International Journal of Science and Research (IJSR)
ISSN: 2319-7064
SJIF (2022): 7.942

Zambia's Health Policy: A Comparison between Traditional and Modern Circumcision Practices in The Prevention of Transmission of HIV and Other STIS among Men in Chavuma and Kapiri Mposhi Districts

Clive Gosa[1], Dr Mafuleka Winston[2]

[1]Department of Political and Administrative Studies, University of Zambia

[2]Department of Political and Administrative Studies, University of Zambia

Abstract: ***This article explores the Zambia's Health Policy by making a comparison between traditional and modern circumcision practices to prevent the transmission of HIV and other new sexually transmitted infections (STIs) among men. The article derives its methodology by the use of Qualitative and Quantitative Designs. The article argues that, whereas HIV is a virus, an STI is actually an infection that is transmissible through sexual encounters. The key argument is that in both practices, circumcision, to a larger extent, prevented HIV transmission among men. However, the incidence and prevalence of STIs were not impacted by the benefits of circumcisionwhich was associated with significantly increased STIs risk among circumcised men with known common STIs (gonorrhea, chancroid and syphilis). The article concludes that, whereas the objective of attaining the HIV epidemic control is being actualized by the Zambian Government, the high prevalence of STIs among men after circumcision is an indication that the health policy's objective on STIs prevention was not being attained. And to attain the goal of zero new STIs among men by the Zambian government, the article suggests that, concerted and heightened efforts through stakeholders and traditional leadership engagement is needed.***

Keywords: Heath, Policy, Circumcision, Prevention, Transmission, HIV, STIs, Modern, Traditional, Zambia.

1. Introduction

Zambia's long - term socio - economic development agenda is guided by the National Vision 2030 which aims at transforming the country into a middle - income prosperous nation by 2030. Through the Vision 2030, the country has prioritized health and is committed to the attainment of 'equity of access to cost - effective quality health services, as close to the family as possible. The provision of a continuum of care is challenged by the burden of diseases in Zambia which is very high and characterized by the high prevalence of communicable diseases and an emerging burden of Non - Communicable Diseases (NCDs). Communicable diseases still constitute a major share of the disease burden affecting Zambians and which in some cases are the major causes of mortality are communicable diseases. According to the National Health Policy of 1991, among the communicable diseases, sexually transmitted infections (STIs), human Immunodeficiency Virus (HIV) and AIDS are the main contributor representing around 65% of all deaths, while Malaria represents 12.5% and diarrheal diseases represent 12.9%. Zambia has a generalized HIV epidemic influenced by structural factors such as gender inequality, social norms that encourage multiple concurrent partnerships, and unequal distribution of wealth.

According to ZDHS 2007, 14.3% of adults aged 15 - 49 years were HIV positive which is a drop by 1.3% from the 15.6% reported in 2001. Females (16.1%) are more likely to be HIV positive than males (12.3%) due to biological, economic, and social factors. Around 80 000 Zambians are infected with HIV every year. The 2009 epidemiological synthesis highlighted the following as the main drivers of the epidemic: multiple concurrent sexual partners, low and inconsistent use of condoms, low rates of male circumcision in some provinces, mobility, Labour migration, vulnerability, and marginalized groups, and vertical mother to child transmission. Over the past 10 years, significant progress has been made in strengthening the policy, legal, institutional and strategic frameworks for multi - sector response to sexually transmitted infections.

The overarching objective of the National Health Policy is to reduce the burden of disease, and maternal and infant mortality and increase life expectancy through the provision of a continuum of quality, effective health care. HIV and other STIs are some of the common communicable diseases that are part of the major share of the disease burden that continues affecting Zambians. STIs are a critical health and social problem affecting many people in Zambia. Therefore, the Government of Zambia through its health policy position on HIV and other STIs, is to end the prevalence of HIV and other sexually transmitted diseases, with increased emphasis on prevention, care, and treatment. To attain this goal, the fundamental objectives of the policy are, to halt and reduce the spread of STIs, HIV and AIDS by increasing access to quality HIV and other STIs interventions for prevention (VMMC), treatment and care. The Zambia Health Policy also recognizes the efforts made by traditional practitioners in reducing the disease burden in the country. The established institutions focus on traditional and alternative

health services, and are organized under the Traditional Health Practitioners Association of Zambia (THPAZ).

HIV and other STIs continue to be among the major public health challenges worldwide. Zambia is one of the countries in the African region seriously affected by STIs, coupled with the AIDS pandemic, is a leading cause of death among men. Along with efforts to continuously increase access to treatment and care, the need for effective preventive strategies is a priority. In this regard, the Zambian government, through its health policy, endorsed voluntary medical male circumcision (VMMC) as a preventive strategy against the transmission of HIV and other STIs among men. The health policy recommends that male circumcision (MC) in Zambia should be clinically based, as opposed to the alternative of traditional male circumcision (TMC). To this end, the policy is anchored on ending the prevalence of HIV and other STIs with increased emphasis on prevention, care, and treatment. On the other hand, traditional male circumcision continues to be an important practice and constitutes one of the ritual initiations into manhood among the Luvales and Lundas in the north - western part of Zambia. Despite the Zambian health policy measures such as the endorsement of modern circumcision practice and its objectives to halt and reduce the spread of HIV and other STIs among men through increased access to quality HIV/AIDS and other STIs interventions for prevention, treatment, and care, and on the other hand, policy measures in place of regulating health services provided by the traditional practitioners such as herbal medicine and circumcision, the problem is that some men continue to contract HIV and other STIs in the communities. STIs can have serious consequences beyond the immediate impact of the infection itself. This knowledge gap, if left unchecked, the men who contract STIs eventually may end up with certain health complications such as HIV and other STDs. And those men who acquire HIV and other STIs over time with the progression of the virus (HIV) would result into AIDS, Cancer, Chancroid, Gonorrhea, deformities, pneumonia (a condition that causes shortness of breathing), and eventually may die. To support this, according to WHO (2016), STIs are a common problem across the world and are responsible for high morbidity and can have severe health implications, and STIs such as herpes and syphilis can increase the risk of HIV acquisition three times or more. What this means is that the country could be deprived of its citizenry especially when men die of the HIV epidemic who probably could have contributed positively towards national development.

Further, Zavreiw (1994) documented that, the traditional practice of circumcision originally was for cultural reasons and not STIs, HIV, and AIDS preventive strategy, however, it is yet to be seen as a preventive measure against transmission of HIV and other STIs among men. In Zambia, circumcision, according to ZDHS (2014) was traditionally practiced on a large scale among Luvales and the Lundas only in the north - western province, an area which had the lowest HIV infection rates, while the central province where there is a prevalence of the modern practice of circumcision recorded the highest STIs prevalence among men at approximately six (6) percent compared to the north - western province that was at 4.6 percent. Therefore, some questions remain unanswered. For instance, why do men still contract HIV and STIs even after undergoing modern circumcision? On the other hand, Chinyama Seleji, (2010) documents that, the old traditional male circumcision continued in attracting men and recorded lower HIV rates of less than 10%, compared to the central province which was at 17% in 2014. Based on this literature, it is clear that, though male circumcision was documented in some National Demographic Health Surveys like the Zambia Demographic Health Survey (ZDHS) of 2014, data on the comparison between modern and traditional circumcision practices on the extent to which both practices prevented the transmission of HIV and other STIs among men was inadequate and required further development. Therefore, based on this knowledge gap and how to close it in literature, the study was conducted.

Generally, this study was to explore Zambia's Health Policy on the prevention of HIV and other STIs among men by comparing the efficacy of traditional and modern circumcision practices in Chavuma and Kapiri Mposhi districts. And specifically, the study compared the extent to which traditional and modern circumcision practices prevent HIV and STIs transmission among men.

2. Methodology

Study Designs*:* The study used both Qualitative and Quantitative Designs. Qualitative data was analyzed using content analysis, while Quantitative data was analyzed using the Statistical Package for Social Sciences (SPSS). The quantitative design had the potential to generate quantifiable result and made it possible to analyze the data. While Qualitative approach offered an in - depth explanation of the phenomenon which was under investigation, and generated information related to comparison between traditional and modern circumcision practices. This approach also entailed the process of collecting and analyzing the data whereby the content from qualitative instruments was categorized and coded, and this facilitated data entry and analysis.

Types of Sampling*:* The study used Convenience, Quasi - Random, and Snowball Sampling.
Sample Size: 255 participants were targeted as a sample size.
*Convenience Sampling***:** 30 respondents conveniently interviewed (VMMC coordinator, director, doctors, COs, Incharges and nurses), lists obtained from 20 clinics conveniently selected from a total of 30 health facilities (HFs) (Source: HR database).

Quasi - Random Sampling*:* A systematic sample of picking every nth entry from list of names of medically circumcised men (100) out of the sampling frame of 1000 (Source: registers).

Snowball Sampling**:** Recruitment involved participants identifying other potential subjects (125);
i) Linear Snowball Sampling: 5 headmen, 10 elderly members and 10 traditional circumcisers.
ii) Exponential Non - Discriminative Snowball Sampling: 100 traditionally circumcised men.

Research Instruments for Data Collection: Questionnaires, consisting of both open and closed questions, were constructed and administered to circumcised men and health workers providing male circumcision services at some selected health facilities. In - depth interviews using the Interview Guide, were another mode of data collection, especially for VMMC Program Co - ordinator, those in charge of clinics, health directors, traditional leaders and community representative. These were assumed to be knowledgeable about the male circumcision.

Pretest: Study instruments developed and pretested in districts not part of the study sample; Kabwe (prevalence of VMMC) and Kabompo (traditional) districts. This helped to ascertain: Reliability and validity of the data collection tools; duration of administering the questionnaire (Measure time spent); and the appropriateness and clarity of the questions that were to be asked.

Data Processing: Questionnaires were edited thoroughly and discarded errors that had potential to influence the analysis of data. This helped the researcher to ensure that raw data was edited, categorized, coded and entered into tables using Excel which later was exported in SPSS for analysis.

Data Analysis: Statistical Package for Social Sciences (SPSS) Version 16.0 was used in the analysis of quantitative data, whilst qualitative data from interviews was analyzed using content analysis. Closed ended questions in the questionnaires were coded. The responses in the open ended questions were categorized, coded by assigning figures, and this made it easier for data entry in SPSS and analysis purposes. Content analysis was used to analyze responses from the key informants. Thereafter, assigning codes with figures made it easier to enter data in SPSS. The SPSS software package was used because it offered some of the following merits: it was user friendly, it had enough space for the long range of numbers; and mathematical manipulations were easily dealt with using its in - built functions. It also permitted various ways of presenting data in the form of tables, frequencies, cross tabulations, percentages, bar charts and other figures. Therefore, data was presented using percentages, tables, bar charts and any in figure forms.

3. Theoretical Framework

The study was guided by Serrat (2017), the Theory of Change, Albert Bandura (1977), Self - efficacy theory, Rosenstock's (1944) Health belief model theory, and Victor Vroom's (1964) Expectancy value theory. These described how the perceived action of motivated behavior in a specific population would result in the desired results. This meant that individuals could have different goals and be motivated toward a particular goal, provided they have expectations or values attributed to the pursued goal. These theories described the process of applicability of the theory in understanding how a given circumcision practice is efficacious in the prevention of transmission of HIV and other STIs among men.

The Expectancy value theory (EVT), Self - efficacy (SET) and Health belief model theory (HBM) had the potential of guiding the study on the Zambia's Health Policy on HIV and other STIs by comparing the efficacy of traditional and modern circumcision practices in Chavuma and Kapiri Mposhi districts. However, the two theories (SET&HBM) were useful in providing guidance than the other theories, hence this was the main reason why they were adopted to constitute a theoretical framework in this study as a way of analyzing the phenomenon under investigation.

4. Review of Literature

In this study, literature was reviewed at Global, Continental and National levels. According to WHO report of 2007, scientists had suspected that male circumcision might reduce rates of HIV and other STIs transmission during sex. They observed that circumcised men were less likely to have STIs than uncircumcised men, and HIV was less common among populations that traditionally practiced male circumcision than in communities where the procedure was rare. However, for a long time it was unclear to what extent this was an effect of circumcision itself and whether other factors might also play a role. Male circumcision is common in many African countries, and is almost universal in Northern parts of Africa and most of West Africa. In contrast, according to WHO (2007), it was less common in southern Africa, where self - reported prevalence was around 15% in several countries (Botswana, Namibia, Swaziland, Zambia and Zimbabwe), although higher in others (Malawi 21%, South Africa 35%, Lesotho 48%, Mozambique 60%, and Angola and Madagascar > 80%). Further, the report by WHO (2007) shows that the prevalence in Central and East Africa varied from approximately 15% in Burundi and Rwanda to 70% in the United Republic of Tanzania, 84% in Kenya and 93% in Ethiopia. This variation was partly due to some groups (mainly Nilotic or Sudanic speakers) who were traditionally non - circumcising, and also to different ethnic traditions among Bantu - speaking populations (which included over 400 different ethnic groups in Africa, from Cameroon to South Africa), some of whom gradually stopped the practice many centuries ago.

In Zambia, traditional circumcision ceremonies such as *Mukanda* initiation ceremony, which was a passage of ritual rites had been practiced by ethnic groups in North - Western Part of the country among the Luvale, Lunda, and Kaonde speaking people. Sometimes, a few months during winter season, young adolescents from these tribes were taken to the camps set up in the bush near the community. At these camps, they were taught traits and dances peculiar to their tradition, cultural values, skills expected of a man from their ethnic groups, roles, duties of a good husband, and later on the teenagers were circumcised using a special knife as a symbol of initiation into adulthood. A study by Chinyama Seleji (2010) showed that some respondents could not correlate HIV transmission at Circumcision. They did not believe that the youngest initiates could be HIV positive because these had not yet engaged in sex. A notable gap in literature was that most of the literature lacked exploration of the health policy: A comparison between traditional and

modern circumcision practices in the prevention of transmission of HIV and other STIs among men in Chavuma and Kapiri Mposhi districts. And therefore, to close this gap, a need to ascertain a more efficacious circumcision practice.

5. Study Ethics

Ethical Consideration

After the study was approved by the School of Humanities and Social Sciences under the department of Public Administration, the proposal was later taken for ethical clearance from the University of Zambia Postgraduate Ethics Committee. The ethics clearance was granted by the ethics committee and the reference number, **HSSREC: 2021 – FEB - 005** was obtained. Once the approval to conduct the study was granted, the approved proposal was then submitted to the Ministry of Health (MOH) and Provincial Health Office (PHO) of Central and North - western provinces with an application letter for permission to go into the selected health facilities and communities for data collection.

The researcher was granted an opportunity to go ahead with the study within the short period in the midst of COVID - 19 pandemic. The Introductory letter about the study was then gotten as authority to proceed in conducting the study.

Issues of Confidentiality and Consent

The study considered issues of confidentiality, thereby instilling confidence and trust in the participants. For example, when interviewing the key informants, the study used a one - to - one approach and made it clear that whatever responses they gave remained confidential. In this case, the respondents did not hide anything but felt free and brought out the information required by the study. In other words, the study considered ethical issues such as participants' rights to ***participation, confidentiality and anonymity, privacy, and self - confidence.***

In addition, the researcher got information from the participants; hence the right to know was upheld. It was also worth noting that before interviews, the participants in the study were first briefed on the aim of the study and clearly stated how relevant their contributions were to the study. It was also made clear in the first place that there was no form of intimidation and completely voluntary and free participation in the study was encouraged. Also, in cases when some participants decided not to take part or withdrew due to one reason or another during the study, it was clearly stated that no form of coercion or penalty was sanctioned on them. Language as a tool of the study was used in soliciting information. Interpretation of the participant's language when necessary was used in situations where the respondent did not speak the language in use. This was done by getting ***verbal consent*** from such participants and in cases that warranted giving of ***written consent forms***, this was done.

6. Discussions and Results

The study findings were categorized into modern, traditional and circumcised men's perspectives towards circumcision as a preventive measure against the transmission of HIV and other STIs among men.

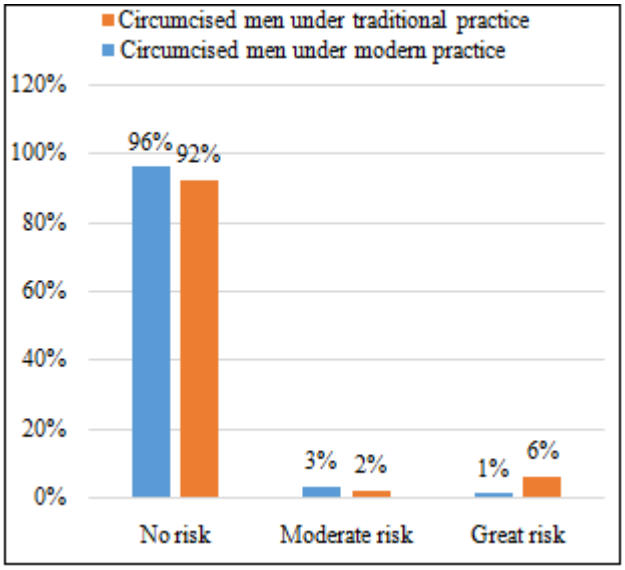

Figure 1: Clients' Extent of Exposure to HIV Transmission after Circumcision

Figure 1 shows that the highest number of circumcised men (96%) under modern circumcision practice reported that there was no risk of HIV related infection after circumcision, followed by those (3%) who reported that the risk was moderate and the lowest (1%) were of the view that they were actually at great risk. In terms of traditional circumcision practice, most of the circumcised men (92%) reported that there was no risk related to HIV infections after they got circumcised, and a few reported that there were at great (6%) and moderate (2%) risk of exposure after unprotected sexual activities.

By circumcision type, it is clear that both men circumcised under traditional and modern circumcision practice, the majority of them (96% - modern and 92% - traditional) were of the view that there was low or no risk at all associated with HIV infection after circumcision and a minority (6% - traditional and 1% - modern) reported of being at great risk of HIV exposure after engaging into unprotected sexual activities. Surprisingly, those (6%) respondents who reported of great risk of HIV after circumcision and doubted the protection that circumcision offered under traditional circumcision, their views were consistent with those of surgical knife and HIV infection among the initiates at *Mukanda* camps.

Even though the exposure to HIV among the initiates under traditional practice was high (great) compared to the modern one, the study, however, did not find any trace of the HIV pattern of infected men after a traditional circumcision. Therefore, though some views of risks (3% - modern and 2% - traditional) associated with HIV - related infections after circumcision, the study concludes that circumcision under modern and traditional practices offers greater protection against HIV infection among men. In this vein, the measure of HIV and circumcision on the scale ranged from moderate risk to low risk or no risk (96% - modern and 92% traditional).

And using the self - efficacy theory (SET) on the extent to which modern and traditional circumcision practices prevent the HIV transmission among men, this theory assisted to

explain that, the larger the extent of the prevention of HIV, the more efficacious circumcision program under modern or traditional practice was in the prevention of HIV, and the less the extent, then the low or less efficacy the practice was. And based on this, the study established that indeed HIV transmission among men was reduced to a larger extent or the risk of HIV acquisition among the circumcised men was low in both practices. However, if the findings of the study showed less efficacious of these practices, then the opposite would have been true implying that circumcision practices were less effective in the prevention of HIV transmission among men, and the use of the self - efficacy theory (SET) become key to ascertain the effectiveness of both practices. Further, the researcher was of the view that any intervention (circumcision) that combines the two theories (HBM and SET) might have better efficacy and the chapter combined the two in understanding the effectiveness of a given circumcision practice towards the prevention of HIV transmission among men. Therefore, since the study established that the traditional and largely modern circumcision practice showed consistent efficacy in reduction of the transmission of HIV infection among the men after circumcision, the study concludes that the chance of acquiring HIV infections among the circumcised men regardless of the circumcision practice they had to undergo was generally low or not there at all. In this regard, the following summarizes the findings under HIV and circumcision:

- The study established that there was reduced or no risk associated with HIV after circumcision.
- The study deduced that circumcision performed under medical or traditional setting to a larger extent, potentially prevented the transmission of HIV transmission among men.
- In the study, circumcision showed consistent patterns of efficacy in the reduction of HIV transmission among men who had a follow - up HIV test at the health facilities.
- Although circumcision lowered the chances of contracting HIV among the men, the levels of efficacy on HIV prevention among the two circumcision practices differed.
- Zambian Health Policy was achieving its objective of halting and reducing the HIV transmission among men.

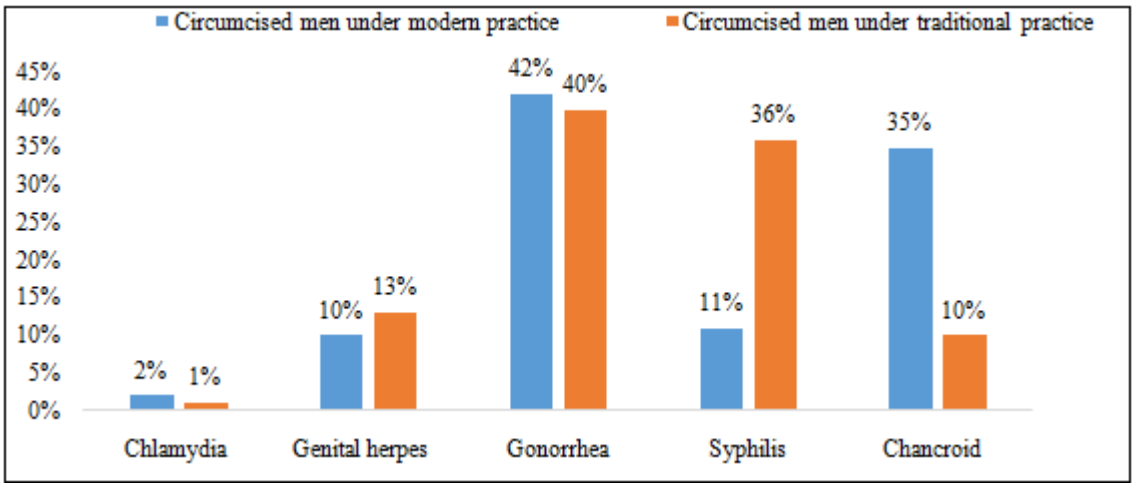

Figure 2: Clients' Extent of Exposure to other STI Transmission after Circumcision and common types of STIs

Figure 2 shows that under modern circumcision practice, the most common sexually transmitted infections (STIs) as reported by the circumcised men was Gonorrhea (42%), and the second reported type of STIs common was chancroid (35%). Syphilis was reported by some circumcised men (11%) as another common STI, while genital herpes accounted for only ten percent (10%) of the circumcised men. And the least reported STIs were chlamydia (2%). On the other hand, under traditional practice, the leading STI common as reported by most circumcised men (40%) was gonorrhea and this was followed by syphilis (36%). Another reported common type of STI was Genital herpes (13%). Further, chancroid accounted for ten percent (10%) and the least reported STI by the circumcised men (1%) was Chlamydia.

The study established that generally, under traditional and modern circumcision practices, the most common STIs reported were gonorrhea, chancroid, syphilis, and the least were chlamydia and genital herpes.

Even though the report by WHO in 2007 reported that neonatal circumcision was associated with reduced STIs among the neonates in the United States of America, probably these findings needed comparison with that of adult populations. However, this study has brought out new findings in adult populations, indicating that most circumcised men substantially had increased STIs risk and the study findings were strongly supported by Robert and Van (2013). According to Robert S. and Van Howe (2013), most specific sexually transmitted infections (STIs) were not impacted significantly by circumcision status. These include chlamydia, gonorrhea, herpes simplex virus type 2 (HSV), and genital human papillomavirus (HPV) infections (HPV). Syphilis showed mixed results with prevalence studies suggesting intact men were at great risk and incidence studies suggesting the opposite in circumcised men. Robert and Van's report of 2013 further indicated, "It is also clear that any positive impact of circumcision on STIs is not seen in general populations. Consequently, the prevention of STIs cannot be rationally interpreted as a benefit of circumcision, and a policy of circumcision for the general population to

prevent STIs is not supported by the evidence currently available in the medical literature".

The findings further show that there were no statistically significant differences noted in circumcision and the prevention of common sexually transmitted infections (STIs). This leads to conclude that the incidence and prevalence of STIs were not affected by circumcision. Therefore, circumcision was associated with noticeably increased STI risk among circumcised men with known STIs (gonorrhea, chancroid and syphilis). The following summarizes the findings under circumcision and other STIs:

- In the study, medically and traditionally circumcised men were associated with increased STIs positivity rates from an average of 1% (2019) to 1.7% (2020) against the National Standard of Zero (0) Sexually transmitted infections (STIs Guidelines, WHO 2017).
- The study established that circumcision was associated with noticeably increased STI risk among circumcised men implying that both practices to a larger extent were not effective in the prevention of transmission of other STIs among men.
- The study established that the most common STIs among the circumcised men were gonorrhea, syphilis and chancroid.
- The study established that, whereas, the main route to other STIs transmission was through sexual activities, HIV on the other hand was transmissible through unsterilized surgical instruments, sex and blood (blood transfusion).
- Zambia's health policy objective of preventing sexually transmitted infections (STIs) among men was not being achieved.

7. Conclusion

From the preceding findings, the study concluded that circumcision performed under traditional and modern practice to a larger extent protects men after circumcision against the transmission of HIV. However, on the other hand, the study concluded that there was no impact of circumcision on STIs prevention, instead consistent patterns of risks of STIs among circumcised men across were common in both practices. The study further concluded that the levels of efficacy in the prevention of STIs and HIV among the circumcised men differed from one practice to another, that is to say, there was a statistical significance of protection of circumcised men on HIV compared with those circumcised under the traditional practice, and similar pattern was found under STI prevention. Therefore, even though most reviewed literature indicated that circumcised men have a reduced chance of acquiring STIs and HIV, the researcher concludes that, in fact, circumcision does not guarantee hundred percent (100%) full protection of the circumcised clients from contracting sexually transmitted infections (STIs), and that, there is still a chance for getting infected with STIs among the circumcised men. On the other hand, the research concludes that circumcision is highly efficacious in the prevention of HIV transmission. And lastly, Zambian health policy's objective on HIV prevention through male circumcision has proven to be an effective intervention in the reduction of the scourge of HIV infection among men, but less effective in the prevention of other STIs apart from HIV.

References

[1] Bandura, A. (1977), 'Self - efficacy: Toward a unifying theory of behavioral change. '*Psychological Review*, 84 (2), 191 - 215.

[2] Chinyama Seleji, (2010), *Tradition male circumcision and risk of HIV transmission in Chavuma District, North western province, Zambia*. The University of Zambia, Lusaka.

[3] Clarke, V. A., Lovegrove, H., Williams, A., & Machperson, M. (2000), '*Unrealistic optimism and the Health Belief Model*. ' Journal of Behavioral Medicine, 23 (4), 367 - 376. Cresswell, J. W.2003. Research design. Qualitative and Quantitative approaches.

[4] Mavhu, W., et al., (2011), *'Prevalence and factors associated in knowledge of the willingness for MC in rural Zimbabwe.* ' Tropical Med Int Health 16 (5): 589 - 597.

[5] Pappas - DeLuca, K. A., Simeon, F. and Kustaa, F. (2008), *Preliminary Results of the Report on Findings from Qualitative Research on Male Circumcision in Namibia: Unpolished report.* Windhoek: Ministry of Health and Social Services.

[6] Parker SW, Stewart A. J, Wren MN, Gollow MM, Straton JA. (1983), *'Circumcision and Sexually transmissible disease.* 'The Medical Journal of Australia, 01 Sep 1983, 2 (6): 288 - 290.

[7] PeltzerK. and Kanta X. (2009), *Culture, Health & Sexuality: Research Support, U. S. Government, Non - P. H. S.,* Journal Article DOI: 10.1080/13691050802389777, 01 Jan 2009, 11 (1): 83 - 97.

[8] Vern L. Bullough and Bonnie Bullough (ed.), '*Human Sexuality: An Encyclopedia*'. New York: Garland Pub., 1994. p.119 - 122.

[9] Weimer, D.; Vining, A. (2005), *Policy Analysis: Concepts and Practice*. (Fourth ed.). Upper Saddle River, NJ: Pearson Prentice Hall. ISBN 0 - 13 - 183001 - 5.

Author Profile

Clive Gosa, Department of Political and Administrative Studies, University of Zambia. **Clive Gosa (MPA)** is a PHD Student under the supervision of Dr Mafuleka Winston. Author can be contacted at +260 977533266

Dr Mafuleka Winston, Department of Political and Administrative Studies, University of Zambia. +260 96222936