THE UNIVERSITY OF ZAMBIA

SCHOOL OF MEDICINE

DEPARTMENT OF POST BASIC NURSING

KNOWLEDGE, ATTITUDE, AND PRACTICE OF PUPILS AT CHIPATA DAY SECONDARY SCHOOL TOWARDS VOLUNTARY COUNSELLING AND TESTING FOR HIV IN CHIPATA DISTRICT

BY

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A RESEARCH PROJECT SUBMITTED IN PARTIAL FUFILMENT FOR THE REQUIREMENT FOR THE AWARD OF THE DEGREE OF BACHELOR OF SCIENCE IN NURSING AT THE UNIVERSITY OF ZAMBIA

UNZA **2009**

Acknowledgement

This study would be incomplete without mentioning the people that played an important role to its success.

- First and foremost to the almighty God for giving me good health and guidance during my whole training.
- Many thanks to my sponsors, USAID through Ministry of Healthy for their support and for accepting me as one of their candidates to sponsor.
- Mrs. C. M. Ngoma, the Head of Department, Post Basic Nursing and Dr Likwa Ndonyo for their guidance during class work which helped me so much in my study.
- My supervisor Ms M. Kabinga for her timely instructions and motherly guidance through out the study.
- My respondents for their cooperation without which the study would have not taken place.
- The Ministry of Education and in particular the Headmaster, Mr. Manda and the coordinate of HIV/VCT at Chipata Day Secondary School, Mr. Nyalutalu for their assistance and for allowing me collect data from their pupils.
- All my classmates and friends at Post Basic Nursing for their encouragement, guidance and support during the research process.
- Finally to my brothers and sisters for their encouragement and support all through my training at the University of Zambia.

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LIST OF ABBREVIATIONS

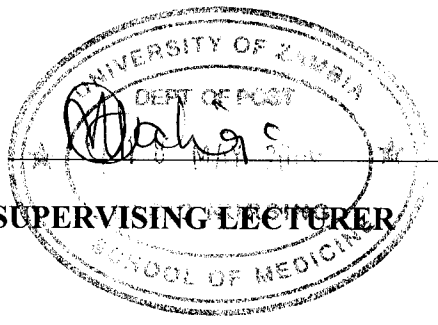
AIDS	Acquired Immune Deficiency Syndrome
CDHO	Chipata District Health Office
CDHMT	Chipata District Health Management Team
CDM	Centre for Disease Management
CSO	Central Statistic Office
FHI	Family Healthy International
HMIS	Health Management Information Systems
HIV	Human Immunodeficiency Virus
NAC	National Aids Council
NGO	Non-Governmental Organization
MOE	Ministry of Education
STIs	Sexually Transmitted Infections
SPAW	Strategy for Advancement of Women
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Plan
VCT	Voluntary Counselling and Testing
WHO	World Health Organization
ZSBS	Zambia Sexual Behavior Survey

DECLARATION

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

Signed: _____ Date: 07 · 05 · 09

CANDIDATE



Signed: _____ Date 18/05/09

SUPERVISING LECTURER

STATEMENT

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

Signed: _____

CANDIDATE

Date: _____

DEDICATION

This study is dedicated to my one and only beloved late mother Mrs. Idah Banda, my late father Mr. Naison Chenjelani Banda for their love and support and, to my beloved late sisters and brothers who saw me to where I am today and my brothers and sisters to whom I am indebted for their love, spiritual and material support.

ABSTRACT

Voluntary Counseling and Testing has become a widely advocated HIV/AIDS preventive measure worldwide. Young people account for nearly half of all new HIV infections. Few young people utilize the health services, therefore using VCT as a strategy to reduce risk behavior among young people appear to be more challenging than it would be among adults.

The study sought to determine the knowledge, attitude and practice of pupils at chipata day secondary school towards VCT for HIV. A descriptive –cross sectional study was used. A total of 50 respondents who were pupils were recruited in the study using convenient sampling method and a self administered questionnaire was used for data collection.

A pilot study was conducted at Libala High School (in Lusaka) and the actual study was conducted in Chipata District during the months of August and September 2008. Fifty pupils (both males and females) were recruited using convenient sampling method. Data was collected from respondents using a self-administered questionnaire. Coding and editing of data was done after data collection. Data was analyzed manually, findings presented in tables, graphs and cross tabulations.

The results of the study indicted that 62% of the respondents had high knowledge on VCT/HIV, while 38% had medium knowledge, 88% had positive attitude and 12% had negative attitude towards VCT/HIV. Despite such a picture the results still indicted that even though the respondents had high knowledge and positive attitude, 66% had poor practice while 34% had good practice of VCT/HIV. 70% of the respondents reported that lack of awareness about VCT contributed to low utilization of the services while 52% blamed it on stigma as the reason for not accessing the services

The study findings revealed that most of the respondents were females 56%, majority of the respondents 42% were in the ages 16-18 years while 58% were the highest grade which is grade 12 and 26% congregated with Roman Catholic Church. How ever there

was no relationship between level of education and knowledge towards VCT/HIV, nor religion with knowledge or attitude towards VCT/HIV.

Therefore, there is need to strengthen the existing VCT services through sensitization of pupils and the community by health workers in collaboration with teachers in schools if we are to yield good response from the pupils as well as reducing the HIV/AIDS infection and promote behavior change.

CHAPTER 1

1.0 INTRODUCTION

1.1 BACKGROUND INFORMATION

Zambia covers an area of 752 612 square kilometers and about 2.5% of Africa. It shares borders with Democratic Republic of Congo, Malawi, Zimbabwe, Botswana, Angola, Mozambique and Tanzania. The country is divided administratively into nine provinces namely Central, Copper belt, Eastern, Luapula, Lusaka, Northern, Northwestern, Southern and Western provinces and 72 Districts. The Copperbelt and Lusaka provinces are predominantly urban and the rest are rural provinces (Central Statistics Office (CSO), 2002).

The country's population stands at 10.3 million people with an annual growth rate of 3.0% and more than 50% of the population is less than twenty years of age (CSO, 2000). Economically, Zambia has a mixed type of economy consisting of a modern urban- oriented sector that mainly follows the line of rail and a rural agriculture sector. The 2005 Human Development Report indicates that Zambia ranks at 166 out of 177 countries, which are poorest, and about 64% of the population is living on less than one dollar per day termed absolute poverty (Ministry of Health (MOH) /United Nations Development Plan (UNDP), 2005).

For many years, the public sector has been dominated by parastatal organizations while private businesses have predominated in the construction and agriculture sectors. With the introduction of liberalized market oriented economy, most parastatal have been privatized and in some cases liquidated. Privatization brought about unemployment, an increase in rural urban drift that lead to increased disease burden such as tuberculosis, sexually transmitted infections (STIs) and Human Immunodeficiency Virus (HIV) infections (CSO,2002).

HIV/AIDS Epidemic

Globally, HIV and Acquired Immune Deficiency Syndrome (AIDS) have in the past two decades continued to spread across all continents. The World Health Organization (WHO) puts HIV/AIDS as the leading cause of death in adults aged 15-59 years (National AIDS Council (NAC), 2005). By the end of 2006, an estimated 39.5 million people worldwide were living with HIV. This represents a considerable increase since 2001 when an estimated 32.9 million people were living with HIV (Joint United Nations Programme for HIV/AIDS (UNAIDS), 2006). The rate of people newly infected with HIV remained around 4 million people per year, while the number of people dying from AIDS grew from 2.2 million in 2001 to 2.9 million in 2006. Since 1981, more than 25 million people have died of AIDS-related illnesses (UNAIDS, 2006).

Sub-Saharan Africa has been the hardest hit by the pandemic. Over 70% of people living with HIV live in the region (UNAIDS 2006). This will have long-term impact on human development, economic growth and stability. HIV affects the general population and is not just a problem that is limited to minority or vulnerable groups. The male–female infection ratio is approximately 1:1 (WHO/UNAIDS 2006). Although the rate of HIV seroprevalence in the Sub-Saharan countries is broad, many other countries are experiencing the widespread financial and social impacts of HIV. These include the deaths of men and women between the ages of 20 and 40 at a time when they are most economically productive as well as a growing number of orphans estimated at 13.2 million worldwide of which 12.1 are in Africa (MOH, 2005).

Zambia is among the seven countries most affected by HIV and AIDS in Sub-Saharan Africa, where the HIV prevalence rate ranges between 16 to 35%. The other countries are Botswana, Lesotho, Namibia, South Africa, Swaziland and Zimbabwe. Majority of the population still does not believe they are at risk. Stigma and discrimination towards people living with HIV further discourage many people from taking an HIV test and determining their status. A recent report

from the Zambia Demographic Health Survey (ZDHS) indicates that the prevalence rates of HIV among ages 15-49 stands at 14% in Zambia (CSO, 2007). This shows a decrease from the 16% observed in the 2001-2002 ZDHS. It further indicates that the proportion of HIV tends to rise with age from 5% among those aged 15-19 to 24% among those in the 35-39 age groups (CSO/MOH, 2007).

Prevention Strategies

The Government of the Republic of Zambia has demonstrated a high level of commitment to address issues of HIV and AIDS. In order to reduce the prevalence of HIV/AIDS many countries including Zambia embarked on voluntary counseling and testing (VCT) for HIV as a very important tool in mitigating the spread of HIV/AIDS (CSO, 2002). As early as 1986, Zambia created the National AIDS Surveillance Committee and National AIDS Prevention and Control Programmes. The country has since developed policies and guidelines for HIV testing including comprehensive pre test and posttest counseling and treatment of AIDS (CSO, 2002).

VCT has emerged as a major strategy for the prevention of HIV/AIDS in Africa. It is an entry point for prevention, care and support. In Zambia VCT was established on a large scale in 1999 with the aim of providing quality and friendly counseling and testing services. Twenty one (21) pilot sites were identified and evenly distributed in each of the nine provinces of Zambia with the major funding from the Norwegian Government. By January 2006, there were 485 counseling and testing centers in all the 72 districts (MOH, 2005).

VCT is a process where an individual volunteers to undergo counseling to enable him/her to make an informed decision about being tested for HIV antibodies (Dyk, 2005). Knowing ones status whether positive or negative is instrumental in affecting behavior change and the adoption of safer sex practices.

1.2 STATEMENT OF A PROBLEM

Most secondary school pupils are between the ages of 16-19, meaning that they all fall under risk age group. Despite the reduction in the prevalence rate of HIV/AIDS among ages 15-49 ((14% from 16%) (CSO, 2007), the prevalence rate is still a threat to the youths and the country as a whole because youths are the majority and most vulnerable group in contraction and spread of HIV infection. Therefore, it is important to strengthen the preventive measures to bring the figure to a much lower rate.

Statistics reveal that youths are well informed about the facts of HIV/AIDS but the knowledge has not been exhibited in their behavior change (UNAIDS 2003). This is true as indicated in the Zambia Demographic Health Survey (2007) report, which states that about 44.1% of adolescents between ages 15-19 were sexually active. Other indicators also revealed that youths remained vulnerable to HIV/AIDS such as an increase in the percentage of 15-24 years who reported having sexual intercourse before the age of 15 years from 10.3 in 2005 to 14.6 in 2007 (MOH/NAC,2008). In the same report, the overall percentage of men and women who received HIV testing and knew their results remained low for youths 15-19 years scoring 10.2% in 2007 against 8.2% in 2005 and the percentage of those who knew of a place to go for VCT was lower than among young adults (20-24).

Few pupils access VCT services in Chipata even though the HIV/AIDS prevalence rate among youths is still high. This has been revealed in the Health Information Systems Report (2007) that there had been a decline in VCT attendance among youths (15-19 years) ranging from 7.9 % in 2003 to 6.5% in 2007 (Chipata District Health Office (CDHO) , 2007). Ideally, with the increase in the number of VCT sites, the attendance is supposed to be high unlike what has been reflected in the report.

From the information above, one may ask a question; do pupils have knowledge about VCT? If they have the knowledge, why are they not utilizing the services or how are they utilizing the services? With these questions, the researcher intends to explore further the Knowledge, attitude and practice of pupils towards voluntary counseling and testing for HIV/AIDS.

1.3.0 FACTORS INFLUENCING KNOWLEDGE, ATTITUDE AND PRACTICE OF SECONDARY SCHOOL PUPILS TOWARDS VCT FOR HIV.

VCT intends to promote good behavior but there are several factors that may influence knowledge, attitude and practice of secondary school pupils towards VCT for HIV. These include socio- cultural and service related factors.

1.3.1 Socio- Cultural and Economic Factors

Sex

Female pupils are more likely to go for VCT than males because females attain menarche early than their male counterparts and are likely to indulge in sexual activities much early. Moreover, females are usually victims of rape and abuse, hence such circumstances will prompt them to seek VCT services.

Stigmatization

HIV/AIDS is associated with shame and blame because of the fact that the major mode of transmission is heavily associated with sex and bad behavior on the part of the individual affected. Therefore, some pupils shun going for VCT for fear of being rejected by relatives or friends and looked down upon as people who are promiscuous.

Peer pressure

Youths usually feel comfortable talking about sexual matters with their friends and often seek their peer's acceptance for VCT. The role played by the peer

educator can influence behavior change concerning VCT. If the peer educator values the benefits of VCT, the impact would yield positive results on the pupil.

Family influence

Youths turn to family members for advice or approval to seek VCT. A disapproving reaction from family members often discourage the youth from attending VCT until they find some one supportive.

Further more there are families that have so much influence on the decisions made by their children regardless of what age they may be. Some people claim that parental involvement will limit the number of students who seek VCT, as children who are sexually active may not want their parents to know about their sexual activity. Therefore, the parent or guardian's decision on VCT determines ones ability to seek VCT services. Conversely, others claim that to place children in a situation where they may discover that they have a fatal disease without the involvement of their family support network is unthinkable.

Fear of the results

Perception of the consequences of those living with HIV and the fear of the out come of the tests may influence the pupil's acceptability of VCT services. There is a tendency of stigmatizing people who are HIV positive. With this experience, pupils are likely to shun the VCT services for fear of what it would be if they tested positive.

Religious beliefs

It is believed that Christians should remain faithful until they are married. Religious beliefs usually take deep root in the minds of believers because they often adhere to norms and values their religion advocates. Those Christians who believe that they should not indulge in sexual activities before marriage may not support counseling of HIV/AIDS and testing. Going for VCT may seem to be a

self-fulfilling prophecy to promiscuity and violation of the religious faith. Other religious orders such as Catholics encourage VCT amongst couples that are intending to marry.

Lack of knowledge

Pupils who get adequate knowledge on VCT are more likely to access VCT services than those with inadequate knowledge because they understand the importance and benefits of counselling and testing. Seemingly, family members or guardians who have sufficient knowledge on VCT are more likely to yield a positive influence on pupils than those with inadequate knowledge.

Lack of sex education

Considering that HIV or sex itself is rarely tackled in homes or community, children often seek such information from somewhere. Depending on the type of information provided, it may affect their acceptance of VCT services positively or negatively.

1.3.2 Service R elated Factors

Attitude of health Provider

Poor attitude of health providers at VCT sites may contribute to low up take of VCT by pupils. Places where health providers conduct VCT services unprofessionally like where confidential information of clients is revealed, pupils are not willing to be counseled and tested, as confidentiality will not be guaranteed.

Previous experience

Good attitude and professional attendance to clients wins the favor of the community and unprofessional conduct diminishes pupil's interest in attending your facility. Pupils that had a good experience with the HIV/AIDS counselor would be more willing to seek VCT services than those treated unprofessionally.

Long waiting hours

The time spent at the Health facility may either encourage or discourage pupils from seeking VCT services. For example, the longer the length of time spent before being attended to, the more discouraging it is to pupils, while efficient services are well accepted. Long waiting hours may be attributed to shortage of staff, where there is only one person attending to so many clients.

Staff shortage

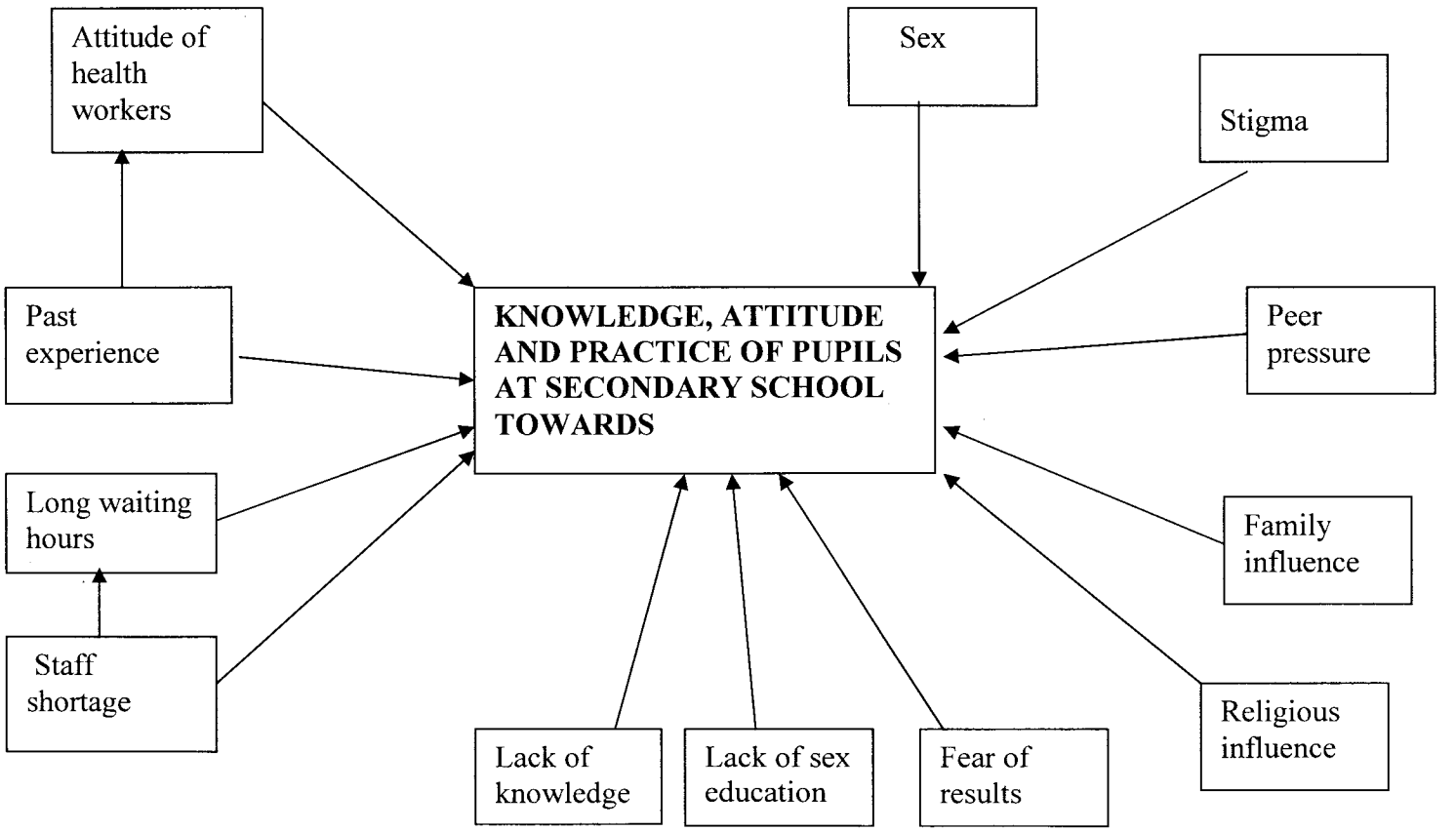
Due to staff shortage, the few available staffs are over burdened with increased workload that compromises the delivery of quality health care. The counselor may hurry in giving information, education and communication in order to clear the line. Furthermore, other laypersons may be engaged in order to fill up the gap and the services offered may not be appealing to pupils seeking VCT services. This might discourage them from utilizing the services.

FIGURE: 1, PROBLEM ANALYSIS DIAGRAM

FACTORS INFLUENCING KNOWLEDGE, ATTITUDE AND PRACTICE OF PUPILS TOWARDS VCT FOR HIV

SERVICE RELATED FACTORS

SOCIO-CUTURAL FACTORS



1.4 JUSTIFICATION

Youths account for nearly half of all the new HIV/AIDS infections worldwide (UNAIDS, 2004) and are the largest population in the youth generation. Hence, they need a protective environment and access to health and support services if they are to play their role in combating the epidemic. Thus reduction in the in the number of youths accessing VCT services could be attributed to lack of knowledge and negative attitude towards VCT.

There has been no study done on the knowledge, attitude and practice of pupils towards VCT of HIV in chipata, however the study done in Lusaka at Libala and David Kaunda high school revealed that there was a negative perception and poor practice of adolescents towards HIV/VCT (Kabinga, 2003). Reasons were that pupils felt they were not at risk because they were young scared and others were not ready. In other places such as Chipata, there could be different reasons to the reduction in the up take of VCT services.

The researcher therefore wishes to explore further in determining the factors influencing the knowledge, attitude and practice of pupils towards VCT. The researcher hopes to use the findings of the study to increase the body of knowledge amongst secondary school pupils on VCT, making recommendations to Ministry of Education on the importance of including VCT in their curriculum if they are to improve sexual behavior among youths and to the Ministry of Health to formulate policies that would benefit the youths. Increasing the knowledge of VCT among youths will help improve their attitude and practice towards HIV/AIDS in that as they know their HIV status they will even be more careful about their lives.

1.5.0 Research Objectives

1.5.1 General objective

The main objective of the study is to determine the knowledge, attitude and practice of Chipata Day Secondary School pupils towards VCT for HIV.

1.5.2 Specific Objectives

1. To asses the level of knowledge about VCT among pupils.
2. To assess the attitude of pupils towards VCT
3. To asses the practice of pupils towards VCT
4. To identify factors contributing to the knowledge, attitude and practice towards VCT for HIV among pupils at Chipata Day Secondary School.

1.6 HYPOTHESIS

The more knowledge the pupils have on the benefits of VCT services the more they are likely to volunteer to be counseled and tested for HIV.

1.7 OPERATIONAL DEFINITION TERMS

- **Knowledge**

  Knowledge is the information possessed by respondents on HIV /AIDs and voluntary counseling and testing.

- **Attitude**

  This is the way pupils think and behave towards VCT.

- **Practice**

  Practice refers to a pupil who has been counselled and tested for HIV.

- **Voluntary Testing**

  This is a test given to the willing candidate. Voluntary testing refers to the pupil who has decided on his or her own to be tested for HIV.

- **Voluntary Counseling**

  Voluntary counselling is a mutual interaction between an HIV Counselor and a wiling pupil.

- **Pupil**

  A secondary school going male or female in grade 8 to 12.

1.8 VARIABLES

A variable is an attribute or characteristic that can have more than one value.

Independent variable

This is the quality, property or characteristic of persons, or phenomena that change or vary and can take different values, (Polit and Hungler, 1999). It is also called the cause, stimulus, experimental variable or treatment that is manipulated by the researcher in order to study the effect upon the dependent variable, (Bassavanthappa, 2006).

The independent variables in this case are:

- Sex
- Peer pressure
- Family influence
- Religious influence
- Attitude of health provider
- Stigmatization

Dependent variable

The dependent variable is the variable that is as a result of the effect of the action of the independent variable and cannot exist by itself (Treece and Treece, 1986).

Dependent variables include;

- Knowledge,
- Attitude and
- Practice

Table 1: Variables, Indicators and cut-off points

VARIABLES	INDICATOR	CUT-OFF POINT	QUESTIONS
Dependent Variable Knowledge	High	Able to score 10 to 14 points	5-15
	Medium	Able to score 5 to 9 points	
	low	Able to score 4 and below	
Attitude	Positive	Able to score 5 to 10 points	16-26
	Negative	0 to 4 points	
Practice	Good	Able to score 3 to 5 points	27-32
	Poor	Able to score 2 and below	
Independent Variables Peer pressure	Positive Negative	Consulted friend(s) Did not consult Friend(s)	30,31,32,33
Attitude of health provider	Good Poor	welcoming unwelcoming	36
Family influence	Negative positive	Seek approval Did not seek approval	30,31
Fear of results	Positive Negative	Got the results Did not get the results	33,

CHAPTER 2

2.0 LITERATURE REVIEW

2.1 Introduction

HIV/AIDS is a major public health problem across the continents. To reduce the size and growth of the epidemic, preventive efforts must be effective. Many countries have embarked on VCT as an effective way of identifying cases that require treatment, meeting their needs for care and support in the community and a key factor in the prevention of the spread of HIV infection. Not only is it a factor for prevention of spread of infection, HIV counseling and testing has been shown to lead to adoption of safer sexual behavior among adolescents (www.fhi.org). Studies (published and unpublished) have been done in different places in special populations such as women, adolescents, young men and men about their practice and attitude towards VCT services. However, there is also need to explore pupils' knowledge, attitude and practice towards VCT for HIV.

Literature review is a key step in a research process and thus refers to an extensive, exhaustive and systematic examination of publications relevant to the research project (Bassavanthappa, 2007). However, the purpose of literature review is to source for ideas to determine what is already known about VCT, avoid unintentional duplication and to use the previous studies to form a basis of comparison when interpreting the findings from the current study. Literature reviewed is presented and discussed from the works of various scholars from around the globe. The Literature is arranged in three parts: global, regional and national perspectives.

2.2 Global Perspective

Voluntary counseling and testing for HIV, a gateway to treatment, care and support is an essential tool in the control of HIV/AIDS epidemic and a global concern (UNAIDS 2002). Studies have been done on the spread of the

HIV/AIDS as well as preventive measures such as VCT. In a study to examine whether there was any correlation between HIV Prevention, Education and Testing among youths in South Florida, Straub et al (2006) found that many youths (80.8%) were more likely to participate in VCT subsequent to education programmes covering topics related to STI/HIV, than (70.5 %) youths who did not have such baseline information.

From this study, we can say that knowledge about HIV and the benefits of VCT influences up take of VCT services. Not all who do not utilize VCT services have the knowledge about VCT. To achieve utilization of VCT services by young people, there is need to strengthen the education and mobilization of the youths through the help of people that are well knowledgeable in the field such as health workers.

In another study, Peltzer et al (2004) examined the attitude towards HIV counselling among university students in India, South Africa and United States of America. They found that 10% of the students in India had been sexually active in the past twelve months prior to the study and admitted to having had an HIV test. American students had much more positive attitude towards HIV testing than South African and Indian students. Students did not feel they were likely to be exposed to HIV infection and did not want to think about it. Others were afraid of loosing friends in case they were found positive, while some did not trust the results to be confidential. Due to perceived greater threats related to stigmatization, Indian and South African students may have been less likely to go for an HIV test.

The other reason could partly be the presence of programmes on education and prevention of infection with HIV in many Universities of United States of America. In some cultures (for example India and South Africa), it is socially unacceptable for young people to be sexually active unless they are married. Consequently, sexually active young people do not openly talk about their

experiences with adults, including health workers. Furthermore, knowledge about HIV and benefits of VCT if well explained yield a positive attitude towards VCT services among youths. Failure to do an HIV test could be as a result of lack of knowledge about VCT.

A cross sectional study conducted by Center for Disease Management (2004) in Iran, showed that sexually active young people under the age of 25 had low knowledge on HIV/AIDS and were less likely to attend VCT. In order to learn about young people's attitude and experiences to HIV testing a sample of 503 youths were interviewed. 14.2 percent of youths were concerned about HIV infection and less than 1% of them had been tested for HIV before. A majority had heard of AIDS, but did not know its transmission pattern properly. The individual risk perception was low too. There was not any formal HIV/AIDS prevention programme in Iranian schools when the study was conducted and television was the most popular mass media for HIV/AIDS introduction. Accessibility and acceptability of services were found to be a major barrier to attending VCT for these young people.

Lack of knowledge and misconception about HIV/AIDS are key factors in the lack of prevention effort. It had been shown that young people need a solid factual understanding of HIV and its transmission, access to relevant services (for example VCT), and the confidence, social power to initiate and sustain behavior change in order to prevent the spread of HIV/AIDS.

2.3 Regional Perspective

In many countries, National and Local initiatives promote VCT as a part of efforts to encourage more people to determine their HIV status. The numbers of VCT service providers including Government, Non Governmental Organization (NGOs) and private institutions have increased over the years but there has never been a Programme designed for youths in VCT. However, some studies have been conducted to determine the knowledge, attitude and practice of youths towards VCT for HIV.

Mugando-Onyanda et al (2003) studied Knowledge Attitude and Practice of secondary school Adolescents towards VCT in Kenya. The main aim of the study was to examine the level of knowledge, attitudes and perceptions of in-school adolescents on voluntary counseling and testing (VCT). Findings revealed that more than 90 % of the respondents had heard about VCT, 45 % knew of a VCT center near by. However, only 10 % had ever gone for VCT. Nearly 63 % reported that they were comfortable to use VCT services and about 50% of the respondents do not have a strong positive attitude towards the use of VCT. The findings of this study confirmed that the level of knowledge on VCT among young people was equally high (92.4%).The quality of this knowledge is however questionable because most young people did not know the services offered at VCT centers. The results further show that despite advertising for VCT many young people were not sure of what to expect. Most young people believed that only testing services are offered at VCT centers.

From this study, we can deduce that knowing a place to go for VCT does not imply knowing the activities involved in VCT. Furthermore, for VCT services to be effective for young people, they must take into account the emotional and social context of young people's lives such as strong influence of peer pressure. Services offered must be user friendly, non-threatening, safe, easily accessible environments, counseling should be appropriate and relevant to the youths, and language should be easy to understand and non- technical.

An exploratory study done by Horizon Project Programme (2001-2003) on HIV/VCT among youths in Uganda and Kenya, sought to understand young people's experiences with HIV testing. Target age group ranged from 14 to 21. Study results revealed that more than 75% of youths from both countries indicated an interest in being tested for HIV but the available VCT centers were not necessarily designed for youths.

Youths in Kenya felt VCT was only for those that were sick unlike the healthy ones. This perception may discourage healthy youths who might want an HIV test. Other youths felt they were not at risk, feared about the test results and the confidentiality of services. The study also revealed that most youths sought their peer's acceptance before undertaking VCT. Young people felt parents who their children wanted an HIV test would be a source of encouragement and support.

In another similar study, Zubairu and colleagues (2006) conducted a study in rural and urban Nigeria to determine knowledge on HIV/AIDS and attitudes towards VCT amongst adults (15-49). Findings indicated that more than half (55.5%) of respondents demonstrated, some understanding of the tests that identifies a person with HIV and 26% knew where they could have a test. None of the respondents was able to describe the steps involved in VCT (pre-test, testing, posttest). Reasons indicated for avoiding VCT included fear of stigma and incurable nature of the disease. Majority of respondents were willing to be tested and would recommend it to friends. The remainder (28%) said they would only consent to the test if care were available.

The process of voluntary counselling and testing for HIV creates an opportunity to educate and expose individuals to information about risks associated with contracting HIV and preventive measures to avert these risks. Dr Mwamburimo and colleagues (2005) did a related study in South Africa with the aim of determining factors that were associated with HIV counselling and testing among youths and reasons for wanting to Know HIV results. Reasons cited for wanting to know the HIV results suggested the desire to be able to take preventive measures, ruling out infections and optimism for future availability treatment. While not wanting to know was often because of the fear of being, stigmatized if found positive and death as a result of the disease.

From the studies above, it is clear that barriers such as in availability and acceptability of VCT services, bases on the part of confidentiality, prevent youths

from accessing VCT services. A report produced by UNAIDS (2004) on Voluntary counselling and testing further explains that VCT has not been seen as a priority in HIV care and prevention programmes for youths in many developing countries and has therefore often not been widely available.

Youths appreciate services rendered in a friendly manner and familiar settings. In Haiti (Moise,2003), it was reported that youths expressed need to know their HIV status and this confirmed that knowledge about their HIV status made youths more sexually responsible. To address the issue and allow people the access to VCT services, a model to deliver VCT for HIV services using youth to youth approach was developed and it proved effective as the Programme obtained a very active participation by youths.

2.4 National Perspective

Young people have always been, and will continue to be, part of the population that is most vulnerable to HIV and AIDS. They often begin their sexual behavior before they have the knowledge and skills to protect themselves, are exploited by others, lack opportunities to improve their lives, and feel a sense of despair about their future that adds to their vulnerability.

In Zambia, VCT is seen as a way of facilitating behavioral change and hence preventing the acquisition and transmission of HIV. Many surveys have been conducted to monitor and evaluate interventions on prevention of HIV/AIDS but have not been translated in to increased access to VCT by youths. Currently although programmes are being developed and expanded, there has been little emphasis on providing care and support services to meet the needs of young people.

Central Statistic Office (2005) in conjunction with the Ministry of Health conducted a Sexual Behavior Survey in Zambia, which aimed at monitoring knowledge, attitude and behaviors regarding HIV/AIDS. The survey revealed that

knowledge about HIV/AIDS among adolescent (15-19) and young adults (20-24) was high (males-95.6 percent and females-96.7 percentage). The means by which respondents thought HIV could be prevented was by abstinence (95%), faithfulness (87.5) and use of condoms (74%). Despite the high levels of general knowledge about HIV/AIDS, misconceptions about transmission persisted and appeared to be more common in the rural areas than the urban areas.

The majority of the respondents (88%) indicated high knowledge of a place to go for VCT. Percentage of those that had ever been tested was 11% males and 15% females. Despite this knowledge, very few people accessed VCT services. The low levels of testing inclined towards fear of stigma, discrimination, and belief that one is not at risk. Nonetheless, amongst those interviewed, 73% of all males and females indicated that they wanted to be tested. The above survey indicates that having knowledge about HIV and a place to go for VCT is not a reason enough to prompt one to go for VCT. Information, education and communication should be intensified to change adolescents' mind set.

To improve the provision of VCT, programmes need a better understanding to which youth turn when making decisions about HIV testing. Supportive relationships may minimize the negative consequences of testing that youth fear including stigma and isolation (Avert, 2003).

A study conducted by Horizons project programmes (2004) in Ndola aimed at assessing individual relation and environmental factors that influenced adolescents' demands for and experiences with VCT. 40 adolescents who had taken an HIV test and 11 family members with whom they shared their HIV result participated in a qualitative in-depth interview. The study revealed that youth relied on their families and friends for support during VCT. A disapproving reaction often discouraged youths from attending VCT services. Youths who discussed getting tested with their family were six times more likely to plan to take an HIV test.

The study also revealed that some adolescents attended a VCT service by themselves citing fears of a positive result and a loss of confidentiality if anyone had gone with them to the testing site. After taking an HIV test, most youths shared their results with families and friends while few youths involved their sex partners in their testing experiences (Denison et al. 2004).

Family members in Zambia expressed a variety of reactions to an adolescent's decision to test for HIV. Parents, who do not traditionally talk about sexual health, reported feeling a growing responsibility for educating youth about HIV by encouraging abstinence and VCT. While parents who spoke broadly about HIV and sex, cultural roles influenced the kinds of information shared. Other families felt that knowledge about a youth's testing should be kept within the family because they could "keep secrets" and would not expose the youth to gossip. This fear of stigma led family members to keep the youth's testing experiences a secret from outsiders but also to encourage other family members to seek VCT. The decision to test was the young person's decision alone, and families encouraged but did not force youth to take an HIV test. With these findings one would assume that Families played an important role in youth's decision –making about HIV/VCT.

Fylkense and colleagues (2000) conducted a population-based survey that included examination of factors that affect readiness to utilize VCT among participants. Ages 15 and above were selected by stratified random sampling after VCT. Readiness in the general population was found to be very low. Provision factors such as concerns about confidentiality and length of time for test results contributed to low utilization rate.

In a study to determine adolescents' perception of voluntary counselling and testing of HIV at Libala and David Kaunda Secondary Schools in Lusaka urban, Kabinga (2003) noted that despite being knowledgeable about HIV/VCT, Adolescents had a poor perception towards HIV/VCT. However, a few of them

had participated in VCT. Other reasons for poor perception were as a result of poor practice. Most of them thought they were not at risk because they were young or they were scared and not ready.

Chishimba (2006) set out to establish the level of awareness about availability of VCT services among adolescents with special emphasis on youths aged 18 and 24 years in institutions of higher learning in Lusaka. Despite the high level of awareness and the perception that VCT services are advantageous, only 16.3 percent of the youths actually utilized VCT services. Low utilization was attributed to factors such as, fear of being identified as an HIV positive individual, lack of psychological preparedness to undertake HIV tests, degree of confidentiality of most centers were perceived to be questionable and fear of stigma and discrimination were also noted..

Most of the studies singled out stigma and discrimination as important factors contributing to low up take of VCT services. Knowledge on VCT has shown to be high among youths. Only if they could be guided and provided with services that are conducive to their level of understanding, they have the potential to improve.

2.5 CONCLUSION

Literature review (global, regional and national perspective) shows that, despite their high-risk status and the devastation caused by HIV and AIDS, young people are capable of making responsible decisions to protect themselves when given the necessary information, skills, and support. Furthermore, youth who engage in HIV and AIDS works are able to educate and motivate their peers to make safe choices and to be important agents in the design and delivery of programs and services.

Various studies have pointed to the fact that knowledge of HIV/AIDS among adolescents based on the response to the question of whether the respondent has heard of the pandemic is almost universal. There is a general assumption that young people have adequate knowledge, which should influence positive values

and attitudes. The fact that behavior change is happening at such a slow pace should raise serious doubts about the quality, appropriateness and presentation of information to youth.

Young people have different needs and seek out VCT services for different reasons. Some countries now acknowledge the importance of targeting youth through VCT though their VCT services are not specifically developed for young people. The researcher intends to obtain more factors contributing to Knowledge Attitude and Practice towards VCT among pupils and whose results may be of help in the future researches

CHAPTER 3

3.0 RESEARCH METHODOLOGY

3.1 Introduction

Research methodology refers to the development of research instruments and methods used in research investigation (Sweeney and Olivieri, 1999). The purpose of the study was to determine the knowledge, attitude and practice of secondary school pupils towards VCT for HIV at Chipata Day Secondary School in Chipata district. This chapter discusses the methodology used for the study (research design) the instrument the researcher used to collect data, the target population, sample size, study setting and ethical consideration.

3.2.1 Research Design

A research design is the overall plan or blue print the researchers select to carry out their study. It provides answers to research questions and control variance (Sweeney and Olivieri, 1999). In this study, the researcher will apply a descriptive, cross sectional survey. A descriptive survey is a non-experimental research design to discover new meaning and to provide new knowledge when there is little known about the phenomenon of interest, (Dempsey and Dempsey, 2001). The purpose of a descriptive study is to systematically collect and present data to give a clear picture of particular phenomena. Cross sectional survey is a design, which is aimed at quantifying the distribution of certain variables in a study population at one point in time, (Sweeney and Olivieri, 1999). In this study, information will be collected once from the respondents at Chipata Day Secondary School and will then be analyzed. This type of research design is appropriate because it is less expensive as respondents remain in their natural environment and the study raises fewer difficulty ethical issues as respondents are not subjected to unpleasant conditions (non experimental).

3.3 Research Setting

Research setting is a place or an area where the research study will be conducted. The research was conducted in Chipata district (which is an administrative district of Eastern province of Zambia) at Chipata Day Secondary School. The district covers an area of about 6112 square kilometers and the largest part being a plateau area surrounded by a range of hills. The majority of the population (70%) lives in the rural area while the rest (30%) live in the urban area, (Chipata DHMT, 2008-2010). Subsistence farming and trading are the main forms of employment. The district has 9 secondary schools, 8 colleges and 135 basic schools. Schools save as outreach stations while pupils are used in publicity of health services such as immunizations and HIV/AIDS campaigns. Chipata district has 39 Government, 2 Private and 3 Mission institutions. Chipata Day is a Government School located in the suburbs of Chipata town and about 3km away from the town center. It has both males and females with a population of approximately 1800 pupils. Chipata Day is a Day School comprising pupils from all corners of the district.

3.4 Study Population

The study population is the total group of individual people or things meeting the designated interest to the researcher (Basavanthappa, 2007). The study population includes all secondary school pupils from grade eight to grade twelve. This group has been selected because they are known to be the most risk group to HIV/AIDS.

3.5.1 Sample Selection

Sample selection is the process of obtaining information about an entire population by examining only a part of it (Basavanthappa, 2007). In this study, the researcher used convenient sampling method. Convenient sampling is a type of non probability sampling procedure in which the sample units are selected because they are available at the time of data collection and are willing to participate in the study (Basavanthappa, 2007).The researcher selected pupils from grades 8 to 12 conveniently, that is where ever they were found.

3.6 Sample size

Sample size is the number of study participants (Polit and Hungler, 1997). In this study, the sample size was 50 participants selected from Chipata Day Secondary School. The relatively small sample size was considered due to limited time and financial resources in which the study was conducted.

3.7 Data Collection Tools

Data collection is gathering of information needed to address a research question (Polit and Hungler, 1997). A self-administered questionnaire was used to collect data from respondents. A questionnaire is a paper-and-pencil instrument that a research subject is asked to complete (Basavanthappa, 2007). It comprises a series of questions prepared by the researcher that is filled in by the respondents in order to gather data from the individuals. The reason for using this type of data collection tool is that, the respondents had limited time to answer questions and the tool is applicable to only those that are able to read and write to which students belong. Questions were formulated in English and comprise open and closed ended questions. The questionnaire also consisted of variables under the study such as knowledge, attitude, practice and factors that contributed to these variables towards VCT for HIV among pupils at Chipata Day Secondary School. The major limitation of this tool was that it was expensive to print questionnaires and it did not allow for clarification of unclear questions. Nevertheless, to overcome this, the researcher ensured that good amount of money was allocated to developing and printing of the questionnaires and questions made precisely.

Advantages of using a Self Administered Questionnaire

The advantages of using a self administered questionnaire are:

- It is a simple and less expensive method of obtaining data
- They are a rapid and efficient method of gathering information.
- Data from closed ended items are relatively easy to tabulate especially if they are check off responses.
- Permits anonymity and may result in more honest responses.

- Does not require research assistants and a large cross-section of the population widely scattered can be covered

Disadvantages of using a questionnaire

The disadvantages include the following:

- It is only applicable to literate people.
- Sometimes may need clarification, completion is rare and tend to be low.
- The technique is an able to probe a topic in depth without becoming unduly lengthy.
- The respondent may omit or disregard any item he/she chooses without giving an explanation.
- Some items may force the subject to select responses that are not his actual choice (forced choice items)

3.8 Data Collection Technique

Data collection techniques are methods or ways used to collect data to answer a research question (Treece and Treece, 1986). A self-administered questionnaire was used to collect data. The secondary school pupils gathered in a classroom and the researcher took time to explain to them how to complete the questionnaire by reading through the instructions before they answered. Thereafter the questionnaires were checked for completeness before the respondents left the classroom. Data collection was done in three days.

3.9 Pilot Study

A pilot study is a mini study conducted before the actual study, which aims at identifying potential problems in the proposed study. The researcher conducted a pilot study to determine and measure the logical sequencing, space for answers, need for further instructions, appropriateness and clarity of the language used in constructing the questionnaire. The pilot study was conducted at Libala secondary school. Libala secondary school had similar characteristics as the actual

population in which the actual study was to be conducted. The Secondary school comprised both males and females from grades 8 to 12 and is a day school like Chipata Day Secondary School. The sample size was 10% of the actual study sample. The sample size was five and respondents were not part of the actual study.

3.10 Validity and Reliability

3.10.1 Validity

Validity is the degree to which an instrument measures what it is supposed to measure (Polit and Hungler, 1997). In this study, the researcher ensured validity by employing strategies that deal with threats to validity. These strategies included, appropriate selection of study design, convenient selection of study participants, careful design data collection tools and pre-testing research instruments. The research instrument was measured to ascertain its ability to bring out the desired information and minimize biases. A pilot study was conducted in order to measure validity of the instrument.

3.10.2 Reliability

Reliability is the degree of consistency or accuracy with which an instrument measures the attribute it is designed to measure (Polit and Hungler, 1997). The instrument used should be able to bring out the accurate information whereby when the same instrument is used after some time it should have the same response. Reliability was ensured by standardizing the instrument. The research tool was tested before the main study using a pilot study in a similar environment with similar characteristics. This is to ensure stability of the data collection tool.

3.11 Ethical Considerations

Ethical issues were addressed by requesting permission to conduct the study from Provincial Education Officer, the District Educational Officer, the Head Teacher and the class teachers. Personal consent was obtained from the pupils who

participated in the study. The respondents were briefed about the purpose of the study and that they have the right to participate or withdraw from the study. The respondents were also assured of anonymity and confidentiality of personal information shared with the researcher by ensuring that the names are not written on the questionnaires. The completed interview schedules were kept under strict security conditions to avoid unauthorized access to the information contained therein.

CHAPTER 4

4.0 DATA ANALYSIS AND PRESENTATION OF FINDINGS

4.1 Introduction

This chapter describes analysis and presentation of data. The aim of the study was to determine knowledge, attitude and practice of pupils towards VCT for HIV/AIDS. Data was collected from 50 pupils at Chipata Day Secondary School in Chipata District from grades 8 to 12 using stratified and random sampling methods. A self administered questionnaire was used to collect data.

4.2 Data Analysis

Data analysis is the process of categorizing, scrutinizing and cross-checking the research data (Treece and Treece, 1986). Data can only be useful when arranged in a meaningful manner, in order to be able to derive patterns of relationships (Polit and Hungler, 2001). Data collected was sorted out, edited for completeness and later entered on the data master sheet for manual procession. Open and closed ended questions were also edited and coded. Analysis was done using a scientific calculator and frequency counts.

4.3 Presentation of Findings

The findings of the study have been presented in frequency tables, pie charts, and graphs. The frequency tables summarised the results of the study to ensure that the readers understand the findings of the research study. The use of pie charts and graphs in the presentation of findings makes the work neat, presentable and easy to read by the reader. Cross tabulations of the variables help to show clearly the relationship between variables and enable the researcher to draw meaningful inferences. The findings from this study are presented according to the sequence and sections in the questionnaire i.e. demographic data, knowledge, attitude and practice towards voluntary counselling and testing for HIV.

4.3.1 SECTION A: DEMOGRAPHIC DATA

Table 2: Distribution of Demographic characteristics of respondents.

VARIABLES	FREQUENCY	PERCENTAGE
SEX		
Male	22	44
Female	28	56
Total	**50**	**100**
AGE RANGE		
13 - 15	10	20
16 - 18	21	42
19- 21	10	20
22 and above	9	18
Total	**50**	**100**
EDUCATION LEVEL		
Grade 8	5	10
Grade 9	3	6
Grade 10	6	12
Grade 11	7	14
Grade 12	29	58
Total	**50**	**100**
RELIGIOUS DENOMINATION		
Roman Catholic	13	26
Pentecost	7	14
UCZ	5	10
SDA	6	12
RCZ	11	22
Others	8	16
Total	**50**	**100**

Table 2 show that there were 22(44%) male and 28(56%) female respondents. Most of the respondents 21(42%) were aged between 16-18, 10(20%) aged between 13-15, 10(20%) aged between 19-21 and the lowest number of respondents 9(18%) were aged 22 and above. Most 29 (58%) respondents were grade 12s and the least 3(6%) were grade 9s. The majority 13(26%) of

respondents belonged to the Roman Catholic while the least 5 (10%) belonged to the United Church of Zambia.

4.3.2 SECTION 2: KNOWLEDGE ON VCT AND HIV/AIDS

Table 3: Definition of HIV (n-50)

DEFINITON OF HIV	FREQUENCY	PERCENTAGE
Human immunodeficiency Virus, a virus that causes AIDS	46	92
I don't know	4	8
Total	**50**	**100**

Majority 46 (92%) of the respondents knew the meaning of HIV while 4(8%) did not know.

Table 4: Transmission of HIV

TRANSMISSION OF HIV	FREQUENCY	PERCENTAGE
Sexual intercourse	48	96
Contaminated blood	23	46
Insect bite	4	8
Blood transfusion with unscreened blood	26	52
Getting together	1	2
Mother to baby through breast milk	29	58
Contaminated razor blade	30	60
I don't know	0	0

*** Multiple Responses, total does not add up to 50**

Ninety six 48(96%) respondents indicated that sexual intercourse is one of the ways in which HIV is transmitted and 1(2%) indicated that it was transmitted through getting together.

Table 5: Prevention of HIV

PREVENTION OF HIV	FREQUENCY	PERCENTAGE
Abstinence	48	96
Sticking to one sexual partner and being faithful	30	60
Use of a condom	36	72
I don't know	0	0

Table 4 show that 48 (96%) of the respondents stated that HIV can be prevented through abstinence, while others 36 (72%) indicated that it can be prevented through sticking to one sexual partner and being faithful. Thirty (60%) of respondents reported that HIV can be prevented through use of condoms

Table 6: Respondents' Responses on How They Can Know Their HIV Status (n-50)

KNOWING IF ONE HAS HIV OR NOT	FREQUENCY	PERCENTAGE
Through voluntary counselling and testing	49	98
When one has malaria	1	2
When one has diarrhea	0	0
I don't know	0	0
Total	**50**	**100**

Majority 49 (98%) of the respondents reported that HIV status can be known through voluntary counselling and testing, while 1(2%) indicated that it can be known when one has malaria.

Figure 2: Heard About VCT (n=50)

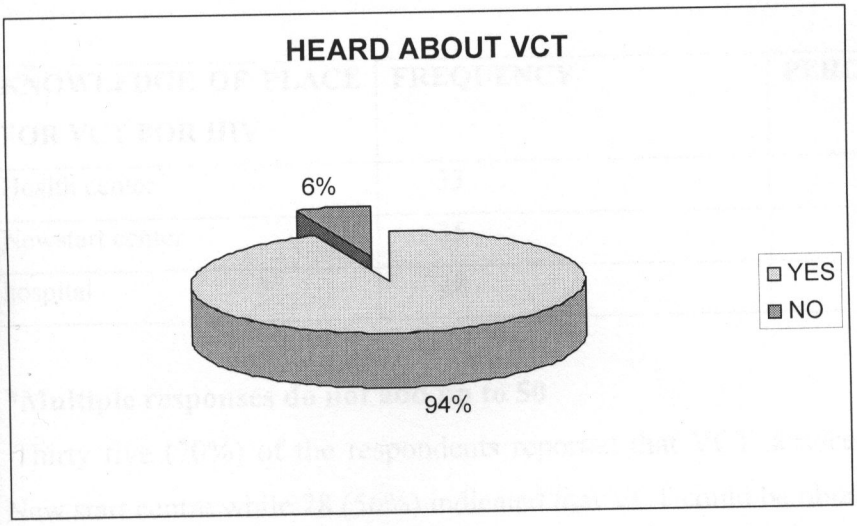


Figure 2 shows that majority 47 (94%) of the respondents had heard about voluntary counselling and testing while the rest 3(6%) had not heard about VCT.

Table 7: Definition of VCT (N=50)

DEFINITION OF VCT	FREQUENCY	PERCENTAGE
Willingly receiving information on HIV/AIDS and being tested	32	64
Going to the clinic/hospital	3	6
Knowing about HIV	15	30
I don't know	0	0
Total	**50**	**100**

Majority 32 (64%) defined VCT as willingly receiving information on HIV/AIDS and being tested while 15 (30%) said it was a way of knowing about HIV, 3(6%) reported that VCT was, going to the clinic or hospital.

Table 8: Knowledge of Where to Get VCT for HIV

KNOWLEDGE OF PLACE FOR VCT FOR HIV	FREQUENCY	PERCENTAGE
Health center	33	66
Newstart center	35	70
hospital	28	56

***Multiple responses do not add up to 50**

Thirty five (70%) of the respondents reported that VCT services could be accessed at New start centre while 28 (56%) indicated that VCT could be obtained at the Hospital.

Table 9: When VCT Should Be Done (n=50)

WHEN VCT SHOULD BE DONE	FREQUENCY	PERCENTAGE
Any time	32	64
When one is sick	7	14
Before marriage and during pregnancy	3	6
Every three months	3	6
When one feels at risk	4	8
I don't know	1	2
Total	**50**	**100**

Majority 32(64%) of the respondents indicted that VCT for HIV can be done at any time.

Figure 3: Who should go for VCT (n=50)

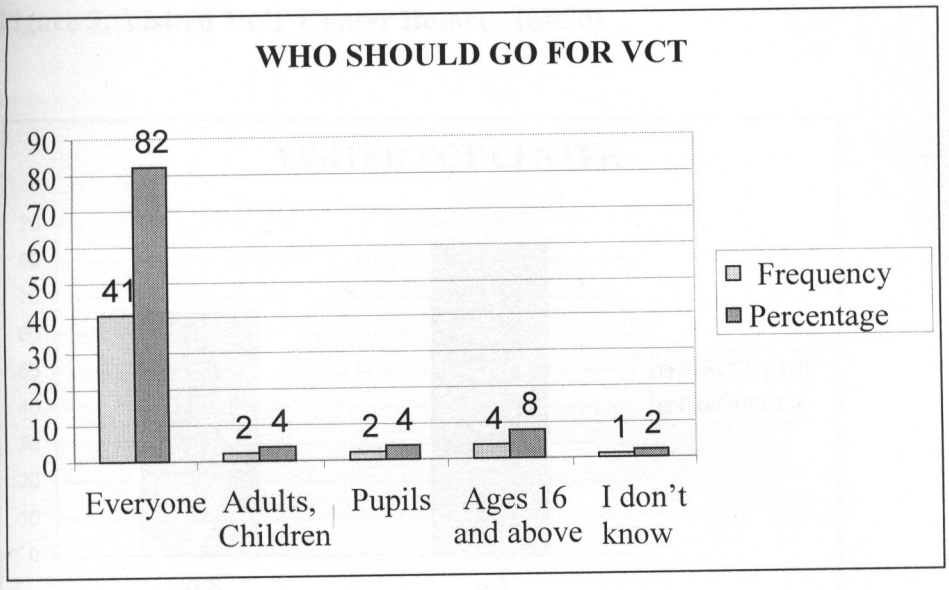
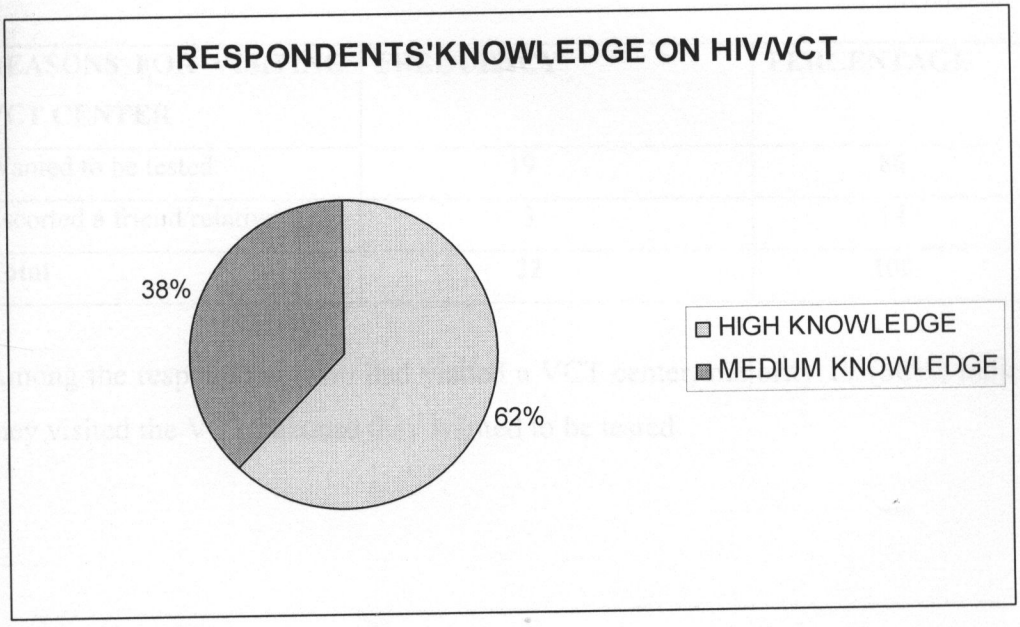


Table ten shows that majority 41 (82%) of respondents indicated that anyone could go for VCT, 1 (2%) did not know who should go for VCT

Figure 4: Respondents' level of knowledge



Majority 62% had high knowledge on HIV/AIDS and VCT.

4.3.3 SECTION 3: ATTITUDE TOWARDS VCT FOR HIV

Figure 5: Visited VCT Center Before (n=50)

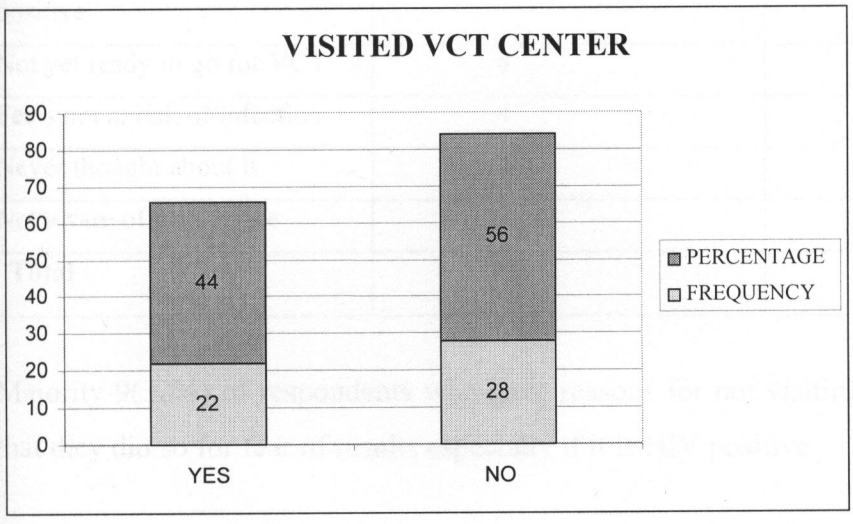


Figure 5 shows that 22 (44%) of the respondents reported to have visited the VCT center before, while 28(56%) indicated not to have visited the VCT center

Table 10: Reasons for Visiting VCT Center (n=22)

REASONS FOR VISITING VCT CENTER	FREQUENCY	PERCENTAGE
Wanted to be tested	19	86
Escorted a friend/relative	3	14
Total	**22**	**100**

Among the respondents who had visited a VCT center, majority 19 (86%) indicated that they visited the VCT because they wanted to be tested.

Table 11: Reasons for Not Visiting VCT Center (n=28)

RESPONSES	FREQUENCY	PERCENTAGE
Afraid of results if HIV positive	9	32
Not yet ready to go for VCT	8	28
Feels not at risk of infection	4	14
Never thought about it	4	14
Not aware of the service	3	12
Total	**28**	**100**

Majority 9(32%) of respondents who gave reasons for not visiting VCT center reported that they did so for fear of results especially if it is HIV positive.

Table 12: Willingness to be Counselled for HIV (n=50)

WILLINGNESS TO BE COUNSELLED	FREQUENCY	PERCENTAGE
YES	44	88
NO	6	12
Total	**50**	**100**

Majority 44(88%) of respondents indicated that they were willing to be counselled for HIV.

Table 13: Reasons for Willingness to be counselled For HIV (n-44)

RESPONSES	FREQUENCY	PERCENTAGE
To know their HIV status	30	68
Know more about HIV/AIDS and prevention	12	27
Plan for the future	2	5
Total	**44**	**100**

Table 13 shows that among respondents who indicated willingness to be counselled, majority 30(68%) gave reasons that they wanted to know their HIV status, while 12(27%) wanted to know more about HIV/AIDS and prevention.

Table 14: Awareness of the importance of VCT

IS VCT IMPORTANT	FREQUENCY	PERCENTAGE
YES	50	100
NO	0	0
Total	**50**	**100**

All the respondents 50 (100%) indicated that VCT is important

Table 15: Reasons Why VCT Is Important (n=50)

IMPORTANCE OF VCT	FREQUENCY	PERCENTAGE
knowing status and initiation of treatment	26	52
Foster behavior change	18	36
Gives information about HIV/AIDS	6	12
Total	**50**	**100**

Majority 26(52%) of respondents indicated that VCT was important because it is the only way that people know their status and are initiated for treatment, 18 (36%) indicated that it fosters behavior change and 6 (12%) gave reasons that VCT provides information on HIV/AIDS.

Table 16: Willingness to Have an HIV Test (n=50)

WILLINGNESS TO BE TESTED	FREQUENCY	PERCENTAGE
YES	45	90
NO	5	10
Total	**50**	**100**

Majority 45 (90%) of respondents indicated that they were willing to be tested for HIV

Table 17: Reasons for Unwillingness to Have an HIV Test (n=5)

RESPONSES	FREQUENCY	PERCENTAGE
Feel not at risk	3	60
Fear of test results	2	40
Total	**5**	**100**

Majority 3 (60%) of respondents who were unwilling to have a test gave the reasons that they did not feel at risk, while 2 (40%) indicated that they were afraid of the results especially if they came out positive.

Table 18: Willingness to Share Results (n=50)

WILLINGNESS TO SHARE RESULTS	FREQUENCY	PERCENTAGE
YES	42	84
NO	8	16
Total	**50**	**100**

Majority 42 (84%) of respondents indicated willingness to share HIV test results, while 8(16%) did not want to share test results.

Table 19: Reasons for Willingness to Share HIV Results (n=42)

RESPONSES	FREQUENCY	PERCENTAGE
To source for support if HIV results were positive	35	83
To encourage others to go for HIV test	5	12
To have a free mind	2	5
Total	**42**	**100**

Among the respondents who were willing to share test results, majority 35(83%) indicated that they would do so in order to source for support if HIV results were positive while 5(12%) gave reasons that they would do so to encourage others to go for VCT and two 2(5%) respondents reported that they would want to have a free mind.

Table 20: Reasons for Unwillingness to Share HIV Results (n=8)

RESPONSES	FREQUENCY	PERCENTAGE
It promotes stigma	5	63
Not ready to share	2	25
It is confidential	1	12
Total	**8**	**100**

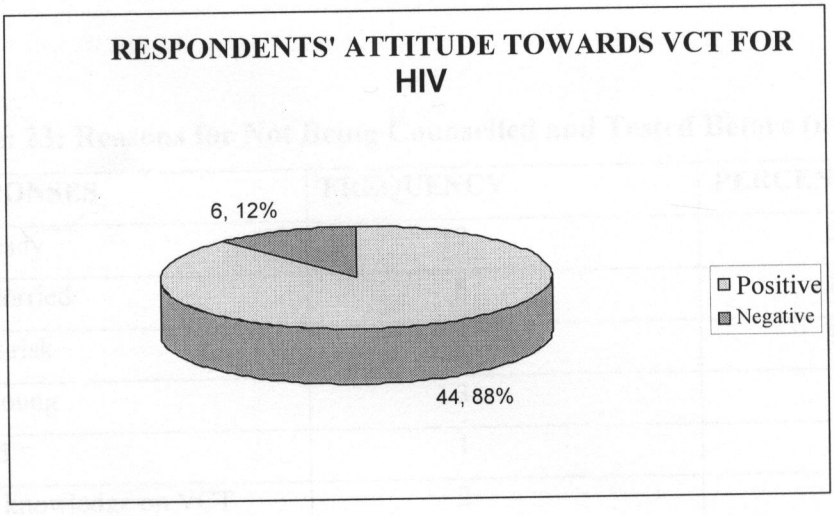
Among respondents who were not willing to share results, most of them 5(63%) gave a reason that it promotes stigma, 2 (25%) reported that they were not ready while 1(12%) gave a reason that it was confidential.

Table 21: Preferred Place for VCT (n=50)

RESPONSE	FREQUENCY	PERCENTAGE
Hospital/health center	18	36
Private clinic	8	16
Newstart center	24	48
Total	**50**	**100**

Majority 24(48%) of respondents indicated that they preferred Newstart center, eighteen (36%) preferred hospital/health center, while 8(16%) preferred private clinic.

FIGURE 6: RESPONDENTS ATTITUDE TOWARDS VCT FOR HIV (n=50)



Majority 44(88%) of respondents had a positive attitude towards VCT for HIV while 6(12%) had a negative attitude towards VCT for HIV.

4.3.4: PRACTICE TOWARDS VCT FOR HIV

Table 22: Counselled and Tested for HIV before (n=50)

COUNSELLED AND TESTED FOR HIV	FREQUENCY	PERCENTAGE
YES	17	**34**
NO	33	**66**
Total	**50**	**100**

Table 22 shows the number of respondents who have been counselled and those who have not been counselled and tested for HIV before. Majority 33(66%) indicated that they have not been counselled and tested for HIV before and 17(34) stated that they had been counselled.

Table: 23: Reasons for Not Being Counselled and Tested Before (n=33)

RESPONSES	FREQUENCY	PERCENTAGE
Not ready	17	52
Not worried	6	18
Not at risk	4	12
Too young	3	9
Afraid	1	3
Little knowledge on VCT	2	6
Total	**33**	**100**

Among respondents who had not been counselled and tested before 17(52%) gave reasons that they were not ready while 1(3%) mentioned that they were afraid.

Table 24: Place Where Counselled and Tested From (n=17)

PLACE WHERE COUNSELLED FROM	FREQUENCY	PERCENTAGE
Health center	6	35
Hospital	3	18
New start center	7	41
Mobile VCT	1	6
Total	**17**	**100**

Majority 7(41%) of those respondents who had been counselled before reported that they were counselled from New start center.

Table 25: Seek Consultation before Taking HIV Test (n=17)

RESPONSES	FREQUENCY	PERCENTAGE
YES	7	41
NO	10	59
Total	**17**	**100**

Majority 10 (59%) of respondents reported that they did not consult from anyone before taking an HIV test, while 7(41%) sought approval from others before undertaking HIV test.

Table 26: Person Consulted From (n=7)

PERSON ASKED FOR APPROVAL	FREQUENCY	PERCENTAGE
Friend	3	43
Brother/ Sister	2	29
Parents	1	14
Pastor/ Father/Bishop	1	14
TOTAL	7	**100**

Table 26 shows that majority 3(43%) of respondents indicated having consulted from a friend before taking an HIV test.

Table 27: Reasons for Not Consulting Before Taking an HIV Test (n=10)

RESPONSES	FREQUENCY	PERCENTAGE
Fear of stigma	6	**60**
Fear of disapproval	1	**10**
Lack of trust/confidence	3	**30**
TOTAL	**10**	**100**

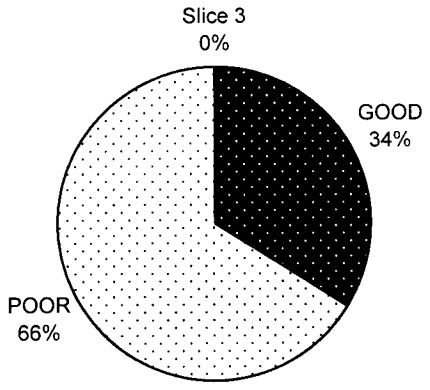
Among respondents who did consult from any one before taking an HIV test, 6(60%) gave a reason that they were afraid of stigma, while 3(30%) indicated that they were lacking trust or confidence and the 1(10%) was afraid of stigma.

Table 28: Collected Results for HIV Test

RESPONSE	FREQUENCY	PERCENTAGE
Yes	6	86
No	1	14
TOTAL	**7**	**100**

Of the 7 respondents who had been counselled and tested before, 6(86%) indicated that they collected the test results.

Figure 7: Respondents Level of Practice



The majority 33(66%) of respondents had poor practice towards VCT services and 17(34%) had good practice.

Table 29: Factors Contributing To Low Utilization of VCT Services by Pupils

RESPONSES	FREQUENCY	PERCENTAGE
Poor timing of VCT services	16	32
Long waiting hours	11	22
Stigma from families,	26	52
Lack of awareness about VCT services	35	70

Multiple Answers do not add up to 100

Majority 35(70%) of respondents reported that lack of awareness about VCT contributed to low utilization of VCT services and 26 (52%) stated fear of stigma from families, friends and the community.

4.3.5 RELATIONSHIPS BETWEEN VARIABLES

Table 30: Respondents' Knowledge Level in Relation to Gender

KNOWLEDGE LEVEL	GENDER		TOTAL
	Male	Female	
High	13 (41%)	19(59%)	32(64%)
Medium	9 (50%)	9(50%)	18 (36%)
Low	**0**	**0**	**0**
Total	**22(44%)**	**28(56%)**	**50(100%)**

Of the respondents with high knowledge on HIV/ VCT, 19(59%) were females and those with medium knowledge, 9(50%) were females and the other 9(50%) were males.

Table 31: Respondents' Level of Knowledge In Relation To Age

LEVEL OF KNOWLEDGE	AGE RANGE				TOTAL
	13-15	16-18	19-21	22-24	
High	6(19%)	10(31%)	9 (28%)	7(22%)	32(64%)
Medium	4(22%)	11(61%)	1(6%)	2(11%)	18(36%)
Low	**0**	**0**	**0**	**0**	**0**
Total	**10 (20%)**	**21(42%)**	**10(20%)**	**9 (18%)**	**50(100%)**

Most of the respondent 10(31%) with high knowledge on HIV/VCT were in the age range of 16-18years, and 11(61%) of the respondents with medium knowledge were in the same age range.

Table 32: Respondents' Level of Knowledge In Relation To Level Of Education

LEVEL OF KNOWLEDGE	LEVEL OF EDUCATION					TOTAL
	Grade 8	Grade 9	Grade 10	Grade 11	Grade 12	
High	2(6%)	3(9%)	5 (16%)	4 (13%)	18 (56%)	32 (64%)
Medium	3(17%)	0(0%)	1 (5%)	3(17%)	11 (61%)	18(36%)
Low	**0**	**0**	**0**	**0**	**0**	**0**
Total	**5 (10%)**	**3 (6%)**	**6 (12%)**	**7(14%)**	**29 (58%)**	**50(100%)**

Of the 32 (64%) respondents with high knowledge on HIV/VCT, 18(56%) were in grade 12, and 11 (61%) with medium knowledge were also in grade 12.

Table 33: Respondents Level of Knowledge In Relation To Religious Denomination

EVEL OF NOWLED E	RELIGIOUS DENOMINATION						TOTAL
	RC	Pentecost	UCZ	SDA	RCZ	Others	
igh	8(26%)	5(16%)	4(13%)	1(3%)	9(29%)	4(13%)	**31(62%)**
ledium	5(26%)	2(11%)	1(5%)	5(26%)	2(11%)	4(21%)	**19(38%)**
ow	0	0	0	0	0	0	0
otal	**13(26%)**	**7(14%)**	**5(10%)**	**6(12%)**	**11(22%)**	**8(16%)**	**50(100%)**

Most of the respondents 9(29%) who had high knowledge on HIV/VCT congregated with Reformed Church in Zambia (RCZ).Those with medium knowledge, 5(26%) congregated with the Roman Catholic (RC) church and another 5(26%) congregated with the Seventh Day Adventist (SDA) church.

Table 34: Respondents' Attitude in Relation to Gender

Attitude Level	Gender		Total
	Male	Female	
Positive	18 (42%)	25(58%)	**43(86%)**
Negative	4(57%)	3(43%)	**7(14%)**
Total	**22 (44%)**	**28 (56%)**	**50 (100%)**

Among the 43(86%) respondents with positive attitude towards VCT for HIV, 25(58%) were females, while 4(57%) respondents with negative attitude were males.

Table 35: Respondents Attitude in Relation to Age

ATTITUDE LEVEL	AGE RANGE				TOTAL
	13-15	16-18	19-21	22-24	
Positive	6 (15%)	19 (47%)	7(18%)	8(20%)	**40 (80%)**
Negative	4(40%)	2 (20%)	3 (30%)	1(10%)	**10(20%)**
Total	**10(20%)**	**21 (42%)**	**10 (20%)**	**9 (18%)**	**50 (100%)**

Most of the respondents 19 (47%) with positive attitude towards VCT for HIV were in the age range 16-18 years, while 4(40%) of the respondents with negative attitude were aged 13-15 years.

Table 36: Respondents Attitude in Relation to their Level of Education

ATTITUDE	LEVEL OF EDUCATION					TOTAL
	Grade 8	Grade 9	Grade 10	Grade11	Grade 12	
Positive	1(2%)	2(5%)	6(14%)	7(17%)	26(62%)	**42(84%)**
Negative	4(50%)	1(12%)	0(0%)	0(0%)	3(38%)	**8(16%)**
TOTAL	**5(10%)**	**3(6%)**	**6(12%)**	**7(14%)**	**29(58%)**	**50(100%)**

Of the respondents with positive attitude towards VCT for HIV, 26 (62%) were in grade 12, while those with negative attitude, 4 (50%) were in grade 8.

Table 37: Respondents' Practice in Relation To Gender

PRACTICE	GENDER		TOTAL
	MALE	FEMALE	
Good	7(41%)	10(59%)	**17(34%)**
Poor	15(45%)	18(55%)	**33(66%)**
TOTAL	**22(44%)**	**38(56%)**	**50 (100%)**

Of the 17(34%) respondents with good practice towards VCT, 10 (59%) were females while those with poor practice 18(55%) were also females.

Table 38: Respondents' Practice in Relation to Age

PRACTICE	AGE RANGE				TOTAL
	13-15	16-18	19-21	22-24	
Good	1(6%)	7 (41%)	4(24%)	5(29%)	**17 (34%)**
Poor	9(27%)	14 (43%)	6 (18%)	4(12%)	**33 (66%)**
TOTAL	**10(20%)**	**21 (42%)**	**10 (20%)**	**9 (18%)**	**50 (100%)**

Among respondents with poor practice towards VCT, 14(43%) were in the age range of 16-18 years, while those with good practice, 5(29%) were also in the same age range.

Table 39: Respondents' Practice In Relation to the Level of Education

PRACTICE	LEVEL OF EDUCATION					TOTAL
	Grade 8	Grade 9	Grade 10	Grade11	Grade 12	
Good	1(5%)	1(5%)	3(16%)	2(11%)	12(63%)	**19(46%)**
Poor	4(13%)	2(6%)	3(10%)	5(16%)	17(55%)	**31(54%)**
TOTAL	**5(10%)**	**3(6%)**	**6(12%)**	**7(14%)**	**29(58%)**	**50(100%)**

Of the 19(46%) respondents with good practice towards VCT, 12(63%) were in grade 12 and those with poor practice, 17(55%) were also in the same grade.

Table 40: Respondents' Practice in Relation to Knowledge on HIV/VCT

PRACTICE	KNOWLEDGE			TOTAL
	HIGH	MEDIUM	LOW	
Good	11(65%)	6(35%)	-	**17(34%)**
Poor	20(61%)	13(39%)	-	**33(66%)**
TOTAL	**31(62%)**	**19(38%)**	-	**50(100%)**

Among the respondents with good practice towards VCT for HIV, 11(65%) had high knowledge, While 20 (61%) respondents with poor practice had medium knowledge.

Table 41: Respondents' Practice in Relation to Attitude

PRACTICE	ATTITUDE		TOTAL
	Positive	Negative	
Good	17(94%)	1(6%)	**18(36%)**
Poor	27(84%)	5(16%)	**32(64%)**
Total	**44(88%)**	**6(12%)**	**50(100%)**

Among respondents with good practice towards VCT for HIV, 17(94%) had positive attitude towards VCT/HIV, while 27(84%) of the respondents with poor practice towards VCT/HIV had a positive attitude. The respondents with negative attitude, 5(16%) had poor practice.

Table 42: Respondents' Knowledge in Relation to Attitude

KNOWLEDGE OF VCT/HIV	ATTITUDE		TOTAL
	Positive	Negative	
High	29(94%)	2(6%)	**31(62%)**
Medium	5(26%)	14(73%)	**19(38%)**
Low	0	0	**0**
Total	**34(68%)**	**16(32%)**	**50(100%)**

Of the respondents with high knowledge on VCT/HIV, 29(94%) had a positive attitude, while among those with medium knowledge 14(73%) had a poor attitude towards VCT/HIV.

CHAPTER 5

5.0 DISCUSSION OF FINDINGS

5.1 Introduction

The discussion of the study is based on analysis of data collected from a sample of fifty (50) respondents using a self administered questionnaire. The study was aimed at determining knowledge, attitude and practice of pupils at Chipata Day Secondary School in Chipata District towards VCT for HIV. The discussion is presented under headings which are in line with the objectives namely, demographic, knowledge, attitude and practice.

5.2 DEMOGRAPHIC CHARACTERISTICS OF RESPONDENTS

The demographic characteristics of the respondents which were relevant to the study included sex, age, level of education and religious denomination. These were essential for interpretation of findings.

The sample included both males and females. Most of the respondents 28(56%) were females and 22(44%) were males (**Table 2, page 32**). This is attributed to the fact that there are more females than males in the school. In the recent past, Schools had more males than females. Thus the Government of the Republic of Zambia like the rest of the world drew up strategies to address gender imbalances. For this reason, strategies that came up included an increase in enrollment and retention of a girl-child at all levels of education by 80% (Gender in Development, 2001).

The research findings revealed that 21(42%) of the respondents were aged between 16-18years, 10(20%) between 19-20years, 10(20%) were aged between 13-15years while 9(18%) were aged 22 years and above (**Table 2, page 32**). This shows that all the respondents were in their adolescence age and this stage is termed the secondary school going period. Adolescence is the most crucial stage in life, a time when young men and women undergo physical change and self

discovery (CSO, 2005). They are often targeted in most reproductive health programmes and media messages because they are at a stage of life when sexual activity (including risk sexual behavior) and reproductive activity is likely to begin (CSO, 2005). This is an important stage in which they should be taught the realities of life because it is also an experimental period in which they would want to try what ever they hear or see from their peers.

Most 29(58%) of the respondents were in grade 12, 7 (14%) grade 11, 6(12%) grade 10, 5(10%) grade 8, while 3 (6%) were in grade 9(**Table 2, page 32**). The grades in secondary schools were chosen because most youths reach adolescence while in these grades. It is also assumed that youths tend to acquire a lot of knowledge related to issues of sexual behavior and initiate sexual behavior in secondary school grades (CSO, 2005). Education on HIV/VCT would be appropriate in this case when they are eager to learn more about it (UNAIDS, 2006).

Thirteen (26%) of the respondents congregated with the Roman Catholic Church, 11(22%) with the Reformed Church in Zambia, 8(16%) with Jehovas' Witness, 7(14%) Pentecost, 6(12%) with the Seventh Day Adventist church while 5(10%) congregated with the United Church of Zambia (**Table 2, page 32**).This was the case probably because the Roman Catholic Church is one of the earliest churches in Eastern province and has the largest membership. The church is another place at which a lot of youths can be captured, thus services such as VCT when offered at the church would yield a positive result (Kelly, 2006).

5.3 KNOWLEDGE ON HIV/VCT

Knowledge may influence one's action. Hence having knowledge on HIV will influence ones' ability to go for VCT. The study showed that 31(62%) of the respondents had high knowledge on HIV/VCT, while 19(38%) had medium knowledge and no one had low knowledge (**figure 4, page 37**). A study done at

Libala and David Kaunda High Schools by Kabinga (2003) also revealed that majority of the respondents had high knowledge 44 (88%) while 6(12%) had medium knowledge. This could be attributed to effective dissemination of information through radio, drama groups in schools and the community and formation of Anti AIDS clubs in schools. It also shows that knowledge has increased due to sensitization that has been done (UNAIDS 2006). A study done by Muganda (2003) in Kenya on the knowledge, attitude and practice of secondary school adolescents towards VCT also revealed that youths obtained VCT information through media and health care providers. Young people seek information and clues about sexual life from a variety of sources (Muganda-Onyando et al, 2003).

The respondents were asked what HIV meant and 46 (92%) knew what it meant (**Table 3, page 33**). This could be attributed to widely sensitization of the information on HIV through the media, drama groups and the training of teachers as counsellors (MOE, 2006). The other reason could be that topics on HIV have been incorporated in to the primary and College Education Curriculum (MOE, 2006) and most pupils could have learnt about HIV whilst in primary school. It is however important to note that 6(8%) did not know the meaning of HIV. These could be staying in far places where the media is difficult to access and the only source is the health care provider who may not be available at their convenient time. It is important that every one learns about HIV because one is either affected or infected and through knowledge, one is able to make choices some of which would reduce the spread of HIV infection (Muganda, 2003).

Regarding transmission of HIV infection (**Table 4, page 33),** 48(96%) of the respondents indicated that sexual intercourse was the commonest route of transmission. The report in the ZSBS (2005) revealed that sexual intercourse was the primary route of HIV transmission. Twenty three (60%) of the respondents mentioned contaminated razor blades as one of the commonest routes, 29(58%) knew that it can be transmitted through mother to child, 26(52%) through blood

transfusion and 23(46%) through contaminated blood. 5 (10%) did not know how HIV is transmitted and they indicated that it was through an insect bite and getting together. Despite the wide knowledge on the transmission of HIV as demonstrated in the study findings, misconception about HIV transmission still persists. The study by CSO (2005) also notes that young people especially in the rural areas still hold that HIV is transmitted through mosquito bite. Lack of knowledge could stem from poor sources of information such as lack of access to the media and cultural influences and could contribute to misconceptions about HIV.

For the question on how to prevent HIV (**Table 5, page 34**), abstinence was the most 48 (96%) frequently mentioned preventive method followed by condom use 36(72%), and the last one was being faithful to one partner which accounted for 30(60%). These results are consistent with the findings of the Zambia Sexual Behavior Survey which showed a high percentage (96.6%) of males and females who recognized abstinence as the method of prevention of HIV, 86% condom use and 70% being faithful to one sexual partner (CSO, 2005). Moreover, abstinence as a preventive method has been widely advocated for in Zambia and many parts of the world. Many studies done and many strategies that are developed in terms of HIV prevention are tailored towards promotion of abstinence or condom use should one fail to abstain among youths (UNAIDS, 2006).

The study findings on the question of how one would know their HIV status revealed that 49 (98%) of the respondents indicated that they could only know their HIV status through VCT, while 1(2%) indicated that one can only know of their HIV status when they have malaria(**Table 6, page 34**) . From these results one would deduce that almost all the respondents knew how one could know their HIV status. VCT is an entry point to other HIV/AIDS services such as prevention and clinical management of HIV related illnesses. VCT facilitates behavior change and offers benefits to those who test negative or positive (Baggaley and Boswell, 2002).

Concerning awareness of VCT, 47(94%) of the respondents reported that they had heard about VCT, while 3(6 %) indicated that they had not heard about it (**Figure 2, page 35**). From this study it was revealed that majority of the respondents 47(94%) new the meaning of VCT for HIV while 6% indicated that it was going to the clinic or hospital (**Table 7, page 35**). The high percentage in awareness of VCT could be attributed to the increased sensitization of VCT services through radios, television, mobile services posters and drama both in the community and at secondary schools. The Ministry of health has introduced programmes of sensitizing the masses about VCT for HIV through posters and advertisements on the radio and television such as "I know, do you". These have been channels through which people get information on VCT (Kabinga 2003).

From **table 8, page 36**, results show that all the respondents knew of at least a place to go for VCT. 22(44%) of the respondents reported that VCT services could be accessed at Newstart Center, 13(26%) stated the hospital/health center, while 4(8%) mentioned the hospital. According to the report in the ZSBS, 77% of the youths knew of a place to go for VCT. However, knowing a place to go for VCT does not mean that one knows their HIV status. It is therefore paramount that the young people know the activities done at these places in order for them to appreciate the availability of the services (Muganda-Onyanda et al, 2003).

Regarding the time when VCT should be done, the study results shows that 32 (64%)of the respondents stated that it could be done at anytime, 7(14%) when one is sick, 4(8%) when one feels at risk,3(6%) before marriage and during pregnancy,3(6%)every three months, while 1(2%) did not know when VCT should be done (**Table 9,page 36**). Awareness of when VCT should be done will encourage pupils to access VCT services; prevent spread of infection and initiation of care early enough. VCT is aimed at helping not only adults but the youths too to cope with stress and make personal decisions related to HIV/AIDS (Baggaley and Boswell, 2002).

Concerning who should go for VCT (**Figure 3, page 37**), the study results shows that 41(82%) of the respondents reported that everyone is legible to go for VCT, 4(8%) indicated that only those with ages 16 and above are legible to go for VCT, 2(4%) mentioned pupils, 2(4%) stated that adults and children, while 1(2%) did not know. These findings indicate that a bigger percentage of the respondents knew of who should go for VCT. However, every one is legible to go for VCT .This implies that those below the age of 16 should be accompanied by their parents or guardian. Those who reported that only 16years and above are legible clients for VCT could be referring to the policy on VCT which states that any one below the age of 16 is not supposed to go for VCT without parental guidance. Children below the age of 16 would not make a good decision hence they need to be accompanied by their parents when being counselled and tested for HIV (NAC, 2004). Countries like Kenya have similar policies indicating that young people below 15 years who seek VCT for HIV services could be counselled only and not tested unless it is done under medical reasons (Baggaley and Boswell, 2002).

5.4.1 ATTITUDE TOWARDS VOLUNTARY COUNSELLING AND TESTING FOR HIV

The results under this section were elicited from the questions asked with regards to the attitude of pupils towards VCT for HIV.

Generally the attitude towards VCT as analyzed indicates that 44(88%) of the respondents had a positive attitude towards VCT for HIV, while 6(12%) had a negative attitude (**figure 6, page 43**). According to UNAIDS (2006) report, studies that were done concerning School based HIV/AIDS prevention in Africa, revealed significant positive attitude towards VCT for HIV. Quality of knowledge offered to young people influences their attitude towards use of services such as VCT.

The study results shows that 28 (56%) of the respondents had never visited a VCT center before, while 22(44%) had done so (**Figure 5, page 38**). A study done by Chishimba (2006) among youths in Lusaka had similar findings indicating that despite high knowledge of awareness and the perception that VCT services are advantageous, only 16% of the youths visited the centers. Youths visit VCT centers that provide quality services and services that are youth friendly. Young people will always appreciate services that suit them (UNAIDS, 2006).

The study findings also reveal that, of the respondents that had visited the VCT center before, majority 19(86%) gave reasons that they wanted to know their HIV status, while 3(14%) escorted a friend or a relative (**Table 10, page 38**). Knowing about HIV status enables individuals to initiate or maintain behaviors to prevent or further the transmission of HIV (Dyk, 2005).

Of the 28 respondents that had never visited a VCT center before, majority 9(32%) gave reasons that they were afraid in case they tested HIV positive, 8(28%) were not ready to go for a test, 4(14%) felt they were not at risk of HIV infection, and another 4 (14%) reported that they never thought about it, while 3(12%) indicated that they were not aware of the VCT services (**Table 11, page 39**). A study conducted in Ethiopia by Family Health International (2004) revealed similar findings adding that youths would only be attracted to VCT services if the services are confidential, and if the test results are reported to be honesty. VCT is a vital process that provides an entry point to other HIV/AIDS services including prevention and clinical management. However VCT for HIV partially depends on the information available among youths. Information is considered as one of the strategies to solve the problem of HIV/AIDS among youths (Muganda-Onyando et al, 2003)

When asked if they were willing to be counselled for HIV, most of the respondents 44(88%) indicated that they were willing to be counselled, while 6(12%) were not willing (**Table 12, page 39**). A study done in Uganda urban

revealed similar findings (Horizons, 2003) that many youths wanted to be counselled and tested. Of the respondents that were willing to be counselled for HIV, 30(68%) indicated that they wanted to know their HIV status, 12(27%) wanted to know more about HIV/AIDS prevention and 2(5%) wanted to plan for their future (**Table 13, page 39**). Young people have different needs and they seek out VCT services for different reasons. They should therefore be attended to accordingly and encouraged to use the services (UNAIDS, 2006)

From the findings of this study, it is revealed that all respondents 50 (100%) indicted that VCT was very important (**Table 14, page 340**). Regarding the reasons why VCT was important, most of the respondents 26(52%) reported that it enables one to know their HIV status and initiation of treatment if tested positive, 18(36%) indicated that it fosters behavior change while 6(12%) gave reasons that it gives information about HIV/AIDS (**Table 15, page 40**). This shows that the respondents were aware of the importance of the service. Therefore they need to be encouraged in order for them to utilize the services effectively (Muganda-Onyanda et al, 2003).

Concerning willingness to have an HIV test, 45(90%) of the respondents revealed that they were willing to be tested for HIV, while 5(10%) were not willing (**Table 16, page 41).** From the findings a conclusion could be drawn that the respondents would want to have an HIV test but there could be other reasons that prevent them from going ahead. An exploratory study done in Uganda and Kenya revealed that there was an increase in the number of youths wanting to be tested including those that had a test before. VCT requires time, courage, acceptance, before one decides to go for it. Those who gain courage and accept the service will be willing to go for VCT (Horizons, 2003).

On the contrary, respondents who indicated unwillingness to have an HIV test, 3(60%) gave reasons that they were not at risk and 2(40%) said they were afraid of the test results (**Table 17, page 41**). Similar findings were revealed in the study

done in Uganda and Kenya adding that VCT was for people who were sick (Horizons, 2003).

When asked if they were willing to share test results, 42(84%) of the respondents reported that they would be willing to share results, while 8(16 %) were not willing (**Table 18, page 38**). However this study findings reveal that respondents who were willing to share results would do so in order to source for support if tested positive 35(83%), others 7(17%) gave reasons that it would encourage others to go for a test and 2(5%)mentioned that it frees ones' mind (**Table 19, page 42**). Willingness to share results could be attributed to the knowledge that youths may have on the benefits of VCT, the relationships both among friends and families and their support. Unwillingness entails one does not understand the importance or benefits of sharing results.

Of the respondents that were unwilling to share HIV results, 5(63%) gave reasons that announcing results promotes an avenue for gossip which brews stigmatization, 2(25%) of the respondents indicated that they were not ready to share results due to lack of courage while 1 gave a reason that it was confidential (**Table 20, page 42**). Sharing of results is vital and it depends on how well one has been informed on the advantages and disadvantages of VCT. It is said that problem shared is problem solved. It is important to emphasize the need for sharing test results if the spread of the infection is to be minimized (Horizons, 2003). Some of the assumed reasons could be the type of services being offered (whether adapted for the youths or not).The findings of a study done in Uganda reveals that youths preferred VCT centers that provided professional services, confidentiality and youth friendly services because it is easier to seek testing with other youths that are kind, and who understand youth issues (Horizons, 2003)

Most people have preferences of places to go for VCT depending on the information regarding the quality of services being rendered. The study results show that most of the respondents 22(44%) preferred Newstart center, 13(26%)

hospital/health center, while 4(8%) of the respondents mentioned private clinic as their preference **(Table 21, page 43)**. From the result it is clear that the most preferred center was Newstart. Newstart center is a Non-Governmental project that offers VCT as one of its services. Despite the differences in the choice of place for VCT, the common reasons alluded to each were that they offered quality services by ensuring that privacy and confidentiality is maintained and professional counsellors are available. Muganda in his study in Kenya, found similar results that most youths preferred Non-Government VCT centers adding that Government centers are located in public places and do not provide privacy (Muganada-Onyando et al, 2003).

5.5 PRACTICE TOWARDS VCT FOR HIV

The information on practice was elicited from section D. With regards to practice towards VCT for HIV, majority 33(66%) of the respondents had poor practice while 17(34%) had good practice (**Figure 7, page 47**). The poor practice could be attributed to the renowned fear of stigmatization and fear of test results. In a study done in Kenya among Secondary school adolescents, findings revealed that some of the barriers to utilization of VCT services included worries about confidentiality, fear of test results, long waiting hours on queues, and worries about stigmatization (Muganda-Onyando et al, 2003). Fears of test result and stigma have been cited as hindrances to HIV/VCT in so many studies. Therefore, strategies that normalize testing by reducing stigma and discrimination will increase acceptability and decrease barriers to VCT (UNAIDS, 2006)

Despite having high knowledge and positive attitude towards VCT, this study finding reveal that 33(66%) of the respondents had not been counselled and tested for HIV before, while 17(34%) had been counselled and tested for HIV before (**Table 22, page 44**). This indicates that having knowledge on VCT/HIV does not determine ones' use of the service. There could be reasons why people would not

go for VCT/HIV. Some of the assumed reasons could be the type of services being offered (adapted or not adapted to youths).

Reasons indicated for not being counselled and tested include not being ready 17 (52%), 6 (18%) felt it did not worry them, 4(12%) were not at risk, 3(9%) felt they were too young for such an activity as they did not indulge in sexual activities, 2 (6%) gave reasons that they had little knowledge on VCT, while 1(3%) reported that they had fear of unknown (**Table 23, page 44**).These study findings are similar to the study done in India, South Africa and United States of America where Indian and South African students demonstrated fear , not wanting to think about VCT, loss of friends and lack of trust in the counselor as some of the reasons for not having been counselled and tested before (Peltzer et al, 2004).

With regards to places where respondents had been counselled and tested, 7(41%) indicated Newstart centre, 6(35%) health centre, 3(18%) Hospital, while 1(6%) mentioned mobile VCT services (**Table 24, page 45**). The preference of a place to go for VCT may be attributed to either good services being provided, familiarity to the place or the location of the site (in an isolated area or public area). A study done in Ethiopia reveals that the preference of one health institution to the other depends on the provision of good treatment, technical competence and quality of health service delivery (Family Health International-FHI, 2008)

Families and friends play an important role in the youth's decision making about going for VCT and getting tested for HIV. When asked if they consulted any one before taking an HIV test, 10(59%) of the respondents indicated that they did not consult anyone, while 7(41%) reported to have consulted someone (**Table 25, page 45**). A study conducted by Horizons (2004) in Ndola revealed similar findings adding that about 4.2% of the youths interviewed, they talked to some one before having an HIV test. Consulting some one before taking an HIV test

has both advantages and disadvantages. Persons that were consulted included friends 3(43%), Brother/Sister 2 (29%), Parents 1(14%), and one (14%) consulted Pastor/Father/Bishop (**Table 26, page 45**). Involving closely related people is instrumental in enhancing the social acceptance of VCT. Youths in most cases would prefer to share secrets with their peers as opposed to any other person. Probably they are not free with their parents or church leaders. Traditionally in the Zambian set up, children are socialized in such a way that they do not feel comfortable to discuss sexual matters with their parents (Horizons, 2004).

Of the respondents who did not consult anybody before taking an HIV test, majority 6(60%) reported that they were afraid of being stigmatized, 3(30%) gave reasons that they did not trust anyone and believed that VCT was supposed to be confidential, while 1(10%) cited fear of being discouraged (**Table 27, page 446**). The respondents who had been counselled and tested, 6(86%) collected their HIV test results while 1(14%) did not collect their results (**Table 28, page 46**). This is normally facilitated by the process of counselling. If counselling has been well done to make the client understand, usually collection of results is not a problem. Therefore it is important that qualified and competent counselors are employed in areas of counselling if the purpose of counselling is to be appreciated (Dyk, 2005).

With regards to factors that contribute to low utilization of VCT services, findings in this study indicated that 35(70%) reported that lack of awareness of the VCT services contributed to it, 26(52%) attributed it to stigma from the community and family members, 16(32%) indicated that poor timing of the services especially to pupils, while 11(22%) gave reasons that it is due to long waiting hours at the VCT centers (**Table 29, page 47**). From these findings one would conclude that stigma and lack of awareness contribute to low utilization of VCT services. This could be supported by the findings in the Uganda and Kenya researches which revealed that young people would want to have VCT in facilities that are conveniently

located where they do not have to run in to parents or neighbors and where it is not clear to casual observers that they are there to have a test (Horizons, 2003).

5.6 RELATIONSHIPS AMONG VARIABLES

The study findings from table 32, page 37, reveals that 19(59%) of the respondents with high knowledge on HIV/VCT were females, while 9(50%) with medium knowledge were males and another 9 (50%) in the same category were females (**Table 30, page 48**). From the results it is clear that gender does not influence ones' knowledge acquisition of VCT for HIV.

From **table 31, page 48**, the research findings reveal that among respondents with high knowledge on HIV/VCT, 28% were aged 19-21years, 19% were aged 13-15years. Majority of the respondents with both high knowledge (31%) and medium knowledge (61%) were aged between 16-18 years. From the UNAIDS (2006) report it reveals that young people seek information from a variety of sources namely parents, teachers, religious leaders and mass media. As one matures in age, they become inquisitive of what happens around them especially in matters relating to sexuality hence the high knowledge (CSO, 2005).

Findings of the research showed that 11(61%) of the respondents with medium knowledge were in grade 12, while 18 (56%) of the respondents with high knowledge were in the same grade (**Table 32, page 49**). This may be attributed to the fact that as one advances in education, knowledge also expands. The same table further indicates that 3(17%) of respondents with medium knowledge were in grade 11, while another 3(17%) of the respondents with medium knowledge were in grade 8(**Table 32, page 49**).

The study results further revealed that religion does not influence one's knowledge on VCT for HIV as seen in **table 33, page 49**, which indicated that of the respondents with high knowledge, 9(29%) congregated with RCZ, 5(26%) with Roman Catholic, 4(13%) with UCZ, while 1(3%) with SDA. Among the

respondents with medium knowledge, 5(26%) congregated with SDA and another 5(26%) of the respondents congregated with RCC, and 1(5%) congregated with UCZ. From the results each group had a representation in each category (high and medium knowledge). This could be attributed to the fact that churches have formed associations such as CHAZ (Churches Health Association of Zambia) that help in dissemination of information and supporting schools and hospitals in issues of HIV/AIDS (NAC, 2005). Besides that some churches such as SDA are discussing the issue of HIV during sermons, marriage counselling, and youth forum and they have actually set up VCT centers within the church grounds (Libala SDA Church Bulletin, 2008).

Among respondents with positive attitude towards VC for HIV, 26 (58%) were females and 18(42%) were males, while 4(57%) of the respondents with negative attitude were males and 3 of the respondents with negative attitude were females (**Table 34, page 50**). From the findings it can be concluded that gender does influence attitude towards VCT for HIV.

Regarding the relationship between age and attitude towards VCT/HIV, the study results revealed that, of the respondents with positive attitude towards HIV/VCT, 19(47%) were in the age range 16-18 years, 4(15%) were in the age range 13-15 years, while 4(40%) of the respondents with negative attitude were also in the age range 13-15years (**Table 35, page 50**). This could be attributed to where one derives his/her information from. Being in the adolescence age which is said to be crucial, many young people become sexually active within this age group and there fore would want to find out more about risk factors related to the reproductive health (CSO, 2005).

When testing the relationship between respondents' attitude with their level of education, the study findings revealed that out of the respondents with positive attitude towards VC for HIV, 26(62%) of the respondents were in grade 12, while 4(50%) of the respondents with negative attitude were in grade 8 (**Table 36, page**

50). From these findings, one would conclude that there is a relationship between the level of education and the attitude towards VCT for HIV. As one advances in their education the knowledge also expands. They tend to acquire new information even as they advance in their grades.

The study findings of this study showed that of the respondents with good practice towards HIV/VCT, 10(59%) were females, while 7(55%) of the respondents with negative attitude were also females (**Table 37, page 51**). This shows that there is no relationship between gender and practice towards HIV/VCT. This could be attributed to where one obtains their influences in terms of decision making.

The findings of this study also revealed that of the respondents with poor practice towards VCT, 14(43%) of the respondents were aged 16-18 years, while 7 (41%) of the respondents with poor practice towards VCT were in the same age range. The same table also revealed that of the 10 respondents in the age range 13-15 years, 1(6%) had good practice and 9(27%) had poor practice (**Table 38, page 51**). The poor practice among the ages 13 -15 years could be attributed to the fact that during this age the youths may have not encountered sexual activity and do not deem it right to go for VCT. While those in the age range 16-18 years may have been exposed to sexual activity and wouldn't want to know their HIV status. On the other hand, one is inclined to follow certain practices depending on how they are cultured regardless of how old they may be. Practice towards VCT for HIV can be influenced by factors such as access to testing sites, attitude towards HIV and the level of stigma in the society (CSO, 2005).

Among respondents with good practice towards VCT, 12 (63%) were in grade 12, while 17 (55%) of the respondents with poor practice were also in the same grade (**Table 39, Page 51**). From the findings, it can be concluded that educational level does not influence the respondents practice towards VCT. A study done in

Ethiopia showed similar findings adding that both youths in the high grades and lower grades had good and poor practice towards VCT for HIV.

When comparing the relationship between knowledge of VCT for HIV and practice towards VCT, the study findings show that knowledge does not influence practice. Of the respondents with good practice, 11 (65%) had high knowledge, 6 (35%) had medium knowledge and of the respondents with poor practice 20 (61%) had high knowledge and 13(39%) had medium knowledge (**table 40, page 52**). According to the study by Muganda (2003) in Kenya, his findings indicated that Knowledge on VCT for HIV among adolescents was high, but despite this picture, the practice towards VCT was low. The main features cited as barriers to VCT up take included lack of access to VCT services and stigma associated with HIV/AIDS. Similarly, the ZSBS (2006) indicated similar findings. Therefore one would conclude that stigma is a universal barrier in many countries and needs to be watched for if VCT services are to be effective.

The study results revealed that of the respondents who had good practice, most of them 17(94%) had positive attitude towards VCT, while 27(84%) of the respondents with poor practice had positive attitude. The same table showed that, 1(6%) of the respondents with negative attitude had good practice, while 5(16%) of the respondents with poor practice had negative attitude **(Table 41, page 52)**. From the findings it can be concluded attitude does not influence practice of the respondents towards VCT.

When testing the relationship between knowledge and attitude towards VCT for HIV, the study findings revealed that most of the respondents 29 (94%) with positive attitude had high knowledge, while 14(73%) of the respondents with medium knowledge had negative attitude (**Table 42, Page 52**). From the results one would conclude that knowledge does influence attitude. When one is knowledgeable, they tend to develop an interest towards a particular thing (in this case VCT). Therefore having a positive attitude towards VCT does not mean having good practice.

5.7 IMPLICATIONS TO THE HEALTH CARE SYSTEM

HIV/AIDS is one of the top ten health thrusts in Zambia (MOH, 2005). The burden of providing care to the people with HIV/AIDS falls on the health care system. Thus VCT is more than drawing and testing of blood and offering counselling services. It is a vital point of entry to other HIV/AIDS services which includes prevention and clinical management of AIDS related illnesses. Therefore it is very vital that youths receive such information if they are to change their behavior towards VCT for HIV. The reports by UNAIDS, 2006 shows that the most vulnerable group for HIV infections are the youths.

Youths are said to be future leaders of tomorrow hence the concern about their behavior and lives. High levels of HIV infection will cause more strain on the already inadequate resources such as human resource, financial and material resources (drugs) of the country.

5.7.1 THE NURSING ADMINISTRATION

Some of the notable factors that the study revealed included poor practice (41%) towards VCT due to services that were not adapted for the youths. The Nursing administration should ensure that VCT programmes have youth service components and facilities for such programmes should be available so as to attract youths to access the services. Training of Counsellors in counselling skills for youths should be increased and refresher courses for the same cadre should be enhanced in order to attract the youth's attention in matters of VCT.

5.7.2 THE NURSING PRACTICE

The study showed that some respondents (40%) were not willing to have an HIV test due to fear of HIV positive results and fear of stigmatization by their friends or family members and fear of disclosure of results by counsellors. In view of these findings, the nurses should strengthen the sensitization about VCT to pupils in schools through school health programmes. Confidentiality among counselors should be emphasized in order to promote the good name of an institution there

by attracting pupils to utilize the services. Unless measures are taken to remove these fears pupils have, HIV infections will continue. Increase in disease burden will further increase the work load of the already under staffed health care providers there by compromising the quality of care rendered.

5.7.3 THE NURSING EDUCATION

Most nurses who qualify after their basic training do lack the counseling skills. Inclusion of the aspect of counselling in the nursing programme is vital so that nurses are able to handle pupils who seek VCT services adequately. The ratio of counselors in relation to non counsellors (nurse counsellors) is high. Therefore to breach the gap orientation courses should be given to nurses in order to have uniformity.

5.7.4 NURSING RESEARCH

Some of the factors that came up in the study findings included fear of test result (40%) and stigma (60%) as one of the barriers to utilization of VCT services. If nothing is done about this, the attainment of the millennium goal which aims at reducing HIV infections to a much lower level than the current 14.2% will not be achieved. Therefore there is need for nurses to research further on the study findings mentioned in order to find a lasting solution to the point where young ones will be visiting VCT centers freely without any fears of being spotted.

5.8 CONCLUSION

The study sought to determine knowledge, attitude and practice of pupils at Chipata Day Secondary School towards VCT for HIV. The study design was drawn as a non-interventional cross-section descriptive study. A self administered questionnaire was used as a tool in data collection. The study parameter was Chipata District in Eastern Province of Zambia and the study site was Chipata Day Secondary School. Fifty pupils were selected by convenient sampling method.

The objective of the study sought to determine knowledge, attitude and practice of pupils towards VCT for HIV, establishing factors leading to low utilization of VCT services, identifying areas needing further research and to come up with recommendations. Variables used were categorized as follows: knowledge variable was categorized into high, medium, and low. Attitude variable was categorized into positive and negative while practice variable was categorized into good and poor practice.

The study revealed that pupils had high knowledge (62%), positive attitude (88%) and poor practice (66%) towards VCT for HIV. The study further revealed that there was no relationship between knowledge and practice, but there was a relationship between knowledge and attitude. Therefore, the study has rejected the hypothesis that pupils with knowledge on the importance of VCT for HIV do utilize the services. The study has failed to reject the hypothesis that pupils' attitude influences their utilization of VCT services.

The study revealed that some of the factors that contributed to unwillingness to utilize VCT services included stigma (60%) fear of test results (40%).However it can be mentioned that the main objective of the study has been achieved in that the knowledge, attitude and practice towards VCT for HIV has been determined by the researcher. It is also important to mention that many young people have the zeal to be counselled and tested but they lack encouragement and the courage to do so.

5.9 RECOMMENDATIONS

Based on the research findings, the researcher would therefore recommend the following to:

5.9.1 The Ministry Of Health

The Ministry of health should ensure standardized service hours (that is the centers should be open during lunch hour and after 1600hrs) for VCT in all the

areas that provide the service to enable school going children to access them at their convenient time as they are in school almost through out the day.

5.9.2 The District Health Management Team (DHMT)

The DHMT should work hand in hand with the Ministry of Education to ensure that mobile clinics for VCT are intensified so as to cater for pupils that stay far away from the health centers. Youth friendly services should be strengthened in order to encourage more youths to utilize the VCT services there by prevent further spread of the HIV infection.

5.9.3 The Ministry of Education(MOE)

The MOE should include HIV/AIDS and VCT in the curriculum of Secondary school pupils to cement the understanding so as to increase service utilization by pupils. Teachers who were trained in counselling for HIV/AIDS should spear head the anti-AIDS clubs in order for pupils to have a forum through which they can learn more about VCT, so they can improve their practice towards VCT for HIV.

5.9.4 The Community

The community members should work in collaboration with the District Health Management team in order to foster change of behavior in relation to HIV to the youths. They should be involved in the fight against HIV by supporting programmes such as VCT sensitization and commemoration of important days such as World AIDS Day. The members of the community should also be taught about the importance of VCT for HIV so as to spear head the programmes in the community.

5.10 DISSEMINATION OF *RESULTS*

A number of copies were printed and distributed to the following areas, that is, the Department of Post Basic Nursing of the University of Zambia, USAID who are my sponsors of the programme, Chipata District Health Office and Chipata Day Secondary School through the Ministry of Education in Chipata district. A one day workshop was organized to give a talk to the pupils at Chipata Day Secondary School pertaining to the research findings.

5.11 LIMITATIONS OF THE STUDY

1) Due to the fact that the sample size was small and only one school was used for data collection, these results cannot be generalized to the rest of the country.

2) The researcher encountered some challenges in the selection of participants. This led to a shift of approach to the method of sample selection. Instead of the planned random sampling method, convenient sampling method was applied because the sampled pupils did not meet the required sample size. One of the disadvantages to this method is that it facilitates multiple biases.

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ANNEX 1

THE UNIVERSITY OF ZAMBIA

SCHOOL OF MEDICINE

DEPARTMENT OF POST BASIC NURSING

SELF ADMINISTERED QUESTIONNAIRE FOR PUPILS AT SECONDARY SCHOOL

TOPIC: KNOWLEDGE, ATTITUDE AND PRACTICE OF SECONDARY SCHOOL PUPILS TOWARDS VOLUNTARY COUNSELLING AND TESTING FOR HIV

Serial No..... Date.....

Place of interview.....

INSTRUCTIONS TO THE INTERVIEWEE

1. Do not write your name on the questionnaire
2. Answer all questions
3. Tick the answer of your choice in the boxes provided
4. Write responses in the space provided for open-ended questions
5. Use a pen to fill in a questionnaire.
6. Respond honestly

SECTION A: DEMOGRAPHIC DATA

OFFICIAL USE

1. Sex

a). Male ( )

b).female ( )

2. What was your age on your last birthday?

.....

3. What grade are you?

a). 8 ( )

b). 9 ( )

c). 10 ( )

d). 11 ( )

e). 12 ( )

4. Which church do you belong?

a). Roman Catholic ( )

b). Pentecostal Assemblies of God ( )

c). United Church in Zambia ( )

d). Seventh Day Adventist ( )

e). Reformed Church in Zambia ( )

f). Others specify.....

SECTION B: KNOWLEDGE

5. What is HIV? (Tick correct answers)

a). Human immunodeficiency Virus ( )

b). A virus that causes AIDS ( )

c). I don't know ( )

6. How is HIV transmitted? (Tick correct answers)

OFFICIAL USE

a). Sexually ( )

b). through contaminated blood ( )

c). Insect bite ( )

d). Getting together ( )

e). I don't Know ( )

7. How can you prevent HIV? (Tick correct answers)

a). Abstinence ( )

b). Sticking to one sexual partner ( )

c). Use of a condom ( )

d). I don't know ( )

e). Others specify .....

8. How can one know that she/he has HIV? (Tick correct answers)

a). Through voluntary counselling and Testing ( )

b). when one has malaria ( )

c). When one has diarrhea ( )

d). I don't know ( )

e). Others Specify.....

9. Have you ever heard of Voluntary counselling and testing?

a). Yes ( )

b). No ( )

10. What is Voluntary Counseling and Testing?

(Tick correct answers)

OFFICIAL USE

a). Willingly receiving information on HIV/ AIDS and being tested for HIV. ( )

b). Going to the clinic/hospital ( )

c). Knowing about HIV ( )

d). I don't know ( )

11. Where would someone go to get HIV counselling and testing?

(Tick all correct answers).

a). Health Center ( )

b). Newstart Center ( )

c). Hospital ( )

d). Others Specify .....

12). When is VCT important? (Tick correct answers)

a). Anytime ( )

b). When one is sick ( )

c). When one wants to go abroad ( )

d). Pre- marriage ( )

e). When in doubt ( )

f). Others specify.....

13 Who should go for VCT? (Tick correct answers)

a). Commercial sex workers ( )

b). Drivers ( )

c). Anyone ( )

d). Pregnant women ( )

e). Young people ( )

f). Others specify.....

SECTION C: ATTITUDE

OFFICIAL USE

14. Have you ever visited a voluntary and counselling center before?

a). Yes ( )

b). No ( )

15. Give reasons for your answer.....

.....

.....

16. Would you be wiling to be counselled for HIV?

a). Yes ( )

b). No ( )

17. Give reasons for you answer?

.....

.....

.....

18. Is VCT important?

a). Yes ( )

b). No ( )

19. If yes, why?

a). To know your HIV status ( )

b). To change behavior ( )

c). Others specify.....

20. If no, give reasons.....

.....

.....

21. Would you be willing to be tested for HIV?

a). Yes ( )

b). No ( )

OFFICIAL USE

22. Give reasons.....

.....

.....

23. Would you tell anyone your test results if tested?

a). Yes ( )

b). No ( )

24. Give reasons.....

.....

.....

25.In your own view which place is preferable for VCT?

a). Hospital/ Health center ( )

b). Private clinic ( )

c). Newstart center ( )

d). Others specify.....

26. Give reasons for your answer?.....

.....

.....

SECTION D: PRACTICE

OFFICIAL USE

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

a).Yes ( )

b). No ( )

28. If no, give reasons .....

....

29. If yes, where were you counselled and tested?

a). Health Center ( )

b). Hospital ( )

c). Newstart ( )

d). Others specify.....

30. Did you consult any one before taking an HIV test?

a). Yes ( )

b). No ( )

31. If yes, who did you consult?

a) Friend ( )

b) Brother/Sister ( )

c). Parents ( )

d). The Pastor/ Father/Bishop ( )

e). Others specify.....

32. If no, give reasons.....

.....

.....

33. Did you collect your results for HIV test?

OFFICIAL USE

a). Yes ( )

b). No ( )

34. How would you describe the attitude of the HIV/AIDS counselor?

.....

.....

35. What do you think are the factors contributing to low utilization of VCT services by pupils.

(Tick correct answers)

a). Poor timing ( )

b). Long waiting hours ( )

c). Stigma from families, friends and the community ( )

d). Lack of awareness about presence of VCT services ( )

e). Others specify.....

36. How can pupils be encouraged to go for VCT?

.....

.....

37. Give suggestions on how voluntary counselling and testing of HIV services can be improved.....

.....

Thank you for your time

RESEARCH BUDGET

ITEM	UNIT	UNIT COST	TOTAL COST
STATIONARY			
Reams of Paper	5	35,000	175,000
Pens (box)	1	20,000	20,000
Rubber	4	I,000	4,000
Note books(Each)	4	5,000	20,000
Tipex (Box)	3	10,000	30,000
Stapler	1	80,000	80,000
Perforator	1	150,000	150,000
Scientific calculator	1	150,000	150,000
Flip charts	3	50,000	150,000
Markers	12	5,000	60,000
Steeples(Box)	1	10,000	10,000
Box Files(Each)	2	30,000	60,000
Small Folders	10	2,000	20,000
Field Bag	1	250,000	250,000
Folder Clips	10	1,500	15,000
Paper Glue	1	15,000	15,000
Bostick	2	15,000	30,000
Disks(CD-ROM)	10	3,000	30,000
Memory Stick 2G	1	250,000	250,000
Diary	1	80,000	80,000
Manila Paper	5	1,000	5,000
		SUBTOTAL:	**K1,454,000**
SECRETARIAL SERVICES			
Questionnaire Typing	10 pages	3,000	30,000
Check List Typing	10 pages	3,000	30,000
Research Proposal Typing and Binding	1	350,000	350,000
Research Report Writing	1 x 60 pages (60)	3,000	180,000
Questionnaire printing	10 x 50(500)pages	3,000	1, 500,000
Check List Printing	10 x 50 (500) pages	3,000	1, 500,000
Binding of Research Reports	6 copies	50,000	300,000
Research Report Photocopying	6 x 60 pages (360)	3,000	1, 080, 000
		SUBTOTAL:	**K 4, 790, 000**
PERSONNEL			
Transport Allowance during Research Activities	20 days	30,000 x 2	1,200,000
Transport to and from Research Areas	2	150,000	300,000
Snacks for Respondents	65	5,000	325,000
INFORMATION DISSEMINATION			
Hall Hire for Dissemination	1	250,000	250,000
LCD Hire for Dissemination	1	150,000	150,000
Refreshments	20	5,000	100,000
		SUBTOTAL	**K 2, 325,000**
		TOTAL	**K 8, 569, 000**
		CONTIGENCY 10%	**K 856, 900**
GRAND TOTAL:		**K9, 425, 900. 00**	

BUDGET JUSTIFICATION

The budget for this research proposal had been divided into four parts namely; stationary, personnel costs, secretarial services and transport costs. The budget was intended to facilitate a smooth conducting of the study. For this to be possible, a number of costs were being incurred as administrative and technical costs.

Stationery is needed in this project for research proposal writing, preparation of questionnaires, data processing and analysis which will be done manually. Finally, stationery will be required for the final research report.

The research project will also incur some personnel related costs such as payment of lunch/meal allowances to the researcher and the two research assistants as they be required to work outside normal working hours especially during data collection and analysis.

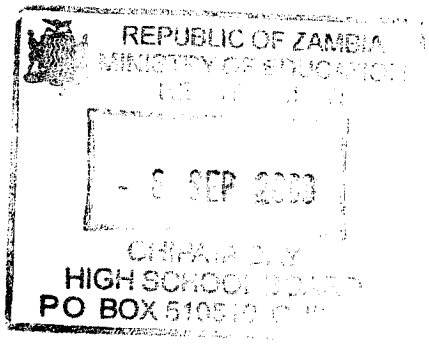
Secretarial services such as typing, photocopying, editing and printing are inevitable and these will be an added cost to the research project. Finally, the researcher will need some funds for transport to move here and there in the course of the research project.

WORK PLAN

TASK TO BE PERFORMED	RESPONSIBLE PERSON	DATES	DAYS REQUIRED
Literature review	Researcher	continuous	
Finalizing research proposal	Researcher	April to August, 2008	
Clearance from Authority	Researcher	August 2008	
Pilot study	Researcher	27th - 30TH August, 2008	3 days
Data collection(actual study)	Researcher	1st to 30th Sept, 2008	30 days
Data analysis	Researcher	1st to 31st October, 2008	30 days
Report writing	Researcher	Dec, 2008 to Jan 2009	
Submission of draft research report to PBN	Researcher	Dec 2008 to Jan 2009	15days
Finalizing of report	Researcher	Jan 2008 to Feb 2009	35days
Monitoring and Evaluation	Researcher	Continuous	Continuous
Dissemination of results	Researcher	Jan to Feb 2009	

GANTT CHART

TASK PERFORMED	RESPONSIBLE PERSON	MAY	JUN	JUL	AUG	SEPT	OCT	NOV	DEC	JAN	FEB
Literature review	Researcher	←	—	—	—	—	—	—	—	—	→
Finalizing research proposal	Researcher		←	—	—	→					
Clearance from Authority	Researcher				←	—	→				
Pilot study	Researcher				←	—	→				
Data collection(actual study	Researcher					←	—	—	→		
Data analysis	Researcher						←	→			
Report writing	Researcher								←	—	→
Submission of draft research report to PBN	Researcher								←	—	→
Finalizing of report	Researcher							←	—	—	→
Dissemination of results	Researcher									←	— →
Monitoring and Evaluation	Researcher	←	—	—	—	—	—	—	—	—	→



8TH SEPTEMBER, 2008

THE PROVINCIAL EDUCATION OFFICER,
P.O. BOX 510024,
CHIPATA

ATTENTION: MR G. CHIZIBA
(SENIOR EDUCATION OFFICER)

Dear Madam,

RE: **PERMISSION TO CARRY OUT STUDY MWATIZA N. BANDA**

I would like to acknowledge receipt of the above captioned letter to us.

We have allowed Miss Banda to carry out her study in the school.

Yours faithfully,

K.C. MANDA
HEADTEACHER

/epm**

The University of Zambia
School of Medicine
Department of Post Basic Nursing
P.O. Box 50110
Lusaka.

The Provincial Educational Official,
Lusaka District,
Lusaka.

u.s.f The Head
Department of Post Basic Nursing
P.O Box 50110
Lusaka.

Dear Sir/ Madam,

RE: PERMISSION TO CARRY OUT A PILOT STUDY

I am a fourth year student at the University of Zambia, School of Medicine, and Department of Nursing. Iam pursuing a Degree course in Nursing. In partial fulfillment of the course, Iam required to conduct a pilot study before an actual research study. My study topic is **Knowledge, Attitude, and Practice of Pupils at Chipata Day Secondary School towards Voluntary Counselling and Testing for HIV.** My actual study will be conducted in Chipata district. During my study, confidentiality will be maintained and informed consent will be obtained from all respondents.

I therefore write to request your good office to allow me conduct a pilot study at Libala High School.

Your favorable consideration of this request will be highly appreciated.

Yours Faithfully
Mwatiza N. Banda