientists in understanding HIV transmission (Connors 1992). In order to modify risk taking behaviours, an understanding of why people take risks and how their perceptions of risk interact with risk-taking behaviour is needed. Risk-taking of one form or the other is part of nature, especially among males, and it can bring benefits (Cook and Bellis 2001). Whilst it is obvious that young men take more risks than most people in other age groups, it is not often obvious how members of this group perceive their risk behaviour and what mechanisms they use in rationalising risk. When does risk-taking start and end, and what are the factors that encourage it?

People often underestimate risk associated with voluntary behaviours (those they choose to undertake) whilst overestimating the risk from external sources. Further, individuals tend to rate their own risk of undesirable consequences as less than that of an average person. Thus people prefer to be in control of the risks they take, so that they perceive the behaviour they are in control to be less risky (Cook and Bellis 2001). In the beginning of the HIV/AIDS epidemic, research conducted in most parts of the sub-Saharan Africa on adolescents showed that most young people did not often perceive themselves as vulnerable to HIV (Mudenda 1992, Macwan'gi 1993, Lemma and Hassan 1994). Although the knowledge about HIV/AIDS has increased, this trend is still visible (Campbell 1997, Ndubani 1998).

Walman (2000) notes that risk is never context free: assessments of cause, gravity and what to do about it are governed by the context. Whilst understanding the social context of risk among men, it is important to answer questions as to why they take HIV-related risks. A detailed description of context also helps us to understand the link between social relationships, behaviour and the larger picture of how social influences may affect individual choices. Prevailing sexuality norms can undermine men's ability to engage in safer behaviours, especially when these are perceived to be

strong signifiers of masculinity. Furthermore, factors such as economic status, educational level, sexual orientation and social contexts influence the kind of risks that men take (Courtenay 2000). Cultural materialism Vs analytic personality psychology: A psychological anthropologist, Robert Levine (1973) has called this dual modality the “two systems” approach. He regards the individuals as having to balance two sets of demands as a member of society. The first stems from his own psychic conflicts; the second derives from without as a result of his need for cultural conformity and acceptance. The individual’s behaviour then is seen as a compromise solution to these separate and sometimes opposing pressures.

Sexual behavioural change

In the absence of a vaccine or cure for AIDS, the spread of HIV must be controlled through behavioural change. In most of sub-Saharan Africa, infections occur among young people with early sexual exposure (Kofi 1995; Venier et al 1998). As already pointed out, young men are likely to take more risks because of their sexuality. They know less about sexuality than older men, even though their knowledge of HIV/AIDS may be good, they can be highly variable in their adoption of safer sex (Lemma and Hassan 1994, NZioka 2001). What makes changing AIDS related behaviours so complex is that the risk behaviours are based predominantly on interpersonal relations. Reducing the risk for AIDS requires not only changing individual behaviour but also the style of negotiation and interaction between people engaged in the risk. The task of changing risk behaviour in a population of young men appears problematic when risk-taking is considered an essential ingredient of successful manhood (Connors 1992).

In the last two decades, a growth of research into the application of behavioural change strategies and models has been witnessed. Earlier studies in the area of behavioural change often focused upon demographic variables such as age, sex, race and socio-economic status as determinants of behaviour (Flowers et al 1997). These kinds of studies often resulted in defining specific groups of people and individuals as risk or non-risk groups. With the advent of HIV, public health research approached prevention from the perspective of population-level reduction of transmission. This also meant identifying groups or categories of persons at highest risk and targeting interventions specifically towards those groups. (Schiller et al 1994). As preventing HIV was seen as an issue of changing individual behaviour, or changing the behaviour of individuals in specific groups, educational campaigns were initially directed towards individuals. Psycho-social analysts working in the area of behavioural change applied models such as the health belief model [HBM] (Becker 1974, Becker and Maiman 1975), Social cognitive-learning theory [SCLT] (Bandura 1986, Bandura 1989), and the AIDs risk reduction model [ARRM] (Catania et al 1990). In applying these models, it is important to acknowledge the interplay of several variables including perceived susceptibility to HIV; perceived severity; perceived benefit of the proposed action; and perceived barriers (Becker and Maiman 1975). SCLT posit that the most important sources of new behaviours among most people are actually the peer group. This model has been said to have positive implications for HIV prevention because it emphasises the understanding of social norms and/or social support (Bandura 1986). The ARRM (Catania et al. 1990) categorises the process of change into three stages - labelling, commitment and enactment. Like the HBM, it rests on the premise that to avoid HIV infection, people exhibiting high risk activities must typically perceive that their sexual behaviours

place them at risk. Simply labelling one's sexual behaviour as a problem may not, however, lead to behavioural change without making a strong commitment to changing the activities.

These models, developed largely in North America, have been criticised mainly for focusing on the individual and paying less attention to the social context within which particular actions became meaningful (Singer and Weeks 1996). The models have also been criticised for the assumptions they make about rationality (Aggleton 1996). Whilst individual behavioural factors contribute significantly to most major health problems, the behaviour takes place in an environmental and a social context (Cates and Holmes 1998). In the prevention of the HIV/AIDS epidemic, particularly in the African context, many social scientists have turned away from the primary focus on individual behaviour to viewing individual behaviour as part of a culture shared by many other individuals (Streefland 1995). Anthropologists show that often individuals do not make decisions on their own and that individual behaviour must be seen in relation to specific social cultural contexts (Wallman 2000).

4. AIMS AND OBJECTIVES

The principal aim of this thesis is to analyse and describe young men's sexuality and implications for sexually transmitted infections (STIs) including HIV/AIDS so as to provide adequate information for the development of effective strategies to reduce sexual health problems among men in Zambia.

4.1 Specific objectives

1. To explore and determine sexual practices and perceptions of STI including AIDS among young men (I).
2. To describe knowledge, practices and the use of indigenous plants by traditional healers in the diagnosis and treatment of STIs (II).
3. To gain a better understanding of the interaction between the young men and traditional healers with regard to the treatment of STIs, infertility and/or impotency (II, IV).
4. To describe views and perceptions regarding men's sexuality including the desired qualities of a "real man". (III, V).
5. To enhance the understanding of young men's sexual health related behaviours in order to determine prospects for behavioural change (V).
6. To compare and contrast perceptions regarding sexuality and the experiences of STI/AIDS between rural and urban young men (Thesis).



Figure 3: "The image of a real man": The village headman in Chiawa.

5. METHODOLOGY

5.1 Study Design

These studies were carried out in two Zambian settings: Chiawa rural; and Misisi urban compound, Lusaka. The studies combined quantitative and qualitative approaches. The data collection techniques included semi-structured interviews, focus group discussions, in-depth interviews and observations. The studies in rural Chiawa were conducted over a period of eight years from 1993 to 2000 whilst in Misisi, a cross-sectional survey was done in 2001. This data offers the opportunity for comparisons both over time in Chiawa rural and cross-sectionally between the rural and the urban settings.

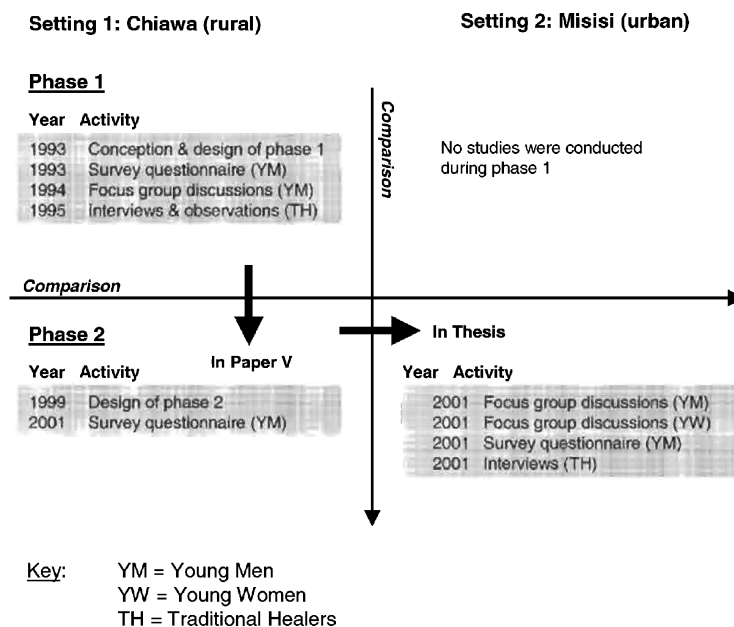


Figure 4: Presentation of study design.

5.2. The Study Contexts

Chiawa (I, II, V).

Chiawa is located in the lower Zambezi valley on Zambia's southeast border with Zimbabwe. It is about 150km from Lusaka, the capital of Zambia, and covers an area of 2,389 sq km. Most of the villages are scattered along the length of the valley, most of which are situated on the single-lane paved road that runs between Chirundu border town and the Lower Zambezi National Park. The estimated total population of Chiawa is 10,544 (CSO 2001). A female Chief is the traditional leader of the area and assisted by a senior village headman (*solomo*). Each village is under the leadership of a headman. This is usually an inherited position although appointments based on kinship relationships can be made. Family units are matrilineal in organisation with many households related to one another (Lancaster 1981). Individual households

(*mhuri*) are large, containing on average, 11 members and most of the units are extended families. The majority (72%) of the population call themselves *BaGoba*, (people of low-lying lands) and they speak *Korekore*, a Shona dialect (Bond and Wallman 1993). Sorghum, millet, maize, banana are the main crops cultivated in the area. Maize and fruits are cultivated along the riverbank gardens (*matoro*). Some of the main economic activities include fishing, trading in groceries and in second-hand clothes (*salaula*). Most young men find employment in the commercial farms and tourist lodges within Chiawa. A significant proportion of women are also employed on the commercial farms on a seasonal basis to pick marigold and paprika. The area has two government health centres located some 20 km apart. They both service villages dotted along the Kafue and the Zambezi rivers on a stretch of about 60 km.

Chiawa has undergone a lot of changes since we first started our project. The widening economic opportunities and increased mobility have exacerbated the HIV/AIDS epidemic. Trading places such as stores, bars, and restaurants have mushroomed. The near by Chirundu border post has grown bigger with over 100 trucks crossing every day. A bridge is being constructed and the construction companies have brought in workers from South Africa, Zimbabwe and other parts of Zambia. The population of commercial sex workers has considerably increased. Because of the worsening HIV/AIDS situation, the local Mission Hospital located at

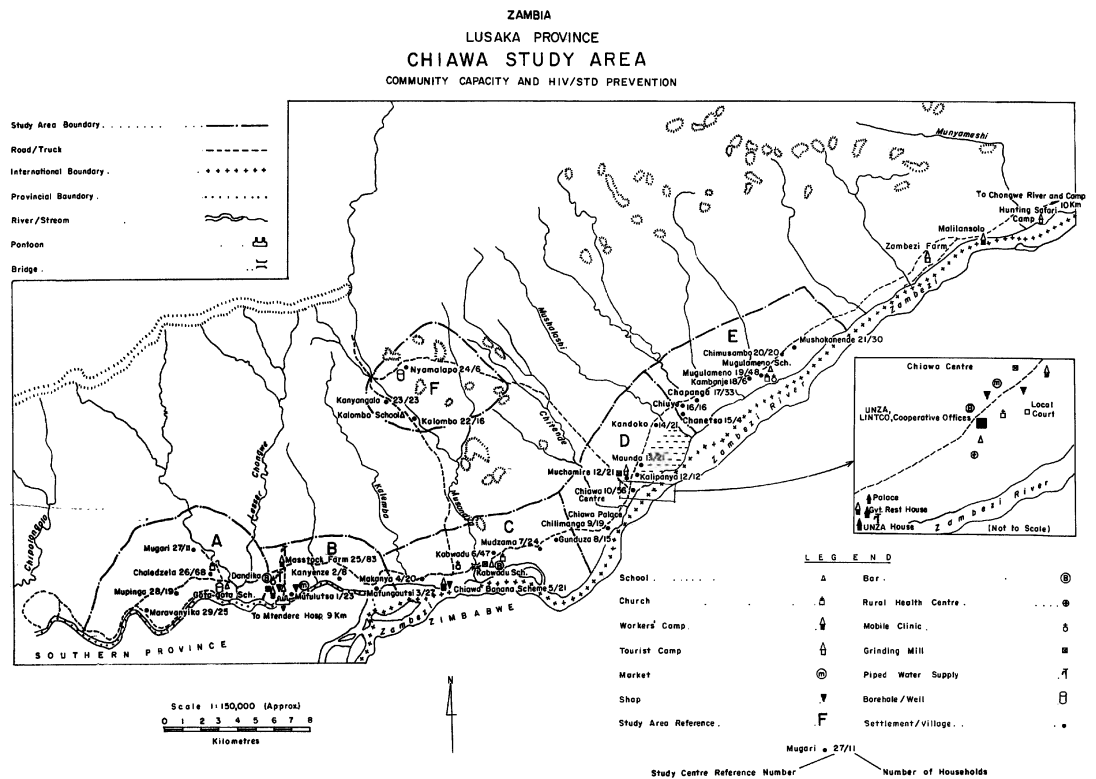


Figure 5: Map of Chiawa.

Misisi

Misisi, a shanty township very close to Lusaka city centre, is one of the many squatter settlements in Lusaka. It is estimated that 54 percent of Lusaka's population live in squatter areas, some of which are designated as illegal. The name Misisi was probably derived from an English word 'Misses or Mrs'. This could suggest that the very early illegal settlers worked as domestic servants in the low residential areas or as shop assistants in the main business centre. Its close proximity to the town centre is an attraction to many people who come to settle or lodge in the compound enabling them to easily access trading facilities in the town centre markets. Economic lives mainly revolve around the informal business activities. Arvidson and Yström (1994) found that the general unemployment rate was 68 percent and the majority of these earned their livelihood through small informal business ventures.

Misisi is one of the most controversial squatter settlements of Lusaka. It is one of those areas that are still considered illegal. According to the town plans of Lusaka Urban District Council (LUDC), this area is reserved for the extension of the city centre business area. But, at the present moment, there are over 23,000 people living in this illegal settlement who would have to be relocated if the council went ahead to develop the area according to its original plans (Arvidson and Yström, 1994). However, there are still plans by the LUDC to relocate the people of Misisi. The LUDC has already started the demolition of new structures on the outskirts. Like the rest of the southern part of Lusaka, Misisi is built on a limestone bed-rock that has been excavated for a long time to provide building sand and crushed stones. This activity has left deep holes in the ground that flood during the rainy season. The main toilet facilities are latrines. The high ground water level is very sensitive to pollution. Because of the environmental risks, cholera outbreaks are common in Misisi.

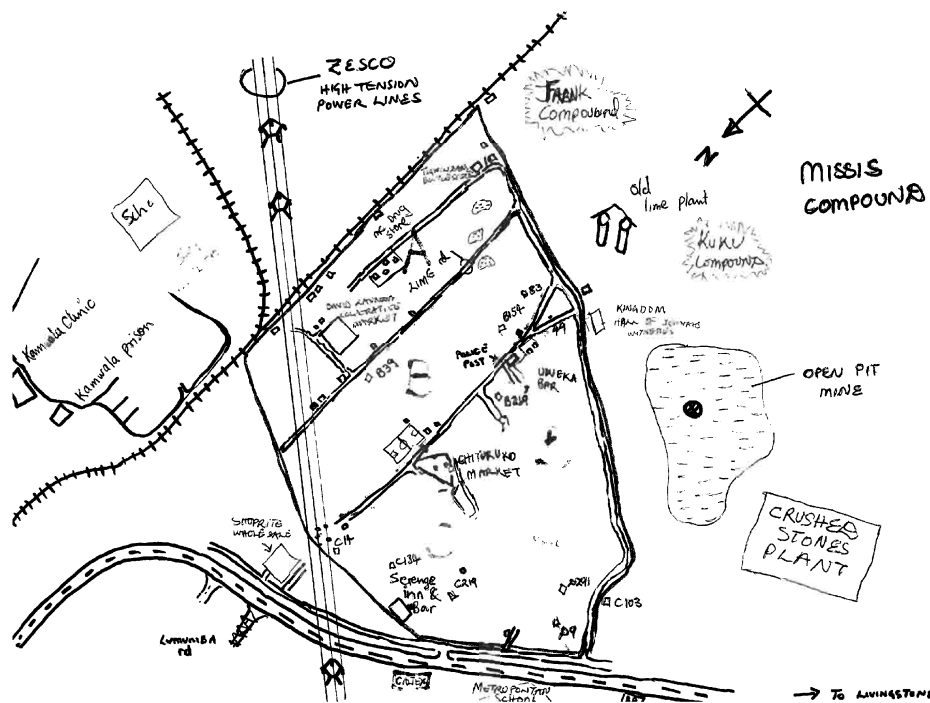


Figure 6: Map of Misisi.

5.3 Subjects and Selection

In Chiawa, the data collection consisted of a series of interviews, FGDs and observations with young men and traditional healers (I, II, V). In 1993, 126 young men aged 16 to 26 were purposively selected to take part in the study; 98 responded to a semi-structured questionnaire and 48 participated in FGD (I). Twenty-three traditional healers participated in the studies in 1995 to 1997 (II). This was a complete coverage of all the accessible healers (II). In 2001, the second survey of the young men aged 16 to 25 was conducted. Seventy-nine (79) of all the men enumerated at the beginning of 2001 were randomly picked and interviewed. As in the 1993 survey, a semi-structured questionnaire was used for data collection (V).

In Misisi, a cross-sectional survey was conducted during the first half of 2001. The study participants were young men aged 16 to 25 years, young women within the same age range and traditional healers. One hundred and fifty-three (153) of all the enumerated men were randomly picked and interviewed using a semi-structured questionnaire (III, IV) similar to the one administered in Chiawa. Another 44 men took part in FGDs. Thirty-seven (37) women were also invited for separate FGDs (IV). All the 36 traditional healers found in Misisi were visited and interviewed (IV).

In Chiawa, FGDs were used to supplement the questionnaire data that had been collected about a year earlier. This was meant to elaborate on some of the issues that were not clearly understood from the questionnaire data. In Misisi, FGDs were conducted before the interviews and so provided baseline information that assisted in focusing the interviews that followed.

Table 1: Presentation of the number of study subjects by site and data collection techniques used for each category of subjects.

Paper No	Site	Subjects	No of subjects	Data collection methods
I	Chiawa	Men	98	Questionnaire
			48	Focus groups
II	Chiawa	Healers	23	In-depth interviews
				Observations
III	Misisi	Men	153	Questionnaire
			44	Focus groups
IV	Misisi	Men	153	Questionnaire
			44	Focus groups
		Women	37	Focus groups
		Healers	34	Questionnaire
			2	In-depth interviews
V	Chiawa	Men	79	Questionnaire

5.4 Data collection process

Social researchers often note that survey response rates are a problem in any population-based community survey. These studies addressed this problem through carefully thought-out design, locally sensitive instruments and questions, appropriate interviewers, strict recruitment of those sampled and assurances of confidentiality. Among the selected respondents, there was also a belief that co-operation will be of benefit to them through improved availability of information on HIV/AIDS. In Chiawa, the tag 'UNZA anti-AIDS research' carried with it the notion that the project was there for research as much as it was there to enhance their understanding of and coping with AIDS (Freudenthal 2000). This notion was reflected in the local expression "*banetibatsira*" (they are helping us) which one often heard in the community. In explaining the high response rates in these studies, it is important to elaborate on the role of the research assistants.

Studies on sexual behaviour are sensitive and a skilful selection and use of research assistants or data collectors is important. In Chiawa, two male research assistants who were originally recruited and trained in 1991 were used throughout the studies. Their main roles were the recruitment of the participants and the administration of the questionnaires. They were local men who commanded some respect within the community. The initial selection of these men was based on the recommendations from the local village leadership and the area Chief. Thus both the young men and the traditional healers we interviewed had confidence in these research assistants. To ensure consistence and to minimize errors, the two assistants often took part in the design and testing of the instruments. Furthermore, their involvement at all levels of the studies was necessary to ensure that the questions were relevant to the local situation. The reliability of the responses also depends on the research assistants' skilful conduct of the interviews. In this case, not only was the selection of research assistants crucial, but also the training. The close supervision of the assistants by myself, as I always accompanied them into the field, ensured that the interviews were executed appropriately.

In Misisi, two men and three women were used for data collection. The men interviewed the young men, traditional healers and assisted me with FGDs. The women conducted FGDs with women. The two men were selected from a pool of 25 research assistants who were trained in 1995 during a community-based study on diarrhoea in which I participated (Kelly et al. 1997). The men have over the past three years been working as research assistants on the continuation phase of the diarrhoea project. They have been in constant contact with the Misisi community. This contact facilitated the interviews and contributed to the high response rate.

5.5 Data Analysis

The EPI-Info statistical programme (version 5 and 2000) was used for the analysis of the quantitative data. Descriptive statistics was used to describe the samples (I-V). Significance of associations, if appropriate, was tested by Chi-square. The FGDs and in-depth interview data was analysed using qualitative techniques. Audio-tapes from FGDs were transcribed and the verbatim transcripts were thoroughly reviewed. Recorded observations of intra-group interactions in the focus groups were also taken into account during this review. Thematic entities, categories and sub-categories were then derived from the data. Relevant excerpts of conversation from the transcribed

raw text were also selected and included in the results. Independent lists of common responses were produced and compared between the groups. Reliability analysis focused on the extent of verbal and non- verbal agreements among participants and consistency of findings across focus groups.

5.6 Ethical Issues

Ethical approval for the study was obtained from the Research and Ethics Committee at the University of Zambia and the Regional Ethical committee of Karolinska institute in Sweden. Studies I and II were approved in 1991 whilst studies III, IV and V were approved in 2000. In Chiawa, as a tradition, permission to carry out the research was granted by the Chieftainess. In Misisi the first level permission was sought from the local political leadership. For each of the individuals that subsequently took part in the studies, informed consent was always sought before they participated in the study. All individual interviews were conducted in confidence. Anonymity was guaranteed as no names have been quoted in any of the materials, published or unpublished. There are no known risks, social or physical, that have arisen from participating in these studies.



Figure 7: A village in Chiawa.

6. SUMMARY FINDINGS

6.1 Socio-Demographic Characteristics of the Study Participants

In Chiawa, a total of 177 men responded to the questionnaires in 1993 and 2001. Of the 177, 98 were interviewed in 1993 and 79 during 2001. Their average age was 21 years and the majority were not married (I, V). Christianity was the only formal religion in both surveys (I, V). Almost all the respondents, (94 percent in 1993 and 99 percent in 2001) reported having attended formal schooling (I, V). More respondents in 2001 (38%) compared with 1993 (15%) reported reaching secondary school level (I, V).

In Misisi, all the selected men (153) were interviewed in 2001. Their mean age was 20 years and like Chiawa, the majority were not married (III, IV). The education levels reported were primary (54%) and secondary (44%). Christianity was the only formal religion but 19 percent did not have any formal religion (IV).

In both sites, FGDs were conducted, in 1994 (Chiawa) and 2001 (Misisi). The participants were young men and women meeting the pre-designed selection criteria. The focus groups were homogenous in terms of age groupings and marital status (I, III, IV).

A total of 59 traditional healers were studied; 23 in Chiawa and 36 in Misisi. In Chiawa, the median age was 64 years whilst in Misisi it was 48.7 years. Two types of healers were interviewed in Chiawa; herbalists and diviners. In Misisi the healers were; herbalists, diviners and faith healers. The healers reported acquiring their healing skills mainly through: inheritance from a family member; trained in the church; taught by a fellow healer; and taught by a family member (II, IV). They reported being specialists in treating a wide range of illnesses (II, IV).

6.2 Social and Economic Situations of the Young Men

In Chiawa, during the 1993 survey, 39 percent of the respondents were in formal employment compared with 44 percent in 2001 (I, V). Men in Chiawa have opportunities for formal employment in the commercial farms, tourist lodges and the Department of National Parks and Wildlife. In 2001, 86 percent of all the men said that they made financial or material contributions to household living in form of money, food or labour in the field (V). Twenty-seven percent said they were heads of households in which they were living. Forty-nine percent owned the houses they lived in.

In Misisi, only 14 percent of the men were in formal employment, reflecting acute shortage of employment opportunities in urban Zambia. About half (52%) said they made financial or material contributions to household living and the contributions made were either in the form of providing money or food (III). Fourteen percent said that they were heads of households in which they were living and only 7% personally owned a house.

Both in Chiawa and Misisi, higher proportions than those who reported formal employment contributed to household living. Most of these earned their income through informal sector economic activities (III, V).

6.3 “Real Man” and Sexuality

A real man was considered to be one who is married, has children, has a decent job, cares for the family, and can sexually satisfy his wife (III, V). Ninety-seven percent in Chiawa and 76 percent in Misisi considered themselves to be real men (III, IV). Almost the same proportions (24%) in Chiawa and (25%) Misisi had children. When those with children and those without children were asked about the number of children they desired to have in a lifetime, four children were found to be the desired number in both Misisi and Chiawa. Economic justification was the rationale behind four children desired (II, V). More young men from Chiawa (30%) than in Misisi (11%) had a member of family whom they considered to have influence on the number of children they would have. In Misisi, the father was the family member mentioned by two-thirds of those who had someone, whilst in Chiawa, the range was wider although a *sekuru* (maternal uncle) or a brother were more likely to be mentioned (III, V).

During the first survey in Chiawa, 50 percent of the unmarried men reported having sexual partners and 11 percent of the married had extra-marital sexual partners at the time of the interviews (I). During the second survey (2001), among the unmarried, 33 percent reported having sexual partners whilst 13 percent of the married had extra-marital sexual partners at the time of the interviews (V). In Misisi, 49 percent of the unmarried and 23 percent of the married had pre-or extra marital sexual partners at the time of the interviews (III). The reasons for multiple sexual relationships were varied but were mainly related to traditional expectations of manhood (I, III, V). More young men in Chiawa, (53%) compared with Misisi (33%) said that they had had someone, such as a grandfather, an uncle or a teacher, socialise them about sexual matters when growing up into men (III, V). They also recalled having been socialised about a number of sexual matters. The common ones in both areas were how to propose and make love to a woman; and, to abstain from sex until marriage (III, V).

6.4 Sexual Health Problems and the Role of Traditional Healers

Fifty-nine percent in Chiawa and 90 percent in Misisi identified some of the sexual health problems affecting the young men. In both sites, the main problems were; inadequate access to health care facilities, diseases including HIV/AIDS, and unemployment (IV, V). In Chiawa, in 1993, 23 percent reported having suffered from an STI in the past (I) whilst in 2001, 24 percent reported that they had suffered (V). In Misisi, 26 percent had suffered in the past (IV). They reported going to different health care providers to treat the STIs (I, IV, V). Both in Chiawa and Misisi, traditional healers were indicated as an essential option for treatment for STIs (I, IV, V). In Chiawa, the healers treated three main STI syndromes using up to 19 different species of medicinal plants to treat STIs (II). Five of the healers could refer clients to the public health facility (II). The healers were also reportedly treating impotency and infertility (IV).

In Chiawa, 31 percent and 41 percent of the men reported infertility and impotency, respectively, as common problems. Slightly over half of all the men said they personally felt concerned that they might be infertile (V). In Misisi, 42 percent and 47 percent of the men reported infertility and impotency, respectively, as common

problems in the area. Twenty-eight percent of all the men said they felt concerned that they might be infertile (IV).

6.5 Perceptions of STIs and HIV/AIDS

Majority (91%) of the men in Chiawa, compared with less than half in Misisi (41%) said they considered themselves to be at risk of contracting HIV infection (III, IV). In Chiawa, they considered themselves to be at risk because of basically their inability as men to control sexual desires; lack of trust in the spouse/sexual partner; unreliability of the condom; ignorance about their own HIV sero-status; and that HIV could be acquired in many ways other than sex (V). In Misisi, over half (59%) did not consider themselves to be at risk of contracting HIV because of they reportedly were; abstaining from sex, had not suffered from STIs in the past, sticking to regular partner or wife, or using condoms. They were aware that if one suffered from an STI it meant that their behaviour put them at a higher chance of contracting HIV. Conversely, it means that those who considered themselves to be at risk were not adhering to the above or may have suffered from an STI in the past.

In Chiawa, 96 percent as against 58 percent in Misisi, said they were aware that HIV could be passed from mother to child. These were asked whether they ever considered the risk of HIV or would in the future consider HIV when making decisions to have a child; 39 percent and 18 percent in Chiawa and Misisi, respectively, responded in affirmative (III, V). In 1993, 94 percent believed that condoms could reduce the risk of HIV whilst only six percent said they used a condom all the time they had sex (I). In 2001, 86 percent believed that condoms could reduce the risk of HIV whilst 27 percent said they used a condom all the time they had sex (V). In Misisi, sixty-seven percent believed that condoms could reduce the risk of HIV. Nineteen percent said they used condoms all the time they had sex (IV).

6.6 Summary of Focus Group Discussions

Discussions with young men in Chiawa (I)

The discussions suggested that most of the men in the area became sexually active by mid-teens. They reported that it was common for young men to experience sex as a teenage. Sexual experience was perceived as an integral part of growing up into manhood. Men were perceived to have uncontrollable sexual desire (*nhomba*). They indicated that at one stage during adolescence, a young man must have sex, failure to which their sexuality will be doubted by both the peers and some of the adult male relatives, especially the *sekuru*. Pre-marital sexual relationships were viewed to be a norm. Unmarried men were perceived to be free to engage in multiple pre marital sexual relationships. For the unmarried, having one sexual partner was equated to "eating the same relish everyday". They said that married men were socially restricted in their freedom to have extra marital relationships. Even then, married men had exceptional circumstances when casual sex was tolerated, such as when the wife was pregnant or breastfeeding. With the exception of HIV, the contraction of curable STI was sometimes expressed as a sign of manhood, although if untreated could have adverse effects on sexual potency. At the same time STIs were stigmatising because they were associated with prostitution, as one of the local terms *matenda ye chihure*, (diseases of prostitutes) suggests. Herbal medicines were preferred in the treatment of

STIs because, some of it helped to restore sexual potency that could have been lost due to the infection. The major problems with the formal health services were stigma and that the young men were not welcome. There were also fears about lack of confidentiality in the health care facilities. The fears about lack of confidentiality are illustrated by the observation made in text box One, which I recorded as my field notes.

There were mixed feelings with regard to the use and efficacy of the condoms. However, it was clear that the majority did not freely subscribe to condom use. Some of them reported meeting resistance from women who insisted that condoms were for prostitutes. Others saw condoms as a threat to manhood, alleging that frequent use of condoms could negatively affect sexual potency.

Text Box 1: The story of Mufalo (Not real name)

The story of Mufalo

One mid-morning, I was at a shop located in the centre of Chiawa village, talking to two men. A third man appeared, looking for Mufalo (a local young man). "Have you seen Mufalo anywhere around here?" inquired the man. "Yes, he has gone to Muyanje village to look for Mr. Chibote" replied one of the men in my company. "Since very early in the morning, Mufalo has been desperately looking for Mr Chibote", continued the man. After the man left and headed for Muyanje, I was curious and asked the two men I was standing with why Mufalo was looking for Mr. Chibote. "Mr. Chibote treats STDs and Mufalo is suffering from one" said one of the men. "How do you know that Mufalo has an STD?" I asked. "One of the staff at the health centre where Mufalo had gone to seek treatment told me", replied the man. "Are you saying that the health centre staff told you this information", I further inquired. "Yes they did", he insisted. "Why should the staff tell people such confidential information?", I protested as I set off to confront the staff at the health centre.

Discussions with young men in Misisi (III, IV)

The discussions revealed that most young men in Misisi were earning their livelihood through small-scale business ventures. Compelled by the need to "fight" for survival, thieving becomes an inevitable option for many. Most of them were of low education and they felt that the limited jobs available were for the educated. They stated that, due to idleness, drinking beer and taking drugs became the main pass-time hobbies for most young men.

A real man was seen to be one with good behaviour. He was considered to have a decent job, married and have children. Those young men who judged themselves against these did not perceive themselves as real men. The men also agreed that a real man was the one who sexually satisfied his wife. A man who satisfied his wife was simultaneously perceived to be capable of making her pregnant. Without children in a marriage, the man was impotent or infertile. They said that if a young man did not

propose a girl, he was not a real man. All the men, in almost all the groups, seemed to agree that 2 to 3 children were the most desired number of children in a family. Economic justification was given for this number.

The discussions from all the groups indicated that STIs were common, most of which were due to the "tavern women". AIDS was perceived as a more fearful disease than the "petty" illnesses like *bolabola* (*lymphogranuloma inguinale*) and other STIs that were also believed to come from women. Among some of the participants, TB was affecting many young men because it was also believed to result from heavy alcohol consumption. They said that, as much as the young men wished to go to the local health centre, in most cases they did not due to lack money to pay for the services. They acknowledged that traditional healers were a viable medical alternative, especially when it came to treating STIs and giving medicines for manhood. Although, generally condoms were seen as a preventive tool worth using, some did not see condoms as a solution. Instead, abstinence was seen as the right thing to do. They mentioned that consistent use of condoms was difficult mainly due to drunkenness.

Discussions with young women in Misisi (IV)

As already mentioned, four group discussions with women were held. The findings on men's sexual health problems are presented in paper IV whilst the women's views about a real man, although presented here, are unpublished.

In all the women groups, the recurring themes describing the men's economic and social situations were; laziness, idleness, loafers, thieves, drunkards and dealers. They acknowledged the genuine fact that employment was hard to come by but also felt that many young men were irresponsible. The women observed that, excessive beer drinking increased the chances of casual sex including interaction between the young men and prostitutes, as a result exposing themselves to the risk of HIV infection. Rooms could be hired in local bars and restaurants for casual sexual encounters. The women said that, some of the young men took psychoactive drugs that made them become physically violent.

The women said that there were a range of places men could go to when ill. They included: the hospital; traditional healers; and the local clinic. Those with money went to private surgeries. Those who wanted medicine for manhood also preferred traditional healers. They said that not many young men accessed the public health care facilities or health information. The women supported the views that most men in Misisi rarely used condoms unless they found that the sexual partner was coughing-coughing seemed to be a strong proxy for HIV in this community. They also pointed out that most men only used a condom during the initial sexual encounters with a new lover. They said that women could not persuade their husbands to use condoms except in situations where the woman "caught him red-handed with a prostitute" then the husband would oblige to use a condom with the wife.

In all the women groups, a real man was considered to be the one who bears children, a man who feeds and dresses his wife, a man who does not beat up the wife, self-disciplined and employed. Sexually, he must be a man who "makes more rounds". They said that, in bed he should be *moto* (fire). A real man ejaculated proper semen, which they said, felt hot and made the woman weak soon after sex. The man should

not be impotent, with a weak penis. They added that an impotent man ejaculated light watery semen and this, according to them, had no capacity to make a baby. They said that a real man was recognised through children. They emphasised the ability to make a woman pregnant and have children.

Interestingly, some of the women added that a real man was the one who did not expose his extra-marital relationships to his wife. If a man exposed his extra-marital relationships to his wife, such a man was disrespectful and lacked affection. They further stated that a real man should never beat his wife but instead should buy her nice clothes. Ironically, some of the women perceived beating by husbands a normal thing in Misisi.

They acknowledged that the man determined the number of children in the family, as he was the head of the household. Because of this, the women were not committal on the desired number of children. However, some women said that these days there was more room for negotiation between the husband and the wife on the number of children. Some of them felt that if the husband needed more children than necessary, the wife could secretly use contraceptives.



Figure 8: Young men outside their *Kantemba* shop in Misisi.

7. DISCUSSION

7.1 Methodological Discussion

Challenges of sexual behaviour survey

Studying sexuality presents methodological challenges. These studies used multiple data collection techniques; semi-structured interviews, focus group discussions, in-depth interviews and observations. This triangulation approach enhances the understanding of social behaviour including sexual behaviour (I, III, V). The advantages of triangulation have been documented (Denzin 1989, Hauser 1993, Webb 1996). The studies drew on data from three main sources: the men; traditional healers; and, to a lesser degree, young women. Triangulation ensured that the data was grounded in the living circumstances of the study participants. The studies in rural Chiawa were conducted over a long period of time thus offering a chance for a better qualitative and quantitative understanding of sexuality and the contexts (V). Having resided in Chiawa facilitated a better understanding of the local culture and rapport with the community.

Because the surveys had to rely on what people said they did sexually, observations were very much an integral part of data collection and validation (I-V). I was aware that, what people said was more likely to be influenced by what they believed they were supposed to tell us. Despite this, survey research techniques are still one of the most efficient methods of assessing sexual behaviours in populations. Sometime ago it was believed that people would never tell the truth about their sexual lives. It has now been demonstrated that people do answer questions about sex and that the trends derived from their answers match other forms of evidence such as condom sales and STI prevalence (UNAIDS 2000).

Focus group discussions

The FGDs are a particularly appropriate method of data collection with populations of men, as found in a study of men's attitudes to female controlled methods of STD prevention in South-Western Uganda (Pool et al. 2000). Apart from the frequently cited benefits of FGDs, namely that they succeed in producing data through interaction and discourse in a group setting that one-to-one interviews may fail to generate they can also be a culturally sensitive data collection method. Invariably, this method is limited in that men are speaking in a group situation and therefore may be tempted to 'present a face', but as a means of accessing men's public discourse on topics of sexuality, this method of data collection is appropriate.

In these studies, FGDs provided a better understanding of how the men perceived their sexuality and the meanings they attached to it as well as how the women viewed some aspects of men's sexuality in Misisi. Unlike the men, I found the women to be more open than the men in their discussion of all the aspects of men's sexuality, especially sexual expectations, i.e. what a real man sexually meant (IV). Men do not generally discuss sexuality, sexual concerns, relationships or problems. As can be discerned from the data, there was much uniformity between the men and the women with regard to opinions about men's sexuality in the urban site. This was probably due to the fact that these men and women are a product of the same environment. Men's living circumstances including their sexuality impacts on the women as much as the

women's situation does on the men. In both men's and women's groups, the social plights as well as the sexual dilemmas of the young men were clearly elaborated (IV).

Observations and in-depth interviews

Focus group discussions and questionnaire surveys may be limited in the extent to which they can generate valid and reliable data on sexual behaviour. Anthropological methods of observations and in-depth interviews undertaken repeatedly over a long period of time may result in improved data generation and recording (Peil 1985). Although these were public health focused studies, the integration of anthropological methods enabled me to elicit an "insider's" view. Observations were more specifically applied on healer-client interaction in Chiawa (II). These involved more than just looking at what was going on; I was able to interact with the traditional healers regularly; listening and asking questions. Because of my stay and association with local people, I fully explored the benefits of observational method. The traditional healers allowed me to observe them during consultations with clients and they freely revealed some of the herbs they used to treat STIs, otherwise knowledge of herbs is held in secret and can only be passed on to a member of the kin (II). In terms of understanding men's sexual behaviour, the observations also complemented both FGDs and questionnaires (I, III, IV, V).

Data validity, reliability and quality

The process of data validation, reliability and quality control was ensured from design, data collection, analysis to interpretation. Using survey interview, FGDs and observations, I was able to crosscheck the validity and reliability of each data source. However, it must be acknowledged that the validity of this data was more difficult to establish than its reliability. Studies on knowledge, attitudes and practices have generally been found to lack validity because stated intentions are never matched by corresponding behaviours (Hauser 1993). On questions about sexual practices, it was not always easy to ascertain whether what the young men said was really what they did. For instance, it was difficult to validate what the respondents said about the number of sexual partners they had.

Beyond the issues of validity and reliability, however, there were usually other problems. Random sample surveys of sexual behaviour of young men required time, logistical and financial resources and that explains our small sample sizes in both urban and rural surveys (I, III, V). Another problem was the low levels of literacy. The use of anonymously self-completed questionnaires was inappropriate in these settings. Instead, trained research assistants and myself administered all the questionnaires. It might have been socially limiting for some respondents to discuss sexual behaviour with people who were older. Using local and familiar people could have had its disadvantage. Being interviewed by a person who is well known raises the question of whether the respondent can truly confide in the interviewer without the fear of the discussions being revealed to other people. In order to overcome this problem, a careful selection of the interviewers was made. We chose people who commanded confidence and respect. In terms of ensuring data quality, they were closely supervised. At the end of every interview day, they would be debriefed and the questionnaires collected and checked to make sure that they were fully completed and correctly filled in.

Statistical limitation

It must be pointed out that there are statistical limitations with the data. In terms of the questionnaires, the individual survey samples were rather small. Although the small samples did not affect the generalisability of the data because of randomisation, they did limit the statistical analyses that could be performed. However, there is consistency in the findings of these studies, an indication that the data was reliable. Triangulation of data collection techniques as well as data sources guaranteed both internal and external validity.

7.2 Socio-Economic Dilemmas

The relevance of socio-economic circumstances for STIs can be viewed from two levels. Firstly, social and economic circumstances may contribute to the greater risk of exposure to HIV. Secondly, local sexual norms, independent of socio-economic status, may contribute to greater risks by promoting perceptions of manhood that influence risk-taking. The young men in Misisi and Chiawa are obviously in the low socio-economic status groups and they are at greater risk of HIV infection (III, V).

One of the most persistent disease patterns observed in public health research is that people in the lowest socio-economic groups have the highest rates of morbidity and mortality. This differential has been observed throughout the world, regardless of whether the dominant disease was attributed to infectious or non-infectious causes. Whether socio-economic status was studied in relation to education, income, or occupation; the lower the socio-economic level, the higher the death rate (Cates and Holmes, 1998). These observations are pertinent to Chiawa and Misisi, and indeed to the rest of Zambia, where young men generally occupy lower socio-economic positions. Zambian young people are victims of both the economic restructuring process and the HIV/AIDS epidemic. Widespread poverty, high levels of unemployment and the high prevalence of STIs, all combine to pose a serious health risk (III, V).

Although a substantial proportion of the men were engaged in informal economic activities, the incomes and the levels of security are very low in the informal sector (III, V). However, this is not to imply that the other groups of people in Chiawa and Misisi are by far better off than the young men, rather the concern with this age group is universal considering their increased vulnerability to HIV. As Hawkes and Hart (2000) have observed, men are characterised not only by their sex and gender, but also a number of other social factors including age, sexuality, income, educational status, geographical location, access to information and their ability to put such information to use. They caution that, when considering the men, socio-economic and demographic factors must be taken into account when researchers wish to look at sexual health problems in men in order to discover their determinants. A survey in India showed that, men with higher levels of education, higher economic status and those living in urban areas, had better knowledge of reproductive health matters; they sought treatment more frequently and were more likely to protect themselves against STIs than other men (Singh et al. 1998). Whilst they found that those living in the urban areas were more likely to protect themselves against STI, to the contrary, we found that men in Chiawa rural were more confident and self-assured than those in Misisi. In Chiawa, the men were socially better off as they were more likely to be employed, own a house, head a household and positive about HIV/AIDS situation (V). This finding may contradict the widely held tradition that urban areas are often

better placed than rural areas in terms of socio-economic opportunities and information. Current development discourse, however, points to the realities of the 'push-back phenomenon' in most of the low-income countries. In recent years, there has been movement of people back to the rural areas as prospects of finding jobs in urban areas are diminished by severe economic hardships (Bergstrom 1994).

7.3 Real man: Local Interpretation of Male Sexuality

Opinions and beliefs about sexual norms were very uniform in this stratum of young men and the women. The concept of a real man (*murume chaiye*) embraced both social and sexual obligations. Sexual performance and the ability to make a woman pregnant is a critical ingredient of a real man (III, V). A real man is recognised, first and foremost, through children. The signs of growing up into a real man include the ability to propose love or to make a girl pregnant. There is a strong impression that both adult kin and peers exert pressure on boys to prove their sexual ability (I, III, IV). This social pressure can be enormous, as other studies have shown that boys or young men who violate actively enforced manhood expectations are usually ridiculed and despised and apparently, this is a worldwide phenomenon (Gilmore 1990). Studies in Latin America confirm that young men who too drastically departed from traditional ideas about male sexuality were almost automatically suspected of being homosexual, and risked being marginalised by their peers. In other areas, there was no evidence of a diversity of sexual types for boys. In general the boys said that one was either a man or a faggot. The Latin American forms of masculinity, represses femininity in men and promotes aggressive manliness (Asthana and Oostvolges 2001).

The labels directed at a man who deviates from the prescribed role imply that he has taken on the female role. My interaction with the young men in the two communities of Chiawa and Misisi, gave the impression that, in this process of disapproval by adult males or the peer, terms like; *se mukadzi or monga Mkazi*- literally meaning 'doing things like a woman') were meant to feminise the males who did not conform to masculine expectations. Asthana and Oostvolges (2001) note that, in India, unlike in Africa or Latin America, there is less pressure placed on the boys to adopt masculine attributes. They further note that, whilst certain qualities such as fighting against and competition with other men are defined masculine, the achievement of successful manhood is strongly bound up with reproductive behaviour than social performance. They further observed that masculinity was asserted and publicly acknowledged through marriage and more importantly through the production of children. In Chiawa and Misisi, as in the rest of Zambia, reproduction also plays a crucial role in defining manhood (III, V). The above accounts show that there are significant variations in the extent to which sexual norms are enforced in different parts of the world. Although there could be subtle differences, there are central aspects that are cross-cultural. This recognition of the relativity of sexual norms has led to the increased popularity of social constructionism, an approach acknowledged in changing the AIDS discourse by replacing the focus on individual behaviour to that of the community (Vance 1991, Streefland 1995, Wallman 2000, Asthana and Oostvogels 2001).

Psychosocial fears and concerns about manhood seem to form part of everyday life (III, IV, V). Concerns and fears about sexual inability in the African context can have devastating physical and psychological effects for both men and women (Isiugo-Abanihe 1994). They do not only lead to disruptions in marital life but can also lead to

risky sexual practices. In marriages where the woman has not been able to conceive, men have gone out to seek other women in order to prove that they can make a woman pregnant. The data from the women in Misisi (IV), and also data from other settings, indicate that women may exhibit the same kind of behaviour by seeking sexual relations with different partners in order to conceive (Gerrits et al 1999).

The men decide on the number of children because they are traditionally socialised to feel that they have the right to determine how many children their wives should have (III, V). In many Zambian societies, this is reinforced by *lobola* (bridewealth) that a man pays to the woman's family as compensation for the loss of her services and for reproduction. This is often interpreted by some men to imply that the man has "almost bought off" the wife and as a way of compensation she must bear him the number of children he wishes. Currently, unscrupulous fathers are abusing *lobola* through demanding exorbitant prices for their daughters. Some of the women NGOs are advocating for abolishment of the *lobola* system or advocate for more modest fees.

7.4. Risky Behaviours and STIs

The ideas about real man are very much related to sexual potency (III, V). Because these ideas connote that a real man is expected to take sexual risks, in this era of HIV/AIDS, the ideas may cause young men to be less receptive to messages regarding safer sex. Notions of what it means to be a real man in a particular social context can powerfully influence sexual risk behaviour. If young men have multiple sexual relationships and they engage in unprotected sex, then they are practising high-risk behaviour (UNAIDS, 2000). We found that the young men in Chiawa and Misisi were engaged in risky sexual behaviours (I, III, V). Risky sexual practices and spots perceived to be responsible for the spread of illnesses were identified (I, IV, V).

In order to modify risk taking behaviours, an understanding of why young men take risks and how the perception of risk interacts with risk-taking behaviour is needed. In Chiawa and Misisi, they took risks because some of the behaviours defined as risky are considered an essential ingredient of successful manhood. Furthermore, risk-taking is related to their age during which they want to experiment with sex (I, III, V). The behaviours are reinforced by the prevailing sexual norms and masculine prescriptions perpetuated mainly by the adult males and the peers. (I, III, V). The importance of peer influence on sexuality are recognised and documented (Feldman et al. 1997, Vanlandingham et al 1998).

It has been shown that people underestimate risk associated with voluntary behaviours. Young people tend to rate their own risk of contracting HIV as less than that of other persons (Mudenda 1992, Macwan'gi 1993, Sederowotz 1995). To the contrary, the majority of the men in Chiawa considered themselves to be at risk of HIV (V). This may be a positive or negative thing. According to behavioural change models, perceived susceptibility or the individual's perception about his own likelihood of contracting HIV is important. The models posit that once someone recognises that their behaviour puts them at risk, they are more likely to make a rational decision and alter that behaviour (Becker and Maiman 1975, Catania et al 1990). It is also important to look at why the young men in Chiawa perceive themselves to be at risk. The inability by men to control sexual desires, lack of trust in the females and the negative views about condom and the view that AIDS can be

acquired in other ways than sex alone, combine to explain why they considered themselves to be at risk (V). Whilst these factors are a true reflection of their perceptions regarding HIV/AIDS, they also demonstrate a lack of confidence in their ability to protect themselves. These are some of the local views that could hinder positive behavioural change even amid high levels of knowledge because they create fatalism. In Misisi, over half did not consider themselves to be at risk because they were abstaining from sex; had not suffered from STIs in the past; were sticking to regular partner or wife; and were using condoms (IV). These are the messages that are aggressively promoted by the anti-AIDS campaign. Studies show that although young people can demonstrate high levels of knowledge by naming these prevention messages, their knowledge does not always translate into safe sexual practices (Feldman et al 1997, Lema and Hassan 1994).

If risk-taking is intrinsic to maintaining manhood, what effects can safer sex messages have? Reducing the risk of HIV requires not only changing individual behaviour but also re-negotiation of dominant norms and patterns of interaction between and among young people engaged in the health risk. Young men are usually in a weaker position to re-negotiate these because of the external pressure from many sources including the peers and in recent years, from the pervasive influence of negative images from the media. For behavioural change to occur, the young men have to begin to realise that some of their behaviours place them at risk. The ARRM says that knowledge about HIV, perceived risk, HIV status and knowing a person with AIDS are an important precondition for progressing from labelling to the commitment stage (Catania et al 1995). My interpretation, based on this model, is that even though the young men in Chiawa and Misisi were able to label the risk behaviours, they were yet to move to the commitment stage. In the commitment stage attitudes to safer sex and positive social norms can be adopted (I, III, IV, V). I must, however, hasten to state that, in real life circumstances behavioural change does not always follow a predefined sequence, as implied by the model. The stages can never be mutually exclusive but, nevertheless, the model is important for guiding behavioural change efforts.

7.5 Sexual Health conditions and Treatment Options

In Zambia, as in many African countries, various medical alternatives are available (Wallman 2000, Good 1980, Sturgård 1985, Ndubani et al 1998). Traditional and western medical systems, and perhaps, many others forms have co-existed for many years. Hospital, local health centres, private surgeries and traditional healers are recognised as alternative sources of treatment (II, IV). Although the introduction of the health reforms was meant to improve efficiency and effectiveness, the reforms have been beset by infrastructural and financial problems. One of the main tenets of health reforms has been the introduction of the user-fees as a cost sharing measure. Due to the economic restructuring that has led to massive retrenchments in Zambia, many people have been systematically alienated from the health services. The unavailability of financial means is hindering many young people from utilising the health services, especially the public health facility. (IV). Drug scarcities are the order of the day in the public health facilities in Zambia. This means that the health sector reforms are not functioning optimally, at least in the eyes of the consumers (van der Geest 2000). Instead of being given the prescribed drugs, many patients usually end up with drug prescription slips with which to purchase the medicines from private pharmacies. There is a belief among the general public that drugs meant for them at

these health centres are diverted, a situation that seems to have given rise to the mushrooming of illegal drug stores and pharmacies.

The role of traditional healers in assisting with various forms of sexual health care needs was recognised (I, II, IV, V). More of the young men who reported having suffered from an STI went to private surgeries and the local health centre (III, V). This treatment-seeking pattern reflects what was more available and easily accessible in each of the settings. Our observations are that, in Misisi, private surgeries, like most traditional healers, operated on personal basis and thus were subject to price negotiations. Nevertheless, traditional healers were recognised as a second preferred option. The role of traditional medicine in dealing with sexual and reproductive health of populations in sub-Saharan Africa has been documented (Leeson & Frankenberg 1977, Gelfand 1980). The healers in Misisi were reportedly administering aphrodisiacs in the form of a wide range of herbal concoctions with various brand names such as 'gunpowder', 'African Viagra', *mutototo* (IV). In Lusaka, at market stands, traditional healers advertise their ability to cure impotency including some STDs. In most of Africa, traditional healers have long been treating STIs using a diversity of indigenous medicinal plants (Gelfand et al 1985, Stuağård 1985, Sofowaro 1993). A recent study by Kambizi and Afolayan (2001) presents a list of 15 plant species that were being used to treat STI in Zimbabwe's Guruve district. In Chiawa, derivatives from 19 plant species were being used to treat STI (II). Given that the public health services are mainly concerned with maternal child health (MCH), it is perhaps not surprising that men are compelled to take their problems to the private and traditional health care providers.

7.6 HIV/AIDS Perspectives and Prevention

In Chiawa and Misisi, HIV/AIDS was identified as one of the obstacles to good sexual health. Furthermore, there are still misconceptions about HIV/AIDS and sexual norms appear to exert influence on young men to be less receptive to safer sex messages (I, III, V). The studies also suggest a potential for behavioural change among the young men in Chiawa (V). Potential for behavioural change is in line with recent published literature in Zambia that show a reduction in HIV incidence attributable to behavioural change (Fylkesness et al 2001). Chiawa young men seem remarkably different from those in Misisi judged by the differences in perceptions about various aspects of HIV/AIDS (III, IV, V). In Misisi, they are rarely targeted by any health interventions (IV). Although many townships in Lusaka have peer educators, the respondents said there were none in Misisi at the time of the studies.

Although many people believe that condoms can reduce the transmission of HIV, in Chiawa, their use was found to be inconsistent (Bond and Dover 1979). Condom use is still problematic in Zambia (CSO 1997c, CSO 1999, CSO 2000). Our data points to the same trend (I, IV, V). For example, in Misisi, the women were insistent in stressing the reluctance by men to use a condom (IV). As with the male participants, the women had learnt from the media that condoms were responsible for some cancer and so were widely perceived to be harmful (IV). The social anxieties regarding the issue of sexuality affects population-level interventions by encourages paradoxical messages in the media (Cates and Holmes, 1998). And indeed in Zambia, young people receive contradictory messages. Condoms use is promoted by the NGOs who

often meet resistance from the church, traditionalist and some politicians who discourage condoms in favour of abstinence.

Scholars consider HIV/AIDS education as one of the most important tools in the prevention of HIV transmission (Awusabo-Asare 1995). However, HIV/AIDS education, especially among adolescents and young people, is not an easy task and many factors have to work together for AIDS education to have an effect. The conclusion that one draws from our data is that, in order for AIDS education to be effective, it has to be appropriate and refer to the specific sexual norms of the young men (I, III, IV, V). Many other researchers have also made the same conclusion (Mogensen 1995, Rivers and Aggleton 1993, Leap and O'Connor 1993). Peer education is considered to be especially suitable and effective in HIV prevention (Bandura 1986, Feldman et al. 1997, Gregson et al 1998).

8. CONCLUSIONS

These studies have been conducted to analyse men's sexuality and its implications for STIs including HIV. The influence of social variables in the field of sexuality is certainly preponderant in Zambia, where male sexuality is given prominence mainly because of its role in fertility. At the same time, young men are disadvantaged by many factors including the HIV/AIDS epidemic and limited economic opportunities that affect their access to formal health services and information. Although both settings are experiencing poverty, the young men in Chiawa are self-assertive. In Misisi, the young men's confidence seems to be eroded by their circumstances- unemployment, poverty, drinking, drugs, clandestine activities, breakdown of family influences- and that they are a group whose disadvantages make them spiral more towards risk.

Even though, sticking to one sexual partner and abstaining from sex, the main messages promoted in anti-AIDS campaign, are almost always verbalised by young men, core sexual norms associated with manhood, seem to make it difficult for them to live up to these messages. Multiple sexual relationships, misconceptions regarding HIV/AIDS, lack of adequate information, and ambiguities about and inconsistent use of condoms, all combine to pose major challenges in the fight against AIDS in Zambia.

In designing interventions to target men's sexual health, we must consider the full range of concerns voiced by the young men themselves. Whilst the policy makers, programme implementers and researchers may be primarily concerned with, and focus upon, the problem of STI/HIV, young men have a wider set of concerns. If men are to be encouraged to access services, services must therefore, reflect and respond to expressed concerns. In the absence of a vaccine or cure, education still remains the only strategy for reducing the spread of HIV. Peer education is specifically suitable and effective for HIV prevention. The way the educational interventions are designed should be such that they take into account the differences between Chiawa and Misisi not only in their rural urban differences but also in the composition and dynamic of the young men's sexuality. Traditional healers can also play a major role in sexual health care.

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