

**FACTORS CONSTITUTING MOTIVATORS AND BARRIERS TO THE
EFFECTIVE UTILIZATION OF VOLUNTARY COUNSELLING AND TESTING BY
GIRLS: A CASE STUDY OF ADOLESCENT GIRLS AT UMOYO TRAINING
CENTRE**

By

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**A Dissertation submitted in partial fulfillment of the requirements for the award of
Master of Arts in Gender and Development Studies**

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DECLARATION

I, Festus Zulu, hereby declare that this dissertation represents my own work, and that it has not previously been submitted for a degree at this or any other University. All published work or materials that have been incorporated have been specifically acknowledged and adequate reference made.

Signature:

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APPROVAL

This dissertation of Festus Zulu has been approved as fulfilling part of the requirements for the awards of Master of Arts Degree in Gender and Development Studies of the University of Zambia.

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ABSTRACT

Voluntary Counseling and Testing (VCT) is a corner stone for successful implementation of prevention, care and support services among HIV negative and positive individuals. VCT is also an effective strategy in risk reduction among sexually active young people.

This study was designed to determine the factors constituting motivators and barriers to the effective utilization of Voluntary Counseling and Testing among girls age between 14 and 21 at Umoyo Training Centre Lusaka. It was prompted by low uptake of VCT services among adolescent girls despite the fact that they are more vulnerable to abuse and in turn have a higher risk of acquiring HIV.

This was a descriptive cross-sectional study that used both qualitative and quantitative research approaches. Data was collected through structured and semi-structured questionnaires, Focus Group Discussions with the girls and key informant interviews with VCT counselors of Kanyama Health Centre.

The findings showed that the level of knowledge on VCT among adolescent girls of Umoyo Training centre was high (80%). Nearly 82 % reported that they know they can be tested for HIV and were comfortable to use the VCT services, 95% of the respondents who have heard about VCT have strong positive attitudes towards the use of VCT. Majority of the young girls believe that the best way to pass VCT information is through the electronic media (TV and Radio) and parents as one of the main sources of VCT information was ranked very low. The results indicated that perceived benefits played a role in influencing the participants' decision to go for VCT. Even though participants acknowledged barriers to VCT, they reported that the perceived benefits for VCT outweighed the barriers.

However, many barriers, benefits and motivators were reported, influencing girls' decision-making process with regard to utilizing VCT. It was reported that fear of stigma and discrimination restricted utilization and access to VCT services. Adolescent girls feel the risks of knowing and disclosing their sero-status outweigh the benefits hence one important challenge in addressing the needs of adolescent girls lies in understanding the extent to which the adolescents know about and use protective measures against the risks.

DEDICATION

This work is dedicated in loving memory of my late father Ezekiel Zulu and my late special friend Innocent Siakondo. I wish you were here to see and taste the fruits of my labour. May your soul continue to rest in eternal peace.

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ACRONYMS/ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
CSO	Central Statistics Office
FGD	Focus Group Discussions
HIV	Human immunodeficiency Virus
MOH	Ministry of Health
MTCT	Mother to Child Transmission
NAC	National HIV/AIDS/STI/TB council
NGO	Non-Governmental Organisation
PMTCT	Prevention of Mother to Child Transmission
SBS	Sexual Behaviour Survey
SPSS	Statistical package for Social Science
STI	Sexually transmitted Infection
UNAIDS	United Nations Programme on HIV/AIDS
UNZA	University Of Zambia
VSO	Voluntary Services Overseas
VCT	Voluntary Counseling and Testing
YWCA	Young Women Christian Association
WHO	World Health Organisation
ZDHS	Zambia Demographic Health Survey

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CHAPTER ONE

INTRODUCTION

1.1 Background

Global HIV and AIDS trends and Statistics

HIV and AIDS have captured people's attention in recent times than any other diseases. Millions of lives, worldwide, are lost to HIV and AIDS on a daily basis and the war is still continuing. In 1987, the World Health Organization (WHO) first recognized the seriousness of the emerging AIDS epidemic, and since then HIV has become a global problem (WHO, 2006).

UNAIDS (2007) report estimates that about 33.2 million people are living with HIV worldwide, a slight reduction from the estimated 39.5 million in 2006. Of the 33.2 million infections worldwide, 22.5 million (representing 68% of global infections) are estimated to be from the Sub-Saharan Africa. Of these (22.5 million) 61% are women, unlike in other regions where males and females are almost equally affected.

In 2007, an estimated 1.7 million people were newly infected with HIV in sub-Saharan Africa. Globally an estimated 2.1 million people died due to AIDS in 2007 and of these 76% occurred in sub-Saharan Africa.

Women are generally infected at a younger age than men, and die younger. AIDS deaths in women in sub-Saharan Africa generally peak in women in their 20s, whereas AIDS deaths peak in men in their 30s and early 40s. This shows that AIDS has worst hit the most

productive people and has resulted in disintegration of most families and many children left in destitution (Helen, 2002).

Zambian HIV and AIDS Situation

In Zambia, the first AIDS case was reported in 1984. By 1997 there were about 45,000 AIDS related cases. Approximately, one million Zambians are HIV-positive, of which over 295,240 are in need of antiretroviral therapy (MOH, 2006-2007).

Zambia is one of the countries hardest hit by HIV epidemic with a national prevalence of 14.3 percent among the 15-49 years age group (ZDHS, 2007).

According to ZDHS 2007, HIV prevalence of women and men age 15 – 49 is 14%. Even though there is a decrease of HIV prevalence from 16% to 14% in Zambia, women still record a high prevalence rate of 16% to 12% HIV positive (ZDHS, 2007). Despite the slight reduction in HIV infections in recent years, these reductions can be accounted for due to more accurate ways of gathering statistics, high numbers of people dying of HIV related illnesses, and the increased number of people who go for voluntary counseling and testing (VCT).

Seroprevalence rates for both men and women are two-fold higher in urban (20%) than rural areas (10%). HIV prevalence varies considerably within the country. Infection rates are high in cities and towns along the major transportation routes and lower in rural areas with low population density. They are at their highest in urban areas of the Lusaka 21%, central 18%, Copperbelt 17% (ZDHS, 2007). The most affected are young women and girls. Although

awareness about HIV and AIDS is high, this does not translate into positive action for prevention such as uptake of Voluntary counseling and testing (VCT) and condom uses.

HIV and AIDS is not a gender-neutral disease, women and girls are much more susceptible to infection than men due to their continuing economic and social marginalization; as well as physical vulnerability. Gender gap is even wider amongst the age of 35. Generally, women (with prevalence rates of 17.8 %) are 1.4 times more likely to be HIV-positive than men (with prevalence rates of 12.6 %) (Zambia Country Report, 2008).

HIV and AIDS have no cure and efforts are geared towards slowing down its spread with view to saving the unaffected. Among the measures currently employed to fight the disease are: sexual abstinence, marital fidelity, condoms, ARV drugs and VCT. VCT is fast becoming an effective weapon to fight HIV and AIDS in Zambia (Ministry of Health, 2005).

National Response to HIV and AIDS

The National HIV/AIDS/STI/TB Council developed interventions strategic plan for the period 2006-2010 in order to reduce the HIV prevalence rate of 15-19 age group. This was to achieve four broad objectives, thus;

- To reduce HIV/STI transmission mainly focusing on children, young women and providing risk of HIV/STI transmission;
- To reduce social-economic impact of HIV and AIDS on individuals, families, at the work place, homes and the society at large.
- To maintain and improve operational and implementation procedures and processes to ensure timely and effective management, decision making;

- To ensure that results oriented co-ordination of activities takes place at different levels of implementation (University of Zambia, 2006).

The problem of HIV/AIDS is recognized as a major issue of both individual and public concern and the devastating effects are clearly outlined in the policy document. Its contribution to mortality and morbidity particularly among young people and other professional staff is having a negative effect on the education system and the economy in general.

HIV/AIDS promote poverty in the sense that the labour force is reduced. It incapacitates households to pay for services such as school and medical fees and other needs. The infection has economic, social, moral and health implications for all citizens (MOE, 2001).

Treatment and care consists of a number of different elements including Voluntary Counseling and Testing, provisions of antiretroviral (ARVs) protection from stigma and discrimination and follow up counseling. Voluntary Counseling and Testing (VCT) is considered an important component of the Zambia government's response to the HIV and AIDS pandemic. Despite this, the numbers of Zambian who have accessed VCT remains low (National HIV/AIDS/STI/TB Policy, 2005).

Voluntary Counselling and testing for HIV programme has become a major component of the expanding responses to the HIV and AIDS pandemic. Early testing for HIV and AIDS offers many benefits for adolescent girls but in many countries it is still rare. HIV counselling has been defined as "a confidential dialogue between a person and a care provider aimed at enabling the person to cope with stress and make personal decisions related to HIV/AIDS. "The counseling process includes an evaluation of personal risk of HIV transmission and facilitation of preventive behaviour."(WHO, 1994).

When the HIV test was developed in the mid 1980s, testing tended to be accompanied by little HIV counseling (Zambia Counseling Council: 2001). However, with the growing awareness of HIV infection and AIDS and the recent availability of antiretroviral therapy (ART), the scope of and reasons for Voluntary Counseling and HIV Testing have broadened.

There is a great urgency to promote HIV care and support services for adolescent girls, including VCT. Currently, although VCT programmes are being developed and expanded there has been little emphasis on providing VCT services to meet the needs of adolescent girls (UNAIDS, 2000). The uptake on ongoing care and support services by adolescent girls following VCT is not known although follow-up of adolescent girls following VCT is difficult, particularly in sites where anonymous VCT is offered (UNAIDS, 2000).

VCT services are becoming increasingly common in Zambia, supported by government and private foundations. Many countries and Zambia inclusive are implementing VCT services where HIV testing may be done free or for a small fee after pre-test counseling. VCT may be set up within a hospital, clinic or other setting, or as independent services in communities. The number of public and private facilities providing VCT/CT services had increased from 1,102 sites in 2007 to 1,563 public and private health facilities at the end of 2008. Of this number, private owned health facilities were 92 while the public health facilities accounted for 1,471 of which 117 were mission and the balance of 1,354 were owned by the Government of the Republic of Zambia (GRZ). This indicates that 100 per cent of all health facilities in Zambia provided HIV counseling and testing services from a combined total of 1,800 HIV counseling and testing sites covering the whole country in 2009 (Zambia Country

Progress Report - 2010). Even though, there are many organizations that offer VCT services, our main interest is Umoyo Training Centre which is under Kara Counselling.

According to Demographic Health Survey 2007, Voluntary Counselling and Testing is more common among the educated and those living in the urban areas. It revealed that, 23.9 percent of women and 13.4 percent of men in the urban areas had ever been tested for HIV as compared to the rural areas at 14.6 percent for women and 10.1 percent for men (ZDHS, 2007).

Umoyo Training Centre which is the site of this study aim to build and sustain the capacity of young females to cope with life situations. This is done through community follow-up and female youth empowerment programmes as follows;

- To build and sustain the capacity of female orphans and vulnerable female youth.
- To contribute to the reduction of the spread of HIV and AIDS in youths and empower them with skills to positively deal or cope with difficult situations they encounter in their lives.
- To lobby and advocate for protection and improvement of the welfare of children.

Kara Counseling and Training Trust (KCTT) was founded in 1989 by Fr. Michael Kelly SJ, but its legal entity received registration in 1991. KCTT's vision is to work towards 'A society free of suffering where all people take charge of and live long and productive lives in freedom and equality, with Zambia taking its place proudly among the great nations of the world.'

The vision of Kara Counseling and Training Trust is to promote integrated Human development by providing counseling, training and caring. Behind this vision, Kara Counseling and Training Trust are running the empowerment programme for orphaned girls called Umoyo Training Centre.

Umoyo Training Centre for life skill programme was started in November 1996 with its aim to build and sustain the capacity of young females to cope with life situations. So far more than 200 girls have graduated from training Centre. The centre is allocated in Lusaka West off Mumbwe road.

Umoyo Training Centre works in collaboration with two Home Based Care, Kanyama and Mtendere to identify the single or double orphaned girls to be enrolled for each year. The following criteria will apply for the youths to join the programme: the youth shall be female; between 14 and 18 years old; be single or double orphans; neglected or are risk; and be disadvantaged youths living in difficult circumstances.

Each year the centre enrolls about 75 girls who are trained in various life skills. Since the training targets vulnerable girls, the programme is free and it is funded by Danish Church Aid and the Stephen Lewis foundation. The training programme takes the duration of one year. In one year duration, the following programmes are offered vocational skills and knowledge based skills as indicated below.

Vocational Skills

- Agriculture – Taught how to grow different types of vegetables
- Poultry - Taught how to keep chickens
- Tailoring - Taught how to make drafts, sew cloths, cut, design
- Knitting - Taught how to make jerseys, head socks, scarves
- Making Blocks - Taught how to make flower pots, blocks, elementary construction

Knowledge Based Skills

- Family Planning & HIV/AIDS prevention
- Household Care Giving
- Financial Budgeting and Book keeping
- Personal Health, Hygiene, & Basic First Aid
- Social Responsibility, Community Values, Ethics, & Awareness

There has also been a good working relationship between the centre, the industry and training institutions for the purpose of further training, industrial attachment and employment of graduates from the project.

The evaluation done on Umoyo training Centre in the year 2000, found that Umoyo Training Centre was working with the Home Based care groups and religious organisations in the identification and selection of the girls for training and in providing them, with further training (e.g. St. Joseph Roman Parish) income generation through making batik, tie and dye (Msisi and Chawama Home based care groups).

1.2 STATEMENT OF THE PROBLEM

Adolescence is often characterised by patterns of thinking in which immediate needs tend to take priority over long-term implications, and by the initiation of behaviours that may be perpetuated over a lifetime (WHO, 1996). HIV incidence rate amongst the adolescent group shows a consistent increase; hence the identification of this group as a vulnerable group in terms of high risk sexual activities. This shows that HIV and AIDS has not only affect adults, but also adolescents and children (UNAIDS, 2006). In 2003, among young people 15-19 years old, 28% of boys and 44% of girls reported having sex within the last twelve months. For many girls, their first sexual encounter is with an older boy or elderly man. This is one reason why girls aged 15-19 are six times more likely to have HIV than boys of the same age (Kelly, 2000). Recognizing the special potency of relationship for adolescents and young adults, it is something valuable and needs safe guards whether these are of no sex, deferred sex or protected sex.

Voluntary Counseling and Testing (VCT), has been recognized as an effective methods in the prevention and care of HIV and AIDS (National HIV and AIDS/STI/TB Policy, 2005). It serves as the entry point to other related services such as Anti-retroviral treatment, TB treatment, PMTCT program, STI treatment and Home Based Care services. Knowing ones' HIV status can be a motivating force for HIV-positive and negative people alike to adopt safer sexual behavior (Kara Counseling, 2006).

Even though many adolescent girls would like to go for VCT, the concern is that the results will not be kept confidential and that stigma and discrimination will follow disclosure of the

HIV positive status. The majority of adolescent girls do not know their HIV status despite practicing risk sexual behavior (Deborah, B & Rachel, B, 2002).

However, VCT low uptake among adolescent girls has been influenced by inadequate knowledge about available VCT treatment and services, negative attitudes towards VCT.

1.3 OBJECTIVE

To identify the factors constituting motivators and barriers to the effective utilization of Voluntary Counseling and Testing of girls at Umoyo Training Centre.

1.4 Specific Objectives

- i. To access the factors influencing girls' decisions to attend or not to attend VCT services
- ii. To determine the sources of knowledge of VCT among girls.
- iii. To identify perceived barriers and benefits of VCT among adolescent girls.

1.5 RESEARCH QUESTIONS

The study will attempt to answer the following questions;

1.5.1 GENERAL RESEARCH QUESTION

What factors constituting motivators and barriers to the effective utilization of Voluntary Counseling and Testing among adolescent girls at Umoyo Training Centre?

1.5.2 Specific Questions

- i. What are the factors influencing girls' decisions to attend or not to attend VCT services?
- ii. What are the sources of knowledge of VCT among girls?
- iii. What are the perceived barriers and benefits of VCT among adolescent girls?

1.6 JUSTIFICATION

Adolescent girls have been exposed to HIV risk with persons who are likely not certain of their HIV status (UNAIDS/UNFPA/UNIFEM, 2004). Focusing on adolescent girls is likely to be the most effective approach to confronting the epidemic. Among the range of measures to enable adolescents protect themselves from HIV and AIDS is to go for Voluntary Counselling and Testing (VCT). National HIV prevention strategies in Zambia have more recourse to Voluntary Counselling and Testing (VCT) programmes (National HIV & AIDS strategic Framework, 2006-2010).

Indeed, these programmes are seen to provide adolescents with the opportunity to learn their HIV status in order to adopt protective behaviours if they are HIV negative and to refer them to appropriate medical and psychosocial care when they are infected. Therefore, VCT is seen to help reducing risky behaviours and HIV infection rates through counselling people about how to avoid spreading HIV.

It is imperative for this research to look at factors constituting motivators and barriers to the effective of VCT among adolescent girls so as to challenge denial of infection and to help

adolescent girls to recognize and accept that one can live with HIV infection and still shows no outward symptom.

With its heavy involvement in HIV and AIDS and empowerment of girl programmes, Umoyo Training Centre under Kara Counseling and Training Trust is in good position to influence change in attitudes and behaviors of the adolescent girls and in turn the Zambian people.

The findings from the study will also be an essential step in the development and implementation of programs that will encourage more adolescents to go for VCT and subsequently change their behaviour. In addition to this, it is hoped that the study findings will contribute to wider literature on promotion of HIV counseling and testing.

1.7 OPERATIONAL DEFINITIONS

Adolescent – **A person who is between childhood and adulthood from 13-19 years.**

Attitudes - are those acquired mental position, negative or positive that a group holds in regard to some idea or object. Often attitude dictates how people behave. Attitudes have been the most widely researched aspect of the TPB (Theory of Planned Behaviour) and continue to receive attention from social and cognitive psychologists (Ajzen, 2001; Bentler & Speckart, 1981). Attitudes toward performing behaviour reflect favourable or unfavorable evaluation of the particular behaviour. Attitude toward the behaviour– in this case, uptake of VCT – is determined by individuals beliefs about the outcome of performing the behaviour (behavioural beliefs; belief that VCT uptake is associated with certain attributes) weighed by the extent to which these outcomes are valued (belief outcomes; value attached to VCT uptake).

Acquired Immunodeficiency Syndrome (AIDS) – is state/disease in which a body is unable to fight infections.

Counseling – is a confidential dialogue between a client and a Counselor.

Discrimination – Unfairness to people with HIV and AIDS.

Effective-effectiveness can be defined as a measure of the quality of attainment in meeting your stated objectives.

Faith Based Organisations – These are church bodies or religious groups advocating for abstinence in the control and prevention of HIV and AIDS and care of the affected or infected with HIV and AIDS.

HIV Testing – Is the obtaining of a bodily sample for the specific purpose or performing a medical test or a number of medical tests to determine the HIV status of a person.

Human Immunodeficiency Virus (HIV) – Is the virus that causes AIDS.

Mother to Child transmission – Us a transmission HIV from infected mothers to unborn babies, which may occur during pregnancy, delivery or after delivery during breastfeeding.

Orphans - These are children whose biological parent(s) is or are deceased.

Double orphans - These are children with both biological parents are dead.

Single orphan – This is a child whose one of the parents is dead

Post-Test counseling – providing when an individual receives his or her HIV test results as well as giving moral support immediately after the client has received the result.

Pre-test counseling – the counseling given to an individual before an HIV test is performed to make sure that the individual has sufficient information to make an informed decision about having an HIV test.

Prevalence rate – Number of reported of HIV and AIDS cases at a particular time or place.

Stigma – Shame, Disgrace or dishonor as a result of someone having HIV and AIDS.

Skills – These are considered as the ability to produce reliable and consistent results. Skill is familiar to knowledge, specific art, trade, a gift or an accomplishment.

Voluntary counseling and testing (VCT) – Is a process by which an individual undergoes counseling to enable them to make an informed decision about being tested for HIV, assess their personal risk for HIV and develop a risk reduction strategy.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter covers the literature review related to this study. The review of the relevant literature contained in this chapter is centered on the following areas:

Knowledge on HIV and AIDS; Voluntary Counseling and HIV Testing; Voluntary Counseling and Testing as an entry point to prevention and care services; The importance of VCT in HIV prevention and management; Facilitators of uptake of VCT; Gender issues in HIV and AIDS and VCT; Adolescent at risk testing HIV negative and positive; Problems common to VCT; Stigmatizing attitudes and conclusion.

2.2 Knowledge on HIV and AIDS

HIV/AIDS education and awareness is one of the key elements in comprehensive HIV prevention. It believed that increased knowledge, along with positive attitudes and beliefs about HIV/AIDS, will lead to positive behaviour changes, that is, behaviours that are less risky, or safer, such as use of condoms, abstinence, and avoidance of risky situations. Globally a majority of the youth aged 15-24 have heard of HIV/AIDS, however, evidence have established that the vast majority of youth do not know how HIV is transmitted or how to protect themselves (United Nations Children's Fund, The Joint United Nations Programme on HIV/AIDS and World Health Organization, 2002). For example, in sub-Saharan Africa, only 8% of out-of-school young people and slightly more of those in-schools have access to

education on HIV prevention (The Joint United Nations Programme on HIV/AIDS, 2004). And even among those who know about HIV/AIDS, perceptions of personal risk are some times at odds with reality. For example, roughly half of adolescent females and males who have heard of HIV/AIDS think they are at some risk of becoming infected. But in Ghana, Niger, Nigeria and Tanzania, no more than three in ten young females consider themselves at some risk; the same is true for young males in Ghana, Niger and Nigeria (United Nations Children's Fund, 2003). Baggaley et al (1997) found that Lusaka, Zambia and London, English students had knowledge about HIV transmission and Sallah, et al (1999) found that most students of the University of Benin in Togo, had knowledge about HIV/AIDS.

According to Zambia Sexual Behaviour 2005, Knowledge on HIV and AIDS among adolescents increased from 75 percent in 1998 to 88 percent in 2005. From this statistics, it shows that there is an increased in knowledge on HIV and AIDS in Zambia. The level of knowledge is also high among both male 97 percent and females 97 percent. In Urban the level of knowledge is 98 percent and rural 96 percent. Rural still have a low level of knowledge compared to urban (ZSB, 2005).

2.3 Voluntary Counseling and HIV Testing

Globally, VCT services have been identified as an important strategy in managing HIV transmission from mother to child. Women are most often offered VCT during antenatal care, after a spontaneous abortion or stillbirth, with death or failure to thrive in a child, with presentation of a sick child or partner to the clinic, after death of a partner, or when seeking treatment for frequent illnesses. VCT has now become part of a wide range of interventions such as PMTCT of HIV, TB and STD programmes (National HIV/AIDS/STI/TB Policy,

2005). The rationales behind VCT strategy are follows; VCT may lead to behaviour change, thus contributing to the reduction of HIV transmission. VCT opens opportunities for the infected individual to access psychological support and care. VCT may also encourage the abuse woman to live positively after receiving counselling.

When the HIV test was develop in the mid 1980s, testing tended to be accompanied by little HIV counseling. However, with the growing awareness of HIV infection and AIDS and the recent availability of antiretroviral therapy (ART), the scope of and reasons for Voluntary Counseling and HIV Testing have broadened. VCT is a process by which an individual undergoes counseling to enable him/her to make an informed decision about being tested for HIV, assess their personal risk for HIV and develop a risk reduction strategy. VCT services are essential components of HIV prevention and care programs (HIV/AIDS Care and Counseling, 2008).

VCT is one of Zambia's adopted critical strategies for addressing the HIV and AIDS epidemic. In Zambia, a person can get an HIV test done at the hospital and some government and private clinics. Usually a client gets tested if he so desires for whatever reasons or when a physician or clinician refers him for HIV testing (as part requirement for the management and care of the patient). Testing facilities are limited particularly in rural communities.

VCT services have expanded since 1999. By 2004 there were 176 operational VCT sites in Zambia, which was an increase from 10 in 2000 (Kara Newsletter, 2006). In Zambia three models delivering VCT services are being used;

- i) The integrated mode which is usually part of other services such as maternal and child health, TB, STI, and blood transfusion services accounts for 70% of the VCT services in Zambia.
- ii) The free standing services are mostly operated by NGOs/FBOs like Kara Counseling and Training Trust, New Start Centre, Africa Directions, ZPCT to mention but a few. These account for 15% of the overall VCT services.
- iii) The Mobile Services account for five percent of the VCT services in the country. Government agencies and NGOs provide these in support of other programmes like PMTCT, HBC. Some organizations like Kara Counseling provide it through the community outreach programmes to reach out to those communities that do not have easy access to such services due to the distance to the nearest centre providing such services (Kara Newsletter, 2006).

In Zambia where VCT services have been developed, there has been a reluctance of people especially adolescent and women to attend testing. The reluctance may be due to denial or discrimination that people who test sero-positive may face and the lack of perceived benefits of testing adolescent and women. To overcome the barriers to establish VCT services, it is important to demonstrate its effective and to challenge stigma and discrimination so that people are free to be tested. The role of VCT as a part of a comprehensive health care, with links to and other essential health care services must be acknowledged. VCT is important for it is human right perspective, the right to know or not to know one's HIV-status (UNAIDS, 2002).

According to statistics released by Kara Counseling's Coordinator Mrs Geogina Mutale, between January and May 2006 a total of 3,494 children and youths in the age group of 20-24 years walked in for counseling of which 1,540 were male and 1,954 were female. Of the total number 2,165 voluntarily decided to undergo testing for HIV of which out of a total number of 718 males who underwent the first test 550 came out negative as compared to only 168 whose results came out sero-positive to HIV infection (Kara's Newsletter, 2006).

There is little specific information on the use of VCT by the adolescent girls and women. UNAIDS, 2000 states that in many high prevalence areas, young people, especially women are at risk from HIV infection yet they often have no access to VCT services.

2.4 Voluntary Counseling and Testing as an entry point to prevention and care services

Voluntary Counseling and Testing has many benefits and one of the benefits is that it is an entry point to other related services such as Anti-retroviral Treatment, TB treatment, PMTCT programmes, STI treatments and Home Based Care services. How this work does for the abused and poor women who have limited access to quality health care services in Zambia and worldwide.

Deciding whether to be tested for HIV can be a major dilemma for a healthy person. A positive result might confirm someone's worst fears. Or if any abused woman at risk of HIV do not seek test, she has to live with the uncertainty of not knowing. They may need to know whether she have HIV in order to make appropriate decisions, such as having children, or protecting an unborn child. Having a test does not change the reality of whether someone

has HIV; it merely provide better knowledge of health status that is relevant to personal health care and to preventing HIV transmission (Hellen, 2002).

VCT is much more than drawing and testing blood and offering a few counseling sessions. It is a vital point of entry to other HIV and AIDS services, including prevention and clinical management of HIV related illnesses, tuberculosis (TB) control, psychosocial and legal support and prevention of mother to child transmission of HIV (MTCT).

VCT offers a holistic approach that can address HIV in the broader context of poverty and its relationship to risk practices. It offers benefits to those who test positive or negative. VCT alleviates anxiety, increases clients' perception of their vulnerability to HIV, access to antiretroviral (ART) therapy – and assists in reducing stigma in the community (HIV/AIDS Care and Counseling, 2008).

VCT aims to help adolescents evaluate their own behaviour and its consequences. A negative test result offers the opportunity to recognize vulnerabilities and develop risk-reduction plans to adopt safe behaviours. Young people who test HIV-positive can receive referrals for care and have opportunities to discuss and understand what their HIV status means and what responsibilities they have to themselves and others as a result (WHO, 2002).

Voluntary counseling and testing employs a two-pronged approach. Firstly it helps to determine who requires care and treatment. This includes both Anti Retro viral Therapy (ART) and interventions to prevent mother-to-child HIV transmission (PMTCT), secondly it helps prevention and transmission of HIV infection to others. Additionally, VCT can also

stimulate discussion about HIV and AIDS and in turn reduce stigma and discrimination (www.fhi.org).

2.5 Facilitators for uptake of VCT

VCT is an important measure for preventing HIV since it allows young women to evaluate their behaviour and consequences (UNICEF, UNAIDS and WHO, 2002).

Young women go for testing because they are planning to marry, planning to work, live or study abroad (temporarily or permanently), planning to attend university (e.g. in Ecuador, mandatory HIV testing is mandatory for any prospective student to gain entry to the university within the country) Those who test positive will be denied entry, refugees, new military recruits (e.g. the china liberation army), hoping to enter the seminary or convent (commonly practiced in high prevalence parts of Africa though this may not be global protocol), and institutionalised including orphanage foster care, detention centers and prisons (Boswell and Baggaley, 2002). Some reports from Kara clinic in Zambia show that increasing number of youths seeks VCT especially in the context of premarital testing (Horizons, 2001).

Most VCT services have not been designed specifically for young women and men; young people actively seek and receive VCT. In Zambia, 14.6% of attendees at Hope Humana VCT site in Ndola were 10-19 years old. There is also an increase of young people in Uganda for VCT uptake, clients between 15-19 years (Deborah B and Rachel B, 2002). There are few countries that have VCT services specifically adapted for young people. Of late, some countries are now targeting youth in their HIV prevention and care strategising and include VCT for youth in their agenda (Deborah and Rachel, 2002).

2.6 Gender Issues in HIV and AIDS and VCT

Women in the world and Africa, in particular are experiencing a unique challenging as manifested by the high prevalence of HIV. Globally, more men are infected and dying than women, but in sub-Saharan Africa UNAIDS estimated that 54% of adult infections by 2002 are women. In 2003 the global HIV epidemic killed more than 3 million, 2.3 million of whom were in Sub-Saharan Africa (UNAIDS, 2005). Women are generally infected at a younger age than men, and die young (Hellen, 2002). The global proportion of HIV-positive women has increased significantly over the last five years, and this process is most visible in countries where the virus spread through heterosexual intercourse, as is the case in most parts of the Caribbean and Central America (<http://.carec.org/publications/presentations.htm>).

The study done by Green (2003) reveals that women are disproportionately affected by HIV, accounting for more than half of the people living with HIV and AIDS in Sub-Sahara countries, the age of sexual debut for women is earlier than men (Green, 2003). This suggests that women are likely to be infected at earlier ages and more frequently than men, particularly among those of aged 15-24 years (UNAID, 2004).

In Zambia, although women constitute half of the population, the HIV disproportionately infects them. About 16 percent of adult females are HIV-positive (ZDHS, 2007). The prevalence is higher among women compared to men of the age below 35. This is thought to be as a result of high levels of social and economic vulnerability, low level of negotiation skills and inadequate access to life skills and information (National HIV and AIDS Strategic Framework, 2006).

With HIV infection rates currently estimated 16 percent of people aged 15-49, it is clear that many more children many lose their parents. Zambia's orphan's crisis is almost 1 million children. This shows that Zambia has highest number of orphans in Sub-Saharan Africa and a much higher proportion than any other country in Asia, Latin America or the Caribbean (UNAID/UNICEF, 2002).

According to ZDHS 2007, Gender based violence is one of the factors which is contributing to high prevalence rate of HIV among women. Sexual violence is the worst manifestation of gender power imbalances that expose women and girls to HIV infection. In Zambia, the issue of gender violence is still a big concern. According to the press statement of Young Women Christian Association (YWCA) of September 29, 2008, from January to June 2008, the centre received 3, 553 cases of gender-based violence compared to 5, 327 cases received from January to December 2007. And of the cases reported from January to June 2008, 291 were sexual offences and 245 rape and defilement (YWCA Report, 2008). The YWCA 2008 report further noted an extreme increase in sexual offences that are perpetuated against women and children in the era of HIV/AIDS. Despite the fact that women and girls are already vulnerable to contracting HIV/AIDS, gender based violence is singled to be contributing to the increasing rate of women and girls infected with the virus (YWCA Report, 2008).

Gender imbalances exist in the area of HIV and AID and VCT. For instance, women are more vulnerable biologically than men to HIV infection during unprotected sexual contact. From the social point of view the women's subordinate position to men can make it difficult

to protect against HIV. More women than men take up the burden of care in AIDS infected households and sometimes in extreme case it falls on the female children (NAC, 2004).

Gender has been found to be a significant predictor in the uptake of VCT (Sherr et al, 2007). Adult men are more likely than their female counterpart to report psychological deterrent to utilization of VCT yet have been found to require reassurance of their HIV status more frequently.

2.7 Adolescent girls Testing HIV Negative

According to Manuel (cited in Bennett et al, 1999) these individuals benefits a great deal from HIV testing; especially psychologically. News such as this offers relief, reassurance and peace of mind to an adolescent girl who was anxious due to uncertainty regarding her HIV status, and anticipated a positive result. Exposure to HIV and AIDS education during counseling; and this close encounter with life as an HIV positive individual is expected to prompt the women to take up some treatment (Manuel, cited in Bennett et al, 1999).

2.8 Adolescent Testing HIV Positive

A test for HIV would usually either be positive or negative. It is important that counselors understand what these results mean. A positive test result implies that HIV antibodies were found in the person's body and that the person has been exposed to the virus, and would gradually suffer from AIDS. Clients who test positive should take great care not to willfully infect others through unprotected sexual intercourse, sharing contaminated needles (or other

skin piercing instruments) or breastfeeding their infant. If a client knows that he is HIV positive it is always advisable not to donate blood for transfusions.

The costs and benefits related to an HIV positive diagnosis are of a psychological; social; therapeutic and a preventive nature. HIV screening of abused women for epidemiological purposes; in other words examining the evolution of the virus, are beneficial to the community since valuable data emerge from these campaigns. The identification of HIV infected individuals is considered crucial in ensuring that these individuals are treated. Once on treatment, their viral load reduces and they become less infectious and pose a minimal threat to society (Mashburn et.al, 2004). This scenario is against individual rights to be coerced into going for testing. The notion of informed consent poses as a barrier to HIV test acceptance and that VCT should be available as part of a package of services for which the client is 'voluntarily' attending. Coercion is not deemed effective since it might lead to poor compliance to treatment; no co-operation from infected individuals; and distrust of medical authorities. It should further be noted that routine or mandatory testing of only young women or certain population are can lead to new stigma against those people and impinges further on their human rights. Focus should be now shifted to how individuals weighing the costs and benefits of HIV testing; and other factors have influenced VCT acceptance (Mashburn et. al, 2004).

People react differently to knowing that they have tested HIV positive. Most clients face the outcome of HIV test results with fear of the threat of family disruption and abandonment, loss of their job and opportunities for personal development and advancement, exposing their private sexual life in view of traditional or religious norms, and fear of prolonged suffering and death. HIV and AIDS poses great psychological challenges related to departure from

beloved ones and person property, including all that the client did during his productive years of life. For some that have witnessed family members or friends dying of HIV and AIDS, the vivid understanding of personal suffering and pain might cause them to develop a crippling anxiety over their own situation.

2.9 Problems common to VCT

a) Late Testing

Another area of concern is the fact that when abused women eventually decide to go for HIV testing, they decide to do so when the virus has already rapidly progressed. Early testing refers to a situation where individuals had their first HIV positive test five or more years prior to, or without a diagnosis of AIDS (Rosenberg, 2003). The following factors were classified as indicators of late testing; AIDS within three months of HIV diagnosis, CD4 below 200 per cubic milliliter blood; and diagnosis at hospital. Patients with late diagnosis should generally be more symptomatic than those with early diagnosis. Late is associated with lower self-reported access to outpatient medical care, lower suspicion of having the virus and, less awareness about testing or its availability. Late testing can also result from fear anticipating the consequences of a positive result, or denial of possible HIV infection (Rosenberg, 2003).

Early testing for HIV/AIDS offers many benefits for young people but in many countries it is still rare in addition to the fact that there may also be negative implications because HIV-positive people have been known to suffer from stigmatization and discrimination. Where services are still poor and low as in Kenya, people may feel the risks of knowing and disclosing their sero-status to outweigh the benefits hence one important challenge in addressing the needs of young people lies in understanding the extent to which the young

people know about and use protective measures against the risks (Deborah B and Rachel B, 2002).

As the epidemic spreads, young people are becoming exposed to the risk of infection at younger and younger ages. As men continue to choose younger sexual partners, infection spreads among younger groups, especially girls. The result is that as each new generation of young people reaches reproductive age, another wave of infection looms large. Although young people suffer most from HIV and AIDS, the epidemic among youth is largely ignored and remains invisible to both young people themselves and to society as a whole. They are more likely to carry the virus for years without knowing that they are infected, consequently the epidemic spreads beyond high-risk groups to the broader population of young people making control harder (William, 2007). Studies conducted in the rest of Africa agree that VCT utilization remains low.

In a Zambian study it became apparent that where VCT has been made readily available, demand has been distributed low. This was found that self-perceived risk and high-risk behaviors were positively associated with initial willingness to test, it did not culminate into the actual uptake of services (Fylkesnes & Siziya, 2004).

b) Infrequent Testing

During HIV testing, a client may be requested to go back after a window period. Window period is basically the period which antibodies to the HIV-virus cannot be detected in the blood. Some individuals, especially young people might therefore take the first HIV testing during the window period and thereafter may not return, after three months with the

impression that they are HIV negative. Individuals are encouraged to go back for a confirmatory test after three months after their first test in cases where they have been subject to possible infection (Williams, 2007).

c) Stigma and Stigmatizing Attitudes

Stigma is largely driven by social and familiar pressure “family name”. For example, in some cases people living with HIV are given names by their relatives, which are associated with their symptoms. Stigma is also driven by some cultural or religious norms and value as well as by fear of AIDS and secrecy.

AIDS-related stigma remains a frequently cited barrier to testing. Most individuals refer to a fear of socially imposed discrimination and stigma, and its adverse consequences such as violence or rejection as common deterrents to HIV testing. In a study conducted by Van Dyk and Van Dyk 2001 fear had a different source for men and women. Women’s fear was mostly related to issues of power, while men’s fear was related to issues of sexuality and sex appeal. Women generally fear violence and rejection from their partners after disclosure while men fear being less attractive to women after testing positive. Denial or ignorance regarding HIV and AIDS closely relates to this pervasive fear. Most women in abject poverty prefer not to know their status since they are concerned about the ability and possibility to care and provide for themselves and their families after testing HIV positive (Solomon et al, 2004). People evade testing because they fear the outcome of the result until they show symptoms indicative of possible HIV infection. A lack of symptoms manifestation might also delay test seeking.

CHAPTER THREE

METHODOLOGY

3.1 Introduction

This chapter presents the methodology of the study. It contains the following; Study Design and Setting, Study Population, Study Sampling, Sampling Technique, Data Collection Tools and Data Analysis. It ends with limitations encountered during data collection process.

3.2 Study Design

A descriptive cross-sectional study design using both qualitative and quantitative approaches was used to collect data for this study.

Quantitative research approach relies upon measurement to analyze different variables and uses various scales. This is a formal objective, systematic process, which aims to describe, compare and analyze different variables. The quantitative research approach was considered to be appropriate for this study because it allows a formal and systematic approach to collect information on the Factors Constituting Motivators and Barriers to the Effective Utilization of VCT by girls.

On the other hand, the qualitative data collection methods was used to reveal the adolescent girls' perspectives and experience of salient matters of VCT and HIV testing that could not have be revealed by quantitative data collection methods alone.

In addition, the qualitative data collection method helped to explain the pattern of behavior regarding attitudes towards VCT and the quality of the services that adolescent girls would want to have.

3.3 Study Population

The study population was all 75 adolescent girls aged (14-21 years) of 2009 in-take at Umoyo Training Centre and the Counselors of Kanyama Health VCT Centre. Each year the centre enrolls 75 or less girls for skills training from two compounds of Kanyama and Mtendere. These girls are identified by the help of the Home Based Care in those two compounds as either single or double Orphans.

3.4 Study Sample

The sample for this study comprised of 40 adolescents girls aged between 14 and 21years old; and 5 Counselors aged 25 to 30 from Kanyama Health Centre.

3.5 Sampling Technique

The study utilized convenience sampling. The reason for selecting this procedure was because; this was the number of adolescent girls at the centre for 2009 intake.

The aim of convenience sampling is to select information-rich cases whose study will illuminate the question under study. The study used convenience sampling because the researcher knew about the event and specific people who are likely to provide valuable

information. The advantage of convenience sampling is that it allows the research to concentrate on those people and generate valuable data for the research.

3.6 Data Collection Procedures

Data was collected between 19th July and 15th August 2009 at Umoyo Training Center and Kanyama Health Voluntary Counseling and Testing center. The content of the questionnaire were explained to participants. The researcher was assisted by the assistant co-ordinator and two female teachers at Umoyo Centre. All the interviews were conducted after informed consent has been obtained from the interviewees. The questionnaires were administered to adolescent girls at the center. Data was collected through questionnaire, Focus Group Discussions and interviews. Questionnaire, Focus Group Discussions and interviews with key informants were the three principal methods for data collection.

Data was gathered using both primary and secondary sources. Primary data came from structured and semi structured questionnaires, while secondary data came from reports materials. Other sources of data were research books, articles and academic materials.

i) Questionnaires

The questionnaires were used to collect information from the adolescent girls. Both structured and semi-structured questions were used to collect data required for the research. Open-ended and closed-ended questions were provided in the questionnaires. Open-ended questions gave the respondents freedom to express their views without restrictions, guidelines and suggestions. Closed-ended questions helped in gathering facts and were used

in situations of confirming or re-establishing already known facts. The questionnaire consisted of the basic socio-demographic characteristics and questions related to the knowledge and attitudes of the study sample towards VCT, and factors that would motivate them to utilize the VCT services.

ii) Focus Group Discussion

This method was used to collect qualitative information that revealed the level of knowledge, views, feelings and attitudes of the respondents about VCT. Two Focus Groups consisted of 11 adolescent girls in each were interviewed. The major instrument used was the FGD guide (Appendix C) which was prepared on various aspects of the topic. All the two focus Group Discussions started with the warm up questions to open up the discussion and make. This method was chosen because it allowed respondents to provide qualitative responses that yielded in-depth data on the subject.

The Assistant Director of the centre and two female teachers from Umoyo Training Centre served as the moderators for the Focus Group Discussions. They were primarily concerned with conducting the discussions according to the questionnaire guide and keeping the conversation flowing. The discussions were mainly conducted in Chinyanja and Bemba, since these were language mostly spoken by the groups.

During the focus group sessions, the researcher had a responsibility of controlling the discussion without inhibiting the flow of ideas and comments. After the discussion group, the researcher had an opportunity to write a report concluding the mood in the group and illustrations quoting personal feeling about the comments made by respondents.

iii) Key Informants

Data was collected from five (5) Counselors from Kanyama Health VCT center. It consisted of three females and two males of the age group of 25 to 30 years, and Key Informant Interviews guides (Appendix D) were used to collect data from the counselors at Kanyama Health VCT center. Kanyama Health VCT Counselors were chosen for the interviews because majorities of the girls (participants) were from Kanyama Compound.

Interviews were used in this research because of the advantage they had of allowing a follow up verbal leads and thus obtained more data. The main issue discussed with counselors is their experiences dealing with girls and motivating factors for girls to seek VCT services.

During these interviews, the counselors were able to reveal the challenges which the counselors and adolescent girls face during visiting VCT services. Examples of their comments, which were noted down and recorded thereafter, are discussed in the data presentation chapter of this study.

3.7 Data Analysis

Data analysis started once all the data had been collected. The quantitative data collected was analyzed and coded using the Statistical Package for Social Sciences (SPSS) to generate frequencies, tables and graphs that were used to describe and summarize the data. The qualitative data collected was manually analyzed, coded and processed using emerging themes.

3.8 Limitations of the study

The research was limited by a number of factors;

1. Only adolescent girls of Umoyo Training Centre of 2009 intake comprised the sample of the study, therefore, the results cannot be generalized.
2. The researcher was assisted by staff members of Umoyo Centre to moderate the FGD. Therefore, their presence might have some effects on the responses that were given by adolescent girls.

3.9 Ethical consideration

Written permission to conduct the study was granted by both Kara Counseling and Training Trust Management and Ministry of Health Lusaka District Health management Team. All the respondents were assured of confidentiality and informed consent was obtained before the commencement of the research. The benefit and purpose of the study was explained to the respondents in order to have a better understanding during the research.

CHAPTER FOUR

PRESENTATION OF FINDINGS

4.1. Introduction

This Chapter presents the main findings. The findings will be presented under the following sub-headings; socio-demographic characteristics, definition of VCT, knowledge, history of testing, knowledge of a place to go for Testing, factors influencing girls' to attend or not to attend VCT services, sources of knowledge of VCT and Barriers and benefits of VCT on girls.

4.2 Socio-demographic Characteristics of the study respondents

The respondents' age was as follows; (33) 82.5 percent were in the range of 14 to 17 years, while (7) 17.5 percent were in the range of 18 to 21. All the respondents were single girls. The mean age of the respondents was 18 years. Table 1 below shows the age of the respondents.

Table 1: Ages of respondents

Age (in years)	Frequency	Percent
14-17	33	82.5
18-21	7	17.5
Total	40	100.0

The respondents' levels of education were as follows; 55% had done primary education while 42.5% had done junior secondary education and 2.5 % has done senior secondary as shown in table 2 below.

Table 2: education level of respondents

Level	Frequency	Percent
Primary	22	55.0
Junior secondary	17	42.5
Senior secondary	1	2.5
Total	40	100.0

4.2.1 Understanding the definition of VCT

All the respondents defined VCT as Voluntary Counseling and Testing. They reported that it is a service given to people who want to know their status especially those with risk sexual behaviour, such as prostitutes. Other views that came out involved willingness of the respondent to accept the service. And VCT means that there is pre-test counseling. It is voluntary in the sense that one is not forced to take a test.

4.2.2 Knowledge on HIV testing

When respondents were asked if they knew that they could be tested for HIV, 82 percent of the respondents said that they knew that they could be tested for HIV and 18 percent did not know that they could be tested for HIV status.

4.2.3 History of testing

The respondents were asked on whether they have been ever tested for HIV, 15 percent of the respondents have been tested. However 67 percent have not been tested HIV and 18 percent are planning to go for testing.

4.2.4 Knowledge of a place to go for Testing

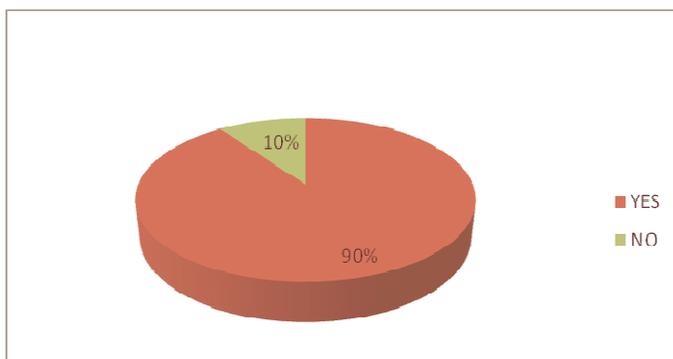
When respondents were asked to indicate whether they knew where the VCT centre was located, 57.5 percent said it was located at clinics/hospitals while 32.5 percent said free-standing VCT-the Kara Counseling and New Start VCT centres and 10 percent did not respond to the question.

When asked about where adolescent could go for HIV test, the majority 60 percent of the respondents indicated that hospital/clinic while 35 percent said community; only 5 percent said mobile centres.

The adolescent girls were further asked to indicate if they knew a place where they could go and get an HIV test. 90 percent of the respondents indicated that they knew of a place where

they could go and get an HIV test, while 10 percent did not know any place as shown by the figure below.

Figure 1: Knowledge of a place to go for testing



4.2.5 Source of Knowledge about VCT

When asked about the source of knowledge about VCT, the most reported source of information about VCT is friends (40 percent) and electronic media (40 percent TV and Radio) with a combined total of 80 percent respondents, 15 percent is through relatives.

4.3.1 Barriers to accessing VCT

Respondents were asked what barriers they face to access VCT services, 65 percent indicated that stigma is a barrier for not using VCT services in case of a positive test result while 25 percent indicated location of VCT services as the reason for not using VCT services. For instance who indicated location as a barrier complained that there is no privacy at the clinics and 10 percent said religion, the negative attitudes towards condom use and other contraceptive methods offered during VCT services attributed by the religious believe.

Figure 2: Barriers to accessing VCT



4.3.2 Ways of overcoming barriers to accessing VCT

Regarding overcoming barriers to the use of VCT, 60 percent respondents indicated the need of education on the importance of VCT, while 35 percent respondents indicated that more mobile centres in the communities while 5 percent of the respondents indicated that abstinence and being faithful to ones' partner as the way of avoiding the infection in relation to their religious beliefs.

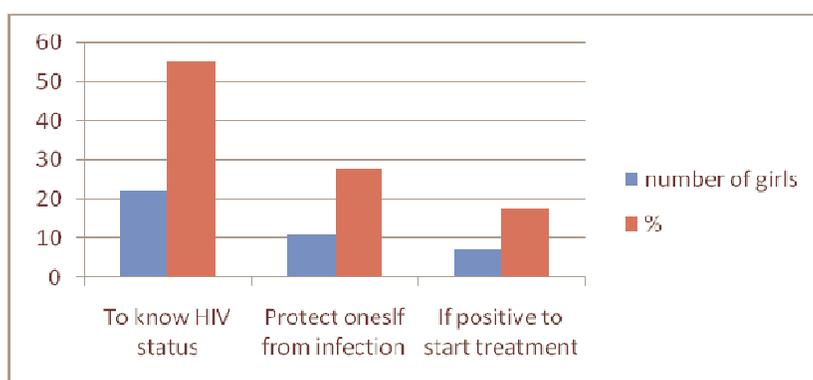
4.3.3 Concerns/fears of testing HIV positive

Respondents were asked whether they were worried about being HIV positive, 67.5 percent of the respondents did not worry about being HIV positive because they were sure of getting treatment even if they were infected. 17.5 percent respondents indicated they did not worry sometimes because they can protect themselves by using condoms and therefore they believe that it is not oblivious that they can contract the HIV, and 15 percent were very much worried about being HIV positive because it is very difficult to tell the status of their boyfriends.

4.3.4 Necessity of VCT

When asked on the necessity of VCT, the following were the reasons; 55 percent indicated that they wanted to know their status because this would help them to plan for their future. 28 percent it was important to protect oneself from infection because once they knew their status it would be easy for them to maintain it especially if they were negative and maybe possibly taking care of themselves if they were infected. 17 percent indicated that if they were positive it would be good for them to start treatment.

Figure 3: Necessity of VCT



4.3.5 Intentions about testing

When respondents were asked to mention if they had plans of getting tested for HIV, majority of the respondents 95 percent expressed that they had plans to be tested for HIV while 5 percent indicated that they had no plans to be tested for HIV in the near future.

4.3.6 Consultation at family level

The respondents were also asked whether they would discuss with the family to be tested for HIV or not. Accordingly, 85 percent indicated they would discuss with the family to be tested because they felt that it is important for their families to know as this would be helpful for them to get the support they need, while 12 percent felt that they would not share with their families because of fear of being discriminated and 3 percent did not answer the question..

4.4.1 Findings from Focus Group Discussion (FGD)

The qualitative data collection involved two Focus Group Discussions that were conducted at Umoyo Training Centre. The FGD consisted of 11 of girls aged 14-21. Eight (8) of the participants were from Kanyama Compound and 3 from Mtendere Compound. Each Focus Group Discussions took almost 45 minutes.

The following were listed as the commonest health problems by participants: T.B, HIV and AIDS, malaria, cholera; and poverty and water as main contributing to health problems.

The issue of poverty was singled out as the most prominent factor that puts adolescents. In trying to break the vicious cycle of poverty, girls start to go out with businessmen who are married. Orphans are more vulnerable as they have no one to protect them, from the vice. Some fail to get basic necessities, and thus become promiscuous and in the process they get infected.

A significant proportion of girls said that, they dropped out of school because they could not afford school fees. The participants further pointed out that those girls who are out-of-school were more likely to be exposed to sexual activities than school going girls. As soon as one drops out of school, the chances of getting exposed to the risks of HIV infection increase and these need to be reduced. By keeping girls in school longer or providing alternatives to keep them busy, this may keep more girls away from engaging in risky sexual behaviour.

The participants expressed happiness to be at Umoyo Training Centre because they believed they will be empowered with life skills to fight the poverty and HIV and AIDS. One of the girls from Kanyama Compound said, “she hopes that she will be able to support herself when she graduate from Umoyo because life out there is difficult since there is less help from her relatives.”

4.4.2 Knowledge about VCT

The participants across all the two FGD said, they have heard about the VCT and expressed that;

“VCT means that there is pre-test and post-test counseling. It is voluntary in the sense that one is not forced to carry out the exercise, it is done out of one’s willingness.” The participants said that, they learnt about VCT services through peers, radio, community drama and TV. Most participants noted that VCT helps an individual to know his or her HIV status. One of the participants a 16 aged girl from Mtendere compound;

Pointed out the importance of VCT and how it has helps many people who want to know their HIV status. She further said that, *“It helps people to make informed decisions, for*

instance if you are HIV positive you can choose the best way to live with the virus, and if one finds out that he or she is HIV negative she/he can choose the best way of living without the virus.”

All the participants from the two focus group discussions were asked if they know how one could be infected by HIV virus; the participants have a sound knowledge on how one is infected by HIV.

The following were the outcomes; sleeping with many men/boys without a condom. 3 of the girls from the first FGD rationalized the use of condoms as an effective way of protecting oneself from STIs and HIV. While most of the participants argued that condoms are not 100 percent safe for HIV protection because condoms can break or contains holes.

Few girls said that, some are born with HIV that is MTCT while others are bewitched. When probed how one can bewitched, the girls could not explain further. The majority of the girls know that blood transfusion can cause HIV.

However, one of the participants explained how her cousin she was staying with believed she had HIV and AIDS because she used to sleep around with a number of men. She even knows one man who was going out with her cousin looks to be sick because of HIV and AIDS.

4.4.3 Barriers to Testing

In all two focus group discussions, participants were asked on the barriers they face to be tested for HIV, in both groups stigma came out as major barrier to accessing VCT.

“I am afraid to be found positive after the HIV test and I will not know how to live as a double orphan, so the best thing is not to know the results,” said a 19 year old girl from Kanyama.

In the first focus group, 2 out of 11 have been tested before and they know their HIV status. One of the two said that she went for VCT because it was a requirement for her to secure a job. She further said that she would not have gone for VCT if it was not for job purposes. The other participant said, she was referred by the clinic officer at Kanyama Health Centre when she was sick. She expressed how uncomfortable it was because of fear of the results after HIV test.

Another participant said; “She would not go for HIV test because she is young (15 years) and not at risk. She does not want to be seen going to a VCT centre especially hospital or clinic for she would be recognized as may have HIV infection.”

When further asked if they were worried about contracting HIV infection. The majority of the participants indicated that they were very much worried about contracting HIV infection. One of the reasons for worry regarding contracting HIV infection from the participants’ perspective is that HIV and AIDS is a deadly disease and has no cure. The following are some of the excerpts of participants who expressed these sentiments;

“Very worried because I may also be infected by my boyfriend. Hence if I happen to contract the HIV, I may fell sick and die young.” (18 years old girl).

“As a double orphan girl, I fear to become sick because no one will take care of me. And I have seen how people suffer from AIDS.” (16 years old girl).

4.4.4 Measures taken if HIV positive

When participants were asked on the measurements they would take if found HIV positive, the majority of the participants they would stop having sex especially casual sex so as to protect their partner. In both focus groups the participants said, they would seek treatment and avoid marriage especially having children because they do not want the children to suffer when they die.

Fear to die young or living with HIV and AIDS were some of the measures would take if found positive. Some of the respondents said that, they would not know what to do, whether to disclose their HIV status or keep it private.

“Having HIV is not the end of everything. One can live positively for a long time and since there are ARVs, one can be taking them to prolong life.” 17 year old girl.

4.4.5 Preventive measures from HIV and AIDS

The participants cited ways of protecting from HIV and AIDS. The following are ways which came up strongly; to use condom every time you have sex with your boyfriend, stick to one partner, abstinence.

One of the participants said, *“You cannot know if one is infected, so the best way is to abstain or be faithful to one partner.”* The participants in both focus groups expressed knowledge on how one can be infected by HIV. The following were cited as ways of being infected by HIV; having sex with an infected person or many partners, not using a condom, born with

HIV. When asked more about born with HIV, they explained how a mother can infect her unborn child with HIV.

A 15 year girl from Kanyama, explained how her uncle had experience frequent ailments. He had prolonged coughing and diarrhea and was in and out of the hospital. After taking HIV test, his test results indicated that he was HIV positive and the wife was negative. The husband refused to use condoms and had unprotected sex with her wife. Of course the wife also feared to refuse sex without a condom with the husband who told the wife to be submissive.

4.4.6 The importance of VCT

Most of the participants noted that VCT is important because it helps an individual to know his/her HIV status. One of the participants from the first FGDs said,

“It helps people to know their HIV status but knowing if one is positive, it brings fears of dying and not knowing what to do. If I am found HIV-negative, I would go back again to confirm the result. She expressed how someone she knows who turned out to be HIV negative turn out to be HIV positive after testing three times.”

Another participant said, *“VCT is necessary to know the HIV status so as to know whether to marry and have children or not. She would not like to have children if she knows that she is HIV positive.”*

The majority of the participants pointed out that VCT can help to protect oneself and others from been infected by HIV after knowing one’s status.

“VCT services are common now even in clinics, mobile VCT and community educators who go around telling people how to protect themselves against HIV and AIDS.” A participant said.

While one participant, who had ever been tested for HIV said that,

“VCT is necessary because the counselor can encourage people. She gave a testimony how she was scared of her status but after testing negative, she became more confident.” In addition, participants recommended that VCT services should better be given during youth activities like sports, drama and at church festivals.

4.4.7 Feelings about going for VCT

When asked the participants how they feel about going for VCT; Most of the informant expressed positive attitudes about VCT. They are very willing to go for VCT. One participant therefore said that; she would go for VCT if only she is sick or been told by the doctor. She further said that, *“I know that I am not HIV-positive because I am still young and not involving in sexual activities.”* Most of girls interviewed fear having questioned by counselors about their sexual behavior or relationships. One of the participants said, she was afraid that the counselor would scold me if found infected with HIV and my guardian would mistreat me.

4.4.8 Encouraging a friend to go for VCT

Most of the participant would encourage a friend to go for VCT even though the majorities have never ever gone for VCT. Out of 11 participants only 5 self confessed of going for

VCT. The rest are planning to go VCT. The reason of not going for VCT is because they are faithful, they trust their boyfriends and they have not been involved in risk behavior.

4.4.9 Fears of going for VCT

Most participants express fear of knowing their result which prevents them from going for HIV test. If the results are positive, which means she will lose the boyfriend. Fear of death was also cited as the reason for not going for HIV test. Some other reasons cited by adolescent girls for not going for VCT included fear of being HIV positive, fear of losing a relationship, lack of confidentiality with the health workers, not being sexually active, using condoms consistently.

The participants' attitude towards people living with HIV and AIDS was also assessed. Accordingly, the majority of the participants replied that they would share a meal and taken care of someone who is identified as having HIV and AIDS.

One of the participants said, *“I would encourage her/him to be on treatment so as to live long. I know many people who are HIV and AIDS positive but they look fit because of treatment.”*

Another participant said she would support the relative who is HIV positive, because she/he is not the first one to have HIV. Another one said Stigma is a biggest problem in her community and they cannot reveal their status.

4.5.1 Key Informant Interviews

Interviews were carried out at Kanyama Health VCT center with five VCT counselors two males and three females. The study used interview guide to collect data from the counselors. The purposive sampling procedure was used and the identification of the Counselors was based on those who were on duty on the days of the interviews.

4.5.2 Access to VCT service at Kanyama

All the five counselors confirm that young/adolescent girls use the VCT services at Kanyama. In most cases the center receives a good number of young women/adolescent girls when they are referred by the medical personnel to have a HIV test. The counselors added that Monday and Friday were very busy days because they receive many clients. The center receives young women/adolescent girls very often, weekly from Monday to Friday.

4.5.3 Reasons for using VCT services

When the five counselors were asked on the reasons for adolescent girls for using VCT services, the following were the reason mentioned by participants; wanting to know their status. Others said that after they experienced prolonged illness, they become scared and went to seek counseling. After being informed about HIV and AIDS, some wanted to know more by under-going HIV test.

According to the counselors interviewed, young women/adolescent girls give the following reasons for coming for VCT services; long illness, worried of their sexual partner, wanting to know their status.

During this interview, the counselor further revealed to the researcher that these young women who come for VCT services did so in order to free their minds by know if they are negative. Some did so because they were about to get married while others were forced by their parents to go for VCT. In this interview it became clear that young women/adolescent girls use VCT services in order to know their status after suspecting their sexual partner having multiple sexual partners.

On the reasons young women/adolescent gives for using VCT services according to one of the counselors interviewed it was brought to the attention to the researcher that some young go for Voluntary Counseling and Testing when one wants to go abroad for studies or for employment purposes.

4.5.4 Challenges the counselors face in service provision

When counselors were asked on the challenges they faced in dealing with adolescent girls, Counselors said that, adolescent girls tend not to open up at pre-testing until they are probed. It is always difficult to do post counseling when someone have tested HIV positive. Most adolescent do not pay much attention or focus during the session. They always worry about their future after they have tested HIV positive.

It was revealed in the interview by the counselors that some of the challenges being faced in the provision of services was that clients did not only go there for VCT but also to present other personal problems like unemployed, dropped school because of no sponsorship and poverty.

During the interview, the counselors revealed that language barrier was another problem they faced. The counselors pointed out how they try to accommodate these people despite difficulties with language. Another challenge was that counselors find it difficult to deal with clients who are forced to go for VCT because they were not prepared to under-go VCT.

According to the counselors, some clients tend to deny their results when tested HIV positive. The client would deny that, it cannot be true. Maybe you have not done it well. They even insisted to have a second test or to go to other VCT testing centre.

The center is not open on weekend so the clients go there between Monday and Friday. *“we overwork ourselves during the week especially Monday,”* one of the counselors said. The counselor revealed to the researcher that some clients did not open up until they got the negative result.

4.5.5 Accessibility of service by adolescent girls

On the question of accessibility to VCT services by adolescent girls, one of the counselors said that, VCT services can be best accessed by adolescent girls by advertising in the press. For instances adverts in newspapers, youth magazines, radio and TV programmes for the youth. Adolescent girls need to be reached through daily activities in their compounds, for

example drama groups performances. There is a need of a massive sensitization in communities and the church should be involved.

In the interview, the some of the counselors thought that services can be accessed to adolescent girls by extending the VCT rooms especially the one at Kanyama Health center. Increasing personnel will also help in the delivering of good VCT services to the young people. Voluntary Counseling and Testing can be accessed by adolescent girls by the formation of support groups both in communities and in schools to help them to understand the importance of VCT. The counselor further said that, formation of drama groups can be used to sensitize people in schools and communities. The counselor also pointed out the necessities of more Voluntary Counseling and Testing centers in the communities.

During the discussion these views were strongly emphasized by some counselors; the formation of support groups in the communities as a way of sensitizing adolescent girls about the benefits of VCT as this would encourage adolescent girls to go for VCT.

In order to make VCT services more accessible to young people especially the adolescent girls, one of the counselors said that, there is need to encourage mobile VCT. Young people need to be followed where they stay so as to increase on the number of young people accessing VCT services.

4.5.6 Hindrances for adolescent girls to go for VCT

During the interview, the counselors singled out discrimination and stigma as some of the reasons that hinder adolescent girls to go for VCT. Lack of information on VCT is another

reason for young women not going for VCT. Adolescent girls think they can only go for VCT if they are very ill or after being referred by the medical personnel.

According to another counselor, most young women do not want to be on treatment in cases of HIV positive. And those who are married are stopped by the husbands. The counselor gave an example on how some husbands do not want to see their wives to go for ART.

There is a lot of misconception about VCT among adolescent girls because of lack of knowledge. For instance, some think that VCT is only for those who are sexually activity and sleep around with many partners. It is also noted that physical appearance deceives people and think they do not need VCT. The counselor also thinks that adolescent girls are not ready to tell the boyfriend for fear of losing the relationship.

In another interview, the counselor thinks that most things which hinder adolescent girls to go for VCT are ignorance and stigma. Ignorance in the sense that adolescent girls do not know that HIV testing can help them to plan for their future whether positive or negative. The question of stigma was also pointed out by the counselor. Stigma by relatives and neighbors is still strong in our communities where we come from.

4.5.7 Motivations to seek VCT services

On the question on what can motivate young women to seek VCT services, the counselor said adolescent girls need confidentiality in service providers. ‘We counselors should offer young ones more time and assure them of confidentiality whenever they come to us. In most

cases, young ones come to us with a lot of social problems, such as poverty and drop out from school. We need more training not only in HIV counseling but also in social problems.’

Distance is one of barriers that cause low uptake of VCT among adolescent girls. In this interview the counselor suggested that if the adolescent girls come for VCT, they needed to be refunded their transport money to encourage more to go for VCT.

They all support the move by offering refreshments, T-shirts so as to motivate adolescent girls to seek VCT.

CHAPTER FIVE

DISCUSSION OF THE FINDINGS

5.1 Introduction

This chapter presents the discussion of the findings of the study sought to investigate the factors constituting motivators and barriers to effective utilization of Voluntary Counseling and Testing by girls at Umoyo Training Centre. The chapter brings out themes from the findings under the objectives.

5.2 Knowledge about Voluntary Counseling and Testing

Knowledge of HIV and AIDS is almost universal in Zambia. According to ZSBS 2009, almost all adolescent had heard of AIDS. This is probably as a result of HIV and AIDS campaign that have been going on throughout the country. Some of the sources of HIV and AIDS information for the adolescents include the community awareness workshops, drama performance, schools, radio and church.

This study confirmed that the level of knowledge on VCT among adolescent girls was equally high with 80% indicated 'Yes' to have knowledge. This study revealed that, most of the respondents know that they can be tested for HIV (82%), of which 18% do not know that they can be tested for HIV status. However, of those aware of VCT, only 15% reported to be tested for HIV and know their HIV status, while 67% have not been tested. What is emerging

is that although there is good knowledge among the adolescent girls, only 15 percent indicated to be tested.

In the survey and FGD's the respondent demonstrated high degree of knowledge about VCT. The higher level of knowledge in this study could be due to the additional health and empowerment information obtained by study group from the centre. The centre provides appropriate information about HIV and AIDS.

In this study, 55 percent had knowledge of the importance of checking ones HIV status, 27.5 percent felt VCT is necessary to protect oneself and 17.5 percent as an entry point for treatment.

The respondents were asked about the location of the VCT centre, the majority of respondents 90% knew the VCT centre, while 10% do not know any VCT centre in their area. Of the respondents who knew the VCT centre in their area, 57.5% know the location at hospital/clinic, 15% know the location at free-standing and 17.5 know of Kara counseling.

5.3 Source of knowledge of VCT

Information adolescent girls had with regards to VCT and planning to go for VCT was also part of this study. In this study the respondent who heard about VCT was informed through the media (T.V/Radio which is 40%). Radio is an important channel for mass communication relative to others because ownership in Zambia is high and more people listen to the radio. In addition, adolescents with high education were likely to have access to radio than those with low education.

These results support the findings of another study conducted in Malawi among young people which revealed that their three main source of information radio (39.5%), youth clubs (34.6%) and 11% schools (Mauwa & kawala 2003:43).

The media and friends have been found to be the most quoted source of information in many studies on reproductive health among adolescent. This calls for a reappraisal of use of the media as a means of reaching adolescents with health information especially those that pertain to HIV and AIDS prevention strategies including VCT. It is also important to empower adolescents with accurate information so that right information about VCT and HIV can reach more adolescent. It is clear from the HIV and AIDS campaign that, even if girls are not receiving HIV and AIDS knowledge in the educational context or from families, they are exposed to this knowledge through media.

The study pointed out that there is less VCT information discussed with the family compared it with information discussed with friends. Parents in this study were ranked very low as a source of VCT information. This is supported by the studies done by Zambia that adolescents often wanted information and guidance from their parents but did not know how to initiate the dialogue (Horizons and Partners 2001).

These results point out to the fact that knowledge and discussion of VCT information among adolescent girls is an important driving force on attitudes towards VCT. The study also points out that knowledge of VCT seems to create the right attitude towards VCT. Even though the majorities have heard and define the term VCT, the study pointed out that there is low VCT uptake among the respondent.

It is assumed that, when adolescent girls have adequate knowledge about VCT, it should also influence a positive attitude. In this study, even though knowledge is good, only few of adolescent girls indicated been tested and half are planning to use VCT services.

5.4 Factors influencing girls' decision to attend or not to attend VCT services

The results indicated no differences between girls with higher and lower intentions to use VCT services in regards to their attitudes towards testing. A non-significant difference is likely to be reflection of the individualistic nature of using VCT services. One's favourable or unfavourable evaluation of the idea to use VCT services is a decision made by the individual and reflects personal opinion. Attitudes reflected here include girls' beliefs that their own personal use of VCT services could lower their chances of HIV infection and make it possible to avoid transmitting HIV. Girls may perceive that HIV services would result in a happy life if the results were negative, help them to plan confidently for their future or facilitate their seeking of therapy if their HIV test results were positive.

The lack of relationship between attitude and intention reflects that girls feel pressures elsewhere when it comes to being tested or not being tested for HIV, but that their own evaluation of HIV service is not a significant determinant. The study done by Van Dyk and Van Dyk, 2003 found that attitudes to VCT are largely positive and this presents programme planners with immense opportunities.

In a study exploring knowledge and attitudes of HIV among University students in United Kingdom and Zambia, Baggaley (1997) found that 7 percent of UK students and 10 percent of Zambia students had an HIV test. A further 35 percent of Zambians and 15 percent of UK students said they would like to be tested. In a study from Rakai province in Uganda, 84

percent of 865 young people interviewed said that they would like to see an HIV and AIDS counselor in future (UNAIDS, 1999).

However, if these attitudes of the adolescents could be practical on the actual ground, it would be highly likely that the incidence of HIV among the adolescent would decrease. Many studies in Africa show that there is great difference in theoretical and actual uptake rate of VCT. In Zambia, for instance the readiness to utilize the VCT services among the study group was 37% and only 3.6% actually came for VCT service. The findings of this study show that, 67% adolescents have not gone for VCT. This is directly linked to less self perceived risk of HIV infections. Most of the adolescent girls perceived themselves as being at low risk of infection hence did not bother to take HIV test.

The motivation to use VCT is low because correctly or incorrectly girls do not view themselves as being at risk for HIV and AIDS. High risk groups tend to be less likely to participate in VCT possibly for fear of learning a positive test result. In Zambia individuals willing to seek VCT were more likely to be a high risk and were likely to test positive (Fylkenes & Sizya, 2004).

It has been proved by this research that, the discussion of VCT is important aspect in improving the level of confidence in the use of VCT among adolescent girls. Those who discuss VCT more frequently especially with friends have greater positive attitudes towards the use of VCT services.

Lack of information about VCT affects adolescents' attitude towards VCT and HIV. This therefore requires that intensive information be provided to adolescent to make them realize

the importance of knowing ones' HIV status and to empower them to have hope whether positive or negative they can live a happy life.

5.5 Perceived Barriers and benefits to Accessing VCT

There are several factors that may be contributing to low uptake of VCT among the adolescent girls. A survey by ZSBS (2005) showed that fear of results is one reason mentioned by young people for choosing not to go for VCT. This reason is mentioned by 72.7 percent of the young people 15 - 24. The other reason mentioned is stigma and discrimination which of almost the one – third of the study group. Less than 4 percent pointed out that not knowing where to go as a reason of not going for VCT.

In this study, it was found that most of the respondents (67%) have not yet gone for VCT. The reason given for not going for VCT is stigma and discrimination in case of a positive test result. Adolescent girls expressed of not accepting VCT because of stigma and discrimination and how to copy out if positive. The stigma associated with HIV and AIDS is the key factor reducing the uptake of VCT services among adolescent girls. A participant in the focus group narrated the following experience; “A sister who is HIV positive is being avoided by community members whenever she is drawing water from the community water tap.” For example in some cases people living with HIV are given names by their relatives which are associated with their symptoms.

Other studies have also shown that perceived stigma can act as a barrier to accessing VCT among adolescents (Mc Cauley 2004). Similar findings reported in a study in Zambia which revealed that 57.0% of boys and 53.0% of girls said they would like to have opportunities of

going for HIV test but the majority of them were not keen to have HIV tests at that time, as they were worried that they might be HIV positive (Baggaley 2001:34).

The study results revealed that privacy and confidentiality are the most important factors that girls are concerned with as far as HIV testing is concerned. The girls could have preferred clinic for the same reasons of privacy and confidentiality. Therefore, it can be inferred that girls would go for VCT and HIV test at any centre if these centres would offer services similar to the services offered at clinic.

In this study, location of VCT centers in health centre and distance to reach VCT (25%). Adolescent girls preferred VCT centers to be at Health centre, mobile so that many can access VCT. However, there is need to ensure that adolescents' requirements of VCT services are met. Long waiting hours was another barrier for adolescent for not going for VCT. In this study, girls indicated that prevention of getting infected and infecting others were the most important benefits of knowing ones status, VCT allows one voluntarily to learn his/her status and reduce risk of acquisition or transmission of HIV.

CHAPTER SIX

CONCLUSION AND RECOMMENDATIONS

6.1 Introduction

This chapter concludes the study and also makes some recommendations based on the findings of the study.

6.2 Conclusion

This study found out that the study group had adequate knowledge about VCT, and the majorities were planning to have VCT. However, fear of stigma and discrimination has coupled with restricted access to VCT services. Adolescent girls feel the risks of knowing and disclosing their sero-status to outweigh the benefits, hence one important challenge in addressing the needs of adolescent girls lies in understanding the extent to which the adolescent know about and use protective measures against the risks. However the study did not establish how much knowledge the girls had and whether that knowledge influences their decision to go for VCT and HIV testing.

The majority of the girls at Umoyo centre perceived HIV prevention and transmitting the HIV infection to others as the greatest benefits of knowing one's HIV serostatus. However privacy and confidentiality are the most important factors that the girls look for in VCT services.

The study also revealed that parents shares less VCT and HIV information with their children. The main source of VCT information was TV and friends. Against this background, there is need for parents to play a bigger role in providing sexual information to their children. This implies a need to develop communication interventions targeting parents to improve dialogue with children about VCT, sexuality, HIV and AIDS.

6.3 Recommendations

In view of the above, the following recommendations are made;

1. According to the research findings from Umoyo Training Centre, there is low uptake of VCT among adolescent girls. This is because of location of VCT centres which in most cases are at health centre and girls fear of being stigmatised. Therefore, VCT centres should be located in youth centres or where youths frequent, such as churches and schools. Voluntary Counselling and Testing services should be designed specifically for adolescent girls.
2. VCT centres should motivate adolescent girls through reimbursement for transportation or incentives such as T-shirt, soft drinks to encourage more young ones.
3. Access to testing should be increased by supportive policies on prevention and care interventions, affordability, convenient locations and hours for the adolescent girls.
4. Umoyo Training Centre should open its doors to many adolescent girls in other Compounds not only to Kanyama and Mtendere. There is need for more centres like Umoyo in Zambia especially in rural areas to empower more girls.

5. Where stigmatizing attitude still a problem, there is need to cultivate a culture of learning among those who are ignorant or who do not have adequate knowledge on HIV testing.
6. Parents or guardians should discuss and support the young ones when it comes to VCT. VCT messages should encourage involvement of family members to help adolescent to cope once they get tested for HIV.

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APPENDIX A: INFORMED CONSENT

TITLE: Factors constituting motivators and barriers to the effective utilization of VCT by Girls aged between 14 and 22

Dear Participants,

I am a student from the University of Zambia, School of Humanity and Social Sciences, doing Master of Arts in Gender Studies. As part of the course, I am doing a research on the factors constituting motivators and barriers to the effective utilization of VCT by girls. I am intending to do this study at Umoyo skills Training Centre for Girls.

In order to collect information for the research, questions about VCT will be asked. Some questions may border on personal matters, but please be assured that the responses will be treated in the strictest confidence, and used purely for academic purposes. Please also note that:

Participation is on voluntary basis.

You are free to withdraw at any stage during the interviews

The information will be very helpful on VCT.

Please be informed that there is no direct risk or harm to you if you did consent to participate in this study. However, some of your time will be used up during the question and answer sessions.

Your participation will be greatly appreciated. If you agree to participate in this research please indicate your consent by signing or putting your thump print, on the release below.

Yours Sincerely,

Festus Zulu.

I accept participation in the study.

Signature or Thumb Print:.....

Date:.....

APPENDIX B: SURVEY QUESTIONNAIRE

QUESTIONNAIRE

Interview No.....

Date.....

Place.....

SECTION A: RESPONDENT'S BIODATA

May you kindly answer the following questions? Simply tick what is applicable. The answers given will only be used for academic purposes.

Identification

1) Your age.

14-17

18-21

22-26

2) Sex

1. Male

2. Female

3) Marital status

1. Single

2. Married

3. Separated

4. Widow

4) Education

1. Nil

2. Primary

3. Junior Secondary

4. Senior Secondary

5) Occupation.

Employed

Self-employed

Unemployed

In school

SECTION B: (KNOWLEDGE ON VCT)

6) What do you understand by the term VCT?

.....

.....

.....

7) Do you know that you can be tested HIV status?

1. YES

2. NO

If the answer to question 7 is Yes, Have you been tested?

1. YES

2. NO

Who are the people who need HIV test if the service is made available?

1. Couple before marriage

2. Pregnant women

3. Female sex workers

4. Any one

10) Do you know any VCT center?

1. YES

2. NO

11. If your answer to question 10 was YES, where are they located?

Clinic/Hospital

Free-standing VCT

Kara Counselling

Other (specify)

12. If your answer to question 10 was YES, how did you know about the VCT centre?

Through friends	<input type="checkbox"/>
Through a relative	<input type="checkbox"/>
Radio/TV	<input type="checkbox"/>
Other (specify)	<input type="checkbox"/>

SECTION C: ATTITUDES TO HIV AND VCT SERVICES

13. Are there any VCT centers in this area?

1. Yes	<input type="checkbox"/>
2. No	<input type="checkbox"/>

14. If yes do people make use of these services?

1. Yes	<input type="checkbox"/>
2. No	<input type="checkbox"/>

15. What do you think are reasons for people not using VCT services?

1. Stigma	<input type="checkbox"/>
2. Location	<input type="checkbox"/>
3. Culture	<input type="checkbox"/>
4. Religion	<input type="checkbox"/>

16. What could be done to overcome these obstacles to the use of VCT?

1. Education

2. More centre

3. Mobile VCT centre

17. Do you worry about being HIV positive?

1. No

2. Sometimes

3. Very worried

18. Do you feel VCT is necessary?

1. No

2. Yes

19. If your answer is YES to question 18, why is it necessary?

1. To know the HIV status

2. To protect oneself from the infection

3. If positive-to start treatment

4. Others

20. If your answer is NO to question 17, are you planning to get tested?

1. No

2. Yes

21. Where would you prefer to be tested for HIV and AIDS?

1. Hospital/Clinic

2. Community VCT Centre

3. Mobile Centre

4. Other sites

22. What are the main fears of having an HIV test?

.....

.....

.....

23. Would you discuss with the family whether or not to test for HIV?

1. YES

2. NO

THANK YOU FOR KINDLY ANSWERING ALL THE QUESTIONS

APPENDIX C: Focus Group Discussion

Introduction:

Greetings and Welcoming remarks to participants:

Purpose of Discussion

I am here to find out and learn from you what you know about VCT. I feel you are the right people who can help on the knowledge and attitudes about VCT. Knowledge is a key to your life. Feel free to contribute during the discussion, as all your contributions are important. Be assured of confidentiality of information.

Discussion Topic

Health: General warm up questions;

What are some of the commonest health problems in your area?

What factors do you think contribute to these health problems?

What do you do in your spare time?

i) Knowledge about VCT.

Have you heard about VCT?

Where did you hear about VCT from?

What prevented some of the adolescent girls from VCT uptake?

How does a person get infected by the HIV virus?

How can one be protected against getting HIV?

ii) Attitudes on VCT.

Do you think VCT is important?

Why is VCT important for you?

How do you feel about going for VCT?

Would you encourage your friend to go for VCT?

What are the fears that you encounter when going for VCT?

What is the general attitude of your community towards people living the HIV/AIDS?

What motivates you to seek VCT?

Thank you for participating in the discussion!

**APPENDIX D: INTERVIEWS WITH KEY INFORMANTS COUNSELORS AT
KANYAMA HEALTH CENTRE**

**TOPIC: Factors Constituting Motivators and Barriers to the Effective Utilization of
VCT by GIRLS**

DATE:

TIME:

GUIDING QUESTIONS

Do young adolescent girls access services from your service?

How often do you receive adolescent girls?

What reasons do they normally give when they come for VCT services?

What challenges do you face in your services provision?

How best do you think your services can be accessed by adolescent girls?

What do you think hinders adolescent girls to go for VCT?

What can motivate adolescent girls to seek VCT services?