

**LOCATION, DISLOCATION AND RISK FOR HIV:
A CASE STUDY OF REFUGEE ADOLESCENTS IN ZAMBIA**

by

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Declaration

I declare that “*Location, dislocation and risk for HIV: A case study of refugee adolescents in Zambia*”, is my own work. None of the material contained in this thesis other than that acknowledged to other authors, has been previously submitted for an academic award in this or any other institution

Signature:

Lenganji Nanyangwe

Cape Town, April, 2006.



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List of acronyms and abbreviations

AHA	Africa Humanitarian Action
AIDS	Acquired Immunodeficiency Syndrome
ARRM	AIDS Risk Reduction Model
FAO	Food and Agriculture Organization
CORD	Christian Outreach Relief and Development
CRC	Convention on the Right of the Child
CSO	Central Statistical Office
DR	Democratic Republic
HIV	Human Immune Virus
IFAD	International Fund for Agriculture Development
IGA	Income Generating Activities
LDHMB	Lusaka District Health Management Board
LWF/ZCRS	Lutheran World Federation/Zambia Christian Refugee Services
MHC	Maternal Health care
MDG	Millennium Development Goals
NGO	Non-Governmental Organizations
OAU	Organization of African Union
P.	Page
PP.	Pages
PHC	Primary Health Care
RHC	Reproductive Health Care
RO	Refugee Officer

SCF	Save the Children Fund
SCT	Social Cognitive Theory
SPSS	Statistical Package for Social Sciences
STI	Sexually Transmitted Infections
UN	United Nations
UNAIDS	Joint United Nations Programme against AIDS
UNDP	United Nations Development Programme
UNESCO	United Nations Education Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations International Children's Emergency Fund
UNSSP	United Nations System Strategic Plan
WHO	World Health Organization
WFP	World Food Programmes

Abstract

Refugees are not a new phenomenon and their plight has been felt the world over. Africa continues to see large numbers of people displaced through armed conflict, producing more refugees on the worlds' most poverty stricken continent than any other.

The implications of these displacements of people dislocated from their places of habitual residence create much concern, particularly in the wake of the HIV/AIDS pandemic. Such dislocations and displacements imply separation from family and communities, including socio-economic benefits that accrue to them. There is an apparent problem of accessing health services, educational services, sources of livelihood and protection from sexual and emotional abuse. Refugee children and women are said to be the most vulnerable, although until recently adolescents in armed conflict were not considered as a special group of children requiring special attention.

The main objective of this research was to investigate levels of risk for HIV among refugee adolescents in Zambia and to determine how location relates to risk. Of particular interest was the difference in risk experienced in rural and urban areas. The researcher's hypothesis was that refugee adolescents in rural camps of Zambia are at greater risk because they lack adequate sources of income, health, and education in comparison to urban areas.

The research was located within two theoretical underpinnings namely the social cognitive theory and the AIDS Risk Reduction Model (ARRM). The theory posits that a reciprocal relationship exists between environmental contexts, personal factors and behavior. The model explains how people change behavior that reduces risk for HIV by changing perceptions on sexual activity and when they enact the knowledge obtained from HIV preventive programmes.

The methodology was located within both the qualitative and quantitative research approaches. Qualitative because firstly, the research is a comparative case study and secondly, it is the first time such a study is being conducted. The researcher also made use of the quantitative through the survey and secondary HIV/AIDS statistical data.

Chapter One

Key Words

Refugees
Adolescents
Dislocation
Rural and urban
Education
Health
Livelihoods
HIV/AIDS
Social Cognitive Theory
AIDS Risk Reduction Model

1.0 Background and Introduction

This thesis presents empirical evidence on the relationship between dislocation, socio-economic context of location (urban vs. rural) and risk for HIV among refugee adolescents residing in Zambia. The study was located within the underpinnings of behavioral theory and was specifically guided by Bandura's social cognitive theory and the AIDS Risk Reduction Model of Catania, Kegeles and Coates. This thesis necessarily unpacks the uses and limitations of the above two theoretical paradigms as well as addressing the issues of dislocation and risk.

Refugee adolescents in general experience varying degrees of dislocation from their families, communities and countries of habitual residence. A comparative methodology is used to analyze the situations and risks for HIV infection of refugee adolescents in a rural area (Mayukwayukwa refugee settlement) and an urban area (Lusaka) of Zambia.

Refugee adolescents residing in Zambia belong to a group of adolescents affected by armed conflicts and until recently were not regarded as a distinct group of children, facing particular challenges and requiring distinct attention.

Their distinctiveness came to the fore in 2000 upon release of the report by the Women's Commission for Refugee Women and Children: "Untapped Potential: Adolescents affected by armed conflict."¹ It was the findings of the report that resuscitated the memories of my own experiences with refugees during my period of humanitarian engagement at a refugee settlement in Zambia. My observations drawn from these experiences were that refugee adolescents experienced different risks for HIV depending on the context of their habitation (rural or urban) and their being dislocated exacerbated these. Theoretically, this is proven by related research on stable populations, but never with regard to refugee adolescents. This thesis has allowed me to test the accuracy of my own earlier observations and revealed in a deeper way the importance of recognizing refugee adolescents as a group of people at particular risk for HIV.

1.1 Rationale

According to the World Bank, children are the 'Window of Hope' forming the foundation for future development progress and security. The many decades of development effort and gains "will come to naught" if (children) cannot be protected from the deadly HIV/AIDS pandemic.² Yet in their policy paper on HIV/AIDS, Save the Children Fund (SCF) indicates that children and young people between the ages of 7 and 19 are the most vulnerable, unsupported, and marginalized group in HIV/AIDS prevention and care.³ Children in armed conflict are said to be especially vulnerable because of the reduction in social and economic services, including health, education and livelihoods.⁴

Despite the importance of this subject, there is little or no research on the subject of refugee adolescents and their vulnerability to HIV based on dislocation and context. Available research analyses the association between dislocation, socio-economic factors and risk for HIV within parameters of variables such as gender and social strata, and not on this distinct group of children. This forms the impetus of this study as it has generated new knowledge on which decisions on intervention and assistance to refugee adolescents

¹ Women's Commission for Refugee Women and Children, 2000, p. 1.

² The World Bank, 2002, p. ix.

³ Save the Children Fund, 1999, p. 5.

⁴ United Nations High Commissioner for Refugees, 2005a, p. 4.

as pertains to geographical context and risk for HIV could be drawn. By exposing some limitations in existing theory guiding HIV/AIDS intervention programmes, this study has contributed towards the search for an improved theoretical framework to model HIV/AIDS programming.

1.2 Statement of the problem

According to the Joint United Nations Programme on AIDS (UNAIDS), an estimated 37.8 million people in the world were living with HIV, while another 4.8 million became infected by the beginning of 2004. By January of 2004, 20 million had died of AIDS since the pandemic was discovered.⁵ The pandemic is said to be concentrated in the age range of 15 to 45 years, considered to be the most socially and economically productive group.⁶ This implies that the pandemic threatens economic development because people with essential energy and skills are either indisposed or killed. When staff is indisposed organizations re-channel productive resources to support them instead of reinvesting for their (organization) expansion to create jobs or build more hospitals and schools.⁷ At the household level, the implication is loss of the household income to feed, cloth, provide shelter and support children in schools.⁸ It further means a loss of parental guidance needed for children to grow into responsible adults that contribute to the development of their communities. Therefore, AIDS contributes to the creation and deepening of household poverty. Poverty in turn reinforces HIV and AIDS.⁹

Sub-Saharan Africa is the region worst affected by the epidemic with an estimated 25.4 million cases.¹⁰ It is also the most poverty stricken, with the United Nations Development Programme (UNDP) estimating 313 million people as income poor.¹¹ According to the International Fund for Agricultural Development (IFAD), 24% of the global distribution of rural poverty is found in the sub-Saharan region compared to larger regions like East

⁵ UNAIDS, 2004a, p. 23.

⁶ Cohen, www.undp.org/seped, 10/11/05.

⁷ UNESCO, 2001, p. 5.

⁸ UNAIDS, 2004a, pp. 44-46.

⁹ *Ibid*, pp. 44-45.

¹⁰ UNAIDS, 2004b, p. 2.

¹¹ UNDP, 2005, p. 4.

Asia with also 24%.¹² This means that in absolute terms sub-Saharan Africa has the majority of its rural population living in poverty. Implications of poverty include inadequate or no education, poor health and limited incomes to sustain livelihoods, and these factors have repercussions for HIV.¹³ In addition, the sub-Saharan Africa region has another factor that is exacerbating the spread of HIV, namely violent conflicts.¹⁴ The consequences of these conflicts are family and societal disruptions,¹⁵ and population movements of people into surrounding countries already burdened with HIV/AIDS and poverty. One such country is Zambia.

Zambia, as at July 2005, was home to 174,747 refugees from the Great Lakes region and Angola.¹⁶ Comprising mostly women and children (includes adolescents), 54% of these refugees reside in rural areas¹⁷ of a nation struggling with its own poverty as mirrored in the statistic of 67% of Zambians living under the poverty datum line.¹⁸ In addition, an estimated 16% of young and adult Zambians are living with HIV and AIDS.¹⁹ With over 50% of Zambia's population being children, among whom 26.5% are adolescents, it is logical to conclude that a significantly large number of young people in Zambia are infected and directly affected by HIV.²⁰ HIV and AIDS have touched every corner of Zambia, with insignificant differences in prevalent rates between urban and rural locations.²¹ Differences in these locations are that in comparison to urban areas, rural areas in Zambia are suffering deprivations in services such as education and health.²²

Poverty is also said to be most prevalent in rural areas because people are more dependent on subsistence agriculture, a sector that the Zambian Government had neglected but, has current strategic plans to revamp.²³ Given such a scenario in Zambia, this research which focused on dislocated refugee adolescents and their vulnerability to

¹² IFAD, 2001, p. 3.

¹³ Save the Children Fund, 1999, p. 5.

¹⁴ UNAIDS, 2004a, p. 32.

¹⁵ Ibid.

¹⁶ Zambia Office of Commissioner for Refugees, 2005, p. 1.

¹⁷ Ibid.

¹⁸ Zambia Ministry of Finance and Development Planning, 2002, p. 21. Poverty line is measured by monthly income needed to meet basic caloric needs of a family of six.

¹⁹ Zambia Central Statistical Office, 2005, p. 1.

²⁰ Ibid, 2004a, p. 15.

²¹ Zambia National HIV/AIDS/STD/TB Council, 2000, p. 3.

²² Zambia Ministry of Finance and Development Planning, 2002, p. 49.

²³ Ibid.

HIV as related to urban and rural location answers in some way the following research question:

To what extent do the effects of location (livelihoods, education and health factors) explain the different levels of HIV risk experienced by refugee adolescents in urban Lusaka district and rural Mayukwayukwa refugee settlement?

Unrelated to the academic outcomes necessarily expressed in the above two questions, yet central to the process of research and understanding is my own experience in conducting and writing up this research. Reading show numbers – research reveals the human condition and hardship behind those numbers. For me, it has also revealed the great strength of the human and in particular refugee adolescents’ will to survive in the face of constrained resources in a totally strange country. It was a re-affirmation of the proposition by the Women’s Commission that adolescents do possess inherent potentials which if tapped could be used to realize their development and that of their communities.



1.3 Structure of the thesis

The thesis is divided into five chapters including the introduction. Chapter two comprises a literature review and theoretical framework. The major concepts and terms including theoretical paradigms are analyzed within this chapter. The methodological section in chapter three describes the empirical research process and the approach used to answer the research questions. Chapters four and five comprise results, conclusion and recommendations, respectively. Attached in the annex are the questionnaires used in the survey with refugee adolescents, interview questions and a provincial map of Zambia showing the provinces where Mayukwayukwa Refugee Settlement and Lusaka district are located.

The next chapter will present a review of related literature and theoretical underpinnings on the topic of study.

Chapter Two

2.0 Literature Review and Theoretical Framework

The aim of the chapter is to answer the research questions theoretically and generally by reviewing related literature and theories. The intention is to theoretically establish the influence of the independent variable on the dependent variable as presented below:

Dislocation and rural/urban location socio-economic context → risk for HIV

Independent variable

dependent variable

The direction of the relationship of these variables is important to mention because it has been established empirically, that HIV/AIDS can also affect rural or urban locations and their socio-economic contexts. These include contexts of for example, education, health and livelihoods.²⁴ The pandemic has implications for dislocation as well. For example, AIDS is dislocating millions of children from their position of childhood by depriving them of the care, love and affection of their parent, forcing them to take up adult roles of heading households.²⁵ Therefore, this study was only specific to investigating whether or not dislocation and rural/urban socio-economic contexts affect risk levels for HIV.

2.1 Literature Review

2.1.1 Population movements in sub-Saharan Africa

Population movements and displacements are not a new phenomenon in Africa. Around the mid - 19th Century, mass population movements within sub-Saharan Africa, resulted from the Mfecane wars of Tshaka into Southern, Central and East Africa.²⁶ The Angolan and Mozambican wars of the 1970s produced many refugees scattered around Central and Southern Africa.²⁷ Currently, East Africa the Sudan and across to Somalia are still

²⁴ UNESCO, 2001, p. 5.

²⁵ Plan Finland, 2005, p. 1.

²⁶ British Broadcasting Corporation: www.bbc.co.uk/worldservice/africa.

²⁷ Women's Commission for Refugee Women and Children, 2002, p. 5.

rocked by armed strife to differing degrees.²⁸ The Great Lakes Region (Congo DR, Rwanda and Burundi) particularly the Democratic Republic of the Congo is still divided with continued fighting between the government and the rebel forces.²⁹ Large populations of people have sought refuge in surrounding countries. For example in Zambia, according to commissioner for refugees, there is an estimated 174,747 refugees, from Angola and the Great Lakes region (Congo DR, Rwanda and Burundi).³⁰

Patterns of population movements have been widely related to transmission of HIV. Theories such as the “truck driver model”, the “urban disease model” emphasizes population movement and the “nature of sexual networking patterns between and within populations”.³¹ Jackson identifies factors common to all populations on the move to include reduced access to health care, welfare and other life benefits, leading to greater vulnerability to HIV infection.³² Refugees constitute one of the highly mobile groups under constrained survival resources. As a result, in addition, they are vulnerable to sexual abuse and violence. Selling sex as a “survival strategy” especially among female refugee is reported as common. Children with little to do and no parents to monitor their behavior become sexually active early. Thus the situation encountered and the behaviors engaged during mobility and migrations are actually what increase HIV risk.

2.1.2 The special place of adolescents in armed conflicts and risk for HIV

According to the World Health Organization (WHO), adolescents lie in the age range 10-19 years. This is an age range of concern because they are humanity’s “Window of Hope”, and yet statistics on the HIV/AIDS prevalence show that these children are the worst hit by the pandemic.³³ They are directly affected by the pandemic as statistics show that worldwide the lead cause of death of people between 15-49 years is AIDS.³⁴

²⁸ International Crisis Group, 2004, pp. 1-4.

²⁹ International Rescue Committee, 2004, p. 1.

³⁰ Zambia Office of Commissioner for Refugees, 2005, p. 1.

³¹ Kalipeni et al, 2004, p. 176.

³² Jackson, 2002, p. 33.

³³ UNICEF, 2004, p. 10

³⁴ Ibid.

As victims of consequences of AIDS, they are left as orphans deprived of parental care, guidance and material provision. These effects are replicated resulting in the downward spiral of social mobility, implying negative consequences for future generations.³⁵

Adolescents in armed conflict have recently been identified as a group that is at greater risk of contracting HIV given their context, but have received little recognition. The Women's Commission on Refugee Women and Children carried out an extensive desk review of programmes and policies regarding this particular group of individuals. The study was aimed at determining "patterns and practices around the education, health, livelihood, protection and psychological needs of adolescents uprooted by armed conflicts." The results showed that in the first instance, there were definitional problems of an adolescent. It was found that adolescents are lumped up in the term "children." The United Nations High Commissioner for Refugees in their breakdowns in numbers of refugees and internally displaced persons include adolescent's statistics with children's figure. This is no wonder because even the UN Convention on the Right of the Child, include adolescents in their definition of child. Indeed governments, humanitarian, relief and development organizations prioritize the needs of children in their bilateral and multilateral assistance, but according to the Women's Commission, they have systematically failed to identify the distinct needs of adolescents. Very limited data existed on adolescents in terms of, "their numbers, profiles or needs, formal assessments and evaluations addressing their concerns. The importance of a clear and internationally recognized definition of adolescents, their needs and rights is that it would allow for designing and undertaking interventions with them and on their behalf. Currently there are efforts to mainstream adolescents in the international community, evidenced by the World Bank's announcement to dedicate the 2007 World Development Report to raise awareness on these individuals.³⁶ Secondly, the Women's Commission found that massive rights violations have been committed against adolescents. They are sexually abused and exploited. They are deprived access to stable livelihoods, education and health services.³⁷

³⁵ Women's Commission for Refugee Women and Children, 2002, p. 12.

³⁶ World Bank, www.worldbank.org, 20/11/05

³⁷ Women's Commission for Refugee Women and Children, 2000, pp. 1-5.

Refugees in camp confinements experience a profound sense of loss of control over their lives and a sense that there will be no end to their suffering.³⁸ This according to the Women's Commission creates a psychological state of hopelessness. In turn this psychological distress places adolescents in armed conflict and those confined in camps doubly vulnerable, particularly to HIV compared to adolescents in stable conditions.³⁹ Thirdly, the Commission reported that adolescents in armed conflicts do have strengths and potentials that could make them constructive contributors to their societies, but these go largely unrecognized and unsupported by the international community.⁴⁰ For example, an evaluation report on UNHCR programmes cited that one of the serious issues facing the agency is adolescents without constructive activities. Educational and vocational activities are nearly non-existence in most refugee camps. Adolescents are mostly idle and stand at risk of sexual and economic exploitation, engage in prostitution and criminality.⁴¹ What exacerbates the situation from the study findings was that little is known about how children and adolescents promote their livelihoods. It was noted though, that of the few adolescents in school, most would sacrifice schooling to: get married, take on domestic chores, provide care and manage their households. This situation gets them caught up in the cycle of dependency, depression, and hopelessness that in turn increases their risk to HIV.⁴²

This study by the Women's commission is a comprehensive work that contains information on the policies and programmes encompassing refugee adolescents identified as part of children affected by conflicts. It gives a general picture of the situation of this particular group of adolescents. This study narrowed down this review to refugee adolescents in Zambia. The Commission used a methodology that employed mostly secondary data, as is the nature of a desk study. The report does indicate that some interviews were also done with the stakeholders, but that mostly it was review of existing data. Secondary data has limitations including validity of information from organization reports written by other people whose research integrity may not be known.

³⁸ Women's Commission for Refugee Women and Children, 2000, p. 34.

³⁹ Ibid.

⁴⁰ Ibid, p. vi.

⁴¹ Ibid, p. 12.

⁴² Ibid, p. 20.

Thus although I made use of statistical information in the empirical study in Zambia, deliberate avoidance of using too much secondary data was employed and rather a survey was carried out instead.

2.1.3 Rural/urban location socio- economic context and risk for HIV

The Women's Commission report pointed out three elements that are globally recognised as important for combating HIV/AIDs. These included education, health and livelihoods.⁴³ According to Save the Children Fund (SCF) and consistent with the Millennium Development Goals (MDG), UNHCR and the United Nations System Strategic Plan (UNSSP) for HIV/AIDS, "Promotion and facilitating the links between education welfare, health and livelihoods is a means of challenging the spread and impact of HIV/AIDS."⁴⁴ However, despite the importance placed on these three socio-economic factors, research shows that rural locations are generally constrained in education and health services compared to urban areas. They also have limited economic opportunities that serve as sources of livelihoods.



In his research on urban and rural dichotomies, Fischer highlighted that urban areas can be distinguished from the rural by their heterogeneity economically and socially.⁴⁵ According to him unlike rural areas, urban areas have a diversity of informal and formal economic activities including industries, financial institutions such as banks, and administrative centers of government ministries.⁴⁶ The good roads, good communication technologies, the wide market base for goods because of the large populations, all allow for increased economic activities.⁴⁷ Thus urban areas presented more sources of livelihoods for their inhabitants compared to the rural areas where smallholder subsistence agriculture was generally the predominant economic activity.⁴⁸ Fischer's work is supported by research by the International Fund for Agricultural Development

⁴³ Women's Commission for Refugee Women and Children, 2000, pp. 1-5.

⁴⁴ Save the Children Fund, 1999, p. 5.

⁴⁵ Fischer, 1984, p. 155.

⁴⁶ Ibid.

⁴⁷ Ibid.

⁴⁸ Ibid, p. 15.

(IFAD). IFAD reported that approximately 73% of the rural populations in Africa are smallholder farmers who depend on subsistence agriculture known to be characterized by low incomes.⁴⁹ The low incomes according to the UN Food and Agriculture Organization (FAO) reflect the low priority most African states place on subsistence agriculture development. This is evidenced by insufficient credit facilities, training and use of rudimentary production technologies (such as hoes instead of tractors). This has led to low agricultural production thereby declining the capacity of the sector to provide for household subsistence.⁵⁰ Research by UNESCO INRULED indicates that although rural communities still heavily rely on subsistence agriculture, poor incomes in the sector has resulted in a tendency of rural communities to diversify into other non-agriculture activities such as trading and services, thereby increasing the cash inflow to rural areas.⁵¹ Despite this situation, rural households, particularly in the third world remain generally poor, making up 75% of the 1.3 billion people living in absolute poverty.⁵²

The poverty of the rural areas is also in the delivery of social services such as education and health. Fischer noted that on a general scale, in terms of social services, urban areas were endowed with more and better health centers and schools, with available qualified health personnel and diagnostic equipment; including better recreational facilities.⁵³ A comparative analysis of National Health Accounts for sub-Saharan Countries also revealed that provision of public resources (health and education) services is skewed towards an urban bias. According to WHO reasons include historical spending patterns by most African governments that pay “no due consideration of varying regional health needs and on the basis of existing infrastructure.”⁵⁴ De Beer and Swanepoel speaking from a South African perspective, argued that rural areas are also under resourced for political reasons, among which are need to appease the urban voter, etc.⁵⁵

⁴⁹ International Fund for Agriculture Development, 1993, p. 6.

⁵⁰ Food and Agriculture Organization, 1993, p. 17.

⁵¹ UNESCO International Research and Training centre for Rural Education, 2001, p. 8.

⁵² Ibid, p. 5.

⁵³ Ibid, p. 27.

⁵⁴ World Health Organization: www.who.int/nha/docs/en/NHA_in_eastern_and_southern_africa.pdf

⁵⁵ De Beer, Swanepoel, 2000, p. 9.

De beer and Swanepoel also found another perspective on the location of the poor. They discovered that the poor are apparently not only found in the rural areas, but in the urban areas as well. The two researchers refer to the shack dwellers of Cape Town as the ‘urban poor’, exhibiting the same constraints as the poor in rural areas.⁵⁶ In Zambia, 52% of the urban population is poor with 32% being extremely poor.⁵⁷ This implies that though the urban areas may comparatively have diverse sources of income, better and more health and educational facilities, there are people living in them that may not access these services.

It can be seen from the above studies that generally, the socio-economic situation in rural areas compared to urban areas is generally poor and that the rural population generally lives in poverty. Poverty may imply lack of access to incomes, employment opportunities, access to basic amenities and services such as education and health.⁵⁸ Theoretically, given what has been discussed on the relationship between the three socio economic variables (livelihoods, education and health) and HIV, brings rural locations in the fame.



Notably, however these studies were not carried out in the context of dislocated refugee adolescents, or on such adolescents in the context of Zambia. It is this gap that this study intended to fill. However, to bridge this gap, there was needed to look at the central concepts and theories relevant to the topic of study to serve as a guide to the empirical work that was done.

2.2 Definition of Concepts and Theoretical paradigms

2.2.1 The refugee

The official definition of refugee is as articulated in the 1951 United Nations Convention on the status of refugees. According to this instrument, the term refers to:

⁵⁶ De Beer, Swanepoel, 2000, p. 5.

⁵⁷ Zambia Central Statistical Office, 2004a, p. 115.

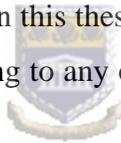
⁵⁸ Zambia Ministry of Finance and National Planning, 2000, p. 10.

“Any person who owing to well founded fear of being persecuted for reasons of race, religion, nationality or political opinion, is outside the Country of His nationality and is unable or, owing to such fear or for reasons other than personal convenience is unwilling to avail himself of the protection of that country.”⁵⁹

There are regional definitions that have been internationally recognized as well. These include; the 1969 OAU Convention governing specific aspects of refugee problems in Africa and the Cartagena Declaration of 1984.⁶⁰ According to these instruments, the term refugee also applies to any person who leaves their country of habitual residence owing to reasons of:

“...external aggression, occupation, foreign domination or events seriously disturbing public order in either part or the whole of his country,”⁶¹ and “generalized violence, internal conflicts and massive violation of human rights.”⁶²

Accordingly, any reference to refugee in this thesis referred to persons defined as leaving their country of habitual residence owing to any one of the reasons stipulated in the three mentioned instruments.



2.2.2 Refugee adolescents

There is not a single definition of the term adolescent. It is defined differently programmatically, across cultural and societal contexts. In their search for a common definition of the term, the Women’s Commission for Refugee Women and Children found three definitional areas in these varied perspectives.

Firstly, the term is defined chronologically pertaining a period in an individual’s life, usually situated in the second decade of life.⁶³

⁵⁹ UNHCR, 1992, p. 4.

⁶⁰ Cartagena Declaration, <http://www.asylumlaw.org/docs/international/CentralAmerica.PDF>, 25/05/05.

⁶¹ OAU Convention on Refugees, 1969, p. 2.

⁶² Cartagena Declaration, <http://www.asylumlaw.org/docs/international/CentralAmerica.PDF>, 25/05/05.

⁶³ Womens’ Commission for Refugee Women and Children, 2000, p. 10.

The World Health Organization definition falls within this classification because an adolescent is regarded as being in the age range 10 to 19 years.⁶⁴

Secondly, there is the functional definition that refers to the transition an individual makes from childhood to adulthood both physiologically and socially.⁶⁵ Physiological changes denoted by the growth and maturity of the body sexually, are also according to Marshall accompanied by “emotional turbulence” manifest in varied behaviors such as experimentation with sex, and alcoholism, which cause society to generally regard adolescence as a “social problem”.⁶⁶ Such perspectives are held by society because along side sexual maturity is an expectation to mature socially by behaving like adults. For example in rural Angola, teenage boys are expected to be petty traders and run agricultural products between farms and markets while girls perform household chores.⁶⁷

Thirdly, the definition may be unique to cultural and societal contexts. For example, among the Xhosa people of South Africa, a boy of 16 who undergoes circumcision is considered an adult man.⁶⁸ A boy or girl of the same age, in an urban society would be a school going individual dependent on parents to pay the school fees, clothe and provide shelter.⁶⁹

In summary adolescence is a highly significant period in which individuals learn future roles, incorporating the norms and values of their society. It is a period that they search for personal identity and a sense of social meaning. This is not to say it is a period of weakness, because as they mature physically, they also develop capacities, which can be tapped into. They can learn skills and knowledge that can be communicated to their counterparts or siblings. This means that families, local communities and governments have to teach them these skills and give them the necessary knowledge, or create opportunities for them, failure of which they are incapacitated materially and emotionally to deal with challenges of life.

⁶⁴ World Health Organization, <http://www.un.org.in/Jinit/who.pdf>, 26/04/05.

⁶⁵ Women’s Commission for Refugee Women and Children, 2000, p. 10.

⁶⁶ Marshal, 1994, p. 5.

⁶⁷ Women’s Commission for refugee Women and Children, 2000, p. 11.

⁶⁸ Ibid.

⁶⁹ Ibid.

Consequently, refugee adolescents are those children within the age range 10-19 years who are refugees as defined. However, as refugees these adolescents face additional challenges resulting from being dislocated, thereby making them distinct from other adolescents.⁷⁰

In this study, the definition of adolescents by the WHO was adopted because it separates a child from the adolescents. This was useful in identifying the adolescents during the field study. The other definitions were also considered, but as being characteristic of individuals in the age range 10-19 years that would or not apply to refugee adolescents in Zambia.

2.2.3 Dislocation

Refugees are referred to as dislocated people.⁷¹ Dislocation is a term that is widely used in the biological sciences to mean a disturbance or disarrangement of the normal relation of bones or displacement or movement of a bone to an abnormal position causing damage to the ligaments, tendons, etc.⁷² More concretely, in society, dislocation refers to the disruption of an established social order so that it fails to continue.⁷³ This disruption may result from governmental policies or could also result from political wars culminating into civil wars.⁷⁴ Refugees are products of such conflict resulting in their seeking asylum in countries outside borders of their own. The implications of dislocation: Loss of education and health provision, loss of livelihood sources and psychological distress all theoretically contribute to circumstances that increase the risk for HIV.⁷⁵ Therefore, by being dislocated, this study assumed refugee adolescents were generally at some risk for HIV.

⁷⁰ These challenges are discussed in section 2.1.2.

⁷¹ Jackson, 2002, p. 23.

⁷² Longman UK, 1987, p. 293.

⁷³ Knodel et al, 2005, p.1.

⁷⁴ Ibid.

⁷⁵ Two theoretical paradigms in section 2.2.6 have been discussed to substantiate the statement.

2.2.4 Context of rural and urban locations

By location, geographers refer to a point in physical space, although they also include a dimension of relativity between these points.⁷⁶ The inclusion of relativity was of importance to this study for two reasons. Firstly, it identifies different points in space; and secondly, allows for comparisons between them. The two specific points in this regard were rural and urban areas. As mentioned in the introduction, this research involved a comparison of elements in these localities, so that a definition that encompassed this aspect (comparison) was rendered suitable. Differences in rural and urban interfaces can be traced back to the post war period. Urban development was a core element of the post-colonial nation-building project.⁷⁷ The modernization school of thought guided this development and the neo-classical economic theory that emphasized industrialization-closely associated with urban growth.⁷⁸ Rural areas at the time were regarded as reservoirs for labor to the industrialized areas and were only developed to the extent needed to reproduce labor.⁷⁹ In time this notion of dual economy came to dominate many regions of the world, including the newly independent countries, such as Zambia.⁸⁰ In the 1980s, there was a paradigm shift that caused development agencies and research to redirect their priorities towards rural development. This was necessitated by radical critique of the modernization approach by dependency theorists such as Micheal Lipton. In his ‘urban bias’ thesis presented in 1977, Lipton showed how most governments had deprived rural areas of resources and infrastructure.⁸¹ The attempts to make up for decades of rural neglect are still on going, although a catch up with urban areas is yet to be seen.

2.2.4.1 Distinguishing characteristics of rural and urban locations

There is no uniformity in the definition of rural or urban location because different parameters apply from country to country. For example, the department of land in South Africa distinguishes rural locations as “sparsely populated areas in which people farm or

⁷⁶ Wikipedia online Encyclopedia: www.en.wikipedia.org/wiki/location_%28geography%29.

⁷⁷ Jerve, 2004, p. 91.

⁷⁸ Ibid, p. 92.

⁷⁹ Ibid.

⁸⁰ Zambia Central Statistical Office, 2004a, p. 6.

⁸¹ Jerve et al, 2003, p. 92.

depend on natural resources.”⁸² These areas are said to comprise villages and the smaller towns within their vicinity.⁸³ In America, areas with a, “population of less than 1,000 per square mile,”⁸⁴ are considered rural, while in Zambia, the threshold for urban areas is typically between “1,000 to 10,000 inhabitants,”⁸⁵ living within the vicinity of each other. According to the United Nations (UN), definitions of urban and rural are as per “national census definitions.”⁸⁶ For example, in Zambia, the demarcating threshold for population of the urban areas is between 1,000 to 10,000 inhabitants.⁸⁷ In India urban areas are places having 5,000 or more inhabitants.⁸⁸ In addition, Fischer in his work on urban and rural experiences highlights that urban areas can also be distinguished from the rural by their heterogeneity socially and economically.⁸⁹ As highlighted in the literature review section, this study focused on the factors of education, health and livelihoods.

Education

Education is an activity that results in the impartation of knowledge, good judgment, wisdom and more tangibly skills. These are “critical life and social skills, including decision making, refusal skills, critical analysis and systematic judgment abilities.”⁹⁰ The importance of education in general is globally recognized. The World Bank indicates that a strong relationship exists between education and economic growth patterns, where growth increases with more education and declines with less.⁹¹ For this reason the Bank maintains that education is essential for global poverty reduction.⁹² This has resulted in the formation of international education promotion efforts such as the Dakar Education for All (EFA) framework and the United Nations Millennium Development Goals (UN MDG).

⁸² South Africa Department of Land, 1997, p. 9.

⁸³ Ibid.

⁸⁴ Ricketts, Johnson-Webb, Taylor, 1998, p. 2.

⁸⁵ World Resources Institute, 2005, p. 3.

⁸⁶ United Nations Demographic Yearbook, 1993, p. 1.

⁸⁷ World Resources Institute, 2005, p. 3.

⁸⁸ United Nations Demographic Yearbook, 1993, p. 1.

⁸⁹ Fischer, 1984, p. 155.

⁹⁰ Vandenberg, 1969, p. 67.

⁹¹ The World Bank, 2002, p. 3.

⁹² Ibid, p. ix.

In emergency situations such as face refugees, education is considered as life saving and sustaining because through it, information on protection against exploitation and on HIV prevention are disseminated.⁹³ UNHCR has set minimum standards to be attained in the provision of education response to refugees.⁹⁴ These are built on the foundations of the 1951 Convention on the Status of Refugees, Dakar (EFA) framework, the Sphere Projects Humanitarian Charter, the UN MDG and the Convention on the Right of the Child (CRC).

Within the context of HIV/AIDS, preventive education has received much emphasis by the international community. For example, UNESCO, in their HIV/AIDS strategy envisages preventive education as not only an economical response but as the most patent and potent response because it also entails behavior change through provision of knowledge and nurturing attitudes.⁹⁵ Explanatory factors for the incidence of the pandemic such as lack of information on how HIV is transmitted, powerlessness of women and girls, are all traced to the education sector. For example, a survey on HIV/AIDS/STI related knowledge and behavior revealed that in Zambia, more men and women (99%) with an education knew about ways to avoid HIV.⁹⁶ They also discussed prevention measures with their spouses or partners than those who did not have an education (71%).⁹⁷ Therefore, education serves as an important factor to lower HIV risk level and in the inverse, without education HIV risk level is increased. The World Bank has re-affirmed education as vital to combat the spread of the pandemic.⁹⁸

As a result of the important role of education, this study considered both general and HIV preventive education. Particularly under general education, focus was on levels of education. This is because evidence from a demographic health survey carried out in Zambia, showed that literacy levels are important for knowledge and discussion of HIV and AIDS issues. For instance only 49.3% with “no education” had ever discussed

⁹³ Inter-agency Network for Education in Emergencies, 2004, pp. 5-7.

⁹⁴ UNHCR, 2004a, p. 493.

⁹⁵ UNESCO, 2001, p. 10.

⁹⁶ Zambia Central Statistical Office, 2003, p. 195.

⁹⁷ Ibid.

⁹⁸ World Bank, 2002, p. 3.

HIV/AIDS prevention compared to 90.3% with “higher education.”⁹⁹ Indicators of education were as per UNHCR minimum standards,¹⁰⁰ and measurement of educational level was confined to the Zambian education system.

Health

Health is one of the most important assets a human being has. Good mental and physical health allows children to grow into productive adults who contribute to the development of a nation.¹⁰¹ Good physical health allows people to work and generate incomes that form bases for livelihoods. Good mental health enhances sound judgments and choices.¹⁰² For example, a study by Murphy et al established that psychological distress associates with increased sexual risk behavior (unprotected sex), alcohol and drug abuse.¹⁰³ The influence of alcohol and drugs is a significantly low likelihood to use condoms during sex, because they inhibit judgment on sexual matters once one is under their influence.¹⁰⁴ In the context of HIV/AIDS, Reproductive Health Care (RHC) is regarded as an important public health service.¹⁰⁵ This is because it is an all encompassing approach to health care that integrates all aspects of physical, mental and social well-being in both males and females of all ages.¹⁰⁶ In practice RHC is associated with prevention and treatment of the reproductive tract infections such as sexually transmitted infections (STI) including HIV/AIDS; pregnancy and abortion problems and; psychological problems resulting from violence such as of the sexual nature.¹⁰⁷ Therefore, reproductive health care is necessary in environments where refugees are involved, particularly because the largest make up (49%) of the refugee population is children (adolescents included) and women.¹⁰⁸

⁹⁹ Mwanamwenge, 2003, p. 201.

¹⁰⁰ Refer to chapter 4, Table 1.

¹⁰¹ The Sphere Project, 2004, pp. 253-255.

¹⁰² Ibid, pp. 253-255.

¹⁰³ Murphy et al, 2001, p. 57.

¹⁰⁴ Renfrew et al, 2002, p. 1.

¹⁰⁵ UNHCR, WHO, UNFPA, 1999, pp. 2-5.

¹⁰⁶ Ibid, p. 2.

¹⁰⁷ Ibid.

¹⁰⁸ UNHCR, 2004b, p. 5.

For the importance attached to RHC, this study investigated specific aspects associated with prevention and treatment of sexually transmitted infections (STI) and psychological distress resulting (in the case of refugees) from traumatic experiences of armed conflicts. Consequently, the following aspects of RHC were measured:

- (1) Accessibility of community centers where reproductive health care information and tools such as condoms are disseminated and distributed at affordable or no cost.
- (2) Number of trained health workers or counselor/population ratios and health centre/population ratios. For consistency purposes, the threshold will be as per UNHCR standards.

Livelihoods sources

Livelihoods refer to the means, activities, entitlements and assets by which people make a living.¹⁰⁹ Assets, in this particular context, are defined as not only natural assets such as land, water, common-property resources, but also social and political assets like community, family, participation and empowerment.¹¹⁰ Most importantly these are assets that accrue to humans such as knowledge and skills, and physical assets including clinics, schools.¹¹¹ There are two different kinds of livelihoods. These are single or multiple livelihoods.¹¹² A single livelihood is when there is only one source of income or support to a household. Multiple livelihoods are when an individual has more than one source of income,¹¹³ for example, an individual in a formal job, who is also a subsistence farmer. It could also mean that members of one household have each a source of a livelihood, and pool their resources together for the household.¹¹⁴

Livelihoods are important because they have repercussions for HIV/AIDS. For example, a research by Mckeown, Reid and Turner, found that some livelihood sources such as prostitution are HIV high risk. Prostitution involves servicing of multiple partners according to their demands, which could include unprotected sex.¹¹⁵ Equally, in the case

¹⁰⁹ Singh, Wanmali, 1998, p. 1.

¹¹⁰ Ibid.

¹¹¹ Ibid.

¹¹² Start, Johnson, 2004, p. 1.

¹¹³ Ibid.

¹¹⁴ Ibid.

¹¹⁵ Mckeown et al, 2002, p. 22.

that females are not economically empowered and have to rely on their spouses or boyfriends for sustenance, it inhibits ability to negotiations for protective sex. This in turn enhances their vulnerability to HIV.¹¹⁶ UNAIDS indicates that having a source of livelihood is vital to combat the spread of HIV. This is because without food and shelter, individuals though knowing about the dangers of HIV/AIDS will still engage in HIV/AIDS risky behavior.¹¹⁷ As a result of the importance of livelihoods I investigated the availability and sources of livelihoods among refugee adolescents in both the rural and urban locations under study.

2.2.5 HIV and AIDS

The Human Immune Virus (HIV) is a virus that attacks the human body causing a condition called the Acquired Immunodeficiency Syndrome (AIDS).¹¹⁸ This condition renders the human body incapable of fighting off diseases culminating into its demise.

The virus is contained in body fluids like blood, breast milk, seminal and vaginal fluids and is transmitted into the human body through ‘unnatural’ openings.¹¹⁹ By unnatural openings are meant cuts, tears, sores or injuries to the skin resulting from, e.g. sexually transmitted diseases, accidents, tears in the vagina/penis resulting from friction during sex, etc. Implicitly, any activity resulting into individuals’ blood and body fluids coming into contact can lead to the transmission of the virus if one of the individuals has HIV. Consequently, the virus can be transmitted from one person to the next through the following four routes considered as the most direct.¹²⁰

- Having unprotected sex with someone who is infected with HIV. This could be oral, anal, or vaginal sex, between same sexes or opposite sex partners. In sub-Saharan Africa UNAIDS reports that heterosexual (between men and women) transmission is the predominant mode.¹²¹ Through the heterosexual mode females in the age range of 15 to 24 years are reported to be 3.4 times more likely to be

¹¹⁶ The World Bank, 2002, p. 20.

¹¹⁷ Cohen, www.undp.org/seped, 10/11/05.

¹¹⁸ Tabeisa, 2002, p. 55.

¹¹⁹ *Ibid*, p. 56.

¹²⁰ *Ibid*, pp. 30-41.

¹²¹ UNAIDS, 2004b, p. 10.

infected than males in the same age range,¹²² for reasons including those routed in poverty.¹²³

- Sharing needles used by someone with HIV.¹²⁴ This is common among intravenous drug users who may share needles to inject drugs. It may be at health centers or between drug addicts.
- From HIV infected blood. This could be through blood transfusion.¹²⁵
- Mother to child transmission is another direct route. Pregnant women with HIV may pass on the virus to the babies at birth or through breast-feeding.¹²⁶

This implies that the virus cannot be transmitted if individuals have protected sex; avoid sharing needles to inject drugs; if blood for transfusion is screened and infected mothers do not breastfeed their babies. It follows that knowledge of the way the virus is transmitted into the body is vital and even more important is when the knowledge is materialized in behavior. In the inverse this means that lack of knowledge could result in involvement in behavior that could lead to HIV infection, or increased risk for HIV. Therefore, ultimately knowledge on HIV/AIDS stands out as important for combating HIV/AIDS, and this knowledge is obtained through education.¹²⁷ Outside the realm of education are other factors that have been recognized as equally important. Generally and specifically in sub-Saharan Africa, these variables have been found to include livelihoods and health.¹²⁸ These variables do not directly increase or reduce risk for HIV, but they create conditions that culminate into HIV risky behavior such as prostitution. The links of these three socio-economic variables to HIV have been discussed in section 2.2.4.1.

Consequently, the indicators of risk for HIV/AIDS included: 1) Unprotected sexual behavior; 2) Habitual drug use and alcohol intake; 3) Knowledge of HIV transmission routes; 4) Application of that knowledge to the lives of refugee adolescents; 5) Type of source of livelihood; 6) Education attainment and access to HIV preventive education; 7)

¹²² UNAIDS, 2004a, p. 40.

¹²³ UNAIDS, 2004b, p. 10.

¹²⁴ Tabeisa, 2002, p. 37.

¹²⁵ Ibid.

¹²⁶ Ibid, p. 36.

¹²⁷ UNESCO International Research and Training Centre for Rural Education, 2001, p. x.

¹²⁸ Since this study was carried out in a sub-Saharan country, the research considered the three variables.

Accessibility and adequacy of Reproductive Health Care services and facilities such as condoms.

2.2.6 Theoretical paradigms

Finding specific theories to apply to this study was not an easy task, as there does not appear to be a theoretical framework explicitly designed for HIV/AIDS risk assessment. Most of the models such as the Health Belief model and the Theory of Reasoned Action focus primarily on behavior change.¹²⁹ The study required both behavioral and risk assessment theoretical approaches that could explain how the variables of livelihoods, education and health in rural and urban locations associate with HIV/AIDS risk to reduce or increase HIV risk for inhabitants of such locations, in the case of this study; refugee adolescents.

The researcher found that socio-psychological theory, such as the Social Cognitive Theory invented by Bandura,¹³⁰ implicitly explained the relationship as discussed below. The AIDS Risk Reduction Model has a dimension to it that the researcher used to apply to this study as detailed under the respective heading below. The two theories provided a framework within which the empirical study in Zambia was undertaken.

2.2.6.1 Social cognitive theory

Social cognitive theory posits “environmental events, personal factors and behavior all operate as interacting determinants of each other.”¹³¹ This means that environmental factors influence personal variables and behavior as much as behavior and personal variables influence environmental factors. The assumptions of this theory are that an individual’s behavior is based on firstly, the benefits (contained in the environment) expected out of that behavior and secondly, the belief that they can perform that behavior (personal factors). It can be drawn from this that individuals are not regarded as passive recipients of environmental influence but rather that they consciously engage in a behavior after weighing the benefits involved.

¹²⁹ Aggleton et al, 1994. pp. 341-345.

¹³⁰ Bandura, 1986, p. 23.

¹³¹ Ibid.

Bandura includes the term ‘social’ in the name of the theory because he mentions that he acknowledges the social foundations of thought. This means that even if people have a “cognitive self regulatory” mechanism that gives them control over environmental pressures, ultimately what they use to regulate their behavior is traced back to the environment. Socio-psychologists through social learning theory explain how people are not born with knowledge and understanding of phenomenon, but rather that it is learned from the social environment. For this reason the direction that this study took was that of the environmental factors influencing personal variables and behavior. Applied to this study this explanation then directly explained the link between location and HIV/AIDS risk. Therefore guided by this theory, the researcher was enabled to examine the variables of livelihood, education and health in the rural and urban location to find out whether they affected refugee adolescents’ decisions to engage in HIV/AIDS risky behavior. This is behavior such as prostitution, drugs and alcoholism. It also allowed for the examination of how personal factors (such as knowledge on HIV, education level, their sources of livelihood) influenced their behavior that increases the likelihood of contracting the virus. Therefore, social cognitive theory could be used for risk evaluation, as was the case in this study.



2.2.6.2 The AIDS Risk Reduction Model (ARRM)

The AIDS risk reduction model was developed by Catania, Kegeles and Coates.¹³² It explains how individuals change behavior that reduces HIV/AIDS risk, by specifically changing their perception on sexual activities and injecting drug use. In the inverse it shows how individuals may not change their behavior. This model like the social cognitive theory proposes that factors external to an individual such as HIV prevention programmes influence an individual’s decision to change behavior. This change occurs in stages so that the more persistent an intervention, the more likely it is to exhibit change. Consequently, to exhibit change, individuals must pass through three stages namely: labeling, commitment and enactment.

¹³² Catania, Kegeles, Coates, 1990, pp. 24 -35.

Labeling: An individual must label their actions as risky for contracting HIV. Elements necessary for this are: knowledge about how HIV is transmitted and prevented; perception of oneself as susceptible for HIV and; belief that HIV is undesirable.

Commitment: This stage is a decision making one. Upon labeling oneself as at risk for HIV, an individual can make three decisions: Can commit to dealing with the situation; remain undecided; wait for the problem to solve itself or resign to the problem.

Important factors that help an individual reach this premise include: relevant information and social norms, perceived enjoyment, self-efficacy and the effectiveness to change.

Enactment: Enactment of what an individual commits to, is regarded important for behavior modification. To enact the commitment, an individual seeks more information or obtains remedies that are actually indicative of the change. For example in case of HIV, an individual may start to use condoms if they never used them before or stop prostitution as a means of sourcing a livelihood. At each stage of change, it is clear that an individual needs inputs such as knowledge of how the virus is transmitted, information that will make them perceive themselves as susceptible to the pandemic. Implied in this are two things that actually rendered this model a useful guide to this study; firstly, the inputs required to change risky behavior were regarded as important elements to investigate because without them, then behavior could not change according to the model.

The ARRM therefore, served as a risk assessment model for this study to the extent that it identifies elements required for change to be enacted without which change in behavior cannot occur. Secondly, the knowledge necessary for change is in the environment an individual is found. In this instance it is the HIV/AIDS prevention and mitigation programmes in a given place. This affirms that if a given place does not have HIV/AIDS intervention programmes, then the people in that area will be at increased risk of getting infected because they depend, for example on HIV/AIDS knowledge, health services or livelihoods to enact such behavior.

2.3 Hypothesis

It is clear from the discussions in this chapter that constrained socio and economic provisions in comparison to urban areas in general characterize rural areas. Refugee adolescents are also generally in a dislocated position that has been shown and found to have implications for HIV risk in the absence of necessary interventions. Social Cognitive Theory and AIDS Risk Reduction Model also show the influence of the environment on the individuals and how individuals influenced by their circumstances make decisions that will benefit them. Guided by these theories I derived the hypothesis from the conceptualizations of the variables in this research that: *Refugee adolescents residing in rural locations are at increased risk for HIV in general. In particular I hypothesized that: Refugee adolescents at rural Mayukwayukwa refugee settlement in Zambia are at increased risk for HIV compared to their counterparts in urban Lusaka district.*

2.4 Aims of the study

- 1) To provide a theoretical framework in which to contextualize the study.
- 2) To investigate the existence of an association between contexts of a rural or urban area and risk for HIV.
- 3) To establish whether or not refugee adolescents in rural locations of Zambia are at greater risk of contracting HIV than their urban counterparts.
- 4) To investigate why refugee adolescents in urban areas would be at greater risk for HIV.
- 5) To provide findings and suggestions.

Having derived the hypothesis theoretically, there was needed to prove it empirically within the context of refugee adolescents in Zambia. The next chapter thus discusses the methodology used to gather data, the research process and challenges encountered during field research.

Chapter Three

3.0 Research Methodology

The study employed both quantitative and qualitative research approaches to collect data. The quantitative method measures objective facts and was used because the measures of indicators of both the independent and dependant variable in this study are expressed in quantifiable terms making it easy to compare their relations.¹³³

The qualitative method was employed because firstly, it allowed for an in-depth understanding of a situation being investigated. Understanding the effects of dislocation and experiences of armed conflict by refugee adolescents could not be expressed in quantifiable terms but rather in narratives, thereby rendering the qualitative methodology inevitable. Secondly, by design comparative studies demand a holistic understanding of the cases under investigation and this called for use of the qualitative approach.

3.1 Data sources and Collection techniques

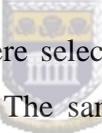
Primary data was mainly collected through the survey among refugee adolescents at both Lusaka district and Mayukwayukwa Refugee Settlement and interviews with government and project staff working with refugees. Semi-structured questionnaires were administered to a sample size of (n) 60 refugee adolescents. This was split into (n) 30 for Lusaka and (n) 30 for Mayukwayukwa. Secondary data was collected from government documentation as well as project reports.

In Lusaka district refugee adolescents resided mainly in three peri-urban areas called Mandevu, Chaisa and Kanyama. They were identified with assistance from the Office of Commissioner for Refugees in Lusaka. A refugee lady from Rwanda introduced the researcher and the two research assistants to the refugee households because the refugees are suspicious of strangers enquiring about their status. The survey was carried out with permission from the parents of younger adolescents after they established from the researcher why only their children were targeted.

¹³³ Taylor, Bogdan, 1984, p. 2.

The survey in Lusaka lasted for 4 days despite the sample being small. This was because most of the adolescents were in school during the morning and available in the afternoon.

The Education Officers at Zambia Red Cross Society and the Ministry of Education through semi-structured interviews supplied information on the education of refugees in urban locations. Semi-structured interviews were preferred because they are versatile and can be adapted to suit the respondent, while at the same time allowing the researcher control of the data collection process by way of giving direction to the interview.¹³⁴ The interview process took a period of one month because of non-availability of the officials for most appointments and scattered information that the officials needed to gather over periods of time. The Community Services Officer at the United Nations High Commissioner for Refugees was also interviewed within a day and gave an in-depth description of the problems presented in refugee children and the constraints UNHCR faced in providing protection and assistance.

The respondents at Mayukwayukwa were selected from 3 camps where most refugees from the Great Lakes Region resided.  The sampling frame used was the registers of refugees kept at the Ministry of Home Affairs by the Refugee Officer (RO). The refugee adolescents were mobilized with the help of four adult refugees within the camps. The survey was undertaken within four days because of the language barrier. The researcher and the two assistants had to explain almost all the questions in the questionnaire to the respondents.

Semi-structured interviews at Mayukwayukwa were conducted with the following officers: Settlement Manager at the Lutheran World Federation/Zambia Christian Refugee Services (LWF/ZCRS). The Manager gave an in-depth description of the situation in the Settlement in general and particularly the activities in the education sector. The Medical Administrator at Africa Humanitarian Action (AHA) discussed the provision of medical services and the Christian Outreach Relief and Development Officer (CORD) described the role of community services within the settlement. The police

¹³⁴ Huysamen, 1994, p. 4.

investigations officer was not present at the time of the study and the officer on duty was instead interviewed.

Secondary data was sourced from the Central Statistical Office (CSO) of the Republic of Zambia. The CSO is the official data bank for the country and international organizations such as the United Nations agencies and World Bank consult this data for reports on Zambia as does the Government for national development planning. Particular documents used were the Living conditions monitoring survey, the demographic and health survey, child labor survey and sexual behavior survey reports. The Zambia education and HIV and AIDS policy document, The National HIV/AIDS/STD framework and the Zambia Poverty Reduction Strategy Paper were also widely consulted. Other official documents referred to were from UNHCR, UNESCO, UNICEF, WHO and SCF. The data from this documentation are widely recognized as valid and reliable and using them minimized the limitation of secondary data of being sometimes unreliable. Project reports from LWF/ZCRS and CORD at Mayukwayukwa were consulted, as were statistical data from Office of the High Commissioner for Refugees.



3.2 Data Analysis

Quantitative data gathered was processed using the Statistical Package for Social Sciences (SPSS). Variables such as education, health and livelihood categories were cross tabulated with those indicative of risk for HIV such as knowledge on HIV transmission routes, to assess relationships between them. Evaluation of quantitative information was done with the aid of descriptive statistics. The interviews were recorded and transcribed.

Transcriptions were done while in the field to ensure that the data collected were verified. Together with secondary data, transcriptions were analyzed using the content analysis technique. All information collected from primary and secondary sources has been presented in the next chapter either as charts or tables, alongside the narrative.

3.3 Limitations

3.3.1 Measuring instruments

The first limitation experienced with the instrument used in the survey (semi-structured questionnaire), was that certain direct and sensitive questions, such as “are you a prostitute” or “do you take drugs” could not be asked because they were unlikely to yield valid responses for religious, cultural and legal reasons. Refugee adolescents in Zambia are in a religious and cultural environment that upholds chastity. Such acts as prostitution and drugs are not apparently revealed for fear of stigma. However, given that issues of prostitution and drugs are of concern because they lead to unprotected sexual behavior, the researcher was still able to indirectly capture them in an interview with the police chief investigations officer, for Mayukwayukwa. The implication of the variable prostitution was also indirectly captured in the question: “If you are sexually active, do you use condoms when having sex?”

The second limitation was that by design, semi structured questionnaires have open and closed ended questions. The researcher asked a closed ended question on what adolescents did to forget some of the bad things they experienced that made them seek asylum in Zambia. The response category the researcher had left out was “I pray”. It turned out that most refugee adolescents were religious. The researcher modified the instrument to capture this element.

Thirdly, the researcher realizes that to capture details of experiences of refugee adolescents, there was need for their voice and face to be attached to the quantitative data. This could have been done by employing more qualitative data collection tools such as observations and narrations. However due to the constraints of time, resources and language, the researcher was unable to employ these techniques in addition to the survey.

3.3.2 Constraints in the field

Protection of refugees in Zambia is mandated to the Office of Commissioner for Refugees in the Ministry of Home Affairs. The Office is so protective of refugees that accessing the refugees is a tedious process. For security reasons, the researcher was

compelled to change the study area from Kala refugee camp to Mayukwayukwa refugee settlement.

Mayukwayukwa is also a rural settlement and is apparently the oldest and serves as a model for the recent camps. The researcher was initially informed that unless French or Swahili were her languages of competence it would be difficult to communicate with refugees at Mayukwayukwa because they could not use English or the Zambian local language familiar to the researcher. The language barrier was experienced at Mayukwayukwa refugee settlement although most adolescents, especially those in school could speak the local language and some English but had difficulty reading. This culminated into the researcher training and familiarizing three interpreters with the instrument. The language problem also forced the researcher to abandon the idea of considering the culture variable that had been initially proposed. This was because there were communication problems encountered with elderly refugees who spoke only Swahili and French. The elders were reluctant to use interpreters whom they regarded as children. They said their culture prescribed that younger people be taught at certain times of their lives, and besides different teachings belonged to different gendered groups (males were used as interpreters because the only older female was running a restaurant somewhere in the settlement). Other than these drawbacks, sufficient and significantly reliable and valid data was collected to dispel any 'reductionism' or ecological fallacies.¹³⁵

3.4 Researchers' notebook

Contemporary research methods, anthropological in particular, pay increasing attention to the narrative or story of the researcher him or her self. The researcher's own experiences and how these experiences continually frame their own view and perceptions of the world in front of them cannot be divorced from the story told by the researcher. To this end, during the research process I maintained a notebook of my own personal reflections on myself that facilitated a beginner's level of personal reflection that I have learned as

¹³⁵ Neuman, 2003, p. 135.

important to the research process itself. I offer some of my own “story” here and in that spirit.

I am a female Zambian and humanitarian worker. I have worked in an emergency situation with refugee populations in Zambia. I served at Mayukwayukwa Refugee Settlement for a period of one year. It was my experience with refugees in camps and with stakeholders in refugee protection and assistance programmes that motivated me to carry out this study. The particular interest in HIV and refugee adolescents arose from the situation I observed among refugee adolescents in the Settlement. From my perspective, there seemed to be insufficient regard to adolescents as pertained to involving them in livelihood sustaining activities such as income generating ventures. I observed that young refugee girls and boys loitered around the camps with nothing much to do. Most of them were at secondary school going age, but they had not undergone primary education. This seemed to be different with adolescents in the cities who seemed more educated and better groomed compared to their rural counterparts. Given the psychological processes that adolescents undergo at that stage in their lives, it raised questions within me as to whether adolescents in rural camps would not be at higher risk for HIV compared to their urban counterparts. Therefore, although over time I tried to do research unrelated to refugees, I was still drawn to refugees and risk for HIV. Because of my experiences with the intermittent funding pattern of UNHCR, I believed it was unlikely that stakeholders in refugee work would carry out research in this regard. As a service to my refugee friends and indeed fellow humanity I cared enough and took the risk to be stigmatized by doing HIV research.

HIV and AIDS exist within multiple contexts of culture, society, politics and history. Throughout the research, my own cultural traits were mirrored to me and often conflicted with what I was meant to be doing in the research itself. I come from a culture that does not openly discuss sexual issues with children that have not undergone initiation into adulthood. This would normally be around the ages of 13 year. Therefore, discussing sexuality with children of 10 years brought upon me such a deep sense of sadness that I sought assistance when dealing with younger adolescents. It was apparent that some of

these children knew about sexual activity as I could hear the giggles in the background. At the same time others seemed fearful and unknowing. They were very young – some only 10 years of age. This required self-reflection on my part as I needed to deal with my own discomfort so that the young people with whom I spoke would not perceive me as judgmental. This is only one of the very many human complexities of the HIV and AIDS phenomenon.

At times I felt as if HIV was an alien who has come to the planet and tampered with our cultures as they are. It is indeed an alien that has tampered with cultures that define who we are. One can identify danger in this feeling. We are called to modify certain aspects of culture in order to combat the pandemic. The danger in this lies in our inability to accept that culture does change and that our very lives, in the instance of HIV and AIDS requires it. The fear is if we disregard this challenge and hold on too tightly to our old and comfortable mechanisms through which we have found our identities. HIV is a reality that confronts us and so is culture a reality that influences our thinking. I can now identify with the difficulty an ordinary person on the street or village has in regard to behavior modification. I am trained and well versed in HIV and AIDS, but I still had deep struggles openly discussing sexuality with children. I however managed to go through the research process that turned out to be a journey of self-discovery as well.

The following chapter contains a report and analysis of the empirical research findings. The findings are reported in order of the arrangement of variables in the hypothesis. The first and second sub-sections present descriptions of the areas of rural Mayukwayukwa Refugee Settlement and urban Lusaka District. This includes the geographic, demographic and socio-economic postures of both locations. The third sub-section is a description of distributions from the survey carried out among refugee adolescents resident in both areas, as per responses to questions in the questionnaire used. The fourth section comprises an analysis of the data collected.

Chapter Four

4.0 Research Findings

4.1 Mayukwayukwa Refugee Settlement

Demographic situation

Mayukwayukwa refugee settlement is the oldest refugee habitat in Zambia established in 1966.¹³⁶ It is situated along the banks of the Luena River, 85 kilometers from the rural district of Kaoma, in the Western province of Zambia. The Settlement has a geographical size of 163 square kilometers, in which reside a total of 5,969 refugees as at August, 2005.¹³⁷ A total 376 refugees are from Burundi (90), Congo (197) and Rwanda (89), 42% of whom are children.¹³⁸ The remaining 5,593 are from Angola.¹³⁹

Sources of livelihoods

Several economic and social activities take place within this community of refugees and with the surrounding Zambian villages. The most prominent economic activity is subsistence agriculture. Refugees are trained in crop production and given farming plots and implements such as seed and hoes.¹⁴⁰ World Food Programme (WFP) provides food rations to ensure that the minimum nutritional requirements are met and also to cater for new arrivals, old people and children who cannot farm.¹⁴¹ UNHCR through CORD facilitates income generating activities (IGA) through micro credit financing. Women and men form groups and are allowed to run the hammer mills provided by WFP. The proceeds from the hammer mills (income) are shared among members.¹⁴² Other micro-economic activities include: handicraft, tailoring, baking, knitting and making candles.¹⁴³ All these form sources of livelihood for refugees in general at Mayukwayukwa.

¹³⁶ Zambia Office of Commissioner for Refugees, 2005, p. 1.

¹³⁷ Ibid.

¹³⁸ Refugee adolescents are clustered within this figure with no specific statistical data on them: Office of Commissioner for Refugees, 2005, p. 1.

¹³⁹ The Angolan refugees are undergoing repatriation. As a result, the population figure changes every month although that of refugees from the Great Lakes is expected to remain constant or increase as a result of continuing instability, especially in Congo DR : Interview with J. Soko, Refugee Officer, Office of Commissioner for Refugees Mayukwayukwa.

¹⁴⁰ Interview with M. Chilando, Settlement Manager, LWF/ZCRS, Mayukwayukwa refugee settlement.

¹⁴¹ Interview with M. Chilando, Settlement Manager, LWF/ZCRS, Mayukwayukwa refugee settlement.

¹⁴² Interview with D. Nawa, Community Development Officer, CORD, Mayukwayukwa refugee settlement.

¹⁴³ Interview with D. Nawa, Community Development Officer, CORD, Mayukwayukwa refugee settlement.

Education activities

UNHCR has set standard measures of general and HIV prevention education for refugees. The following table below is a summary of the education situation at the Settlement.

Tab. 1 Measure of education at Mayukwayukwa refugee settlement

Description	UNHCR Standard Measure	Actual measure
Enrollment of school going refugees (6 to 17 years)	100%	85%
Teacher/ pupil ratio	1:40	1:30
Percentage of trained and qualified teachers	80% or more	39%
Percentage of refugees (18 and less) in HIV/AIDS programmes	10% or more	All are involved

Source: LWF/ZCRS, 2005.

Table 1, shows that except for the teacher pupil ratio and the percentage in HIV/AIDS programmes the rest of the standards fall short of the expected by UNHCR.¹⁴⁴

Health Care

There are three health centers (clinics) for the entire refugee population. One is a government clinic used by both refugees and the local Zambian community, while the other two were built for refugees. The two refugee health centers have 11 professionally trained staff, including 2 counselors, short of UNHCR standard of 50.¹⁴⁵ Health care provided included environmental and primary health care (PHC), maternal health care (MHC) and reproductive health care (RHC).¹⁴⁶ CORD implements the HIV/AIDS reproductive health care programme.¹⁴⁷

Through this programme:

¹⁴⁴ UNHCR, 2005b, p. 2.

¹⁴⁵ Interview with C. Zulu, Health Administrator, AHA, 9.08.05, Mayukwayukwa refugee settlement.

¹⁴⁶ Interview with C. Zulu, Health Administrator, AHA, 9.08.05, Mayukwayukwa refugee settlement.

¹⁴⁷ CORD, 2005, p. 1.

- Reproductive health motivators and peer educators within the camps distribute condoms. They are also distributed at the social clubs, schools and some administrative offices within the settlement.
- Information, Education and Communication materials are distributed in the language understood by the adolescents (i.e., Swahili, Portuguese and Mbunda)
- Counseling services are provided
- Community awareness of HIV/AIDS/STD/RHC is carried out within the settlement.

A community participatory approach is used to implement these activities. The community leaders convene community meetings in every village where through various modes of communication including door-to-door visitation, peer education, drama, sporting tournaments and reproductive health youth camps for boys and girls HIV/AIDS is discussed. There are also 10 anti-AIDS clubs targeted particularly for adolescents' reproductive health and life skills. There is sport and other recreational activities for adolescents in these clubs.



Additionally, CORD has a psychosocial and trauma-counseling office that targets especially children traumatized by various experiences such as war.¹⁴⁸

4.2 Urban Lusaka district

Demographic situation

Lusaka district is situated in Lusaka province and covers an area of 360 square kilometers within which a population of 1,391,329 inhabitants reside. Of the entire provincial population, 81% reside in Lusaka district. This presents a population density of 3013.1 persons per square kilometer, making Lusaka district the most densely populated district in Zambia and Lusaka province the second most populous province in the Country.¹⁴⁹

¹⁴⁸ CORD, 2005, pp. 1-5.

¹⁴⁹ Zambia Central Statistical Office, 2004c, p. 1.

Added to the district figure is another 5,197 urban refugees. 71% of this figure comprises people from Congo DR (1,881), Rwanda (1,127) and Burundi (693) and 29% from other countries like Angola and Somali.¹⁵⁰

Sources of livelihood

Secondary data contained in the analytical report on the district shows that compared to all other towns and cities in Zambia, Lusaka has the widest range of economic activities encompassing commercial investments such as shops, and small-scale enterprises, manufacturing and farming.¹⁵¹ Headquarters of government ministries, NGOs, banking corporations and trading organizations are concentrated in Lusaka.¹⁵² These form sources of livelihoods for the people in the district. However, the huge population density has proved to have negative repercussions on social service delivery, ranging from shelter, water and sanitation, including education and health services.

Educational services

The Ministry of Education coordinates education delivery in the district. Lusaka district has a shortage of primary and basic public schools to absorb the school going population. Currently there are 97 schools for a school going population of 6,200,300. Strategies to cater for the excess school going population include: formation of partnerships with the private sector in providing private schools, formation of community schools and interactive radio schooling programmes.¹⁵³ Issues of HIV/AIDS transmission, prevention and management are integrated within the education curriculum.¹⁵⁴ District education boards work with the 97 schools in the district to ensure the implementation of these plans.

¹⁵⁰ Zambia Office of Commissioner for Refugees, 2005, p. 1. (The percentage of children is not at all reflected in this figure, although the researcher managed to get 30 adolescent respondents).

¹⁵¹ Zambia Central Statistical Office, 2004c, p. 2.

¹⁵² Please note that even if it seems that there are many employment opportunities, refugees may not necessarily have access to them because they have to compete with locals, may not have the skills needed, or they may be constrained by language, given that they come from French speaking countries.

¹⁵³ Interview with M. Lukama, Education Standards Officer, Ministry of Education, 6.07.05, Lusaka.

¹⁵⁴ Zambia Ministry of Education, 2000, pp. 1-20.

Health services

The Lusaka District Health Management Board (LDHMB) coordinates the health sector in Lusaka. The board provides integrated health services through the provision of the Basic Health Care Package. According to data from the district council, the boards' priority areas from 2003 have been among others reproductive and adolescent health, STI/HIV/AIDS and mental health. These are being implemented in 34 government health institutions and about 134 registered private clinics owned by industry and missions within the district.

4.3 Refugee adolescents and risk for HIV survey

4.3.1 Personal characteristics

Age last birthday

The first question that was asked was on the age of the refugee adolescents last birthday and the responses were as shown in table 3 on the next page.



Tab. 2 Age distributions of the respondents in both locations

	Mayukwayukwa		Lusaka	
Age group	Count	Percentage	Count	Percentage
10 - 12 years	9	30%	7	23.3%
13 - 15 years	9	30%	5	16.7%
16 - 19 years	12	40%	18	60%
Total	30	100%	30	100%

The data in table 2, shows that Mayukwayukwa had a younger population concentrated around the age of 14.3 (Arithmetic mean age = 14.3 and Standard deviation = 2.8). More refugee adolescents in Lusaka were older (Arithmetic mean age = 15.6) than those in Mayukwayukwa. The age distribution in Lusaka was wider, with more adolescents being older than 15.6. (Arithmetic mean age=15.6 and SD=3.1).

Sex of respondents

Tab. 3 Distribution of refugee adolescents by gender and location

	Mayukwayukwa		Lusaka	
Sex	Count	Percentage	Count	Percentage
Female	14	46.7%	14	46.7%
Male	16	53.3%	16	53.3%
Total	30	100%	30	100%

Table 3, shows that there were less females in both locations, but the discrepancy between the number of males and females was by 2 male persons only.

Sex and age of the adolescents

Tab. 4 Distribution of refugee adolescents in Mayukwayukwa and Lusaka by age and sex

	Mayukwayukwa		Lusaka	
	Sex		Sex	
Age group	Female	Male	Female	Male
10 - 12 years	3	6	6	1
13 - 15 years	6	3	3	2
16 - 19 years	5	7	5	13
Total	14	16	14	16
Arithmetical mean (age)	15.1	14.9	17.6	17.2

Table 4, shows that on average, female adolescents were older than their male counterparts in both Mayukwayukwa and Lusaka. Between the sexes, on average females in Lusaka were older than their female counterparts in Mayuwayukwa, as were the males in Lusaka older than the males in Mayukwayukwa.

Marital status and sex of adolescents

Of the 60 respondents, only 3 were married in each of the two samples. There were no location differences in married figures.

Country of origin of respondents

Fig. 1 Distribution of refugee adolescents by country of origin

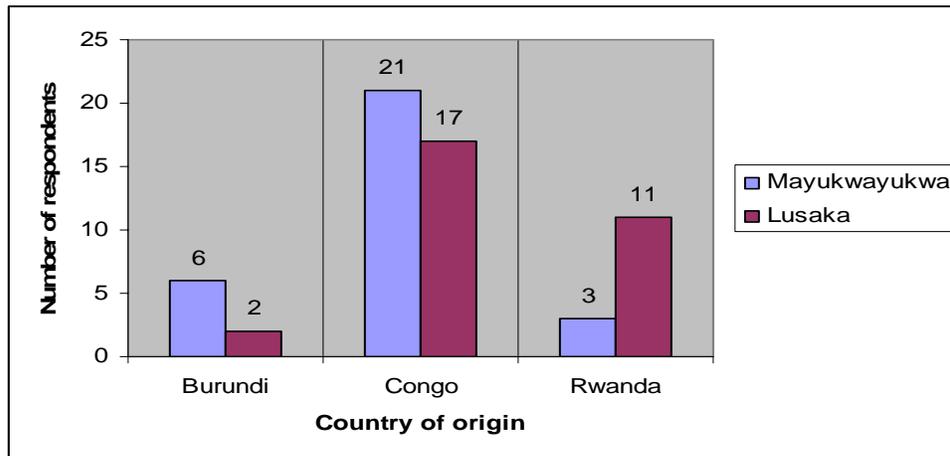


Figure 1, shows that there were more Congolese refugee adolescents in both locations than they were from Rwanda and Burundi.

Persons with whom the refugee adolescents lived

Tab. 5 Distribution of refugee adolescents by location and persons with whom they lived

	Mayukwayukwa		Lusaka	
	Count	Percentage	Count	Percentage
Parents	11	36.7%	12	40%
Guardian	11	36.7%	9	30%
Other	8	26.7%	9	30%
Total	30	100%	30	100%

Table 5, shows that most of the refugee adolescents in both Mayukwayukwa and Lusaka lived with either “parent” or “guardian”. Of the adolescents living with “parent” or “guardian” Lusaka had 92% (13 of 14 persons) females and 50% (8 of 16 persons) males, while Mayukwayukwa had (78.6% (11 of 14 persons) females and males 62.5% (10 of 16 persons).

4.3.2 Education status of adolescents

Fig. 2 Distribution of refugee adolescents in school by location

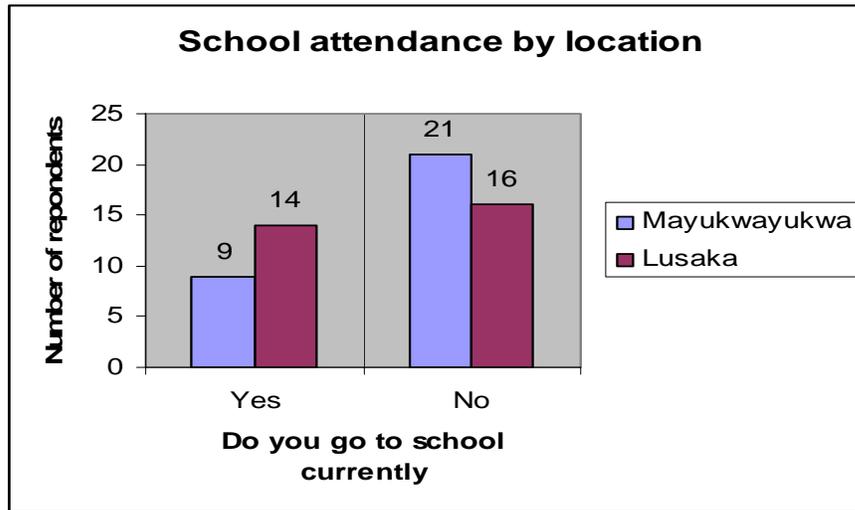


Figure 2, shows that 70% (21 of 30 persons) of refugee adolescents in Mayukwayukwa were not in school, while in Lusaka 53.3% (16 of 30 persons) were not in school. More males (13 of 21) than females (8 of 21) were not in school at the settlement and in Lusaka (11 of 16 males against 5 of 16 females).



Age and current school attendance

Tab. 6 Distribution of refugee adolescents by age, current school attendance and location

Age	Mayukwayukwa		Lusaka	
	Do you go to school		Do you go to school	
	Yes (count)	No (count)	Yes (count)	No (count)
10-12	4	5	5	2
13-15	3	6	3	2
16-19	2	10	6	12
Total	9	21	14	16

From table 6, it can be seen that there were more adolescents out of school in Mayukwayukwa (11 of 21) in the age range 10-15 than they were in Lusaka (4 of 16). More female adolescents in both locations were in school than their male counterparts (6 of 9 in Mayukwayukwa and 9 of 14 in Lusaka).

Level of formal education

88.9% (8 of 9 persons) of adolescents who were in school in the settlement were at primary school level and the other 11.1% (1 of 9 persons) in secondary school. The situation in Lusaka was different with 57.1% (8 of 14 persons) in primary school, while 42.9% (6 of 14 persons) were in secondary school. As expected none of the refugee adolescents in both locations was at tertiary level of education.¹⁵⁵ Of those who were not currently in school in the settlement, 52.4% (11 of 21 persons) stopped school at primary level and 28.6% (6 of 21 persons) of them had reached secondary school level, while 9.5% (2 of 21 persons) had gone as far as tertiary level.

43.7% (7 of 16 persons) of all respondents in Lusaka who were not currently in school had reached secondary school, while 31.3% (5 of 16 persons) had a primary school experience. Only 1 respondent (6.3% of 16 persons) had reached tertiary level. The rest of the adolescents (18.7% of 16) said they did not know the level at which they stopped school.



Asked the reasons for currently not being in school, the common reason was war. However, it turned out that 23.8% (5 of 21 persons) of refugee adolescents in Mayukwayukwa, “could not afford school fees.” Only one person mentioned lack of space in school. The result was similar in Lusaka where 21.4% (3 of 24 persons) could not afford school fees.

Are you undergoing or have had any vocational training?

None of the respondents in Lusaka was undergoing vocational training although 3 of them had been trained before. 4 adolescents in Mayukwayukwa were receiving vocational training in unspecified skilled and 9 had already been trained.

¹⁵⁵Zambia Central Statistical Office, 2004a, p. 35: This situation of education level is normal and expected in the Zambia education system. This is because the official entry age of people into primary school is 7 years and the exit age from secondary school is 18 years.

4.3.3 Knowledge on how HIV is transmitted

Tab. 7 Knowledge of HIV transmission routes by location.

Transmission Routes	Mayukwayukwa			Lusaka		
	Yes (count)	Yes (%)	Total (count)	Yes (count)	Yes (%)	Total (count)
Sex without a condom	30	100%	30	29	96.7%	30
Sharing pit-latrines	2	6.7%	30	1	3.3%	30
Sharing razor blades	28	93.3%	30	29	96.7%	30
Kissing	4	13.3%	30	12	40%	30
Drinking alcohol	2	6.7%	30	1	3.3%	30
Sharing toothbrushes	23	76.7%	30	21	70%	30
Sharing clothes	1	3.3%	30	0	0%	30
Sharing needles to inject drugs	28	93.3%	30	30	100%	30

Table 7, shows that in general refugee adolescents are knowledgeable of how HIV is transmitted. One transmission route that a significant number of adolescents were not familiar with in both locations (Mayukwayukwa = 7 respondents and Lusaka = 9 respondents), was “sharing toothbrushes” and “kissing”. The other differences were statistically insignificant, although it can be seen that 2 respondents (6.7%) in Mayukwayukwa did not know that “sharing needles to inject drugs” can lead to HIV infection.

To further probe HIV transmission knowledge, the adolescents were asked whether they considered the following statements presented in table 8 below.

Tab. 8 Beliefs on HIV transmission situations

Situation	Mayukwayukwa			Lusaka		
	Disagree (Count)	Disagree (%)	Total (Count)	Disagree (Count)	Disagree (%)	Total (Count)
Protected sex should only be a rule if you are not a virgin.	27	90%	30	24	80%	30
When in love it is impossible to think about condoms.	27	90%	30	23	76.7%	30
It is safe to have sex with a fellow adolescent boy or girlfriend	29	96.7%	30	29	96.7%	30
It is safe to have sex with two steady boy or girl friends without a condom	29	96.7%	30	29	96.7%	30



Table 8 shows that refugee adolescents in both locations were knowledgeable about the pandemic and the situations that can lead to an individual contracting HIV.

The researcher asked the refugee adolescents whether or not the information on the pandemic had changed their lives. The responses showed that in Mayukwayukwa 93.3% (28 of 30 persons) had their lives changed by the information in contrast to 86.7% (26 of 30 persons) in Lusaka. Asked on how the information had changed their lives, 64.3% (18 of 28 persons) adolescents in Mayukwayukwa said they knew that unprotected sex was dangerous and condoms should be used when having sex.

33.3% (6 of 18) in Mayukwayukwa decided to abstain, while 38.5% (10 of 26 persons) of their counterparts in Lusaka said that they had learnt to abstain. 60% (18 of 30 persons) of refugee adolescents in Lusaka said they were not sexually active compared to 16.7% (5 of 30 persons) of their counterparts at the settlement. 100% (12 of 12 persons) of

sexually active females in Mayukwayukwa used condoms “all the time” they had sex, in Lusaka only 2 females were sexually active. Only 1 of the 2 used condoms, every time she had sex.

Among the sexually active males at the settlement, 84% (11 of 13 persons) used condoms all the time of sexual encounter, while 70% (7 of 10 persons) of their male counterparts in Lusaka used condoms. It is can be seen from this data that across location, more female refugee adolescents had protective sex than their males counterparts.

Do you use condoms when having sex (for the sexually active)?

Tab. 9 Distribution of age and frequency of condom use every sexual encounter by location

	Mayukwayukwa				Lusaka			
	Condom use when having sex (sexually active)				Condom use when having sex (sexually active)			
Age	All the time	Sometimes	Never	Total	All the time	Sometimes	Never	Total
10-12 years	6	0	0	6	1	0	0	1
13-15 years	8	0	0	8	0	1	0	1
16-19 years	9	1	1	11	7	3	0	10
Total	23	1	1	25	8	4	0	12

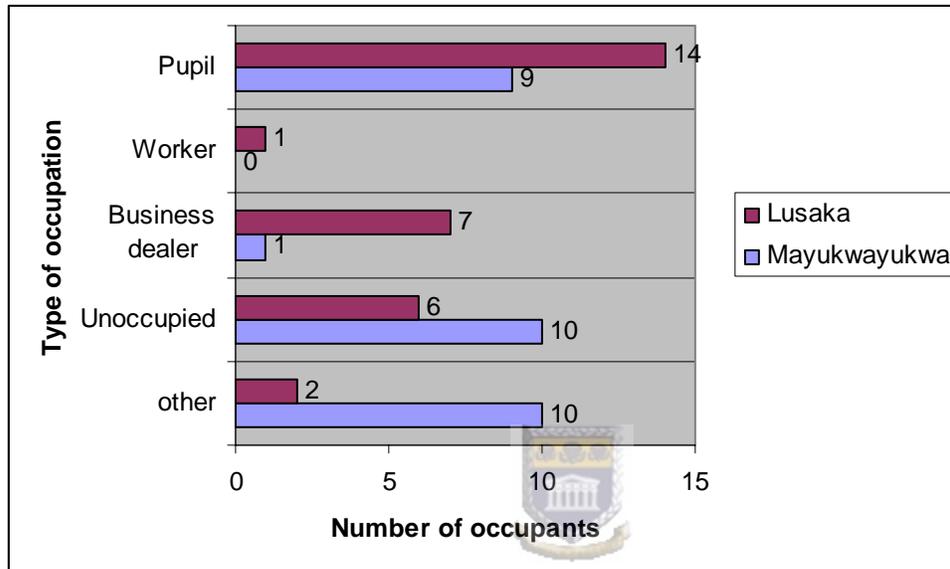
Table 9, shows that for the 25 sexually active adolescents in Mayukwayukwa, 92% always used condoms.

1 respondent used condoms sometimes and another 1 respondent never used condoms. In Lusaka of the 12 sexually active, 66.7% (8 persons) used condoms all the time and 33.3

(4 persons) use them sometimes. The table also shows that 60.9% (14 of 23) of sexually active adolescents in Mayukwayukwa were between the ages of 10 to 15 years, 16.66% (2 of 12) sexually active adolescents were in the same age range in Lusaka.

4.3.4 Source of livelihood.

Fig. 3 Number of refugee adolescents and occupation by location



According to figure 3, more refugee adolescents in Lusaka were occupied with school (46.7% of 30) followed by those dealing in business (23.3% of 30 persons) while 20% of 30 adolescents were unoccupied. Compared to Lusaka, Mayukwayukwa had fewer pupils (30% of 30) and more unoccupied adolescents (33.3% of 30 persons). More adolescents in the settlement (33.3% of 30) were occupied by ‘other things’ than in Lusaka (6.7% of 30). These included “church leader”, "house wife” and “gardener”, while the fewer in Lusaka “helped in the shop” and “cleaned and cooked at home”.

What kind of material assistance do you receive?

At Mayukwayukwa refugee settlement, World Food Programme provided food items to 29 of the 30 respondents. Refugee adolescents in Lusaka received little or no assistance outside the household.

Only 6.7% (2 of 30) got some form of assistance from UNHCR. 80% (24 of 30 persons) got assistance from relatives and friends, one was a beggar and the rest had a business.

4.3.5 Accessibility of health services

Do you go for medical treatment when you are sick?

60% (18 of 30 persons) of refugee adolescents in Lusaka sought medical treatment when they were sick against 76.7% (23 of 30 persons) of their counterparts in Mayukwayukwa. 78.6% (11 of 14 respondents) females and 75% (12 of 16) males at the settlement sought medical treatment “all the time” they were sick, while lesser of their counterparts in Lusaka (64.3% of 14 females and 56.2% of 16 males) did. Less refugee adolescents in Lusaka go for treatment because they “can’t afford medical fees” and in the Settlement because “medical centers” are far. The health administrator at the settlement confirmed that the AHA/UNHCR clinic was 15 km away from the camps,¹⁵⁶ where the adolescents surveyed resided.

How easy is it to access condoms in the location?

Fig. 4 Condom accessibility by location

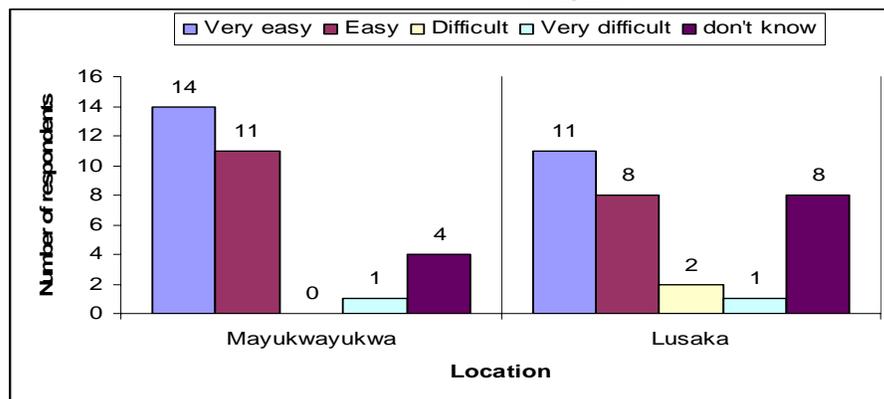


Figure 4, shows that in both locations, more refugee adolescents (14 of 30) in Mayukwayukwa and (11 of 30) found condoms “very easy” to access. A negligible percentage in both locations (1 person in each location) said they (condoms) were “very

¹⁵⁶ The researcher was informed that refugee camps make up a settlement. This means that Mayukwayukwa refugee settlement is a collective of several camps. Interview with J. Soko, Refugee Officer, Office of Commissioner for Refugees, 08.08.05, Mayukwayukwa.

difficult” to access. The “don’t know” is a reflection of refugee adolescents who were not sexually active and also those who did not use condoms.

4.3.6 Psychological distress among refugee adolescents

Do you remember the bad things that happened to you during the war?

More than half of all the respondents in the survey remembered the bad things that happened to them during the war (63.3% in Mayukwayukwa and 60% Lusaka). Asked on what they do to deal with these memories, all the adolescents who did something about it mostly prayed at Mayukwayukwa (30% of 19 respondents) and in Lusaka (16.7% of 18 respondents).¹⁵⁷ The rest of the refugee adolescents at Mayukwayukwa, “do nothing” (20% of 19), while 43% of 19 do “other” things to forget. In Lusaka 50% of 18 respondents did “other” things to deal with these memories. “other” in both locations included: “playing sport”, “play with friend”, “imagine a time when my country will be at peace again”, and “listen to music”.



4.3.7 Are you actively involved in any recreational activities?

Most refugee adolescents are involved in some form of recreational activities in both Mayukwayukwa and Lusaka (73.3% and 76.7%). The rest gave the following reasons for lack of involvement in recreational activities: “no free time”, “stay home”, “escort my sister to braid hair”, “stay home and sleep” “farming” and “no recreation facilities in the settlement”.

4.4 Analysis of the findings

The data that was collected shows that in general, majority of refugee adolescents in both rural and urban locations (Mayukwayukwa and Lusaka) were knowledgeable of the HIV transmission routes. It is also eminent that refugee adolescents in both locations were also knowledgeable about the situations that could lead to an individual contracting HIV.

The explanation for the high prevalence of knowledge on HIV/AIDS among the refugee adolescents could be attributed to HIV/AIDS prevention and mitigation programmes that

¹⁵⁷ The instrument did not initially contain the option of ‘prayer’ among alternative answer to the question ‘what do you do to forget some of these bad things’, but was adjusted upon realizing that most of the refugee adolescents had religious inclinations.

take place within the settlement under the HIV/AIDS and reproductive health project by the Christian Outreach and Relief and Development organization at Mayukwayukwa. It could also be as a consequence of the countrywide campaign against the pandemic articulated in the HIV/AIDS/STD Strategic Framework and the Poverty Reduction Strategy Paper.¹⁵⁸

The responses to the question whether information on HIV/AIDS had changed the lives of the refugee adolescents in the rural and urban location indicated that the majority of adolescents in both locations had their lives changed. The type of change that had occurred was different. More refugee adolescents at Mayukwayukwa said their lives had changed because they knew that unprotected sex was dangerous and condoms should be used when having sex. While in Lusaka most of the adolescents knew that they should abstain from sex. This could partially explain why most of the refugee adolescents in Lusaka were not sexually active compared to their Mayukwayukwa counterparts. The explanation could also be that more adolescents in Lusaka went to school and therefore do not have time for sex.



Using condoms during sex reduces the likelihood of an individual contracting HIV.¹⁵⁹ The data shows that use of condoms at every sexual encounter was common among the mostly sexually active population at Mayukwayukwa than in Lusaka. The explanation could partially be that adolescents in Mayukwayukwa were more knowledgeable about HIV/AIDS and their lives had been changed more by preventive information, than their urban counterparts. However, the discrepancy in the number between the adolescents in the two locations is minimal. Data on condom accessibility could be another explanation.

Adolescents in Mayukwayukwa found it easier to access condoms than their Lusaka counterparts. This was expected at the settlement than Lusaka because of the distribution pattern of condoms in the settlement through the reproductive health programme by

¹⁵⁸ Zambia National HIV/AIDS/STD Council, 2000, pp.1-5.

¹⁵⁹ Jackson, 2002, p. 139.

CORD and the channel through which the distribution is carried out (peers) may be an additional factor to the discrepancy.¹⁶⁰

This discrepancy in condom use between the adolescents can also be a re-affirmation of the proposition by the ARRM that, the more persistent an intervention intended to change risk behavior is, the more likely it is to exhibit change in the intended object. Accordingly, the HIV/AIDS programme at the settlement compared to Lusaka is close to the refugees and implemented through different approaches targeted at adolescents therefore, making it easier for them to ‘enact’ change (use condoms all the time).

From this discussion it can be seen generally, that whether in Mayukwayukwa or Lusaka, the refugee adolescents’ knowledge on HIV/AIDS and impact of that knowledge on their lives was similar. There was a difference in the use of condoms between locations, although the number of the sexually active in Lusaka was too small to make generalizations. Given this situation, the next chapter therefore aims at answering the following research question:



To what extent do the effects of location (livelihoods, education and health factors), explain the different levels of HIV risk experienced by refugee adolescents in urban Lusaka district and rural Mayukwayukwa refugee settlement?

The hypothesis that was derived from the theoretical relationship between variables under study will therefore, also be either accepted or rejected. The hypothesis was that:

Refugee adolescents at rural Mayukwayukwa refugee settlement in Zambia are at increased risk for HIV compared to their counterparts in urban Lusaka district.

¹⁶⁰ Refer to chapter 4, section 4.1.4.

Chapter Five

5.0 Discussion of the findings, Conclusion and Recommendations

In the context of this study, in order to identify the location (rural or urban) where refugee adolescents were at an increased risk of contraction HIV, three socio-economic variables of education, health and livelihood had been identified as bases for the analysis. To aid in this analysis is the understanding of the general risk for HIV in both locations.

5.1 Refugee adolescents in rural and urban locations and risk for HIV

Three indicators of high risk for HIV were identified and measured. These included: Knowledge on HIV transmission routes and beliefs on HIV transmission situations; application of that knowledge to the lives of refugee adolescents; and use of condoms for the sexually active.

- *Knowledge on HIV transmission routes and beliefs on HIV transmission situations.*

According to the AIDS Risk Reduction Model (ARRM), knowledge on how HIV is transmitted is foundational to behavior change. Accordingly, for an individual to “label” their actions as risky for HIV, they need the elements of knowledge on how the pandemic can be transmitted and prevented.¹⁶¹

Data shows that in general, majority of refugee adolescents in both rural and urban locations (Mayukwayukwa and Lusaka) were knowledgeable of the HIV transmission routes. It is also clear that refugee adolescents in both locations were also knowledgeable about the situations that could lead to an individual contracting HIV.

However, knowledge solely is not sufficient to explain the level of risk for HIV; it forms the basis upon which individuals can make decisions to change behavior. The ARRM demonstrates that it is the “Enactment” or the application of the knowledge that brings about “behavior modification” that would indicate the level of risk for HIV for an

¹⁶¹ Refer to chapter two, section 2.2.2.

individual. This was established in the question on whether the information on HIV/AIDS had changed the lives of the refugee adolescents.

- *Impact of knowledge to the lives of refugee adolescents*

The responses to the question whether information on HIV/AIDS had changed the lives of the refugee adolescents in the rural and urban location indicated that the majority of adolescents in both locations had their lives changed. The type of change that had occurred was different. More refugee adolescents at Mayukwayukwa said their lives had changed because they knew that unprotected sex was dangerous and condoms should be used when having sex. While in Lusaka most of the adolescents knew that they should abstain from sex. Most important to note for this section is that in both locations majority of adolescents indicated information had changed their lives.

- *Use of condoms for the sexually active*

Using condoms during sex reduces the likelihood of an individual contracting HIV.¹⁶² The data shows that use of condoms at every sexual encounter was common among the most sexually active population at Mayukwayukwa than in Lusaka. The explanation could partially be that adolescents in Mayukwayukwa were more knowledgeable about HIV/AIDS and their lives had been changed more by information on HIV/AIDS, than their urban counterparts. Additionally fewer adolescents in Lusaka were sexually active.

Therefore, as analysed earlier, there are negligible variations in the relationship between refugees in rural and urban locations and risk for HIV level.

5.2 Refugee adolescents, education and risk for HIV

The importance of both general and preventive education approaches in combating the spread and mitigating the effects of HIV/AIDS have been articulated in the earlier chapters. An analysis of the general education situation at Mayukwayukwa indicates that generally, education provision in the settlement is below the standards set by UNHCR.¹⁶³

¹⁶² Jackson, 2002, p. 139.

¹⁶³ Refer to Chapter 4, section 4.1.

The general education situation in Lusaka is also below standards and a reflection of the national problem of inadequate social sector expenditure, although with current initiatives by government the situation may change for the better. Theoretically, this situation places individuals at risk as articulated in section 2.1.2. In particular education attainment and level were discussed as necessary to negotiate for sex, etc. However, it was found, in this study that being in or out of school does not influence HIV/AIDS knowledge, frequency of use of condoms or the effect of HIV/AIDS information on the lives of refugee adolescents. This was reflected in both locations. The explanation for this situation could be the prevalence of HIV preventive education in both locations. The positive impact of HIV preventive education in both locations is evidenced through the knowledge levels and responses to the pandemic among the refugee adolescents as shown in chapter 4.

A separate comparative analysis of level of education was not possible because only one person in Mayukwayukwa was in secondary school and in Lusaka all the sexually active were in secondary school. Therefore, although level of education is noted as important, a valid conclusion to that effect could not be drawn in this study.



5.3 Refugee adolescents, livelihoods and risk for HIV

All but for one refugee adolescent in Mayukwayukwa had a source of livelihood. In Lusaka most of the adolescents (70% of 30 persons) lived with their parents and guardians. This means that most of the refugee adolescents had people looking after them but does not necessarily indicate a source of livelihood. However, by 47.7% of 30 being in school is an indicator that there were livelihoods for these adolescents, with some excess to pay the schools fees. Parents and guardians also looked after 5 of the 6 “unoccupied”. The others were “business dealers”. This means that majority of refugee adolescents had a source or sources of livelihood.

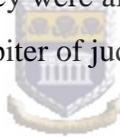
Pertaining to livelihoods and HIV/AIDS, in Mayukwayukwa theoretically refugee adolescents in this aspect should be at lower risk for HIV. This is applicable to Lusaka. In summary, there were negligible variations between access to livelihoods and HIV/AIDS risk in both locations.

5.4 Refugee adolescents, health and HIV risk

Over half of the refugee adolescents in both locations sought medical attention when they were sick. This implies that they had access to medical care. Mayukwayukwa had more adolescents seeking medical attention than Lusaka. This could be explained by the fact that medical services in the settlement were free. However, as regards HIV AIDS risk, the results showed it was difficult to establish the relationship between health care and HIV risk because such services were available in both locations. Therefore, going by theoretical underpinnings refugee adolescents in both locations should be at lower risk for HIV.

5.5 Effects of dislocation and risk for HIV

Effects of dislocation ranged from a loss of the three socio-economic variables of education livelihoods and health services to psychological trauma. These were theorised as causing socio-economic situations that forced refugee adolescents into behaviours that increase risk for HIV (prostitution). They were also said to cause psychological problems such as alcoholism, regarded as an inhibitor of judgement.



As discussed under their respective headings, the three socio-economic variables were available to refugee adolescents in both locations. In Mayukwayukwa there CORD has set up a psychosocial and trauma-counselling office targeting various children traumatised by experiences of War. In Lusaka, all health centres offer integrated health care services that included reproductive and adolescent health, STI/HIV/AIDS and mental health. Recreational facilities that keep children occupied are available in both locations as evidenced by over 72% of all the respondents being involved. Alcoholism drugs and prostitution, according to the data, do not appear to be a problem among refugee adolescents in both locations. The explanation could be that adolescents do not have resources to consume alcohol and also that UNHCR and the Zambia Office of Commissioner for Refugees keep a watchful eye on refugees as mandated by the United Nations. Protection and assistance to refugees is demanded of all hosting countries.

From this analysis it can be concluded that effects of dislocation have been mitigated in the context of refugee adolescents within the areas of study, therefore minimising their

risk to HIV. After analysing the major variables that this study identified as important in influencing level of risk for HIV in refugee situations, the researcher analysed other variables that other studies have identified. These included age and gender.

5.6 Refugee adolescents, age and risk for HIV

The relationship between age and risk for HIV has been researched, and it has been found that adolescents are prone to HIV infection, because of many factors that include biological, economic and social pressures.¹⁶⁴ It was for this reason that the researcher analysed the age factor among refugee adolescents.

Tab. 10 Knowledge of HIV transmission routes by age and location of refugee adolescents

Transmission Route	Mayukwayukwa				Lusaka			
	Age range				Age range			
	10-12	13-15	16-19	Total Count	10-12	13-15	16-19	Total Count
	yes	yes	yes	yes	yes	yes	yes	
Sex without condom	9	9	12	30	7	5	17	29
Sharing razor blades	8	8	12	28	7	5	17	29
Sharing toothbrushes	6	7	10	23	6	3	12	21
Sharing needles to inject drugs	9	7	12	28	7	5	18	30

From table 10, it can be seen that in both Mayukwayukwa and Lusaka, more refugee adolescents over the age of 16 were knowledgeable about the ways by which HIV is

¹⁶⁴ Refer to Chapter 2, section 2.2.2.

transmitted. The explanation could be that they are targeted more with reproductive health information because between the age ranges 15-24,¹⁶⁵ for particularly females, the HIV prevalence rates are highest. It could also be that at age 16 and older, refugee adolescents had a clearer understanding about the pandemic. Compared to the younger adolescents, older adolescents would be expected to be more sexually active and therefore again expected to know more about the virus. Thus although there are minimal variations between locations, there are apparent differences between age groups.



¹⁶⁵ Refer to Chapter 1, section, 1.2.

Tab. 11 Knowledge of HIV transmission situations

Beliefs on HIV Transmission Situation	Mayukwayukwa				Lusaka			
	Age range			Total Count	Age range			Total Count
	10-12	13-15	16-19		10-12	13-15	16-19	
	Dis- agree	Dis- agree	Dis- agree	Dis- agree	Dis- agree	Dis- agree	Dis- agree	Dis- agree
Protected sex should only be a rule if you are not a virgin.	8	7	12	27	6	4	14	24
When in love it is impossible to think about condoms.	8	9	10	27	3	4	16	23
It is safe to have sex with a fellow adolescent boy or girlfriend	8	9	12	29	7	4	18	29
It is safe to have sex with two steady boy or girl friends without a condom	9	9	11	29	7	5	17	29

Table 11, shows that majority of the older refugee adolescents (16-19) in both locations, were knowledgeable about situations that result in HIV transmission than the younger ones. The explanations could be similar to those given on transmission routes knowledge. Generally fewer adolescents know about situations that lead to HIV infection than the HIV transmission routes. The situation between locations remains the same.

5.7 Refugee adolescents' gender and risk for HIV

The relationship between gender and risk HIV has already been articulated in this paper.¹⁶⁶ The results show that all sexually active female adolescents in the settlement used condoms every time they had sex, compared to 11 of 13 of their male counterparts. In Lusaka, 1 of the 2 sexually active females used condoms every time of sexual encounter as 7 of 10 of their male counterparts. All males at Mayukwayukwa knew that HIV can be transmitted by sharing “razor blades” and “needles to inject drugs into the body.” 12 of 14 females knew about the danger of sharing blades and 12 of 14 knew about the danger of sharing needles. All males in Lusaka knew about the danger of sharing razors and needles. All females knew about needles and 13 of 14 knew about razors. 13 of 16 males in Mayukwayukwa knew that sharing toothbrushes can lead to HIV infection and 10 out of 14 females knew as well. 12 out of 16 males in Lusaka against 9 out of 14 females knew about sharing toothbrushes being dangerous. 15 out of 16 males in Lusaka knew that having sex without using a condom can result in HIV infection, and all the females knew as well. All the males and females in Mayukwayukwa knew about condom use.

15 out of 16 males in Mayukwayukwa and 12 out of 14 females knew that protected sex should be a rule, while 12 out of 16 males and 12 out of 14 females in Lusaka were also aware. 14 out of 16 male adolescents in Mayukwayukwa indicated that it was possible to think about condoms when in love and 13 out of 14 females knew. 15 of 16 males in Lusaka knew that it was not impossible to think about condoms, as did 8 out of 14 of their female counter parts.

¹⁶⁶ Refer to chapter 2, section 2.2.5.

All males in Mayukwayukwa knew that unprotected sex with fellow adolescents could lead to HIV, while 13 of 14 of their female counterparts knew.

All males knew that sex with two steady partners could lead to HIV infection and 15 of 16 females knew in the settlement. In Lusaka all the males and the females knew.

This data shows that generally male refugee adolescents were more knowledgeable about HIV transmission routes and situation that could lead to infection than did their than females counters.

5.8 Summary

In conclusion, variations in HIV risk levels are not between location (rural or urban), but within the adolescent characteristics. This was evidenced by majority of refugee adolescents in both Mayukwayukwa and Lusaka being knowledgeable about HIV transmission routes and situations that could lead to infection. The majority of adolescents' behaviour positively changed as a result of the knowledge, shown by use of protection when having sex.



Variations between adolescents were evidenced by lesser female refugee adolescents than males in both locations being knowledgeable about HIV transmission routes and situations that may lead to HIV infection. Older refugees were typically more knowledgeable than the younger ones. Consequently the research question that was asked was:

To what extent do the effects of location (livelihoods, education and health factors) explain the different levels of HIV risk experienced by refugee adolescents in urban Lusaka district and rural Mayukwayukwa refugee settlement?

The answer is: Livelihoods, education and health in general may affect HIV risk, but based on the data available, refugee adolescents have access to these services in both locations. It has also been shown that refugee adolescents are well versed on HIV

preventive measures, with the majority reporting that their lives had changed. This is directly indicative of the lowered risk for HIV. Thus it can be concluded that to the extent that the mentioned socio-economic variables are available in Mayukwayukwa and Lusaka, refugee adolescents in these locations face a lower risk of contracting HIV. Consequently, because there are no significant variations in these variables between Mayukwayukwa and Lusaka, a judgement cannot be made on what location makes adolescents more vulnerable than the other.

Accordingly, the hypothesis that: “*Refugee adolescents at rural Mayukwayukwa refugee settlement in Zambia are at increased risk for HIV compared to their counterparts in urban Lusaka district.*” is rejected on the basis of the discovered data.

These findings are the re-affirmation of the theoretical paradigms used to guide this study. However, the Social Cognitive theory that shows environmental factors as guiding the responses of individuals living in them was challenged. It was established that adolescents upon receiving HIV preventive education have to choose whether to conform to preventive behaviour or not. At the point of decision the individual is influenced but not controlled by the environment. This missing aspect in social cognitive theory was resolved by the ARRM, thereby making the theoretical paradigms chosen as a pair suitable to guide the study.

Recommendations

Based on these findings, the researcher makes the following recommendations:

The refugee adolescents as described by UNHCR are in need of protection and assistance in all areas that place them at risk for the deadly pandemic. The findings in this study have explicitly highlighted the need to treat the problems of refugee adolescents case by case and not using a blanket approach, as has been the case for the refugee adolescents in Zambia. This is because although the adolescents in either location appear not to be at higher risk for HIV, in terms of livelihoods, those at the settlement are better off as they receive rations every fortnight, while those in Lusaka do not. It is clear that refugees in Lusaka do have guardians or parents looking after them, but what is not apparent are the

sources of livelihood for these parents and how far or what activities the adolescents engage in to contribute to these livelihoods. Further research would be needed to establish this matter.

Additionally, the researcher recommends that HIV intervention and poverty intervention programmes can compliment each other in important ways. Both must take into account the differing needs of younger, female and male adolescents in both rural and urban locations. Such a dual approach to poverty and the pandemic is not currently practiced in refugee settlement areas of Zambia, and I suggest that this pairing warrants serious consideration.

Finally, adolescent refugees in Zambia receive sufficient physical protection by the government as per host government mandate. UNHCR also co-ordinates assistance programmes as has been already articulated. These strengths are good and should be continued. What is also clear is that assistance programmes apart from being temporary, are also in reality not durable solutions for poverty among most refugees. Refugee adolescents may be provided with food and non-food items, HIV/AIDS education and health centres, but if majority of them can only attain primary education and have, for example, and no vocational training, in the long run poverty will catch up with them – and poverty, we know, can increase risk for HIV infection. But poverty itself is also complex, and being a poor refugee adolescent in a foreign land has its own unique challenges and risks. The assistance offered in terms of food and non-food items are notably just bare necessities for existence. As young people undergoing the process of self-discovery and identity formation, refugee adolescents will search for more money to get better clothing and groom themselves physically and behaviourally in ways to appeal to the opposite sex for acceptance. The complexities of adolescence are important determinants of behaviour that can increase risk for HIV, let alone among these dislocated children. Thus although this aspect of adolescence is not explicitly reflected in this study it is not completely ruled out as unimportant.

Notably and somewhat disturbingly, results from this study can be replicated in the Zambian context given that the socio-economic position of refugees is not far afield from what the Zambian adolescent faces as a result of economic difficulties. Therefore, as the Government of Zambia implements programmes under the Poverty Reduction Facility and the HIV/AIDS/STD Strategic Framework to prevent and mitigate the impact of HIV/AIDS, it would be of necessity that a similar study be conducted among adolescents in the stable but poor environment of Zambia.

In closing, inferred in these observations and arguments is that same old ‘adage’ by the development researcher, that poverty undermines progress and therefore, the way forward for HIV requires addressing poverty, regardless of the location individuals find themselves. **How** we address poverty and **how** we define development, however, are questions central to our future as people, as nations and as human beings.



BIBLIOGRAPHY

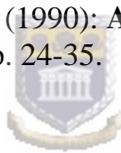
Aggleton, Peter et al. (1994): **Risk Everything? Risk Behaviour, Behaviour Change and AIDS.** In: *Science new series*, Vol. 265, No. 5170, pp. 341-345.

Bandura, Alfred (1986): **Social foundations of thought: A Social Cognitive Theory.** New Jersey (Prentice-Hall).

British Broadcasting Corporation (2006): **The Story of Africa: Southern Africa:** www.bbc.co.uk/worldservice/africa.

Cartegena Declaration: www.asylumlaw.org/docs/international/CentralAmerica.
PDF, 25/05/05.

Catania, J.A; Kegeles, S.M; Coates, T.J (1990): **AIDS Risk Reduction Model.** In: *Education Quarterly*, Vol.17, No. 53, pp. 24-35.



Christian Outreach Relief and Development (2005): **Mayukwayukwa Refugee Settlement HIV/AIDS Reproductive Health Program.** Mayukwayukwa (CORD).

Cohen, Desmond, www.undp.org/seped, 10/11/05.

De Beers, Frik and Swanepoel, Hennie (eds., 2000): *Introduction to Development Studies.* CapeTown(Oxford University Press, Southern Africa).

Food and Agriculture Organization (1993): **Agricultural Extension and Farm Women in the 1980s.** Rome (FAO).

Fischer, S. Claude (1984): **The Urban Experience.** San Diego (Harcourt Brace Jovanovich, Inc), 2nd edition.

Huyshamen, G.K (1994): **Methodology for Social and Behavioral Sciences**. Cape Town (National Book Printers).

International Fund for Agricultural Development (2001): **Rural Poverty Summary Report**. www.Ifad.org/poverty/e_sum.pdf.

Inter-agency Network for Education in Emergencies (2004): **Minimum Standards for Education in Emergencies, Chronic Crises and Early Reconstruction**. Paris (UNESCO/INEE).

International Crisis Group (2004): **Sudan's Dual Crises: Refocusing on Igad**. Nairobi (International Crisis Group).

International Fund for Agriculture Development (1993): **The State of the World Rural Poverty: A profile of Africa**. Rome (IFAD).



International Rescue Committee (2004): **Mortality in the Democratic Republic of Congo: Results from the nationwide survey**. New York (International Rescue Committee).

Jackson, Helen (2002): **AIDS Africa: Continent in Crisis**. Harare (SAfAIDS).

Jerve, M. Alf et al (2003): **Sustaining Local Level Development: What worked and what did not; Lessons from the phasing out of Norwegian aid to the Hambantota Integrated Rural Development Programmes**. Norway (Chri. Michelsen Institute).

Kalipeni, E., et al (2004): **HIV and AIDS in Africa: beyond Epidemiology**. USA (Blackwell Publications).

Knodel et al (2005): **Older persons in Cambodia: A profile from the 2004 Survey of Elderly**. Michigan (Population Studies Centre at University of Michigan).

Longman UK limited (1987): **Longman Dictionary of Contemporary English: New Edition.** Essex (Longman UK Limited).

Marshal, Gordon (ed.; 1994): **The Concise Dictionary of Sociology.** Oxford (Oxford University Press)

McKeown, et al (2002): **Sexual Violence and Dislocation as Social risk factors involved in the acquisition of HIV among women in Manitoba.** Winnipeg Manitoba (Prairie Women's Health Centre of Excellence).

Murphy, et al (2001): **No Change in Health Risk Behavior among HIV Infected Adolescents in Care: Role of Psychological Distress.** In: Journal of Adolescent Health, Vol.29S, pp.57-63.

Murphy, et al (2000): **Psychological Distress among HIV⁺ Adolescents in the REACH Study: Effects of Life Stress, Social Support, and Coping.** In: Journal of Adolescent Health, Vol.27, Issue/No.6, pp.391-398.



Mwanamwenge, Margaret T. (2003): **HIV/AIDS/STI-Related Knowledge and Behaviour.** In: Zambia Demographic Health Survey Final Report 2001/02, Chapter 13.

Neuman, W. Lawrence (2003): **Social Research Methods: Qualitative and Quantitative Approaches.** University of Wisconsin (Allyn and Bacon).

Office of Commissioner for Refugees (2005): **Briefing Notes for Mayukwayukwa Refugee Settlement.** Lusaka (Ministry of Home Affairs).

Organization of African Unity/African Union (1969): **Convention Governing the Specific Aspects of Refugee Problems in Africa.** Addis Ababa (OAU).

Plan Finland (2005): **Helping AIDS Orphans in Child headed Households in Uganda: From relief interventions to supporting child-centered community coping strategies.** Helsinki (Plan Finland).

Renfrew, Megan et al (2002): **Guide to Implementing Teens for AIDS Prevention (TAP): A Peer Education Program to Prevent HIV and STI.** Washington DC (Advocates for Youth). 2nd edition.

Ricketts, Thomas, Johnson-Webb, Karen and Taylor, Patricia (1998): **Definitions of rural: A handbook for health policy makers and researchers.** USA (Federal Office of Rural Health Policy)

Save the Children Fund (1999): **Policy Paper: HIV/AIDS.** United Kingdom (SCF UK).

Singh Naresh and Wanmali, Samir (1998): **Sustainable Livelihoods: Concept paper.** New York (UNDP Sustainable Livelihoods Unit).

South Africa Department of Land Affairs (1997): **Rural Development Framework.** South Africa (Department of Land Affairs).



Start, Daniel and Johnson, Craig (2004): **Livelihoods Options: The Political economy of Access, Opportunity and Diversification.** UK (Overseas Development Institute).

Taylor, J., Steven and Bogdan, Robert (1984): **Introduction to Qualitative Research Methods: The Search for Meanings.** New York (John Wiley and Sons). 2nd edition.

Technical and Business Education Initiative in South Africa (2002): **Working Towards AIDS Awareness.** United Kingdom (Tabeisa Coventry University).

The Sphere Project (2004): **Humanitarian Charter and Minimum Standards in Disaster Responses.** Geneva (Sphere Project).

The World Bank (2002): **Education and HIV/AIDS: A Window of Hope.** Washington DC (Library of Congress).

UNESCO (2001): **UNESCO's Strategy for HIV/AIDS Preventive Education**. Paris (IIEP publications).

UNESCO International Research and Training Centre for Rural education (2001): **Education for Rural Transformation: Towards a Policy Framework**. Paris (UNESCO).

United Nations Development Programme (2005): **Sub-Saharan Africa: The human costs of business-as-usual scenario**. New York (UNDP Report Office)

United Nations High Commissioner for Refugees (1992): **Handbook on procedures and criteria for determining Refugee Status under the 1951 Convention and the 1967 Protocol relating to the status of refugees**. Geneva (UNHCR).

United Nations High Commissioner for Refugees (1997): **UNHCR Policy regarding Refugees and Acquired Immuno Deficiency Syndrome**. Geneva (UNHCR Secretariat).



United Nations High Commissioner for Refugees, World Health Organization, United Nations Population Fund Activities (1999): **Reproductive Health in Refugee Situations: An Inter-agency Field Manual**. Geneva (UNHCR).

United Nations High Commissioner for Refugees (2004a): **UNHCR Global Report**. Geneva (UNHCR).

United Nations High Commissioner for Refugees (2004b): **2003 Global Refugee Trends: Overview of refugee population, new arrivals, durable solutions, asylum seekers and other persons of concern to UNHCR**. Geneva (UNHCR).

United Nations High Commissioner for Refugees (2005a): **Refugees, HIV and AIDS: UNHCR's Strategic Plan 2005-2007**. Geneva (UNHCR Secretariat).

United Nations High Commissioner for Refugees (2005b): **2005 Standards and Indicators Report**. PCOS and PGDS/DOS) Version 1.0.

United Nations Demographic Yearbook (1993).

United Nations Joint Programme on AIDS (2004a): **Report on the global AIDS epidemic**. Geneva (UNAIDS).

United Nations Joint Programme on AIDS (2004b): **AIDS epidemic update**. Geneva (UNAIDS and WHO).

Wikipedia Encyclopedia: www.en.wikipedia.org/wiki/location_%28geography%29

World Health Organization: <http://www.un.org.in/Jinit/who.pdf> 26/04/05.

World Bank: www.worldbank.org, 20/11/05

Women's Commission for Refugee Women and Children (2000): **Untapped Potential: Adolescents affected by armed conflicts**. New York (Women's Commission for Refugee Women and Children).



Women's Commission for Refugee Women and Children (2002): **Watch list on Children and Armed Conflict**. New York (Women's Commission for Refugee Women and Children).

World Resources Institute: **Population, Health and Human wellbeing: Zambia**. 9/05/05 at 8am: http://earthtrends.wri.org/pdf_library/country_profiles/Pop_cou_894.pdf

Zambia Central Statistical Office (2004a): **Living Conditions Monitoring Survey 2002-2003**. Lusaka (Central Statistical Office).

Zambia Central Statistical Office (2004b): **Zambia Sexual Behaviour Survey 2003**. Lusaka (Central Statistical Office).

Zambia Central Statistical Office (2004c): **Zambia Census of Population and Housing: Lusaka Province Analytical report**. Lusaka (Central Statistical Office).Vol. 5.

Zambia Central Statistical Office (2005): **Zambia HIV/AIDS Epidemiological Projections 1985-2010**. Lusaka (Central Statistical Office).

Zambia Ministry of Finance and National Planning (2002): **Zambia Poverty Reduction Strategy Paper**. Lusaka (Ministry of Finance and National Planning).

Zambia Office of Commissioner for Refugees (2005): **Zambia Refugee Population**. Lusaka (Ministry of Home Affairs).

Zambia National HIV/AIDS/STD Council (2000): **Strategic Framework 2001-2003**. Lusaka (National HIV/AIDS/ STD Council).



ANNEX A: Questionnaire

**QUESTIONNAIRE FOR REFUGEE
ADOLESCENTS**

Date: _____

Location:
 Mayukwayukwa (1)
 Lusaka (2)

Elements of HIV/AIDS Risk (Adolescent Characteristic)

A. Interviewee personal characteristics

1. Date of Birth:

_____._____._____
dd mm year

2. Sex:

Male (1)
 Female (2)

3. Marital status:

Single (1)
 Married (2)

4. Which Country are you from?



5. Whom do you live with?

Parents (1)
 Guardians (2)
 Other (6)

Specify other: _____

6. Are you the head of the household?

Yes (1)
 No (2)

B. Education status and constraints

7a. Do you go to school currently?

- Yes (1) please go to qn. 7b.
- No (2) please go to qn. 7c.

7c. If no (to qn.7a), at which level did you stop schooling?

- Never been to school (1)
- Elementary (2)
- Primary (3)
- Secondary (4)
- Tertiary (5)
- NA (7)

- Don't know (9)

8a. Are you currently undergoing any vocational training?

- Yes (1)
- No (2)

7b. If yes (to qn.7a), what is your level of formal education currently?

- Elementary (1)
- Primary (2)
- Secondary (3)
- Tertiary (4)

7d. Why did you stop schooling?

- Could not afford school fees (1)
 - There was no space in school (2)
 - War broke out (3)
 - NA (7)
 - Other (6)
- Specify other: _____
- _____

8b. Have you had any vocational training?

- Yes (1)
- No (2)



Education/knowledge about HIV/AIDS and the impact

9. How is HIV/AIDS transmitted?

	Yes(1)	No(2)
a) Having sex without a condom		
b) Sharing the same pit-latrines		
c) Sharing razor blades		
d) Kissing		
e) Drinking alcohol		
f) Sharing toothbrushes		
g) Sharing clothes		
h) Sharing needles to inject drugs in the body		

10. Do you consider the following statements or not?

	Agree(1)	Disagree(2)
10a) Protected sex should be a rule only if you are not a virgin.		
10b) When in love it is impossible to think about condoms.		
10c) It is safe to have unprotected sex with a fellow adolescent boy/girlfriend		
10d) It is safe to have sex with two steady boy/girl friends without a condom.		

11a. Has the information about HIV/AIDS changed your life?

- Yes (1)... if yes please go to qn. 21.
- No (2)

11b. If yes to qn.11a, please specify why the information about HIV/AIDS has changed your life?

12. If you are sexually active, do you use condoms when having sex?

- All the time(1)
- Sometimes (2)
- Never (3)

C: Source of livelihood

13a. What is your occupation?

- Pupil (1)
- Worker (2)
- Business dealer (3)
- Other (6)

Specify other: _____

14a. What kind of material assistance do you receive?

- Financial support (1)
- Food and non-food items (2)
- Nothing (3)... go to qn 15.
- Other (6)

Specify other: _____



13b. If you are a worker, how easy was it to find employment?

- Very easy (1)
- Easy (2)
- Difficult (3)
- Very difficult (4)

14b. From where do you get assistance?

- UNHCR (1)
- Other NGOS (2)
- Nowhere (3)
- My boy/girl friend (4)
- Other (6)

Specify other: _____

15. If nothing,(qn 14a) what is your source of livelihood?

D: Accessibility of health services

16a. Do you go for medical treatment when you are sick?

- All the time (1)
- Sometimes (2).....please go to 13b.
- Never been (3)

16b. If not “all the time” (to qn.16a) why not?

- Can't afford medical fees (1)
 - Medical centers are far (2)
 - NA (7)
 - Other (6)
- Specify Other: _____
-

17a. How easy is it to access condoms in the city/camp?

- Very easy (1)
- Easy (2)
- Difficult (3)
- Very difficult (4)
- NA (7)
- Don't know (9)

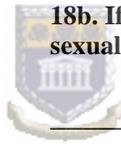
17b. Do you pay to get condoms from the clinics?

- Yes (1)
- No (2)
- NA(7)
- Don't know(9)

E: Cultural issues

18a. Would you disclose to anyone if you were sexually active or not?

- Yes (1)
- No (2) ...please go to qn. 15b.



18b. If no. why would you not disclose to anyone if were sexually active?

F: Psychological distress

19a. Do you remember the bad things that happened to you during the war?

- Yes (1)... please go to qn.14b.
- No (2)

19b. If yes to qn. 19a, what do you do to forget some of these bad things?

	Yes (1)	No(2)
Drink beer to forget		
Drink/or inject some drugs to forget		
Get away from everyone else		
Pray		
Nothing		
Other		

Specify Other: _____

G: Recreation activities

20a. Are you actively involved in any recreational activities, e.g. sports, dance, etc?

- Yes (1)
 No (2)...go to 20b

20b. If no (to qn.20a) what do you do with your free time?

ANNEX B: Interview Questions

i. UNHCR

1. What are the main problems presented in refugee adolescents upon entry into Zambia?
2. What are some of the policies on how to deal specifically with adolescent refugees particularly pertaining HIV/AIDS?
3. What assistance is rendered to both urban and rural refugees regarding access to health, education and livelihood?

4. Who are unaccompanied minors? What assistance is rendered them?
5. What are some of the problems distinct to adolescents in urban areas and rural areas?
6. What is the refugee population? (Demographic breakdown).

iii. AHA , LWF and CORD

1. What health provisions are available to assist adolescents?
2. Do they make use of these provisions, e.g. primary health care services?
3. Do you provide condoms, and how are they administered?
4. What are some of the psychological problems among adolescents?

5. Would you estimate the statistics of psychological problem cases?
7. Do you have trained counselors in trauma and HIV/AIDS?
8. How many schools are available to refugees?
9. Does the curriculum include HIV/AIDS issues?

iv. YMCA/ZAMBIA RED CROSS

1. How many adolescent have access to higher education? (Secondary to tertiary).
2. How many make it through to University and complete the studies?
3. Among those in higher education institutions, what are some behavioral problems reported of them?
4. Would you know whether they are exposed to HIV/AIDS information in these institutions?



v. Government officials at home affairs, Education and Health

1. What is government policy regarding refugees in Zambia?
2. What is government policy regarding refugees and HIV/AIDS in Zambia?
3. What is government policy regarding adolescent refugees, HIV/AIDS, education and health?
4. What are some of the frequently reported cases against refugee adolescents?
5. What regulations exist regarding alcohol intake, prostitution and drug use among adolescents?
6. How many schools/education institutions are in Lusaka?
7. How is HIV/AIDS integrated in the school curriculum?
8. How many health centers are in Lusaka?

ANNEX C: Provincial map of Zambia: Mayuykwayukwa Refugee Settlement is located in the Western Province and Lusaka district in Lusaka Province

