

THE UNIVERSITY OF ZAMBIA

SCHOOL OF MEDICINE
POST BASIC NURSING DEPARTMENT

**DETERMINING ADOLESCENTS' PERCEPTION OF VOLUNTARY
COUNSELLING AND TESTING OF HIV AT LIBALA AND DAVID
KAUNDA HIGH SCHOOLS IN LUSAKA URBAN**

BY

MARJORIE C. KABINGA
ZRN (KITWE) 1996

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R003

**A RESEARCH PROJECT SUBMITTED TO THE DEPARTMENT OF POST BASIC
NURSING, SCHOOL OF MEDICINE, UNIVERSITY OF ZAMBIA, IN PARTIAL
FULFILMENT FOR THE AWARD OF BACHELOR OF SCIENCE IN NURSING
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ACKNOWLEDGEMENT

Many people and indeed institutions contributed greatly towards the completion of this study and I will always be indebted to them, as I wish to acknowledge my gratitude to them

My first thanks go to my 60 respondents who constituted my sample.

I wish to thank my supervisor Miss. P. Mweemba whose guidance, encouragement, helpful advice and unflagging patience made this study a success.

I wish to thank the head of Post Basic Nursing Department Miss. E. Lambwe and all the lecturers for emotional and spiritual support.

I also wish to thank my sponsors, Ministry of Health for awarding me sponsorship to undertake the Bachelor of Science in Nursing, World Health Organization for assistance in research literature and Kara Counselling centre for allowing me to use their services.

I am also grateful to my friends at PBN especially my course mates who gave me all the support I needed and Mr. Muleya for his immaculate typing services without whom the study would have not been presented in this form.

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LIST OF ABBREVIATIONS

AIDS	-	Acquired Immune Deficiency Syndrome
ANS	-	Advanced Nursing Sciences
CBoH	-	Central Board of Health
CSO	-	Central Statistical Office
DHS	-	Demographic Health Survey
HIV	-	Human Immunodeficiency Virus
ICN	-	International Council of Nurses
KCTT	-	Kara Counselling and Training Trust
NASTL	-	National AIDS/STDs/TB and Leprosy Control Programme
STI	-	Sexually Transmitted Infections
UNAIDS	-	Joint United Nations Programme on HIV/AIDS
UNICEF	-	United Nations International Children's Fund
UNISA	-	University of South Africa
USAID	-	United States Agency for International Development
VCCT	-	Voluntary Confidential Counselling and Testing
VCT	-	Voluntary Counselling and Testing
WHO	-	World Health organization

DECLARATION

I hereby declare that with the exception of the assistance acknowledged, the work presented in this study for Bachelor of Science in Nursing Degree is the result of my own studies. This work has not been presented either wholly or in part for any other degree and is not being currently submitted for any other degree.

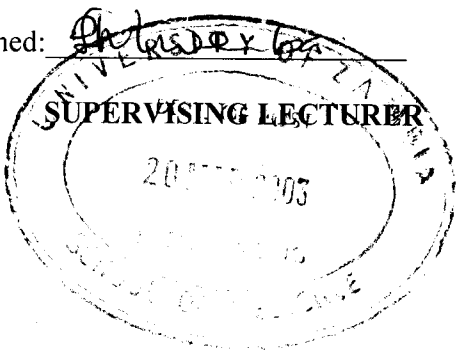
Signed: Mohab'ga

Date: 20/03/03

CANDIDATE

Signed: Dr. Widad Y. Al-Sayid

Date: 20/03/03



STATEMENT

I *Marjorie Kabinga* hereby certify that this study is in all entirety, the result of my own independent investigation. The various sources to which I am indebted are clearly and gratefully acknowledged in the text and in the references.

Signed: M Kabinga

CANDIDATE

Date: 20/03/03

DEDICATION

This study is passionately dedicated to my parents Mr. and Mrs. Kabinga for their love, support and helping me to believe in myself; also to my brothers and sisters for their love and prayers.

ABSTRACT

This study was carried out in order to determine adolescents' perception towards HIV voluntary counselling and testing in Lusaka urban with an aim of encouraging the adolescents to go for voluntary counselling and testing in order to prevent HIV spread and promote behaviour change.

The literature reviewed was from studies done in Zambia, Africa and other countries around the world on knowledge, attitudes and practices of adolescents towards HIV VCT and other related literature.

A pilot study was conducted in Kalingalinga compound and it consisted of six (6) respondents. For the main study, a descriptive, quantitative, cross sectional study design was used.

The study sites were two high schools in Lusaka urban that is, Libala and David Kaunda. Both schools are co-education and they were selected using purposive sampling technique.

The study was conducted from June 2002 to January 2003. The sample consisted of sixty (60) respondents and these were selected using simple random sampling technique.

Data was collected by use of a self-administered questionnaire from 9th to 23rd September over a period of two weeks. The data was analysed manually by use of

spreadsheets and a scientific calculator and it has been presented in tables, pie charts and cross tabulations.

The findings revealed that 88% of adolescents had high knowledge of HIV/AIDS and voluntary counselling and testing while 12% had medium knowledge.

Fifty-three (53%) percent of the respondents had a negative perception towards HIV VCT and 54% of these were aged 15-20 years. The findings also revealed that only 10% of the respondents had received voluntary counselling and had done an HIV test.

The results further revealed that 71% of respondents with medium knowledge had a negative perception and 51% of those with high knowledge had a negative perception. 57% of respondents with medium knowledge had poor practice while 68% of respondents with poor practice had high level of knowledge.

It was also noted that 81% of respondents with a negative perception had poor practice.

Some of the reasons as to why adolescents did not want to go for counselling and testing were that they felt they were not at risk of being infected with HIV, while others said they were not involved in sexual activities. Others still gave the reasons that activities were not accessible in the community and others said they were too scared in case they tested HIV positive.

When asked as to whether they would want to be counselled for HIV, 72% of respondents agreed but only 57% were willing to be tested for HIV and they said, they would like to know their HIV status.

In order to help adolescents change their perception of HIV VCT, some of the recommendations that were made to the concerned parties are;

- ❖ The Ministry of Health should embark on an intensive health education programme to sensitise the adolescents on the advantages of VCT, so that many of them can go for VCT.
- ❖ VCT services should be youth friendly so that youths can feel free to seek help in the centres offering these services.
- ❖ The Ministry of Health and the Ministry of Education should work hand in hand and integrate VCT in the School Health Programmes.
- ❖ The community and families should actively participate in HIV prevention programmes including VCT.

CHAPTER 1

1.0. BACKGROUND INFORMATION

Zambia is a landlocked country located in the Sub-Saharan African region with an average elevation of between 1000 and 1500 meters above sea level. It covers an area of 752,614 square kilometres and it has common borders with Democratic Republic of Congo and Tanzania in the North, Malawi and Mozambique in the East, Zimbabwe and Botswana in the South, Namibia in the Southwest and Angola in the West (Zambia Demographic and Health Survey (ZDHS), 1996).

Background information

Administratively, the country is divided into nine provinces and seventy two (72) districts. The capital city is Lusaka and other major centres include towns of the Copperbelt, Kabwe and Kapiri Mposhi in the central Zambia, and Livingstone in southern part of the country.

According to the 2000 census, the population of Zambia stands at 10,285,631. Zambia being the third most urbanized country in Africa, presents an unusual African scenario with 42% of the population living in urban areas, primarily the mining area of the Copper belt and the urban centre of the Lusaka province (Central Statistical Office, 2000). In any part of the world, adolescents comprise a large percentage of the entire population. In 1995, the World Bank estimated a total number of 512 million young people aged 15 to 19 years, that is 262 million boys and 250 million girls worldwide; and 426 million of them living in developing countries (Senanayake and Ladjali, 1994). Sub-Saharan Africa has one of the world's youngest populations. At the beginning of the

21st century, that is estimates for the year 2000; about one out of every four people in the Sub-Saharan Africa was 10 to 19 years old (United Nations, 1999).

This type of population distribution is similar to the Zambian situation. In Zambia, 67.5% of the population is under 24 years of age with approximately 26% (2.8 million) being aged between 10-19 years. In a report compiled by United Nations International Children's Fund (UNICEF) (1996), it was estimated that in the Copper belt province, 28% of the population is between the ages of 10-19, while in Lusaka province 26% is in the age group. Because of the large group of adolescents, they represent an important age group or element in the growth of the nation.

Adolescent health is a primary element in the long-term development of any country. The high proportion of young people aged under 20 years in Zambia indicates a youthful population and constitutes the productive age which will develop the nation's economy in future, as young people are future leaders (UNICEF, 1996).

According to the World Health Organization (WHO), 1994, the term adolescence comprises those aged between 10 and 19; 'youth' those aged between 15 and 24; and 'young people' those aged between 10 and 24. For the purpose of consistency, the definitions employed in this study will be that of an adolescent being a young person between the ages of 12-24 and the terms adolescents, young people and youths will be used interchangeably.

During adolescence, the following changes take place; biological development from the onset of puberty to full sexual and reproductive maturity; psychological development from the cognitive and emotional patterns of childhood to those of adulthood, and emergence from the childhood state of total socio-economic dependence to one of relative independence (Senanayake, and Ladjali, 1994). It is in this stage where adolescents take risks and test limits. Taking risks and testing limits are necessary for normal adolescent psychosocial development, however, for most adolescents, these developmental tasks are accomplished without risks to health. When risk taking and limit testing includes sexual risk behaviours, the chances of sexually transmitted diseases including Human Immunodeficiency Virus infection increases (Senanayake, and Ladjali, 1994).

The Human Immunodeficiency Virus (HIV) is a virus that causes Acquired Immune Deficiency Syndrome (AIDS). The HIV infection affects the immune system, which is the body's defence against invasion by microorganisms. The disease manifests through presentation of opportunistic infections and a person may be infected for many years without presenting any symptoms but pass on the infection to others (Ministry of Health/Central Board of Health, 1997). The HIV can be transmitted mainly through sexual contact, intravenously through blood transfusion with unscreened blood, transplacental to the foetus in utero, to an infant through breast milk and in the use of unsterilized needles for injections (Ministry of Health/Central Board of Health, 1997).

The HIV infection continues to spread around the World, and estimates by the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the World Health Organization (WHO) indicate that 40% of people are infected with HIV. According to UNAIDS (2000), 50% of all new HIV infections are among the young people, those aged between 10 and 24 years and that 7,000 young people become infected everyday, and that means about 6 of them get infected every minute globally. From these figures, we can say that young people or adolescent population is an endangered species. Moreover, many millions still have not heard of HIV/AIDS and many more harbour misconceptions about the disease. In addition young women in many countries are far less knowledgeable about HIV than young men (UNAIDS, 2000)

Of the total number of HIV/AIDS cases globally which stands at 40 million, 28,500,000 of these are in Sub-Saharan Africa and about 15 million have already died of AIDS with devastating economic and social impact (UNAIDS, 2001). In Sub-Saharan Africa, more than 30% of the HIV infected people are in the age group 15-20 years (UNAIDS, 2000). In Africa, an estimated 1.7 million young people aged 10-24 are infected annually (UNICEF, 1996).

In Zambia, HIV was first diagnosed in 1984 and the disease was quickly recognised as an important threat to the public health of the nation. By 1998, an estimated 950,000 people were infected with HIV and half of these were the young people aged 15-24 years and about 700,000 children in Zambia are infected with HIV. According to the report on global HIV/AIDS epidemic for the year 2001, in Zambia, a total number of 1.2 million (21.5%) adults and

children are infected with HIV, that is, adults 15-49 years 1 million and out of these, young people aged 15-24 years infected with HIV consists of 25.18% females and 9.68% males (UNAIDS, 2002).

Owing to the long delay in developing symptoms associated with HIV, many young adults were probably infected during adolescence, because during the adolescence stage, they are very active sexually (Webb et al, 1996). Prevention of HIV/AIDS among adolescents is increasingly recognised as an important public health priority. In Zambia, like any other developing country, counselling has become an integral part of different HIV/AIDS support, prevention and educational programme. Voluntary counselling and testing has a vital role to play within a comprehensive range of measures for HIV/AIDS prevention and support, and should be encouraged (UNAIDS, 1997).

Counselling according to the National AIDS/STDs/TB and Leprosy Programme (1995) is the skilled and principled use of relationships that develop self-knowledge, emotional acceptance and growth, and personal resources. The overall aim with counselling is for the client to live a more satisfying life and may be concerned with addressing and resolving specific problems, making decisions, coping with crises, working through feelings and inner conflicts or improving relationships with others.

Voluntary counselling and testing (VCT) has several purposes and potential benefits;

- Early detection of HIV infection.

- Assisting HIV positive individuals in accessing intervention and support services, including management of other infectious diseases.
- Education about living with HIV and avoiding infection of others.
- Assisting uninfected individuals in assessing their personal risk and adopting risk reduction behaviour, and
- Strengthening prevention efforts, particularly at the community level (UNICEF, 1996).

Voluntary counselling and testing is very crucial in adolescents, and the adolescents have the right to information about their own HIV status and the right to use counselling and testing services without stigmatisation and fear. VCT services and the overall infrastructure should take advantage of rapidly changing testing technologies by making testing more attractive to those who have not been tested (UNICEF, 1996). The act of testing also represents an important step in a young person's emotional and psychological development. Demand for, or impact of VCT among young people in Eastern and Southern Africa is low except that experience indicates that adolescents are known to seek and receive VCT (even though the services are not designed for young people). Several VCT centres in Eastern and Southern Africa consist of client-centred pre and post test counselling and the development of individual risk reduction plans.

VCT services in Zambia were first set up by Kara Counselling and Training Trust in November 1992 then the ZAMBART project began in 1992. Initially, funds for HIV testing were provided by the ZAMBART project and people who tested seropositive were offered entry into a trial of tuberculosis

preventive therapy by the ZAMBART project at the University Teaching Hospital. Following this, more substantial funding was provided by the USAID, and Kara Counselling and Training Trust (KCTT) opened up counselling centres in Chawama and Helen Kaunda compounds in addition to their established centres at Thorn Park, Kara house and Hope house. Initially demand for HIV VCT was relatively low and the majority of people who wanted an HIV test were symptomatic (Kara Counselling and Training Trust, 1997). Since then, many more centres have been offering VCT services.

Following a cabinet decision to establish a council and secretariat on HIV/AIDS/STD/TB, the Ministers of Information and Health made a formal announcement on 16th March 2000 launching the National AIDS Council and Secretariat in Lusaka. The National AIDS Council and Secretariat is the body that advocates for effective multisector approaches towards prevention of HIV transmission, care and social support, as well as impact mitigation for those infected and affected by HIV/AIDS (UNAIDS, 2000). In 1998 the Norwegian Aid Development Agency (NORAD) gave the Central Board of Health funds to set up voluntary counselling and testing centres countrywide with 35,000 people targeted for tests.

VCT should be done in a non-stigmatising environment, with high levels of confidentiality and in privacy. A trained and experienced counsellor should handle the adolescent. The services should include pre-test counselling (where possible and desired), informed consent, and post-test counselling.

Information about VCT is gotten from the National AIDS Council and apart from this, the Government of Zambia has also incorporated into the curriculum of all educational programmes issues of HIV/AIDS prevention. The Ministry of Education has included into the school curriculum from primary schools to secondary schools topics on HIV and AIDS and these topics include the causative organism, the mode of spread, signs and symptoms and prevention of HIV transmission which includes the voluntary counselling and testing.

Various clubs such as Anti-AIDS club have been set up in schools. These disseminate information on HIV/AIDS through drama, and issues such as prevention are tackled. Others like youth-friendly programmes are very instrumental in the prevention of HIV/AIDS and dissemination of information on VCT. Youth-friendly programmes actively involve adolescents in programme design and service delivery. All the health centres in Lusaka have set up youth friendly corners, to offer information and education to young clients and counselling concerning reproductive health and HIV/AIDS and STD prevention is offered. Peer educators have also been trained to provide information, education and counselling to adolescents. The peer health educator strategy features the identification and training of natural leaders of the high-risk group to be health educators to their peers. The peer educators undergo special training on how to educate their peers. They do dramatic presentations and educational lectures in places like bars, markets and within the compounds. Information on HIV prevention is given and issues like HIV voluntary counselling and testing are also addressed.

The media is also another source of information on HIV voluntary counselling and testing. Several programmes on television and radio, like 'your health matters' sponsored by the Central Board of Health help disseminate information on VCT. The church is another key place where information is obtained from, concerning VCT. The coming together of Zambia's three church mother bodies, that is, the Christian Council of Zambia, Evangelical Fellowship of Zambia and the Zambia Episcopal Conference to set up a task force to fight the HIV/AIDS pandemic has given a great impetus to this war. There is an urgent need for the church to formulate a common way forward in the fight against HIV/AIDS and come up with practical activities aimed at preventing HIV/AIDS within and outside the church (The Church and HIV/AIDS, 2000). The church's intention to start training programmes in psychosocial counselling and promoting VCT at all levels deserves greatest support of all, including the government. In 1997, the youths from the Christian, Muslim and Bahai Faith groups came together to develop a sexual training manual for Zambian youths. In this meeting issues of HIV/AIDS prevention were addressed, and one of those is the VCT. The group wrote a book entitled Lusaka Inter-Faith HIV/AIDS Networking group and it has been included in the school life skills programme of the Zambia's Ministry of Education (Hobb, 1999).

Family is very important in providing information on HIV voluntary counselling and testing. In an article '*Zambia youth is in crisis over HIV/AIDS*', Hachonda, says "Parents must be in the forefront in not only living exemplary lives, but also talking openly and plainly to their children

about dangers posed by early and unprotected sex. Men must discuss issues of abstinence, safer sex, and protection with their children. They must also talk to their children about values and peer pressure and how they can influence their peers positively” (UNAIDS, 2000). As they discuss these issues, they should also talk to their children about HIV voluntary counselling and testing so that they maintain a negative status. Where they have been able to access appropriate knowledge and skills and means, today’s young people have shown a remarkable propensity to adopt safer behaviours more than previous generations or older adults.

1.2. STATEMENT OF THE PROBLEM

Despite all the above measures of prevention of HIV through voluntary counselling and testing introduction, numbers of those going for VCT still remains low and incidence of HIV continues to rise among adolescents. Investment has been done in informing young people about HIV/AIDS prevention and evidence shows that young people ‘know the facts’, but knowledge acquisition has not led to large-scale behaviour change among them.

Adolescents are very vulnerable towards getting infected with HIV because they are sexually active. A significant body of research including national surveys and qualitative studies have been done to review and identify sex behaviours and to pinpoint the determinants of behaviours. According to a research done by UNICEF (2000), the majority of Zambian youths including

adolescents are sexually active by the age of 19 years. Many have sex by the age of 14.

Another research done by CARE International also indicates that 17% of adolescents have sex by the age of 10 in the urban compounds of Lusaka. Also in the same study, it was revealed that many youths had multiple sexual partners of whom 55% of males and 40% of females reported more than one (1) partner in the last 3 months. Only 25% of Zambian youths abstain from sex. 71% of sexually active youths reported not to have used a condom during the last sexual act (Mwansa, 1995). Discussions on the topic of refraining from sex indicate that young men and women agree that it is difficult to abstain or refuse an invitation to have intercourse. Reasons why they fail to abstain differ. In a Lusaka study (Mudenda, 1992), it was noted that although the females cited love of a boy and liking sex as the reasons for difficulty in saying no, most of them alluded to pressure put on them to consent in form of fear of physical beatings or repeated requests. The male response was centred on the desire for sex and poor self-control. Others are having sex in exchange for money and gifts and for economic support. Girls in their mid-teen years are often having sex with older men who can give them the gifts and money, while boys are having sex with age mates.

An increase in teenage pregnancy also indicates vulnerability of adolescents. These pregnancies are common in Sub-Saharan Africa. Even though fertility rates worldwide are declining among all women, the pregnancy rate among adolescents is increasing. In certain parts of Africa 30 to 40% of all adolescent

females experience motherhood before the age of 18. In some Sub-Saharan African countries, one out of every five adolescent females are likely to have had a child by the age of 20 (Senanayake. and Ladjali. 1994). In the Demographic Health Survey of 1994-1998, 36% of adolescents in Zambia aged 15-19 had unintended pregnancies (Hisel. 2001).

Many of these pregnancies end up in abortion. Early onset of sexual activity means that pregnancies end up being unwanted and the solution for many adolescents is abortion, often, illegal abortion (Webb et al, 1996). Adolescents aged 15-19 years account for at least 10% of the 50 million induced abortions that occur each year throughout the world (Senanayake. and Ladjali, 1994). In Zambia, records indicate that unsafe and poorly performed abortions account for 30% of maternal mortality.

An increase in the sexually transmitted infections among adolescents also indicates their vulnerability. The synergistic relationship between HIV and sexually transmitted infections (STI) is well documented and STI facilitates HIV transmission and, evidence is increasing that HIV infection also increases susceptibility to other STIs (Webb et al, 1996). According to a recent World Health Organization report, persons with traditional sexually transmitted infections are up to 20 times more likely to contract infection (WHO, 1999). Worldwide, an estimated 333 million new cases of four major curable sexually transmitted infections (Gonorrhoea, Chlamydial infections, Syphilis and Trichomoniasis) occur each year among adults, with at least one third of these among youths 15-24 years of age.

All these problems could be avoided if adolescents are confidentially counselled and tested. Once they have adequate knowledge on voluntary counselling and testing, they will be able to teach other adolescents, because adolescents are more likely to discuss and share feelings about sexual and reproductive health among themselves than with their parents. Peer groups are very influential and programmes, which involve their participation, are more likely to be effective in changing behaviour (Senanayake. and Ladjali. 1994). The knowledge on VCT will not only be shared with peers but it is hoped that it will influence behaviour change and stimulate youths to undergo VCT. This will be the first step in curbing the scourge among the youths. The question is, “how do youths perceive VCT?”

I.3 FACTORS INFLUENCING ADOLESCENTS’ PERCEPTION OF HIV VOLUNTARY COUNSELLING AND TESTING

There are other several factors that may influence adolescents’ perception of HIV voluntary counselling and testing.

Service Factors

Services that offer counselling and testing of HIV have been set up around the nation. In Lusaka there are several centres where one can access these services. These are places where the adolescents can get information on HIV voluntary counselling and testing and have a test done on them. These services must be readily available and accessible and they must be convenient to the adolescents.

A lot of factors can affect accessibility of these services. Clinic working hours may be unsuitable for the adolescent. Most adolescents would prefer weekends and hours such as after school, to those that go to school. Distance to these centres may also affect the accessibility of services. If the centre is too far from the adolescent stays or lives, he might find it cumbersome to walk there and if they manage to go, they are made to wait long hours before being attended to, and this makes them shun visiting counselling and testing centres.

At times, the quality of services that are offered may be poorly organized and inefficient. Adolescents would want confidentiality, to be accepted with no moralising or judgement and respect for opinions. Staff attitudes may either encourage adolescents to seek help in VCT centres or may discourage them. If a staff assumes a condemnation attitude and shows no respect and dignity, the adolescents will never go to seek help or information from these centres. The staff may also be hurrying through the information and this may just put off this adolescent. At times it is the unfriendliness of services to the youths like lack of privacy, which may cause an adolescent to have a negative perception of HIV VCT, especially where you combine services for adults and adolescents.

Staff training can also have a bearing on the quality of HIV voluntary counselling and testing services and this may influence adolescent perception of HIV VCT. A staff that is not adequately trained in the counselling skills may not know how to handle an adolescent. This may lead to loss of confidence and lack of trust in these counsellors. Most centres have few

counsellors and these may also be committed to other duties like giving clinical care, this also impinges on the quality of services offered.

Social – Cultural and Economic Factors

The way adolescents perceive HIV voluntary counselling and testing may also be influenced by fear of testing positive and the stigma and rejection that are attached to it. They may feel that if they go for VCT and they are positive, their families will reject them and they may not get adequate social support from friends and relatives. Others feel shy and may think that people will think of them as being promiscuous if they are seen going to a VCT centre.

Economic situation may also play a role in influencing adolescents' perception of HIV VCT. In all the centres, people are required to pay K500 or K1000 to be counselled and tested. Most adolescents cannot afford this much because they are poor and their parents cannot spare this money just for VCT.

Inadequate knowledge may also be a factor in that, the adolescents may have scanty information on HIV/AIDS and VCT. This usually stems from parents and teachers who themselves may not have the adequate knowledge on HIV and VCT and they cannot share it with their children. Ignorance of the benefits and purposes of VCT can also influence adolescent perception of VCT. An adolescent who understands the benefits of VCT can have a positive perception.

The educational level can also play a big role in the way an adolescent perceives HIV VCT. Those that are in school have the access to information VCT because HIV topics have been incorporated into the curriculum and it gives them an advantage to accessing these services because they are better informed.

The Zambia Counselling Council of the Ministry of Health identified some of the constraints to supply of and demand for voluntary confidential counselling and testing of HIV;

Constraints to supply of VCCT:

- ❖ High cost of services
- ❖ Unavailability of counsellors and over reliance on volunteers
- ❖ Centre based services

Constraints to demand for VCCT:

- ❖ Individual reticence or fear, including fear of stigma and discrimination.
- ❖ Poor quality services, including poorly organised or inefficient services.
- ❖ Unfriendliness of services to youths.
- ❖ Lack of community “ownership” of services (Ministry of Health/ Central Board of Health, 1997).

FIGURE 1: FACTORS INFLUENCING ADOLESCENTS' PERCEPTION OF HIV VOLUNTARY COUNSELLING AND TESTING

SOCIO ECONOMIC FACTORS

SERVICE FACTORS

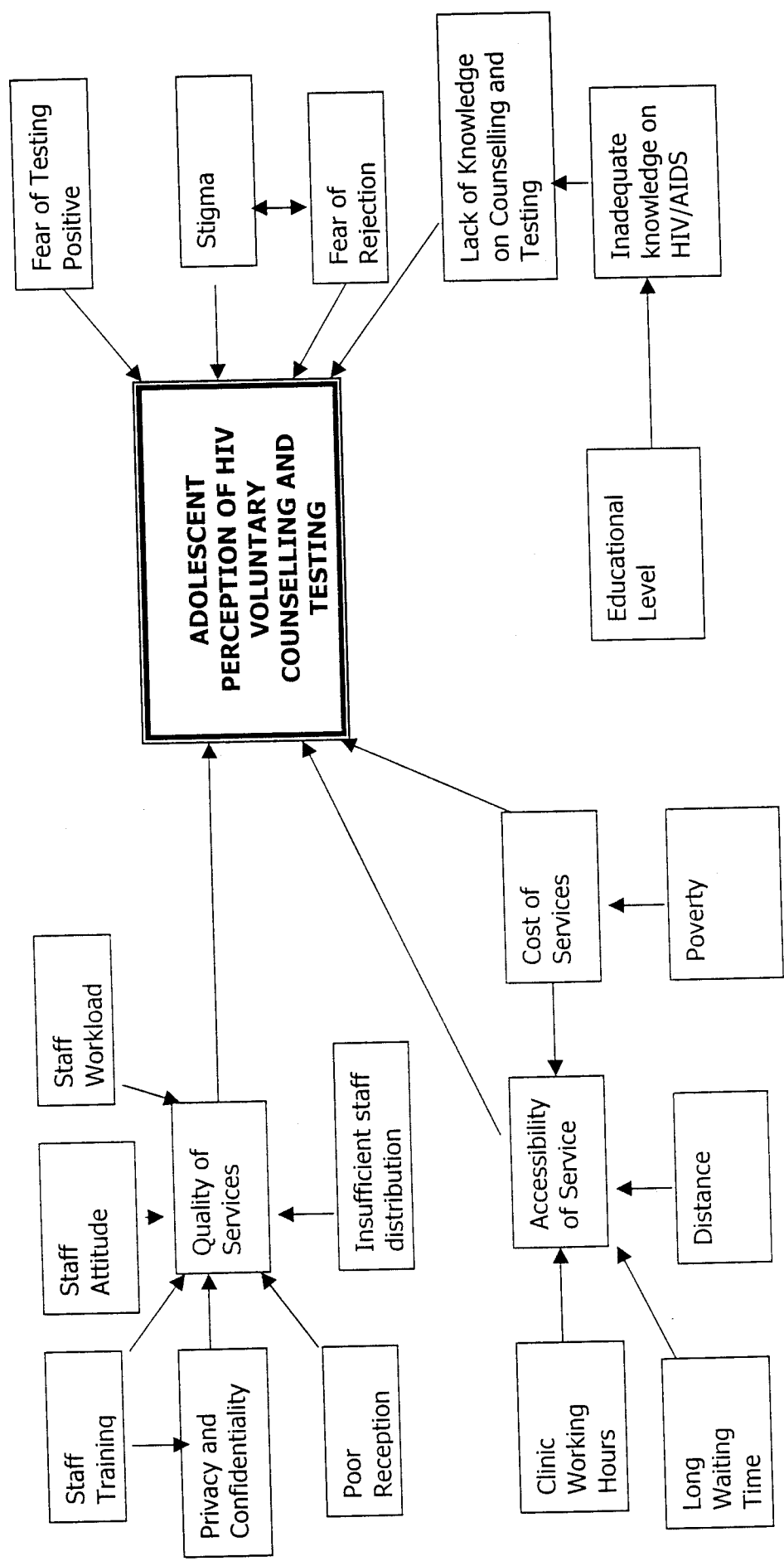
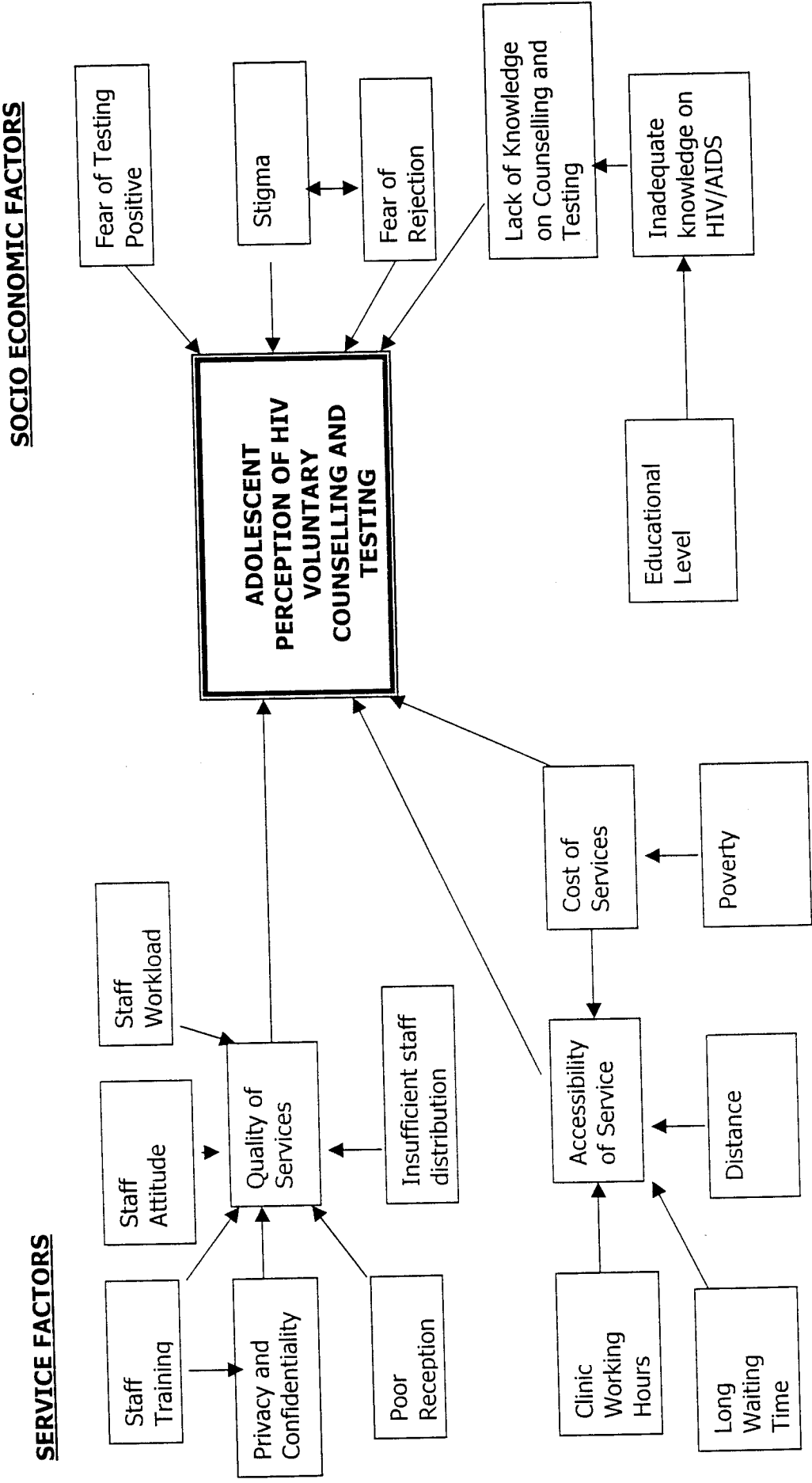


FIGURE 1: FACTORS INFLUENCING ADOLESCENTS' PERCEPTION OF HIV VOLUNTARY COUNSELLING AND TESTING



1.5 JUSTIFICATION OF THE STUDY

HIV/AIDS has been recorded to be on the increase especially in the young people as documented by the UNAIDS 2000. For the year 2001, a total number of one (1) million young people aged 15-24 years in Zambia were infected with HIV. This impacted negatively on the social and economic development of the nation, therefore care and prevention of HIV becomes very essential. Voluntary counselling and testing of HIV is the process by which an individual undergoes counselling enabling him or her to make an informed choice about being tested for HIV. This is an entry point for HIV prevention and care. It gives an opportunity for the youth to get emotional and spiritual care and social support.

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. At times it is understood that VCT will often not have an easily measurable effect, because of the complexity of sexual behaviour and relationships.

In Zambia, VCT services have been under utilized especially by the youths or adolescents despite the increase in the sensitisation programmes. VCT services started in 1988 and people have conducted different studies on HIV VCT, however, not much has been done to determine the adolescent's perception towards HIV VCT in Lusaka. The investigator therefore has been compelled to carry out a study on the adolescents' perception of HIV VCT focusing on the knowledge, perception and participation in Lusaka urban.

It is envisaged that the findings from this study will be useful in the continued programme for HIV prevention and control in relation to HIV voluntary counselling and testing through dissemination of findings and recommendations to the relevant authorities.

1.6 STUDY OBJECTIVES

1.6.1 GENERAL OBJECTIVE

To determine adolescents perception of HIV voluntary counselling and testing at Libala and David Kaunda High Schools in Lusaka urban.

1.6.2 SPECIFIC OBJECTIVES

1. To determine the knowledge of adolescents on HIV/AIDS and voluntary counselling and testing.
2. To determine the perception of adolescents towards HIV voluntary counselling and testing.
3. To identify factors that influence adolescents' perception of HIV voluntary counselling and testing.
4. To identify areas for further research related to HIV voluntary counselling and testing.
5. To make recommendations to policy makers for implementation.

1.7 HYPOTHESIS

The higher the knowledge of adolescents on HIV voluntary counselling and testing the more positive their perception towards HIV voluntary counselling and testing.

1.8 OPERATIONAL DEFINITIONS

1. Adolescent: - refers to a young person aged 12 to 24 years.
2. Knowledge: - Refers to information possessed by adolescents on Human Immune Deficiency Virus infection and voluntary counselling and testing.
3. Perception: - A mental view, opinion or disposition towards voluntary counselling and testing of HIV.
4. Practice: - Putting in action what is known or learnt about HIV VCT.
5. Voluntary counselling: - This is mutual interaction between an HIV counsellor and a willing client.
6. Voluntary testing: - This is an HIV test given to a willing client.

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1.9 VARIABLES

TABLE 1: VARIABLES, INDICATORS AND CUT OFF POINTS

VARIABLE	INDICATOR	CUT-OFF POINT
Knowledge	<ul style="list-style-type: none">• High knowledge	If one scores 12-17 On knowledge questions of HIV/AIDS and VCT.
	<ul style="list-style-type: none">• Medium knowledge	If one scores between 6-11 on knowledge questions
	<ul style="list-style-type: none">• Low knowledge	If one scores less than 5 on knowledge questions
Perception	<ul style="list-style-type: none">• Positive	If one scores between 4 and 6 in perception question.
	<ul style="list-style-type: none">• Negative	Scores les than 3 in perception questions
Practice	<ul style="list-style-type: none">• Very good	If one scores 2
	<ul style="list-style-type: none">• Good	If one scores 1
	<ul style="list-style-type: none">• Poor	If one scores 0

CHAPTER 2

2.0. LITERATURE REVIEW

2.1. INTRODUCTION

Young people aged 10 to 24 accounts for over 50% of all HIV infection occurring worldwide (excluding perinatal cases) (WHO/UNAIDS, 2000). In countries with a high prevalence, young people become vulnerable to the sexual transmission of STDs and HIV as soon as they start sex, because the pool of potential partners is often already heavily infected and this is true for both young men and women (UNAIDS, 1999).

Since no cure has been found yet for HIV/AIDS, preventing the virus from spreading in the first place is the most effective way of reducing the impact of the epidemic on families, communities and the society. Many approaches to HIV prevention and care require people to know their HIV status. Voluntary counselling and testing of HIV is the entry for HIV prevention and care and it provides people with an opportunity to learn and accept HIV serostatus in a confidential environment with counselling and referral for ongoing emotional support and medical care. In counselling, an individual is enabled to make an informed choice about being tested for HIV.

The literature reviewed focuses on the global, regional and local perspectives of HIV voluntary counselling and testing in relation to adolescents' perception of HIV voluntary counselling and testing. However, little is known about VCT

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The literature reviewed focuses on the global, regional and local perspectives of HIV voluntary counselling and testing in relation to adolescents' perception of HIV voluntary counselling and testing. However, little is known about VCT

for youths especially among adolescents aged 14 to 19 (UNAIDS, 2000). In many high-prevalence areas, young people, especially young women, are at high risk from HIV infection, yet they often have no access to VCT service.

2.2. GLOBAL PERSPECTIVE

Globally, Voluntary counselling and testing of HIV has been accepted as a key factor in the prevention of HIV and it is an entry point to care, prevention and support. Several studies have been done on VCT in special groups, youths being one of them and there are new studies available to show that VCT is a cost-effective intervention in preventing HIV transmission.

A study was carried out in 1997 by Samet, J. H et al on factors associated with HIV testing among sexually active adolescents in Massachusetts, United States of America. The objectives of the study were to assess sexually active adolescents' knowledge, attitudes and behaviours associated with HIV testing and to determine the factors important in their decision to obtain voluntary counselling and testing. The findings revealed that of the 567 adolescents surveyed who had sexual intercourse within the past year, 127 (22%) had received HIV testing, with 54 (10%) stating that this testing was for personal reasons.

Misconceptions were common about aspects of HIV testing: 35% did not believe or did not know whether the HIV tests were held in confidence, 19%

thought that AIDS testers informed partners if the results were positive, and 30% did not think that HIV test was very accurate.

In the same study, multivariable analysis identified five factors as independently associated with adolescent HIV testing: the first is that having had more than one sexual partner within the past year; believing that condoms are only somewhat effective at preventing the spread of AIDS; having discussed AIDS with a doctor; and not having a teacher to discuss AIDS with them.

From this study, we can say that among sexually active Massachusetts' adolescents, voluntary counselling and testing of HIV is uncommon, and this may apply to the Zambian youths. Communication on testing process and availability of confidential counselling should be addressed. Health workers can play an influential role in the promotion of VCT of HIV in adolescents.

In another study done in the United States of America by the Centre for Disease Control and Prevention (CDC) in 1998 on the impact of HIV voluntary counselling and testing showed that sexually active young people under 18 years were less likely to attend VCT than their adult counterparts aged 18 to 44, although half of new HIV infection in the United States of America (USA) is in men and women under 25 years.

In order to learn about young people's attitudes and experiences in 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 by Kaiser Family Foundation, 1999). Availability and accessibility of VCT services were found to be a major barrier to attending VCT for these young people. Worries about confidentiality and that results be shared with parents without consent also prevented young people from accessing VCT.

Another study was done in Brazil by Gomes et al in 2000 to determine the uptake of VCT amongst adolescents and results revealed that the uptake of VCT by young people (13 to 19 years) is reported to be increasing and this suggests that knowledge about VCT is increasing.

2.3 REGIONAL PERSPECTIVE

Most VCT centres in Africa have not offered services to adolescents. VCT has not been seen as a priority in HIV care and prevention programmes in many developing countries and has therefore not been widely available.

Young people do actively seek and receive VCT in several Sub-Saharan countries such as Uganda and Kenya, even though the VCT services available have not been designed specifically for young people (Nabwitso et al, 1993).

The AIDS Information Centre (AIC) in Uganda has reported an increase in the number of youths seeking VCT especially for premarital testing (Kakooza, 1992 and Gumisiriza et al, 1996). About 15% of AIDS Information Centre

clients are between the ages of 15 to 19. By the end of 1995, 39, 000 adolescents had visited the centre. Of these, 78% were females and 40% came to the centre with their sexual partners. In this study females tend to visit the VCT centre more than the males. In the pilot phase of a study of young couples in rural western Kenya, 95% of participants said that they would accept a free HIV test. If they had to pay for the services (a \$4 fee), potential demand remained relatively high with 31 to 40% saying that they would pay for the test. The mean age of couples participating in the study is 22 (Damesyn et al, 1998). If the services are available and affordable, the young people are able to go for a test and their perception changes in the more positive aspect.

A participatory study from Uganda with adolescents (12-19 years) in Mpigi district on demand for HIV voluntary counselling and testing was done by Bohmer et al in 1997 and it revealed that the most frequently discussed topic initiated in group discussions was HIV transmission, followed by issues of sexuality and the initiation of sexual relationships. Males (17-19) females (14-16) showed the greatest interest in HIV testing. However, many young people expressed concerns about issues of confidentiality, cost and location of services, as well as a lack of trust in their sexual partners to remain faithful after having the test.

Attitudes towards HIV voluntary counselling and testing are likely to change if these adolescents become more knowledgeable about the services and issues of confidentiality and trust are addressed.

In another knowledge, attitude and practices and belief study done in Rakai province of Uganda, in the year 1993, Kelly et al showed that 84% of 865 young people questioned (18-25 years), said that they would like to see an HIV/AIDS counsellor in the future. From this study, we can say that, with more information, adolescents can change their perception on voluntary counselling and testing and seek these services more often.

In a recent study of voluntary counselling and testing services in Kenya, only 11% of untested youths in Nairobi could name a service provider within their communities though more knew that testing (though not necessarily counselling) was available at a large hospital (UNAIDS, 2002).

2.4. NATIONAL PERSPECTIVE

A lot of studies have been done on the voluntary counselling and testing of HIV in couples and women in Zambia but few have been done on adolescents' perception of HIV voluntary counselling and testing of HIV.

A study was done in 1993 by Kelly et al to establish and evaluate HIV counselling and testing in Lusaka. From the findings, it was deduced that there was a wide age distribution of clients from 16-55 attending, with the most frequent attendees in the 26-30 age group. This study shows that the people attending the voluntary counselling and testing centres in Lusaka come from the adult, and few from the adolescents.

In another study, Baggaley et al carried out a series of focus group discussion and in-depth interviews among young people from three provinces in Zambia in 1998. There were 465 young people (males-217, and females-248 ages 12-21, mean age 17) who took part in the study. Young people proposed several theoretical reasons for HIV testing. 57% of boys and 53% of girls said that they would like to have the opportunity of going for an HIV test. However, the majority of them were not keen to have an HIV test at the present time, as they were worried that they would be positive (despite HIV prevalence being relatively low in this age group). Some young people said that they would consider having a test in the future. The small number who had been tested thought it was better to know, even if the result was positive. Fear in this study could be attributed to early age for sexual indulgence. If potential benefits are clearly explained to the young people in relation to the VCT of HIV, their perception is likely to change and improve, and it is the responsibility of the health workers to explain to the young people.

In a study to explore knowledge and attitudes to HIV among University students in the United Kingdom and Zambia, 7% of the United Kingdom (UK) students (n=1240) had an HIV test. A further 35% of Zambian and 15% of United Kingdom students said that they would like to be tested (Baggaley et al, 1997). This shows that less than half of the students (who usually are youths) are ready to be tested for HIV and it could be that those that may not seek VCT services may not be knowledgeable about it's benefits.

Some cohort studies were done between 1989-1995 and these documented changes in sexual behaviour after voluntary counselling and testing. The reported changes in sexual behaviour were accompanied by decline in HIV incidence particularly among young people. A follow up study of 3,000 voluntary counselling and testing clients 3 and 6 months after testing showed significant changes in sexual behaviour (Ministry of Health, 1997).

2.5. **CONCLUSION**

From the discussion above, there is generally low uptake of voluntary counselling and testing or a negative perception towards voluntary counselling and testing of HIV amongst adolescents and this has been attributed to several reasons. Some of these could be inadequate knowledge on these services, unavailability and inaccessible voluntary counselling and testing services and fears on lack of confidence and trust.

However, from the studies done in the developing nations, Uganda shows an increase in demand for VCT amongst adolescents. It is hoped that other contributing factors to adolescents', perception of HIV voluntary counselling and testing will be identified and these will be used to make further recommendations to the relevant authorities and the community on how to improve the VCT services for adolescents.

CHAPTER 3

3.0 RESEARCH METHODOLOGY

3.1 INTRODUCTION

This chapter describes the research methodology that was used in the study. The purpose of the study was to determine the adolescents' perception of HIV voluntary counselling and testing at Libala and David Kaunda High Schools. This was with an aim of coming up with recommendations, which were presented to the relevant authorities for implementation.

3.1. RESEARCH DESIGN

A research design is a scheme of action (framework) for answering the research questions. It includes such factors as the research setting, operational definitions, assumptions, relationships between variables, delimitation, sample, sampling procedure, instrument, approach to be used, and the method for analysing data, ethical questions concerning subjects' rights and use of data (Treece and Treece, 1986).

In this study, a descriptive, quantitative and cross sectional study was used. A descriptive design is a non-experimental research designed to discover new meaning and to provide new knowledge when there is very little known about a phenomenon of interest (Dempsey and Dempsey, 2000). A descriptive design involves a systematic collection and presentation of data to give a clear picture of a particular situation. The design was chosen for the study because in this study, data was collected from the subjects and this data gave a clear

account on the perception of adolescents' on HIV voluntary counselling and testing. The design also gave a clear picture of what was obtaining on the ground in terms of knowledge, perception and practices of the adolescents towards the voluntary counselling and testing of HIV. The type of descriptive design that was used is the survey and in this type, data was collected directly from the study subjects by way or means of a self-administered questionnaire.

The study was also quantitative research, which is a research method in which the study variables are pre-selected and defined by the investigator and the data are collected and quantified (that is translated into numbers), then statistically analysed, often with a view to establishing cause and effect relationships among variables. The subjects' responses were quantified and measured objectively.

A cross-sectional design was used. This is a study in which data are collected from subjects at one point in time (Dempsey and Dempsey, 2000). Data was collected from the subjects at Libala and David Kaunda high schools just once and data was analysed. The study aimed at quantifying the distribution of certain variables, that is knowledge, perception and participation of adolescents towards HIV voluntary counselling and testing, at one point in time. This study design was found suitable because it is less costly and less time consuming considering the limited time in which we carried out the study.

3.2. **RESEARCH SETTING**

Research setting is the location or place where the study takes place. The study was conducted in Lusaka urban at Libala and David Kaunda High Schools. Lusaka urban is one of the four districts in Lusaka province. It has an estimated population of 2 million, according to the 2000 census (Central Statistical Office, 2000).

There are slightly over ten secondary schools in Lusaka urban and majority of these are Government schools. Libala and David Kaunda are now High Schools offering education from grade 10 to grade 12. Both schools enrol male and female pupils. Libala high school is found in Libala Township and is situated approximately 6 kilometres from the town centre while David Kaunda high school is approximately 5 kilometres from the town centre. Pupils at these schools come from all corners of Lusaka and pupils at David Kaunda are even from around the country. Libala is a day school while David Kaunda is a boarding school.

3.3. **STUDY POPULATION**

Target population is the entire population in which the researcher is interested in and to which he or she would like to generalize the results of the study (Polit and Hungler, 1997). The target population consisted of all the adolescents in Lusaka urban. The study population or accessible population is the population of people available for a particular study, often a random subset of the target population (Polit and Hungler, 1997).

For this study, the study population was adolescents aged 12 to 24 years at Libala and David High Schools. These were male and female. This group was selected because of their vulnerability to HIV infection and high incidence rates occur in the adolescent period.

3.4. SAMPLE SELECTION

To select the subjects, simple random sampling technique was used. This is the most basic type of probability sampling, where a sampling frame is created by enumerating all members of a population of interest, and then selecting sample from the sampling frame through completely random procedures (Polit and Hungler, 1997). Names of all the pupils were written on small pieces of paper, which were folded and put in a box and shuffled. Using an independent person, 9 respondents were sampled from grade ten (10), eleven (11) respondents from grade 11 classes and 10 respondents from the grade 12 classes at Libala high school. At David Kaunda high school, the same sampling method was used and nine (9) respondents were sampled from grade 10 classes, 10 respondents were sampled from grade 11 classes and 11 respondents from grade 12 classes.

3.5. SAMPLE SIZE

Sample size is a smaller part of the population selected in such a way that the individuals in the sample represent (as nearly as possible) the characteristics of the population. Typically shown as 'n' (Dempsey and Dempsey, 2000).

A sample size of 60 adolescents who were in the age range of 12-24 years old was included in the study. This sample size was selected because it was manageable considering the available finances, time and manpower.

3.6. DATA COLLECTION TOOL

A data collection tool is an instrument designated to collect information in a form useful to the researcher (Treece and Treece, 1986). A self-administered questionnaire was used to collect data from the subjects. Self-administered questionnaire is a method of gathering self-reports information from respondents through self-administration of questions in a paper and pencil format (Polit and Hungler, 1997).

The questionnaire contained questions on all the variables under study. It had four sections. The first section obtained demographic data of the subjects. The second section measured the knowledge of adolescents on HIV/AIDS and VCT while the third section elicited data on perception and the last section determined the practice.

3.7. DATA COLLECTION TECHNIQUE

Data collection technique is the process of gathering information needed to address a research problem (Polit and Hungler, 1997). For this study a self-administered questionnaire was used to collect data.

This data collection technique was preferred because it was less costly and required less time and energy to administer considering the time in which data

had to be collected. It was also appropriate because it offered the possibility of complete anonymity, which is crucial in obtaining information about illegal, or embarrassing characteristics. In this case, it was advantageous because most respondents would have felt shy to give information.

Questionnaires are also advantageous in that the absence of an interviewer ensures that there will be no bias in the responses that reflect the respondents' reaction to the interviewer rather than to the questions themselves.

After sampling the adolescents, verbal permission was sought from the teachers and the subjects, and then the investigator introduced herself to the respondents. The purpose of the study was explained carefully to the respondents, they were assured of confidentiality, verbal consent was obtained and questionnaires were distributed. The instruction given was that, names were not to be written down to ensure anonymity. Their questions were answered and they were thanked for their participation.

3.8. PILOT STUDY

The pilot study for this research was conducted before the actual study. A pilot study is a mini study conducted before the major study in order to make revisions and find flaws in the methodology. It should include every step expected in the major study (Treece and Treece, 1986).

The pilot study was done in Kalingalinga compound for easy accessibility and this was also for convenience sake because school pupils were still on holiday.

The pilot study tested validity and reliability of the instrument in order to detect and solve unforeseen problems. The sample was selected randomly and the sample size was 10% of the sample size of the actual study, that is 6. Questions 5, 13, 18, 19, 27 and 29 were modified in order to make the instrument effective and relevant.

3.9. VALIDITY

In a quantitative research, validity is the ability of data gathering instrument to measure what it intended to measure and in a qualitative research it is the extent to which research findings represent reality (Dempsey, and Dempsey, 2000). In this study, validity was measured as the pilot study was done. The investigator measured the ability of the instrument used to see if it was going to bring out desired information. Validity was measured in order to minimise biases.

3.11 RELIABILITY

Reliability in quantitative research is the stability of a measuring instrument over time and in qualitative research, it is the measure of the extent to which random variation may have influenced stability and consistency of results (Dempsey, and Dempsey, 2000). Reliability of the instrument was measured in the pilot study. This was done to establish consistency and dependability in the instrument, that is if the same information was to be elicited from the same questions.

3.12 ETHICAL AND CULTURAL CONSIDERATIONS

According to Polit and Hungler (1997), ethics is a system of moral values that is concerned with the degree to which research procedures adhere to professional, legal, and social obligations to the study participants.

Before conducting the research, the investigator sought permission from the facilitator to get ethical clearance. After being cleared, then permission to conduct the study at Libala and David Kaunda High Schools was sought from the District Educational Officer. After permission from the District Educational Officer had been sought, the investigator got permission from the school headmasters and class teachers. After sampling the pupils, permission was sought from the respondents after explaining the purpose of the study. Seeking personal consent from respondents helped maintain confidentiality of the subjects. It was explained to each respondent the intentions for utilising data to the benefit of society as a whole. Questionnaires were given to the respondents to answer individually, to ensure privacy, and findings have been reported collectively.

CHAPTER 4

4.0. DATA ANALYSIS AND PRESENTATION OF FINDINGS

4.1. INTRODUCTION

The purpose of the study was to determine adolescents' perception of HIV voluntary counselling and testing. The data collected were analysed and presented in frequency tables, cross-tabulations and pie charts.

4.2. DATA ANALYSIS

Data analysis is the systematic organization and synthesis of research data, and the testing of research hypothesis using those data (Polit and Hungler, 1997).

After data were collected, all the questionnaires were sorted out and checked for completeness and internal consistency and entered on a master for manual analysis. Data were further analysed by use of a scientific calculator.

Frequency tables and pie charts were found to be more appropriate means of presenting the findings because they are easy to interpret and they accord one with a rough idea and picture about the findings even before they read the discussions of the findings. They are also useful in drawing meaningful inferences.

Cross tabulations were useful to combine information on two or more variables in order to arrive at positive explanations of the problem.

4.3 PRESENTATION OF FINDINGS

TABLE 2: DEMOGRAPHIC DATA OF RESPONDENTS

n=60

AGE RANGE	FREQUENCY	PERCENTAGE (%)
15-20 years	57	95
21-25 years	3	5
TOTAL	60	100
SEX		
Male	29	48
Female	31	52
TOTAL	60	100
EDUCATIONAL LEVEL		
Grade 10	18	30
Grade 11	21	35
Grade 12	21	35
TOTAL	60	100

Majority of the respondents (95%) were aged 15-20 years. 52% were females and 48% were males. 30% were in grade ten (10), 35% in grade eleven (11) and another 35% in grade twelve (12).

**TABLE 3; RESPONDENTS' KNOWLEDGE ON HIV/AIDS AND
VOLUNTARY COUNSELLING AND TESTING.**

n=60

RESPONSES	FREQUENCY	PERCENTAGE
HEARD OF HIV/AIDS		
Yes	60	100
No	0	0
SOURCE OF INFORMATION		
Radio/Television	57	95
Friends	54	90
Books/Pamphlets	51	85
Health workers	38	63
Parents	44	73
Teachers	43	72
Church	7	12
CAUSES OF HIV INFECTION		
Mosquitoes	1	2
HIV virus	59	98
Witchcraft	0	0
I do not know	0	0
TRANSMISSION OF HIV		
Sexual intercourse	60	100
Sharing cups and spoons	0	0
Mosquito bite	2	3

RESPONSES	FREQUENCY	PERCENTAGE (%)
Blood transfusion with unscreened blood	58	97
Contaminated razor blades and needles	55	92
Mother to baby through breast milk	37	62
I do not know	0	0
HEARD OF VCT		
Yes	60	100
No	0	0
SOURCE OF INFORMATION		
Radio/Television	58	97
Friends	31	52
Books/Pamphlets	30	50
Health workers	29	48
Parents	16	27
Teachers	22	37
Church	5	8
WHAT IS HIV VCT		
Going to the clinic	1	2
Willing receiving information on HIV and being tested for HIV	52	86

RESPONSES	FREQUENCY	PERCENTAGE (%)
Knowing about HIV	6	10
I do not know	1	2
KNOWLEDGE ON WHERE TO GET HIV VCT SERVICES		
Health centres	49	82
Kara Counselling Centre	40	67
Hospital	45	75
New Start Centre	58	97
Society for family Health	34	57
Private Clinics	5	8
ANY ADVANTAGES OF VCT		
Yes	58	97
No	0	0
I do not know	2	3
ADVANTAGES OF VCT		
One can make informed decisions about health	56	93
One will not knowingly infect others	34	57
One may take up positive behaviours	51	85
Knowing your HIV status	2	3

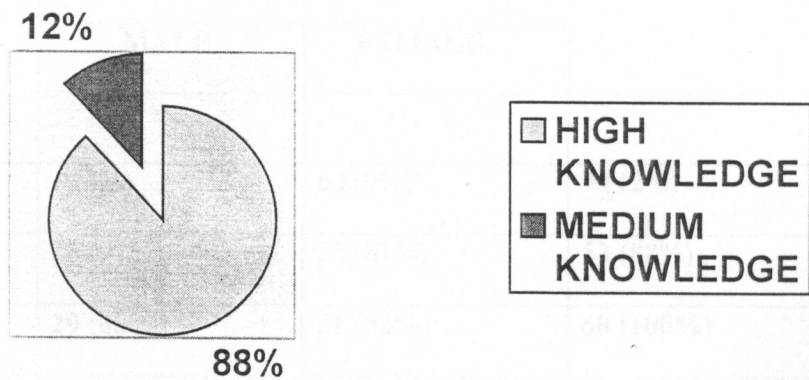
All the respondents had heard about HIV/AIDS and the commonest source of information (95%) was radio/television. Only 2% of the respondents did not know the cause of HIV infection. All the respondents knew sexual intercourse to be one of the ways in which HIV infection is transmitted and only 62% knew that HIV can be transmitted from the mother to the baby through breast milk.

All the respondents had heard about HIV Voluntary Counselling and Testing and the commonest source of information (97%) was the radio and television.

86% of the respondents knew the meaning of HIV VCT while 14% did not. Majority (97%) of respondents indicated that VCT services could be obtained from New Start Centre. Most of the respondents (97%) knew the advantages of VCT.

FIGURE 2; RESPONDENTS' LEVEL OF KNOWLEDGE

LEVELS OF KNOWLEDGE



Majority (88%) of the respondents had high knowledge of HIV/AIDS and VCT.

**TABLE 4; RESPONDENTS' LEVEL OF KNOWLEDGE IN RELATION
TO AGE**

n=60

LEVEL OF KNOWLEDGE	AGE RANGE		TOTAL
	15-20	21-25	
Low	-	-	-
Medium	7 (12%)	-	7 (12%)
High	50 (88%)	3 (100%)	53 (88%)
TOTAL	57 (95%)	3 (5%)	60 (100%)

All the respondents (100%) aged 21-25 years had high level of knowledge.

**TABLE 5; RESPONDENTS' LEVEL OF KNOWLEDGE IN RELATION
TO SEX**

n=60

LEVEL OF KNOWLEDGE	SEX		TOTAL
	MALE	FEMALE	
Low			
Medium	1 (3%)	6 (19%)	7 (12%)
High	28 (97%)	25 (81%)	53 (88%)
TOTAL	29 (48%)	31 (52%)	60 (100%)

More females (19%) than males (3%) had medium level of knowledge of HIV/AIDS and VCT.

**TABLE 6; RESPONDENTS' RESPONSES TO QUESTIONS ON
PERCEPTION OF HIV VOLUNTARY COUNSELLING AND
TESTING**

n=60

RESPONSES	FREQUENCY	PERCENTAGE
TALKED TO A HEALTH PROVIDER ABOUT HIV VCT		
Yes	15	25
No	45	75
VISITED A VCT CENTRE BEFORE		
Yes	11	18
No	49	82
WILLING TO BE COUNSELLED FOR HIV		
Yes	43	72
No	10	17
Not sure	7	12
WILLING TO BE TESTED FOR HIV		
Yes	34	57
No	16	27
Not sure	10	17
WILLING TO BE INFORMED OF THE RESULT		
Yes	41	68
No	4	7
Not sure	15	25

VCT SERVICES TO BE WIDELY DISTRIBUTED IN THE COMMUNITY		
Yes	53	88
No	3	5
I do not know	4	7

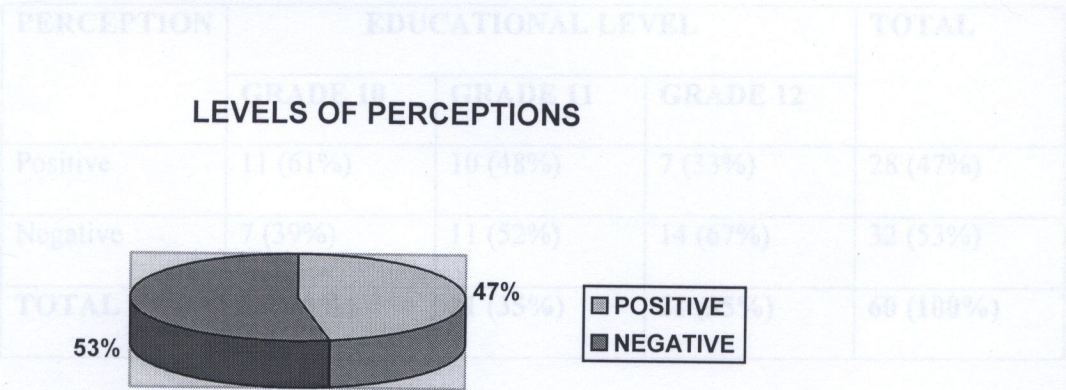
75% of respondents indicated that they had never talked to a health provider about HIV VCT and 82% had never visited a VCT centre before. 72% of respondents said that they would be willing to be counselled for HIV, 17% said they were not willing while 12% were not sure.

On being tested for HIV, 57% indicated that they would be willing to be tested for HIV while 27% said they would not be willing and 17% were not sure.

68% of respondents said that they would be willing to be informed of the results of the test while 25% were not sure.

Majority of respondents (88%) said that VCT services should be widely distributed in the community.

FIGURE 3; LEVELS OF PERCEPTION



61% of respondents in grade 10 had a positive perception and majority of respondents (67%) with a negative perception were in grade 12.

Majority of respondents had a negative perception towards HIV VCT.

**TABLE 7; RESPONDENTS' PERCEPTION OF HIV VCT IN RELATION
TO AGE**

n=60

PERCEPTION	AGE RANGE		TOTAL
	15-20	21-25	
Positive	26 (46%)	2 (67%)	28 (47%)
Negative	31 (54%)	1 (33%)	32 (53%)
TOTAL	57 (97%)	3 (5%)	60 (100%)

54% of the respondents aged 15-20 years had a negative perception. 67% of respondents aged 21-25 had a positive perception.

**TABLE 8; RESPONDENTS' LEVEL OF PERCEPTION IN RELATION TO
EDUCATIONAL LEVEL**

N=60

PERCEPTION	EDUCATIONAL LEVEL			TOTAL
	GRADE 10	GRADE 11	GRADE 12	
Positive	11 (61%)	10 (48%)	7 (33%)	28 (47%)
Negative	7 (39%)	11 (52%)	14 (67%)	32 (53%)
TOTAL	18 (30%)	21 (35%)	21 (35%)	60 (100%)

61% of respondents in grade 10 had a positive perception and majority of respondents (67%) with a negative perception were in grade 12.

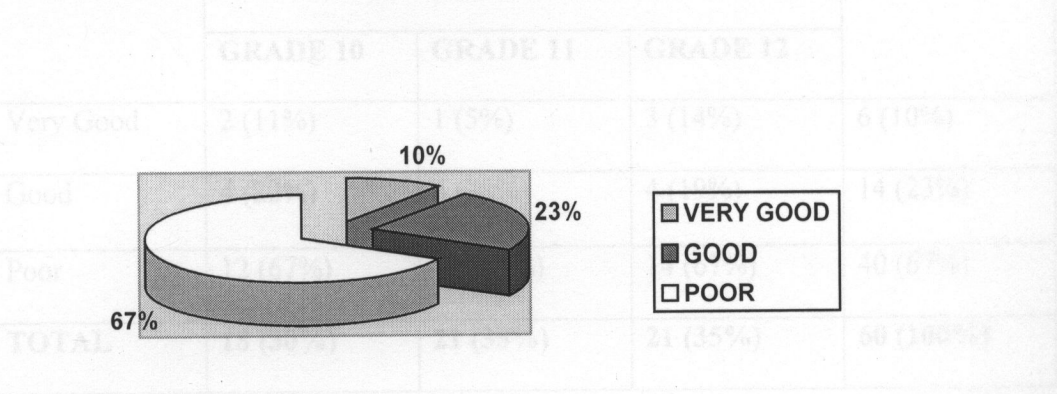
TABLE 9; RESPONDENTS' RESPONSES ON PRACTICE QUESTIONS

n=60

RESPONSE	FREQUENCY	PERCENTAGE (%)
HAD ANY COUNSELLING ON HIV/AIDS		
Yes	19	32
No	41	68
WHERE COUNSELLED		
Health centre	4	7
Hospital	1	2
New Start Centre	2	3
Family health	1	2
Kara counselling Centre	4	5
School	6	10
Youth Alive Ministry	2	3
HAD ANY HIV TEST		
Yes	7	12
No	53	88
WHERE TESTED		
Health centre	3	5
Hospital	0	0
New Start Centre	2	3
Family Health	0	0
Kara counselling Centre	2	3

68% of respondents said that they had never received any counselling on HIV/AIDS before and only 32% had. Only 12% had had their blood tested for HIV, the majority (88%) had never been tested before.

FIGURE 4; RESPONDENTS' LEVELS OF PRACTICE



10 % of the respondents had very good practice and the majority (67%) had poor practice.

TABLE 10; RESPONDENTS' PRACTICE IN RELATION TO AGE

n=60

LEVEL OF PRACTICE	AGE RANGE		TOTAL
	15-20	21-25	
Very Good	6 (10%)	-	6 (10%)
Good	13 (23%)	1 (33%)	14 (23%)
Poor	38 (67%)	2 (67%)	40 (67%)
TOTAL	57 (95%)	3 (5%)	60 (100%)

All the respondents with very good practice were aged 15-20 years.

TABLE 11; RESPONDENTS' PRACTICE IN RELATION EDUCATIONAL LEVEL

n=60

PRACTICE	EDUCATIONAL LEVEL			TOTAL
	GRADE 10	GRADE 11	GRADE 12	
Very Good	2 (11%)	1 (5%)	3 (14%)	6 (10%)
Good	4 (22%)	6 (28%)	4 (19%)	14 (23%)
Poor	12 (67%)	14 (67%)	14 (67%)	40 (67%)
TOTAL	18 (30%)	21 (35%)	21 (35%)	60 (100%)

67% of all the respondents had poor practice while the majority of respondents with very good practice (14%) were in grade 12.

TABLE 12; RESPONDENTS' PERCEPTION IN RELATION TO LEVEL OF KNOWLEDGE

n=60

PERCEPTION	LEVEL OF KNOWLEDGE			TOTAL
	LOW	MEDIUM	HIGH	
POSITIVE	-	2 (29%)	26 (49%)	28 (47%)
NEGATIVE	-	5 (71%)	27 (51%)	32 (53%)
TOTAL	-	7 (12%)	53 (88%)	60 (100%)

71% of the respondents with medium knowledge had a negative perception.

TABLE 13; RESPONDENTS' PRACTICE IN RELATION TO LEVEL KNOWLEDGE

n=60

PRACTICE	LEVEL OF KNOWLEDGE			TOTAL
	LOW	MEDIUM	HIGH	
VERY GOOD	-	1 (14%)	5 (9%)	6 (10%)
GOOD	-	2 (29%)	12 (23%)	14 (23%)
POOR	-	4 (57%)	36 (68%)	40 (67%)
TOTAL	-	7 (12%)	53 (88%)	60 (100%)

57% of respondents with medium knowledge had poor practice while 68% of respondents with poor practice had high level of knowledge

TABLE 14; RESPONDENTS' PERCEPTION IN RELATION TO PRACTICE

N=60

PRACTICE	LEVEL OF PERCEPTION		TOTAL
	POSITIVE	NEGATIVE	
VERY GOOD	6 (21%)	-	6 (10%)
GOOD	10 (36%)	6 (19%)	16 (27%)
POOR	12 (43%)	26 (81%)	38 (63%)
TOTAL	28 (47%)	32 (53%)	60 (100%)

81% of respondents with a negative perception had poor practice.

CHAPTER 5

5.0. DISCUSSION OF FINDINGS AND IMPLICATIONS FOR THE HEALTH CARE SYSTEM

5.1. INTRODUCTION

The results of this study were based on the analysis of responses from a sample of sixty (60) adolescents from Libala and David Kaunda High Schools. The study determined the perception of adolescents towards HIV voluntary counselling and testing by establishing the basic knowledge adolescents have of HOV/AIDS and VCT and their perception and practice.

5.2 SAMPLE CHARACTERISTICS

Section A of the questionnaire (appendix 1) had questions that elicited demographic information from the respondents.

The results revealed that 95% of respondents were aged between 15 and 20 years while the other 5% were aged between 21 and 25 years. More respondents were aged between 15 and 20, probably due to the fact that one is expected to start school at the age of 6 or 7 years and thus complete secondary education by the age of 17 and 18. Most adolescents will be in grade 10-12 by the ages of 15-20 years. Fewer respondents were between the ages of 21-25 years and this is expected because by the age of 21, one should have completed school.

Most of the respondents (52%) were females and 48% were males. These results agree with the Zambian population, which shows that there are more females than males. However, in most cases there are more males in schools than females, thus the findings above could have been due to the reason that at the time of data collection, schools had just opened and the classes were not complete and at this time there could have been more females in class thus giving a picture of having more female respondents.

The other reason could have been due to the girl-child sensitisation, which has been going on in Zambia, where girls are given equal opportunity to be in school with the boys.

The educational level of respondents showed that 35% were grade 12, 35% in grade 11 and 30% of respondents were in grade 10. These were chosen because it is assumed that by this time, may have been exposed to HIV/AIDS and sex educators and thus are expected to have some knowledge on the subject. These grades were also chosen because in these grades, pupils are in the age group at which sexual intercourse begins.

5.3 KNOWLEDGE ON HIV/AIDS AND VOLUNTARY COUNSELLING AND TESTING.

Section B of the questionnaire (appendix 1) contained questions that were measuring the knowledge of respondents on HIV/AIDS and VCT. The section had a total number of eleven (11) questions.

The study results showed that all the respondents had heard of HIV/AIDS (Table 2). This demonstrated that most adolescents had some basic knowledge on HIV/AIDS. This agrees with a quantitative focus group discussion study done by Macwan'i, M, (1993) in Lusaka in adolescents aged between 15-30 years which showed that knowledge about HIV/AIDS was very high among youths. The commonest source of information (95%) was the radio and television (Table 2). These findings are similar with the results of a study done by Pempelani, M et al, (1990) which revealed that the major and effective channel for disseminating AIDS information was the radio (85.3%).

From the same table, the results also revealed that 98% of respondents knew the cause of HIV infection and all of them knew sexual intercourse to be the commonest route of transmission of the HIV infection. In a similar study done by Pempelani (1990) on male and female students within the age range of 10-33 years concentrating on those in grade 9-12, it was indicated that 92% of respondents were aware of the existence of AIDS in Zambia. Awareness of AIDS, however, is only a superficial measure of knowledge. An important factor is whether adolescents know how to prevent the disease.

Although many adolescents have heard of HIV/AIDS, fewer knew of at least one way to prevent sexual transmission of HIV. However, in the study, it was revealed that all the respondents (100%) knew that HIV infection could be prevented through abstaining from sex (Table 2). These results agree with the results of the Demographic Health Surveys 1994 – 1998, which showed that 81% and 63% of male and female adolescents respectively had the knowledge

of at least one preventive measure of sexual transmission of HIV in Zambia. (Hisel, 2001)

Majority of the respondents (86%) knew the meaning of voluntary HIV counselling and testing. This could be due to the sensitisation that has been done through the media, since most of the respondents (97%) said that they got the information from the radio and television (Table 2). This can be seen from the way the Ministry has put up programmes in sensitising the masses about HIV VCT through the media. Programmes like 'your health matters' and other advertisements on VCT have been some channels through which people get the information from. Most of the respondents (97%) knew the advantages of undergoing VCT(Table 2).

From figure 2, the results showed that all the respondents aged 21-25 years had high level of knowledge compared to the 88% of those aged 15-20 years. This is probably due to the fact that youths are shy to discuss sexuality issues with adults and as one grows older, the way of understanding issues changes.

More females (19%) than males 3% had medium level of knowledge of HIV/AIDS and VCT. This seems to be a common phenomena and it could be due to the fact that normally males are free to discuss issues pertaining to sexuality amongst themselves than females do. As males discuss they gain more knowledge and enrich their knowledge base.

These results seem to agree with the results of the survey done by DHS – 1994-1998 where findings revealed that there were some gender-related differences notable in Mali and Mozambique. Among those adolescents aged 15-19, it was discovered that young women were less likely than young men to have heard of AIDS, (Hisel, 2001). In Zambia more young men know how to prevent HIV/AIDS than young women. During the same demographic health survey 1994-1998, it was discovered that amongst adolescents aged 15-19 in Zambia only 63% of females against 81% in males, knew preventive measures. In other countries like Ghana, Senegal and Tanzania, less than 57% of young women can name at least one of the four preventive measures, which are condom use, avoiding multiple partners, being faithful to one partner, and abstaining from sex.

From a general point of view, the study showed that 88% of respondents had high level of knowledge of HIV/AIDS and VCT, while 12% had medium level of knowledge and no one had low level of knowledge. From this picture, we can say that a lot of sensitisation has been done on the subject and knowledge has increased.

As knowledge of HIV/AIDS and VCT increases it is hoped that the uptake of VCT will increase among adolescents and this will lead to behavioural change, thus preventing spread of HIV. In a study done by Gomes et al (2000) in Brazil, it was revealed that the uptake of VCT by young people (13-19 years) is increasing.

5.4 PERCEPTION OF HIV VOLUNTARY COUNSELLING AND TESTING

In the questionnaire (appendix 1), section C contained questions on the perception of adolescents towards voluntary HIV counselling and testing. In this section ten (10) questions were asked and information on perception was elicited.

The study results showed that 75% of respondents had never talked to a health provider about VCT and 82% had never even visited a VCT centre before (Table 7). These results do not agree with the results of a study that was done in Rakai province of Uganda among young people aged 18 to 25 years. In this study, 84% of young people questioned were willing to see an HIV/AIDS counsellor in the future (Kelly et al, 1993).

In another study in Uganda, it was revealed that there was an increase in the numbers of youths seeking VCT and by the end of 1995; thirty nine thousand (39,000) adolescents had visited the AIDS information centre (Kakooza, 1992; Gumisiriza et al, 1996).

One of the reasons given by the respondents as to why they had never visited a VCT centre or talked to a health provider about VCT was that if they were seen going to a VCT centre, people might think that they are promiscuous. If the vulnerable group of adolescents can think and feel like this, then there is a

problem in the preventive programmes we have set up. The youth-friendly programmes have not been user friendly to the adolescents.

Another reason given was that services were not accessible in the community. Some youths said there are no such services in the communities where they live, whilst others said these services are actually very far and they cannot afford transport costs. This becomes a problem, especially when we consider the economic situation of our nation, services may need to be very close to where the youths are found in the compounds and residential areas for easy accessibility. In a study done in Kenya on VCT services, only 11% of untested youth in Nairobi could name a service provider within their communities though more knew that testing (though not necessarily counselling) was available at a large hospital (UNAIDS, 2002).

Table 6 showed that 72% of respondents were willing to be counselled for HIV and 17% were not willing while 13% were not sure. Those who were willing gave the reasons that they would want to know more about HIV/AIDS and how they can help those that are infected with HIV. When asked on whether they would be willing to have an HIV test, only 57% were willing. Those who were willing gave the reasons that it is better for them to know their HIV status. Those who were not willing said, they felt they were not at risk. Very similar findings were encountered in a series of focus group discussions and in-depth interviews carried out among adolescents from three (3) provinces in Zambia by Baggalety et al (1998). In these studies young people of ages 12 to 21 who took part proposed several reasons for testing.

57% of boys and 53% girls said that they would like to have the opportunity of going for an HIV test, but the majority of them were not keen to have an HIV test at the present time, as they were worried that they would test positive.

In another study conducted in Uganda in Mpigi district, findings were that males (17 to 19 years) and females (14 to 16 years) showed greatest interest in HIV testing, although they expressed concerns about issues of confidentiality, cost and location of services (Bohmer et al, 1997).

Most of the respondents (88%) were in support of services being widely distributed in the community (Table 6), and they gave the reasons that people in the community needed more information about HIV/AIDS and they needed to know their HIV status in order to reduce the spread of HIV infection.

5.5 PRACTICE OF HIV VOLUNTARY COUNSELLING AND TESTING

The last section in the questionnaire (appendix 1) elicited data on participation of adolescents in HIV VCT. The section had four questions.

The study findings showed that only 10% of respondents had received counselling and had been tested for HIV. 23% had only received counselling, while 67% had never been counselled or tested for HIV (Figure 4). Most of the adolescents gave reasons that they were too young to be tested for HIV and that they felt they were not at risk because they did not involve themselves in sexual activities. In surveys done by the DHS from 1995 to 1998, it was found that 77% of adolescent females and 87% of boys aged 15-19 believed

themselves at low risk or no risk of contracting HIV and most of them gave explanation that they had only one partner, while others (about 25-37%) said they abstain from sex. The boys also said they are at low risk because they use condoms.

The reason of having one sexual partner, a practice that might reduce risk, does not negate the risk of getting AIDS. These adolescents may not be aware that their partners' sexual history may put them at risk or that their partners might have other partners.

In the study, some respondents gave the reasons that they were scared of testing HIV positive because they had past sexual experience. In the study done by Baggaley et al, 1998, the adolescents feared to be tested because they thought they would test HIV positive. A small number who had been tested thought it was better to know even if the results were positive.

Most of the adolescents gave another reason for not being tested, that they would do it later when they grow up and are ready to marry.

5.6 KNOWLEDGE, PERCEPTION AND PRACTICE

From table 13, the results revealed that 57% of respondents with medium knowledge had poor practice while 68% with poor practice had high levels of knowledge. The same table showed that out of the 10% who had very good practice, 83% of these had high levels of knowledge. However, from these results, we can say that despite the high level of knowledge, adolescents still

do not go for voluntary counselling and testing. This could probably be due to reasons of young people's perception of low risk, their concerns about lack of confidentiality and unresolved, issues about parental consent. In many settings including Zambia, issues such as age of consent for VCT for young people and parental involvement in decisions to test hinder many adolescents from testing. The allowed age at which an adolescent can go for testing without parent consent is 18 years (UNAIDS, 2001).

Table 14 showed that 81% of respondents with a negative perception had poor practice. They had never been tested nor counselled for HIV. From table 12, the results showed that 71 % of the respondents with medium knowledge had a negative perception while still 51% of those with high knowledge had a negative perception. Despite the high knowledge on HIV and VCT, the perception of respondents remained low and this could have been due to the reasons like fear of testing positive, lack of trust in the VCT services being offered in terms of confidentiality. In a study done by Baggley et al (1997) '*to explore the knowledge and attitudes to HIV among university students in the United Kingdom and Zambia*'; 7% of United Kingdom students and 10% of Zambian students had had an HIV test. A further 35% of Zambian and 15% of UK students said they would like to be tested. The rest had never had a test and were not willing to have it done. From the study we can say that adolescents who do not participate in testing have a negative perception.

In view of this, the hypothesis which states that "the higher the knowledge of adolescents on HIV voluntary counselling and testing, the more positive their

perception towards VCT” has been rejected because despite the high level of knowledge among adolescents on HIV/AIDS and VCT their perception is negative.

5.7 IMPLICATIONS TO THE HEALTH CARE SYSTEM

The health care system has a leading role in the dissemination of information on HIV and VCT and in prevention of HIV. With the increase in HIV infections in the country, the health care system has continued to experience strain on its services and resources.. This is because people with AIDS are always presenting with various illnesses and ailments and require medical services.

Youths are more vulnerable to getting infected with HIV because they are sexually active. This makes the youth to be an important group to consider in the prevention of HIV and AIDS.

The study results revealed that most of the adolescents had high knowledge of HIV and VCT, and the most common source of information noted was the radio and TV. Information from the health workers as a source was low. This means that health workers have not done much in dissemination of information on VCT and the implications for the health care system are that there is need to improve the health education system on HIV VCT. This can be done by health workers through visiting the schools and giving health education to the pupils.

The study also revealed that there was a negative perception towards HIV VCT amongst the respondents. Most of them gave reasons that they are not at risk of getting infected because they are young. Unless measures are taken to sensitise the youths about the advantages of going for VCT, they will continue to be an increase in HIV infections amongst them. The health workers should continue to disseminate information on the importance of taking VCT. Youths need to understand that HIV infection can occur even in the young ones and they need to understand that as long as they are sexually active, they are at risk of being infected with HIV.

Other respondents gave the reason that the VCT centres are very far from where they live and most of the time they are in school. The Ministry of Health should consider taking the services closer to the youths and they should work hand in hand with the Ministry of Education.

It was discovered that despite the fact that majority of the respondents (88%) had high knowledge on HIV and VCT and 47% had a positive perception towards HIV VCT, only 10% of respondents had undergone VCT. This was mainly due to fear of testing HIV positive and many youths said they were not ready to go for VCT. This implies that the information given may not have had an impact on the adolescents and they do not think it necessary to go for VCT. In view of this, there is need for the health care system to reinforce positive behaviour continuously by explaining the advantages of VCT; this will also remove fears that these adolescents have. If the adolescents do not know their HIV status, they will continue to engage in risky behaviour and

will end up being infected with HIV. This will cause more strain on the already inadequate resources in terms of drugs, money, manpower and space in the hospitals.

It was also discovered in the study that some youths had a negative perception because at the VCT centres they are not taken seriously and that once they are seen going for VCT, people might think they are promiscuous. This entails that the health care system should improve the provision of adolescent reproductive health services to ensure that all such concerns are taken care of. Most of the services on VCT offered are not convenient and ideal for the youths because they are not youth friendly. The Ministry of Health in conjunction with other departments of the Ministry of education, Ministry of Youth and Sport, Community Based Organizations (CBOs) and Non Governmental Organizations (NGOs) should organize programmes to address adolescent reproductive health such as youth friendly services where confidential counselling will be done and where adolescents can open up.

CHAPTER 6

6.0 CONCLUSION AND RECOMMENDATIONS

6.1 CONCLUSION

The study was carried out in order to determine the adolescent perception of HIV VCT with the aim of coming up with recommendations that will encourage the adolescents to go for VCT. VCT is an entry point for HIV prevention and care because it facilitates behavioural change, it normalises HIV/AIDS, it will provide an opportunity for referral to social and peer support and it also leads to acceptance of sero-status and coping.

The study results have yielded a lot of valuable information and it is hoped that the information will be utilised by relevant authorities to improve the accessibility of VCT services and adolescent perception towards VCT.

The most significant findings were that despite being knowledgeable about HIV/ VCT, the adolescents had a negative perception towards HIV/VCT and only a few of them had actually participated in VCT. Some of the reasons for the negative perception and poor practice were that most of them thought they were not at risk because they are young while others said they were not ready or that they were scared.

It is therefore noteworthy to mention that the main objective of the study has been achieved in that the perception of adolescents towards VCT has been established.

6.2. RECOMMENDATIONS

- ❖ The Ministry of Health should embark on an intensive health education programme to sensitise the adolescents on the advantages of VCT, so that many youths can go for VCT.
- ❖ The Ministry of Health should work hand in hand with the Ministry of Education in providing VCT services close to the adolescents in the schools, so that even those that are in communities where there are no services can benefit in schools.
- ❖ The Ministry of Education should get involved in the health education on VCT and VCT to be integrated in the School Health Programme.
- ❖ The health centres and VCT centres should provide outreach sessions to the schools to give health education on VCT and do VCT to those that may be willing.
- ❖ Counsellors in the VCT centres should make the services user friendly.
- ❖ The time for the services in the centres should be rescheduled to the convenience of adolescents.
- ❖ The community, family and peers should work hand in hand in influencing adolescents' behaviour and attitude towards HIV/AIDS and VCT. The Churches should be active and encouraged to participate in these services.

6.3. DISSEMINATION OF FINDINGS

For dissemination of findings, four (4) reports will be printed. One copy will go the Post basic Nursing Department, one to the Medical Library for

reference, one to the sponsors, that is, the Ministry of Health and the other copy for the investigator.

Executive summaries will be sent to counselling centres and recommendations will be given for implementation. When resources are available, the results will be published and presentations will be done on research days.

6.4. LIMITATIONS OF THE STUDY

1. Due to a small sample size, the results could not be generalised to all the adolescents in Zambia.
2. The study could not be done on a larger scale due to limited time and financial resources.

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UNIVERSITY OF ZAMBIA

SCHOOL OF MEDICINE

SELF ADMINISTERED QUESTIONNAIRE TO ADOLESCENTS

TOPIC: DETERMINING ADOLESCENTS' PERCEPTION OF HIV
VOLUNTARY COUNSELLING AND TESTING

QUESTIONNAIRE NUMBER.....

INSTRUCTIONS TO RESPONDENT

1. Do not write your name on the questionnaire.
2. Tick in the box next to your answer, write in the space provided
3. Do not omit any questions.
4. Answer all questions accurately

SECTION A: DEMOGRAPHIC DATA

1. How old were you on your last birthday? _____

2. What is your sex?

1). Male

2). Female

--

3. What is your marital status?

1). Single

2). Married

3). Cohabiting

4). Separated

5). Divorced

6). Widowed

--

4. What is your highest level of education?

1). Grade 8

2). Grade 9

3). Grade 10

4). Grade 11

5). Grade 12

--

SECTION B: KNOWLEDGE

5. Have you ever heard of HIV/AIDS?

1). Yes

2). No

--

6. If your answer is yes, where did you hear it?

- 1). Radio/television
- 2). Friends
- 3). Books/pamphlets
- 4). Health workers
- 5). Parents
- 6). Teachers
- 7). Others Specify_____

--

7. What causes Human immunodeficiency virus (HIV) Infection?

- 1). Mosquitoes
- 2). HIV virus
- 3). Witchcraft
- 4). I do not know

--

8). How is HIV infection transmitted? (Tick all correct answers)

- 1). Through sexual intercourse
- 2). Sharing cups and spoons
- 3). Blood transfusion with unscreened blood
- 4). Mosquito bite
- 5). Contaminated razor blades and needles
- 6). Mother to baby through breast milk
- 7). I do not know

--

9. How can HIV infection be prevented? (Tick all correct answers)

- 1). Abstain from sex
- 2). Use a condom.
- 3). Hygiene
- 4). I do not know

--

10. Have you ever heard of HIV voluntary counselling and testing?

- 1). Yes
- 2). No

--

11. Where did you hear it from?

- 1). Radio/television
- 2). Friends
- 3). Books/pamphlets
- 4). Health workers
- 5). Parents
- 6). Teachers
- 7). Others (Specify)_____

--

12. What is HIV voluntary counselling and testing?

- 1). Going to the clinic
- 2). Willing receiving information on HIV/AIDS and being tested for HIV
- 3). Knowing about HIV
- 4). I do not know

--

13. Where would someone go to get HIV counselling and testing services? (Tick all correct answers).
- 1). Health centre (clinics) ☐
 - 2). Kara counselling centre ☐
 - 3). Hospital ☐
 - 4). New start centre ☐
 - 5). Society for Family health ☐
 - 6). Others (Specify) _____

☐

14. Are there any advantages associated with taking voluntary counselling and testing of HIV?
- 1). Yes ☐
 - 2). No ☐
 - 3). I do not know ☐

☐

15. What are the advantages of taking voluntary counselling and testing? (Tick all correct answers)
- 1). One can make informed decisions about health ☐
 - 2). One will not willingly infect others ☐
 - 3). One may take up positive behaviours ☐
 - 4). Others (Specify) _____

☐

SECTION C: PERCEPTION

16. Have you ever talked to a health provider about voluntary counselling and testing?
- 1). Yes ☐
 - 2). No ☐

☐

17. Give reasons_____

18. Have you visited a voluntary counselling and testing centre before?

- 1). Yes
- 2). No

--

19. Give reasons for your answer_____

20. Would you be willing to be counselled for HIV?

- 1). Yes
- 2). No
- 3). Am not sure

--

21. Give reasons for your answer_____

22. Would you be willing to have an HIV test?

- 1). Yes
- 2). No
- 3). Am not sure

--

23. Give reasons for your answer_____

24. After the test would you be willing to be informed of the results?

- 1). Yes
- 2). No
- 3). I do not know

--

25. In your opinion, should HIV VCT services be widely available in your community?

- 1). Yes
- 2). No
- 3). I do not know

--

26. Give reasons _____

SECTION D: PRACTICE

27. Have you had any counselling on HIV/AIDS before?

- 1). Yes
- 2). No

--

28. If no, give reasons _____

29. If yes, where were you counselled?

- 1). Health centre
- 2). Hospital
- 3). New start centre
- 4). Family health
- 5). Kara counselling centre
- 6). Others (Specify) _____

--

30. Have you had any HIV test done on you?

1). Yes

2). No

--

31. If no, give reasons_____

32. If yes, where were you counselled?

1). Health centre

2). Hospital

3). New start

4). Family health

5). Others (Specify)_____

--

33. Give suggestion on how voluntary counselling and testing of HIV services can be improved in your community_____

THANK YOU FOR YOUR PARTICIPATION

The University of Zambia
School of Medicine
Department of post Basic Nursing
P.O. Box 50110
LUSAKA

4th September 2002

District Education Officer
Ministry of Education
P.O. Box 50093
LUSAKA



f.s. The Head
Department of Post Basic Nursing
Box 50110
LUSAKA

Dear Sir,

Re: PERMISSION FOR RESEARCH STUDY

I am a fourth year student at the University of Zambia, School of Medicine, Department of Post Basic Nursing. I am currently pursuing a Degree Course in Nursing.

In partial fulfilment of this program, I am requested to conduct a research study and my research topic is: **“Study to Determine Adolescents’ Perception of Voluntary Counselling and Testing of HIV at Libala and Kamwala Secondary Schools in Lusaka”**

I am requesting your good office to avail me with the information.

Your continue support is highly appreciated.

Thank you,

Marjory Kabinga
IV YEAR STUDENT

The University of Zambia
School of Medicine
Department of post Basic Nursing
P.O. Box 50110
LUSAKA

4th September 2002

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Thank you,

Marjory Kabinga
IV YEAR STUDENT



REPUBLIC OF ZAMBIA
MINISTRY OF EDUCATION

DEO/LU/102/5/7

DISTRICT EDUCATION OFFICER
P.O. BOX 50297
LUSAKA

10th September, 2002

The Headteacher,
Libala and Kamwala High Schools
LUSAKA

**RE: PERMISSION TO CONDUCT A RESEARCH STUDY: MISS. MAJORIE
KABINGA**

This serves to introduce to you Miss. Marjorie Kabinga a iv year student at University of Zambia School of Medicine, under the Department of post Basic Nursing.

Miss. Kabinga has my permission to visit your School and conduct a research study testing of HIV.

Please kindly welcome her and give her every support she may require for the success of this research project.

A handwritten signature in black ink.

S.N. Kaimika
Education Officer
For/DISTRICT EDUCATION OFFICER
LUSAKA URBAN

APPENDIX 4

BUDGET

ITEM	UNIT COST(ZMK)	QUANTITY	TOTAL
<u>STATIONERY</u>			
Bond paper A4	25,000*1 Rim	5	125,000
Spiral binders	1,500*1	10	15,000
Pens	15,000*1 box	1	15,000
Pencils	10,000*1 box	1	10,000
Stapler	15,000*1	1	15,000
Staples	5,000*1 box	1	5,000
Research bags	40,000*1	2	80,000
Tipp-ex	10,000*1 set	2	20,000
Rubbers	1,500*1	2	3,000
<u>SECRETARIAL</u>			
Typing proposal	3,000*1 page	30	90,000
Photocopying proposal	300*1 page	90	27,000
Binding proposal	5,000*1 copy	3	15,000
Typing questionnaire	3,000*1 page	6	18,000
Photocopying questionnaires	300*1 page	336	109,800
Typing report	3000*1 page	100	300,000
Photocopying research	300*1 page	300	90,000
Binding report	40,000*1 copy	4 copies	160,000
<u>PERSONNEL</u>			
Transport allowance	40,000*1 day	21	840,000
Lunch allowance	35,000*1 day	21 days	1,470,000
Sub total			3,407,800
Contingency 10%			340,780
Grand total			3,748,580

BUDGET JUSTIFICATION

The budget prepared was supposed to cater for all the costs of the research study.

Stationery

The bond paper was used for writing and printing the proposal, questionnaires and reports. The pens and pencils were used for writing the proposal and in data collection. Tipp-ex was used to make corrections in the proposal and report. Stapler and staples were used to staple and keep papers together. Research bags were used to carry questionnaires and keep them safe and confidentially.

Secretarial services

Money was required to type the proposal, photocopy it and bind all the copies. Three copies of the proposal were needed, one for the facilitator, one for the investigator and the other one for the sponsors. Money was also required for typing the questionnaire and photocopying sixty (60) questionnaires. Money was again required to type the report, photocopy three other reports and bind all the reports. One report was sent to the department of Post Basic Nursing, one report to the medical library, another to the sponsors and the other one for the researcher.

Personnel

Transport money was required for the researcher and the research assistant to move to and fro the research setting. The research team collected data for 14 days. Whilst in the field, money was needed for lunch since they were unable to go back home for lunch.

Contingency

The contingency money was required in cases of unforeseen costs and was also to cater for any inflation costs.

APPENDIX 5

Table 2

WORK SCHEDULE

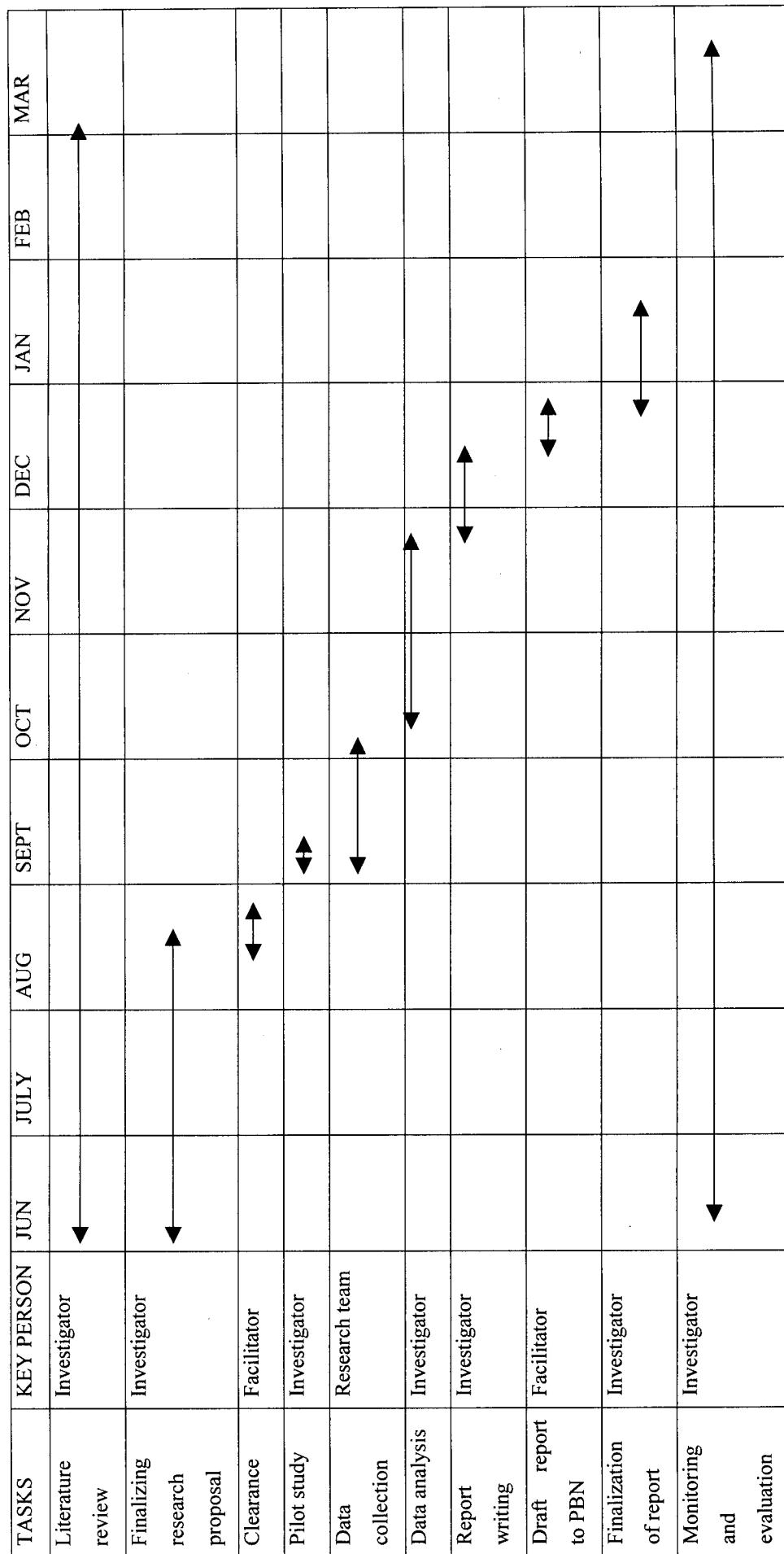
TASKS TO BE PERFORMED	DATES	PERSONNEL ASSIGNED TO TASKS	PERSON DAYS REQUIRED
Literature review	Continuous	Investigator	Continuous
Formulation of research proposal and data collection tool.	Week 1-10, June 3 rd –August 19 th	Investigator	70 days
Clearing from national and funding authority	Week 11-12, August 19 th –August 26 th	PBN Facilitator, Study setting.	7 days
Conducting Pilot Study	Week 13-14, Sept 02 nd – Sept 6 th	Investigator	5 days
Data collection	Week 15-18, Sept 09 th – Oct 7 th	Investigator (1) Research assistant (1)	56 days
Data analysis	Week 19-26, Oct 7 th –Nov 25 th	Investigator (1)	49 days
Report writing	Week 26-29 Nov 25 th – Dec 16 th	Investigator	21 days
Draft report to PBN	Week 30 Dec 16 th –Dec 23 rd	Facilitator	7 days
Finalization of report	Week 31 Dec 24 th –Jan 20 th	Investigator	26 days
Monitoring and Evaluation	Continuous	Investigator	Continuous

Table 3 -GANTT CHART

[illegible]

APPENDIX 6

Table 3 -GANTT CHART



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