

UTILISATION OF VOLUNTARY COUNSELLING AND TESTING  
SERVICES BY THE YOUTH AGED BETWEEN 18 AND 24 YEARS  
IN INSTITUTIONS OF HIGHER LEARNING IN LUSAKA, ZAMBIA.

By

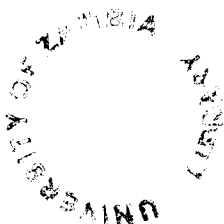
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2006

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A Dissertation Submitted in partial fulfilment of the requirements for the  
award of Masters of Public Health.


The University of Zambia

2006



Declaration

I, **Sarah Shawa Chishimba**, do hereby solemnly declare that this dissertation represents my own work and that; it has not previously been submitted for any degree at this university.


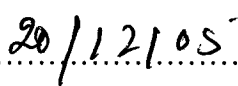
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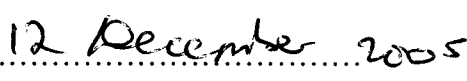
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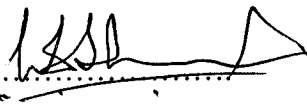
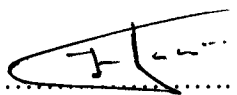
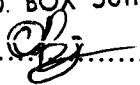
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## **Abstract (Executive Summary)**

The advent of the HIV/AIDS pandemic has raised important questions for policy makers, practitioners and researchers on finding appropriate strategies to mitigate its impact on society, particularly on the youth, who form a very important potential resource for future development. It has long been identified that behaviour change, especially among the youth, is critical in reducing the transmission of HIV. In recent years, Voluntary Counselling and Testing (VCT) has emerged as an important tool in bringing about behaviour change. Studies show that VCT is a cost-effective intervention in preventing HIV transmission, and that it gives seropositive people earlier access to medical care and preventive therapies among other benefits.

Despite the widespread recognition of VCT as an effective strategy for reducing HIV sexually risky behaviour, there is limited information about the impact of VCT on young people, or its effectiveness in assisting the youth to change their behaviour. There is also limited information about the accessibility of VCT services to the youth, how young people who test seropositive cope, who they share their test results with, and who provides emotional support to them after they have undertaken the test.

This study intended to explore the effectiveness of VCT in changing the sexual behaviour of the youth by examining their attitudes about VCT and VCT services currently being provided. The primary objective of the study was to establish the level of awareness among the youth about VCT. Specifically, the study sought to determine the utilisation of VCT services currently being provided, and to determine whether VCT services are readily accessible to the youth within their immediate vicinity. The study also sought to establish whom the youth in institutions of higher learning share their test results with when they use VCT services, and to ascertain the general perception of the youth towards VCT services. The study was based on a sample of 320 youth in three institutions of higher learning in Lusaka, namely University of Zambia, Evelyn Hone College of Applied Arts and Commerce, and Chainama College of Health Sciences. The study used a combination of a structured survey questionnaire and focus group discussions. Literature reviewed was based on contemporary thinking among researchers and practitioners on VCT, and the existing studies on the general impact of VCT.

The study found a very high level of awareness about VCT services among the target group. 90.3 percent of the youth covered by the study were not only aware about what VCT was, but they were able to identify a VCT centre nearest to them. However, despite this awareness, utilisation of VCT services was much lower than the level of awareness exhibited. It was found that only 22.4 percent of the respondents had visited a VCT Centre, and only 16.3 percent of the entire population covered by this study had actually undertaken an HIV test.

As regards accessibility, this study found that VCT services were readily accessible to the youth in institutions of higher learning, as 92.8 percent of the respondents knew where the centres were. However, there were other factors that inhibited the youth from effectively utilising VCT services. Some factors mentioned by respondents included the location of VCT centres, and the perception by some respondents that VCT is only supposed to be for those involved in high risk sexual behaviour. Furthermore, this study found that the youth were largely unwilling to share test results after utilising VCT services. Of the respondents that had undertaken an HIV test, 64 percent indicated that they were not willing to share their test results. On the other hand, the remaining 36 percent who were willing to share their test results indicated that they would rather have shared them with family members.

Finally, this study found that the perception of the youth in institutions of higher learning towards VCT was largely positive with 77.1 percent responding that VCT was a good concept. However, most respondents felt that the focus by providers was too narrow, as it focused on VCT as an end in itself.

# Dedications

This work is dedicated to my children Mwamba and Mukuka Chishimba, whom I hope this work will inspire to follow my footsteps.

To my loving husband Nathan Bwalya Chishimba. Thank you for all the support and encouragement you gave me.

To my parents, Mr.and Mrs Joseph Shawa. Dad, I hope this work fulfils your expectations and makes you proud of me.

To my brothers and sisters, for the encouragement you have shown me.  
God bless all of you.

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Completing this work was an involving task that required the cooperation and support of a lot of people. I would like to thank the following for assisting me in completing this dissertation.

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I am also grateful to the students at the University of Zambia, Evelyn Hone College, and Chainama Hills who graciously agreed to be interviewed.

I would also like to thank my husband, Nathan Chishimba, for his assistance in editing the final draft report, and the University of Zambia Management for granting me leave and putting me on the Staff Development Programme.

Lastly, but by no means the least, I would like to thank the almighty God for giving me the strength to carry on even in difficult circumstances when my father, Mr. Joseph Shawa was diagnosed with leukaemia and had to cope with frequent spells of hospitalisation.

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# Acronyms And Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ANC	Ante Natal Clinic
CDC	Centre for Disease Control (United States)
DHMT	District Health Management Team
FGD	Focus Group Discussion
HIV	Human Immunodeficiency Virus
NGO	Non-Governmental Organisation
RR	Relative Risk
STI	Sexually Transmitted Infection
TB	Tuberculosis
UNZA	University of Zambia
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation
ZCC	Zambia Counselling Council
ZVCTS	Zambia Voluntary Counselling and Testing Service

# **Chapter One: Introduction**

## **1.1 General Introduction**

Zambia is ranked among the countries in sub-Saharan Africa most affected by HIV/AIDS epidemic. It is administratively divided into 9 provinces and 72 districts. Further it has a mixed economy consisting of an industrial sector confined along the line of rail and a rural agricultural sector in which subsistence farming is predominant. The structural adjustment programme, balance of payment deficit, high inflation, depreciation of the local currency, and the privatisation of most parastatal companies comprising the industrial sector have all adversely affected the economy and significantly contributed to poor living conditions and lowered life expectancy in the general population.

According to the most recent National Census conducted by the Central Statistical Office (2000) the population of Zambia is currently estimated to be 10,285,631. The annual growth rate averages 2.9 percent. Projected life expectancy at birth is 53 years for males and 55 years for females, although anecdotal predictions suggest that the life expectancy has drastically dropped to below 40 years primarily because of death caused by or associated with HIV infections and AIDS.

Voluntary Counselling and Testing (VCT) is the process by which individuals undergo counselling to enable them to make an informed choice about being tested for HIV (Chiboola et al, 2001). The decision must entirely be the choice of the individual and they must be assured that the process will be confidential. Therefore, VCT is a specific means by which people acquire information about their HIV status. VCT is recognised internationally as a critical strategy in a comprehensive primary prevention campaign against HIV/AIDS as well as an early entry point to prevention and care. According to the World Health Organisation (WHO), young people account for over 50 percent of all global HIV infection rates (WHO, 2000). The need to prevent HIV infection among young people in sub-Saharan Africa has become particularly urgent because young people have HIV prevalence rates in excess of 10

percent and comprise over 30 percent of the population of most of the countries. There are several cultural, biological and environmental factors that place young people at increased risk of HIV infection in Africa.

VCT has a vital role to play within a comprehensive range of measures for HIV/AIDS prevention and support, and should be encouraged (UNAIDS, 2003). The potential benefit of testing and counselling for the individual include improved health status through good nutritional advice and earlier access to care and treatment/prevention for HIV related illness; emotional support, better ability to cope with HIV-related anxiety; awareness of safer options for reproductive and infant feeding, motivation to initiate or maintain safer options for reproduction and infant feeding, and motivation to initiate behaviour change. Other benefits include safer blood donations.

UNAIDS therefore encourages countries to establish national policies along five common lines. Firstly, national policies should make good quality, voluntary and confidential HIV testing and counselling available and accessible. Secondly, they should ensure informed consent and confidentiality in clinical care, research, the donation of blood, blood products or organs, and other situations where individuals' identity will be linked to his or her HIV test results. Thirdly, they should strengthen quality assurance and safeguards on potential abuse before licensing commercial HIV home collection and home self-test. Fourthly they should encourage Community involvement in sentinel surveillance and epidemiological surveys. Finally, national policies should discourage mandatory testing (UNAIDS, 2002).

Many of the countries most severely affected by HIV are also among the poorest countries. In Zambia, according to the Ministry of Health, the HIV/AIDS challenges have heightened the need for social service delivery settings at community level (GRZ Ministry of Health, 1996). However, establishing VCT services is often not seen as a priority because of cost, lack of laboratory and medical infrastructure and lack of trained staff. This has resulted in VCT being unavailable to most people in high-prevalence countries. It is therefore important to document the practice and societal attitudes to VCT in order to promote and expand access to it.

In Zambia where VCT services have been established there has been a reluctance of people especially young ones to attend for testing. This reluctance may be due to denial, or discrimination that the people who test seropositive may face and the lack of perceived benefits of testing among the youth. To overcome the barriers to establish VCT services, it is important to demonstrate its effectiveness and to challenge stigma and discrimination so that people are no longer reluctant to be tested. The role of VCT as a part of a comprehensive health care, with links to and from other essential health care services (such as tuberculosis services and antenatal care), must be acknowledged. The structure of VCT services should be flexible and reflect an understanding of the needs of the communities they serve. Services should be easily accessible and closely linked with community organisations that can provide and support resources beyond those offered by VCT services alone. Fylkesnes et al (1999) said access to voluntary HIV counselling and testing (VCT) is important in a human rights perspective: the right to know or not to know one's HIV-status.

## **1.2 Review Of Literature**

The issue of VCT raises a lot of debate, as different researchers look at the problem from different perspectives. According to (WHO 2001), in Zambia VCT services have been provided by Non-Governmental Organisations (NGOs) since the late 1980s. However, with 19.7 percent of Ante-Natal Clinic (ANC) attendants testing positive and estimates of 500 new HIV infections and 200-300 HIV related deaths per day, there was recognition of the need for government involvement in VCT Chiboola et al (2001). A one-year pilot project on the establishment of a National VCT services was initiated in 1999 to determine acceptability of VCT among the Zambians and examine feasibility of setting up same day service (Chiboola et al, 1997). Twenty-two sites were identified across the country using criteria that included availability of trained counsellors and laboratory technicians, and support of the district management teams.

One of the major lessons learned from the pilot were the need for sustained community mobilisation, staff motivation, linkages between local Non-Governmental Organisations (NGOs) and Zambia Voluntary Counselling and Testing Services (ZVCTS), and a clear organisational structure for the ZVCTS. Same day service was also found to be more acceptable. A consolidated phase was subsequently designed in

which a national organisational framework was established for the ZVCTS and a technical working group representing various stakeholders formed on VCT and care. The objectives of the group were to integrate and establish joint work plans on VCT with local NGOs, Zambia Counselling Council (ZCC), District Health Management Teams (DHMT) and other stakeholders and to provide logistics support to other established VCT services. As a result of these efforts, VCT services were better co-ordinated and joint training programs were established for counsellors and laboratory technicians with local NGOs and DHMTs. VCT coverage was increasing from 22 centres to 37, with approximately 100,000 clients attending ZVCTS over the first 15 months.

Despite all this there is very little specific information on the use of VCT by the youth aged between 18 and 24 years. (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. There have been many studies that acknowledge the special vulnerabilities of young people, but this has not been translated into increasing access to VCT services for them. Furthermore, according to experts like De Burca (1994), issues such as age of consent for VCT for young people, parental involvement in the decision to test, confidentiality and coercion of testing vary, and need careful consideration in many settings.

According to FOCUS, a program for young adult reproductive health, young people play a pivotal role in slowing the rate of HIV transmission in many countries affected by the HIV/AIDS pandemic (FOCUS, 2001). Consequently there is great urgency to provide HIV care and support services for young people, 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 young people. The uptake of ongoing care and support services by young people following VCT is not known although follow-up of young people following VCT is difficult, particularly in sites where anonymous VCT is offered. Operational research to determine the long-term outcomes of young people following VCT should be considered, to ensure that young people (particularly those who test seropositive) are not left unsupported and disadvantaged following testing. Additionally, as pointed out by Sabin and others

(1998), ongoing emotional support must also be considered when developing VCT services for young people.

In many developing countries VCT has not been available to young people (Baggaley, 1997). However, when young people are asked whether they would like to be tested, they often say they would like VCT to be more widely available and would like to be tested. In a pilot phase of study of young couples in rural western Kenya, 95 percent of participants said they would accept a free HIV test. The mean age of couples participating in this study was 22 years.

In a study exploring knowledge and attitudes to HIV among University students in the United Kingdom and Zambia, Baggaley (1997) found that 7 percent of UK students and 10 percent of Zambian students had an HIV test. A further 35 percent of Zambian 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/AIDS counsellor in future (UNAIDS, 1999).

Fylkesnes and Siziya (2004) carried out a study to examine factors affecting readiness for and acceptability of voluntary counselling and testing (VCT). Participants in a population-based HIV survey conducted in an urban population in Zambia in 1996 were offered VCT. Although 29 percent of them expressed interest in being tested (readiness), 4 percent of this group used the services (i.e. acceptability). When the survey was repeated 3 years later, VCT was designed differently to assess acceptability. At the cluster level the participants were randomly allocated to VCT either at the local clinic (similar to 1996, n = 1102) or at an optional location (n = 1343). Readiness varied significantly by age group (47 percent in age group 20-24 years vs. 18 percent in age group 40-49 years).

There were contrasts between young (15-24 years) and older age groups (25-49 years) regarding the main factors associated with readiness. Whereas self-perceived risk of being HIV infected was the only significant factor among the young, poor self-rated health and ever HIV tested were important factors among older respondents. The acceptability was 11.8 percent among the group allocated to VCT at the local clinic compared with 55.5 percent for the group allocated to an optional location (Relative

Risk, 4.7). Perceived risk of HIV infection had a major influence on VCT readiness among young people, whereas declining general health status, as indicated by self-rated health, was most evident among those of older age. A strong effect of placement on acceptability of VCT was demonstrated, indicating this barrier to be important in explaining low demands for VCT in the past. Differences in perceptions of how confidentiality is handled at the two locations might be an important underlying factor.

The United States Centre for Disease Control – (CDC, 1998) showed that sexually active young people under 25 years of age were less likely to attend VCT than their adult counterparts aged 24 to 44 years, although half of new HIV infection in the United States is in men and women less than 25 years old. In order to learn about young people's attitudes and experiences to HIV testing, 73 high risk sexually active and economically or socially marginalized youth living in urban areas with relatively high rates of HIV infection were interviewed in-depth. Availability and acceptability of VCT services were found to be a major barrier to attending VCT for these young people. Worries about confidentiality and fear that results would be shared with parents without their consent also prevented young people from accessing VCT.

Sangiwe (2000) looked at VCT in the sense that young people are often particularly vulnerable to HIV infection. For VCT services to be effective for the young people they must take into account the emotional and social contexts of young people's lives, such as strong influence of peer pressure (e.g. to take alcohol or drugs) and development of sexual and social identities. They must also be 'user-friendly' offered in non-threatening, safe, easily accessible environments. Counselling should be age appropriate, using examples of situations that are familiar and relevant to the youth and language that is non-technical and easily understood.

According to UNAIDS (2002) anonymous VCT services may be preferable for young people. However 'different countries and cultures may have their own legal requirements and social expectations that prevent young people from accessing VCT services without parental consent or notification. Although VCT services must always take into account any relevant laws regarding the rights and autonomy of minors and

the responsibilities of parents for their children, they must also remember that the dignity and confidentiality of the young persons must be protected and respected.

Speaking at the Organization of African Unity Summit on HIV/AIDS, Tuberculosis (TB) and other infectious diseases in Abuja Nigeria, Carol Bellamy (2001) said “In addition we must also ensure young people’s access to youth-friendly health services that provide HIV testing and counselling, treat sexually transmitted diseases and offer frank and unabashed information and services on how sexually active young people can protect themselves and their partners from infection.” She continued saying the majority of new HIV infections in developing countries occur among young people through unprotected sexual intercourse with girls being particularly vulnerable. There are increasing efforts for young people in utilizing VCT services. However few programmes are currently providing counselling and testing as well as post-test services that are tailored to the special needs of young people.

According to Chilangwe (1995) in many cultures, it is socially unacceptable for young people to be sexually active unless they are married. Consequently sexually active young people don’t openly talk about their experiences with adults, including health workers. They fear that confidentiality might not be maintained in health facilities. In addition, young people tend to seek services only when symptomatic, for example, Sexually Transmitted Infections (STI’s).

A report produced by UNAIDS (1999) on Voluntary Counselling and Testing explains that VCT has not been seen as a priority in HIV care and prevention programmes in many developing countries and has therefore often not been widely available. Reasons for this include: complexity of the intervention, the relatively high costs of its various components, the lack of evidence of its cost-effectiveness as measured by number of cases of HIV

According to Demographic and Health Surveys conducted by the Zambian Government (1997), in Zambia, for example 31 percent of women and 65 percent of young people were sexually experienced but not yet married. Most adolescents, when entering into sexual relations for the first time, do not use any form of contraception. This leaves them vulnerable to HIV infection, STI’s and unplanned parenthood.

According to a paper by USAID (2000) half the population of Zambia are young people. One-fifth of this population is living with HIV. Fewer than 4 percent of young people in Zambia have taken an HIV test and know their status. Based on current trends, a young Zambian faces a 60 percent risk of becoming HIV-positive during his lifetime. Yet, two-thirds of young people don't believe they are at risk, although they have very good knowledge about HIV/AIDS.

### **1.3 Statement Of The Problem**

Recent study results from Zambia reveal that high quality VCT is an effective strategy for reducing HIV sexual risk behaviours among young adults. However, not much is known about the impact of HIV testing on young people, or whether it helps them change their sexual behaviour. It is also not known how young people who test seropositive cope, who they share there test results with, and who provides emotional support and if they are able to access support services following VCT.

This study on young people intended to explore the effectiveness of VCT in changing the sexual behaviour of young people. It intended to examine their attitudes about VCT. The study was concentrated in Lusaka's tertiary institutions of learning. Admittedly, it is sometimes difficult to measure the impact of counselling on behaviour change. It is also difficult to isolate and quantify the specific influence of VCT because of the complexity of sexual behaviour, relationships and factors that affect these, such as gender inequalities and lack of empowerment of women in many prevalence settings.

### **1.4 Objectives Of The Study**

#### **1.4.1 General Objective**

To establish the level of awareness about availability of VCT services among adolescents.

### **1.4.2 Specific Objectives**

1. To determine the utilisation of VCT services currently provided for young people, particularly those in institutions of higher learning.
2. To determine accessibility of VCT services currently provided for young people, particularly those in institutions of higher learning;
3. To establish whom the target group share their test results with when they use VCT services;
4. To determine the perception of VCT among the youth.

### **1.5 Rationale**

There has been a general concern over young people and the use of VCT. Until recently, there was a paucity of data indicating that VCT may be important in changing sexual behaviour and a cost effective intervention in reducing HIV transmission. However, there are now studies available showing that VCT is a cost effective intervention in preventing HIV transmission and that VCT gives seropositive people earlier access to medical care, preventive therapies and the opportunity to prevent mother to child transmission of HIV.

A key intention of the study was to generate valuable data to aid planning and decision-making concerning VCT targeted for young people. Secondly, field data yielded by the study on what is obtaining on the ground was to help with setting standards and guidelines necessary for the regulation and control of quality and sustainable VCT services in the country. Thirdly, information gathered during the study was intended to establish a baseline of information about relevant issues, both to help in the design of future programmes and to measure their results and impact.

# Chapter 2: Methodology And Design

## 2.1 Design and Setting

A cross sectional study was conducted. The study population was drawn from the University of Zambia, Evelyn Hone and Chainama Colleges. The reason these three institutions were picked was because they are the largest institutions of higher learning in Lusaka.

## 2.2 Sample Size Determination

### 2.2.1 Cross Sectional Study

The sample size was calculated using the standard formula:

$$N = \frac{Z^2 \cdot p(100 - p)}{D^2}$$

Z = 1.96 from normal distribution

P = estimated period prevalence of 25%

D = Absolute sampling error of 5%

$$N = \frac{1.96^2 \cdot 25(100 - 25)}{25}$$

$$N = 280$$

The formula yielded a sample of 280. However to adjust for finite population size, a response rate of 90 percent was considered. Therefore, the required minimum sample size was

$$\frac{280}{0.9} = 312$$

On this basis 320 students were considered.

The sample size took into account the number of students aged between 18 and 24 years in these institutions as follows:

<u>Institution</u>	<u>Number of Students</u>
University of Zambia	6,000
Evelyn Hone College	3,000
Chainama College	600
<b>TOTAL</b>	<b>9,600</b>

The sample size for each institution was then drawn up as follows:

$$\frac{\text{Number of students in institution}}{\text{Total number of students}} \times \text{sample size}$$

On this basis,

$$\begin{aligned} \text{UNZA} &= \frac{6000}{9600} \times 320 = 200 \\ \text{Evelyn Hone} &= \frac{3000}{9600} \times 320 = 100 \\ \text{Chainama} &= \frac{600}{9600} \times 320 = 20 \end{aligned}$$

Purposively, 50 percent of the sample were male and 50 percent female.

### 2.2.2 Focus Group Discussions (FGD)

FGD comprised of young students of both sexes aged between 18 and 24 years willing to take part in focus group discussions. 4 Focus group discussions consisting of 6 to 10 were held .Two focus groups were held at the University of Zambia, and one each at Evelyn Hone and Chainama colleges.

## 2.3 Sampling

A random sample of the area’s population was drawn. Simple random sampling was used. The reason for using simple random sampling was to ensure that every student between the ages of 18 and 24 years had an equal chance of being selected. The study consisted of both males and females from the university and colleges. The sub-sample from the different strata was interviewed. Due to the nature of the

investigation, a sample of randomly selected units of either sex was used. 320 respondents were then selected using simple random sampling.

## **2.4 Data Collection Methods**

Two principal methods of data collection were used – a questionnaire and focus group discussions.

### **2.4.1 Questionnaire**

Both open-ended (free responses) and closed-ended (fixed choice) questions were provided in the questionnaire. 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 and capturing variables which were quantifiable.

### **2.4.2 Focus Group Discussions**

Focus Group Discussions consisted of 6 to 10 participants of mixed sexes aged between 18 and 24 years. The major instrument used was the FGD Guide, which was prepared on various aspects of the topic. This method was chosen because it allowed respondents to provide qualitative responses that could not be yielded from the restrictive questions in the administered questionnaire.

## **2.5 Data Analysis**

The data was analysed using both qualitative and quantitative methods.

### **2.5.1 Quantitative Analysis**

The raw data was checked for completeness and internal consistency. The SPSS computer statistical application was used for all data processing and analysis. Chi-square tests were used to test differences between proportions.

## **2.5.2 Qualitative Analysis**

Qualitative analysis was included to catch the feelings as well as innermost thoughts of the young people on the issue of VCT. This method allowed more detailed investigation and exploration of responses. The responses from the Focus Group Discussions (FGD) were used for comments and recommendations.

The collected data was analysed manually. This involved looking through common answers to each of the key themes. All the answers relating to similar things were compared and contrasted in order to identify common patterns within and between different FGD.

## **2.6 Limitations Of The Study**

**2.6.1 Time factor:** A study such as this one normally requires more time than the six months in which this study was conducted.

**2.6.2 Openness of Respondents:** Some respondents may not have been as open as was required due to the personal nature of the study topic. This may have affected the quality of answers to some extent.

**2.6.3 Scope:** Lusaka has a lot of colleges. A larger sample from different colleges would have been more representative and generalised. However, due to the time factor and lack of resources to carry out a bigger research, the sample was restricted to the three largest institutions in Lusaka.

## **2.7 Ethical Considerations**

Throughout this study, the confidentiality of the data collection and the anonymity of the respondents or participants was assured. The data collection was not in any way associated with any identifier other than the numbers which were not cross-referenced with a name. The numbers were personal and were designed only for the purpose of facilitating the study.

Access to the interview guides, tapes and transcription was restricted only to those actively participating in the research project throughout the duration of the study. Data was collected only through the informed consent of the respondents or participant. None of the respondents was compelled to give information without their consent.

Approval was obtained from the Research and Ethics Committee of the University of Zambia to conduct the study. Permission to conduct the study was also sought from the University of Zambia, Evelyn Hone College of Applied Arts and Commerce and Chainama Hills Training College.

## Chapter 3: Findings

This chapter presents the findings obtained from the field. Data was collected between 15<sup>th</sup> September and 30<sup>th</sup> October 2004.

### 3.1 Findings From Focus Group Discussions

Part of the study entailed holding Focus Group Discussions (FGD) with selected students at University of Zambia, Chainama College and Evelyn Hone College aged between 18 and 24 years old. The FGD were on voluntary basis and were structured in accordance with a pre-determined outline (Appendix C), to ensure structured and consistent discussion across all groups. The following text is a summary and analysis of the four Focus Group Discussions (FGD'S) that were held:

#### 3.1.1. Knowledge and Views of Voluntary Counselling and Testing

Participants from all the Focus Group Discussions demonstrated a good understanding of Voluntary Counselling and Testing (VCT). They were able to define what VCT was in detail, and they recognised that before anyone goes for an HIV test, they needed to be counselled. They also recognised that VCT had to be voluntary and no one should force anyone to undergo it. VCT should come from deep down one's heart using an individual's own free will. Some of the statements attesting to this were:

*“Voluntary means, willing, out of your own choice, reasoning with yourself and an individual conviction within oneself.”*

*“VCT is going to the centre where someone's blood is tested to see if they have the HIV Virus.”*

*“VCT is a process of an informed decision that goes a long way in determining your fate on HIV/AIDS.”*

Members of the FGD also felt that VCT was important in order to safe guard ones life, and not to live in fear or suspense. They felt that VCT enables one to face life in a positive way.

*“The choice to have VCT means you want to know your status and therefore safe guard the spread of the infection.”*

*“VCT is also a means of people to open up and talk to somebody who will help them to go on with their life, whether positive or negative.”*

*“VCT is also important in knowing the status because you might have gotten the HIV Virus from other means like needles, accidents etc and might think you are safe from HIV/AIDS but were not.”*

Having said this, other members of the FGD revealed that they see VCT as a tool for the campaign against HIV and not a means in itself.

*“VCT is not voluntary. Campaigners are forcing people to go for VCT but after the test there is nothing they are doing about it. People just want to use VCT to get numbers, to know statistics on HIV/AIDS.”*

It was also evident from the FGD that not all youth have confidence in VCT. Some participants said that VCT has a negative effect on people. People get depressed after they have been for VCT and have been told they are positive. When pressed further on this point, it was apparent that this perception stemmed from the experiences of people who go for VCT and HIV tests before they are really emotionally, financially and psychologically ready.

*“People are not well informed about VCT and therefore don’t know what they are getting themselves in.”*

*“An HIV test is not like a malaria test. You can cure malaria, but with HIV, it’s for life and therefore a person should be counselled in order to understand what he/she is getting into.”*

Despite this consensus, participants felt that no amount of counselling was enough to prepare one for the emotional impact of a positive HIV result.

Additionally, members of the FGD seemed to be agreed that counselling was necessary to weigh whether one was ready or not for the HIV test.

*“Counselling means empowering yourself with knowledge and making an informed decision.”*

*“Testing means detecting for HIV/AIDS antibodies in your blood.”*

*“Know your status to free your mind and you will know what to do with yourself.”*

Participants also agreed that counselling must take into account the detailed circumstances of individuals in order to fully prepare them prior to undergoing an HIV test.

Another issue that was raised during the FGD was that adequate time should be given to the Counselling Sessions. An example was given where, on 24<sup>th</sup> September 2004, a team of health personnel from the Family Health Unit of UTH went to Evelyn Hone College to administer VCT. One student narrated how this was carried out.

*“Firstly there was group counselling and after wards students were asked to test one by one. In the counselling they were explaining the procedure of how the test will be done.”*

When the exercise was discussed in the FGD with Evelyn Hone students, it was evident that there was considerable interest from students in undergoing VCT. However, participants felt that the procedures of counselling were not followed. Ideally in counselling, both the counsellor and the client should establish the problem in order to get to the best solution in a given situation. However, in the case of the UTH Family Health Unit and Evelyn Hone College students, the counselling was administered to the whole group.

Group counselling is not the right method for VCT as different individuals have different problems that need to be talked or handled differently. As one participant put it:

*“In a group, people won’t be honest about themselves as sexual matters are very sensitive.”*

The Evelyn Hone FGD calculated the average time spent on counselling and testing, based on the record that 66 students participated in the VCT exercise between 13:00 hours and 16:00 hours. Total counselling and testing time worked out to be:-

$$\begin{aligned} & 3 \text{ hours} \times 60 \text{ minutes} \\ = & 180 \text{ minutes} \\ \frac{180}{66} & = 2.7 = 3 \text{ minutes} \end{aligned}$$

It was therefore concluded that the counselling and testing took 3 minutes, which was not adequate and effective.

As a result of the cursory manner in which the exercise was conducted, students concluded that the mobile team on the VCT services was just there to collect statistics and not to do the intended purpose of VCT. They said that the exercise was more like a survey or sample statistics just to know the numbers on HIV/AIDS. The exercise seemed to have undermined confidence of students in mobile VCT as summed up in the comments below:

*“Mobile VCT Services should be done away with. They don’t take into consideration the emotions and feelings of the students. Students need to be prepared psychologically and not partially.”*

*“These Mobile VCT Services are cheating people, they should change the name from VCT to Testing and Surveying for statistics purposes. A lot of harm is done to those that test positive and nothing is done for them.”*

*“The event on Friday was not voluntary.”*

The FGD at Evelyn Hone felt that VCT Services should be conducted at established centres or places. There should be a permanent structure to provide confidential, effective and efficient services.

The students said that they must be understood on this point. They were not condemning VCT but Mobile VCT. Mobile VCT should not go there in the name of VCT because it contradicts the whole purpose of VCT.

*“It’s like doing the right thing wrongly.”*

Another example on Mobile VCT was given. On World Aids Day 1<sup>st</sup> December 2003, students from Evelyn Hone were invited to Matero Stadium. They were introduced to Mobile VCT Services. Students were made to take the HIV/AIDS tests without understanding the consequences.

*“It was more like peer pressure than voluntary.”*

These services were conducted in a tent. There was no privacy and confidentiality. The students who went in were all running out happy and it seemed every one tested negative. But when the VCT teams went on break, one of the students taking Med Lab sneaked in there and called his fellow students inside. He was showing them the slides and explaining.

*“If this shows like this, then it is positive or like this then its negative.”*

The incident above shows that VCT was carried out in an atmosphere lacking adequate privacy and confidentiality of test results. This works against the fundamental principles of VCT and should not be encouraged as it undermines confidence in VCT, as illustrated by comments made during the FGD:

*“They probably give wrong results, inadequate counselling and no follow ups are made.”*

*“Mobile VCT Services force students to take tests when they are not ready. I (student representative) was put to task that I should take the test. As a leader I should lead by example, but I was not ready and prepared for a test.”*

The FGD said with VCT, it should be a decision that one won’t regret whether positive or negative and that is why one needs to be adequately counselled.

At the University of Zambia, the FGD agreed that VCT should serve its purpose.

*“If you know the truth, the truth shall set you free.”*

*“One must have a personal conviction within oneself before a VCT”.*

*“You need a certain conviction. As long as your mind is questioning itself that is when you can go for VCT.”*

However, the UNZA FGD seemed to convey an impression that people who usually go for VCT do so because of lingering doubts about their HIV status. They just go for the test to confirm their thoughts. They are usually prepared for the results unlike people who have never given it a thought. Some of the statements captured from the groups attesting to this impression were:

*“As the bible says in Proverbs 3 – 3: “As a man thinks, so is he” meaning what you think is what you are”. If you convince yourself that you want to go for the HIV test, it’s because you know in your conscious that you might be positive.”*

*“Out of the abundant of the heart the mouth speaks.”*

*“My mother and father were a happy couple. We were three children. When we had grown up; my father abandoned my mother and us. He started living with another woman. Because of this, my mothers’ heart wasn’t settled. Her husband had been unfaithful and she was scared that she might have contracted the HIV virus. She decided to go for an HIV test. Lucky enough she tested negative.”*

As a result of this perception the UNZA FGD felt that VCT is all about freeing your mind. Another student gave this example.

*“I had malaria on and off for 3 months. My mother was on my case telling me that it can’t be malaria alone but HIV/AIDS as well. I was troubled about what my mother said and I decided to go for an HIV test just to prove a point to my mother. I went to the New Start Centre to get myself tested.”*

*“At the New Start Centre, the receptionist was very warm. I was in the reception area for less than 5 minutes. I was asked if I wanted a male or*

*female counsellor. The counsellor came and invited me in her office. I felt warm and welcome. I was asked about my sexual habits. I told the counsellor that the reason I was there was because my mum was stressing me about my malaria. It was a very emotional moment for me. The counsellor didn't force me to take the test. She told me to go back another time. You can see that if it were not for my mother, I would not have thought of an HIV test. I needed to prove a point."*

*"I went back after 4 days, but I was still not ready to take the test. The counsellor was patient with me. After several counselling sessions, I think two weeks; I was able to take the test. After 10 minutes, I was told that I was negative. I thought the counsellor was good and experienced. She gave me all the time I needed to make up my mind about having the HIV test."*

Some students felt that counselling was not 100 percent effective. Acceptance was very important. How the counselling is done is therefore very important.

*"If you are below 25, the counsellors start scolding you. That is why people don't usually go for counselling. The ones that go for counselling are usually referred from the wards."*

From these discussions, it was clear that students that participated in the Focus Group Discussions have a good working knowledge of VCT. However, it would appear that there were still doubts about the way VCT was currently being conducted. There was also a lingering perception among some participants that VCT was only supposed to cater for people who had indulged in high risk sexual activity.

### **3.1.2. Accessibility**

During the FGD, there was general consensus that VCT services are accessible in most places. It is just that people don't utilise much of VCT. It was also acknowledged that Government has tried to give VCT services the attention it deserves with the limited resources it has to address the HIV/AIDS situation.

Having said this, participants in the FGD thought that most of the centres are not conveniently located. An example was given of the New Start Centre, which is located just next to Shoprite, a high traffic supermarket. A participant observed:

*“You can imagine you are going to New Start Centre and you meet one of your relatives going to Shoprite obviously he will wonder what you are doing there.”*

This example stresses the need for VCT Services to be located in areas that are private. At Chainama College the students complained that the VCT centre is located at the clinic. The clinic doubles as a health facility for the surrounding community and a teaching clinic and this means there is high traffic and no privacy. The doorway to the counselling room just has a curtain and people in the waiting room can hear what is being said. Participants highlighted why such an arrangement is a clear breach of privacy:

*“Because of how small Chainama College is most of us know each other very well. Students would wonder if you went into the counselling room.”*

*“Even students who are treated for STD’s we all know about them.”*

As a result of the anxieties expressed by the views above, participants at Chainama College suggested that VCT services should be free standing sites like Kara Counselling Centre, where counsellors are coming from somewhere else instead of the same ones who are teaching you.

On the other hand Evelyn Hone students expressed a need to have VCT services in their college, as shown by the sentiments they expressed:

*“Qualified student counsellors must be placed in institutions of Higher Learning. You can imagine with all this VCT talk, there are no counsellors here at Evelyn Hone where you can go to if you had a problem.”*

*“If a student has any problem concerning a sexual matter, they are told to tell their Hostel Masters. These usually are not very educated; they have no idea of counselling and always look at things in a traditional way.”*

*“Even the management here don’t respond very well to issues concerning HIV/AIDS or sexual problems.”*

From these sentiments, it is clear that there is no one way of delivering VCT, because while members of the Chainama FGD felt very strongly against having in-house

VCT, their counterparts at UNZA and Evelyn Hone were not averse to the concept of an in-house VCT facility.

### 3.1.3. Perceptions

From the FGD, a general consensus emerged that Government should ensure that personnel conducting VCT services should be well qualified and trained.

In all the institutions where the FGD were conducted, it was strongly emphasized that whoever was administering VCT should be a well qualified and confident counsellor. Concerns were raised about the criteria used to train existing counsellors. Participants stressed that proper training was required for one to give counselling, and not the current training, which participants felt was too brief. When asked about whether the age of the counsellor is an important factor, the students said the age didn't matter, what mattered were the skills and qualifications of the counsellor. As one student observed:

*“People in the counselling job should have the heart for the job. Maturity in the job should be important.”*

Participants in the FGD also felt that people are tired of the information on VCT. What is now needed is action. Programmes and projects should be put in place to benefit the communities and touch the hearts of the people. There should be more works and services than mere talk. There was a perception among participants that most personnel dealing with issues of HIV/AIDS and VCT have no passion for their job. They're in it for money. Participants observed that a lot of money had been pumped into HIV/AIDS and its activities, but most of it was used on workshops and big salaries. Participants also acknowledged that a lot of research has been done and recommendations have been made. However, much had not been done to utilise the recommendations from the many workshops and research activities. Projects and programmes seemed to benefit the coordinators and not the community. The communities are usually used as a sample population just to collect data and write reports, and it ends there.

It was also said that the approach taken by most practitioners towards HIV/AIDS seems to be pessimistic. Participants felt that a lot could be done if adverts and information leaflets used people living with HIV. These are good examples so that people see that even with HIV you can still lead a positive and normal life.

Another key issue raised during the FGD was Behaviour Change. Participants felt that it should be emphasized. A lot has been said about HIV/AIDS and a lot of people have heard about it, but still the statistics on HIV are still high and the stigma and discrimination still remains high. Members across all FGD suggested that campaigns on Behaviour Change need to start from the family level. There is need to instil values and morals in our families if we are to conquer HIV. There should be more education starting with the family perceptions of VCT.

The students suggested that the direction of counselling should change. An example was given on the issue of VCT, where it was suggested that a preferred family member or close friends should be included as these play a very important role after a person has been tested.

*“Close family and friends should also be counselled in the follow up sessions after the tests to avoid stigma and discrimination. This enables the family to be prepared and deal with the situation better especially in cases where one tests HIV positive.”*

Some students suggested that permission or consent should be gotten from parents and guardians before a test so that they also are prepared in cases where one comes out positive. This also allows the family to give support and also for the client to have a shoulder to cry on. This helps the client cope with the situation better. It is therefore important that during the counselling family issues must be brought in. The families and guardians should also be part of the counselling since they are the ones who will give you immediate care and support.

It was further suggested that VCT should give after care through continued counselling to individual and the family. Education on VCT is also important to the families and guardians.

Some participants argued that adverts on TV and Radio are not enough. Some family members don't put these adverts in mind. One student had the following suggestion:

*"There should be door-to-door campaigns on VCT, like the way the Jehovah's Witnesses or the census people do it, because VCT needs to be explained and understood."*

Participants in the FGD also highlighted the need for both positive and negative issues to be talked about. Not just the positive aspects so that when one makes the decision to go for VCT, it should be through ones informed choice.

*"Like now all they say in the adverts was just go and know your status and after that what? The empowerment is not there. There is no proper information going to the hearts of the people."*

A further observation that came out of the discussions was that currently VCT services are too generic. To improve this, some participants felt other services should be included in VCT like types of ARV's available, their side-effects and nutritional information. As some participant stated:

*"If one is on T.B. treatment you don't give ARV's it might trigger herpezooster. And sometimes they opt to put you on treatment according to the disease you have instead of ARV's."*

*"So regardless with or without ARV's counselling should be a number one priority. The psychological status of a person is very important. Healing usually starts psychologically."*

*"Also they should explain to the clients about his or her CD4 count. ARV's are very toxic. If they give somebody who has a good CD4 count, they might cause liver damage."*

*"But the way it's being advertised its like when you take ARV's then that's it, you will never show symptoms of HIV/AIDS."*

These observations highlight the need for VCT services to take into account the varying circumstances affecting clients going for VCT, and the need to respond to these different situations.

### 3.1.4. Attitudes Towards VCT

It was agreed that even if people talk and seem to understand what VCT is all about and say the good things about it, they still don't accept VCT because of stigma and discrimination. A participant related the following experience:

*"I had an Uncle who was sickly. His wife died and my dad asked my Uncle to stay with us. My dad forced him to go for VCT. There he was told that he was HIV positive. He became so depressed and saw no reason to live. Probably this was because he was not given adequate counselling and understanding of his fate. To him, being HIV was as good as dying. As if that was not enough, even me who has read widely about HIV/AIDS couldn't get myself to accept him. I couldn't get myself to sit next to him in the house or eat at the same table with him, and every time I went to use the toilet or bathroom I always found myself disinfecting the places. What I was doing was not right, but I couldn't help myself discriminating against him. It just came naturally despite all the advertisement I have seen and heard about how to or how not to get HIV/AIDS."*

This experience confirms that even if VCT is widely talked about, most people think VCT is just an advert on HIV/AIDS. Participants suggested that there is need to come down to the community and make them understand what VCT is all about. The perception among the participants was that right now, all efforts seem to be focused on getting people to go for VCT and know their status, but little is said about what happens afterwards. The empowerment is not there.

*"There is no proper information going to the hearts of the people."*

The statement above seems to be confirmed by an experience a student at one of the UNZA FGD related:

*"One of my friends right here at UNZA tested positive. He tells me it's the worst feeling anybody can experience. Even if he has accepted his status, he says life will never be the same again and he still questions himself why he went for the test. He should have just stayed, what you don't know doesn't hurt."*

Clearly, if adequate empowerment through information was there, this student's colleagues would not have come to the conclusion he did about going for VCT.

Furthermore another participant said that counsellors also contributed to attitudes towards VCT. The participant related how the bad attitude of counsellors can undermine confidence of clients:

*“One of my Aunts went to the Kalingalinga Clinic for VCT. The welcome she got from the nurse was horrifying. Before she could say anything, the nurse told her to join the rest of her friends in the waiting room. Later the same nurse came and said to them that those who wanted to go for VCT should go the other side. My Aunt ended up not going for VCT.”*

### **3.1.5. Suggestions From The FGD**

When asked what they felt should be done about making VCT services more effective and efficient, participants in the FGD said an efficient and effective VCT service should: -

- i. Provide information of both positive and negative aspects of VCT to give room for an informed decision.
- ii. Provide adequate counselling.
- iii. Provide passion driven people to do the work.
- iv. Start implementing what has been researched to see the way forward.
- v. Not overlooking reality especially in their adverts where they want people to abstain from sex. But how is that possible when God made us with sexual feelings.
- vi. Put HIV/AIDS and VCT in the school curriculum.
- vii. The Church should be brought in and work hand in hand with VCT services.

It was concluded that as human beings we shouldn't fear what will happen. We need to drive out fear from our life situations and therefore need to go for VCT to know our status. When one was ignorant of their status, they would not easily take any precautions. But with knowledge, one would be able to adjust their life according to their HIV status.

## 3.2 Findings From Survey Questionnaire

### 3.2.1. Demographic Characteristics Of Respondents

Table 1: Socio-Demographic Characteristics Of Respondents

	Number	Percent
<b>1. Age</b>		
18	5	1.6
19	21	6.7
20	58	18.5
21	79	25.2
22	65	20.7
23	45	14.3
24	41	13.1
Total	314	100.0
<b>2. Marital Status</b>		
SINGLE	304	95.0
MARRIED	3	0.9
WIDOWED	1	0.3
ENGAGED	7	2.2
COHABITING	4	1.3
SEPARATED	1	0.3
TOTAL	320	100.0
<b>3. Field of Study</b>		
NATURAL SCIENCES	120	37.5
SOCIAL SCIENCES	104	32.5
ADMINISTRATION AND MANAGEMENT	65	20.3
ARTS AND CRAFTS	23	7.2
OTHER	8	2.5
TOTAL	320	100.0
<b>4. Religious Affiliation</b>		
CHRISTIAN	286	89.4
NON CHRISTIAN	15	4.7
OTHER	19	5.9
TOTAL	320	100.0

Table 1 shows that the ages of the respondents ranged from 18 to 24 years. The majority 95% were single while 89.4% were Christians.

3.2.2. Awareness And Perceptions Of VCT

Table 2: Knowledge Of VCT Centre

	NUMBER	PERCENT
YES	287	90.3
NO	32	9.7
TOTAL	319	100.0

Table 2 shows the majority of the respondents 90.3% exhibited knowledge of a VCT centre.

Table 3: Knowledge Of VCT Center By Institution

	YES	NO
UNZA	183 (91.5%)	16 (8.0%)
EVELYN HONE	85 (85.0%)	15 (15.0%)
CHAINAMA COLLEGE	19 (95.0%)	1 (5%)
TOTAL	287 (89.7%)	32 (9.7%)

Table 3 shows Knowledge levels of VCT center by institution. Chainama College had the highest with 95% compared to 91.5% and 85.0% for UNZA and Evelyn Hone College respectively.

TABLE 4: Source Of Knowledge About VCT Centre

METHOD	NUMBER	VALID PERCENT
THROUGH A FRIEND	69	23.2
THROUGH A RELATIVE	13	4.4
THOUGH ADVERTISEMENTS	203	68.4
OTHER	10	3.4
TOTAL	297	100.0

Table 4 shows that 68.4% knew about a VCT Center through advertisements while 23.2% knew through a friend.

**TABLE 5: Respondents’ Feelings About VCT**

	NUMBER	PERCENT
<b>ITS GOOD; MAKES PEOPLE KNOW THEIR STATUS</b>	<b>229</b>	<b>77.1</b>
<b>BAD</b>	<b>17</b>	<b>5.7</b>
<b>PERSONAL DECISION</b>	<b>17</b>	<b>5.7</b>
<b>SCARY/ FRIGHTENING</b>	<b>11</b>	<b>3.7</b>
<b>SHOULD BE RUN BY PROFESSIONALS</b>	<b>10</b>	<b>3.4</b>
<b>SHOULD BE MANDATORY</b>	<b>8</b>	<b>2.7</b>
<b>ITS AN NGO</b>	<b>5</b>	<b>1.7</b>
<b>TOTAL</b>	<b>297</b>	<b>100</b>

Table 5 shows that on general feeling on VCT, 229 (77.1%) of the respondents felt it is good as it makes people know their status while 17 (5.7%) felt it is bad and the other 17 (5.3%) felt it should be a personal decision.

**3.2.3. Accessibility Of VCT Services**

**TABLE 6: Location Of VCT Centres**

LOCATION	NUMBER	PERCENT
<b>WITHIN THE CAMPUS</b>	<b>118</b>	<b>36.9</b>
<b>NEARBY CLINIC/ HOSPITAL</b>	<b>89</b>	<b>27.8</b>
<b>FREE-STANDING VCT SITE</b>	<b>76</b>	<b>23.8</b>
<b>OTHER</b>	<b>14</b>	<b>4.4</b>
<b>TOTAL</b>	<b>297</b>	<b>92.8</b>

The results in Table 6 show that 36.9% of the VCT Centers known to the students were located within the campus while 27.8% were located at the nearest clinic or hospital.

3.2.4. Utilisation Of VCT Services

TABLE 7: Respondents Who Have Visited A VCT Center

	NUMBER	PERCENT
YES	71	22.4
NO	246	77.6
TOTAL	317	100.0

Table 7 shows that out of the 317 only 71(22.4%)respondents had visited the VCT center.

TABLE 8: Utilization Of VCT Centers By Sex

	Yes	No	Total
Male	40 (56.3%)	118 (47.9%)	158
Female	31 (43.7%)	128 (52.0%)	159
Total	71	246	317

Table 8 shows that of the 71 that had utilised VCT services, 40 (56.3%) were male and 31 (43.7%) were female. No significant association was observed between sex and utilisationof VCT center. (Chi-square = 1.544, df = 1, p= 0.214).

**TABLE 9: Utilisation Of VCT By Institution**

INSTITUTION	HAVE YOU EVER VISITED A VCT CENTRE?		Total
	YES	NO	
UNZA	53 (26.9%)	144 (73.1%)	197
EVELYN HONE	12 (12.0%)	88 (88.0%)	100
CHAINAMA COLLEGE	6 (30.0%)	14 (70.0%)	20
TOTAL	71	246	317

Table 9 shows that of the 71 that utilised the VCT services 26.9% were from UNZA, 12.0% were from Evelyn hone, 30.0% of the respondents were from Chainama College.

A significant association was observed between institution and utilization of VCT services. (Chi-square = 9.186, df= 2, p= 0.010).

**TABLE 10: Number Of Respondents Who Took HIV Test After VCT**

	NUMBER	PERCENT
YES	52	16.3
NO	268	83.7
TOTAL	320	100.0

Table 10 shows that of the 320 respondents, only 52 (16.3%) proceeded to take an HIV test.

**TABLE 11: Respondents Taking HIV Test After VCT By Sex**

Sex	DID YOU GET ROUND TO TAKING AN HIV TEST?		Total
	YES	NO	
MALE	27 (51.9%)	8(66.6%)	35
FEMALE	25 (48.1%)	4 (33.3%)	29
TOTAL	52	12	64

Table 11 shows that of the 52 respondents that got round to taking an HIV test 51.9% were males and 48.1% were females.

**TABLE 12: Respondents Taking HIV Test After VCT By Institution**

INSTITUTION	DID YOU GET ROUND TO TAKING AN HIV TEST?		TOTAL
	YES	NO	
UNZA	40	7	47
EVELYN HONE	7	4	11
CHAINAMA COLLEGE	5	1	6
TOTAL	52	12	64

Of the 52 respondents that had taken an HIV test, 40 were from UNZA, 5 were from Chainama College while 7 were from Evelyn Hone College.

**TABLE 13: Reason For Respondents Not Taking HIV Test At VCT Centre**

	NEVER BEEN IN RISKY BEHAVIOR	WAS NOT IN A HURRY	STUDY PURPOSE	LACK OF CONFIDENTIALITY	TOTAL
DID YOU GET ROUND TO TAKING AN HIV TEST?	25.0%	12.5%	37.5%	25.0%	100%

Table 13 shows that (37.5%) of the respondents had gone to the VCT Centre for study purposes. The other common responses (25.0%) were that respondents had not been involved in risky behaviour, or that there was lack of confidentiality at the VCT Centre visited.

**3.2.5. Sharing Of HIV Test Results**

**TABLE 14: Respondents' Willingness To Share HIV Test Results**

	NUMBER	PERCENT
YES	23	35.9
NO	41	64.1
TOTAL	64	100.0

Table 14 shows that 35.9% of the 64 respondents who utilised VCT services agreed that they could share their HIV test results.

**TABLE 15: Respondents' Preference For Sharing Results**

	Number	Percent
FAMILY	4	16.7
CLOSE FRIENDS	4	16.7
PARTNER	5	20.8
ANYONE WILLING TO KNOW	3	12.5
FAMILY AND CLOSE FRIENDS	2	8.3
PARENTS	3	12.5
PASTOR	2	8.3
OTHER	1	4.2
TOTAL	24	100.0

Table 15 shows that of the 24 respondents willing to share test results 20.8 % said they would share with their partners. 16.7% responded that they would rather share with their family, while 12.5% said with their parents.

**TABLE 16: Respondents' Reasons For Not Sharing HIV Test Results**

	NUMBER	PERCENT
STIGMA	17	43.6%
LACK OF CONFIDENTIALITY	12	30.8%
RESULTS ARE PRIVATE	10	25.6%
TOTAL	39	100%

Table 16 shows that of the 39 respondents who didn't want to share their HIV test with anybody, 17 (43.6%) said it was due to stigma, 12 (30.8%) due to lack of confidentiality and 10 (25.6%) said results are private hence cannot be shared with anybody.

3.2.6. Perception Of VCT Services

TABLE 17: Perception Of VCT Among Respondents

PERCEPTION	Number	Percent
ITS GOOD; MAKES PEOPLE KNOW THEIR STATUS	229	77.1
ITS BAD	17	5.7
PERSONAL DECISION	17	5.7
SCARY/ FRIGHTENING	11	3.7
SHOULD BE RUN BY PROFESSIONALS	10	3.4
SHOULD BE MANDATORY	8	2.7
ITS AN NGO	5	1.7
TOTAL	297	100.0

Table 17 shows that most of the people (77.1%) interviewed, felt that VCT is good and that it makes people to know their status.

TABLE 18: Respondents' Perception Of Good Attributes Of Counsellors

	Number	Percent
WELL INFORMED/ KNOWLEDGE	15	24.2
CONFIDENT/ ASSERTIVE	6	9.7
FRIENDLY/ WELCOMING	21	33.9
UNDERSTANDING/ ENCOURAGING	11	17.7
OPEN	3	4.8
MATURE	5	8.1
YOUNG	1	1.6
TOTAL	62	100.0

Table 18 shows that 33.9% of the respondents described their counsellors as being friendly and welcoming and 24.2% as being well informed and knowledgeable.

**TABLE 19: Respondents' Perception Of Bad Attributes Of Counsellors**

	Number	Percent
ATTITUDE	4	13.8
KEPT SUSPENSE/ SLOW	4	13.8
SHY	4	13.8
NOT KNOWLEDGEABLE/ INEXPERIENCED	13	44.8
DIFFERENT SEX	4	13.8
TOTAL	29	100.0

Table 19 shows that 44.8% of the respondents described their counsellors as being not knowledgeable and inexperienced.

**TABLE 20: Respondents' Preference Of Counsellor**

	Number	Percent
SAME SEX	8	12.1
DIFFERENT SEX	10	15.2
OLDER	8	12.1
YOUNGER	37	56.1
NO PREFERENCE	3	4.5
TOTAL	66	100.0

Table 20 shows that 56.1% of the respondents’ preferred younger counsellors and 15.2% preferred counselors of opposite sex.

**TABLE 21: Venue Of VCT Sessions**

	Number	Percent
PRIVATE OFFICE	38	56.7
CUBICLES	29	43.3
TOTAL	67	100.0

Table 21 shows that 56.7% of the respondents specified the area in which counselling was conducted as a private office while 43.3% said they were cubicles.

**TABLE 22: Respondents' Assessment Of Privacy Of Counselling Sessions**

	Number	Percent
YES	62	93.9
NO	2	3.0
TOTAL	66	100.0

Table 22 shows that out of 66, 62(93.9%) of the respondents concerted that there was privacy during their counselling sessions.

**TABLE 23: Respondents' Suggestions For Improvement Of VCT Services**

	Number	Percent
TOTAL CONFIDENTIALITY	8	14.0
HAVE COUNSELORS OF ALL AGE GROUPS	7	12.3
ADEQUATE INFORMATION AND MORE SENSITIZATION	9	15.8
MORE YOUTH FRIENDLY VCTS	10	17.5
SERVICES IN RURAL AND REMOTE AREAS	4	7.0
COUNSELORS SHOULD BE WELL TRAINED	6	10.5
VCT MUST BE MANDATORY	5	8.8
RESULTS SHOULD BE WRITTEN AS PROOF AND NOT JUST TOLD	6	10.5
REDUCE THE RATE OF HIV	2	3.5
TOTAL	57	100.0

Table 23 shows that 17.5% of the respondents would have liked to have more youth friendly VCT services in their communities, while 15.8% said they wanted adequate information and more sensitization, 14.0% said there should have been total confidentiality, 12.3% and 10.5% said they wanted counsellors of all age group and who are well trained .

## **Chapter 4: Discussion Of Findings**

### **4.1 Characteristics of Respondents**

A structured questionnaire was administered to three hundred and twenty students in all the three institutions of Higher Learning. The respondents to the structured questionnaire included one hundred and sixty male (50 percent) and 160 female (50 percent) students. The ages of the respondents ranged from 18 – 24, with an average of 21.5 years. The most common religion among the respondents was Christianity. The majority of the students in the sample came from the Natural Sciences (37.5 percent) and Social Sciences (32.5 percent). 95 percent of the students were single while the rest were engaged, cohabiting, married, widowed or separated.

In addition to the structured questionnaire, four Focus Group Discussions (FGD) were held. Two of the FGD were held at UNZA, and one FGD each was held at Chainama and Evelyn Hone Colleges respectively. Participants in the FGD's were drawn from both sexes, and their characteristics were similar to the participants in the survey.

### **4.2 Level of awareness about VCT Services**

A significant majority of respondents from both the survey and FGD's were aware of VCT services that are currently being provided. They knew that it was possible to get an HIV test in their communities. Participants in the survey also exhibited a high degree of knowledge about VCT centres in their communities, with 90.3 percent indicating that they knew a VCT center and only 9.7 percent indicating no knowledge of any VCT center. When knowledge levels of VCT centers was looked at by institutions, it was seen that Chainama College had the highest knowledge 95.5 percent and then followed by UNZA with 91.5 percent and 85 percent and Evelyn Hone College respectively. Evelyn Hone had a relatively lower awareness about VCT Centres probably because Evelyn Hone does not have its own clinic and VCT centers as compared to the other two institutions. Another contributing factor to the relatively low awareness at Evelyn Hone, which came out of the FGD's, is that there

does not seem to be any policy or commitment by management of the College towards provision of VCT.

When asked how they knew about the VCT center, it was discovered that 68.4 percent knew through advertisements while 23.2 percent knew through a friend. The rest knew through other means such as relatives. This finding is consistent with the outcome of the FGD's, where a similar trend on sources of awareness about VCT centres was established. The fact that majority of the participants in this study derived their knowledge about VCT centres from advertisements suggests that the advertising campaign promoting awareness about VCT is having a significant impact on the youth in institutions of higher learning.

When asked about how they feel about VCT, 71.6 percent said it was good because it makes people know their status, 5.3 percent said it was a personal decision, while another 5.3 percent thought it was bad. Other respondents felt that VCT services are scary and frightening while others thought that they should be run by professionals.

The high levels of awareness about VCT exhibited by the participants in the study, and the positive perception on the benefits of VCT indicate that the concept of VCT is now largely accepted among students in institutions of higher learning.

**4.3 Accessibility of VCT Services**

When asked about the location of the nearest VCT centre, 297 of the respondents (92.8 percent) indicated that they knew where it was. However, only 36.9 percent of these respondents knew of a VCT center within their campus while 27.8 percent of the respondents knew of a centre located at the nearest clinic or hospital. Another 23.8 percent indicated that they knew of VCT centers known as free-standing VCT sites. The rest of the respondents indicated knowledge of VCT centres located in places other than the ones mentioned above. When compared to the high levels of awareness about the existence of VCT centres among participants in the survey, this finding indicates that specific information about the existence of VCT centres within

their immediate vicinity may not be readily available to students in institutions of higher learning.

#### **4.4 Utilization of VCT Services**

Out of the respondents, only 71 (22.4 percent) acknowledged having visited a VCT centre. When compared to the high number of respondents indicating awareness about the existence and location of a VCT centre near them, the low number of respondents acknowledging having visited a VCT centre suggests that there may be difficulties associated with utilization of VCT services.

In proportional terms 56.3 percent of those who had visited a VCT centre were males compared with 43.7 percent were females. When VCT seeking behavior was looked at by institutions, it was found that 26.9 percent of the respondents from UNZA acknowledged having visited a VCT centre, while 73.1 percent had not. From Evelyn Hone College 12.0 percent of the respondents as opposed to 88 percent agreed to having visited a VCT center. 30.0 percent as opposed to 70 percent of the respondents from Chainama College had visited a VCT center. From the above statistics, Chainama College had the highest percentage of those who had visited a VCT centre, followed by UNZA and Evelyn Hone College. A significant association was observed between institution and visitation of VCT centre ( $p = 0.01$ ).

When asked if they had undertaken a test at the VCT centers 64 respondents of the 71 that had visited a VCT centre had utilized VCT services. This represents 20 percent of the entire sample. Of the 64 respondents that had utilized VCT services, 52 respondents, representing 16.3 percent of the entire sample, had got round to taking an HIV test. In absolute terms, of the 52 persons that had taken an HIV test, 27 were males and 25 females. When the respondents that had taken an HIV test after VCT were looked at in terms of the institutions they belonged to, 40 were from UNZA, 7 were from Evelyn Hone and 5 were from Chainama College. If this sample is taken as representative of the entire student population, these findings indicate a marginal increase from the levels of students going for HIV testing recorded by the study

undertaken by Baggaley in 1997. The Baggaley study found that 10 percent of the students surveyed had gone for HIV testing.

It is significant to note that out of 317 respondents who filed a response, 246 (77.6 percent) had not visited a VCT centre, or utilized VCT services. A further group of 12 respondents (4 percent of the sample) had visited a VCT centre, but had not gotten round to taking an HIV test. Collectively, this means that 80.6 percent of the participants in the survey did not utilise VCT services, despite the high awareness exhibited about the availability of these services.

When asked why they did not get round to taking an HIV test despite having visited a VCT centre most of the respondents (37.5 percent) said they had only gone to the VCT centre for study purposes. Another group (25 percent) felt there was no confidentiality in the centre. Another 25 percent of the respondents said they have *never been involved in risky behaviour. Others (12.5 percent) responded that they* were not in a hurry to take an HIV test.

These findings are consistent with the discussions in the FGD's, where participants were very categorical in stating that going for VCT required one to be prepared mentally for the prospect of VCT. Participants in the FGD's also indicated that those who go for VCT will normally only do so when they suspect that they are HIV positive, or they have been exposed to situations that had placed them at risk of becoming HIV positive.

#### **4.5 Respondents' Preference For Sharing Results**

When the 64 respondents who had utilised VCT services were asked about whom they would share their test result with, 23 (35.9 percent) of them indicated that they would be willing to share their test results with someone. 41 (64.1 percent) of the respondents said they couldn't share their results with someone. Of the respondents that were willing to share their test results, 20.8 percent said they would share with their partners, 16.7 percent said they would share with close family and friends, 12.5 percent said with anyone willing to know and another 12.5 percent said with their

parents, 8.3 percent said with their pastors and 4.2 percent with persons other than those mentioned above. Of the respondents who didn't want to share their test with anybody, 43.6 percent said it was due to stigma, 12 percent due to lack of confidentiality and 25.6 percent said results are private hence cannot be shared with anybody.

These findings indicate that although some youth in institutions of higher learning are willing to utilise VCT services and undergo an HIV test, majority of these youth are not willing to share the results of their HIV test with anybody. The chief reason cited for unwillingness to share test results was stigma. In the FGD's, participants suggested that efforts to promote VCT should include families to facilitate support. This view seems to be supported by the preferences expressed by those willing to share the test results as indicated above.

These findings also seem to be consistent with the observations made by De Burca (1994) on the need for careful consideration of all circumstances when undertaking VCT among the youth.

## **4.6 Perceptions of VCT Among The Youth**

Perception of VCT among the respondents was generally positive. 229 respondents (77.1 percent) felt that VCT was good because it made people know their status while 17 (5.7 percent) felt it was bad. The rest of the respondents felt it was a personal decision, or that it was scary and frightening. Others thought VCT should be run by professionals; with some saying VCT should be mandatory while another group felt that it was just an NGO.

Perceptions of counsellors among respondents who utilised VCT services were mixed. When asked to describe the good attributes of the counsellor they encountered at the VCT centre, 33.9 percent of the respondents described them as being friendly and welcoming, 24.2 percent as being well informed and knowledgeable, 17.7 percent as being understanding and encouraging, 9.7 percent as being confident and assertive, 8.1 percent as being mature, 4.8 percent as being open while 1.6 percent as being

young. When asked about the bad attributes of their counsellors, 44.8 percent of the respondents described their counsellors as being not knowledgeable and inexperienced, while 13.8 percent described them as having a bad attitudes, kept them in suspense/slow/shy and being of opposite sex to that of the respondents.

When asked what kind of counsellor they preferred, 56.1 percent of the respondents preferred younger counsellors, 15.2 percent preferred counsellors of opposite sex, 12.1 percent preferred counsellors of the same sex and those old enough while 4.5 percent had no preference.

93.9 percent of the respondents indicated that there was privacy during their counselling sessions as opposed to 3.0 percent who said there wasn't enough space to ensure privacy during counselling sessions. When asked to specify the type of area where counselling was conducted, 56.7 percent of the respondents specified the area in which counselling was conducted as a private office while 43.3 percent specified to say they were cubicles.

When asked about the privacy of the counselling sessions, 93.9 percent of the respondents that underwent VCT were comfortable with the privacy of the area in which the counselling was done.

Lastly when asked what they would like to see happen in the area of VCT 17.5 percent of the respondents would like to have more youth friendly VCT in the area of VCT, while 15.8 percent said adequate information and more sensitization, 14 percent said that there should be total confidentiality, 12.3 percent said counselors of all age groups, 10.5 percent said they wanted counselors who are well trained and that results should be written as proof and not just being told. 8.8 percent said VCT should be mandatory, 7.0 percent said services should be introduced in rural and remote areas and 3.5 percent said the rate of HIV should be reduced.

The findings from the responses to the survey questionnaire and the FGD's indicated that there was very high awareness among the youth in higher institutions of learning about the existence of VCT services. The awareness seems to have largely been drawn from ongoing advertising campaigns about VCT services. On the other hand,

the findings on the perception of VCT services among participants in the study, while positive, was that it was a facility for those who perceived themselves to be HIV positive, or at risk of having contracted HIV. This perception seemed to account for the relatively low utilisation of VCT services despite the high level of awareness about the existence of VCT centres.

The findings from this study indicated that accessibility to VCT centres does not seem to be a major problem, as a large majority of the participants in the study seemed to know a VCT centre within their vicinity. However, some participants indicated that while VCT centres could be accessible, they were located in areas that could not guarantee confidentiality, and this affected their ability to visit these centres.

Among participants who got round to utilising VCT services, there was a general feeling that they would not be willing to share their test results, largely because of stigma. However, those participants that were willing to share test results largely favoured sharing them with parents, family and partners.

The attitude of participants who utilised VCT services towards the quality of the service they received was mixed. In particular, while respondents rated being welcoming and friendly at the top of the good attributes of counsellors at VCT centre they visited, the knowledge and quality of information was only rated second. Additionally, lack of proper knowledge by counsellors was ranked as the top bad attribute by respondents, while in some instances respondents cited bad attitudes of counsellors and being forced to use counsellors of the opposite sex against their own preference.

In general, participants in the study agreed that VCT was an important tool in responding to the HIV pandemic. However, most participants felt that present efforts to promote VCT seemed to focus on VCT as an end in itself, and did not promote the inclusion of the social support structures like family, the Church, and peer groups. This means that even if benefits of VCT were appreciated, stigma would remain a major obstacle to effective utilisation of the facility.

## **Chapter 5: Conclusions And Recommendations**

### **5.1 Conclusions**

This study set out to establish the level of awareness about availability of VCT services among adolescents, with specific emphasis on youth aged between 18 and 24 years in institutions of higher learning in Lusaka.

After analysing the quantitative and qualitative findings yielded by the survey and Focus Group Discussions, this study noted that:

90.3 percent of the youths between 18 and 24 years of age of all sexes in institutions of higher learning had awareness about VCT. 77.1 percent of the total of 320 of the youth thought that VCT services were of great advantage to them.

It is noteworthy that despite the high levels of awareness and the perception that VCT services are advantageous, only 16.3 percent of the youth actually utilised VCT services according to information obtained by the study. The low utilisation of VCT services was attributed to the following factors:

1. Fear of being identified as an HIV positive individual;
2. Lack of psychological preparedness to undertake HIV tests;
3. Many of the VCT centres were located within the learning institutions' premises;
4. Counsellors who gave VCT services had poor knowledge of HIV and AIDS;
5. The degree of confidentiality of VCT services at most centres was perceived to be questionable;
6. Students were unwilling to share test results with anyone due to fear of stigma; and
7. There is inadequate information about the wider context of VCT, and that current messages seem to target VCT as an end in itself, and not as part of a bigger process of managing the HIV/AIDS pandemic.

These are some of the important issues surrounding VCT services that need attention if fruitful results are to be obtained. It is a well known fact that high use of VCT would help in implementing quick interventions that would reduce the disease burden in the community, especially among the youth.

## **5.2 Recommendations**

This study has shown a very sharp contrast between awareness about VCT services, and actual utilisation of the services. On the one hand, a very high level of awareness about VCT was exhibited. On the other hand, utilisation levels were very low (16.3 percent of the sample). Data from this study presents a very interesting insight into the patterns of refusal rate for utilisation of VCT among youths aged between 18 and 24 years in institutions of higher learning. Hitherto, most of the information collected on utilisation of VCT services has tended to be from communities with relatively low education or low socio-economic status. This information has shown utilisation rates of between 16 and 25 percent. The studies have often attributed this low rate of utilisation of VCT services to low levels of education and understanding among the communities. It is therefore interesting that this study, which was conducted among highly knowledgeable and educated youths, reveals a level of utilisation (16.3 percent) that is similar to those conducted among less educated communities. It is also interesting that youths that participated in this study cited stigma and fear of being diagnosed HIV positive as inhibiting factors to their utilisation of VCT services.

These findings suggest that it is not the level of education or social status that determines low utilisation of VCT services. Going by the inhibiting factors cited by participants in the study, it is clear that there are serious constraints and weaknesses in the way VCT services are currently provided.

Based on the data yielded, this study makes the following recommendations on the future planning and decision making relating to VCT services for the youth, particularly those in institutions of higher learning:

- Intensifying training of and support for counsellors in confidentiality issues and dealing with the psychosocial aspects of HIV testing. In particular, counsellors should be trained to give specific support to families to reduce potential tensions and negative consequences;
- Adopting and enforcing a code of ethics and good practice for counsellors to ensure professionalism in counselling;
- When planning youth VCT services, consider location as a critical factor in their accessibility and utilisation by the target group.
- There should be a dedicated package of information and campaigns relating to VCT that recognises the specific context of the youth, particularly those in higher institution of learning, to address specific concerns relating to this context;
- Promotion of VCT for the youth should recognise the pivotal role that family plays in the lives of the youth, even when they are engaged in studies at institutions of higher learning. As such, any efforts to promote VCT among this age group should include families to foster confidence in the concept among the youth;
- VCT addresses issues of personal health, including psycho-social matters. Approaches to VCT must therefore include appropriate information about general personal health, and emphasise the physical and health implications as one develops during their youth to assist the youth to seek the correct advice. Such approaches should also include publicising or promoting the options of assistance available after one takes an HIV test.
- VCT Centres should be encouraged to provide information to youths on the next steps after counselling. This would motivate youths to take up testing and share information with their partners and families, and take the necessary action based on their test results
- Adopting a quality assurance system with effective oversight over the provision of VCT services; and
- Promoting client feedback on the quality of VCT services through the quality assurance system.

This study has pointed to some considerations that can be made by decision makers and planners as they approach provision of VCT to the youth, particularly those in institutions of higher learning. The conclusions and recommendations presented here are intended to highlight some of the key areas that need to be addressed in relation to provision of VCT services for the youth. More importantly, it is hoped that the field data yielded from the study will give policy makers, practitioners and researchers a platform to conduct further incisive analysis into some of the issues raised.

This study observes that the underlying issue affecting confidence in VCT relates to the lack of effective standards and guidelines to guide provision of VCT. In Zambia at present, there are many providers of VCT, ranging from government institutions to donor funded projects and community based organisations. In most instances, techniques and standards applied vary depending on the organisation delivering VCT.

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# Appendix A: Informed Consent

## INFORMED CONSENT

TITLE : THE UTILISATION OF VCT SERVICES AMONG YOUNG STUDENTS IN SELECTED HIGHER LEARNING INSTITUTIONS IN LUSAKA.

Dear participants,

I am a student from the University of Zambia, School of Medicine, studying a Master in Public Health (MPH). As part of the course a study on the utilisation of VCT services among the young students in selected higher learning institutions in Lusaka is being conducted.

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

- 1. Participation is on voluntary basis.
- 2. You are free to withdraw at any stage during the interview.
- 3. All information given will be treated with strict confidentiality.
- 4. The information will be very helpful on VCT.
- 5. Please be informed that there is no direct risk or harm to you if you did consent to participate in this study. How ever some of your time, will be used up during the question and answer session.
- 6. If you have any questions or would want any clarifications please call Sarah Chishimba on Telephone 095751930 or University of Zambia, Counselling Centre, box 32379, Lusaka.

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

Yours sincerely,

SARAH CHISHIMBA

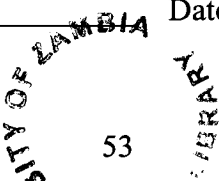
I accept participation in the study.

Name: \_\_\_\_\_

Signature or thumb print: \_\_\_\_\_ Date: \_\_\_\_\_  
(Participant)

Witnesses Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



Appendix B: Survey Questionnaire

QUESTIONNAIRE

INTERVIEW NO----- DATE-----

PLACE-----

SECTION A RESPONDENT’S BIODATA

1. Respondent’s sex

1.Male

2.Female


2. Age \_\_\_\_\_

3. What is your marital status?

1.Single

2.Married

3.Divorced

4.Widowed

5.Engaged

6.Cohabiting

7.Separated


4 Nationality

1.Zambian

2.Non-Zambian


5. What is your field of study?

1.Natural Sciences

2.Social Sciences

3.Administration and Management

4.Arts and Crafts


Other (Specify) \_\_\_\_\_

6. Year of study?

1.First Year	<input type="text"/>
2.Second Year	<input type="text"/>
3.Third Year	<input type="text"/>
4.Fourth Year	<input type="text"/>
5.Fifth Year	<input type="text"/>

Other (Specify) \_\_\_\_\_

7. Religious affiliation \_\_\_\_\_

SECTION B (KNOWLEDGE AND VIEWS)

8. What do you understand by the term VCT?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

9. How do you feel about Voluntary Counselling and Testing?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

10. Do you know any VCT centres?

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

11. If your answer to Question 10 was yes, where are they located?

1.Within the Campus	<input type="text"/>
2.Nearby Clinic/Hospital	<input type="text"/>
3.Free-standing VCT Site	<input type="text"/>
4.Other (Specify) _____	

12. If your answer to Question 10 was yes, how did you know about the VCT CENTRE?

1.Through a Friend	<input type="text"/>
2.Through a relative	<input type="text"/>
3.Through Advertisements	<input type="text"/>
4.Other (Specify) _____	

13. Have you ever visited a VCT centre?

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

14. If your answer to Question 13 was yes, what did you think of the atmosphere in the VCT Centre?

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14(B) If your answer to question 13 was no, why?

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15. What is your general opinion of VCT Services currently offered in Zambia?

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### SECTION C ATTITUDES TOWARDS VCT

This section is for young people who have been to the VCT centre.

16. Have you talked to your counsellor about:

Having an HIV Test	yes	no
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Receiving test results	yes	no
------------------------	-----	----

Issues arising from an HIV Test taken sometime ago	yes	no
--	-----	----

Other issues (specify) \_\_\_\_\_

17. How did you first go to the centre?

Referred (Specify By Whom)

Recommended (Specify)

Just Dropped In


18. Why did you go to the Centre?

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\_\_\_\_\_

19. How much time did you spend?

19.1. Getting your first appointment \_\_\_\_\_

19.2. Waiting to see the counsellor \_\_\_\_\_

19.3. Getting your Test  
Results \_\_\_\_\_

19.4. In the session with your  
counsellor \_\_\_\_\_

20. How did you view your counsellor? Describe the good and bad things about him/her.

Good

- a. \_\_\_\_\_
- b. \_\_\_\_\_
- c. \_\_\_\_\_
- d. \_\_\_\_\_

Bad

- a. \_\_\_\_\_
- b. \_\_\_\_\_
- c. \_\_\_\_\_
- d. \_\_\_\_\_

21. Would you have preferred a different counsellor (different sex, older, younger)?

\_\_\_\_\_

\_\_\_\_\_

22. Did you get round to taking an HIV test?

Yes

No

23. If no, why not?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

24. If yes were you able to see the same counsellor for discussions both before and after the discussions?

\_\_\_\_\_

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25. If a friend or relative were in a similar position as you were in before you went to the VCT Centre, would you recommend that he/she use the same service?

Yes No

26. Why (give reason to answer 25)

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27. Have you recommended the service to any one else? (Specify who and how many people)

Who

How many

28. What HIV prevention services were available at the VCT Centre when you visited it?

Condom supplies	Yes	No
Services for IUD's	Yes	No
Ongoing counselling	Yes	No

Other (Specify)

29. Which services were you offered when you visited the VCT Centre? (Tick were appropriate)

1.Pre-Test Counselling	<div style="border: 1px solid black; width: 100px; height: 25px;"></div>
2.Post- Test	<div style="border: 1px solid black; width: 100px; height: 25px;"></div>
3.Counselling	<div style="border: 1px solid black; width: 100px; height: 25px;"></div>
4.Ongoing Counselling	<div style="border: 1px solid black; width: 100px; height: 25px;"></div>
5.HIV Testing	<div style="border: 1px solid black; width: 100px; height: 25px;"></div>

Other (Specify)

30. What time are the VCT centres in your area open?

Normal working hours (8hrs to 17hrs)	Yes	No
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Early evening (after 17 hours)	Yes	No
--------------------------------	-----	----

Lunch hour	Yes	No
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Weekends (specify Saturday,  
Sunday or both)

31. Was there adequate space to ensure counselling sessions were private?

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

Specify the type of area counselling was conducted in  
Private office \_\_\_\_\_

Cubicles \_\_\_\_\_

Curtained office area \_\_\_\_\_

Other (describe) \_\_\_\_\_

32. Was there adequate privacy in the waiting area of the VCT Centre you visited?

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

33. Were there follow-ups arrangements discussed?

1. Yes	2. No
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34. If yes what arrangements were made?

35. Would you share your test results with another person?

1. Yes	2. No
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36. If yes who

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37. If No why

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38. What would you like to see happen in the area of Voluntary Counselling and Testing?

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39. State any other relevant information, comments or suggestions pertaining to implementation or improvement of counselling and testing services?

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THANK YOU



## **Appendix C: Interview Guide For Focus Group Discussions**

### **INTERVIEW GUIDE FOR FOCUS GROUP DISCUSSIONS**

#### **INSTRUCTIONS**

- (a) Welcome the participants.
- (b) Introduce yourself and your recorder to the group.
- (c) Ask participants to introduce themselves in order to "break the ice".
- (d) Assure participants of confidentiality of information and encourage them to feel free to express themselves freely.

#### **TOPIC FOR DISCUSSIONS**

- 1. Knowledge and views of VCT
- 2. Attitudes towards VCT.
- 3. Accessibility of VCT services.
- 4. Perception of VCT Services.



# THE UNIVERSITY OF ZAMBIA

## RESEARCH ETHICS COMMITTEE

Telephone: 256067  
Telegrams: UNZA, LUSAKA  
Telex: UNZALU ZA 44370  
Fax: + 260-1-250753  
E-mail: unzarec@zamtel.zm

Dean's Office  
P.O. Box 50110  
Lusaka, Zambia

**Assurance No. FWA00000338**  
**IRB00001131 of IOR G0000774**

Ref: 004-07-04  
19 September, 2004

Ms Sara S. Chishimba, BSV  
Counselling Centre  
University of Zambia  
P.O. Box 32379  
LUSAKA

Dear Ms Chishimba,

### RE: SUBMITTED RESEARCH PROPOSAL

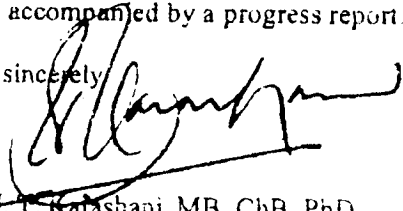
The following research proposal was presented to the Research Ethics Committee Meeting on 28 July, 2004 where changes were recommended. We would like to acknowledge receipt of the corrected version. The proposal has now been approved. Congratulations!

**Title of proposals:** 'The utilisation of VCT services among young students in selected higher learning institutions in Lusaka'

#### Conditions:

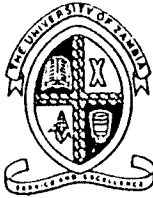
- This approval is based strictly on your submitted proposal. Should there be need for you to modify or change the study design or methodology, you will need to seek clearance from the Research Ethics Committee.
- If you have need for further clarification please consult this office. Please note that it is mandatory that you submit a detailed progress report of your study to this committee every six months and a final copy of your report at the end of the study.
- Any serious adverse events must be reported to the Committee.
- Please note that when your approval expires you may need to request for renewal. The request should be accompanied by a progress report. Progress Report forms can be obtained from the Secretariat.

Yours sincerely

  
Prof. J. T. Kafashani, MB, ChB, PhD  
**CHAIRMAN**  
**RESEARCH ETHICS COMMITTEE**

Date of approval: 9 September, 2004

Date of Expiry: 8 September, 2005



**THE UNIVERSITY OF ZAMBIA**  
**SCHOOL OF MEDICINE**


**INTERNAL MEMORANDUM**

**TO :** Mrs. Sara Shawa Chishimba  
**FROM :** Assistant Dean, Postgraduate, Medicine  
**DATE :** 2<sup>nd</sup> November 2004  
**SUBJECT :** Research Proposal

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Your research proposal was discussed at the last meeting of the Graduate Studies Committee of the School.

The proposal was approved and you may proceed with the research component of your study.



Prof. Y. Mulla

**ASSISTANT DEAN, POSTGRADUATE**

CC: The Director, Directorate of Research and Graduate Studies  
The Head, Department of Community Medicine



# **THE UNIVERSITY OF ZAMBIA**

## **OFFICE OF THE DEAN OF STUDENTS**

### ***INTERNAL MEMORANDUM***

**TO:** Mrs Sara Chishimba – Student Counsellor

**FROM:** Acting Senior Assistant Dean of Students

**DATE:** 16<sup>th</sup> September 2004


**SUBJECT: PERMISSION TO CARRY OUT RESEARCH AT UNZA**

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I acknowledge receipt of your letter in which you sought permission to undertake a study at UNZA, towards your masters programme in Public Health.

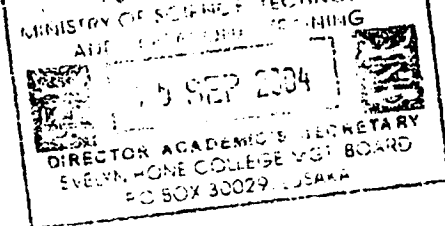
I am pleased to inform you that permission has been granted for you to proceed with the purported study.

I wish you all the best.

  
P.H Namangala

**ACTING SENIOR ASSISTANT DEAN OF STUDENTS**

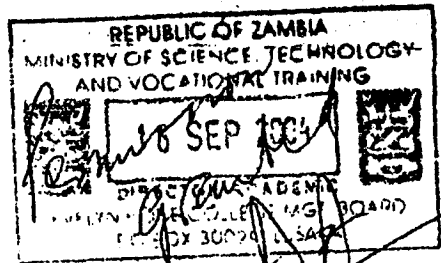
**Cc:** The Dean of Student Affairs



Sarah Chishimba  
University of Zambia  
Counselling Center  
Box 32379  
Lusaka

14<sup>th</sup> September 2004

The Dean of Students  
Evelyn Hone College  
Lusaka



Dear Sir

**RE: PERMISSION TO CARRY OUT RESEARCH AT EVELYN HONE COLLEGE**

Reference is made to the above subject. I am a Post-graduate student in the University of Zambia, School of Medicine, studying a Master Degree in Public Health (MPH). As part of the course I am carrying out a study on the 'Utilisation of VCT services by Youths aged between 18 and 24 years in institutions of higher learning in Lusaka.' Evelyn Hone College is one of them.

In order to collect information for the research, questionnaires about VCT will be administered to selected students at your institution.

The information to be obtained will be strictly confidential and will be purely used for academic purposes.

Your approval will be highly appreciated.

Yours faithfully

SARA SHAWA CHISHIMBA

D/A

for your approval  
Chishimba  
A/DOS

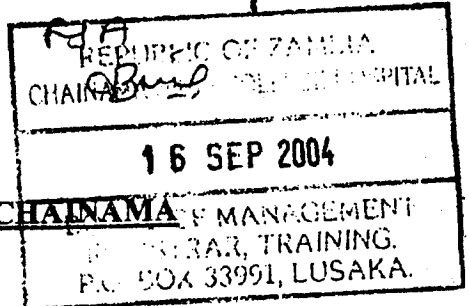
Sarah Chishimba  
University of Zambia  
Counselling Center  
Box 32379  
Lusaka

4<sup>th</sup> September 2004

The Registrar  
Chainama Health College  
Lusaka

Dear Sir

RE: **PERMISSION TO CARRY OUT RESEARCH AT CHAINAMA HEALTH COLLEGE.**



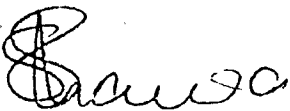
Reference is made to the above subject. I am a Post-graduate student in the University of Zambia, School of Medicine, studying a Master Degree in Public Health (MPH). As part of the course I am carrying out a study on the 'Utilisation of VCT services by Youths aged between 18 and 24 years in institutions of higher learning in Lusaka.' Chainama Health College is one of them.

In order to collect information for the research, questionnaires about VCT will be administered to selected students at your institution.

The information to be obtained will be strictly confidential and will be purely used for academic purposes.

Your approval will be highly appreciated.

Yours faithfully



SARA SHAWA CHISHIMBA

② No objection  
The SHANES  
Project to  
assist  
A. Ngweni