A STUDY INTO FACTORS CONTRIBUTING TO LOW UTILISATION OF VOLUNTARY COUNSELLING AND TEST OF HUMAN IMMUNODEFICIENCY VIRUS.

A case of Mufumbwe District, North – Western Province, Zambia

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THE CASE OF MUFUMBWE DISTRICT, NORTH-WESTERN PROVINCE, ZAMBIA

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DEDICATION

This study is dedicated to my children; Kasemuka, Chibanda, Stanley and Clifford, niece Kellyne and Mama Lute Kakoma for their patience, love, tolerance, spiritual support and encouragement during my time of absence from home.

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ABSTRACT

This research was conducted to elicit factors contributing to low utilisation of VCT in HIV in Mufumbwe District in North-Western of Zambia.

The study reviewed that knowledge of VCT in Mufumbwe district is high; 95% among health workers and 75% among community respondents. The main sources of information include health workers, radio/TV, relatives/friends and through seminars/workshops. 60% of the community respondents do not know where VCT is offered in the District.

Utilisation of VCT is still very low; 30% for health workers and 6% of community respondents had ever gone for VCT services. The main reasons given for lack of utilisation of VCT are attributed to fear to know one's HIV status, lack of knowledge or awareness of VCT and inaccessibility of the service.

The research further reviewed that only one public institution offers VCT and there was one NGO rendering care and support to the community.

Therefore, whereas knowledge of VCT is very high, its utilisation is indeed very low.

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LIST OF ABBREVIATIONS

AIDS -	Acquired Immune Deficiency Syndrome
CBoH -	Central Board of Health
CSO -	Central Statistics Office
FGD -	Focused Group Discussion
DATF -	District AIDS Task Force
DHB -	District Health Board
DHMT -	District Health Management Team
DHS -	Demographic and Health Survey
HIV -	Human Immunodeficiency Virus
MoH -	Ministry of Health
NAC -	National Aids Council
PTCT -	Parent-to-Child –Transmission
SAFAIDS -	Southern Africa AIDS Dissemination Information Service
STIs -	Sexually Transmitted infections
UNAIDS -	Joint United National Programme on HIV/AIDS.
UNICEF -	United Nations Children's fund
VCT -	Voluntary Counselling and Testing
WHO -	World Health Organisation
ZVCTS -	Zambia Voluntary Counselling and Testing service.

CHAPTER ONE

INTRODUCTION

Mufumbwe is located in the Central part of North-Western Province of the Republic of Zambia. It shares boundaries with eight (8) districts and these are; Kabompo on the West, Solwezi and Mwinilunga on the North-East and North respectively, Kasempa on the East (all in North-Western Province), Mumbwa on the South-East (in Central Province), and Kaoma and Lukulu on the South and South-West respectively (in Western Province).

The District Health Office (DHO) is situated on the Solwezi-Zambezi Road commonly known as "the M8" a gravel road currently undergoing macadamisation. It is 244km from Solwezi, the Provincial Headquarters and 256km from Zambezi.

POPULATION

According to the CSO census (2003) report, Mufumbwe district had a population of 40,876 people, which is now projected at 54,730. It has a very high population growth rate of 5.7% per annum. The district has area acreage of 20,856km^2 with a population density of about 3 persons per km^2.

SOCIO – ECONOMIC

The district comprises of different ethnic groups; the Kaonde, Chokwe, Lunda, Luvale and the Luchazi.

Much of the district consists of vast woodlands and plains with rich soils and abundant rains. It is an important farming district though farming is at subsistance levels. The commonly grown crops include maize, groundnuts, cassava and sorghum.

Mufumbwe district is also endowed with mineral deposits, wildlife and timber, which are exploited as a source of income.

A few people are in formal employment while others are either self-employed or involved in business.

As a result of the above factors, there is a high influx of traders from other districts and the Democratic republic of Congo including a high number of refugees from Maheba Refugee Camp engaged in businesses.

HEALTH SERVICES.

The district has only eleven (11) health centres as illustrated in the table below with their distances from the District Health Office.

Table 1: Health Centres/distances from the DHO

Serial No.	Health Centre/ Institution	Distance (KM)
01	Boma Clinic	0.5
02	Jivundu RHC	50
03	Kabanda RHC	210
04	Kabipupu RHC	86
05	Kaminzekenzeke RHC	230
06	Kalengwa RHC	56
07	Kashima RHC	50
08	Matushi RHC	30
09	Mufumbwe District Hospital	3
10	Munyambala RHC	40
11	Mushima RHC	198

Data Source: Mufumbwe DHB (2004).

VCT SERVICE

Mufumbwe District Hospital is the only institution where VCT is done in the district. The table below shows the number of people who had undergone HIV

testing in the first one year since the inception of VCT services in Mufumbwe District.

Table 2: VCT utilisation – July, 2003 to June, 2004.

Year/Months	Blood Donors	VCT	Others	Counselling		No. HIV Positive
				Pre-Test	Post-Test	
2003 July – December	0	25	9	34	30	7
2004 January – June	0	96	9	105	100	13

Data Source: Mufumbwe VCT report (2004).

NB. The majority seeking VCT service are those that feel they are HIV negative whilst the number mainly found HIV positive are those that come with clinical signs of HIV/AIDS.

Consequently, Mufumbwe district has the highest HIV prevalence in North-Western Province of 12.9% with Solwezi trailing on 12.5% (MoH/CBoH, 1999).

THE BACKGROUND OF VCT

Voluntary Counselling and Testing (VCT) is a concept that has emerged with the emergence of Human Immunodeficiency Virus (HIV), the virus that causes Acquired Immune Deficiency Syndrome (AIDS).

The first case of AIDS was diagnosed in Zambia in 1984. The epidemic had risen to 20% of the population (Central Board of Health, 2002). Adults in the productive age group (15-49 years) are the worst affected. According to Central Statistics Office (CSO) (2003) Demographic and Health Survey (DHS) report, HIV prevalence has documented a decline from 20% to 16%.

The high prevalence of HIV/AIDS has had a marked negative impact on the social, economic and political well-being of people and the nation at large.

As a result, the Government of Zambia has come up with various interventions to mitigate the effects of HIV/AIDS. These measures included the formation of the National Aids Council (NAC) and the Zambia Voluntary Counselling and Testing Services (ZVCTS). There has also been a proliferation of various Non-governmental organisations (NGOs) in the fight against HIV/AIDS.

In 1987, Zambia started doing HIV Counselling in Centres that had diagnostic capacity (National AIDS preventions stated control programme, et al, 1990). However VCT services started in Zambia in 1999 (ZVCTS profile, 2004), first piloted in twenty-two (22) districts. Following successful results, the project expanded to approximately over eighty (80) VCT centres throughout the country in 2003, Mufumbwe District inclusive.

STATEMENT OF THE PROBLEM

In Zambia, there is no policy on HIV testing. The Ministry of Health policy statement on HIV/AIDS advocates for voluntary HIV counselling and testing in addition to other preventives measures against HIV transmission (Central Board of Health, 2002).

Although the Ministry of Health (MoH) policy statement advocates for integration of VCT in the mitigation of HIV prevalence in Zambia, utilisation of VCT services in Mufumbwe District is still very low.

This study was conducted to investigate factors contributing to low utilisation of VCT services in Mufumbwe district.

PURPOSE OF THE STUDY

The purpose of the study was to investigate factors contributing to low utilisation of VCT services in Mufumbwe District and make appropriate recommendations. The study also was intended to;

(1) determine the current knowledge about VCT services in the community; and,

(2) establish the current VCT service delivery.

OBJECTIVES OF THE STUDY

The following were the objectives of the study, to;

1. identify factors contributing to low utilisation of VCT services in the district;
2. determine the current knowledge about VCT services in the district; and,
3. established the current VCT services delivery in the district

ASSUMPTIONS OF THE STUDY

The study assumed that factors contributing to low utilisation of VCT service were not known. It also assumed that knowledge about VCT service delivery in Mufumbwe district was essential in the fight against HIV transmission. However, the study further assumed that VCT service delivery in the district was unknown.

RELEVANCE OF THE STUDY

The study aimed at generating necessary information that would identify the factors that contributed to low utilisation of VCT services in Mufumbwe. The information would be useful to service providers (health and social workers) and NGOs involved in HIV/AIDS fight (the District AIDS Task Force (DATF) and VCT advocacy.

Policy-makers (MoH, Central Board of Health [CBoH] and ZVCTS) would also find it useful for policy and decision-making.

The donor community would also find a case for supporting VCT services in Mufumbwe district and the nation at large.

LIMITATION OF STUDY

The study was limited in scope due to insufficient finances and time, and lack of transport to cover the whole district including the hard-to-reach area.

ETHICAL CONSIDERATIONS

Informed consent was sought from every respondent and confidentially was assured prior to conducting the research and maintained.

DEFINITION OF TERMS

Confidentiality - doing something secretly and not to be talked about anywhere.

Defilement - make someone less clean or pure by forced sexual intercourse.

Discrimination - is the unfair and unjust treatment of an individual or group of people based on his/her/their real perceived HIV status.

Mandatory Counselling and Testing – HIV counselling and testing which must be done on everybody.

Parent-to-child-transmission - Transmission of HIV to a child from an HIV positive parent through pregnancy, delivery or breast-feeding.

Rape - To violently force a woman to have sex against her Will.

Routine Counselling and Testing – HIV counselling and testing which can be regularly performed as a person attends medical services.

Seronegative (HIV negative) - Persons who takes an HIV test and know their results are not HIV infected.

Seropositive (HIV positive) - Persons who take an HIV test and results have been confirmed and know they have HIV infection

Specimen - Small sample for testing

Stigmatisation - is a mark of shame or discredit upon a person or a group of people just because they are either suspected or known to be HIV positive.

Testing - A short medical examinations on part of the body like a blood test in HIV infection

Voluntary - A doing something of your own choice not forced

Voluntary Counselling and Testing - HIV testing with pre- and post-test counselling, which is voluntary, with full informed consent, and is confidential.

Chapter Two

REVIEW OF LITERATURE

Zambia has had a sentinel surveillance system that provided data for estimations of HIV infection in every province at selected hospitals and health centres since 1990 (MoH, 1997). Blood specimen was taken from different people or groups especially from pregnant women at Antenatal clinics anonymously and results were used to understand the status of the epidemic.

From the DHS reports of 1996 and 2001-2002, the knowledge of HIV/AIDS by Zambians was 96% and 100% respectively (CSO, 1997, and 2003). The main sources of information on HIV/AIDS include health workers, friends, relatives, radio, and television.

Despite the high levels of knowledge of HIV/AIDS among the people, the number of people undertaking VCT is still very low. According to MoH/CBoH (1997), this problem has been made worse by the lack of accessible and confidential voluntary counselling and testing.

However, the Ministry of Health (MoH) and the Central Board of Health (CBoH) have placed VCT at the core of priority interventions in the control of the HIV infection and mitigation of its impact on the people (MoH and CBoH, 2002).

The Concept Of Counselling

Counselling has been used differently by people and in different circumstances since the genesis of mankind. It has been used in marriage ceremonies, initiation ceremonies and other functions by parents, teachers, friends, peers and the clergy (Kunda, 2003). Kunda (2003) quoting Msimuko (1987) stated that in the traditional counselling, the qualification to be a counsellor was experience and demonstration of understanding the cultural norms and traditional practices. Counselling was prescriptive in nature, as there was little or no room for decision-making. However, other authors had stated that people

were autonomous beings who had the capacity to decide what is good for them. Kunda (2003) quoting Rodgers (1957) alluded that the autonomy of human beings is also known as the "free will" which is the main focus of the Western approach of counselling.

In Zambia, counselling has been offered by trained health workers, physicians, teachers, clergy, social workers or peer group leaders.

Counselling refers to providing information appropriate to an individual or group needs in such a way as to allow the patient/client or group to make decision in an atmosphere of mutual respect and trust. It is a means of good two-way communication. The counsellor is a good listener (National Aids Prevention and Control Programme et al, 1990).

Counselling is a process that assists individuals to reach their own informed decisions about what they should do, or to come to terms with a problem that is facing them (CBoH, 2002). It can be conducted on a one-to-one (person-centred) basis or in groups.

In the Zambian context, counselling is defined as helping patients, relatives and eventually the communities to help themselves in facing and preventing the AIDS epidemic (MoH and World Health Organisation [WHO], 1989).

The concept of counselling has since been expanded to include voluntary HIV counselling and testing. The Zambia Voluntary Counselling and Testing Services (ZVCTS) has spearheaded this. The following are the ZVCTS objectives;

- To establish a free same day client friendly VCT service accessible to majority of Zambians.
- To assess the acceptability of VCT among Zambians.
- To establish VCT as an entry point into specific intervention to all HIV programmes in Zambia like Tuberculosis preventive therapy, Sexually

Transmitted Infections (STIs), Parent-To-Child-Transmission (PTCT), vaccine and Anti-retroviral administration (ZVCTS, 2004).

Promoting VCT Services

Studies documented by United Nations Children's Fund (UNICEF), Joint United Nations Programme on HIV/AIDS (UNAIDS), and World Health Organisation (WHO) indicate that nine (9) out of ten (10) people living with HIV Infection do not know they are infected (UNICEF, UNAIDS and WHO, 2002). They further state that 75% of young Kenyans and 90% of young Ugandans indicated strong interest that they would like to be tested while still healthy but had no access to VCT services.

The Southern Africa AIDS information Service Bulletin (SAFAIDS News, 2001) studies in Zimbabwe had documented that voluntary HIV counselling and testing was proven HIV prevention and support strategy employed in many countries and provides tangible benefits for those who test either positive or negative. In the same vein the Anglican Church leaders recommended the promotion of VCT and establishment of support groups and other counselling services for those who are orphaned, ill, afraid, dying, or bereaved, and the provision of health care and basic needs, training people and the clergy in counselling (UNAIDS Focus, 2001).

World Health Organisation recommends that VCT services should be integrated into the existing services like;

- Antenatal Care (ANC)
- Youth-Friendly Clinics
- Family Health Services
- Youth Clubs
- Free-standing clinics
- Mobile Vans

These should be accessible to young people from the marginalised groups such as sex workers and migrants (UNICEF, UNAIDS and WHO, 2002).

Despite the strong interest by people to have HIV/AIDS testing, VCT promotion has been hindered by unavailability of test kits, lacks of knowledge and access to VCT centres.

VCT Service Providers

UNAIDS (2000) recommend that access to VCT should be expanded rapidly. It further recommends that countries should explore ways of sharing the counselling load, ensure that counsellors are supported and that quality counselling is guaranteed.

According to SAFAIDS News (2001), there are many institutions that provide VCT services in different countries. However, in Zambia, these institutions fall under the following service providers:

1. **Public Sector Clinics:**

   These are government hospitals and health centres. In Zambia, they report to Zambia Voluntary Counselling and Testing Services (ZVCTS) which is based at the University Teaching Hospital (UTH) virology laboratory. ZVCTS supplies the testing kits to these centres. There are over 80 centres that provide VCT free of charge.

2. **Non-Governmental Organisations (NGOs):**

   They include institutions like Kara counselling and the New Start Counselling Centres. They are mainly found in urban areas where they charge a fee for VCT services, but it is free for those that can't afford to pay for the service.

3. **Public Sector/NGO partnership:**

   These institutions include the research centres (Tropical Diseases Research Centres [TDRC]) and Mission hospitals like Chikankata Mission Hospital.

4. **Private Sector:**

   These include institutions like those run by the mining companies and different companies that run VCT at the places of work. They offer the service to their employees and their families. There are also those who

provide the service on profitable lines by charging clients (CSO, 2003; Kara Counselling, 2004 and SAFAID News, 2001).

A Good VCT Setting

Counselling can take place in many different settings. Potentially these settings include health centres, maternity services, family planning clinics, schools, churches and Youth outreach centres (commonwealth Youth Programmes, 1995). A good counselling Centre should have the following characteristics;

a. Confidentiality

There must be assurance that the client's concerns are not discussed outside the counselling session unless they give permission, and that other people cannot overhear the conversation with the counsellor.

b. Accessibility to the VCT service

The centre should be within reachable distance. People should also know it. Therefore information should reach people by any mean possible like radio, printouts, person-to-person, peer education and mass education campaigns.

c. A Counsellor

The counsellors must be trained to develop their skills and equip them to assist their clients. Trained counsellors may include health workers, teachers, church leaders and the youths (CBoH, 2002). The Ministry of Health and CBoH recommend that every health worker should be trained in counselling skills to deliver successful VCT services.

d. Testing Services

There should be a laboratory with staff to carry our HIV test. However, the Ministry of Health recommend that even if a health centre does not provide testing services, counselling can be done and make appropriate referrals to centres that do testing or make arrangements with the District Health Management Team (DHMT) to have specimen collected and tested elsewhere (CBoH, 2002).

Who Needs VCT?

It is said, "everyone is positive unless proved otherwise". Therefore, everyone needs to have VCT done. In Zambia, VCT is optional and not mandatory. The National Aids Council (NAC) has been advocating for mandatory HIV screening (Times of Zambia, 2004). The Defence Forces in Zambia have also echoed the same sentiments. The argument is based on the premise that the current approach of referring sick people to VCT is wrong. In addition, the number of people accessing Anti-Retroviral drugs (ARVs) is very low. However, the Commonwealth Youth Programme (1995), UNAIDS (2000) and CBoH/MoH (2002) recommend that the following specific cases should undertake VCT:

- Those who are worried that they might be infected with HIV
- Those that want to test for HIV (Pre-test counselling) and after testing (post-test counselling) regardless of their results
- Those that are worried that their past or present behaviour has put them at risk, especially those with sexually transmitted infections (STIs)
- The AIDS patients or those with diseases related to HIV infection
- Those experiencing difficulties with employment, housing, finances, family and so on as a result of HIV infection
- For the families and friends of those infected with HIV
- Those that are sexually active including those with extra marital affairs and those in polygamous marriages
- Those intending to enter into marriage so that the couple makes an informed choice prior to marriage
- Victims of sexual defilement or rape
- Those planning to bear children to avoid parent-to-child-transmission (PTCT) of HIV infection
- Those that have been in contact with blood or bodily fluids of other people, including needle pricks or in accidents.

The value of VCT

When people know their HIV status, they are able to make important decisions in their lives and live positively.

Studies have confirmed that voluntary and confidential HIV counselling and testing is an important tool for preventing HIV infection. VCT helps people to evaluate their behaviour and its consequences. A negative test result offers a key opportunity to enforce the importance of safe and risk-reduction behaviour (UNICEF, UNAIDS and WHO, 2002).

Those that are HIV seronegative are encouraged to maintain their negative status through the following;

a. abstinence from penetrative sexual intercourse (homosexual or heterosexual);
b. being faithful to the spouse (for those that are married);
c. use of condoms consistently and correctly if they can't adhere to (a) and (b);
d. avoid contact with infected sharps, needles or blood and bodily fluids; and,
e. have VCT done preferably every after three (3) months (CBoH and MoH, 2002).

Studies conducted in Zimbabwe have shown that those who test negative are more likely to change their behaviour to maintain their negative status (SAFAIDS News, 2002).

Nonetheless, those that test positive receive referrals for care and opportunities to talk to knowledgeable people who help them understand what their HIV status means and the responsibilities they have to themselves and others as a result (UNICEF, UNAIDS and WHO, 2002). They are motivated to protect themselves and others, prevent the spread of HIV and live positively. According to SAFAIDS (2004), Kara Counselling (2004) and the Commonwealth Youth Programme (1995), those living positively need to;

a. seek medical attention early and as frequently as possible to prevent opportunistic infections;
b. access laboratory investigation for Cell-Count (CD_4) and Viral load;
c. access treatment of Anti-retroviral therapy (ARVs);
d. referral to local support groups like post-test clubs where HIV positive people share their experiences and encourage each other to live

positively. Examples are the Network of Zambian peoples living with HIV (NZP+) and People with AIDS (PWAs);

e. improve their nutritional status by eating balanced diet;
f. encourage the client to be doing some physical exercises;
g. avoid indulging in unprotected sexual intercourse which may put them at further risk of contracting or transmitting to other HIV infection;
h. discourage smoking, drinking alcohol and taking narcotics that reduce their immune system further
i. avoid stress to their bodies and their mind; and,
j. keep healthy and active.

Therefore, VCT empowers people who are negative to remain uninfected and motivates those that are positive to "live positively" and stay healthy

According to the Commonwealth Youth Programme (1995) counselling before and after HIV testing is important in helping young people decide whether or not to be tested, and in supporting them after they know the results of an HIV test. Therefore the counselling opens up possibilities for the young people to explore so that they make choices and solve problems in a health way.

However, studies on causes that contribute to low utilisation of VCT services have reviewed many factors.

Mugusi, et al (1999) studied factors affecting response to VCT among Police Officers in Dar-es-salaam concluded that fear by Police officers to know their HIV status and lack of accessibility to VCT were some of the major factors that hindered VCT utilisation by Police officers.

Suzane (1999) studied the intersection of HIV, VCT and violence in Dar-es-salaam, Tanzania, also found that disclosure of serostatus was associated with partner violence. That was also demonstrated in the United States of America and other countries in Africa.

Other studies conducted on the barriers of HIV counselling and testing in Lusaka by Baggley, et al (1995) indicated that many people were apprehensive about knowing their HIV status. It was found that, although VCT was useful in HIV prevention especially for the majority who were negative, it was very much under-utilised. Some of the major causes included lack of perceived benefits of testing HIV positive, fear for recrimination by spouse or family, fear that being HIV positive will add to the many problems in the world and some were frightened. Other factors included fear of stigmatisation and discrimination by people. The study recommended that if barriers were to be overcome, the need for HIV education to create awareness of potential benefits of HIV VCT and creation of supportive environment for those that test HIV positive is inevitable.

CHAPTER THREE

METHODOLOGY

This chapter will outline the process of the study, research design, population, sampling techniques, data collection and analysis.

The Paradigm

In an attempt to inquire into this subject, the commonly used paradigms were qualitative and quantitative researches. A paradigm is a framework that helps to organise broad based views (Urlin, et al, 2002). It creates boundaries in which facts are arrived at in a given field of inquiry.

In qualitative research, the researcher is the prime instrument for data collection and analysis (Merriam and Simpson, 1995). "Qualitative data are open ended in order to find out what people's lives, experiences and interactions mean to them in their own terms and in their natural setting" (Ibid:157). This measurement adds depth and details to data gathered for objective techniques. The method "allows us to know people personally and to see them as they are developing the view of the world" (Bogdan and Taylor, 1975:4). It involves fieldwork as the researcher goes to the site, the group of people, or the institution to collect data. For this study, the researcher used interview guides during focused group discussions.

Quantitative research measurements use objective and standardized instruments to limit data collection to prescribed categories of responses (Merriam and Simpson, 1995). It is used to determine and quantify data. For the purpose of this research, structured questionnaires were used.

Research Design

A research design is a programme to guide the researcher in collection, analysis and interpreting observed facts (Bless and Achola, 1988). The descriptive research design was used. This design gives a frame of reference that can enable the researcher report the results more precisely and accurately.

Population

The population of the study comprised men and women above the age of fifteen (15) years. It was expected that the total population was 2,000 people in six communities.

Sample Population

For the purpose of this study, 100 informants were sampled from six communities. These included twenty (20) health workers (inclusive of community health workers and home based caregivers). Apart from that, each of the six communities was to have a focused group discussion comprising of 8-12 people. However, only five communities were organised for a focused group discussion as the sixth one could not turn up on the appointed date.

Method of Sampling

Sampling is a process through which the study subjects are chosen from a population (Treece and Treece, 1986). It is a subset of a population. It helps focus the study on characteristics of interest (Merriam and Simpson, 1995). There are two methods of sampling; the probability or random sampling and the non-probability or non-random sampling methods. Probability sampling provides a statistical base for a sample to be representative of the target population (Bless and Achola, 1988). It gives every member of the population an equal chance to be selected. In this study, respondents from the community were sampled using a simple random sampling technique. The lottery method was applied without replacement using "yes" or "no" with pieces of paper in a box. The six communities were also selected by lottery method.

The non-probability sampling is based on the researcher's judgement or convenience and the characteristics of the sample (Merriam and Simpson, 1995). In this method, some members will have a chance to be selected while others may not. This method was used to selected health workers and community members for group interviews (Focused Group Discussions). The justification for that was that, there were very few health workers and therefore all the health institutions sampled were to have the staff present at the time of the study

selected. In addition, respondents for Focused Group Discussion (FGD) were selected by convenience. That involved workers and members of the community who were present at the time of the interview.

Data Collection

Data collection allows for a systematic way of collecting information about subjects and the setting in which they occur (Treece and Treece, 1886). For this study, the research will use questionnaires and interview guides. A questionnaire method is one in which a number of printed questions are used for data collection (Ghosh, 1992). Two closed-questionnaires with a few open-ended questions were used. One questionnaire for members of the community respondents and the other for health workers. Questionnaires were handed to informants physically and collected at an appointed time. Those who could not read and write were asked to answer questions translated by research assistants.

The interview method is a kind of verbal technique for obtaining data (ibid). it is a direct method of data collection in the study of human behaviour. This method was used during FGDs.

Data Analysis

This is a process of brining ordered structure and meaning to the mass of collected data (Bless and Achola, 1988). It is a systematic way of arriving at conclusions. For this study, it involved data sorting, grouping, classifying and then entered on the computer in Microsoft excel.

Data from the questionnaires was analysed using; pie charts, graphs and tables of frequency and percentage as shown in the dummy table below.

Table 3: Gender Distribution dummy table

Sex	Frequency	Percentage
Male		
Female		
Total		

Data from the interview guides was sorted and analysed by identifying and prioritising frequently occurring themes.

CHAPTER FOUR

FINDINGS

This chapter presents findings of the research on low utilisation of VCT in Mufumbwe district. For more details, refer to the tables on appendices A and B for Health Workers and members of the community respondents respectively.

1.0. HEALTH WORKERS

A. BIO DATA

Gender distribution

The research sampled 55% of males and 45% as female respondents

Age range distribution

Majority of the respondents were aged between 26 – 35 years who were 40%, 25% were between 36 – 45 years, 20% between 15 – 25years while those between 46 – 55 years were 10% and 5% for those above 55years old.

Marital status distribution

The study reviewed that majority of respondents 65% were married, 20% were single, 10% were widowed and 5% were engaged for marriage.

Range of number of children

35% of the respondents had 5 -6 children, 30% had 1 - 2 while those without a child and those with more than 6 children were 15% each, and 5% had 3-4 children.

Profession/position at work

The study had 40% of respondents as Nurses, 5% were Clinical Officers, Laboratory Technicians and Environmental Health Technologists each while 45% were other cadres representing: Community Health Workers, Classified Employees, Caregivers and Nutritional Assistants.

Range of duration of Service

55% of the respondents had served between 1 - 5 years, 15% had served between 6 – 10, 11 – 15 and above 20 years each. None of the respondents had served between 16- 20 years.

B. KNOWLEDGE OF VCT

The research found that majority of the respondents 95% have ever heard of VCT while 5% had never. Of those that have ever heard of VCT, 39% had heard it from fellow health workers and in seminars/workshops each while 9% had read it from printed materials (posters). Others 13% had heard it from College and Church.

Training in VCT

80% of the respondents had never received training in VCT while 20% had been trained in VCT. However, 45% indicated that they could do HIV counselling confidently, 30% could do it but not confidently and 25% cannot do HIV counselling at all.

Value/benefits of VCT

Majority of the respondents know that the value of going for VCT include;

- to know one's health status;
- to know how to take care of oneself and prevent HIV transmission;
- to access Anti-Retroviral drugs;
- to plan for one's future;
- for behavioural change;
- to invest for one's family;
- to protect one's spouse and oneself; and,
- to remove one's worries and free one's mind.

Creating awareness on VCT

68% of the respondents indicated that they were giving health education to create awareness on VCT, 16% were using printed materials (posters) and 8%

through community workshops while the other 8% were doing nothing about it. No mass campaign was done to create awareness on VCT.

C. UTILISATION OF VCT

The study reviewed that 49% of the respondents indicated that people were utilising VCT services actively while 35% disagreed and 25% were not sure of VCT utilisation in the district. Of the total respondents, 70% had never gone for VCT while 30% had done it from Loloma, Mufumbwe, Solwezi and Kitwe hospitals.

Table 4 below stipulates some of the reasons that hindered many people from going for VCT as perceived by health worker respondents;

Table 4. Reasons for not going for VCT – Health Workers

	Frequency	Percentage(%)
(a) Unavailability of HIV test kits	2	2
(b) Inaccessibility to VCT centres	4	4.5
(c) Lack of knowledge or awareness by people	12	14
(b) Fear to know	16	18
(e) Fear if partner violence after HIV disclosure	11	13
(f) Apprehension (anxiety) of knowing HIV status	3	3
(g) Lack of perceived benefits of testing HIV positive	5	6
(h) Fear for recrimination (blame for bad behaviour) by others	14	16
(i) Fear that being HIV positive adds to many problems in the world	4	4.5
(j) Fear of stigmatisation (marked shame or discredit upon a person)	10	11
(k) Fear of discrimination (unfair and unjust treatment by others)	7	8
(l) others	0	0
Total	88	100

Source: Research data

Fear of knowing one's HIV status (self stigmatisation) constituted 18%, 16% fear recrimination (blame for bad behaviour) by others while lack of knowledge or awareness by people were 14%. Some partners fear violence after HIV disclosure 13%, whereas stigmatisation (marked shame or discredit upon a person) was 11% and discrimination (unfair and unjust treatment by others) 8%. Lack of perceived benefits of testing HIV positive were 6% and inaccessibility to VCT centres were 4.5%.

With the above findings, majority of the respondents proposed that Voluntary Counselling and Testing should be done 85%, while 15% recommended Routine Counselling and Testing. None of the respondents proposed to have Mandatory Counselling and Testing introduced.

D. SERVICE DELIVERY

Figure 1 shows 68% indicated that VCT was done in Mufumbwe at the public hospital, 20% by non-governmental organisations while 12% didn't know where VCT was offered in the district. None of the respondents knew any private institutions that offer VCT in the district. In figure 2, 64% indicated that HIV counselling was done by health workers in the district, 32% by caregivers and 4% by social workers. No teachers do HIV counselling in the district.

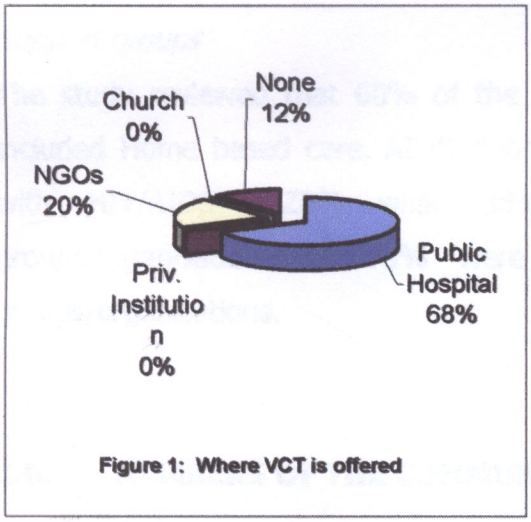

Figure 1: Where VCT is offered

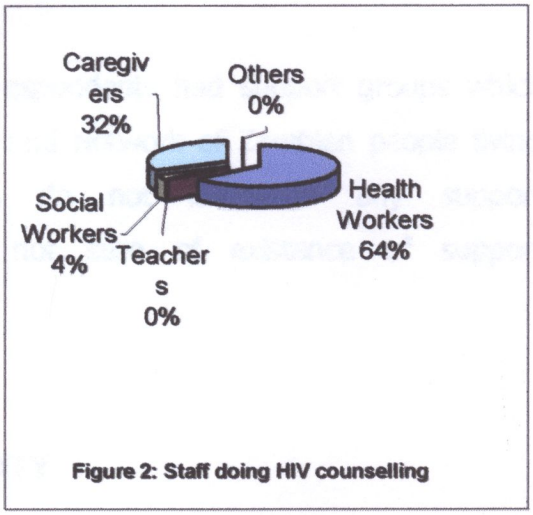

Figure 2: Staff doing HIV counselling

Source: Research data

The research also found that 75% of respondents had HIV counsellors at their Health institutions while 25% didn't have HIV counsellors.

Regarding HIV testing facilities, 55% indicated that Mufumbwe district hospital had, while 45% did not know that Mufumbwe district had testing facilities. 100% of respondents indicated that their Hospital/ Health centres do not have Anti-Retroviral drugs. 75% of the respondents indicated that the district do not have peer counsellors while 25% acknowledged the presence of peer counsellors. Figure 3 refers for details

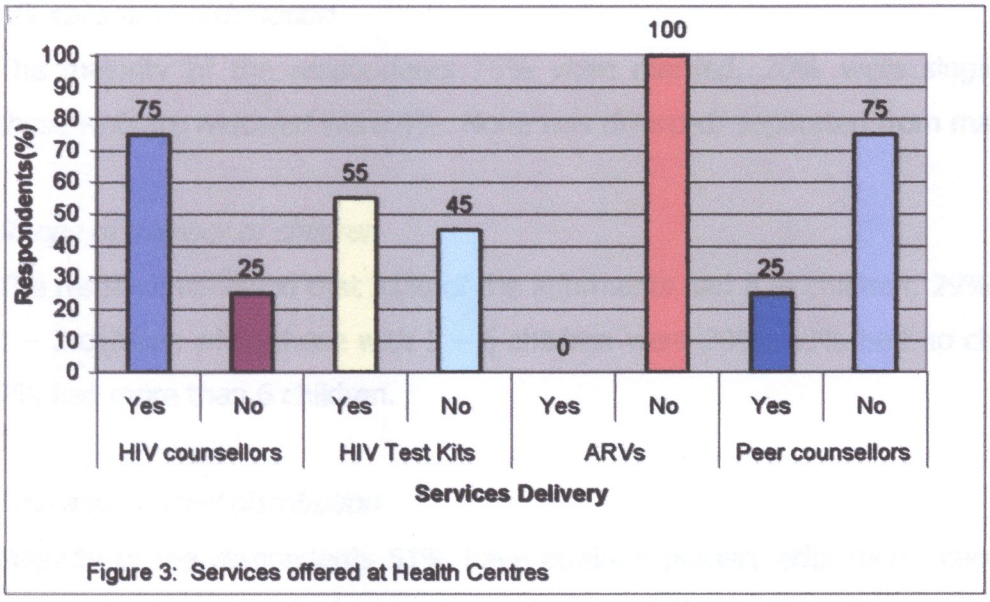

Figure 3: Services offered at Health Centres

Source: Research data

Support groups

The study reviewed that 60% of the respondents had support groups which included Home based care, AIDS clubs and Network of Zambian people living with HIV/AIDS (NZP^+) while 35% do not know of any support groups/organisations and 5% were not sure of existence of support groups/organisations.

2.0. MEMBERS OF THE COMMUNITY

A. BIO DATA

Gender distribution

The study had more male respondents 54% than 46% female respondents.

Age range distribution

45% of respondents were aged between 26 – 35 years, 29% between 15 – 25 years, 19% between 36 – 45 years while those between 46 – 55 years constituted 5% and 2% were above 55 years of age.

Marital status distribution

The majority of the respondents 76% were married, 20% were single while those who are widowed were 4%. None was divorced/ separated from married.

Range of number of children

The research reviewed that 31% of the informants had 3 -4 children, 29% had 1 – 2 children while those with 5 – 6 children were 20%, 13% had no child and 7% had more than 6 children.

Educational level distribution

Majority of the respondents 51% have attained primary education, followed by those who have acquired secondary education 25%, 20% had been to college and 1% university education. 3% had never been to school.

Occupation

The research reviewed that majority of the respondents 45% were earning their living on farming, 24% were government employed while the self-employed were 10% and Private Company employed were 4%. Others constituted 17% of which 43% were housewives, 21.5% were school going and dependents each while hunting and those without any occupation were 7% each.

B. KNOWLEDGE OF VCT

According to figure 4, the research found that majority of the respondents 75% have ever heard of VCT while 24% have never heard about it. 1% expressed some ideas of VCT.

Of those who have ever heard of VCT, 33% have heard it from health workers, 31% from radio/TV while 27% from friends/relatives. 6% read it from printed materials (posters) and 3% from church.

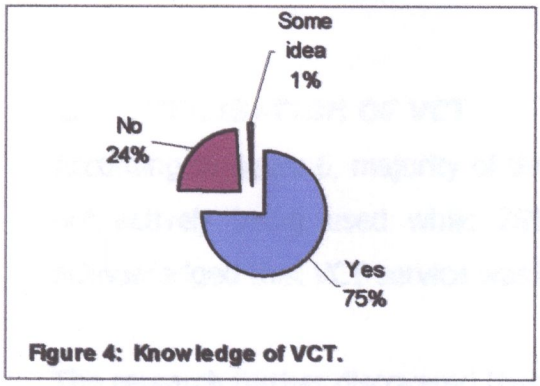

Figure 4: Knowledge of VCT.

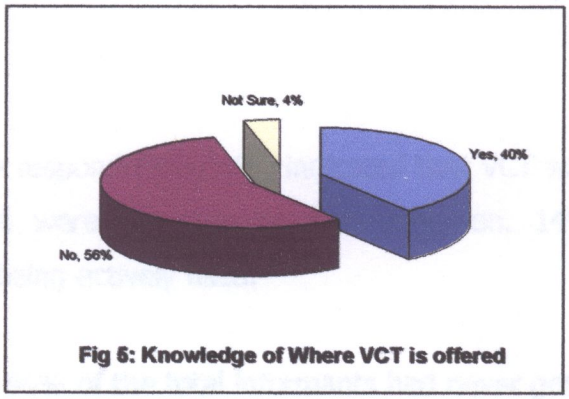

Fig 5: Knowledge of Where VCT is offered

Source: Research data

Figure 5 indicates that 56% didn't know a place where VCT was offered while 40% knew that it was done at Mufumbwe District Hospital and 4% were not sure of the place. Others indicated that it was offered at Mukinge Mission Hospital in Kasempa district and at Kaminzekenzeke and Kalengwa Rural Health Centres in Mufumbwe district.

The value of knowing one's HIV status

The community's knowledge regarding the value/ benefits of VCT was as follows, to;

- know one's HIV status;
- prevent being infected by HIV;
- change one's behaviour;
- learn to live positively;
- plan for the future;
- protect oneself and others from being infected by HIV;
- turn to God and repent one's sins and to live long;
- have information for statistical purposes by the government; and,
- improve one's nutrition and avoid being pregnant.

However, some indicated that VCT had no value because it would increase one's problems.

C. UTILISATION OF VCT

According to figure 6, majority of the respondents (61%) indicated that VCT was not actively being used while 25% were not sure of VCT utilisation. 14% acknowledged that VCT service was being actively used.

The research further discovered that 94% of the total informants had never gone for VCT while only 6% had as shown in figure 7 below. Of those who attended VCT, 60% had done it at Mukinge MH, 20% in Mufumbwe and Solwezi each.

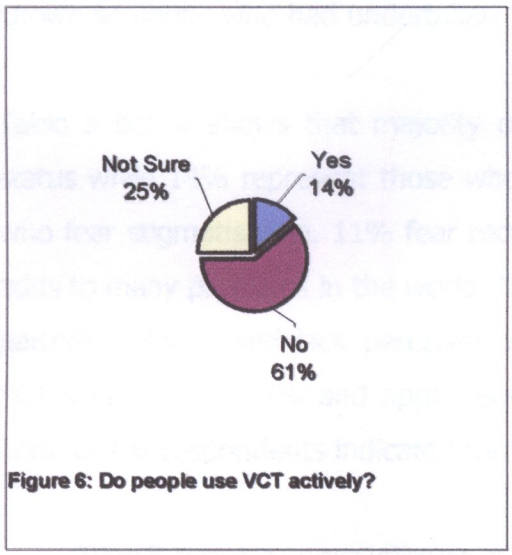

Figure 6: Do people use VCT actively?

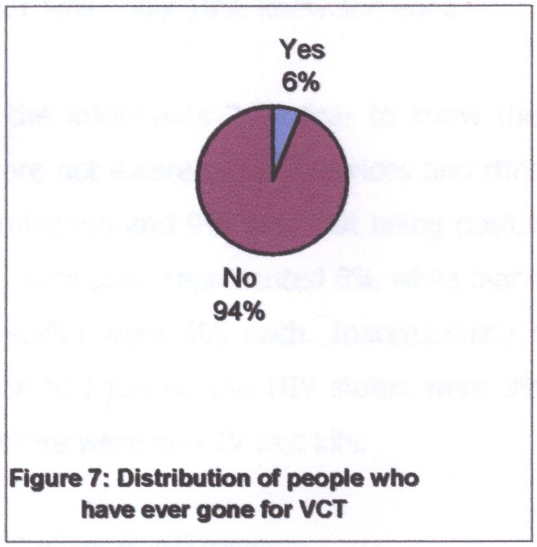

Figure 7: Distribution of people who have ever gone for VCT

Source: Research Data

Some of the reasons given for non-utilisation of VCT services included the following;

- Lack of awareness of VCT in the district;
- Inaccessibility of VCT services;
- some people felt that they don't have HIV infection ;
- Fear to know one's HIV status;
- some stated that they were not sick because it was on for the sick;
- Lack of treatment for those who are HIV positive;

- Some stated and of quote, "I trust my partner, it is for the sick, I'm a Christian, if I'm found positive I will commit suicide and I have no money to pay for the services"; and,
- Others indicated that they were too old to test, they fear recrimination (blame) from others and still some indicated that their partners (husbands) didn't want to test and if they did, they would be divorced.

However, some still did not have time to go for VCT while others did not see the value of HIV testing.

The research further discovered that majority of the respondents 82% had never known someone who had undertaken VCT while only 18% knew someone.

Table 5 below shows that majority of the informants 24% fear to know their status while 14% represent those who are not aware of VCT services and those who fear stigmatisation. 11% fear recrimination and 9% fear that being positive adds to many problems in the world. Discrimination represented 8% while fear of partner violence and lack perceived benefits were 6% each. Inaccessibility of VCT services were 5% and apprehension to knowing the HIV status were 3%. None of the respondents indicated that there were no HIV test kits.

Table 5: Reasons for non-utilisation of VCT by community members

	FREQUENCY	PERCENTAGE %
Unavailability of HIV test kits	1	0
Inaccessibility to VCT centres	12	5
Lack of knowledge or awareness by people	32	14
Fear to know	56	24
Fear if partner violence after HIV disclosure	14	6
Apprehension (anxiety) of knowing HIV status	8	3
Lack of perceived benefits of testing HIV positive	14	6
Fear for recrimination (blame for bad behaviour) by others	25	11
Fear that being HIV positive adds to many problems in the world	22	9
Fear of stigmatisation (marked shame or discredit upon a person)	32	14
Fear of discrimination (unfair and unjust treatment by others)	18	8
Total	234	100

Source: Research data

Some of the respondents still indicated that if they were found to be HIV positive, they would commit suicide while others feared to pay for the services.

Others indicated that if the partner dies, the surviving spouse could be charged by relatives to the deceased and therefore better not to know. Others claimed they were Christians; hence they could not be infected while some claimed there were no drugs for those who were found HIV positive. Some indicated that they were not ill, there was no confidentiality by counsellors while others claimed it was better not to know one's status or else one can die fast.

D. SERVICE DELIVERY

Majority of the respondents 74% indicated that VCT was offered at the public hospital while 25% didn't know any place where VCT is offered in the district. 1% indicated that VCT is done at Church. Regarding who does HIV counselling in the district, 68% knew that health workers (H/Ws) were doing it, 17% by Teachers, 6% by church leaders and 5% by caregivers. The other 1% did not know the providers of HIV counselling in the district.

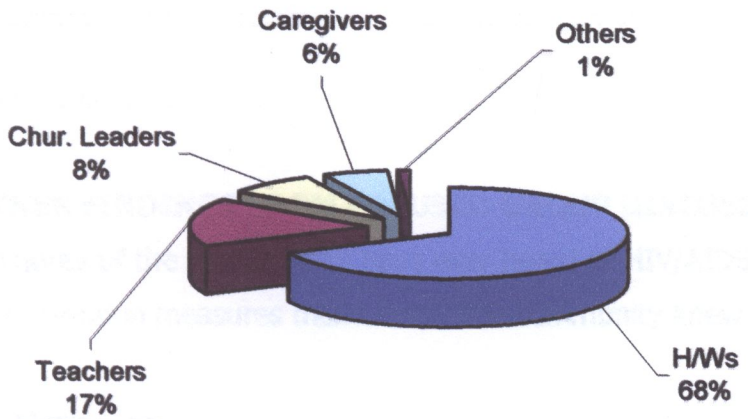

Figure 8: Distribution of VCT providers

Source: Research Data

Accessibility of VCT

40% did not know the distance to the nearest VCT centre, 30% stayed over 15kilometers away from the nearest VCT centre while 22% were within 5kilometers and 8% within 5 – 15Kilometers.

Support Groups

Majority of the respondents indicated that there were no support groups for the HIV positive, orphaned, ill people or afraid. Figure 9 refers for details.

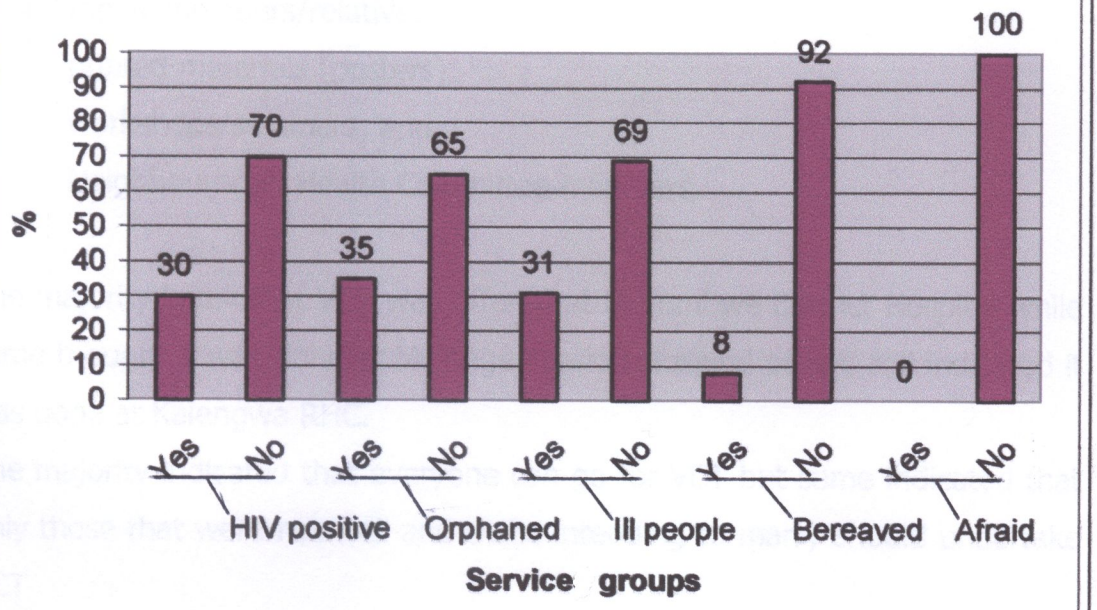

Figure 9: Distribution of Support groups

Source: Research Data

3.0. OTHER FINDINGS FROM FOCUSED GROUP DISCUSSIONS

- The majority of the respondents have ever heard of HIV/AIDS
- Some prevention measures members of the community knew included;
  - Abstinence;
  - being faithful to one partner;
  - use of condoms during sexual intercourse;
  - avoid injury with infected sharps like razorblades, needles or scissors;
  - wearing gloves during delivery;
  - close open wounds to prevent blood contact; and,
  - belief in Christ.

- Majority indicated that they have ever heard of VCT but one group indicated they had never heard about it. Those who have heard about it, have heard if from;
    - the radio;
    - family members/relatives;
    - printed materials (posters);
    - workshops/seminars; and,
    - Neighbourhood Health Committee members.

- The majority knew that VCT was offered at Mufumbwe District Hospital while some thought it was done at Mukinge Mission Hospital others still indicated it was done at Kalengwa RHC.
- The majority indicated that everyone can go for VCT but some indicated that only those that were not well and those intending to marry should undertake VCT
- The following were some of the reasons why many people do not go for VCT;
    - VCT was inaccessible;
    - fear that people would laugh at them (stigmatisation);
    - fear that people could blame them for having brought it in the family (recrimination);
    - fear that one can die fast after knowing the results;
    - knowing that one was HIV positive could bring about misunderstanding in the home leading to violence and divorce or charge for being unfaithful to one's spouse and bringing HIV in the home;
    - knowing that one was HIV positive can add to problems
    - some feel that they were HIV negative and therefore there was no need to have an HIV test;
    - lack of confidentiality by counsellors;
    - lack of perceived benefit for testing HIV positive;
    - lack of awareness of VCT in the communities; and,
    - no money to go and have an HIV test.

- fear that blood from an infected patient can be transfused in another person during testing or change one's results which are negative with the positive ones; and,
- there was no need for those who were well to test for HIV.

Some of the perceived value/benefits of going for VCT include;

- if one was negative, he/she could protect oneself from contracting it;
- to plan for one's future and the children;
- to change one's behaviour;
- to live positively;
- to avoid witch-hunting and waste resources in the process;
- for the government to know the number of people who were infected and use it for planning (statistical purposes); and,
- to get advice on good nutrition.

Regarding the type of counselling and testing people would propose to have, the majority 44% proposed Voluntary, 33% recommended Routine and 23% proposed mandatory.

The majority indicated that information was not adequate in the communities but those who knew, have heard it from either a Health Worker or from Radio. One community informed the term that information was not available because there was no health education in the communities.

Some of the solutions to increasing information in the community include;

- increase sensitisation in the community on VCT through meetings in the villages, Neighbourhood Health Communities and person-to-person talks;
- train counsellors in VCT in the communities;
- increase information education communication (IEC) materials; and,
- form committees on VCT in the communities.

some of the measures to increase VCT in the communities include;

- integrate VCT in routine outreach sessions;
- increase sensitisation on VCT in the communities; and,
- form VCT committees in the communities.

CHAPTER 5

DISCUSSION, CONCLUSION AND RECOMMENDATIONS.

DISCUSSION OF THE FINDINGS.

KNOWLEDGE OF VCT.

The research elicited that Health Workers and members of the community had enough knowledge regarding VCT; 95% among health workers and 75% of members of the community. This correlates with the CSO (2003) report that knowledge of HIV/AIDS among Zambians was 100%. Despite the high knowledge levels in both, there was inadequate understanding of VCT among members of the community.

Whereas many health workers have heard VCT from fellow health workers and in workshops/seminars, majority community members have heard it from radio/TV, friends/relatives and posters. Therefore, the quality and quantity of information disseminated in this manner is questionable and cannot bring about proper understanding or appreciation of VCT because it's normally distorted. That entails why about 60% of respondents in the community did not know where VCT was offered in the district. It also underscores the fact that majority of the community member did not express the value/benefit of VCT in terms of accessing ARVs; which is the more reason why the government through the Ministry of Health has placed much emphasis on VCT. Baggley, et al (1995) recommended the need for HIV education to create awareness of potential benefits and creation of supportive environment for those that test HIV positive.

Psychologically, mere knowledge of one's HIV status cannot remove worries or free one's mind unless one understands the value/benefits of it and receives the necessary help.

UTILILISATION OF VCT.

The findings reviewed that majority of the respondents were not utilizing VCT services actively. Both health workers (60%) and members of the community (86%) indicated either that VCT was not actively used or they were not sure of its utilisation.

The fact that 94% of community respondents and 70% of health worker informants have never gone for VCT services illustrates the magnitude of the problem. Health workers have attributed the low utilization of VCT service to fear of knowing one's status whereas community members expressed it further in terms of lack of awareness and inaccessibility of VCT services in the district especially during FGDs.

These findings are in consonant with the other findings by Mugusi, et al (1999) in Dar-es-salaam and MoH/CBoH (1997) who attributed it to lack of accessibility of VCT services, lack of confidentiality by counsellors and fear of knowing one's status. Suzanne (1999) intimated this viewpoint to partner violence of HIV serostatus disclosures. The same was documented by Buggley, et al (1995) on barriers of HIV VCT in Lusaka.

SERVICE DELIVERY.

The research discovered that only one public hospital offers VCT services and that is Mufumbwe District Hospital. It was also unveiled that the hospital had only two trained staff in VCT but only one is active. The hospital does not offer ARVs to its clients found HIV positive because it does not stock these drugs.

The research also found that the only support group in VCT service delivery was the Home Based Care group under the Catholic Relief Services supporting only clients that test HIV positive. This is in contrast with UNICEF, UNAIDS and WHO (2002) and SAFAIDS (2001) who urged that VCT service delivery should be

accessible and provided in public, NGOs, partnership and private sectors, which can include youth friendly clinics, ANCs, free – standing clinics and mobile vans.

Because all these services were offered around the township, majority of the respondents found them inaccessible and therefore do not get their benefits.

Notwithstanding that, 80% of health workers are not trained in VCT however 75% indicated that they could do HIV counselling confidently or not. Though 75% of health workers claim that they can do HIV Counselling, lack of sufficiently trained staff in HIV VCT coupled with shortage of staff in the district could lead to untrained staff being involved in HIV counselling. That is not only unethical but also unprofessional in the Medical and Nursing practice and may lead to lack of confidentiality, subsequently leading to stigmatisation of patients. These findings are at variance with Commonwealth Youth Programme (1995) who advocated that a good VCT centre should have a counsellor, confidentiality, testing services and be accessible. Moreover, for centres without VCT testing services, CBoH and MoH (2002) recommend that counselling can be done and appropriate referral for testing of specimen should be established, hence, inaccessibility of VCT service cannot arise.

To sum it up, knowledge of HIV VCT is very high in Mufumbwe District, however, its utilisation and service delivery can be said to be in the infancy stage and therefore requires a lot of support to improve it.

CONCLUSIONS.

The study has identified and explored factors that contribute to low utilisation of HIV VCT in Mufumbwe district. A number of factors have been enlisted and prominent among them is that, VCT as new concept is not well understood by majority of the people. To many people, the benefits associated with undertaking VCT are still vague and not explicit. While majority of health

workers articulate the value of undertaking VCT, to many members of the community it is an illusion especially the value and benefits related to mitigation, care and support.

It is clear from the findings that majority of the people don't want to know their HIV status due to fear of knowing one's HIV status, lack of knowledge or awareness and inaccessibility of VCT services. That goes to show that the quality and quantity of information of VCT service delivery is very low. When ignorance reigns, then services rendered are not appreciated at all.

The research also elicited that the district does not have sufficiently trained staff in HIV programme management like counselling and testing, Health education and care and support. Furthermore, only one organization apart from the Public Hospital offer VCT service. This has made service delivery inaccessible to majority of the people and therefore making utilization of VCT very low.

From the above findings, we can conclude that VCT utilization in Mufumbwe district is indeed very low. The many factors contributing to this low utilization can be related to:

- Members of the community lack understanding of the concept of VCT,
- VCT service delivery is inaccessible to many people,
- Benefits associated with undertaking VCT are not well articulated, appreciated and felt by majority of the people, and
- The district does not have adequate mitigation, care and support interventions for those found HIV positive.

To overcome these obstacles, various interventions should be put in place to ensure active utilization of VCT.

RECOMMENDATIONS

Therefore, the following recommendations are made at all level of health services delivery; the policy-makers (MoH and CBoH), the implementing agency

(Mufumbwe DHMT), the recipient of service (members of the community) and the donor community, in order to optimise VCT utilization and realize the desired Health Reforms vision "*to provide Zambians with equity of access to cost-effective quality health care as close to the family as possible*" (CBOH, 1997: iii).

A. The Ministry of Health/Central Board of Health.

The Ministry of Health and the Central Board of Health must be in the forefront of formulation of positive policies and spearhead there implementation. The following are the recommendations;

- introduce routine counselling and testing as a policy;
- make ARVs available in all the districts by training personnel to handle ARVs, or;
- the provincial focal person (the Doctor handling ARVs) should introduce mobile clinics to cover underprivileged communities and districts;
- introduce free ARVs for the marginalized poor majority; and,
- refashion VCT to initiate HIV Counselling, Testing and Care (CTC) concept.

B. The District Health Management Team.

The following recommendations are made for Mufumbwe DHMT in order to increase VCT service utilisation;

- train members of staff in VCT as HIV counsellors in all the health centres and should be readily available most of the time;
- HIV Counsellors to exercise and maintain confidentiality in dealing with clients;
- open more VCT centres, if possible all health centres should provide clients with HIV counselling but refer specimen for testing to diagnostic centers;

- there is need to train HIV peer educators and peer counsellors and form youth friendly clinics;
- use participatory learning approaches in community sensitisation on VCT including popular theatre;
- intensify VCT sensitisation campaigns especially among the schoolgoing youths who the *Window of Hope;*
- train members of the public in VCT;
- integrate VCT in normal outreach sessions; and,
- DHMT to facilitate formation of community VCT sensitisation committees.

C. COMMUNITY

For the community, the following recommendation are made;

- form VCT committees in the communities to continue sensitizing people. These can include those that have undergone HIV counselling and testing whether they are positive or negative, to work on voluntary basis; and,
- come up with post-test clubs for those that have tested.

D. The NGOs and the Donor Community

The donor community including NGOs can do a lot in alleviating the suffering rural populace and bring about upliftment of people's standard of living; therefore the following is recommended;

- increase support to the community especially people in the rural areas who are the poverty-stricken majority, marginalized and underprivileged in terms of care and support for those found HIV positive;
- Organizations like NZP+ and PLWA should increase their activities in Mufumbwe district;
- encourage Income Generating Activities (IGAs) by supporting community based projects; and,
- other than concentrating in urban areas, they must encourage and do research in rural areas; the findings of which may be inferred also to urban areas.

Future Research

The researcher acknowledges that several questions have not been fully answered in this research report. Therefore, further research should be conducted to elicit other factors. Suggested areas of future research include;

i) research into the influence of traditional healers on VCT utilisation;

ii) the effects of HIV VCT on those who had undergone it; and,

iii) an HIV/VCT training need assessment study among Health workers and members of the public.

This would enable policy makers to know which among the factors are critical and need to be redressed urgently. It will also test the effectiveness of some of the stated recommendations to raise VCT utilisation in Mufumbwe district later alone Zambia.

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TABLES OF FREQUENCY AND PERCENTAGES

APPENDIX A. HEALTH WORKERS

Table.A 1. Gender distribution

Sex	Frequency	Percentage(%)
M	11	55
F	9	45
Total	20	100

Table.A 2. Age distribution

Age(years)	Frequency	Percentage(%)
15-25	4	20
26-35	8	40
36-45	5	25
46-55	2	10
>55	1	5
Total	20	100

Table.A 3. Marital status distribution

	Frequency	Percentage(%)
Single	4	20
Married	13	65
Divorced	0	0
Widow	2	10
others	1	5
Total	20	100

Table.A 4. Number of Children

No.	Frequency	Percentage(%)
zero	3	15
1-2	6	30
3-4	1	5
5-6	7	35
>6	3	15
Total	20	100

Table.A 5 Professional qualification distribution

	Frequency	Percentage(%)
Clin. Officer	1	5
Nurse	8	40
EHT	1	5
Lab. Techn.	1	5
others	9	45
Total	20	100

KNOWLEDGE OF VCT

Table.A 7. Ever heard of VCT

No.	Frequency	Percentage(%)
Yes	19	95
No	1	5
Not sure	0	0
Total	20	100

Table.A 8. Source of information

	Frequency	Percentage(%)
Fellow H/workers	9	39
Workshops	9	39
Posters	2	9
others	3	13
Total	23	100

Table.A 9. Knowledge of place where VCT is offered

	Frequency	Percentage(%)
Yes	15	75
No	4	20
Not sure	1	5
Total	20	100

Table.A 10. Staff Trained in VCT

	Frequency	Percentage(%)
Yes	4	20
No	16	80
Total	20	100

Table.A 11. Can do HIV counselling

	Frequency	Percentage(%)
confidently	9	45
Not confidently	6	30
Not at all	5	25
Total	20	100

Table.A 12. Means of creating awarenesson VCT

	Frequency	Percentage(%)
H. education	17	68
Mass campaign	0	0
Workshops	2	8
Posters	4	16
Nothing	2	8
Total	25	100

Table.A 6. Duration of service

No.(years)	Frequency	Percentage(%)
<5	11	55
6-10	3	15
11-15	3	15
16-20	0	0
>20	3	15
Total	20	100

Table.A 13. Do people use VCT actively

	Frequency	Percentage(%)
Yes	8	40
No	7	35
Not sure	5	25
Total	20	100

Table.A 16. Type of counselling proposed

	Frequency	Percentage(%)
Voluntary	17	85
Routine	3	15
Mandatory	0	0
Total	20	100

Table.A 17. Ever gone for VCT

	Frequency	Percentage(%)
Yes	6	30
No	14	70
Total	20	100

Table.A 18. Where VCT is offered

	Frequency	Percentage(%)
Public Hospital	17	68
Priv. Institution	0	0
NGOs	5	20
Church	0	0
None	3	12
Total	25	100

Table.A 19. Staff doing HIV counselling

	Frequency	Percentage(%)
Health Workers	18	64
Teachers	0	0
Social Workers	1	4
Caregivers	9	32
Others	0	0
Total	28	100

Table.A 20. Does your centre have?

	Frequency	Percentage(%)
HIV counsellors	Yes - 15	75
	No - 5	25
HIV Test Kits	Yes - 11	55
	No - 9	45
ARVs	Yes - 0	0
	No - 20	100
Peer counsellors	Yes - 5	25
	No - 15	75

Table.A 21. Presence of support groups

	Frequency	Percentage(%)
Yes	14	70
No	5	25
Not sure	1	5
Total	20	100

APPENDIX B:
MEMBERS OF THE COMMUNITY

Table. B 1. Gender Distribution

	FREQ.	%
M	43	54
F	37	46
TOTAL	80	100

Table.B 2. Age Distribution

	FREQ.	%
15 - 25yrs	23	29
26 - 35yrs	36	45
36 - 45yrs	15	19
46 - 55yrs	4	5
> 55yrs	2	2
Total	80	100

Table.B 3. Marital status distribution

	FREQ.	%
Single	16	20
Married	61	76
Div./Sep.	0	0
Widow	3	4
others	0	0
Total	80	100

Table.B 4. No. of Children

	FREQ.	%
Zero	10	13
o1 - 2	23	29
o3 -4	25	31
o5 - 6	16	20
> o6	6	7
Total	80	100

Table.B 5. Education Attainment

	FREQ.	%
Primary	41	51
Secondary	20	25
College	16	20
University	1	1
Others	2	3
Total	80	100

Table.B 7. Knowledge of VCT

	FREQ.	%
Yes	60	75
No	19	24
Some idea	1	1
Total	80	100

Table.B 8. Source of information

	FREQ.	%
H/W	23	33
Friend/Rel	19	27
Radio/TV	22	31
Poster	4	6
Church	2	3
Total	70	100

Table.B 9. Know where VCT is Offered

	FREQ.	%
Yes	49	40
No	23	56
Not Sure	3	4
Total	80	100

Table.B 11. Do people use VCT actively

	FREQ.	%
Tes	11	14
No	49	61
Not Sure	20	25
Total	80	100

Table.B 12.Have you ever gone for VCT?

	FREQ.	%
Yes	5	6
No	75	94
Total	80	100

Table.B 13. Do you know someone who has done VCT?

	FREQ.	%
Yes	14	18
No	66	82
Total	80	100

Table.B 6. Occupational Distribution

	FREQ.	%
Govt Employ	19	24
Priv. Employ	3	4
Self Employ	8	10
Farming	36	45
Others	14	17
Total	80	100

Table.B 15. Service Delivery

	FREQ.	%
Pub.Hosp.	60	74
Priv. Instit.	0	0
NGOs	0	0
Church	1	1
None	20	25
Total	81	100

Table.B 16. Who offers VCT?

	FREQ.	%
H/Ws	55	68
Teachers	14	17
Chur. Leaders	6	8
Caregivers	5	6
Others	1	1
Total	81	100

Table.B 17. Accessibility of VCT

	FREQ.	%
<5km	18	22
5 -15km	6	8
>15km	24	30
Not known	32	40
Total	80	100

Table.B 18. Support groups for ;-

		FREQ.	%
HIV positive	Yes	24	30
	No	56	70
Orphaned	Yes	28	35
	No	52	65
Ill people	Yes	25	31
	No	55	69
Bereaved	Yes	6	8
	No	74	92
Afraid	Yes	0	0
	No	80	100

APPENDIX C

QUESTIONNAIRE FOR HEALTH WORKERS (No.....)

A STUDY INTO FACTORS CONTRIBUTING TO LOW UTILISATION OF VOLUNTARY COUNSELLING AND TESTING (VCT) SERVICES IN MUFUMBWE DISTRICT.

Dear Respondent,

I am a second year student at the University of Zambia carrying out a research on voluntary counselling and testing in the district.
This questionnaire is intended to be answered by all the participants selected in the study. It is hoped that this will come up with findings that will be beneficial to our society.
Please feel free to answer all questions as faithfully and truthfully as you can. The answers given shall be treated with confidentiality. You may remain anonymous and not include your name.

Specific instructions

You are asked to read each question and decide how you feel about it. Answer all questions by ticking in the box ☐ provided on each question that reflect your opinion(s) or write statements in the space provided.

SECTION A: BIO DATA

1. Your sex (a) Male ☐
   (b) Female ☐
2. Your age (a) 15 - 25 ☐
   (b) 26 – 35 ☐
   (c) 36 – 45 ☐
   (d) 46 – 55 ☐
   (e) Above 55 ☐

3. Marital status
   (a) Single ☐
   (b) Married ☐

(c) Divorced/separated ☐

(d) Widow/widower ☐

(e) Others; specify .....

4. How many children do you have?

(a) Zero ☐

(b) 1 – 2 ☐

(c) 3 – 4 ☐

(d) 5 – 6 ☐

(e) over 6 ☐

5. Your position at work?

(a) Clinical officer ☐

(b) Nurse ☐

(c) Environmental health technician/officer ☐

(d) Laboratory technician ☐

(e) Others; specify .....

6. Duration of service

(a) 1 – 5 years ☐

(b) 6 – 10 years ☐

(c) 11 – 15 years ☐

(d) 16 – 20 years ☐

(e) above 20 years ☐

SECTION B: KNOWLEDGE OF VCT

7. Have you ever heard of VCT?

(a) Yes ☐

(b) No ☐

(c) Not sure ☐

8. If yes, from who?

(a) Fellow workers ☐

(b) Workshops/seminars ☐

(c) Printed materials (posters) ☐

(d) Others; specify .....

9. Do you know a place where VCT is offered?

(a) Yes; ☐ Specify .....

(b) NO ☐

(c) Not sure ☐

10. Have you ever received training in VCT?

(a) Yes ☐

(b) No ☐

11. Can you do HIV counselling?

(a) Confidently ☐

(b) Not confidently ☐

(c) Not at all ☐

12. What is the value/benefit of going for VCT?

.....

.....

13. What are you doing to create awareness of VCT?

(a) Health education ☐

(b) Mass campaigns ☐

(c) Community workshops ☐

(d) Printed materials (posters) ☐

(e) Nothing ☐

SECTION C: UTILISATION OF VCT

14. Do you think people use VCT services actively?

(a) Yes ☐

(b) No ☐

(c) Not sure ☐

15. Why don't many people go for VCT?

(a) Unavailability of HIV test kits ☐

(b) Inaccessibility to VCT centres ☐

(c) Lack of knowledge or awareness by people ☐

(d) Fear to know ☐

(e) Fear if partner violence after HIV disclosure ☐

(f) Apprehension (anxiety) of knowing HIV status ☐

(g) Lack of perceived benefits of testing HIV positive ☐

(h) Fear for recrimination (blame for bad behaviour) by others ☐

(i) Fear that being HIV positive adds to many problems in the world ☐

(j) Fear of stigmatisation (marked shame or discredit upon a person). ☐

(k) Fear of discrimination (unfair and unjust treatment by others) ☐

(l) Others; specify .....

16. What kind of HIV testing would you propose is done in Zambia?

(a) Voluntary counselling and testing ☐

(b) Routine counselling and testing ☐

(c) Mandatory counselling and testing ☐

17. Have you ever gone for VCT before?

(a) Yes; ☐ where? .....

(b) No ☐

SECTION D: VCT SERVICE DELIVERY

18. Which institution(s) offer VCT in your district?

(a) Public hospital ☐

(b) Private institution ☐

(c) Non-governmental organizations ☐

(d) The church ☐

(e) None of the above ☐

19. Who does HIV counselling in your district?

(a) Health workers ☐

(b) Teachers ☐

(c) Social workers ☐

(d) Care givers ☐

(e) Others; specify .....

20. Does your hospital/centre have?

		Yes	No	If yes; where?
(a)	HIV counsellors	☐	☐	.....
(b)	HIV testing facilities	☐	☐	.....
(c)	Anti-retroviral drugs	☐	☐	.....
(d)	Peer counselling	☐	☐	.....

21. Do you have any support groups or organisations for those who are HIV positive?

(a) Yes; ☐ specify .....

(b) No ☐

(c) Not sure ☐

22. Any suggestions or comments to increase VCT utilisation?

.....

The End. I wish to thank you very much for your cooperation.

Kakoma K. Ernest
Department of Adult Education and Extension Studies
School of Education
University of Zambia
P.O.Box 32379 Lusaka

APPENDIX D

QUESTIONNAIRE FOR MEMBERS OF THE COMMUNITY (No.....)

A STUDY INTO FACTORS CONTRIBUTING TO LOW UTILISATION OF VOLUNTARY COUNSELLING AND TESTING (VCT) SERVICES IN MUFUMBWE DISTRICT.

Dear Respondent,

I am a second year student at the University of Zambia carrying out a research on voluntary counselling and testing in the district.

This questionnaire is intended to be answered by all the participants selected in the study. It is hoped that this will come up with findings that will be beneficial to our society

Please feel free to answer all questions as faithfully and truthfully as you can. The answers given shall be treated with confidentiality. You may remain anonymous and not include your name.

Specific instructions

You are asked to read each question and decide how you feel about it. Answer all questions by ticking in the box ☐ provided on each question that reflect your opinion(s) or write statements in the space provided.

SECTION A: BIO DATA

1. Your sex:

   (a) Male ☐

   (b) Female ☐

2. Your age:

   (a) 15 – 25 ☐

   (b) 26 – 35 ☐

   (c) 36 – 45 ☐

   (d) 46 – 55 ☐

   (e) above 55 ☐

3. Marital status

(a) Single ☐

(b) Married ☐

(c) Divorced/separated ☐

(d) Widow/widower ☐

(e) Others; specify .....

4. How many children do you have?

(a) Zero ☐

(b) 1 – 2 ☐

(c) 3 – 4 ☐

(d) 5 – 6 ☐

(e) over 6 ☐

5. Your highest level of education attainment

(a) Primary ☐

(b) Secondary ☐

(c) College ☐

(d) University ☐

(e) Others; specify .....

6. What do you do in your life?

(a) Government employee ☐

(b) Private company employee ☐

(c) Self employed ☐

(d) Farming ☐

(e) Others; specify .....

SECTION B: KNOWLEDGE OF VCT

7. Have you ever heard of voluntary counselling and testing (VCT)?

(a) Yes ☐

(b) No ☐

(c) Some idea ☐

8. If yes, how did you know about it?

(a) Health workers ☐

(b) Friends/relatives ☐

(c) Radio/TV ☐

(d) Printed materials (e.g. billboards, posters, etc) ☐

(e) Church ☐

9. Do you know a place where VCT is offered?

(a) Yes; ☐ specify .....

(b) No ☐

(c) Not sure ☐

10. What do you think is the value/benefit of knowing your HIV status?

.....

.....

Section C: Utilisation of VCT

11. Do you think people are using VCT services actively

(a) Yes ☐

(b) No ☐

(c) Not sure ☐

12. Have you ever gone for VCT?

(a) Yes; ☐ where.....

(b) No ☐

If no, why not? .....

13. Do you know of someone who has gone for VCT?

(a) Yes ☐

(b) No ☐

14. In your view, why do you think many people do not go for VCT?

(a) Unavailability of HIV test kits ☐

(b) Inaccessibility to VCT centres ☐

(c) Lack of knowledge or awareness by people ☐

(d) Fear to know ☐

(e) Fear if partner violence after HIV disclosure ☐

(f) Apprehension (anxiety) of knowing HIV status ☐

(g) Lack of perceived benefits of testing HIV positive ☐

(h) Fear for recrimination (blame for bad behaviour) by others ☐

(i) Fear that being HIV positive adds to many problems in the world ☐

(j) Fear of stigmatisation (marked shame or discredit upon a person). ☐

(k) Fear of discrimination (unfair and unjust treatment by others) ☐

(L) Others; specify .....

.....

SECTION D: VCT SERVICE DELIVERY

15. Which institution(s) offers VCT in your district?

(a) Public hospitals ☐

(b) Private institution ☐

(c) The church ☐

(d) Non-governmental organizations ☐

(e) None of the above ☐

16. Who offers HIV counselling in your district?

(a) Health workers ☐

(b) Teachers ☐

(c) Church leaders ☐

(d) Care givers ☐

(e) Others; specify .....

17. How accessible is VCT service to you?

(a) Within 5 km ☐

(b) 5 – 15 km ☐

(c) More than 15km ☐

(d) Not known ☐

18. Are there any support groups or organisations for the?

		Yes	No
(a)	HIV positive	☐	☐
(b)	Orphaned	☐	☐
(c)	Ill people	☐	☐
(d)	Bereaved	☐	☐
(e)	Afraid	☐	☐

19. Do you have any suggestions or comments to increase utilisation of VCT?

.....

.....

The end of the questionnaire. I wish to thank you very much for your cooperation.

Kakoma K. Ernest
Department of Adult Education and Extension Studies
School of Education
University of Zambia
P.O.Box 130005
LUSAKA.

APPENDIX E

INTERVIEW GUIDE **(No.....)**

FOCUSED GROUP DISCUSSION

INSTRUCTIONS

- Greet and welcome the participants to the discussion.
- Introduce the participants.
- Introduce the topic of discussion and then start using the interview guide.

1. Have you ever heard of HIV/AIDS?
2. What are some of the preventive measures?
3. Have you ever heard of VCT?
4. If yes, from who?
5. Where is VCT offered in your area or district?
6. Who are offering VCT in your district?
7. Which people should go for VCT?
8. Why do you think people are not going for VCT?
9. What are some of the benefits of going for VCT?
10. How do you think HIV counselling and testing should be done; Mandatory, Voluntary or Routine?
11. Do you think there enough information about VCT in your area? If Yes, who provides it? If No, why?
12. Any suggestions/comments about VCT information dissemination.
13. In your opinion, what should be done to increase VCT utilisation?

Kakoma K. Ernest
Department of Adult Education and Extension Studies
School of Education
University of Zambia
P.O.Box 130005
LUSAKA.

APPENDIX F: TIME SCHEDULE

No.	Activity	May	June	July	Aug.	Sept.	Oct.
1.	Writing the proposal	xxx					
2.	Complying the final proposal		xxx				
3.	Printing data collection instruments			xx			
4.	Briefing DHMT			xxx			
5.	Orientation of Research assistants			xxx			
6.	Data Collection			xx			
7.	Data analysis				xx		
8.	Writing draft report				xxx		
10.	Final report					xxx	xxx

APPENDIX G: BUDGET BREAKDOWN

Description	Unit Cost	Qty/ Pax	Day	Total
PERSONNEL				
Research – Sub allowance	150,000	1	1	150,000
- Lunch	50,000	1	10	500,000
Research assistants				
- Sub allowance	150,000	3	1	450,000
- Lunch	50,000	3	10	1,500,000
Sub total				**2,600,000**
TRANSPORT				
Fuel – Diesel	4,500	100	-	**450,000**
STATIONERY				
Reams of paper	30,000	3		90,000
Binding proposal	30,000	4		120,000
Binding report	30,000	4		120,000
Arch lever file	15,000	4		60,000
Research bag	50,000	1		50,000
Sub total				**440,000**
SECRETARIAL				
Typing proposal	2,500	40		100,000
Typing report	2,500	80		200,000
Photocopying	200	1000		200,000
Sub total				**500,000**
GRAND TOTAL				**3,999,000**

The prices quoted are the ruling rates in Solwezi District

Client Profile Recording Format (CPRE03.1)

Form: F1

(To be updated by the counselor on first and subsequent visits if new information has to be recorded or changed. This format should be maintained in high confidentiality)

A. General Information

Province: **District:** **Name of the Center:**

B. Client Information

ID	Name (Optional)	Address (Optional)	Sex	Age	Remarks(Use this space to write observations/advice during each visit of the client)

APPENDIX H

Facility Client Service Recording Format (FSRE03.1)

(To be updated by the counselor every time a service is provided)

Form: F2

A. General Information

Province: District: Name of the Center: Month: Year:

B. Listing of Clients

ID[1]	Came as couple(cp)	New(a)	Old(b)	Took test / Sample sent to lab(c)	Age Group in Years (Put results only here i.e P, N or I in appropriate sex and age-group column only for clients who took test)																Marital[2] Status				Multiple[3] Partners				Reason for visit (Put ✔ for all clients. Tick only the most pressing reason)										U/R (✔ for all clients)		Post-Test (✔ only for tested clients)			
					1-14(d)		15-19(e)		20-24(f)		25-34(g)		35-39(h)		40-44 (i)		45-49(j)		50+(k)		Singl e(l)		Married(m)		Yes(n)		No(o)		Sick(p)	Partner HIV Positive(q)	ANC / Pregnant(r)	Just to make sure(s)	Partner tested & Advised(t)	Worried about partners behavior(u)	Planning to get married(v)	Planning to have a baby(w)	Others(x)	Urban(y)	Rural(z)	Result available same day(aa)	Result collected(ab)	Attended post-test counseling(ac)	Referred to post test service(ad)
					M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F																
C. Summary Information																																											
Positive																																											
Negative																																											
Indeterm.																																											
Page Total																																											

[1] Assign client ID in the format YYMMDDXXXX. For example, ID for a client visiting on 12 March of 03 would be 0303120015 (assuming the last serial number of the client was 14)

[2] Put P, N or I in appropriate sex and marital status column and √ (tick) for clients who did not take test

[3] Put P, N or I in appropriate sex and marital status column and √ (tick) for clients who did not take test

PPENDIX I

THE UNIVERSITY OF ZAMBIA

SCHOOL OF EDUCATION

DEPARTMENT OF ADULT EDUCATION AND EXTENSION STUDIES

Telephone: 292702
Telegrams: UNZA LUSAKA
Telex: UNZALU ZA 44370
Fax: + 260-1-292702

P O BOX 32379
Lusaka, Zambia

Your Ref:

29TH June, 2004

TO WHOM IT MAY CONCERN

RE: RESEARCH UNDERTAKING

The bearer(s) of this letter is a student in the Diploma/Degree in Adult Education. He/~~she~~ has been requested to undertake research in your organization as part of his/~~her~~ learning experience. Your help and cooperation in this regard will be highly appreciated by the department, as this will enable the student to link theory work, which is offered in the class, and practical work, which can only be obtained from organizations like yours.

I look forward very much to a favourable response in this regard.

Yours faithfully

for D.M. Sibalwa (Dr.)
ACTING HEAD OF DEPARTMENT
ADULT EDUCATION AND EXTENSION STUDIES.

UNIVERSITY OF ZAMBIA
DEPARTMENT OF ADULT EDUCATION
P.O. BOX 32379
LUSAKA ZAMBIA

APPENDIX J

Department of Adult Education and Extension Studies
School of Education
University of Zambia
P. O. Box 130005
LUSAKA.

25th October, 2004

The District Director of Health
Mufumbwe District Management Team
P. O. Box 130005
Mufumbwe.

Dear Sir,

RE: APPRECIATION LETTER

I hereby write to convey my heartfelt gratitude you, your Management team and members of staff of Mufumbwe District Health Board for allowing me to conduct a research on the factors contributing to low utilisation of VCT in Mufumbwe District.

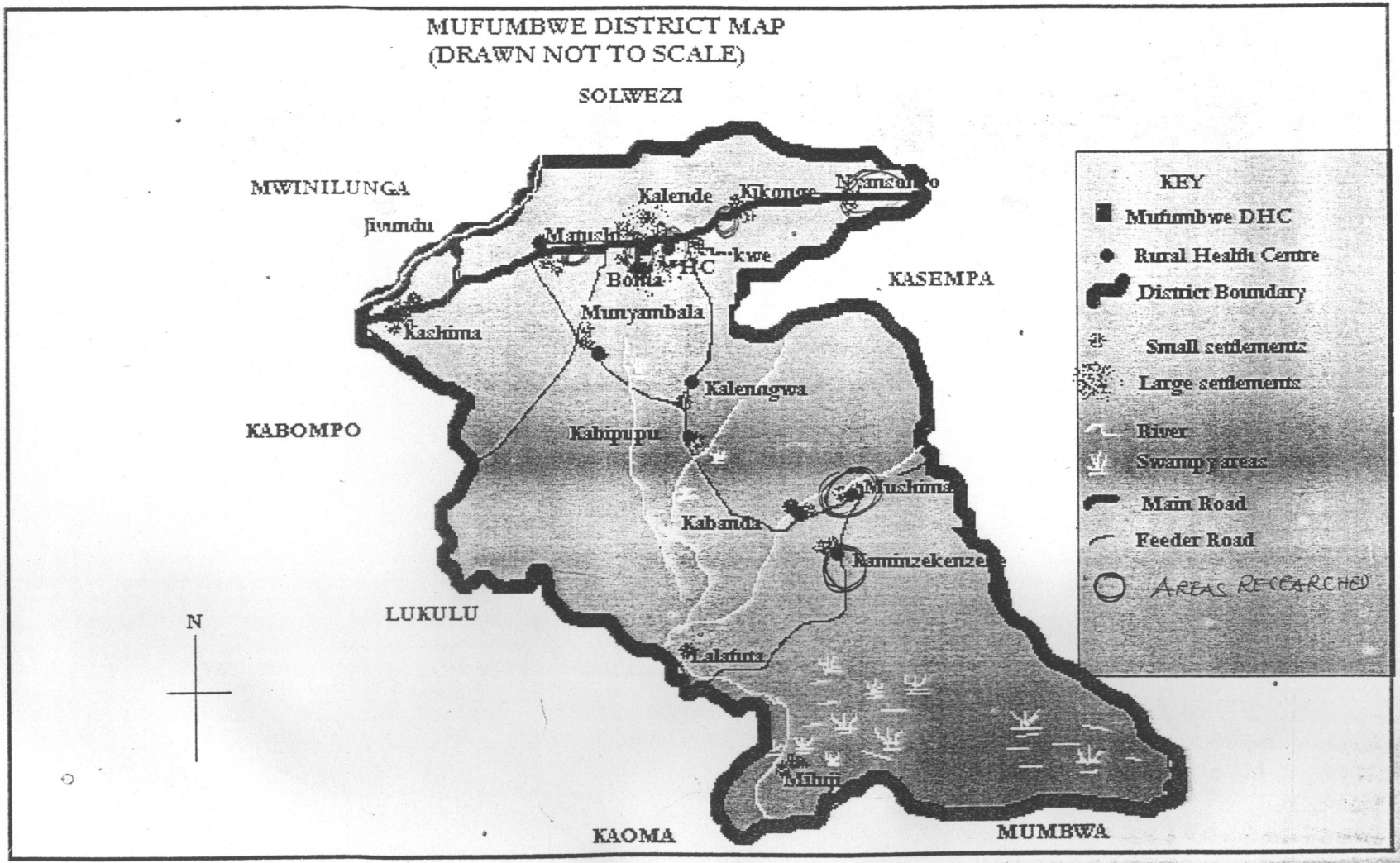
Your support both materially and morally was very encouraging.

I also pay special tribute to the research assistants, Mrs. Irene Kambangu and Mr. Caleb Konde, for their unfailing support.

Your good work will pay you and will remain in history – Keep it up and may God bless you all.

Yours truly,

Ernest K. Kakoma – MA/3546
Clinical Officer Gen



APPENDIX. K