THE UNIVERSITY OF ZAMBIA

SCHOOL OF MEDICINE

DEPARTMENT OF POST BASIC NURSING

A STUDY TO DETERMINE THE CHALLENGES FACED BY HIV POSITIVE PERSONS IN DISCLOSING THEIR HIV STATUS TO THEIR PARTNERS

BY

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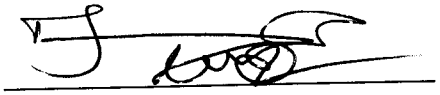
LIST OF ABBREVIATION

AIDS	-	Acquired Immune Deficiency Syndrome
CBoH	-	Central Board of Health
CSO	-	Central Statistics Office
HIV	-	Human Immune Deficiency Virus
LDHMB	-	Lusaka District Health Management Board
LDHMT	-	Lusaka District Health Management Team
MOFNP	-	Ministry of Finance and National Planning
MoH	-	Ministry of Health
NGO	-	Non Governmental Organization
NZP+	-	Network of Zambian People living with HIV/AIDS
SAP	-	Structural Adjustment Programme
STIs	-	Sexually Transmitted Infections
TB	-	Tuberculosis
UNAIDS	-	United Nations Programme on HIV/AIDS
UTH	-	University Teaching Hospital
VCT	-	Voluntary Counselling and Testing
WHO	-	World Health Organization
ZDHS	-	Zambia Demographic and Health Survey
ZIHP	-	Zambia Integrated Health Programme

DECLARATION

I hereby declare that the work presented in this study for the degree of Bachelor of Science in Nursing has not been presented either wholly or partially for any other degree and is not being currently submitted for any degree at the University of Zambia.

Signed:  Date: 07.05.04

(Candidate)

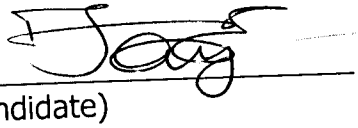
Signed:  Date: 07/05/04

(Supervisor)

STATEMENT

I hereby certify that this study is entirely the result of my own independent investigations and efforts.

The various persons and sources to which I am highly indebted have been clearly acknowledged in the text and the references.

Signed: 
(Candidate)

DEDICATION

I dedicate this study to my dearest wife, Jane Mulenga Kapembwa and my son Joseph K. Jr. for their patience and support when they needed my love and care that I owe them.

I also dedicate this study to all the brothers and sisters of mine, my mother and late dad, who died while I was at school pursuing the same degree.

ABSTRACT

The aim of the study was "To determine the challenges faced HIV positive persons in disclosing their status to their partners.

The study was conducted in Lusaka which is the capital city of Zambia. Fifty respondents of HIV positive persons (male and female) aged 15 to 49 years which is a reproductive age group were sampled.

Literature was reviewed which included global, regional and national. Most of the literature revealed showed that HIV/AIDS infection is on the increase especially in reproductive age 15 to 49 years. The HIV AIDS crises is of public concern and needs serious action. Literature review further showed that despite knowing that one is HIV positive, such persons do not inform their partners neither do they use condoms to protect their partners.

The study sought to identify and assess the HIV positive persons perception on partner notification in order to explore the impact of partner notification in the presence of socio-cultural factors and then make recommendations to relevant authorities and policy makers on how to minimise the challenges of disclosure. And also to make recommendations for further research. A non-experimental descriptive research design was used. The study comprise of 50 respondents for the actual study and five respondents for the pilot study. The pilot study was conducted to test the suitability of the methodology. The data was analysed manually with the aid of the calculator and the findings were presented in form of graphs and tables.

The study revealed that majority that is 56% of the respondents informed their partners of their HIV positivity while 14% did not. Thirty percent of the respondents were those who were not in any sexual relationship at that moment. The study findings showed that majority (40%) of the respondents were faced with challenges of fear to loose their status to their partners. (2%) of the respondents said that they lacked knowledge on how to break the news to their partners while 28% said that they faced none of the challenges since they underwent couple voluntary counselling and testing (VCT).

Majority of the respondents (60%) suggested that couple voluntary counselling and testing services could greatly minimise the fear of disclosing ones status to his or her partner, 10% said increasing community sensitization while 6% suggested giving social support. Two percent said that Government should enact laws aimed at punishing those wilfully infect others.

Only 8% of the respondents gave the answer (I do not how to minimise the challenges of disclosure).

The major recommendations include the following: the study should be done on a large scale to determine the challenges faced by HIV positive persons in disclosing their HIV status to their partners. Couple voluntary counselling and testing services should be intensified to easy disclosure and information, education and communication by healthy workers should be complimented by religious leaders and the community in order to fight stigma impedes disclosure. Women should also be empowered to enable them make decisions which are beneficial to them.

CHAPTER ONE

1.0 INTRODUCTION

1.1 BACKGROUND INFORMATION

Zambia is a land-locked country covering an area of 752,612 square kilometers (about 2.5 percent of Africa). It shares borders with the Democratic Republic of Congo (DRC) and Tanzania in the North, Malawi and Mozambique in the East Zimbabwe and Botswana in the South, Namibia in the South-west and Angola in the west. Administratively the country is divided into 9 provinces and 72 districts. Of the nine provinces, two are predominantly urban, namely Lusaka and Copperbelt provinces. The remaining provinces – Central, Eastern, Northern, Luapula, North-western, Western and Southern are predominantly rural provinces. Four (4) of ten (10) Zambians live in urban areas (ZDHS 2003).

Zambia has a mixed economy consisting of a modern urban sector that follows a line of rail and rural agricultural sector. The 1980s marked the start of the first phase of implementing Structural Adjustment Programme (SAP) which has failed to substantially alter the economy and increased the poverty of the majority of Zambians. Currently, around 73 percent of Zambians are classified as poor. Poverty is more prevalent in rural areas than in urban areas (83 percent and 55 percent respectively). Poverty in the Zambian context can be defined as lack of access to income, employment opportunities, entitlements for citizens to such things as freely determined consumption of foods and services, shelter and other basic needs of life (MOFNP, 2003).

The 2000 National Census reported the total population of 10.3 million with a growth rate of 2.9 percent per annum in 2000. The life expectance at birth for males is 47.5 and 51.7 for females (CSO, 2003).

Lusaka is the capital city of Zambia and has a population of 2 million people. It has a mixture of different cultures from the different ethnic groupings (http://www.cdc.gor/nchstp/od/gap/countries/zambia.htm, 2003).

Globally, the HIV/AIDS epidemic has become a serious health and developmental problem in many countries around the world. The AIDS epidemic claimed more than three (3) million lives in 2002 and an estimated 5 million people acquired the HIV infection in 2002 bringing to 42 million the number of the people globally living with the (HIV) virus (UNAIDS/WHO, 2002). A summary report by UNAIDS/WHO (2002) is as follows:

- Number of people living with HIV/AIDS being totaled at 42 million and this is further broken down as follows:
    - Adults 38.6 million
    - Women 19.2 million
    - Children under 15 years 3.2 million.
- People newly infected with HIV in 2002.
    - Total 5 million
    - Adults 4.5 million
    - Women 2 million
    - Children under 15 years 800,000
- AIDS deaths in 2002
    - Total 3.1 million
    - Adults 2.5 million
    - Women 1.2 million
    - Children under 15 years 610,000

By far the worst affected region, the sub-Saharan Africa is now home to the 29.4 million people living with HIV/AIDS. Approximately 3.5 million new infections occurred in 2002, while the epidemic claimed the lives of an estimated

2.4 million Africans in 2001. Ten million young people (aged 15 – 24 years) and almost 3 million children under 15 are living with HIV (UNAIDS/WHO, 2002).

Zambia is one of the nine African countries hardest hit by the HIV epidemic with one in five adults infected with HIV (UNAIDS, 2002). The HIV/AIDS pandemic has influenced the Demographic situation of Zambia as follows:

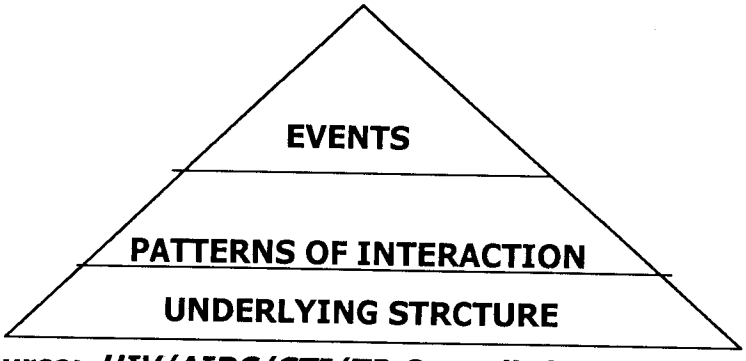
- Reduced fertility – slower rate of population growth (estimated to fall to 17% in 2010 from 23% in 2000).
- Altered aged structure, percentage of people in economically active age group decreases (potentially reducing work force by 17 million by 2010).
- Working age cohort is estimated to be 26%. Smaller by the end of the decade compared to 'no' AIDS scenario (National HIV/AIDS/STI/TB Council, 2002).

TABLE 1: HIV PREVALENCE AGES 15 TO 49 BY PROVINCE: 2001 - 2002

PROVINCE	PERCENTAGE
Lusaka	25.0
Northern	10.0
North-western	8.8
Southern	20.2
Eastern	16.1
Luapula	13.3
Central	16.8
Copper belt	22.1
Western	16.9

Source: ZDHS (2003)

The National HIV/AIDS/STI/TB Council illustrates "understanding the prevention of HIV" by the following structure:



Source: HIV/AIDS/STI/TB Council, (2002)

The structure above is of importance to the topic under study because it deals with patterns of interaction, which involves the challenges faced by HIV positive persons in disclosing their status to their partners. The study did cater for respondents aged between 15 – 49 years who know their HIV sero positivity.

TABLE 2: HIV PREVALENCE RATES AMONG WOMEN 15-49 AND MEN 15-59 IN ZAMBIA 2001-2002

AGE RANGE IN YEARS	SEX PERCENT	
	MALE	FEMALE
15 – 19	2.4	6.6
20 – 24	4.4	16.3
25 – 29	15.0	25.1
30 – 34	20.5	29.4
35 – 39	22.4	22.6
40 – 44	20.5	17.3
45 – 49	20.2	13.6
50 – 54	7.3	N/A
55 – 59	11.7	N/A
TOTAL 15 – 49	12.9	17.8
TOTAL 15 – 59	12.6	N/A

SOURCE: ZDHS (2003)

Overall, the proportion HIV positive rises with age from 5 percent among those 15-19 to 25 percent in 30-34 age group, before falling to 17 percent among those 45-49. Among women the proportion found to be HIV positive rises abruptly with age from 7 percent among the 15-19 Cohort to 29 percent in the 30-34 age group and then drops off to 14 percent in the 45-49 Cohort. Among men, HIV prevalence is below 5 percent among those under age 25, rises to 15 percent in the 35-39 age group and stays around 20 percent in the 40-49 age group. HIV prevalence is higher in the 55-59 Cohort (12 percent) than in the 50-54 Cohort (7 percent) (ZDHS, 2003).

1.2 STATEMENT OF THE PROBLEM

According to MoH/CBoH, 1999 report, the HIV/AIDS epidemic is a major challenge both to public health and socio-economic development of the country. It is threatening to arrest, or even reverse, some of the important hard-known

gains in various sectors such as health, education, agriculture and human resource development. The physical, psychological and emotional devastation consequence upon the HIV/AIDS epidemic has brought great suffering not only to the people of Zambia but also other people throughout the world.

A significant number of Zambian adults do engage in what are, from the perspective of HIV transmission, risky sexual relationships in that they do not use condoms to protect themselves. Luo, N. (1999) notes that a significant number of Zambian adults do engage in risky sexual relationships and this has caused an increase in the new cases of HIV infections. As a result, most new HIV infections are due to heterosexual contact. Programmes designed to show the spread of HIV will need to focus on reducing transmission through unprotected sexual contact (MoH/CBoH, 1999).

The interaction between males and females in sexual relationship, for instance the male dominance over females cuts across the Zambian society. This gender bias is seen to be perpetuated by cultural beliefs and socio-economic factors which put females on the disadvantage. It is almost un heard of for a female to have dominance over a male in our cultural setting. The imbalance in the interaction has an effect on how the partners who are HIV positive handle the challenge of disclosing their status to their partners, especially for women.

The Zambia Demographic and Health Survey, (2003) notes that in the intervention for HIV/AIDS counselling and testing, there is need to support and advocate for people living with AIDS. There is also need to introduce non discriminatory practices and laws to protect those who test positive.
Dzekedzeke, K. and Mulenga, C. in ZDHS (2003) study reported that 22% of women and 32% of men with an STI or associated symptoms did not inform their partners and one (1) in three (3) women and men with an STI took no protective measure to protect their partners.

MoH/CBoH, (1999) stated that voluntary counselling and testing needs to be available for couples where one or both of the partners are infected to help them understand the HIV test and choices facing them. Voluntary counselling and testing must be made available and encouraged for those about to marry.

UNAIDS, (2002) reports that although there are important benefits to knowing one's HIV status, HIV is, in many communities a stigmatizing condition and the stigma may actively prevent people from accessing health care, gaining support and preventing onward transmission of HIV.

National HIV/AIDS/STI/TB Council (2001) outlines the responses of the government to reduce transmission of HIV through information, education and communication, promotion and distribution of condoms, enhancement of life skills, work place prevention, STI treatment, blood screening, strengthening health services and counselling and testing of individuals as primary measures. The government also embarked on reducing the socio-economic impact of HIV/AIDS through special support such as support for orphans.

There are many challenges faced by persons who are HIV positive and these challenges can be minimized by community involvement. This is especially important because HIV/AIDS is an important global problem. The people living with HIV/AIDS are stigmatized because of the following:

- HIV/AIDS is life threatening and people are scared of getting it.
- Lack of information about the virus and how it is transmitted.
- HIV is often incorrectly linked with behaviors that are considered shameful.
- There is no cure for HIV (UNAIDS and ZIHP, 2000)

The HIV sero positive persons are partners in the prevention of HIV/AIDS transmission. Therefore knowledge on the challenges faced by HIV positive

persons in disclosing their status to their partners is vital. The challenges could be influenced by the following factors:

Lack of information

Lack of information on HIV in order to meet the challenges in positive terms such as partner notification. HIV positive persons must have access to information such as confidential anonymous HIV testing services. Van Praag, E. (2001) said that people who learn that they are infected will become aware of the urgent need to adopt safe sexual behaviors to avoid infecting others.

Cultural/Christian beliefs

Culture has an influence on how HIV positive persons face the challenges of disclosing their status to their partners. Helmann, C. (1984) noted that culture guides an individual as a member of a particular society on how to view the world and how to behave in it in relation to other people, to supernatural forces and to natural environment. Therefore culture can influence the HIV positive persons in facing the challenges of disclosing their status to their partners. Beliefs such as the Christian belief of one sexual partner may compel one not to disclose his/her status for fear of being labeled "unfaithful."

Age

Waszak, C. in Network Family Health International vol. 21 (2001), noted that youths are very sensitive to the idea that the information they share about their sexual behavior will not be held in confidence, but instead will be shared with their parents and other adults with severe consequences to follow. This special group may need a lot of assurance on confidentiality and counselling. The rights of adolescents just like for adults should be respected.

Level of Education

Those who are able to read and write are better placed because they can access the written, audio and visual materials on HIV/AIDS. This helps them in making decisions than their illiterate counterparts in facing challenges of HIV/AIDS – status disclosure. Illiteracy levels are higher among women than males.

Sex

MoH/CBoH, (1999) noted that although women constitute about half of Zambia's population, they are disproportionately affected by the HIV/AIDS epidemic. National HIV/AIDS/STI/TB Council (2002) also reported that the percentage of HIV positive persons between 15 – 49 years by sex are 18% for females and 13% for males. This shows how women are more affected than males. ZDHS (2003) notes that there's a clear indication of the critical level of the epidemic among women than men. For, example 26.3% of urban women between the age of 15-49 years are HIV positive compared to 19.2% for men of the same age and residence. Generally women lack complete control over their lives and are taught from early childhood to be obedient and submissive to males, particularly father, uncle, husband, elder brother or guardian. In sexual relationships, a woman is expected and is taught to please her male partner even at the expense of her pleasure or well being. The dominance of male interests and lack of self assertiveness of women puts them at risk of HIV and it also influences how they face the challenges of disclosing their HIV positive status. Women are taught to never refuse having sex with their husbands regardless of the number of partners he may have or if he is suspected of having HIV. This inequality in gender reflects the impact on the challenges of disclosing the HIV status between partners, depending on who learns first of his/her HIV positivity.

Economic factors

UNAIDS/WHO, (2002) in the global summary of the HIV/AIDS epidemic noted that women and girls are commonly discriminated against in terms of access to

education, employment, health care and inheritance. The downward trend of many African economies has increased the poverty levels. This has affected women mostly. As a result these women resort to marriage or even sexual work as a means to earn a living. The combination of dependence and subordination of women can make it difficult for girls and women to demand for safer sex or to end relationships that seem to carry a threat of infection.

Health care system

Network Family Health International, (2001 Vol. 2) states that many clients who are HIV positive or have other STIs do not know that they are infected. In many settings testing is unavailable. Others may be reluctant to be tested for fear of receiving a positive test result. They also fear that the positive result will not remain confidential, leading to severe social consequences. Clients who fear to be tested may be over whelmed by the positive test results.

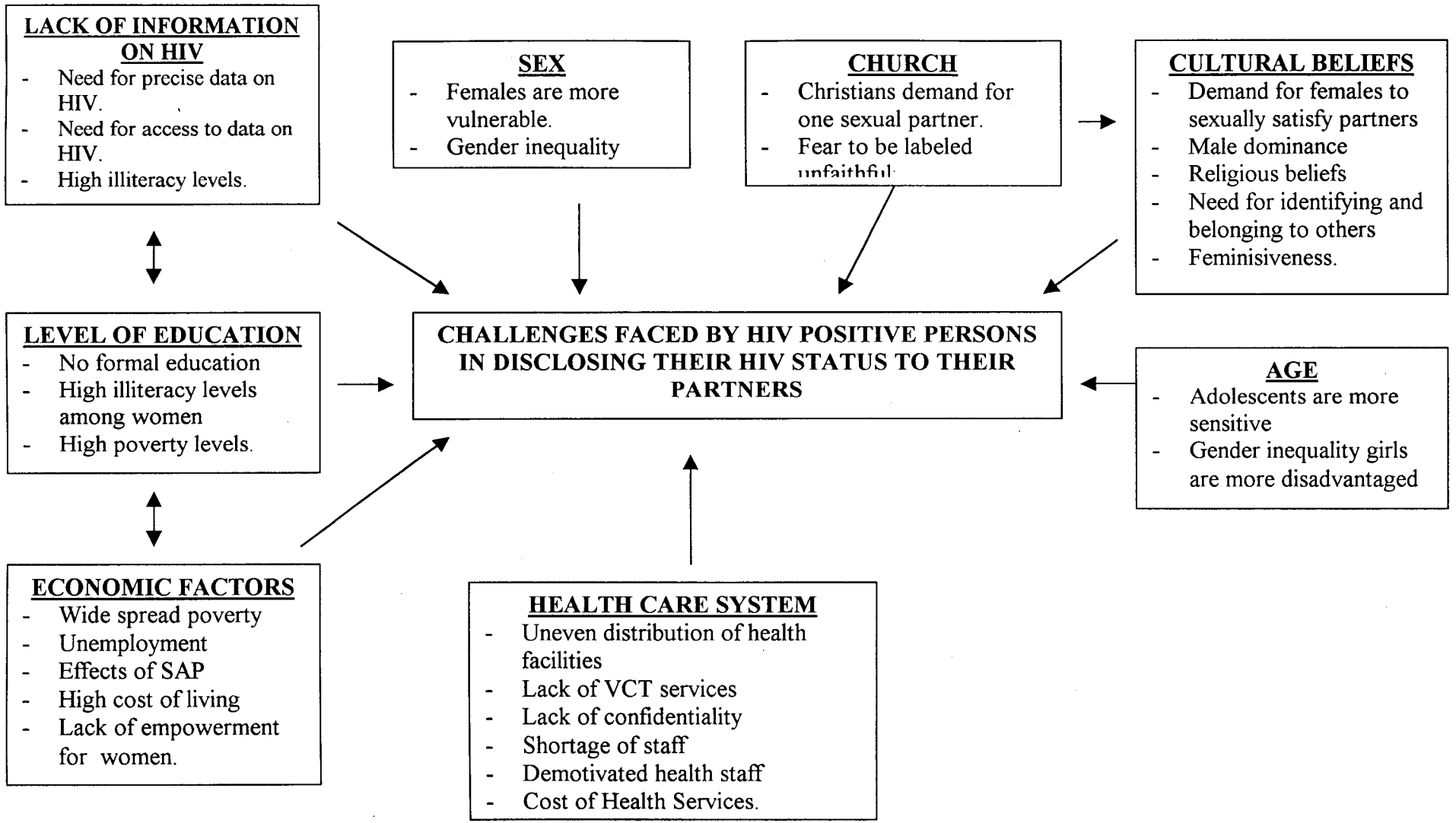
An unequal distribution of health facilities in Zambia has an impact on how HIV positive persons handle the challenges of disclosing the HIV status to their partners.

The Church

The church has an influence on how the HIV positive persons face the challenges of disclosure. For instance, the church demands for one sexual partner and disclosing one's HIV positive status will mean that he/she was an unfaithful to the partner and could lead to stigmatization. The church has also been silent for a long time on issues of HIV/AIDS. This makes it difficult for partners to discuss issues pertaining to HIV/AIDS which is mainly seem to be a result of being promiscuous. If any of the partners test HIV positive, partner notification is faced with a challenge of unfaithfulness.

There are many challenges which are faced by HIV positive persons in disclosing their status to their partners. These must be identified and minimized so that partner notification is promoted. This is important because at the centre of HIV/AIDS are people who face the challenges of disclosing their HIV positivity to their partners.

FIGURE 1: DIAGRAM OF PROBLEM ANALYSIS



1.3 JUSTIFICATION

The study aimed to determine the challenges faced by HIV sero-positive persons in disclosing their status to their partners. In the fight against the spread of HIV/AIDS, partner notification is one of the approaches. It is therefore important to look at the challenges that these persons face in disclosing their status to their partners. The need to undertake the study is based on the following reasons:

Partner notification is encouraged hence the need of taking into consideration the challenges of informing one's partner about HIV sero-positivity. This will facilitate for partner notification when challenges are identified and dealt with.

No research has been undertaken on the challenges of partner notification in Zambia. Therefore undertaking a study on this topic will be beneficial to the counsellors and counsellees on HIV/AIDS.

Most persons who are diagnosed HIV sero-positive do not inform their partners and there is need to know the difficulties they face in doing so. This is vital because the HIV positive person knows about the effect of not informing the partner. It is only after knowing the challenges that solutions to overcome them can be found.

Women are culturally discriminated against and there is need to know the challenges that they face in disclosing their HIV status to their partners. The knowledge gained after this study will be used to advocate for women's empowerment. This will enable women to make choices that are beneficial to their lives

Men may have multiple partners and hence the need to know the challenges they face in disclosing their status.

The researcher will disseminate findings and make recommendations which could be used during the provision of VCT services. This would concretize the VCT information provided to persons who come for the services.

1.4 HYPOTHESES

1.4.1 Persons who are HIV positive don't disclose their status to their partners for fear of being labeled as being unfaithful to their partners.

1.4.2 The HIV positive persons who live without notifying their partners suffer the psychological pain of not informing their partners about their status.

1.4.3 Non disclosure leads to spreading of infection to multiple partners.

1.5 STUDY OBJECTIVES

1.5.2 GENERAL OBJECTIVE

Determine the challenges faced by HIV positive persons in disclosing their status to their partners in order to promote partner notification.

1.5.3 SPECIFIC OBJECTIVES

1. To determine HIV/AIDS knowledge levels among HIV positive persons
2. To determine HIV positive person's practices with regards to HIV/AIDS prevention
3. Assess the HIV positive persons perception on partner notification.
4. Identify challenges faced by HIV positive persons in disclosing their status to their partners.
5. Make recommendations to relevant authorities and policy makers on how to minimize the challenges of disclosure.
6. Make recommendations for further research.
7. Explore the impact of partner notification in the presence of socio-cultural factors.

1.6 OPERATIONAL DEFINITIONS

Person – male or female who is 15-49 years and is sexually active.

Challenges – difficulties that males and females face in disclosing their HIV status to their partners.

HIV status – the state of being infected with HIV virus or not.

HIV positive persons – males or females who have undergone the HIV test and are diagnosed as being infected with the HIV virus.

Epidemic – out break of an infection that affects a large number of people.
Disclosing – the act of informing one's partner on the HIV positive test result.

Positive persons – males and females who are HIV positive.

1.7 VARIABLES AND CUT OF POINTS

VARIABLES	CUT OF POINTS	INDICATORS
Independent variables		
Cultural Beliefs	Strong	Respondents acknowledged that culturally they have no control over their partners' extra sexual relationships and that they must take up a submissive role.
	Weak	Respondents claim that their cultural beliefs have nothing in relation to disclosure of their HIV status.
Level of education	High Medium Low	Tertiary education Secondary Non or primary education
Socio-economic status	High	Able to have all the basic necessities of life and can afford to pay for medical care
	Medium	Have some of the basic necessities of life such as shelter but cannot afford to pay medical fees.
	Low	Unable to afford both basic necessities of life and medical fees.
Marital status	Monogamy	Respondents who are legally joined in a sexual relationship to one partner.
	Widow	Respondent who has lost the husband.
	Widower	Respondent who has lost the wife.
	Cohabiting polygamous	Sexual relationship which is not legal. Sexual relationship with multi sexual partners.
Disclosing HIV positivity to partners	Good	Respondents indicate the importance and their ability to willingly disclose their status to their partners

	Poor	The respondents indicate the inability to disclose their status to their partners due to various fears such as loss of marriage.

CHAPTER 2

2.0 LITERATURE REVIEW

Many studies have been carried out on HIV/AIDS and efforts on how to prevent the spread of HIV have been identified and initiated. One of the measures is that of partner notification in which the persons who test HIV positive are encouraged and counselled on the importance of informing their partners. Although many people know their HIV sero positivity, most of them do not inform their partners. One would wonder why they do not inform their partners and they do not use protective measures such as the use of condoms. The researcher noted that literature on the study topic is very inadequate and the researcher had problems in getting the literature.

MoH/CBoH (1999) states that, voluntary counselling and testing is one of the many interventions that can be adopted to influence the transmission mechanisms of HIV. This can slow the spread of AIDS because when partners know their HIV status they resort to use family planning methods such as condoms to avoid pregnancies and further HIV re-infection. MoH/CBoH further states that VCT needs to be available for couples where one or both partners are infected.

UNAIDS (2000) notes that, HIV voluntary counselling and testing has been shown to have a role in both HIV prevention and, for people with HIV infection as an entry point to care. VCT provides people with an opportunity to learn and accept their HIV sero status in a confidential environment with counselling and referral for ongoing emotional support and medical care. UNAIDS also notes that, knowledge of HIV sero status can also help people to make decisions to protect themselves and their sexual partners from

infection. VCT is a process by which an individual undergoes counselling enabling him/her to make an informed choice about being tested for HIV.

2.1 GLOBAL PERSPECTIVE

HIV prevalence is also rising rapidly in may parts of Eastern and Southern Asia. China and India have relatively low overall prevalence rates but the absolute numbers of infected persons are staggering 850,000 in China and nearly 4 million in India (UNAIDS, 2002). The challenge faced by HIV positive persons in disclosing their status is noted to be influenced by culture. In reporting on strengthening India's response to HIV/AIDS, Motihar, R. and Mahendra, V.S. in Sexual Health exchange (2003), noted that despite the rapid spread of HIV, the national response has been inadequate because the unfavourable political cultural context have impeded progress. HIV/AIDS has led to the threatening questioning of moral and cultural mores. Therefore, if discussing sex and HIV/AIDS is seen as taboo, it certainly has an influence on how partners notify their spouses and other sexual partners. The growing number of HIV infected women in India highlights the importance of specific programmes to empower women and challenging aged-old traditions regarding women's position in Indian society.

Similarly, more intensive AIDS education for the in and out of school youths is crucial. India's low school enrolment and high school-drop out rates leads to, out of school youths being more vulnerable to HIV/AIDS. This means that women are more affected than men and this plays a role in facing the challenge faced by HIV positive women in disclosing their status to their partners hence the need to empower women.

The epidemic is now spreading most rapidly in India and South East Asia because of denial and stigma. Here people find it to be a taboo to discuss sex and HIV despite their knowledge of the HIV crisis. This has resulted in an

increase of HIV/AIDS infections. Estimates reveal that India has 5 million people living with HIV/AIDS (UNAIDS, 2002).

The global HIV/AIDS pandemic shows no sign of slowing, despite concerned efforts to control it. In 2001, more people contracted HIV and more died of AIDS than in any previous year. 5 million people became infected with the virus, and 3 million died of AIDS, Piot, P. in sexual health exchange (2003).

UNAIDS (2000), revealed that men all over the world have more sexual partners and extra marital affairs than women. This behaviour puts men at high risk of contracting HIV which is compounded by the secrecy, stigma and shame surrounding the disease. UNAIDS further states that men who know that they are infected with an STI are often less likely to seek health care than women. The report further stated that women world wide usually found themselves at special risk of HIV infection because of their lack of power to determine where, when and how sex takes place.

Disclosure of one's HIV status is a process and not an event. It is a major decision that has consequences for the person living with HIV and those around him or her. Possible consequences include stigma and discrimination attached to HIV and AIDS. This means that disclosure can cause problems in your relationships. You may experience rejection or feel that your family or even friends are constantly judging you.

UNAIDS (2000) notes that, studies have demonstrated that VCT can prevent HIV transmission among couples. A recent multisided study conducted in Kenya, United Republic of Tanzania and Trinidad has provided data on the role of VCT in HIV prevention. This study demonstrated that VCT significantly reduced sexual risk behaviour, specifically, unprotected sex with non primary partners, with commercial sex workers and among couples who have been tested and counselled together. Further more .VCT did not increase

stigmatization or disintegration of relationships. The study also showed that VCT was cost effective in terms of the cost per HIV infection averted (UNAIDS, 2000).

2.2 REGIONAL PERSPECTIVE

Sub-Saharan Africa is the hardest hit region in the world where more people die from AIDS - related illnesses than any other cause. South Africa has the highest absolute number of infections than any country in the world: 5 million, Botswana has the highest adult HIV prevalence rate of 39% of the country's adults infected with HIV(UNAIDS, 2002).

In the early stages of the HIV epidemic, the highest prevalence rates were concentrated along the major transportation routes that cut across sub-Saharan Africa i.e. through Tanzania and Uganda, around Lake Victoria, Democratic Republic of Congo and into Coted'voire on the coast of Western Africa. Infected soldiers, truck drivers, migrant workers, affluent businessmen and commercial sex workers spread the disease to their families and communities.

By 2001, at least 5% of adults in nearly every Sub-Saharan country were infected with HIV. Prevalence rates have reached alarming levels in Southern Africa. For instance more than 20% of adults in Botswana, South Africa, Zambia and Zimbabwe were reported to be HIV positive in 2001. UNAIDS sees no evidence that rates have leveled off even in these high prevalence countries. (UNAIDS, 2002)

HIV prevalence rates have risen in most Eastern African countries also, but Uganda stands out as a success story to stem the epidemic. HIV in Kampala, Uganda's Capital, prevalence declined from a peak of nearly 30 percent in 1992 to 11% in 2000. An estimated 5 percent of Ugandan adults were HIV positive in 2001, down from an estimated 10 percent or more in the early 1990s (www.kit.nl/exchange, 2003).

Network Family Health International, (2001), volume (21) notes that in a study conducted in Kenya, Tanzania and Trinidad between 1995 and 1998, showed that HIV counselling and testing reduced risky behaviours associated with the sexual transmission of HIV infection. However, the study showed that clients were reluctant to disclose test results for fear of stigmatization and discrimination.

UNAIDS/WHO, (2001) notes that in the Sub-Saharan Africa alone there were an estimated 5,500 funerals per day as a result of HIV/AIDS.

TABLE 3: SUMMARY OF THE PREVALENCE OF HIV:

REGION	ADULT PREVALENCE RATE	ADULT & CHILDREN LIVING WITH HIV/AIDS
Australia and New Zealand	0.1	15,000
Eastern Europe and Central Asia	0.1	1,200,000
North Africa and Middle East	0.1	550,000
Caribbean	2.0	1,500,000
East Asia and Pacific	0.1	1,200,000
Western Europe	0.2	570,000
North America	0.6	980,000
Latin America	0.6	1,500,000
South and South East Asia	0.7	6,000,000
Sub-Saharan Africa	8.0	29,400,000
TOTAL		**42,000,000**

SOURCE: UNAIDS/WHO (2000)

Nyblade, L. et al, 2003 notes the following on stigma and HIV/AIDS in Ethiopia, Tanzania and Zambia:

The main causes of stigma relate to incomplete knowledge, fears of death and disease, sexual norms and lack of recognition of stigma. This leads to

avoidance of those with HIV. For example the knowledge that HIV can be transmitted sexually combined with an association of HIV to promiscuity, makes people with HIV to be stigmatized for their perceived immoral behaviour. Infact people often do not recognize that their words or actions are stigmatizing to those with HIV/AIDS. Socioeconomic status, age and gender all influence the experience of stigma. The poor are blamed less for their infection than the rich, yet they face greater stigma because they have fewer resources to hide on HIV positive status.

Youths are blamed in all three countries for spreading HIV through what is perceived as their high risky sexual behaviour. While both men and women are stigmatized for breaking sexual norms, gender-based power results in women being blamed more easily. At the same time, the consequences of HIV infections, disclosure, stigma and the burden of care are higher for women than for men. People living with HIV and AIDS face physical and social isolation from family, friends and community and they internalize these experiences and consequently feel guilty, ashamed and inferior.

People living with HIV/AIDS and their families develop various strategies to cope with stigma. Decisions around disclosure depends on whether or not disclosing would help to cope or make the situation worse through added stigma. Stigma impedes various programmatic efforts. Testing, disclosure, prevention and care and support for people living with HIV are advocated for, but are impeded by stigma. Testing and disclosure are recognized as difficult in relation to stigma.

The above findings by the international Centre for Research on Women (ICRW) in partnership with organizations in Ethiopia, Tanzania and Zambia from 2001 to 2003 unvelled the complexities around stigma as noted above. This shows how stigma impedes on disclosure of one's HIV status to his/her partner (Nyblade, L. et al, 2003).

2.3 NATIONAL PERSPECTIVE

Initially, the concentration of HIV/AIDS cases was in urban areas but soon affected all parts of the country. In 2000, CSO and MoH carried out a Zambia sexual behaviour survey (ZSBS) whose indicators covered knowledge, attitudes and sexual and health seeking behaviours. The findings were that some respondents among women said that HIV can be prevented by condom use, and by having one faithful partner. The study also noted that the ability of women to negotiate decisions about engaging or not to engage in sexual activity has important implications for HIV and whether women can protect themselves from infections (CSO, 2000).

The 2001-2002 Zambia Demographic and Health Survey (ZDHS 2003) noted the following:- 79% of women and 76% of men know someone personally who has HIV/AIDS or has died of AIDS, 78% of women and 86% of men know two or more effective ways of avoiding HIV infection. 72% women and 79% men mentioned the use of condoms as a specific way to avoid HIV infection while 82% of women and 86% of men mentioned limiting the number of sexual partners to one as a means of avoiding the HIV infection.

The survey further noted that 32% of men and 22% of women with an STI or associated symptoms did not inform their partner and one in three men and women with an STI took no action to protect their partner. Given such a situation it is necessary to look at the reasons as to why they do not inform their partners (ZDHS 2003).

The 2001-2002 ZDHS data on HIV testing found that of the individuals tested, 16 percent were HIV positive. HIV prevalence is more than twice as high in urban areas as in rural areas (23% and 11% respectively). The HIV testing in the ZDHS was anonymous and unlinked to other variables except for sex, age and geographical location of the respondent.

HIV/AIDS related programmes in Zambia are concentrated on prevention and on health care. Social Welfare interventions by the government or NGOs to systematically assist AIDS affected households in order to at least ensure their survival are non existent (Ministry of Community Development and social Welfare, March 2003).

According to UNAIDS (2000), nearly half of new HIV infections today are among young people aged between 10 and 25 years. Africare Zambia a non governmental organization has expressed concern at the impact HIV/AIDS has continued to have on adolescents in Southern Africa. Africare indicated that new infections have become a concern among young people. Africare attributes this to young peoples risk of having sexual encounters with the HIV positive partners as soon as they become sexually active (Zambia Information Service, 2000).

According to Mateyo, S.T. (2003), in a study to determine the knowledge and attitude and practice of commercial sex workers towards HIV/AIDS prevention in Kashikishi, poverty was singled out as the prominent factor influencing sex work and prostitution. Eighty two percent (82%) of the respondents in this study confessed that they would not encourage sex work for others who are not involved because it is a risky practice and 98% lamented that they would not continue with sex work if they tested HIV positive to prevent spreading the disease. Sex work has become the source of income for livelihood for some women. Given such a situation, it is different for a sex worker who knows her status to disclose for fear of losing the business.

In a study by Lungwebungu, R.M. (2001), it was revealed that the majority of the respondents (96%) exhibited poor practices towards the prevention of STIs. Most of the women said that they would not initiate condom use during sexual activity as they would be considered promiscuous. Some of the respondents still stated that they would not tell or inform their sexual partners if they were infected with a sexually transmitted infection for fear of losing

their sexual relationships. Some of the respondents said that they only use condoms for family planning.

Himwila, L.M. (2000), in a study to determine knowledge and practice of condom use for prevention of STIs and family planning in Siavonga noted that 12% of the study respondents said that condom use in marriage was a sign of admission to having extra marital sexual relations which could bring about problems in the home. Four (4%) of the respondents said that husbands did not want the practice and (12%) said that it was against religion.

2.4 CONCLUSION

The HIV/AIDS epidemic is a major problem in Zambia and needs everyone's involvement if the fight is to be meaningful. There are several players in the fight against the HIV/AIDS crisis such as UNAIDS, WHO, NGOs, like Africare but at the centre are people who are infected by HIV. Many programmes such as VCT and partner notification are encouraged. There is a great need therefore, to understand the challenges that these persons face in disclosing their status to their partners.

CHAPTER THREE

3.0 RESEARCH METHODOLOGY

3.1 INTRODUCTION

To address a research problem meaningfully, some method must be developed to measure the research variables as accurately as possible (Polit, F.D. and Hungler, B.P. 1997). It is only when a certain method is followed and adhered to that the expected findings of a study can be accurately arrived at, and when a given method is followed, it will be easier for other people to verify the research findings using the same method.

3.2 RESEARCH DESIGN

The research design is the overall plan on how to obtain answers to the questions being studied and how to handle some of the difficulties encountered during the research process (Polit, D.F. and Hungler, B.P. 1997). In this study a non experimental research design was used since the data was collected from the respondents from their natural environment.

The data from the respondents was collected and interpreted without manipulation. A descriptive survey was used to discover the new knowledge about the phenomena of interest. This is intended to explore and define the phenomena under study by collecting data directly from the study subjects by interview/questionnaire. The descriptive study design was chosen because it described the characteristics of the subjects and the challenges that they face in disclosing the HIV positive status to their partners.

3.3 RESEARCH SETTING

The study was carried out in Lusaka which is the Capital City of Zambia with the population of about 2 million. The respondents were picked through the Network of Zambian People Living with HIV/AIDS and VCT Centre at UTH. Lusaka is picked because the researcher lives here and it cuts on costs on

transport, accommodation and meals. Lusaka also has reflected 22% of HIV prevalence rate (ZDHS, 2003) which needs a lot of research to facilitate for research based interventions.

3.4 STUDY POPULATION

Study population is "the total group of individuals, people or things meeting the designed criteria of interest to the researcher" (Dempsey, P.A. and Dempsey, A.D. 2000). The population included married persons and those that are single but are in sexual relationships and belong to a sexual active age group from 15-49 years. This age group was targeted because it was the most affected group.

3.5 SAMPLE SELECTION

Sampling is "the process of selecting a portion of the population to represent the entire population"(Polit, D.F. and Hungler, B.P. 1997). For this study probability sampling was used to select the subjects using a simple random sampling so that the subjects to be selected were to be a more representative sample without biases. This also gave all the study respondents an equal chance of being selected and included in the sample. According to Polit, D.F. and Hungler, B.P., (1997), simple random sampling is the type of probability sampling where a sampling frame is created by numbering all members of the population of interest and then selecting a sample from the sampling frame through complete random procedures.

3.6 SAMPLE SIZE

A sample is "a sub-set of a population to represent the entire population" (Polit, D.F. and Hungler, B.P. 1997). The sample size was 50 HIV positive persons both males and females aged from 15-49 years which is a sexual active age.

3.7 DATA COLLECTION TOOL

Treece, E.W. and Treece, J.W. (1996) defines an instrument as "a tool or equipment used to collect data." For this study an interview schedule was used. The tool had a set of predetermined questions using the same wording and order. Open and closed ended questions were phrased. It also included demographic data, HIV positivity status and challenges.

3.8 RELIABILITY AND VALIDITY

Treece, E.W. and Treece, J.W. (1986), defines reliability as "the ability of the data gathering device to obtain consistent results." For this study an interview schedule was used to collect data on the challenges faced by HIV positive persons in disclosing their status to their partners. The use of an interview schedule did keep the interview focused.

Validity refers to "the degree to which an instrument measures what it is intended to measure" (Polit, D.F. and Hungler, B.P. 1997).

3.9 DATA COLLECTON TECHNIQUE

Polit, D.F. and Hungler, B.P. (1997) defines data collection as "the gathering of information needed to address a research problem." An interview schedule was used, this is where the investigator asked a number of predetermined questions based on an established questionnaire. The questionnaire was administered by the Researcher in form of an interview. The advantage is that it is suitable for both illiterate and literate persons, as questions can be clarified there and then if not clear and it yields a high response rate. Nevertheless, it is time consuming and expensive and it leads to high reactivity rate as respondents know that they are being watched. It may also be difficult to make arrangements with the study subjects. The research assistant was used to lead the researcher to the respondents.

3.10 PILOT STUDY

A Pilot Study is "a small preliminary investigation of the same general character as the major study" (Treece, E.W. and Treece, J.W. 1986). The pilot study was carried out in Lusaka on 10% of the study sample which was 5 respondents. These five respondents were not included during the major study. The pilot study gave the researcher the general overview of the likely responses to the actual study and also served as a means of testing the instrument. This would enable for necessary adjustment to be made to the interview schedule that was used in the major study. However, no adjustments were done to the tool.

3.11 ETHICAL AND CULTURAL CONSIDERATION

Polit, D.F. and Hungler, B.P. (1997), defines ethics as "a system of moral values that is concerned with the degree to which research procedures adhere to professional, legal and social obligations to the research subjects." It is important to consider the ethics in the research design to ensure the protection of human rights. The researcher got permission to carry out the study from all the relevant authorities i.e. he was cleared by the supervising lecturer at P.B.N. to go ahead with the study, to get verbal consent from the heads of the communities where the research study was conducted after explaining the purpose and benefit of the study to them as well as getting verbal consent from the study subjects. The nature and purpose of the study was explained to the respondents before the interviews and participants did take part voluntarily. The respondents were assured of privacy and that the information would be treated strictly confidential; names of respondents would not be written on the questionnaires and reporting was on aggregates.

CHAPTER FOUR

4.0 DATA ANALYSIS AND PRESENTATION OF FINDINGS

INTRODUCTION

The study sought to determine the challenges faced by HIV positive persons in disclosing their status to their partners. The results in this chapter were obtained from 50 respondents through the network of Zambian People Living with HIV/AIDS (NZP+).

4.1 DATA ANALYSIS

Raw data was collected using a questionnaire, edited for accuracy and completeness and was tallied on a data master sheet. Responses were categorized and coded and data was analysed manually with the aid of a calculator.

4.2 PRESENTATION OF FINDINGS

Findings of the study are presented in graphs and frequency tables. Cross tabulation of variables used in some of the tables in order to elicit relationships among certain variables.

DEMOGRAPHIC DATA

Table 4

variable	male	female	relative frequency
	Frequency	**Frequency**	
15 – 19 years	3	6	18
20 – 24 years	1	5	12
25 – 29 years	2	4	12
30 – 34 years	3	5	16
35 – 39 years	3	6	18
40 – 44 years	5	2	14
45 – 49 years	3	2	10
TOTAL	**20**	**30**	**100**

Majority of the respondents were from the age ranges of 15 – 19 and 35 – 39 which had 18% for each age range.

TABLE 5: RESPONDENTS' TRIBE

variable	male	female	relative frequency
	Frequency	**Frequency**	
Lozi	4	9	26
Luvale	2	3	10
Bemba	6	5	22
Nyanja	1	4	10
Tonga	3	4	14
Kaonde	2	2	8
Others	2	3	10
TOTAL	**20**	**30**	**100**

Majority of the respondents (26%) were Lozi while only 8% were Kaonde.

TABLE 6: RESPONDENTS DENOMINATION

variable	male	female	relative frequency
	Frequency	Frequency	
Catholic	10	9	38
SDA	4	5	18
UCZ	1	8	18
RCZ	1	3	8
Other	4	5	18
TOTAL	**20**	**30**	**100**

Most of the respondents (38%) were Catholics. Only 8% were Reformed Church in Zambia (RCZ).

TABLE 7: RESPONDENTS' RESIDENCE

variable	male	female	relative frequency
	Frequency	Frequency	
Low	3	6	18
Medium	3	3	12
High	14	21	70
TOTAL	**20**	**30**	**100**

Majority of the respondents (70%) were from high density area while the least number (12%) was from medium density area.

TABLE 8: RESPONDENTS EDUCATIONAL LEVEL

variable	male	female	relative frequency
	Frequency	Frequency	
No education	*4*	*5*	*18*
Primary	3	12	30
Secondary	6	11	34
College	6	1	14
University	1	1	4
TOTAL	**20**	**30**	**100**

A large number (34%) of the respondents attained secondary education while only 4% attained university education.

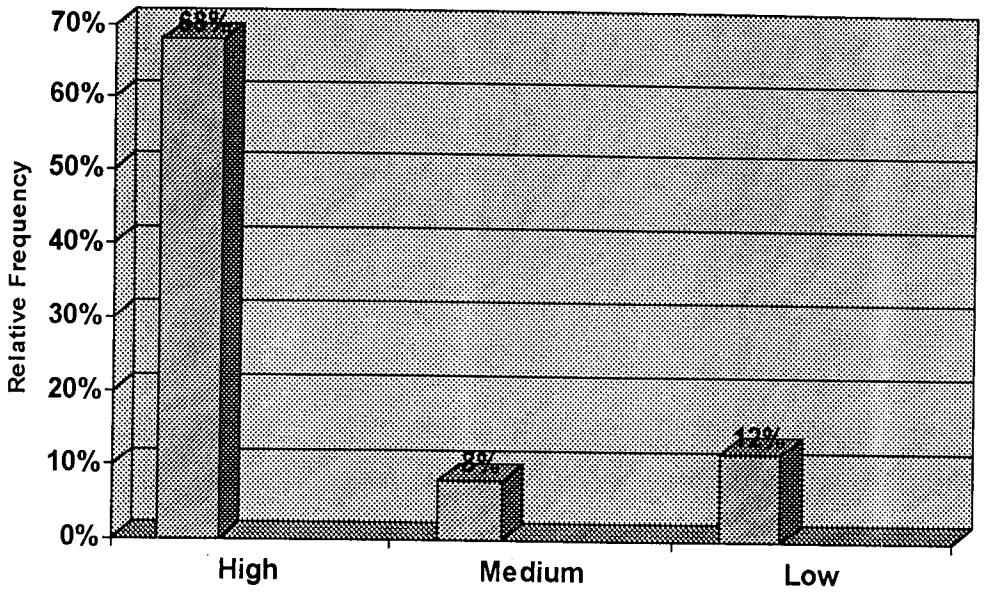
TABLE 9: RESPONDENTS' MARITAL STATUS

variable	male	female	relative frequency
	Frequency	Frequency	
Single	7	14	42
Married	8	5	26
Widowed	1	7	16
Divorced	4	4	16
TOTAL	**20**	**30**	**100**

Majority of the respondents (42%) were single.

KNOWLEDGE

FIGURE 2: RESPONDENTS' LEVEL OF KNOWLEDGE ON HIV/AIDS



Majority of the respondents (68%) had high knowledge on HIV/AIDS.

TABLE 10: RESPONDENTS' EMPLOYMENT

Variable employment	male	female	relative frequency
Formal	7	3	20
Informal	13	27	80
TOTAL	**20**	**30**	**100**

Most of the respondents (80%) were in informal employment.

TABLE 11: RESPONDENTS' SOURCE OF INFORMATION ON HIV/AIDS

source of information on hiv/aids	male	female
Health worker	28	56
Friends	9	18
Parents	4	8
Television	5	10
Radio	3	6
Print media	1	2
TOTAL	**50**	**100**

(56%) of the respondents indicated that the health worker was their source of information on HIV/AIDS while only (2%) indicated the print media as their source of information.

TABLE 12: RESPONDENTS' KNOWLEDGE ON HIV/AIDS TRANSMISSION FROM ONE PERSON TO ANOTHER

KNOWLEDGE ON HIV/AIDS TRANSMISSION from one person TO ANOTHER	FREQUENCY	RELATIVE FREQUENCY
Yes	50	100
TOTAL	**50**	**100**

All the respondents (100%) knew that HIV/AIDS can be transmitted from one person to another.

TABLE 13: RESPONDENTS' KNOWLEDGE ON HIV MAIN MODE OF TRANSMISSION

KNOWLEDGE ON HIV MAIN MODE OF TRANSMISSION	FREQUENCY	RELATIVE FREQUENCY
Unprotected sex	33	66
Mother to child transmission of HIV	7	14
Contact with infected blood	50	100
TOTAL	**50**	**100**

Most of the respondents (66%) said that unprotected penetrating sexual intercourse with an infected partner is the main mode of HIV transmission.

TABLE 14: RESPONDENTS' KNOWLEDGE ON PREVENTION OF HIV/AIDS

KNOWLEDGE ON PREVENTION OF HIV/AIDS	FREQUENCY	RELATIVE FREQUENCY
Yes	50	100
TOTAL	**50**	**100**

All the respondents (100%) knew that HIV/AIDS can be prevented from spreading from person to person.

TABLE 15: RESPONDENTS' SUGGESTIONS ON HOW TO PREVENT HIV TRANSMISSION

SUGGESTIONS ON HOW TO PREVENT HIV TRANSMISSION	FREQUENCY	RELATIVE FREQUENCY
Abstinence	9	18
Be faithful to one sexual partner	5	10
Condom use	32	64
Avoid blood contaminated items	2	4
Government should enact laws to punish those who infect others knowingly	1	2
MTCT prevention of HIV	1	2
TOTAL	**50**	**100**

Majority of the respondents (64%) suggest that the use of condoms as the best way to prevent HIV transmission.

TABLE 16: RESPONDENTS' LEVEL OF KNOWLEDGE IN RELATION TO AGE

AGE	LEVEL OF EDUCATION			TOTAL
	High	Medium	Low	
15 – 19 years	14 (8%)	1 (2%)	4 (8%)	9 (18%)
20 – 24 years	3 (6%)	1 (2%)	2 (4%)	6 (12%)
25 – 29 years	6 (12%)	-	-	6 (12%)
30 – 34 years	7 (14%)	1 (2%)	-	8 (16%)
35 – 39 years	6 (12%)	-	3 (6%)	9 (18%)
40 – 44 years	4 (8%)	1 (2%)	2 (4%)	7 (14%)
45 – 49 years	4 (8%)	-	1 (2%)	5 (105)
TOTAL	**34 (68%)**	**4 (8%)**	**12 (24%)**	**50 (100%)**

Majority of the respondents with high level of knowledge comprising of (14%) were aged between 30 – 34 years followed by those between 25 – 29 and 35 – 39 years of age (12%) respectively. Those within the age group 45 – 49 years had the lowest level of knowledge on HIV/AIDS.

TABLE 17: RESPONDENTS' LEVEL OF KNOWLEDGE IN RELATION TO EDUCATION

LEVEL OF EDUCATION	LEVEL OF KNOWLEDGE			TOTAL
	High	Medium	Low	
No education	5 (10%)	-	3 (6%)	8 (16%)
Primary	6 (12%)	3 (6%)	6 (12%)	15 (30%)
Secondary	14 (28%)	-	3 (6%)	17 (34%)
College	6 (12%)	-	1 (2%)	7 (14%)
University	1 (2%)	1 (2%)	1 (2%)	3 (6%)
TOTAL	**22 (44%)**	**4 (8%)**	**14 (28%)**	**50 (100%)**

Majority of the respondents with secondary education had high level of knowledge (28%).

TABLE 18: RESPONDENTS' LEVEL OF KNOWLEDGE IN RELATION TO SEX

SEX	LEVEL OF EDUCATION			TOTAL
	High	Medium	Low	
Male	15 (30%)	1 (2%)	4 (8%)	20 (40%)
Female	19 (38%)	3 (6%)	8 (16%)	30 (60%)
TOTAL	**34 (68%)**	**4 (8%)**	**12 (24%)**	**50 (100%)**

Majority of the female respondents(38%) had high level of knowledge, while 8% of the male respondents had low level of knowledge.

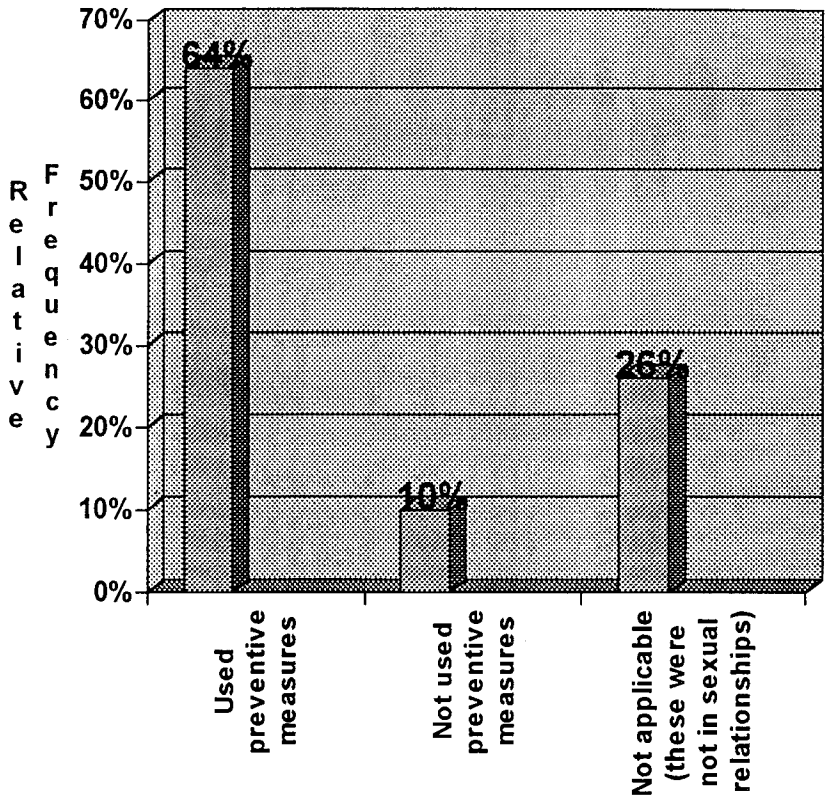
TABLE 19: RESPONDENTS LEVEL OF KNOWLEDGE IN RELATION TO AREA OF RESIDENCE

AREA OF RESIDENCE	LEVEL OF EDUCATION			TOTAL
	High	Medium	Low	
High	22 (44%)	3 (6%)	10 (20%)	35 (70%)
Medium	5 (10%)	-	1 (2%)	6 (12%)
Low	7 (14%)	1 (2%)	1 (2%)	9 (18%)
TOTAL	**34 (68%)**	**4 (8%)**	**12 (24%)**	**50 (100%)**

Most of the respondents (44%) from high density area exhibited high level of knowledge.

PRACTICE

FIGURE 3: RESPONDENTS WHO USED PREVENTIVE MEASURES DURING SEX WITH THEIR PARTNER



64% of the respondents used some preventive measures during sex with their partners while only 10% of the respondents said that they never used any form of preventive measures during sex.

TABLE 20: RESPONDENTS WHO INFORMED THEIR PARTNER(S) ABOUT THEIR HIV STATUS

INFORMING PARTNERS ABOUT their HIV STATUS	FREQUENCY	RELATIVE FREQUENCY
Yes	28	56
No	7	14
N/A	15	30
TOTAL	**50**	**100**

Majority of the respondents (56%) disclosed their HIV status to their partners. Only 14% of the respondents never did disclose their status to their partners while 30% of the respondents represented those who were in no sexual relationships at the time of the study.

TABLE 21: CHALLENGES FACED BY RESPONDENTS IN DISCLOSING THEIR HIV STATUS TO THEIR PARTNER

CHALLENGES FACED BY RESPONDENTS IN DISCLOSING THEIR HIV STATUS TO THEIR PARTNER	FREQUENCY	RELATIVE FREQUENCY
None	14	28
Fear to lose support/stigma	20	40
Lack of knowledge	1	2
N/A	15	30
TOTAL	**50**	**100**

Forty percent (40%) of the respondents said that they feared to lose social support and stigma when disclosing their status while only one respondent had lack of knowledge as a challenge. Twenty eight (28%) said that they faced no challenges since they went for couple counselling.

TABLE 22: RESPONDENTS WHO INITIATED PREVENTIVE MEASURES DURING SEXUAL INTERCOURSE

WHO INITIATED PREVENTIVE MEASURES DURING SEXUAL INTERCOURSE	FREQUENCY	RELATIVE FREQUENCY
Male	19	38
Female	14	28
N/A	17	34
TOTAL	**50**	**100**

Thirty eight 38% males initiated preventive measures during sex and 34% of the respondents were not in sexual relationships.

TABLE 23: RESPONDENTS SUGGESTIONS OF HOW TO MINIMIZE THE FEARS OF PARTNER NOTIFICATION

suggestions ON HOW TO MINIMIZE FEARS OF PARTENR NOTIFICATION	FREQUENCY	RELATIVE FREQUENCY
VCT	30	60
Community sensitization	5	10
Social support	3	6
Being public	7	14
Government should enact the law	1	2
I don't know	4	8
TOTAL	**50**	**100**

Majority of the respondents 60% said that the challenges of disclosure of HIV status to partners can be minimized through VCT and 8% of the respondents said that they never knew how to minimize the challenges.

TABLE 24: RESPONDENTS WHO WOULD ENCOURAGE PARTNER NOTIFICATION

ENCOURAGING PARTNER NOTIFICATION	FREQUENCY	RELATIVE FREQUENCY
Yes	45	90
No	5	10
TOTAL	**50**	**100**

Majority of the respondents 90% said that they would encourage partner notification, while 10% of the respondents said that they cannot encourage partner notification.

TABLE 25: RESPONDENTS REASONS FOR ENCOURAGING PARTNER NOTIFICATION

REASONS FOR ENCOURAGING PARTNER NOTIFICATION	FREQUENCY	RELATIVE FREQUENCY
To live positively	40	80
To prevent further	5	10
TOTAL	**45**	**90**

Eighty percent 80% of the respondents said that they would encourage partner notification to promote positive living with HIV/AIDS. Ten percent 10% of the respondents said partner notification could help prevent further HIV infections.

TABLE 26: RESPONDENTS LEVEL OF SEXUAL PRACTICE IN RELATION TO AGE

AGE	LEVEL OF SEXUAL PRACTICE		relative frequency
	Good	Poor	
15 – 19 years	4 (8%)	5 (10%)	9 (18%)
20 – 24 years	3 (6%)	3 (6%)	6 (12%)
25 – 29 years	5 (10%)	1 (2%)	6 (12%)
30 – 34 years	6 (12%)	2 (4%)	8 (16%)
35 – 39 years	7 (14%)	2 (4%)	9 (18%)
40 – 44 years	5 (10%)	2 (4%)	7 (14%)
45 – 49 years	3 (6%)	2 (4%)	5 (105)
TOTAL	**33 (66%)**	**17 (34%)**	**50 (100%)**

Ten percent 10% of the respondents aged between 15 – 19 years exhibited poor sexual practice while 14% of respondents in the age range of 35 – 39 exhibited good sexual practice.

TABLE 27: RESPONDENTS LEVEL OF SEXUAL PRACTICE IN RELATION TO SEX

SEX	LEVEL OF SEXUAL PRACTICE		total
	Good	Poor	
Male	14 (28%)	6 (12%)	20 (40%)
Female	19 (38%)	11 (22%)	30 (60%)
TOTAL	**33 (66%)**	**17 (34%)**	**50 (100%)**

Majority of the females 38% had good sexual practices. 12% of the males had poor practice.

TABLE 28: RESPONDENTS LEVEL OF SEXUAL PRACTICE IN RELATION TO DENOMINATION

DENOMINATION	LEVEL OF SEXUAL PRACTICE		total
	Good	Poor	
Catholic	12 (24%)	6 (12%)	18 (36%)
SDA	7 (14%)	2 (4%)	9 (18%)
UCZ	4 (8%)	5 (10%)	9 (18%)
RCZ	3 (6%)	1 (2%)	4 (8%)
Other	7 (14%)	3 (6%)	10 (20%)
TOTAL	**33 (66%)**	**17 (34%)**	**50 (100%)**

Majority of the respondents 24% who were Catholics had good sexual practice, while RCZ only 2% of the respondents had poor sexual practice.

TABLE 29: RESPONDENTS' LEVEL OF SEXUAL PRACTICE IN RELATION TO LEVEL OF KENOWLEDGE

LEVEL OF KNOWLEDGE	LEVEL OF SEXUAL PRACTICE		total
	Good	Poor	
High	22 (44%)	12 (24%)	34 (68%)
Medium	2 (4%)	2 (4%)	4 (8%)
Low	9 (18%)	3 (6%)	12 (24%)
TOTAL	**33 (66%)**	**17 (34%)**	**50 (100%)**

Majority of the respondents with high level of knowledge 44% had good sexual practice and the least 4% were those with medium level of knowledge.

TABLE 30: RESPONDENTS LEVEL OF SEXUAL PRACTICE IN RELATION TO LEVEL OF EDUCATION

LEVEL OF EDUCATION	LEVEL OF SEXUAL PRACTICE		total
	Good	Poor	
No education	5 (10%)	4 (8%)	9 (18%)
Primary	8 (16%)	8 (16%)	16 (32%)
Secondary	13 (26%)	8 (16%)	21 (43%)
College	6 (12%)	2 (4%)	8 (16%)
University	1 (2%)	1 (2%)	2 (4%)
TOTAL	**33 (66%)**	**17 (34%)**	**50 (100%)**

Majority of the respondents 26% with secondary education had good sexual practice followed by those 16% with primary education, while those with university education 2% had poor practice.

CHAPTER FIVE

5.0 DISCUSSION OF FINDINGS AND IMPLICATIONS FOR THE HEALTH CARE SYSTEM

5.1 INTRODUCTION

The data pertaining to the topic under study was collected from 50 respondents at the offices of the Network of Zambian People Living with HIV/AIDS (NZP+) in Lusaka. The aim of the study was to determine the challenges faced by HIV positive persons in disclosing their HIV status to their partners.

The researcher acknowledges that he had a lot of difficulties in literature review because the topic under study has never been researched before. Therefore, data that is related to the topic is the one that has been reviewed.

The study's assumptions were that:

- Persons who are HIV positive do not disclose their status to their partners for fear of being labeled as being unfaithful to their partners.
- The HIV positive persons who live without notifying their partners suffer the psychological pain of not informing their partners about their status.
- Non disclosure leads to spreading of infection to multiple partners.

A reflection on the above assumptions will help in understanding the study results as discussed below.

5.2 CHARACTERISTICS OF THE SAMPLE

The findings revealed that the majority of the respondents were from the age ranges of 15 – 19 and 35 – 39 years which had 18% for each age range. This could be attributed to the fact that young people are at risk of having sexual encounters with HIV positive partners as soon as they become sexually

active (UNAIDS, 2000). 16% were aged between 30 – 34 years followed by (14%) age ranges of 40 – 44 years. Twelve percent (12%) were aged 20 -24 years and another 12% were aged 25 – 29 years. Only (10%) were aged 45 – 49 years (Table 4). Majority of the respondents (60%) were females.

The study also revealed that majority (26%) were Lozi, (22%) were Bemba followed by (14%) Tonga, then Luvale and Nyanja who comprised of (10%) each. The least (8%) were Kaonde (Table 5). The study revealed that most (38%) of the respondents were Catholic followed by 18% SDAs, 18% UCZ and 18% Pentecostal churches. Only (8%) were RCZ (Table 6).

The study also revealed that majority (70%) of the respondents were from a high density area followed by (18%) from low density and 12% were from medium density area (Table 7). This may be associated to poverty as reported by Mateyo S. T. (2003) that poverty is a prominent factor influencing HIV infections.

Most of the respondents (42%) were single, followed by those who were married (26%). Sixteen percent (16%) were widowed and another 16% were divorced. One of the reasons for single persons to be among those infected lies in their vulnerability of having sexual encounters with HIV positive partners as soon as they become sexually active (Table 9). A number of the respondents were widowed due to AIDS.

Majority of the respondents (34%) attained secondary education, 30% had primary education, 18% had no education and only 4% had attained university education (Table 8).

5.3 DISCUSSION OF EACH VARIABLE

5.3.1 KNOWLEDGE

Majority of the respondents (68%) had high knowledge on HIV/AIDS (figure 2). This could be attributed to the fact that NZP+ members are taught through their workshops as well as the lessons they receive via the voluntary counselling and testing centres (VCTs). This could also be due to the fact that most of the respondents had attained secondary education (34%). The level of education enabled them to access and read data on HIV/AIDS and with this knowledge it could be better to apply it into practice. Four percent (4%) had medium knowledge while 24% had low knowledge.

The findings showed that most (80%) of the respondents were in informal employment and 20% were in formal employment (Table 10). This could be attributed to the fact that HIV positive persons are stigmatized and usually discriminated against several opportunities including employment. This could be the reason why most of them are in informal employment.

In this study, it was revealed that 56% learnt of HIV/AIDS first from a health worker, while 18% from friends, 10% from television and (8%) from their parents. It was revealed that 6% learnt from radio and only (2%) learnt of HIV/AIDS through a print media (Table 11). This could be attributed to the fact that issues on HIV/AIDS were not being discussed openly except by health workers. Infact to discuss sex and HIV with parents is considered to be a taboo, as reported by Mahendra, V. C. and Motihar, R. (2003) in sexual health exchange 2003. This is why only a few learnt of HIV/AIDS from their parents.

All the respondents (100%) knew that HIV/AIDS can be transmitted from one person to another (Table 12). This could be attributed to the fact that as these persons underwent VCT and clinical tests for HIV, they were told on how HIV/AIDS is transmitted from one person to another. Infact, with

increased sensitization through various media, on HIV/AIDS, it has become universal knowledge in our nation that HIV can be transmitted from an infected person to another.

The study also revealed that majority 66% of the respondents said that having unprotected penetrating sexual intercourse with an infected partner is the main mode of HIV transmission. This view agrees with what the ZDHS (2003) noted that 72% women and 79% men mentioned the use of condoms as a specific way of avoiding HIV infection. The study also revealed that 14% of the respondents mentioned mother to child transmission (MTCT) while 20% of the respondents mentioned contact with contaminated blood (Table 13).

The study findings revealed that all 100% of the respondents had knowledge on the prevention of HIV/AIDS (Table 14). This could be attributed to the fact that the respondents underwent VCT and belong to NZP+ where there is an exchange of information on HIV/AIDS and its prevention (Table 14). Another reason is that NZP+ persons have made themselves public and are united to fight the spread of HIV/AIDS. Therefore, they are well equipped with knowledge on the prevention of HIV/AIDS.

Majority of the respondents 64% suggested use of condoms can be employed in the prevention of HIV transmission while 18% mentioned abstinence as a preventative measure. Five percent (5%) of the respondents said being faithful to one sexual partner, 2% mentioned avoiding contact with blood contaminated items, 2% mentioned prevention of mother to child transmission (PMTCT) of HIV and another 2% suggested that the government should enact the laws, which should punish those who willfully infect others (Table 15).

The study revealed that the majority of the respondents 14% with high level of knowledge were aged between 30-34 years followed by those between 25

– 29 years and 35 -39 years who both had (12%) respectively. The respondents within the age range of 45 – 49 years had the lowest (2%) level of knowledge on HIV/AIDS. From the above findings, it can be concluded that there is no strong relationship between age and level of knowledge on HIV/AIDS (Table 16).

Other findings revealed that most of the respondents with secondary education had (28%) high level of knowledge on HIV/AIDS followed by those with primary and college education with (12%) high level of knowledge each respectively. Those with no education had (10%) high level of knowledge and those who attained university had (2%) high level of knowledge.

Majority of the respondents with low level of knowledge attained primary education, (12%) followed by those with no education and secondary education respectively 6%. Respondents with college and university education had 2% low level of knowledge each respectively.

The study findings also revealed that majority (38%) of females had high level of knowledge on HIV/AIDS compared to 30% males. Two percent (2%) of the males and 6% of the females had medium level of knowledge respectively while 8% of males and 16% of females had low level of knowledge on HIV/AIDS.

Although women are more knowledgeable on HIV/AIDS, they are more exposed to risk factors than their male counterparts. For example in 2000 CSO and MoH carried out a Zambia sexual behaviour survey and health seeking behaviours. The findings showed that most respondents among the women said that HIV can be prevented by condom use and having one sexual partner.

The study also noted that the ability of women to negotiate decisions about engaging or not to engage in sexual activity has important implications for

HIV and whether they can protect themselves from infections. It is therefore important to empower women to enable them have complete control over their lives. On the other hand, UNAIDS (2000), revealed that men all over the world have more sexual partners and extra marital affairs. This behaviour puts men at risk despite their knowledge on HIV/AIDS.

The findings also showed that the majority of the respondents 44% from high density areas exhibited high level of knowledge followed by low density and medium density areas with 14% and 10% respectively. Six percent (6%) of respondents from high density areas and 2% from low density areas had medium level of knowledge. Twenty percent (20%) from high density areas, 2% from medium density and 2% from low density areas had low level of knowledge respectively.

Ten percent (10%) of the respondents respondents from low density and 6% from high density areas had medium level of knowledge (Table 19). Six percent (6%) were from the high density areas. It can be concluded that there is a strong relationship between area of residence and level of knowledge on HIV/AIDS. Respondents from low residential area were more knowledgeable on HIV followed by those from the medium residential areas and the last was those from high residential areas.

5.3.2 PRACTICE

In order to determine challenges faced by HIV persons in disclosing their status to their partners, respondents were asked questions on the number of sexual partners they had, whether they used preventive measures and if so, who initiated it. They were also asked on how they learnt that they were HIV positive, whether they informed their partner(s) and if so, what were the challenges they faced in informing their partners. The respondents were also asked on how to minimize these fears of informing one's partner and whether they could encourage partner notification or not and why.

The study revealed that majority (64%) used preventive measures during sex with their partners and only 10% had sex without using preventive measures. Twenty six percent (26%) represented those respondents who were widowed and those who were single but had no current sexual partner (Figure 3). The above findings contradicts with the ZDHS, 2003 survey report which stated that 32% of men and 22% of women with STIs or associated symptoms took no action to protect their partner. Most of the respondents (64%) exhibited good practice while 10% exhibited poor practice.

The findings further showed that the majority (56%) of the respondents informed their partner(s) about their HIV positivity while 14% did not. Thirty percent (30%) of the respondents represents those who had no sexual partner at that moment. Fifty six percent (56%) and 30% are taken to be good practice while 14% of those who did not inform their partners exhibited poor practice (Table 20).

The study findings also revealed that the majority (40%) of the respondents were faced with challenges of fear to loose support if they informed their sexual partner of their status and they also feared to be stigmatized as having a deadly disease. Two percent (2%) of the respondents said that they lacked knowledge on how to break the news to their partners while 28% of the respondents said that they faced none of the challenges since they underwent couple voluntary counselling and testing (VCT). The study also revealed that 30% of the respondents fell under a category which comprised of those respondents who were not in any sexual relationship at the time of the study (Table 21). The above finding is consistent with the assumption that most people do not disclose their HIV status for fear of loosing social support and sexual partners.

The findings indicated that most males (38%) did initiate the use of some preventive measures during sexual intercourse while 28% of female respondents initiated the use of preventive measures. Thirty four percent

(34%) of the respondents fell under the category of those who were not in sexual relationships during the time of the study (Table 22).

The study findings above is supported by the 2003 Zambia Demographic and Health Survey (ZDHS) report which noted that 32% of men and 22% of women took no action to protect their partners despite knowing that they had the infection. The 38% and 28% for males and females respectively had exhibited good sexual practices.

Some of the suggestions by respondents on how to minimize the fears of partner notification included the following:

Encouraging voluntary counselling and testing, especially couple counselling.

This was seen as one major way to minimize the challenge of informing one's partner since both partners are counselled together and the trained counsellor is there to help them. They also said that an increased community sensitization can help a great deal in reducing stigma and discrimination of HIV positive persons. If these persons received community support, partner notification can be eased and it can enhance them to go public. Others said that government should enact the law to punish those who willfully infect others while others said that they did not know how to minimize the challenges of partner notification.

The findings showed that the majority of the respondents (60%) suggested that couple VCT can greatly minimize the fears of partner notification, 14% suggested being public, 10% said increasing community sensitization while 6% suggested giving social support and 2% said that government should enact the law aimed at punishing those who willfully infect others. Only 8% of the respondents gave the answer, "I don't know", (Table 23). This showed that there is need to increase community awareness campaigns on HIV/AIDS prevention.

According to the study, majority (90%) of the respondents would encourage partner notification while only 10% said that they would not encourage partner notification to prevent being stigmatized and discriminated against. The study further revealed that majority (80%) of the respondents would encourage partner notification to enhance living positively with HIV/AIDS while only 10% of the respondents said that they would encourage partner notification in order to prevent further HIV infections (Table 25). The above findings showed good practice being encouraged by the respondents.

The study findings also indicated that the majority (14%) of the respondents aged between 35 – 39 years had good sexual practice followed by those aged 30 - 34 years who were (12%) with good sexual practice. Majority of the respondents (10%) had poor sexual practice followed by (6%) of the respondents.

From the findings above, it can be concluded that respondents who are aged 15 - 19 had poor level of sexual practice (10%). Good sexual practice tends to rise with an increase in age only to drop from 40 through 49 years of age. Therefore there is a relationship between age and sexual practice (Table 26).

The study also revealed that (38%) of the female respondents and 28% of the male respondents have good sexual practice respectively. Majority (22%) of the respondents exhibited poor level of sexual practice and only 12% of males exhibited poor level of sexual practice (Table 29).

The above data is supported by UNAIDS (2000) which revealed that women worldwide usually found themselves at special risk of HIV infection because of their lack of power to determine where, when and how sex takes place.

The findings also revealed that most Catholics (24%) of the respondents had good sexual practice followed by SDA (14%) and others Pentecostal churches

(14%), UCZ (8%) and RCZ (6%). The Catholic denomination still had the highest (12%) poor level of sexual practice, attributed to not using the condom due to their faith followed by UCZ, Pentecostal Churches, SDA and RCZ and (10%, 6%, 4% and 2%) respectively, (Table 28).

Other study findings were that majority (44%) of the respondents with high level of knowledge had good level of sexual practice followed by those (18%) with low knowledge (18%). Only 4% with medium knowledge had good level of sexual practice. Most (24%) respondents with high level of knowledge had exhibited poor sexual practice followed by those (6%) with low level of knowledge (Table 29). From the findings above, it can be noted that the level of knowledge influences the level of sexual practice. This is supported by MoH/CBoH, 1999 which said that voluntary counselling and testing is one of the many interventions that can be adopted to influence the transmission mechanism of HIV. This is because when partners know their HIV status, they resort to use of condoms to avoid pregnancies and further HIV re-infection. UNAIDS (2000) also supports these findings in a statement that says that knowledge of HIV serostatus can help people to make decisions to protect themselves and their sexual partners from infection.

The study results also revealed that most of the respondents (26%) with secondary education had good level of sexual practice followed by primary (16%), college (12%), no education (10%) and university (2%) (Table 30). The study objectives have been achieved as reflected by the study findings above.

5.4 IMPLICATIONS ON THE HEALTH CARE SYSTEM

The study revealed that the majority of the respondents had high level of knowledge on HIV/AIDS. Most of them got their information from the health workers. Only a few respondents got their information from friends, parents or through the media. Most of the respondents used some preventive measures during sex with their partners while a few never employed preventive measures during sex.

Majority of the respondents feared to lose social support and to be stigmatized when disclosing their status while a few said that they face no challenge due to the fact that they underwent couple voluntary counselling and testing (VCT) which made disclosure easy.

There is a great need for health workers to stress the importance of partner notification and the use of preventive measures during sex so as to prevent new HIV infections and re-infecting of partners. Once this is done it will lead to good practice by all those who are infected. The health workers should also make use of other modes of communication such as electronic and print medias. This will be of great help since health workers have more accurate knowledge on HIV/AIDS and will be able to reach many people.

Information must be targeted to all age groups since HIV/AIDS has affected all age groups. Women should also be equipped with quality information to enable them make reasonable and health sexual behaviour choices.

Community involvement should be taken on board so that information on HIV/AIDS should be community driven where health workers can act as facilitators. Counselling of couples in which churches are involved should be intensified to easy partner notification so as to promote good practice among HIV positive persons.

Church leaders from various denominations should be involved in the fight against the spread of HIV/AIDS which also affected those in the Christian community. Persons from organizations like NZP+ who have come in the open must be encouraged, supported and accorded an opportunity to speak in different fora on how to overcome the challenges of partner notification.

Information, Education and Communication on HIV/AIDS must address stigma and fear to lose social support as the main challenges which stand in the way of disclosing one's HIV status to the partner (s).

5.5 CONCLUSION

The main objective of the study was to determine the challenges faced by HIV positive persons in disclosing their status to their partners in Lusaka. The study revealed that most respondents feared to lose social support and stigma while the minority had no fears since they underwent couple counselling. The study revealed that most of the respondents had good level sexual practice and they suggested that the challenges of disclosing one's HIV status to his/her partners could be minimized through VCT. Other respondents said it could be minimized by community sensitization, giving social support, being public and a few others said they did not know how to minimize the challenges of partner notification. It was also noted that 100% of the respondent were knowledgeable about HIV/AIDS.

The majority of the respondents said that they would encourage partner notification in order to promote positive living with HIV/AIDS as well as to prevent HIV infections. There is need to address the challenges faced by HIV positive persons in order to effectively prevent the spread of HIV/AIDS through partner notification.

5.6 RECOMMENDATIONS

1. The study should be done on a large scale to determine the challenges faced by HIV positive persons in disclosing their HIV status to their partners.

2. The government should enact laws to allow the health workers to inform any person of their partner's status if she/he refuses to inform the partner.

3. A specific study on how to overcome the challenges faced by HIV positive persons in disclosing their HIV status to their partners should be undertaken.
4. Couple counselling should be encouraged in order to encourage partner notification.

5. The government should enact the law that puts a demand on anyone who tests positive to inform their partners.

6. There is need to offer physical and socio-economic support to those who test HIV positive in order for them to disclose their HIV status with minimized fears.

7. Women should be empowered economically in order for them to make choices that are beneficial to their lives and their families.

8. Community sensitization on HIV should be intensified in order that people acquire behaviour change that promotes healthy living.

9. Government should enact the law to punish those who do not disclose their HIV status to their partners but instead infect people willfully.

10. Information, Education and Communication (IEC) by health workers should take various channels such a role plays, print and electronic medias, face to face to those who present themselves to the health facilities as well as community outreach programmes.

5.7 DISSEMINATION OF FINDINGS

Executive summaries will be sent to NZP+, National HIV/AIDS/STI/TB Council, VCT Centres in Lusaka and the Home Based Care Department on how to minimize the challenges of HIV positivity disclosure. The researcher will also present the findings through presentations at workshops and clinical meetings within Lusaka. Reports will also be given to the school (PBN) and UNZA Medical Library.

5.8 LIMITATIONS

5.8.1 It was very difficult to get adequate literature on the topic under study because no similar study has been done.

5.8.2 The researcher found it very difficulty to get permission to collect data and this delayed the study coupled with the limited time available as one had to consider other courses.

5.8.3 The funds allocated by the sponsors were not adequate to meet the necessary costs of the study.

5.8.4 The size of the sample was small (50) to allow for generalization of the study findings to a larger population.

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RESEARCH WORK SCHEDULE

TASK PERFORMED	DATE	PERSONNEL ASSIGNED TO TASK	DAYS REQUIRED
Literature Review	Continues	Researcher	
Data collection tool	25/08/ - 30/08/03	Researcher	1 x 7 days
Clearance from necessary authorities	05/09/ - 09/09/03	Supervisor, subjects and community leaders	4 days
Pilot study	05/09/ - 09/09/03	Researcher	5 days
Data collection tool amendment	13/09/ - 17/09/03	Researcher	5 days
Data collection	22/09/ - 03/10/03	Researcher	12 days
Data analysis	14/10/ - 28/10/03	Researcher	15 days
Report writing	29/10/ - 10/11/03	Researcher	22 days
Draft presented to PBN	20/11/ - 28/11/03	Researcher	9 days
Finalized report binding	02/12/ - 22/12/03	Researcher	21 days
Disseminating of findings	11/01/ - 20/01/04	Researcher	10 days
Monitoring project	Continuous	Supervisor	

TO DETERMINE THE CHALLENGES FACED BY HIV POSITIVE PERSONS IN DISCLOSING THEIR STATUS TO THEIR PARTNERS

DATE OF INTERVIEW :

SERIAL NUMBER :

INSTRUCTIONS TO THE INTERVIEWERS

1. Introduce yourself to the respondents
2. Explain the purpose of interview
3. Ensure no names or address of respondents will be written down.
4. Ensure respondents are free when answering questions through out the interview
5. Tick in the space provided and fill in the space provided according to the respondents given answer.

FOR OFFICIAL USE ONLY

1. SEX Male [ ]
   Female [ ]

2. What was your age at your last birth day?
   15-19
   20-24
   25-29
   30-34
   35-39
   40-44
   45-49

3. What is your tribe?
   Lozi [ ]
   Luvale [ ]
   Bemba [ ]
   Nyanja [ ]
   Tonga [ ]
   Kaonde [ ]
   Other – specify_____

4. What is your religion?
   Catholic [ ]
   SDA [ ]
   UCZ [ ]
   RCZ [ ]
   Other – specify_____

FOR OFFICIAL ONLY

5.Where do you live?

Low density [ ]

Medium density

High density [ ]

6. What is your highest educational level?

No education [ ]

Primary education [ ]

Secondary [ ]

College [ ]

University [ ]

7. What is your marital status?

Single [ ]

Married [ ]

Divorced [ ]

Widow [ ]

Other – specify_____

8. What is your employment?

Formal [ ]

Informal [ ]

SECTION B: KNOWLEDGE ON HIV/AIDS

9. Where did you first learn about HIV/AIDS from?

Health worker [ ]

Friends [ ]

Parents [ ]

Television [ ]

Radio [ ]

Print media [ ]

Other – specify_____

10. Can HIV/AIDS be transmitted from one person to another?

Yes [ ]

No [ ]

11. If yes to question number 8 state the main mode of transmission?

_____

_____

12. Can HIV/AIDS be prevented from spreading from person to person?

Yes [ ]

No [ ]

13. If yes to question number 10 please explain_____

_____

SECTION C: PRACTICES

14. How many sexual partners do you have?

One [ ]

Two [ ]

More than two [ ]

15. Do you use any preventive measures during sex with your partner?

Yes [ ]

No [ ]

FOR OFFICIAL USE ONLY

16. If yes to question number 15 who initiated the use of a Specific preventive measure MALE [ ] FEMALE [ ]

17. How did you learn that you were HIV positive?_____

_____

18. Have you informed your partner(s) about your status?

Yes [ ]

No [ ]

19. If Yes to question number 18 what were the challenges you faced in informing your partner about your status?

_____

_____

_____

20. If No to question number 18 what challenges are you facing_____

_____

_____

21. How can we minimize the fears of informing your Partner about your HIV positive status?

_____

_____

_____

22. Can you encourage partner notification?

Yes [ ]

No [ ]

23. If yes to question number 22 please explain

_____

_____

_____

24. If No to question number 22 please explain_____

THANK YOU FOR SPARING TIME TO PARTICIPATE IN THE INTERVIEW.

THE UNIVERSITY OF ZAMBIA
SCHOOL OF MEDICINE
DEPARTMENT OF POST BASIC NURSING
P.O. BOX 50110
LUSAKA

Mr Kapembwa
to see me
DNSB.
19/11/07

The Coordinator
VCT Services
U.T.H.
Lusaka

u.f.s.: Head of Department
Post Basic Nursing
Lusaka

Dear Sir/Madam,

Re: PERMISSION TO CONDUCT A RESEARCH

I am a 4th Year Student in the School of Medicine, Department of Post Basic Nursing. As part of the fulfillment of my degree programme. I am required to carry out a study and my topic is "To determine the challenges faced by HIV positive persons in disclosing their status to their partners.

I am therefore asking for permission to conduct a research study in your Organization.

Your earliest positive response will be appreciated.

Yours faithfully,

Kapembwa Joseph

University Teaching Hospital

(Board of Management)

P Bag RW 1
Lusaka - Zambia
Tel: 253947 (Switch Board)
250305 (Direct)
Fax: 250305
Telex: [illegible]

OFFICE OF THE MANAGING DIRECTOR

Our Ref:

Your Ref: 21st November, 2003

The Head
Voluntary Counselling and Testing Centre
UTH Board
LUSAKA

Dear Sir/Madam,

STUDENT: JOSEPH KAPEMBWA

The above named student from Post Basic Nursing requires to do some research at your centre to determine the challenges faced by HIV positive persons.

This letter is to confirm that permission has been granted for him to conduct his research.

Kindly assist him with the information that he may require.

Yours faithfully
UTH BOARD OF MANAGEMENT

DR T K LAMBART
MANAGING DIRECTOR

/mmm

THE UNIVERSITY OF ZAMBIA
SCHOOL OF MEDICINE
DEPARTMENT OF POST BASIC NURSING
P.O. BOX 50110
LUSAKA

The Coordinator
NZP+
Box
Lusaka

u.f.s.: Head of Department
Post Basic Nursing
Lusaka

Dear Sir/Madam,

Re: PERMISSION TO CONDUCT A RESEARCH

I am a 4th Year Student in the School of Medicine, Department of Post Basic Nursing. As part of the fulfillment of my degree programme. I am required to carry out a study and my topic is "To determine the challenges faced by HIV positive persons in disclosing their status to their partners.

I am therefore asking for permission to conduct a research study in your Organization.

Your earliest positive response will be appreciated.

Yours faithfully,

Kapembwa Joseph

NETWORK OF ZAMBIA
PEOPLE LIVING WITH HIV/AIDS
27 FEB 2004
P.O. BOX 32717
LUSAKA

Permission granted to carry out survey.

K. E Mwanza

BUDGET FOR RESEARCH

BUDGETARY CATEGORY	ITEM COST ZAMBIA KWACHA	QUANTITY	TOTAL
1. STATIONARY			**K**
Bond Typing Paper	26,000	4	104,000
Note Books	2,500	4	10,000
Flip Charts	30,000	1	30,000
Files	3,000	5	15,000
Pencils	200	4	800
Pens	1,000	4	4,000
Rubbers	200	2	400
Correcting ink	15,000	2	30,000
Stapler	20,000	1	20,000
Staples	5,000	1 box	5,000
Calculator	45,000	1	45,000
SUB-TOTAL			**264,200**
2. PERSONNEL			
Lunch allowance	K20,000	2 x 14 days	560,000
Transport	K10,000	2 x 14 days	280,000
Research Assistant	K10,000	2 x 14 days	280,000
SUB-TOTAL			**1,120,000**
3. TYPING SERVICES			

Typing Questionnaire	K2,500/page	1 x 5 pages	K12,500
Photocopying Questionnaire	k200/PAGE	5 x 55 pages	K55,000
Typing report	K2,500/PAGE	1 x 55	K137,500
Binding reports	K15,000/copy	3 copies	K54,000
SUB-TOTAL			**K250,000**
4. MISLANEOUS			
Diskettes	K5,000	3	K15,000
Bag for Questionnaires	K60,000	1	K60,000
Padlock	K10,000	1	K10,000
A token of appreciation to respondents	K10,000	50 respondents	K550,000
SUB-TOTAL			**K635,000**
Aggregate totals			K2,269,200
10% contingency			K226,920
GRAND TOTAL			**K2,496,120**

BUDGET JUSTIFICATION

STATIONARY

Paper, note books, pens and pencils were needed to document the necessary data to be collected. Correcting ink is important for correction of mistakes. The stapler, staples and files were needed to put the data that is collected together in an orderly way i.e. the five pages of each questionnaire are supposed to be stapled together and secured in a file. The calculator was used during data analysis and a bag was used for carrying the questionnaires during the study.

PERSONNEL

The researcher and his research assistants did need transportation and lunch allowances whilst in the field during data collection. The research assistant also needed transport during the study. The researcher and his assistant

used public transport to reach the subjects in the various townships in Lusaka urban.

TYPING SERVICES

These services are important to enable the researcher have a finished well written document. These include photocopying of the documents so as to cut on the time and cost of typing all the 55 questionnaires and reports.

MISCELLANEOUS

These include the diskettes, the bag and a pad lock which were used to store confidential information. All the information from the respondents is strictly confidential and was kept under lock and key hence the need for a pad lock.

A token of appreciation to the respondents was given after an interview to appreciate them for taking part in such a sensitive study on HIV and the challenges they face in disclosing their status to their partners.