



Department of Health Sciences

Dissertation in Public Health and Education,
20 credits
(Public health 51-60 credits and education 51-60 credits)

**Opinions, knowledge and attitudes about sexual and
reproductive health**
A quantitative study among girls in Zambia

2005-05-09
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Dissertation, in partial fulfillment of the requirements for a Bachelor's degree in Public Health and Education, Kristianstad University
Equivalence: 10 credits, Public Health Science and 10 credits, Education.

Jansson, Susanne (2005). *Opinions, knowledge and attitudes about sexual and reproductive health - A quantitative study among girls in Zambia* (44 p).

Supervisor: Åsa Bringsén

Abstract

Socialisation is a life long process in which people acquire the knowledge, rules, opinions and attitudes they need to adjust into a culture and a society. The cultural and traditional beliefs in a society influence gender roles in a society. Women in Zambia are subordinated men and suffer more from sexual and reproductive ill-health. Previous research show that females engage in more risk behaviors even though they have more positive attitudes towards safe sex which makes them more vulnerable when it comes to sexual and reproductive health. The aim was to study opinions about sex related information and knowledge and attitudes about sexual and reproductive health among young girls. To get these answers a quantitative study was made in Kitwe, Zambia. The result showed that most of the respondents believe it to be important to get information about sex but almost half of them thought that they had got too little information. It also showed that the respondents believe themselves to have good knowledge about HIV/AIDS but a lower knowledge about contraceptives. To reduce the inequalities in health between women and men empowering women is of great importance. The traditional and cultural norms have a great impact on the girls which means that giving them information about sex is not enough.

Keywords: Socialisation, gender, attitudes, sexual and reproductive health, HIV/AIDS, Zambia.

Uppsats för filosofie kandidatexamen vid Högskolan Kristianstad
51-60 poäng i folkhälsovetenskap och 51-60 poäng i pedagogik.

Jansson, Susanne (2005). *Åsikter, kunskap och attityder om sexuell och reproduktiv hälsa – En kvantitativ studie bland flickor i Zambia* (44 s).

Handledare: Åsa Bringsén

Sammanfattning

Socialisation är en livslång process där människor tillägnar sig de kunskaper, regler åsikter och attityder de behöver för att anpassa sig till en kultur och ett samhälle. Den kulturella och traditionella tron i ett samhälle påverkar könsrollerna. Kvinnor i Zambia är underordnade männen och de är mer utsatta för sexuell och reproduktiv ohälsa. Tidigare studier visar att kvinnor oftare än män har riskfyllda beteenden trots att de har mer positiva attityder till säkert sex. Detta gör dem mer sårbara när det handlar om deras sexuella och reproduktiva hälsa. Syftet med denna studie var att undersöka unga flickors åsikter om sexrelaterad information samt kunskap och attityder om sexuell och reproduktiv hälsa. För att få svar på dessa frågor genomfördes en kvantitativ studie i Kitwe, Zambia. Resultatet visade att de flesta respondenter tycker att det är viktigt att få information om sex men nästan hälften ansåg att de hade fått för lite information. Resultatet visade även att respondenterna anser att de har goda kunskaper om HIV/AIDS men mindre kunskaper om preventivmedel. För att minska ojämlikheterna mellan kvinnor och män i hälsa är det mycket viktigt att stärka kvinnor. De traditionella och kulturella normerna har en stark påverkan på flickorna, vilket innebär att information om sex inte är tillräckligt.

Nyckelord: Socialisation, könsroller, attityder, sexuell och reproduktiv hälsa, HIV/AIDS, Zambia.

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Acknowledgement

Even though my name is the only one printed on this dissertation the work has not been a one man's work. I would like to take the opportunity to show my appreciation to all people who have given me invaluable support during the process to accomplish this dissertation in public health and education.

In Zambia I would first of all like to thank all the schools and the principals who welcomed me and allowed me to perform my study there and especially the girls who participated in this study and contributed with all the valuable information. Big thanks to all friends at the *Copperbelt Health Education Project* (CHEP) for their kindness and interest in me and my study. A special thanks to my Zambian supervisor Mrs. Evelyn Lumba who made it possible for me to accomplish my study in Kitwe and to Timothy for practical assistance and guidance through the schools in Kitwe.

In Sweden I would especially want to thank my supervisor, Åsa Bringsén for having patience and time with me, and not least for giving me valuable advices and guidance during my work on this dissertation. Thank you also Karin Permer for comments and assistance.

Finally, I would like to thank Kristianstad University who believed in my idea and the *Swedish International Development Cooperation Agency* (SIDA) for the financial support through the Minor Field Study Scholarship, which enabled me to do this study.

Susanne Jansson

Kristianstad, 2005

1. Introduction

In April 2004 I spent eight weeks in Zambia to perform the field work which is a part of my education in public health and education. I spent most of my time with Copperbelt Health Education Project (CHEP), a non-governmental organisation (NGO) which focuses on HIV/AIDS-prevention in the Copperbelt province. The main public health issues I experienced through the field work were about the inequality between gender, disadvantaged for women and sexual and reproductive ill-health, especially HIV/AIDS. Through my experiences in Zambia, my interest in the problem field about gender differences in health, particularly sexual and reproductive health, started to grow.

Gender affects health and illness through social norms, traditions, economic circumstances, work and family responsibilities, lifestyle choices, and social interaction with health institutions. Women and men experience health in two major but different ways. Women are sicker and use health services more frequently, but live longer than men. (Ahlberg, 2002). Gender is a social phenomenon which is socially constructed and evolves through socialisation. Since gender is created by society its meaning will vary from society to society and will change over time (Momsen, 1991). Gender inequity in health emerges when there exists an unequal distribution of resources, responsibilities and rights of access for health between the sexes. Varying underlying and interacting biological, social and political causes may be the reason for inequity in diseases occurrence and consequences between men and women. Women have a higher share of morbidity and mortality related to sexual and reproductive ill health. Unwanted pregnancy, sexual abuse and violence, HIV/AIDS, genital mutilation, social ostracism and marginalisation due to unwanted pregnancy and complications of pregnancy are some of the problems they are exposed to (Lindstrand, et. al. 2003). For example, women are biologically more vulnerable to heterosexual transmission of HIV infection and they contract HIV at younger ages than men (Martinez-Donate, Hovell & Blumberg, 2004; Norr, Tlou & Moeti, 2004). HIV/AIDS is globally the leading cause of the disease burden in women (Bonita & Mathers, 2003).

The HIV/AIDS epidemic is the most devastating epidemic in recent history. Globally the worst situation is in Africa, the HIV/AIDS epidemic is the major threat to development, economic growth and poverty alleviation (Whiteside, 2002). Zambia is one of the countries in sub-Saharan Africa that is hardest hit by HIV/AIDS (Abrahamsen, 1997). In 1996, Zambia's president Chiluba declared "Our nation is at war with AIDS" (Rasing, 2003). Zambia's most critical developmental and humanitarian crisis today is HIV/AIDS. The projected life expectancy has reduced from 60 years at birth (without HIV/AIDS) to 37 years, due to HIV/AIDS. The HIV prevalence rate (15-49 years) at the end of 2003 was 16.5% (UNAIDS, 2004). In Zambia people are infected or affected by AIDS, either by suffering from it oneself or having lost relatives, friends or neighbours (Rasing, 2003).

Adolescents start having sex in an early age. According to a research in Zimbabwe, where the social situation is similar to that in Zambia, the mean age when children start having sex is 11 years. Many NGOs, both local and international, and churches try to control HIV/AIDS and promote sexual and reproductive health in Zambia by

programs of information, programs on condom use and by emphasizing behavioral change. Also schools, in cooperation with local NGOs, have introduced HIV/AIDS education in their lessons (ibid.).

With the theoretical part of this study I want to know what former studies in public health, social psychology and pedagogy has shown regarding gender differences in sexual and reproductive health and adolescents attitudes, knowledge and behavior about sexual and reproductive health. With the empirical part of the study I want to study opinions about sex related information and knowledge and attitudes about sexual and reproductive health in a limited group of young girls in a town in Zambia.

2. Theory and previous research

The aim of this chapter is to give an overall picture about the problem field of this study. It will present the actual knowledge of today and previous research in the area through the following topics:

- Socialisation
- Attitudes
- Behavior
- Habitus
- Gender
- Health
- Women in developing countries
- Liberating pedagogy
- Sexual and reproductive health
- Health promotion

In the end of this chapter there will be a summary of the theory and previous research of the study.

2.1. Socialisation

When children are born they are born into a society whose culture preceded them and will most certainly continue after their death. The children have inherited no or minimal instincts to help them live in the society and adjust to its culture. They have to acquire the culture. Every society has its own culture i.e. its own language, knowledge, skills, values and beliefs. Culture is the sum of all these elements which makes social living possible and these elements appear to be common to all the members of a social group. To take their place in society, children have to acquire the culture through socialisation (Jarvis, 1992). The concept of socialisation can be referred to upbringing, growth conditions and the child's way into adulthood. Socialisation is a process when people acquire the knowledge, rules, opinions and attitudes they need to serve as members of the society (Helkama, Myllyniemi, Liebkind, 2000). Socialisation can be seen as a lifelong process, which starts in childhood and continues throughout life. There is a distinction between primary and secondary socialisation. (Säljö, 2000).

The *primary* socialisation is mainly the process in which the child gets cognitive, emotional and social knowledge during the first years. The primary socialisation mainly takes place in smaller groups, often in the family. Many of the principally and important knowledge and skills are intermediated during this period. The child learns the language, rules for social cooperation and respect. It learns to act in team with people they have a relation to, like parents, siblings, relatives, friends and in some cases preschool and similar institutions (ibid.). Primary socialisation is not only limited to the first years. During the whole life individuals often live in different primary contexts, in close contact with other people, in which their life is being affected (Angelöw & Jonsson, 2000).

The *secondary* socialisation refers to the process when the individual acquires the skills that are needed to serve in accordance with the norms and rules of the society. This socialisation is mainly connected to the educational system and other institutionalized environments. The conditions for learning are different than in the primary socialisation. The child does not have the same bonds to these environments and its representatives as to the family. Another difference is the way the child gets in contact with knowledge and skills in the school compared to in the home. In the home the pedagogy is invisible, the child learns through observation, imitation and participation. In school however, learning and education is the main goal (Säljö, 2000).

2.2. Attitudes

An attitude can be described as a feeling about some person, object or issue (Helkama, et. al. 2000). Attitudes serve four different purposes. First of all it helps us to understand the surrounding world and how to interpret everyday happenings. The second function is that attitudes help us to satisfy our needs and reach our goals. Our values have often been formed by earlier experiences, through these experiences we learn which incidents are being rewarded and which incidents are being punished. The attitudes help us to achieve the goals that give us reward and to avoid punishment. The third function is to defend the self-esteem, strengthen the self-confidence and defend ourselves against criticism. The fourth function of attitudes is to express our values by telling the world who we are, what we like and dislike etc. (Angelöw & Johnsson, 2000). People's attitudes are made up of two components, *cognitive* – the knowledge and the information they possess and *affective* – their feelings and emotions and evaluation of what is important. It is difficult to change attitudes, they may be changed by providing more or different information, or by increasing a person's skills. (Naidoo & Wills, 2000).

2.3. Behavior

There is no clear association between people's attitudes and their behavior. Sometimes changing attitudes can influence a change in behavior and sometimes behavior change may influence the attitudes of a person (Naidoo & Wills, 2000). The following models can be used to explain the relation between attitudes and behavior.

2.3.1. Health belief model

The health belief model was developed by Rosenstock, 1974 to explain and predict behavior in health contexts. The model is described by Bunton & MacDonald (2002). The health belief model suggests that whether or not people will change their behavior will be influenced by an evaluation of its feasibility and benefits, weighed against its costs. It may include their susceptibility of the illness/injury, the severity of the illness/injury and the costs and benefits of engaging in the action (ibid.).

For a behavior change to take place individuals need to:

- have an incentive to change
- feel threatened by their current behavior
- feel that a change would benefit them and that it has few negative consequences
- feel competent to carry out the change (Naidoo & Wills, 2000).

2.3.2. *Theory of planned behavior*

According to this model human action is influenced by three major factors:

- *Attitudes towards the behavior*: A favourable or unfavourable evaluation of the behavior.
- *Subjective norms*: Perceived social pressure to perform or not to perform the behavior.
- *Perceived behavioral control*: Self-efficacy in relation to the behavior.

In combination, attitudes towards the behavior, subjective norms and perception of behavioral control lead to the formation of behavioral intention. The model has been used successfully in attempts to provide a better understanding of different behaviors such as exercising, donating blood, adhering to a low-fat diet, using illegal drugs and using condoms for AIDS prevention (Davis, et. al. 2002).

A study about factors promoting unsafe sexual behavior in South African youth was made by Eaton, Flisher and Aaro between 1990 and 2000. According to the study, HIV risk behavior is influenced by factors at three levels: within the person (personal factors and behavior), within the proximal context (interpersonal relationships and physical and organisational environment) and within the distal context (culture and structural factors). In terms of explanations for unsafe sexual behavior among South African youth, the findings illustrate the powerful impact of the proximal and distal contexts, and in particular, the effect of poverty and social norms that subordinate women in sexual relationships (Eaton, Flischer & Aaro, 2003).

2.4. Habitus

According to Bourdieu's concept of habitus the culture has a central role in the reproduction of social structures. All individuals have a habitus which is formed by economic, political, social and cultural aspects throughout the lifecourse. Habitus can be explained as a collective and cultural unconscious formed habit which is influenced by external circumstances. The social structures are programmed in the individual and constitute some kind of cognitive or mental structures from where the individual interpret, understand and value the world she lives in.

Habitus is conceptualized in various ways. These are as follows:

- Empirical tendencies to act in particular ways (lifestyle)
- Motivations, preferences, tastes and emotions
- Embodied behavior
- A kind of worldview or cosmology
- Skills and practical social competence
- Aspirations and expectations concerning life chances and career paths

The concept of habitus states that behavior is not only consciously organized. Socioeconomic circumstances determine habitus which in turn determines behavior. The structures which the habitus consists of, guides the individual's thinking and doing and is shown in almost everything that she does: i.e. language, manners, taste and interests. Individuals who are socialized within a certain lifestyle, develop a preference or a taste for that lifestyle. Every individual has its own habitus but people from the same social class or social background tend to have similar habitus. Different lifestyles are linked to different social identities, which makes it difficult for an individual to uncouple the two factors. (Bourdieu, 1984; Bourdieu, 1990; Johansson & Miegel, 1996).

2.5. Gender

Gender roles are socially constructed and therefore they change over time and vary between societies and places. The cultural and traditional beliefs within a society may influence gender roles, attitudes, behavior and health outcomes in a society. Gender relations refer to the power relations between men and women and the social construction of both femininity and masculinity. Gender describes male and female characteristics that are socially constructed. As individuals are born female or male and grow into women and men, behaviors, psychological and social characteristics that are acquired over the lifecourse help form gender identity and determine gender roles. Gender is related to how we are perceived or expected to think, behave and act as women and men because of the way society is organized, not just because of the biological differences (Wamala & Lynch, 2002).

Gender identity evolves through a socialisation process throughout childhood and adulthood. The construction of gender responsibilities is an on-going process. Parents, siblings, relatives and friends play a part in reinforcing expectations for girls and boys. Even the broader society play an important role through the influence of schools, churches, media and other organizational institutions that mediates values and role models during childhood, adolescence and early adulthood. Certain attitudes and behaviors are encouraged for girls respective boys while others are discouraged or denounced (Hannan, 2000).

In 2001-2002 a survey about gender differences in condom-related behaviors and attitudes were made among 370 high-school students in Mexico. The students completed a face to face interview and a self-administered survey including questions about sexual initiation, condom use, intentions to use condoms in the future and attitudes about condoms. The study indicates that females engage in more risk behaviors even though they have stronger intentions and hold more positive attitudes

toward safe sex. The results showed that male students initiated sexual practice earlier than females and that females were more likely to have unprotected sex. Females perceived themselves as more likely to avoid unprotected sex in the future and held more favourable attitudes towards condoms. Most tended to agree with traditional ideas regarding who should propose using condoms within a couple and thought that men, older partners and more sexually experienced partners should be responsible for using condoms. These ideas were more common among men. Most of the males (79%) and the females (76%) disagreed that condoms should be proposed by women. The results suggest that stereotypical gender roles placed the females in the study at higher risk for HIV infection than their male peers (Martinez-Donate, et. al. 2004).

2.6. Health

According to Bispfors and others (1995) there is no single definition of health. Every definition arises from the human and social outlook. Naturally the conceptions change with time and develop as the human being gets new knowledge. The experience of health arises from the individual. Health is mainly founded in childhood.

A common and well used definition is WHO:s definition from 1947:

Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (Naidoo & Wills, 2000).

The sense of coherence (SOC) is a key concept in Antonovsky's (1987) theoretical model of salutogenesis which attempts to explain the origins of health. SOC is defined as:

A global orientation that expresses the extent to which one has a pervasive, enduring though dynamic, feeling of confidence that one's internal and external environments are predictable and that there is a high probability that things will work out as well as can reasonably be expected (ibid.).

The theory assumes that stress-producing experiences are common, but also that individuals have resources for coping with them. When people experience frequent availability of these resources during their personal development, a strong SOC develops. It is a general way of appraising the world, both cognitively and emotionally, it is not a particular coping style but rather a disposition which allows individuals to select appropriate strategies to deal with stressors confronting them. Individuals with a strong SOC are more likely to show a readiness and willingness to use the resources that they have at their potential.

SOC consists of three central components:

- *Comprehensibility*, refers to how a person experience interior and external stimuli as comprehensible, coherent, structured and clear.
- *Manageability*, refers to the extent of resources that a person experience herself to manage to handle the demands which are made by the stimuli she is exposed to.

- *Meaningfulness*, mean to what extent a person experience that life seems meaningful and that the demands that are put on her are worth engaging and investing in (ibid.).

2.6.1. Global health

Overall there have been impressive gains in health status worldwide in the twentieth century. Life expectancy at birth has increased from a global average of 46 years in 1950 to 65 years in 2000. However many populations in poor countries still have life expectancies and disease profiles typical European countries a century ago. The global inequalities in health can be explained by the large variations in child (under five years of age) mortality. Globally 11 million children under the age of five years die each year. Seven out of ten deaths occur in low-income countries and can be attributed to just five preventable conditions – pneumonia, diarrhoeal diseases, malaria, measles and malnutrition (Bonita & Mathers, 2003).

In September 2000 the world’s leaders gathered to commit their nations to strengthen global efforts for peace, human rights, democracy, strong governance, environmental sustainability and poverty eradication and to promote principles of human dignity, equality and equity. It resulted in the Millennium Development Goals, made up of 8 goals, 18 targets and 48 indicators. By the year 2015, all 191 United Nations member states have pledged to meet these goals.

The 8 Millennium Development Goals are:

- Eradicate extreme poverty and hunger
- Achieve universal primary education
- Promote gender equality and empower women
- Reduce child mortality
- Improve maternal health
- Combat HIV/AIDS, malaria and other diseases
- Ensure environmental sustainability
- Develop a global partnership for development (UN, 2005).

I believe that the aim of this study correspond to three of the Millennium Goals. The first one is Goal 3 – promote gender equality and empowering women, the target is to eliminate gender disparity in primary and secondary education, preferably by 2005 and in all levels of education no later than 2015. The second one is Goal 5 - improve maternal health, the target is to reduce by two-thirds, between 1990 and 2015, the maternal mortality rate. The last one is Goal 6 – combat HIV/AIDS, malaria and other diseases. The target of goal 6 regarding HIV/AIDS is to have halted it by 2015 and to have begun to reverse the spread of HIV/AIDS (ibid.).

2.7. Women in developing countries

According to the United Nations Population Fund (UNPF) (2002) more women than men live in poverty and the disparity has increased over the past decades, particularly in developing countries. A report from the International Labour Organisation (ILO) indicates that half of the world’s population is women. They own 1% of the world’s

property, receive 10% of the world's income and account for around 66% of the world's working hours (Lankinen, et. al. 1994). The costs of ignoring women's needs are many: uncontrolled population growth, high infant and child mortality, a weakened economy, ineffective agriculture, a divided society and a poorer life for all. For young girls and women it means unequal opportunities, a higher level of risk and a life determined by fate and the decisions of others rather than by their own choice (Momsen, 1991).

2.7.1. Women in Zambia

In the Zambian society, women are underrepresented in all professional fields, they are behind men in education and training, access to health care and resources and ownership of land and business. In modern Zambia, Christianity has a powerful influence and the belief that the woman was created from the rib of man is frequently quoted to justify women's inferior status in marriage and society. The lives of many Zambian women revolve around marriage and child-bearing. A marriage constitutes the main source of economic and social security for the Zambian women (Rude, 1999).

Women in Zambia often can not refuse unsafe sex due to their subordinate position towards men, and most women find it impossible to suggest condom use. Condoms are associated with prostitutes and a woman who suggests the use of condom is seen as either accusing her partner of infidelity or admitting that she is HIV positive. As most women depend economically on their partners they do not want to jeopardise the relationship (Abrahamsen, 1997).

2.8. Liberating pedagogy

Freire fought for the oppressed in the society. He struggled to make people conscious of themselves and their social situation and by that make the oppressed feel like having their own value and their own creating consciousness (Egidius, 2000). According to Freire (1972; 1974) the task of the oppressed is to liberate themselves and their oppressors as well. This must come from the oppressed themselves because they are the ones that understand the significance of an oppressive society. The oppressors and the structure they bring with them is created by the people in the society who have the power and who decide over other people. Freire mean that the oppressors want to change the oppressed's consciousness, because the more they adjust to the situation the easier it becomes to rule over them. To surmount the situation of oppression, people must first critically recognize its causes, so they can create a new situation. However the oppressed are inhibited from waging the struggle for freedom as long as they feel incapable of running the risks it requires.

Freire's (1972) educational theories are about the ideas of how education helps people to create consciousness. It helps them to get hold of their own life situation, see the problems and solve them with reflection and action. One of Freire's strongest points of view is that theory and practice can not be separated from each other and that reflection leads to action. He claims that people have their own wishes and nobody but themselves know what they want and what they need. Therefore people have to seek their own knowledge and can only create the liberation by themselves. The

education must have a meaning for the people, otherwise it will not be relevant for them.

2.8.1. Empowerment

According to Janlert (2000) empowerment can be explained as the work to strengthen the possibilities of weak groups to affect their own lives and thereby also their health conditions. There is a distinction between self-empowerment and empowerment on a community level. Self-empowerment refers to increasing people's possibilities to make their own decisions and to take control over their own lives. Empowerment at a community level aims to increase people's influence over the health determinants and the quality of life in the community. According to Raeburn and Rootman (1998) empowerment is closely connected to health. It has to do with a body-mind-spirit condition of wellness, confidence and wisdom and being fully alive. According to Narayan (2002) empowerment refers to the expansion of freedom of choice and action to shape one's life. It implies control over resources and decisions. For poor people the freedom is severely curtailed by their voicelessness and powerlessness in relation to the state and the market. There are important gender differences in the causes, forms and consequences of empowerment or disempowerment.

Efforts to empower poor people, increasing their freedom of choice and action, often share four elements:

- *Access to information:* A two-way information, from government to citizens and from citizens to government is important for the empowerment of poor people.
- *Inclusion and participation:* It is important for people to be involved in decision-making and to create space for people to participate in local and national settings.
- *Accountability:* State officials, public employees, private providers, employers and politicians must be answerable for their policies and actions that affect the wellbeing of the citizens.
- *Local organizational capacity:* The ability of people to work together, organize themselves and mobilize resources to solve problems of common interest. Organized groups and communities are more likely to make their voices heard (ibid.).

According to Lindén (1991) empowerment is an important strategy for women's health as the power relations which characterizes women's lives then can be visible. Not before that has been visible the life conditions of the women can change. Through a successful empowerment women can help themselves to handle their problems and act promoting.

2.9. Sexual and reproductive health

Sexual and reproductive health can be defined as everything that has to do with sexuality and reproduction for both men and women through life. The concept of reproductive health was introduced during the 1970s. In unison with WHO:s definition of health, reproductive health can be described as not only absence of disease but a state of complete physical, mental and social wellbeing in all areas that has to do with the reproductive system and its functions. Reproductive health care includes care of pregnant women, information of contraceptives, care during childbirth and abortion and prevention of sexually transmitted infections (STI) (Östlin, et. al. 1996). The concept of reproductive health focuses on prevention and treatment of diseases that impair reproduction and has both male and female dimensions. Many diseases affecting the reproductive organs do not necessarily affect reproduction, but have their significance in their sexual transmission, as for example HIV infection. Therefore it is now common to talk about it as sexual and reproductive health (SRH) (Lindstrand, et. al. 2003). To improve the sexual and reproductive health in developing countries a change between the social differences has to occur. The basic condition is social and economic development but also equal rights for men and women. This includes access to education, means to plan pregnancy and the right to make own choices and have control over one's life (Östlin, et. al. 1996).

The sexual reproductive health and well-being of adolescents face many problems and threats today. HIV/AIDS, sexual violence, early marriage and high rates of early and unwanted pregnancy are some of the threats to young people's sexual health and well-being. The biggest problem is that most adolescents in the world have little or no access to sexual health information, communication and services. Gender inequalities place girls in a particular disadvantaged position when it comes to access to education, health services and income. This influences their ability to choose when, with whom and under what conditions they have sexual relations (Sida, 2002).

Maternal morbidity refers to pregnancy and abortion-related health problems and includes all complications of pregnancy, delivery and abortion. Maternal death is extremely rare in high-income countries, 99% of these deaths occur in low-income and middle-income countries. An overview from low-income countries have shown that around 40% of women during pregnancy had acute health problems, 10-15% of these women developed chronic health problems as a result of disease burden pregnancy. Every year at least 50 million abortions are made in the world and at least 20-25 million of them are unsafe interventions. The diseases associated with unsafe abortion are especially genital infections. They can be expected to occur in at least 30% of all abortions (Lindstrand, et. al. 2003). Unsafe abortion is among the five top causes of maternal death in many settings (Sida, 2002).

The HIV/AIDS epidemic is the most devastating epidemic in recent history (Whiteside, 2002). Since the first cases of AIDS were identified over 20 million people have died. Globally, the number of people living with HIV is growing, from 35 million in 2001, to 38 million in 2003. In 2003 almost five million people became newly infected with HIV, the greatest number in any one year since the beginning of the epidemic, and almost three million people died of AIDS. In 2003 almost 25 million living with HIV lived in sub-Saharan Africa, where around three million people became newly infected and 2.2 million died. In 2003 an estimated 920 000

people (0-49 years) were infected by HIV and 89 000 died because of AIDS in Zambia. The estimated number of children under the age 17 who had lost their mother or father or both parents due to AIDS in Zambia, at the end of 2003, was 630 000. In southern Africa all seven countries have prevalence rates over 17% (15-49 years). ILO claims that the labour force in 38 countries (all but four in Africa) will be between 5% and 35% smaller by 2020 because of AIDS (UNAIDS, 2004).

A study in South Africa investigated the relationship between sexual risk taking and attitudes to AIDS precautions. There were 815 participants in the study, 413 females and 402 males in the second year in polytechnics. In general, most males and females were found to have less knowledge about HIV transmission and less favorable attitudes toward safe sex behavior than adolescents in the west. The findings of the study underscore that attitudes to AIDS precautions are multidimensional and that these various dimensions are related to gender and sexual risk taking behavior. The result shows that greater knowledge did not result in safer sex and greater knowledge about the transmission of HIV did not result in greater intentions to use condoms. Nor did this knowledge lead to actual increased use of condoms. The study also shows that young women in general had more positive attitudes to AIDS precautions than young men. (Akande, 2001).

2.10. Health promotion

According to the Ottawa Charter "Health for all", health promoting work can be described as a process, which will help people to take control over their own health. Health should be seen as a resource in every day's life so people can feel satisfaction and be aware of their demands and have the ability to change their life situation (Ottawa Charter, 1986). The goal of health promotion activity is not to produce behaviour change in a particular direction to create a perfect health, but to help people be as healthy as they want to be (Weare, 2002). According to Tones and Tilford (1994) the key principle of health promotion activity is empowerment. For people to be empowered, they need to: recognize and understand their powerlessness, feel strongly enough about their situation to want to change it and feel capable of changing the situation by having information, support and life skills (Naidoo & Wills (2000). Education plays a vital role in the empowerment process and is therefore central to health promotion (Weare, 2002).

According to Svederberg and Svensson (2001) there is a wish in health promoting work that people make their own decisions on the basis of their understanding and knowledge, especially when it comes to their own wellbeing and lifestyle. The aim of public health education is to support individuals and groups in their own development of knowledge and values towards health aims.

A supportive environment is of great importance for health. The concept of supportive environments in a health context refers to the physical and the social aspects of our surroundings. It includes where people live, their local community, their home and where they work and play. Action to create supportive environments has many dimensions: physical, social, spiritual, economic and political and are linked to each other in a dynamic interaction. Action must be coordinated at local, regional, national and global levels to achieve sustainable solutions (WHO, 2005).

A study made in the United States compared the effectiveness of two different group interventions for reducing new STI's among heterosexual women. The participants consisted of 229 women at risk and were randomly assigned to skills training (ST) or health education (HE). The participants were controlled during one year following intervention for STI acquisition, self reports on sexual behavior and risk reduction skills. The result showed that ST intervention was superior to HE for reducing STI acquisition. Participants in the ST intervention group were significantly less likely to be diagnosed with STI in the year following the intervention and showed higher risk reduction skills at 12 month follow-up. On the following 12 months intervention, 8.6% participants in the ST intervention group were diagnosed with a new STI while 15.4% in the HE intervention group got such a diagnose (Baker, Beadnell & Stoner, 2003).

2.10.1. Promotion of sexual and reproductive health

Through my experiences in Zambia I have noticed that peer education is an often used strategy in promoting sexual and reproductive health.

Peer education is one of the most popular strategies for providing information and services to young people. Peer programs have been identified by WHO as effective in promoting behavior change and have become a major component of HIV/AIDS prevention programs around the world, particularly those targeted to youth. Peer education is perceived as being effective and inexpensive by reaching a large number of youth (Brieger, et. al. 2001). Peer groups foster behavioral change in many ways, including providing social support, detailed information, local development of new norms and values that support HIV prevention, specific safer sex skills and increased self-efficacy through rehearsal and role-modeling. For maximum effectiveness, peer group interventions must be closely tied to the specific cultural and social environment of the target group (Norr, Tlou & Moeti, 2004).

Traditionally, sex education for young girls and boys in Zambia is given by grandparents. The grandmothers talk to their granddaughters and sometimes even their grandsons and the grandfathers talk to their grandsons. The information given is usually not straight forward but indirect in form of stories or examples, while the young girl or boy is told to do or not to do certain things. Traditionally it is a taboo to discuss sexual matters with somebody from the opposite sex, it is also a severe taboo to discuss sexual matters with one's own child. These taboos do not exist between grandparents and their grandchildren. The last few years, however, women see themselves obliged to talk to their daughters about sexual matters. This is in particular among people who belong to the middle or working class in urban areas, because the families often live far away from the grandparents, who usually remain in the villages. Yet the information women give to their daughters is rather superficial, and usually consists of warnings not to have sex before marriage and to keep away from men (Rasing, 2003).

Since the mid 1990s HIV/AIDS is part of the curriculum at all schools, from grade five in primary schools. HIV/AIDS education is integrated with lessons about human biology, christian norms and values, relationships, self-esteem, the family and making choices and decisions. The aim is to provide students with information about sex and HIV/AIDS and to make them reflect on risky situations they may find themselves in

and discuss unsafe situations. Teachers mainly teach about abstinence, which is also emphasized by the church, and the use of condoms to protect oneself against HIV/AIDS. Drama and poetry is often used as a way to talk about HIV/AIDS. The children write and proclaim poems and perform drama for their classmates about HIV/AIDS and how it has affected the lives of many Zambians. Sex education is not only given in schools, there are many NGOs that mainly work with information and prevention of HIV/AIDS (ibid.).

2.11. Summary

Socialisation means that children are born into a specific society and when growing up they acquire the culture through socialisation, so they can live in that society and adjust to the culture and the rules. Also gender inequity evolves through the socialisation process. According to Bourdieu's concept of habitus the culture has a central role when it comes to acquiring the social structures. Habitus is formed by economic, political, social and cultural aspects throughout childhood and adulthood. According to the concept of habitus, socioeconomic factors determine people's habitus which in turn determines their behavior. A person who is socialized in a certain society or culture often develops a preference to live in that way. The Zambian culture put women in a disadvantaged position, they are underrepresented in almost all fields. When it comes to sexual and reproductive health women have a higher share of morbidity and mortality. Biologically they contract HIV/AIDS more easily than men and they are especially vulnerable, due to maternal morbidity and mortality. Empowerment is a part of health promoting work and is an important strategy to strengthen women so they can take control over their own lives so a change can occur. They need to be aware of their situation so they can see the problems and try to solve them. In Zambia sex education is given by schools, NGOs and other institutions in the society. The sex education is mainly focused on HIV/AIDS prevention and the aim is to make them aware of the risks of it.

There are many studies that are focused on the sexual behavior among youths. I believe it is a very complex problem field and that it is important to study the causes behind the behaviors. The knowledge, the attitudes and the received information seem to affect the behavior and therefore I have chosen to focus on these factors.

3. Aim

The aim is to study opinions about sex related information and knowledge and attitudes about sexual and reproductive health, among girls, 14-17 years in Kitwe, Zambia in order to increase the knowledge in how to promote the sexual and reproductive health in the group.

4. Material and methods

In this chapter the choice of method for data collection will be motivated, the target group will be defined and the sample will be described. Further some thoughts about validity and reliability will be presented. The pilot study and its effect will be described and finally the process of data collection and the analysis of the results will be explained.

4.1. Method for data collection

The main reason for using a quantitative method was the fact that I wanted the study to be done on a larger number of people. By doing the study with more people the result will show the opinions, knowledge and attitudes about sexual and reproductive health of the girls in *general* and not in *particular*. Of course there are also some disadvantages using a quantitative method. According to Ejlertsson (1996) the main one is that there is a higher risk for internal non-response. To decrease that risk a pilot study was made before the actual study.

The questionnaire (appendix 2) was based on three different themes, *Information*, *Knowledge* and *Attitudes* about sexual and reproductive health and was composed by 30 closed questions, of which some had multiple answering alternatives. A few questions also had open answering alternatives together with the closed ones. Most of the questions were composed by me but a few questions were borrowed from former studies. The borrowed questions were number 13, 22 and 23.

4.2. Sample

As mentioned earlier adolescents start having sex in an early age. That was an important reason for choosing the age group. A practical and important detail was that the girls in this age have reading and writing ability. The reason for choosing the school as arena was because it was the easiest way to reach the target group.

The study was implemented in six different schools in Kitwe, with a total of 160 girls. The target group was chosen by a cluster sample which was made in two steps. There were around ten basic schools in the area and in the first step six basic schools were chosen by simple random sample. I contacted the chosen schools by visiting them. I talked to the principal, presented myself and the study and asked if they were interested in taking part of the study. Some of them were more enthusiastic than others but the principals of the six schools were all interested in letting their girls participate in the study. In the second step a sample of girls was chosen by the teachers or the headmaster. During the process of the second sample I was not

present. As the schools were of different sizes, the number of girls from each school varied.

Of 160 distributed questionnaires 154 were responded, which means that the answering frequency was 96%. The division of age and school belonging is shown in table 1.

Table 1. Numbers of girls by age and school (n=154).

Age	School A	School B	School C	School D	School E	School F	Total
14	7	12	10	3	11	20	63
15	3	15	18	4	11	1	52
16	2	5	5	1	1	7	21
17	3	3	2	4	0	6	18
Total	15	35	35	12	23	34	154

4.3. Validity, reliability

Before going out to the schools a pilot study was done. The aim was to try the questionnaire on a group, similar to the target group, and by that decrease the risk of external and internal non-response. I wanted to find out if the respondents understood the questions in the way they were intended. The pilot study was made on four girls, aged 15-17 years in another school in Kitwe and was a way to work with the validity and reliability of the questions. According to Hansagi & Allebeck (1994) reliability indicates the accuracy of the questions, if the question has a high reliability the random error should be small. Validity indicates the ability of a question to measure what it intends to measure. The pilot study was made through dialogue with the girls who participated, and led to some corrections of the questions in the questionnaire. When working with the questionnaire I also had a dialogue with some of the staff from CHEP. They have a high knowledge in the subject sexual and reproductive health and they are used to work with youths. They also have a good insight in the cultural aspects. This was a way to make the questions more straight and proper for the target group so that they could understand the questions.

4.4. Data collection

The distribution of the questionnaires took place during three days, I visited two schools each day. When I came to the schools the girls had gathered in a classroom or the assembly hall. I noticed that the girls in some of the schools had been informed about me coming there and others had not. In all schools I started the meeting by

presenting myself and the study. I explained about the study, about their rights to say no to participate and that they were anonymous. The questionnaires were distributed to all present girls. Together with the questionnaire was an accompanying letter (appendix 1) with the same information I had given them orally and some practical details. I was present during the whole process since I wanted them to feel free to ask questions if there were any obscurities. In three of the schools a teacher was also present and in the other schools I was the only one present with the participants during the process. When completed, the questionnaires were placed in a box and collected by me.

4.5. Analysis

To analyse the collected data the computer program Statistical Package for the Social Sciences (SPSS) was used. The questionnaires were numbered and the questions with one answering alternative were put in the computer program as single variables. In the questions where several answers could be given all answering alternatives were put in the computer program as single variables. There were some open questions in the questionnaire, these questions were not analysed in SPSS but were handled manually. Frequency tables were made to get an overview of the result. To see if there were any significant differences between the age groups, cross-tabs and chi squared tests (χ^2) were used. In the χ^2 -tests the significance level was set to 5% ($p < 0.05$). Spearman's correlation (r_s) was used to see if there were any correlations between different variables and the significance level was set to 1% ($p < 0.01$).

4.6. Data transformation

In some questions the variables were put together. This was made in order to meet the requirements for the tests.

The age group, 14-17 years was divided in two groups, 14-15 years and 16-17 years. There was an over representation of girls in the first age group. The first age group constituted 75% (115/154). The second age group constituted 25% (38/154).

4.6.1. Information

Question 24:

- What do you think about the information you have been given about sex?

Answering alternatives: *Far too much*, *A little too much*, *Enough*, *Not enough* and *Far too little* were put together in three groups: *Too much*, *Enough* and *Too little*.

Question 28 and 30:

- Would you feel comfortable to access any youth center where you can get information about sexual and reproductive health?
- Do you think that information about sex can affect your behavior?

Answering alternatives: *Yes absolutely, Yes maybe, No not really, No not at all* and *I don't know* were put together in three groups: *Yes, No* and *I don't know*.

4.6.2. Knowledge

Question 13:

How much do you know about the following aspects:

- Puberty
- Sexual intercourse
- Pregnancy
- Contraceptive methods
- STI's
- HIV/AIDS

For each one of the six variables there were four answering alternatives which were given the numbers 1 (nothing) to 4 (very much). An index of the self perceived knowledge was made. By a summarization, an index in the interval 6-24 was given. The lower sum of the index, the lower self perceived knowledge. The level of the self perceived knowledge was set to low (6-11), middle (12-18) and high (19-24). The division of the three levels were made by myself and to the greatest extent possible divided in equal groups by the points.

Question 15, 16 and 19:

- What does condom protect against
- What do birth control pills protect against
- How can one be infected by HIV/AIDS

An index of the actual knowledge was made. For each one of the questions there were some right answering alternatives and some wrong answering alternatives. By a summarization, an index in the interval 0-15 was given. For each right answer 1 point was received and for each wrong answer 0 points were received. The lowest number one could get was 0 (no rights answers) and the highest was 15 (all answers right). The lower sum of the index, the lower actual knowledge. The level of actual knowledge was set to low (7-9), middle (10-12) and high (13-15). The lowest number that anyone had was 7 and therefore that was the limit for low knowledge. The division of the three levels were made by myself and to the greatest extent possible divided in equal groups by the points.

4.6.3. Attitudes

Question 3, 4, 5, 6 and 10:

- It is important to have sex in order to show your love
- Dating is never completed without sex
- It is ok for an unmarried couple to live together
- It is ok for an unmarried couple to have sexual intercourse
- Do you believe it is right to make an abortion

Answering alternatives of question 3, 4, 5 and 6: *Strongly agree, Agree, Disagree* and *Strongly disagree* were put together in two groups: *Agree* and *Disagree*.

Answering alternatives of question 10: *Yes absolutely, Absolutely, No not really, No not at all* and *I don't know* were put together in three groups, *Agree, Disagree* and *I don't know*.

An index of the attitudes was made. By a summarization, an index in the interval 5-10 was given. Agreeing in a question gave 1 point, disagreeing in a question gave 2 points. Those who had answered I don't know in the question about abortion were struck. The lowest number one could get was 5 (untraditional) and the highest number was 10 (traditional). The attitudes were divided in three different levels, untraditional (5-6), in between (7-8) and traditional (9-10). The lower sum of the index the more untraditional attitudes. The division of the three levels were made by myself and to the greatest extent possible divided in equal groups by the points.

4.7. Ethical considerations

Research is important both for the society and for the individuals. This in turn puts demands on the research to be true and essential. In Sweden there is a demand, the demand of research, which means that the knowledge that emerges improves and develops, which in turn creates better methods for research. In Swedish research there is a demand to protect the individuals from psychological and physical harm, humiliation and insult. All researchers ought to take this into consideration in their research. For the protection of participants there are some principles for research in humanistic and social sciences, made by the research council for humanistic and social sciences. The fundamental demand for the individual's protection is divided in four important parts: *Demand of information, Demand of approval, Demand of confidentiality* and *Demand of use* (Vetenskapsrådet, 2002).

Demand of information: The researcher ought to inform the participants about the actual aim of the research, they should also be informed about their rights and the voluntariness of participating (Vetenskapsrådet, 2002). Before distributing the questionnaires, the participants got information about the aim of the study and about me. The participants were also informed that their participation was completely voluntary. Forsman (1997) points out the importance of researchers giving truthful information about the study to the participants. I believe that the girls who participated in the study understood the information and participated through their own free will. At least this was what I tried to achieve.

Demand of approval: The participants in a research should have the right to decide over their own participation and the researcher should get approval from the participant. The participant has the right to decide if he/she wants to participate, for how long they want to participate and under which conditions (Vetenskapsrådet, 2002). Before distributing the questionnaires there was a dilemma about getting approval from the parents as the participants were under age. As all the participants were treated anonymous it was decided that it was not necessary to get approval from their parents, but approval were given from principals, teachers and from the participants themselves. The participants had the right to say no to participate whenever they wanted during the whole process and they were informed about this before they entered the study.

Demand of confidentiality: The participants in a research should be given highest confidentiality possible and personal information should be kept away from unauthorized persons. The participants have the right to be deleted from the research material. The details should be unidentified so it becomes impossible to identify the participants by reading the dissertation (Vetenskapsrådet, 2002). The questionnaires have been treated anonymous during the whole process and it is not possible to identify the individuals.

Demand of use: The details that have been collected from each individual should only be used for research purposes (Vetenskapsrådet, 2002). The collected data will only be used for this research and will not be used for any other purposes. Only the data that is presented in the final version of this dissertation will be available for the public. After finishing the work all the questionnaires will be destroyed and thrown away.

The study has been approved in the ethical trial which is made by the ethical council at Kristianstad University.

5. Results

In this chapter a presentation of the results will be given. The presentation of the results has been divided in three parts: *Information*, *Knowledge* and *Attitudes*. Each part is presented individually and then compared to the other parts. All the results in the tables are presented in percentages. In the end of the chapter there will be a summary of the results.

In case there is a significant difference the p-value is written in bold type, otherwise it is not significant.

5.1. Information

The respondents had to answer from where they had got information about sex and from where they thought it was important to get information about it. The results varied a great deal but the three alternatives which had the highest frequencies on both of the questions were parents, teacher and youth center. The result also showed that there was a moderate positive correlation between all the variables about the information that the respondents had got about sex and from where they thought it was important to get that information (table 2).

Table 2. Proportion (%) and correlation between from where they have got sex related information and from where they think it is important to get that information. Several answers could be given.

	Have got information <i>(n=153)</i>	Is important to get information <i>(n=154)</i>	r_s	p
Grandparents	25	30	0.547	0.000
Parents	45	49	0.518	0.000
Brother/Sister	16	20	0.557	0.000
Friend	31	25	0.586	0.000
Teacher	52	55	0.595	0.000
Youth center	44	66	0.513	0.000
Magazine	40	33	0.656	0.000
Nowhere	5	3	0.488	0.000

On the question about the importance of getting information about sex, the majority, 78% believed it to be very important, 13% answered that it is quite important, 3% answered that it is not so important, 3% believed it not to be important at all and 3% answered that they did not know.

A big part of the respondents (43%) stated that the information they had got about sexual and reproductive health was enough and 41% indicated that they had got too little information about it. Of the respondents, 17% believed that they had got too much information about sexual and reproductive health.

Almost all respondents (95%) would like to get more information about sex while 5% would not like to get more information about it.

Most of the respondents (73%) meant that sex education should be given in school.

More than half of the respondents (52%) did not believe that information about sexual and reproductive health could affect their behavior while 43% thought that it could, 5% did not know.

Slightly over half of the respondents (55%) stated that they knew about any youth center where to get information about sexual and reproductive health. The majority (78%) would feel comfortable to access a youth center, 17% would not feel comfortable to do it and 5% did not know.

5.2. Knowledge

There was a question about what the respondents thought it was important to get information about (n=149). The two factors that differed a lot from the others were HIV/AIDS and contraceptives. The majority (69%) stated that they thought it was important to get information about HIV/AIDS while only 23% believed that it was important to get information about contraceptives. The results are presented in table 3.

Table 3. Answering proportion (%) of what is important to get information about. Several answers could be given (n=149).

	Puberty	Sexual intercourse	Pregnancy	Contraceptives	STI's	HIV/AIDS
Yes	36	53	37	23	38	69
No	64	47	63	77	62	32

5.2.1. Self perceived knowledge

The respondents answered a question about how they looked at their own knowledge about different sex related factors. It will from here on be called self perceived knowledge. Like in the question about what is important to get information about, the two factors HIV/AIDS and contraceptives differed a lot from the others. Of the respondents, 80% stated that they knew very much or enough about HIV/AIDS while only 13% stated that they knew very much or enough about contraceptives (table 4).

Table 4. Answering proportion (%) of how much knowledge they believe themselves to have about different sex related factors.

	Puberty (n=146)	Sexual intercourse (n=146)	Pregnancy (n=144)	Contra-ceptives (n=146)	STP's (n=145)	HIV/AIDS (n=145)
Very much	28	23	29	3	32	52
Enough	23	25	32	10	28	28
Too little	27	33	24	29	28	14
Nothing	22	19	15	58	12	6

Table 5. Proportion (%) of the relation between level of self perceived knowledge and age (n=143).

Level of knowledge	Age 14-15 (n=104)	Age 16-17 (n=39)
Low	14	(18)
Middle	65	(67)
High	21	(15)

(Numbers in brackets when n<50). There was no significant difference of the level of self perceived knowledge between the different age groups ($\chi^2=0.878$, $df=2$, $p=0.645$).

5.2.2. Actual knowledge

As a comparison to how the respondents looked at their own knowledge about sexual and reproductive health they got to answer questions about HIV/AIDS transmission and about what condom and birth control pills protects against. It will from here on be called actual knowledge.

The results from the questions about HIV/AIDS transmission showed that 92% believed that one could be infected by HIV/AIDS by having sex but only 63% thought that HIV/AIDS could infect by blood and 57% that it could infect from mother to child. The majority (98%) did not believe that HIV/AIDS could infect by air, 98% did not believe that it could infect by using the same toilet, 97% did not believe that it could infect by hugging and 87% did not believe that it could infect by kissing. The results from the questions about what condom and birth control pill protects against showed that 59% believed that condom protects against pregnancy and 66% believed that it protects against HIV/AIDS. Only 30% believed that condom protects against STI's and 3% believed that it protects against malaria. When it comes to birth control pills, 82% believed that it protects against pregnancy, 17% believed that it protects against HIV/AIDS, 11% believed that it protects against STI's and 7% believed that birth control pills protects against malaria.

Table 6. Proportion (%) of the relation between level of actual knowledge and age (n=148).

Level of knowledge	Age 14-15 (n=110)	Age 16-17 (n=38)
Low	20	(8)
Middle	62	(71)
High	18	(21)

(Numbers in brackets when n<50). There was no significant difference of the level of actual knowledge between the different age groups ($\chi^2=2.948$, $df=2$, $p=0.229$).

5.2.3. Comparison between self-perceived and actual knowledge

The index about the self perceived knowledge and the index of the actual knowledge were compared with each other to see if there was any correlation between them. The result is presented in table 7 and shows that there was a very weak positive correlation ($r=0.226$, $p=0.008$).

Table 7. Correlation and answering proportion (%) of the self perceived and actual knowledge ($n=138$).

Self perceived knowledge	Actual knowledge		
	Low	Middle	High
Low	2	12	1
Middle	12	42	11
High	2	10	8

5.3. Attitudes

The results of the three questions about power relations between gender in intimate situations varied a great deal. The majority of the respondents (60%) stated that both the girl and the boy decide when to have sex. When it comes to who has the right to say no to sex on the other hand, 61% of the respondents stated that only the girl has that right. Again when it comes to the responsibility to use a condom, the majority (57%) stated that the responsibility lies in both the girl and the boy (table 8).

Table 8. Answering proportion (%) of power relations between gender in intimate situations.

When to have sex ($n=152$)		Right to say no to sex ($n=154$)		Responsibility to use condom ($n=154$)			
The girl	3	The girl	61	The girl	27		
The boy	36	The boy	1	The boy	16		
Both of them	60	Both of them	32	Both of them	57		
Somebody else	1	Nobody	6				

The respondents answered five questions which dealt with attitudes about different sex related factors. The result shows that the majority disagreed with the statements, which is seen as having traditional attitudes (table 9).

Table 9. Answering proportion (%) of attitudes about sex related factors.

	Right to make an abortion (n=154)	Dating is not completed without sex (n=153)	Unmarried couple can live together (n=154)	Unmarried couple can have sex (n=153)	Important to have sex to show love (n=154)
Agree	7	20	32	27	13
Disagree	85	80	68	73	87
I don't know	8				

Table 10. Proportion (%) of the different attitudes by all ages and divided by age.

Attitudes	All ages (n=140)	Age 14-15 (n=103)	Age 16-17 (n=37)
Untraditional	6	6	(8)
In between	21	18	(27)
Traditional	73	76	(65)

Numbers in brackets when n<50. The difference of the attitudes in the different age groups (table 11) did not meet the requirements for χ^2 .

A high perceived level of the received information was not correlated to traditional attitudes (n=137, $r_s=-0.013$, p=0.881).

A high level of self-perceived knowledge was not correlated to traditional attitudes (n=131, $r_s=0.032$, p=0.714).

A high level of the actual knowledge was weakly correlated to traditional attitudes (n=134, $r_s=0.227$, **p=0.008**).

5.4. Summary

The result of the study showed that the majority of the respondents believe that it is important to get information about sex but almost half of the respondents claimed that they had got to little information about it and almost everybody wanted more information about sex. Most of the respondents had got information about sex from parents, teacher and youth center. Slightly over half of the respondents knew about any youth center where to get information about sexual and reproductive health and 78% would feel comfortable to access a youth center for that matter. The results also showed that the respondents believe themselves to have adequate knowledge about HIV/AIDS but low knowledge about contraceptives which also is shown when the actual knowledge is measured. The respondents did have more knowledge about HIV/AIDS transmission than about condoms and birth control pills. When it comes to the attitudes, the majority of the respondents have attitudes which can be seen as traditional attitudes. The majority believe that it is not right to make an abortion or for an unmarried couple to have sex and 36% believe that only the boy decides when to have sex. The study showed that there was no correlation between the self perceived knowledge and the actual knowledge. Neither was there a correlation between the self perceived knowledge and attitudes or between the actual knowledge and the attitudes.

6. Discussion

In this chapter there will be a discussion about the method that was used and how it worked out. There will also be a discussion around the ethical considerations. The results of the study in relation to the theory and previous research about young girls' opinions, knowledge and attitudes about sexual and reproductive health and the different parts of the study will be discussed and reflected over. Finally there will be some conclusions and discussion about the relevance for health promotion work and proposals for future research in the area.

6.1. Discussion of method

The aim of this study can be a sensitive subject for young girls. Talking about sex, especially to a complete stranger can be difficult in their age. This was something that I really considered before going on with the study. The reasons for using a quantitative method were that I believed that it would be easier for the participants to answer sensitive questions in a questionnaire rather than expressing themselves to a stranger. By using a quantitative method the respondents also had time to contemplate and did not have to feel pressure to answer immediately. By validity Ejlertsson (1996) mean that it is important to go through all questions in a questionnaire so they are asked in a correct way and measures what it intends to measure. The methods above together with doing a pilot study was my way to try to make the validity of the questions as high as possible. As English is the official language in Zambia I believe that the language comprehension did not constitute any problem.

The study was carried out among schoolgirls during school time and I was present all the time. I believe that these two factors contributed to the high answering frequency (96%). The fact that the questionnaire was distributed while the girls were in school could have an impact as the teachers had informed them about me coming there to do the study and that they should participate. As they had been told this by their teacher I believe that their option to say no to participate decreased. In the Zambian culture the students does what the teachers tell them to do. My intention for being present during the process was mainly that I wanted to decrease the external non-response by straighten out possible obscurities. I also believe that my presence contributed to the high answering frequency. According to Vetenskapsrådet (2002) the respondents must have a choice to participate in a study of free will and the researcher should always get approval from the participant. I believe that the fact that the girls had been told by the teachers or principals to participate in the study they felt a pressure to do that. By giving them the option to fill in a box whether or not they wanted to participate I believe that I made it easier for them to say no. The participants had the opportunity to fill in the box that said no, but still fill in the questionnaire so that it looked like they did participate. This opportunity was used by 4 girls and their questionnaires were thrown by me afterwards.

The internal non-response was relatively low, but it was higher on some of the questions. According to Ejlertsson (1996) reliability of a question depends on the construction of the questions. If a question is badly constructed the effect could be that the answers will be given by random which means that repeated questions will

not give the same results. On some of the questions in the questionnaire it was possible or requested to give more than one answer. These were the questions with a higher internal reduction. I believe that the reliability on these questions is lower than on the other questions in the questionnaire. Probably it was too difficult for the respondents to understand the difference between when to give one or several answers and that is why they did not answer them, which probably increased the internal non-response. Besides that, it could have an impact on the results as it is impossible to know if those who only have given one answer did it because they believe it is right or that they did not understand the question.

The sample of the study consisted of girls from Kitwe, the second largest city in Zambia, which makes it difficult to generalise the results to all girls in that age group in Zambia. The sample is not representative for all girls in the age group as there are big differences between the city and the countryside. In the countryside it is not as common for the girls to go to school as it is in the larger cities. Not going to school is a factor that might have a great impact on the knowledge, the attitudes and the information they have got about sexual and reproductive health. Therefore I believe that the results should be generalised carefully. On the other hand maybe the results could be generalised to girls in the same age group in other larger cities in sub-Saharan countries which has a social situation similar to the one in Zambia. Another factor which can have an impact on the possibility to generalise the material is that I am not really sure about how the sample of the girls was made. According to Ejlertsson (1996) the sample must be made correctly from the concerned sample if a generalisation can be done. I handled the task of the sample over to the schools with the information that it should be a random sample, but as I was not present I can not really say if that is the way the sample was made at the chosen schools.

The indexes of self perceived knowledge, actual knowledge and attitudes have been constructed by myself and should therefore be interpreted carefully.

6.2. Discussion of results

The discussion of the results has been divided in the three different parts: *Information*, *Knowledge* and *Attitudes*.

6.2.1. Information

The majority of the respondents believed it to be important to get information about sex while almost half of the respondents stated that they had got too little information about it. According to Narayan (2002) information is power and people who are informed are better equipped to take advantage of opportunity, access services and exercise their rights. The results also showed that over half of the respondents knew about any youth center where to get information about sexual and reproductive health and the majority would feel comfortable to access a youth center. Also this is in accordance with Narayan's (2002) thoughts about information. My opinion is that if the youths know about youth centers and what they offer they will probably take advantage of the opportunity to access that service and feel more comfortable to do it.

Just over half of the respondents did not believe that information about sexual and reproductive health could affect their behavior. This can be interpreted in two different ways. Either they did not believe that information could affect their behavior in a positive way or they did not believe that it could affect their behavior in a negative way. Either way, parallels can be drawn to Antonovsky's (1991) theory of SOC. If the girls do not believe that they can affect what happens around them they probably have a low level of SOC, and if they feel capable of using the resources they have in their life they probably have a high level of SOC. According to Antonovsky there seems to be a tendency of a relation between having a high level of SOC and good health. I consider that a parallel can be drawn between the level of SOC and the health belief model. The health belief model (Bunton & MacDonald, 2002) suggests that for a successful behavior change, people need to have an incentive to change and feel competent to carry out that change. People also weigh the benefits against the costs before engaging in a new behavior. According to Janlert (2000) empowerment strengthens the possibilities of weak groups to affect their own lives and their health. As Lindén (1991) claims, a successful empowerment can help women to change their life conditions and by that also improve their health conditions. My opinion is that if the girls do not believe that they can affect their behavior themselves they might not try to engage in a new behavior, while girls who are empowered feel more competent to carry out that change.

Most of the respondents had got information about sex from parents, teacher and youth center which was also from where they thought it was important to get that information. My interpretation is that the information that they had got was good, comprehensible, manageable and meaningful. According to Antonovsky's (1991) theory people who see their life as comprehensible, manageable and meaningful are more likely to have resources to cope with difficulties in life. In my point of view this is a very positive result as there was a correlation between the two factors. If the girls feel that they can understand and handle the information they get and find it meaningful, they probably feel that they can handle difficult situations in their life. Over half of the respondents (52%) stated that they had got information about sex from a teacher. According to Säljö (2000) the secondary socialisation mainly takes place in school and other institutionalized environments. This is where children learn the skills they need to serve in accordance with norms and rules in the society. According to Medin & Alexandersson (2000) supportive environments are of great importance for people's health. The school is an essential supportive environment for youths (WHO, 2005) and therefore I believe it is of utmost importance that they get information about sex related factors there. My opinion is that even the youth center constitutes an important supportive environment in that context. The fact that 44% indicated that they had got information about sex from a youth center and 66% believed that it was important to get that kind of information shows that some of the girls believed that it was important even if they had not got any information about sex from there.

6.2.2. Knowledge

People in Zambia are affected by HIV/AIDS direct or indirect, which makes HIV/AIDS a big threat for the Zambian population. As a result of this there are many local initiatives to inform people about HIV/AIDS. The schools and churches mainly teach about abstinence (Rasing, 2003). The study gave a very interesting result of the

knowledge. It showed that 69% thought that it was important to get information about HIV/AIDS while only 23% thought that it was important to get information about contraceptives. The results of the self perceived knowledge showed that 80% believed themselves to have adequate knowledge about HIV/AIDS while only 13% believed themselves to have adequate knowledge about contraceptives. This tendency is also shown in the results of the actual knowledge. The respondents had higher knowledge about HIV/AIDS transmission than about what condom and birth control pill protects against. An interesting result is that in the question about HIV/AIDS transmission the respondents seemed to have more knowledge about HIV/AIDS transmission in relation to sex than to other factors. For example 92% believed that it infects by sex while only 57% believed that it infects from mother to child. The result showed a tendency that getting knowledge about HIV/AIDS seem to be the most important goal in sex education. My opinion is that since HIV/AIDS constitutes such a big threat (Rasing, 2003) it is understandable that it gets such a big scope in the sex education and it really should. But either way I consider that it should still be of great importance that even other sex related factors are brought up. Even though abstinence is the most effective way to be protected against HIV/AIDS it is well known that adolescents have sex anyway and that they start in an early age. Therefore it is of great importance that the institutions which teach about sex education are open for teaching about contraceptives and how to protect oneself. One of Freires (1972) theories was that theory and practice can not be separated from each other. The education must have a meaning for people, otherwise it will not be relevant for them. According to Rasing (2003) HIV/AIDS education is part of the education in schools and drama and poetry is often used as a way to talk about HIV/AIDS. I believe that the fact that the students learn about HIV/AIDS both by theory and practice increases their possibilities to gain knowledge in the subject.

Another interesting result is that there was no correlation between the self perceived knowledge and the actual knowledge. Either there is actually no correlation or the respondents underestimated or overestimated their knowledge.

6.2.3. Attitudes

The results from the questions about power relations between gender in intimate situations showed that even though 60% believed that both the girl and the boy decides when to have sex, 36% believed that only the boy gets to make that decision. Young girls are in a disadvantaged position as they have a higher share of morbidity and mortality related to sexual and reproductive health (Lindstrand, et. al. 2003). The balance of economical, social and physical power between men and women is an important factor, for example in the fight against HIV/AIDS, and will require changes in women's social and economic status (Abrahamsen, 1997). According to a study in Mexico females were more positive to safe sex than males but females were more likely to engage in risky situations (Martinez-Donate, et. al. 2004). I believe that information and education about HIV/AIDS and other sex related factors are supporting and promoting factors for women but it does not seem to be enough. A study made in South Africa showed that poverty and the social norms that subordinate women in sexual relationships have a powerful impact on unsafe sexual behavior among youth (Eaton, et. al. 2003). According to Abrahamsen (1997) a woman who suggests condom use is believed to either be HIV positive or accusing her partner for infidelity. As the marriage constitutes an economic and social security for women

they rather do not suggest condom use. This fact is shown in a study by Martinez-Donate et. al. (2004). The majority of the female and males in the study disagreed that condom should be proposed by women. My opinion is that cultural and social norms seem to have a great impact on the inequality between men and women in sexual and reproductive health. I believe that the cultural norms and values puts the women in a more vulnerable position as they may find themselves at higher risk for HIV infection and other sexual problems. Women need to be empowered so they can take control over their own lives and decide over their own bodies if a change in the inequality in sexual and reproductive health is to occur. The fact that empowering women is one of the eight Millennium goals shows the great importance of women empowerment.

The construction of gender identity goes on during socialisation. Different behaviors are reinforced for girls respective boys (Hannan, 2000). According to Wamala and Lynch (2002) the cultural and traditional beliefs in a society has an impact on the gender roles. This can be referred to Bourdieu's concept of habitus. People's habitus are formed by the culture and the society in where they live. The concept states that socioeconomic circumstances determine habitus which in turn determines behavior (Bourdieu, 1972). Zambian women are subordinated men and they do not have the same rights as men do (Rude, 1999). In my point of view there is a connection between women's subordinated position and Freire's liberating pedagogy. According to Freire (1972) the oppressed need to be aware of their social situation to liberate themselves. My opinion is that if the context, in which many girls grow up, is that they are less worth then boys and are being treated that way, they will be socialized into that way of thinking and in the end they do not reflect over it. Even if the women are aware of their social situation and want a change, it is probably still difficult to really do something about it in their subordinated position. In my point of view this is where empowerment becomes such an important issue. Narayan (2002) states that larger groups are more likely to make their voices heard. In accordance with that statement I believe that if women organize themselves in women groups and networks and work together with a common goal their possibility to gain freedom will increase.

The results from the five questions about attitudes of different sex related factors showed that the majority, 67% have attitudes that can be seen as traditional attitudes. For example 85% did not believe that it is right to make an abortion. According to Jarvis (1992) many of an individual's experiences are influenced by class, gender, ethnicity and other social factors which means that learning processes are related to the social structures in which people live. Hannan (2000) also stresses that the society play an important role in socialisation. She claims that the churches mediate values and role models during childhood, adolescence and early adulthood. According to Rude (1999) the church in Zambia has a powerful influence and the belief of the Zambian church is that women have an inferior status. I believe that the fact that most of the respondents have the traditional attitudes is a sum of the culture and the norms where they are brought up. As abortion is not accepted in the Zambian culture, the respondents do not think that it is right to make an abortion. According to Angelöw and Johnsson (2000) people's values are often formed by earlier experiences in which they learn which incidents are being rewarded or punished. Attitudes also help people defend themselves against criticism. The attitudes help people to achieve the goals that give reward and to avoid punishment. In accordance with Angelöw and Johnsson (2000) I believe that it might be difficult for the girls to have other attitudes than those which are socially and culturally accepted. So to avoid punishment and to defend

themselves against criticism it is just easier for them not to express untraditional attitudes. Another result that is strengthened by Jarvis' theory about social structures as the main influence on learning processes is the result which showed that there was no correlation between actual knowledge and attitudes or between thoughts about the received sex related information and attitudes. This means that there were no significant differences in attitudes between those who had high or low knowledge and between those who thought that they had got too much, enough or too little information about sex. In all the three groups of level of knowledge or received information the traditional attitudes were most common. Naidoo and Wills (2000) state that attitudes may be changed by more or different information but this does not seem to be the case in this matter. This result rather show a tendency that the primary socialisation i.e. the family and other smaller groups, have the strongest influence on the girl's attitudes about sex related factors and that knowledge did not have such a strong impact on the attitudes. As Rasing (2003) states, sex education is traditionally given by the grandparents and often in form of stories or examples. The result showed that 25% had got information from grandparents. This probably has a great impact on the young girl's attitudes.

So what is the most effective way in working with health promotion in order to promote SRH? According to Weare (2002) the aim of health promoting work is to help people to be as healthy as they want to be and not to create a perfect health. According to a study about different intervention methods for reducing STI's, skills training was better than health education (Baker, et. al). This is also in line with Naidoo and Wills thoughts that an effective way to change attitudes is by increasing a person's skills. Studies also show that peer education is effective in promoting behavior change in a sex related context (Norr, et. al. 2004). According to Bourdieu's concept of habitus it is possible to create people's new habits by changes of the external conditions i.e. availability and propaganda, which are non-pedagogic alternatives. On that there has not been a change through increasing the knowledge or changing the thinking but through forming new habits by external circumstances (Johansson & Miegel, 1996).

6.2.4. Conclusions and relevance in health promotion work

In summary, this study has examined opinions about sex related information and knowledge and attitudes about sexual and reproductive health among a sample of young girls in Zambia. The main goal in health promotion work is to increase the equality in health by strengthening the most vulnerable groups in the society (Health 21, 1998). As Zambian women constitute a vulnerable group in the Zambian society (Rude, 1999) it is of great importance to strengthen them in order to improve their health. With the results I wanted to contribute with knowledge that may be useful in the work to improve the health situation for women in the promotion of sexual and reproductive health. According to Tones and Tilford (1994) the key in health promotion is empowerment. I believe that empowering women is the key to reduce the inequalities in health between women and men. According to WHO (2005) supportive environments are of great importance for health and I believe that this is something that will help the subordinated women to take control over their lives and improve their health.

The results in this study showed a tendency that the traditional and cultural norms have a great impact on the girls. The majority agreed with the more traditional attitudes and there was no difference if they had got much or little information about sex or if they had a high level of self perceived/actual knowledge. The study shows that the cultural attitudes about sex related subjects have a strong influence in the society. The supportive environments from where the girls get sex related information (mainly parents, school and youth center) probably also have these attitudes. Therefore it is not enough to just teach the girls about sex as that will not change their attitudes. The girls need to be empowered so they can make healthy choices and take responsibility over their own sexuality.

My opinion is that the cultural norms put the Zambian women in an exposed position. To gain success in health promoting work there needs to be a change in the attitudes towards women. Not before that, it is possible to increase women's value and decrease the inequality between women and men in sexual and reproductive health.

6.2.5. Future research

This study has a cross-sectional character, meaning that it has given a momentous picture of the opinions, knowledge and attitudes among the girls. Therefore it has not been possible to study the relations between those factors and the actual behavior, something that I find of great interest. Even though this actual study did not study the relation between attitudes/knowledge and sexual behavior it is shown in previous research that higher knowledge about sex related factors seem to have little or no relation to safer sex and condom use (Akande, 2001). The theory of planned behavior (Bunton & MacDonald, 2002) is an often used theory to explain and understand behaviors. For future research, the model could be used to understand and predict the influence of knowledge on behavior but particularly the impact of attitudes and social norms on behavior in this context. It would also be interesting to do a study to follow up different interventions in the area. In a public health point of view this would be of great importance as the effects of the interventions could be studied further and give a higher knowledge and competence in how to work health promoting with sexual and reproductive health.

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