EVALUATION OF UTILISATION OF VOLUNTARY COUNSELLING AND TESTING SERVICES BY UNIFORMED PERSONNEL IN THE ZAMBIA NATIONAL SERVICE IN LUSAKA DISTRICT

BY

LIEUTENANT COLONEL EDITH KASIA SOSALA
Bsc. Nursing, ZRM, ZRN

A Dissertation submitted to the University of Zambia in partial fulfillment of the Degree of Master of Public Health

University of Zambia
School of Medicine
Department of Community Medicine

May, 2008

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STATEMENT

I hereby certify that this study is entirely the result of my own independent Investigation. The various sources to which I am indebted are clearly indicated in the text and in the references.

Signed----------

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DECLARATION

This Dissertation is the original work of Lieutenant Colonel Edith Kasia Sosala. It has been prepared in accordance with the guidelines for MPH Dissertation of the University of Zambia. It has not been submitted elsewhere for a Degree at this or another University.

Signature:_____ **Date:** 07/07/15

(Student)

Signature:_____ **Date:** 07/07/15

(Supervising Lecturer))

CERTIFICATE OF COMPLETION OF DISSERTATION

I ..... Hereby certify that this dissertation is the product of my own and submitting it as part of my MPH Programme, and further attest that it has not been submitted in part or in whole to another University.

Signature:_____ Date_____

APPROVAL FOR SUBMISSION OF DISSERTATION

---having supervised and read this Dissertation, I am/are satisfied that the work has been completed satisfactorily and is ready for presentation to the examiners.

Supervisor's Signature:----------Date----------

Department----------

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DEDICATION

This study is dedicated to the Almighty God for the many times He has come through for me during my study period and indeed in my entire life. I also dedicate this study to my late mother who tirelessly worked to make me what I am today.

ACKNOWLDGEMENTS

This dissertation would not have seen the light of the day without sharing of knowledge, ideas, resources and support with other people. Therefore my appreciation go to all those who contributed to the success of this study in one way or the other.

I would also like to sincerely thank the government of Zambia through the Zambia National Service and the Commandant in particular, for according me this opportunity to undertake this Master of Public Health program at the University of Zambia.

Special thanks go to my supervisor Professor K. S. Baboo for his guidance, correction of the proposal and final thesis.

Many thanks go to the Director General Defence Force Medical Services, Brig. Gen. J. S. Banda, University Teaching Hospital Executive Director, Dr Peter Mwaba and Dr. Sekelani Banda for their interest, guidance and assistance in this study.

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I am indebted to my dear husband Lieutenant Colonel Edward Chanda Sosala and my children for their love, patience and support.

ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ART	Anti Retroviral Therapy
CDC	Centre for Disease Control and Infection Prevention
CSO	Central Statistical Office
GIPA	Greater Involvement of People Living with AIDS
HIV	Human Immune Deficiency Virus
ILO	International Labour Organisation
JHPIEGO	John Hopkins Programme International Education of Gynaecologists and Obstetricians
MoH	Ministry of Health
MSMH	Maina Soko Military Hospital
MTCT	Mother-To-Child-Transmission of HIV
NGOs	Non Governmental Organizations
PLWHA	People Living With HIV and AIDS
PMTCT	Prevention of Mother to Child Transmission of HIV
PSI	Population Services International
SANDF	South African Defence Force
STIs	Sexually Transmitted Infections
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV and AIDS
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation
ZDF	Zambia Defence Force
ZDHS	Zambia Demographic Health Survey
ZNS	Zambia National Service

OPERATIONAL DEFINITIONS

WORKING DEFINITIONS

Adjutant: An Officer in a Camp responsible for general administration, welfare and morale of personnel in the Camp (ZNS ACT. 1972).

Acquired Immune Deficiency Syndrome: The many diseases/infections that a human being suffers when infected with the virus that destroys the immune system (Park. 2005).

Anti-Retroviral Therapy: Treatment to control the HIV and AIDS infection (UNAIDS. 2006).

Barriers to VCT: Factors or things that prevent or discourage people from accepting to undergo HIV testing (UNAIDS. 2006)

Camp/Unit: A residential area for Officers and Soldiers (ZNS ACT. 1972).

Commanding Officer: An Officer in charge of a Camp/Unit of about 500 personnel (ZNS ACT. 1972).

Officer Commanding: An Officer in charge of a Camp/Unit of about 300 personnel (ZNS ACT. 1972).

Commissioned Officers: Officers in the Zambia National Service (ZNS ACT. 1972).

Confidentiality: The ethical principle or legal right that health providers will hold secret all information related to a patient, unless the Patient gives consent permitting disclosure (UNAIDS. 2006).

Consent: Voluntary agreement with what is being done or proposed (expressed or implied) by another person or health provider (AIDSmark. 2007).

Human Immune Deficiency Syndrome: The virus that destroys the humane immune system (UNAIDS. 2006).

Non-Commissioned Officers: Soldiers in the Zambia National Service (ZNS ACT. 1972).

Policy: A working document that guides decisions and actions of an Organization (ZNS ACT. 1972).

People Living With HIV and AIDS: People who have sero-tested HIV positive (UNAIDS. 2006).

Prevalence: Refers specifically to all current diseases (old and new) existing at a given point in time, or over a period of time in a given population (PARK. 2005).

Sampling: The method used to select the study population and study units (UNAIDS. 2006).

Stigma: A mark or sign of disgrace (MoH. 2006).
Stigmatise: Regard or treat as shameful (UNAIDS. 2006).
Discriminate: Make an unjust distinction in the treatment of different groups of people on the grounds of race, sex, age, Disease/Affliction (WHO.2004).

The Researcher: The person responsible for investigating a problem (Sokhey. 2003).

Utilisation: The use of an object or a service by people (Singh. 2003)

Voluntary Counseling and Testing: Is the process by which an individual undergoes confidential counseling to enable the individual to make an informed choice about learning his or her HIV status and to take appropriate action (UNAIDS. 2006).

ABSTRACT

The purpose of the study was to ascertain the reasons why uniformed personnel in the Zambia National Service did not utilise the VCT services which were located in the ZNS Camps.

This would be of value to the management in the ZNS to be aware of the barriers existing that prevent VCT utilisation and how these barriers could be overcome in order to enhance the service, thereby promoting good health and productivity among personnel.

OBJECTIVES

The general objective of the study was to find out the barriers and perceptions of VCT which contributed to lack of utilisation of VCT services among ZNS personnel

Specific objectives were to determine extent of utilization of VCT services; to evaluate factors associated with utilisation or lack of utilisation of VCT services; to evaluate the knowledge and perceptions of VCT services; to find out the percentage of VCT clients accessing ART services and to make recommendations on the VCT programmes in the Zambia National Service in the light of the research findings.

RESPONDENTS

The study included male and female Commissioned and Non-Commissioned Officers of the rank from Private to Lieutenant Colonel aged between 18 and 49 years, who had not previously utilised the Camp VCT services. A total of 596 personnel participated in the study.

METHODS

Data was collected both quantitatively and qualitatively. Quantitative data was collected by administering a standardised pre-tested questionnaire to each participant. In addition, four focus group discussions were conducted; one in each Camp. A total of 24 personnel participated in the discussions. A checklist was also used in which information was collected from staff managing the VCT clinic and from the clinic VCT records.

The study was a cross-sectional survey. A convenient sample was chosen from the four Camps. However, due to the low ratio of female to male personnel in ZNS, all female personnel were purposely included in the study.

FINDINGS

The findings show that the overall knowledge of HIV and AIDS was very high (97%), and that over 97% of the respondents were aware that VCT services were available at the Camp clinics. Although records indicated that HIV and AIDS programmes such as HIV and AIDS Sensitization, Home Based Care, PMTCT, Peer Education and VCT were being implemented in the Camps, only 74% of the respondents said that they would like to know their HIV status but only 53.7% knew their status. The respondents who knew their status had done their HIV test either at the government or NGO facilities.

The respondents listed the barriers preventing VCT utilisation in ZNS Camps as fear of stigma (59.4%), fear of intimidation by Senior Officers (14.8%), fear of dismissal from employment (4.9),

lack of confidentiality of VCT results by health providers (58%). Respondents felt that VCT services were attached with a lot of stigma and discrimination (70%).

Focus Group Discussions strongly criticised the centralised structure for ART which lacked confidentiality of HIV and AIDS information of personnel.

The VCT clinic Audit revealed that only 77 personnel had utilized VCT services and only 60 personnel were on ART during the period under review despite the 28.2% HIV prevalence rate in the ZNS.

Some of the major respondents' suggestions for improvement in the management of HIV and AIDS programmes in ZNS included retraining of health providers in issues of confidentiality, decentralising laboratory and ART services to Camps, sensitisation of Camp leadership on HIV and AIDS and continued campaigns in education on HIV and AIDS in order to reduce the problem of stigma.

CONCLUSIONS

A number of organisational procedures need to be followed in ZNS to ensure safeguards for the collection, transfer, storage, use, dissemination and disposal of personnel identified data and other HIV related information. Policies and procedures developed must cover both paper-based and electronic systems. Whenever possible, release of HIV-related data must be kept to a minimum. A written data policy should exist in ZNS and should be reviewed at regular intervals. This needs to define the purpose and uses of HIV data, outline which data elements can be released and for which purpose.

Security breaches and loss of confidentiality on the part of health providers should be thoroughly investigated and appropriate sanctions imposed on culprits in order to win back the integrity of the Health profession.

LIST OF TABLES

CHAPTER ONE

1.0 Introduction

The Zambia National Service is a wing of the Zambia Security Forces, and is headed by a Commandant. Structures relevant to this study are the Ministry of Defence, Zambia National Service and the Defence Force Medical Services. This Study evaluates the extent of utilisation of VCT services in ZNS in Lusaka District and other related factors influencing utilisation.

1.2 Background information

Zambia is grappling with a devastating impact of the HIV and AIDS epidemic. There is an estimated one million people living with HIV and AIDS (PLWHA), while at least 690,000 have already died from HIV/AIDS related illnesses, resulting in about 540,000 orphans (MoH & CSO. 2001-2002). Current sero-prevalence rates for the country range between 11% and 26% with a country average of 16% (MoH & CSO. 2001-2002). The HIV and AIDS epidemic ravaging the country has not spared the military. Available data, worldwide, show that HIV and AIDS prevalence among members of the uniformed services is constantly higher compared to that in the general population (ZDF. 2005).

Available evidence suggests that most military personnel acquire HIV the way much of the general public does - through high-risk sexual behaviour. However, specific military ethos, which applauds risk-taking behaviour, coupled with loneliness, stress, lessened restrictions and inhibitions in areas of deployment away from home, and the influence of alcohol and peers may all combine to further increase the likelihood of military personnel to engage in casual sex, thereby putting them in the risk group for HIV infection (Health Link Wildlife. 2002).

From the ZDF study of 2005, indications are that a similar situation obtains in the Zambian Defence Force. Increased morbidity and mortality have been observed in the Zambia Defence Force Health Institutions since the advent of HIV and AIDS. HIV-related illnesses are nowadays the most common reason for employment standard re-categorisation and medical treatment (ZDF. 2005).

The Zambian Government has responded to the pandemic with a series of planned interventions, one of which is VCT.

The National response began with the establishment of a National AIDS surveillance Programme in 1996, with assistance from the WHO. National management structures to spearhead effective responses to HIV and AIDS were also put in place.

Voluntary Counselling and Testing Services were established on a larger scale in Zambia in 1999 with the aim of providing quality friendly counselling and testing service on the same day. It was initiated with the establishment of 21 pilot sites evenly distributed in each of the nine provinces of Zambia with the help of the Norwegian Government through NORAD. The Zambian Government provided the required human resource through the establishment of the Zambia Voluntary Counselling and Testing Service (MoH. 2005).

It is against this background that a consolidation and expansion phase was then undertaken. Counselling and testing services have become an important entry point for prevention, care and support. By January 2006, 485 counselling and testing centers were established in all the 72 districts of Zambia (MoH. 2005).

Similarly, the ZDF draft HIV and AIDS Policy of 2002 states that all ZDF Units shall offer free and confidential VCT services (ZDF. 2002). In 2000, VCT centers were established and VCT services implemented in all ZDF Units with the help of the American Government. The human resource was provided by the ZDF.

In the meantime, all sectors of the republic of the Zambian society continue to feel the negative impact of HIV and AIDS. In recognition of this situation and the need to involve all stakeholders and partners in the fight against the epidemic, the Government formulated and implemented a national HIV/AIDS/STI/TB Policy in 2005 which adopted a multi-sectoral approach. It is anticipated that the measures contained in this Policy will help in arresting the rapid spread of HIV infections (MoH. 2005).

The multi-dimensional strategy against HIV and AIDS places emphasis on building strategic partnerships at all levels and will require effective co-ordination of human, material and financial resources. It is expected that this policy document will provide the requisite environment for achieving this requirement (MoH. 2005).

1.3 Problem Statement

The research findings (ZDF. 2005) on HIV and AIDS prevalence in the Zambian Defence Force revealed that since the inception of VCT services in ZDF Units in 2000, only a total of 1,346 clients had undergone VCT in all the Defence Units; Army, Air Force and ZNS. At the time of writing 281 personnel were accessing ART in the ZNS Units. The Defence Force draft HIV and AIDS Policy requires that only confirmed HIV sero - positive clients should be considered for ART (ZDF. 2002).

Some of the factors that could be affecting the utilisation of VCT could include the following: Stigma and discrimination, hostile environment due to poor Camp leadership, lack of knowledge about HIV and AIDS, location and operating hours of VCT services, lack of confidentiality by members of staff managing VCT services, cultural influence etc.

Given the 28.2% HIV and AIDS prevalence rate in ZNS (ZDF. 2005), and the total number of staff in ZNS (restricted disclosure), if VCT services are not utilised a large number of personnel cannot access ART.

The importance of VCT for military personnel therefore cannot be over-emphasized. It is important that military personnel utilise the VCT services that are being offered free so that those found HIV positive can access treatment, care and support.

1.4 Aims of the study

To find out the barriers and perceptions of VCT which contribute to lack of utilisation of VCT services among ZNS personnel.

1.4.1 Specific objectives

i. To determine factors associated with lack of utilisation of VCT services
ii. To evaluate the knowledge and perceptions of VCT services
iii. To find out the percentage of VCT clients accessing ART services (from VCT clinic records)
iv. To make recommendations on the VCT programmes in the Zambia National Service in the light of the research findings.

1.5 Rationale of the study

Given the 28.2% HIV and AIDS prevalence rate, if personnel do not utilise the VCT services they will not be able to access the ART being offered free in all Zambia National Service clinics, which is a pre-requisite for treatment (ZDF. 2002). This will lead to a compromised security wing that will be unprepared for national and international tasks. Currently only a mean of 79 clients per Unit in all the ZNS Units have undergone VCT since 2002 when the VCT programme was introduced, and only 281 clients are on ART. It is important that barriers to VCT among personnel are removed or reduced in order to increase the uptake of ART in those living with HIV and AIDS.

VCT also promotes both safe sexual behaviour (prevention of HIV infection) and is an entry for treatment and prevention from mother to child infection of HIV (PMTCT). These interventions will greatly reduce the disease burden for the Zambia National Service personnel and their families in that the spread of HIV infection will be controlled and reduced.

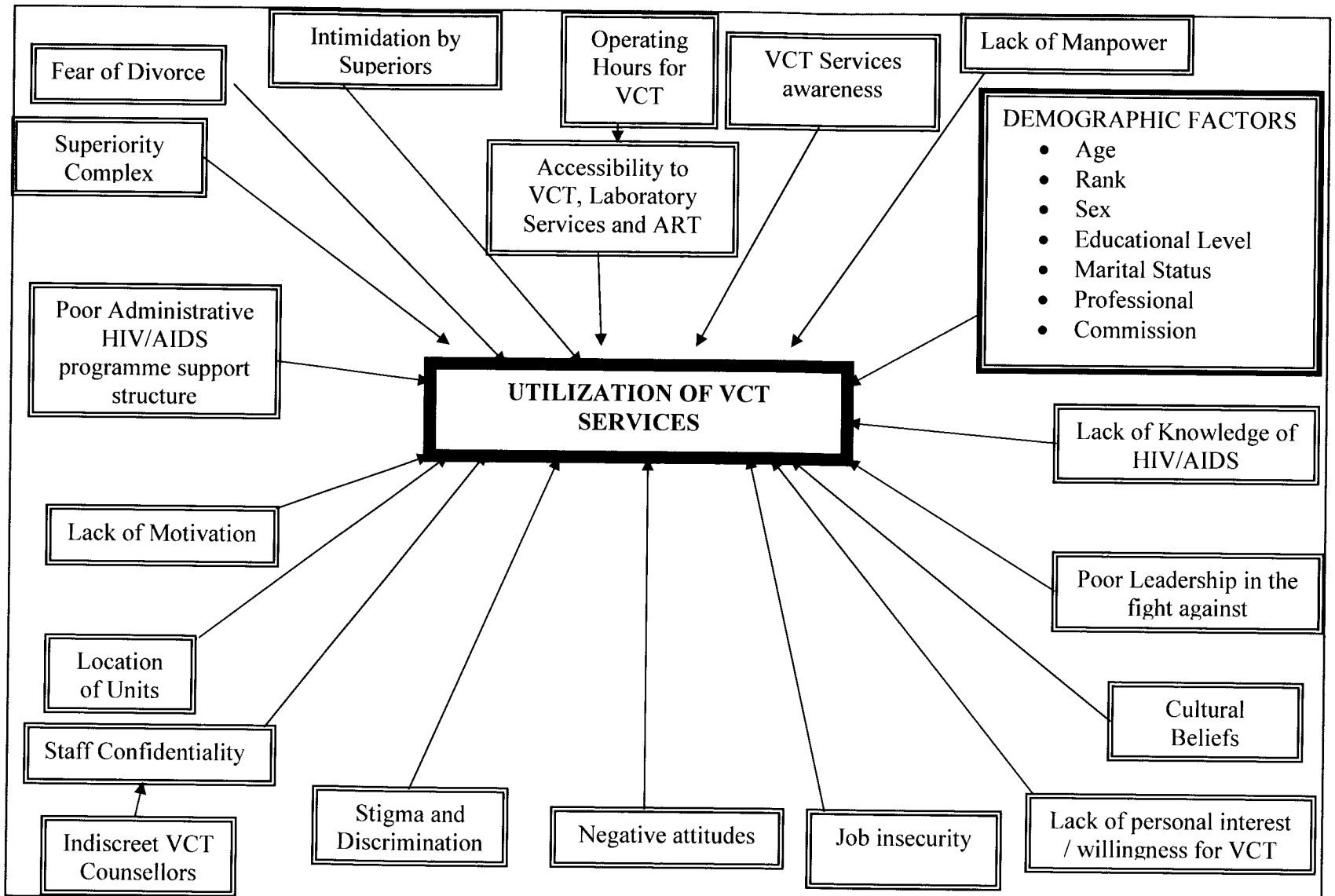
1.6 Significance of the study

It is clear from the statement outlined above that there are serious problems concerning the utilisation of VCT services in the ZNS that needed to be identified by the users of the service themselves in order to increase the uptake of VCT services. It was therefore important to carry out an in-depth investigation among the Zambia National Service personnel to find out the impact of VCT in reducing the burden of disease among them. Such an investigation has not been reported and it is probable this would be the first study to explore this important matter.

1.7 Scope of the study or study delimitation

The study was limited to uniformed personnel of the Zambia National Service in Lusaka District. The study was conducted in two urban and two peri-urban Camps (restricted disclosure). The sample was also only limited to female and male Commissioned and Non-Commissioned Officers of the rank from Private to Lieutenant Colonel.

1.7 Conceptual Framework; Dependent Variables will be conceptualized as follows:



1.8 Ethical considerations

Permission for the study was sought from the Director General Defence Force Medical Services (DGMS) who then solicited for permission from the Permanent Secretary Ministry of Defence (MoD) and the ZNS Commandant. Research clearance was sought from the Ethics Committee of the University of Zambia, Graduate studies.

When the study was authorised, the ZNS Commandant informed the Unit Commanders through meetings and correspondence to inform personnel about the intended study during staff meetings and parades.

They informed participants that participation in the study was voluntary and would only be done with their permission and consent.

They assured them that their identity would remain anonymous and all information that would be collected would be treated as confidential.

A copy of the Information Form/Consent Form to the research participants was displayed on the Unit notice boards to further facilitate informed consent. The research date, time and venue were also displayed on the notice boards by Unit Commanders so that interested personnel would willingly avail themselves for the study on the day of data collection.

On the actual day of data collection, informed written consent was obtained from the participants. Participants were again assured of confidentiality of their identity and responses. They were also informed that the study was voluntary therefore they had the right to withdraw from the study at any time they felt uncomfortable. Participants were given time to ask questions for clarification on the questionnaire. Other questions about the study were also answered. Participants were informed that they should remain in the hall after answering the questionnaire, for focus group discussions, if they were willing to participate in that phase of the study. The researcher gave the address and telephone number of the Ethics Committee of the University of Zambia and her contact address and telephone number to participants in case they wanted further clarification on the study. The researcher left the hall in order to enhance voluntary participation. Research assistants remained on standby in the hall for any queries

1.9 Budget

The total budget for the study was K3,072,400.00. The study was co-funded by the ZNS and Office of the Director General Defence Force Medical Services (DFMS). ZNS provided resources such as secretarial personnel, transport, fuels computers, meals, venue and research Assistants while DGMS provided the funds.

1.10 Time frame

The study commenced on 2nd January 2008 and was completed on 29th February 2008.

CHAPTER TWO

2.0 Literature review

2.1 Background of the HIV and AIDS

AIDS, the acquired immune-deficiency syndrome, is a fatal illness caused by a retrovirus known as the human-immune deficiency virus (HIV) which breaks down the body's immune system, leaving the victim vulnerable to a host of life-threatening opportunistic infections, neurological disorders, or unusual malignancies. Among the special features of HIV infection are that once infected, it is probable that a person will be infected for life. Strictly speaking, the term AIDS refers only to the last stage of the infection. AIDS can be called our modern pandemic, affecting both industrialised and developing countries (Park. 2005).

The global summary of the AIDS pandemic as at December 2006:

1. Number of people living with HIV;	
- Total	40.3 million (36.7-45.3 million)
- Adults	38.0 million (34.5-42.6 million)
- Women	17.5 million (16.2-19.3 million)
- Children under 5 years	2.3 million (2.1-2.8 million)
2. People newly infected with HIV;	
- Total	5.9 million (4.3 – 6.6 million)
- Adults	4.2 million (3.6 – 5.8 million)
- Children under 15 years	700,000 (630,000 – 820,000)
3. AIDS deaths;	
- Total	3.1 million (2.8 – 3.6 million)
- Adults	2.6 million (2.3 – 2.9 million)
- Children under 15 years	570,000 (510,000 – 820,000)

(UNAIDS. 2006).

Globally unprotected heterosexual route is the predominant route of transmission of the virus. The time between infection with HIV and the onset of full disease is on average 9 - 11 years in the absence of treatment (Park. 2005).

It is estimated that HIV prevalence rates in Southern Africa's Armed Forces average between 20-40 per cent. Soldiers contract HIV in the same way that civilians do; through unprotected sex, sharing equipment in drug use, receiving infected blood transfusions etc. In order to monitor the development of the epidemic, epidemiologists and social scientists track prevalence and incidence in different population groups. Intravenous drug users, for instance, are considered a high-risk group, while data collected from women attending pre-natal clinics and blood donors are used to indicate whether the epidemic has become generalized in the population. In developing countries, commercial sex workers, truck drivers and migrant labourers have often been considered among the key vectors of HIV transmission. More recently, soldiers have been added to the list as both high risk and key 'bridging' group, acting as a conduit for the spread of HIV into the wider population (http://www.155.co.za).

Armies are generally composed of young men of sexually active age, imbued with a risk-taking ethos and deployed on tours of duty away from home with money in their pockets. A 1997 study found a correlation between HIV clusters in northern Namibia and the proximity of military bases. Similarly, studies on the effects of demobilization in Uganda "revealed devastating results for the rural areas where the demobilized HIV-positive troops had retired" (UNAIDS. 2001).

Accurate data on HIV and AIDS in the armed forces, both in Africa and other continents are scanty and speculative (http://www.155.co.za; Harker. 2002; UNAIDS. 2004; Sokhey. 2003; Singh. 2003; WHO. 2001).

In sub-Sahara Africa, the higher prevalence rates make HIV and AIDS a more immediate and acute issue for the armed forces. According to Lindy Heinecken, Deputy Director of the Center for Military Studies at the South African Military Academy, the SANDF's concern "is largely sparked by the high rates found in soldiers between the age 23 and 29, as officers and non-commissioned officers in this age group normally fulfill critical operational and supervisory roles" (HEINECKEN. 2002).

2.2 Evolution of VCT Practice

Voluntary Counselling and Testing (VCT) is a relatively new field of clinical practice and there is little evidence about which models of practice are most appropriate and effective for various populations. Models of VCT practice have also evolved in response to changes in the volume and demographics of

test seekers at publicly funded test sites. The earliest model of VCT was developed in San Francisco by the University of California San Francisco (UCSF) AIDS Health Project in early 1985. At that time, nearly 20% of the test clients, mostly gay men, were testing HIV positive. As a result, VCT centered on crisis management and explaining to clients what little was known about the significance of the antibody test for the disease prognosis. Following basketball star Earvin "Magic" Johnson's disclosure that he had tested HIV positive in November 1991, testing volume nearly doubled in the United States as predominantly low-risk heterosexual clients flooded testing centers (CDC. 2006).

Demand for testing has remained relatively steady since that time, as "the test" has become incorporated into mainstream American culture as a routine part of dating rituals and clinical practice. As research developed new treatments and a better understanding of the routes of HIV transmission, VCT in publicly funded test sites evolved into a more didactic health education format, providing basic information on routes of transmission and advice on safer sex. Although HIV testing has become a routine procedure in private practice, little is known about the quality or scope of the counseling, if any, that is provided with the test in such settings (CDC). 2006).

2.3 Current trends in VCT

Voluntary Counselling and Testing (VCT) is proven to be one of the most powerful weapons in halting the spread of HIV and AIDS. Knowing one's HIV status and being able to discuss this anxiety-provoking subject with a trained professional induces sustainable, positive behaviour change in both infected and uninfected people (AIDSMark. 2007).

People who test negative for HIV and undergo quality reduction counselling are more likely to change their behaviour and to maintain their negative status, and those who test positive and receive counselling are motivated to protect themselves and others from HIV infection and seek medical, social and psychological support (AIDSMark. 2007).

Unfortunately, VCT is often not available to the people who could benefit from this service the most. However, these programmes are affordable. Establishing and strengthening high quality VCT programmes are a priority for every country (AIDSMark. 2007).

It is estimated that up-to 90% of HIV positive people in low income countries do not know their HIV status. This is largely due to the fact that there are few facilities available to the populations most affected by HIV and AIDS. However, even where testing is available, many people do not want to be tested because of a perception that "nothing is to be gained" by knowing an HIV-positive status. For the poor there will be little access to HIV and AIDS treatment and care. Furthermore, there will likely be stigma and discrimination to be faced if found to be HIV positive (UNAIDS. 2004).

However, even in resource-poor settings much can be done to improve access to Voluntary Counselling, HIV testing, treatment and care, though this may involve a shift of resources from "traditional" HIV programmes and activities. Primarily there must be greater investment in establishing VCT services in communities. Secondly, incentives must be created to encourage people to undergo testing. These should take the form of community services providing support, treatment and care. Finally, disincentives to test, such as stigma and discrimination should be removed (UNAIDS. 2004).

2.4 Implications of VCT

More and more employers in developing countries are welcoming workplace HIV and AIDS prevention and treatment initiatives. While most focus on HIV prevention education and condom promotion, some larger employers have expanded their programmes to include VCT, care and treatment. Yet stigma and discrimination often present major challenges to the successful implementation of workplace HIV and AIDS programmes. Employees may experience HIV-related stigma from their colleagues and supervisors, and may be fired due to real or perceived HIV status. A fear of negative reactions may discourage workers from undergoing VCT as an entry point to further HIV and AIDS services. "Hence, managers and staff of workplace programmes need a better understanding of workers' perceptions and experiences related to stigma and discrimination to develop appropriate responses" (Worldwide Journal. 2006).

Many approaches to HIV prevention and care require people to know their HIV status. For an individual, taking a test is a very serious matter. Not only is the result important for him/her, but it will also have implications for their partner, their family, their employment, and in some countries, their life insurance. In many countries being positive can mean total isolation in society, or perhaps even

expulsion. This is because of the many inaccuracies and myths that surrounded AIDS when the mass media and irresponsible scientists first reported on the problem. Because of this, every person who asks for or is offered a test must be counselled about the meaning of the test and the consequences if the test is positive or negative. Whatever the result of the test, each individual must then be counselled appropriately after the test, and there must be facilities for long term follow up counselling, care and support should the result be positive, or if the individual is likely to seek another test. There may also be the need for counselling of the sexual partner and family of the individual (Gordon & Kouda. 2002).

Mandatory pre-deployment HIV testing is a controversial and polarising issue. Respect for human rights has become the critical international framework for the response to HIV and AIDS and has led to a strong emphasis on informed voluntary consent and counselling, a position considered by some analysts to be counter-productive in combating the epidemic. According to Gruskin and Loff, however, a human rights approach is not at odds with sound public health policies. The friction, they argue, comes from the misconstrued assumption that the human rights approach automatically places greater value on protecting individual rights rather than those of the larger community. In fact, Gruskin and Loff contend, a human rights approach is about making sure that public health strategies are evidence-based and openly debated. This approach protects against unproved and potentially unproductive strategies, even those motivated by genuine despair in the face of overwhelming public health challenges (Gruskin & Loff. 2002).

In high-prevalence contexts within Africa increased VCT up-take with ARV provision, could make a significant impact on prevention by substantially increasing the percentage of people who know their HIV-positive status. "If VCT has proven preventive benefits, especially for those testing positive, then the ongoing counselling and psychosocial support with effective ARV drug treatment could substantially multiply and augument these benefits" (MEDICAL RESEARCH COUNCIL. 2005).

Of particular significance of VCT services in South Africa is the requirement attached to most ARV treatment programmes that patients "attend regular individual and group support sessions as well as disclosing their HIV status to at least one person who co-habits with them and who can act as a treatment assistant. This requires disclosure" (HEINECKEN. 2004).

VCT services, which are available for many groups of people in various settings, vary greatly in their aim. This makes comparing VCT interventions difficult and sometimes misleading (UNAIDS. 2003).

2.5 VCT Goals

1. Prevention of HIV transmission - from tested HIV positive people to untested HIV negative partners and from positive tested mother to child.
2. Prevention of HIV acquisition by negative tested people from HIV positive or untested partners.
3. Early and appropriate uptake of VCT services for positive tested people;
    - Family planning (including counselling about reproductive choices)
    - Emotional care (individual, couple and family support)
    - Counselling for positive living (nutrition, ongoing counselling, disclosure issues and identification of safety network)
    - Social support
    - Improved coping and planning for the future
    - Legal advice
4. Societal Benefits
    - Normalisation of HIV
    - Challenging stigma
    - Promoting awareness
    - Supporting human rights
5. Counselling for adherence
    - Adherence to Anti-Retroviral Therapy and preventive therapies
    - Coping with adverse effects
    - Counselling about adherence in mother to child transmission (MTCT) interventions.

According to WHO, a number of studies in developed and developing countries have been undertaken to determine if, in addition to its diagnostic and referral benefits, VCT may lead to reductions in risky behaviours and reductions in HIV infection rates. Overall, data from randomised controlled trials and observational studies show mixed results in this regard (WHO. 2003).

Additionally, utilisation of VCT remains low in most communities with a high prevalence of HIV, chiefly because access to services is often limited and stigma and discrimination continue to surround HIV infection (WHO. 2003).

2.6 VCT Services in developed and developing countries

Voluntary Counselling and Testing is a key entry point for a range of interventions in HIV prevention and care, like preventing HIV transmission fro mother to child during childbirth referrals for STD treatment, condom promotion, care and support for treatment for opportunistic infections, management of HIV-TB co-infection and more recently for referrals to designated medical centers for Anti-Retroviral Therapy (ART) (Park. 2005)..

At present there is no cure for HIV and AIDS infection. However the development of drugs that suppress the HIV infection itself rather than its complications has been an important development. These antiviral chemotherapy, while not a cure, have proved to be useful in prolonging the life of severely ill patients. On 21st December 2003, WHO and UNAIDS announced a detailed plan to reach the "3 by 5 target" of providing antiretroviral treatment (ART) to three million people living with HIV and AIDS in the developing countries by 2005. It is a vital step towards the ultimate goal of providing universal access to treatment for HIV and AIDS to all those who need it (Park. 2005).

Although the HIV sentinel surveillance data has been primarily used for monitoring the trend i.e to assess how rapidly HIV infection increases or decreases over a time in different groups and areas, it can also provide an estimate of the total disease burden of HIV infection in the country (Park. 2005). However, if people are not coming forward to be tested for HIV infection, they will not be able to access ART.

2.6.1 United States

Each year, approximately 17 million HIV antibody tests are performed at private and public health clinics in the United States. HIV voluntary counseling and testing traditionally has comprised a large component of the Centre for Disease Control and Prevention (CDC) budget for HIV prevention services. This investment in counselling and testing is premised on the notion that test clients receive personalised counselling to identify and reduce risky behaviour. For those receiving positive results, HIV antibody testing can serve as a gateway to clinical care, support services and counselling to reduce the chance of transmitting to others. However, the role of VCT in changing the behaviour of those receiving negative test results is far less clear. Research on testing behaviour suggests that many repeat testers do not reduce their risk behaviour. In 1985, when HIV testing became available, the main goal of such testing was to protect the blood supply. At that time, professional opinion was divided regarding the value of HIV testing and whether it should be encouraged. In 1993, CDC recommendations for voluntary counselling and testing were extended to include patients and persons

obtaining health care as outpatients in acute-care hospital setting, including emergency departments. In 2001, CDC modified the recommendations for pregnant women to emphasise HIV screening as a routine part of prenatal care. In 2003, CDC introduced the initiative Advancing HIV Prevention Strategy which ensured that HIV testing became a part of medical care on the same voluntary basis as other diagnostic and screening tests. This included universal HIV testing for all pregnant women and the use of rapid tests during labour, delivery or postpartum.

2.6.2 Brazil

In Brazil currently all but two states offer VCT services that are confidential and free of charge. Counselling services have been available since 1988, but the quality and uptake of these services vary considerably. Strategies to evaluate implementation of HIV prevention programmes have been developed. During 1997, ten public health services were visited. "Although VCT counsellors were able to offer care and support for PLWHA they were found not to be effective in helping PLWHA to overcome their difficulties in adopting safer sex practices" (MEDICAL RESEARCH COUNCIL. 2005).

2.6.3 Thailand

A study in Thailand, Lampanq Province, aimed at determining the extent to which unmarried young Thais accepted VCT revealed that very few Thais accepted voluntary HIV counselling and testing. Although VCT was being promoted by the Thai government only 23% of young people of marriageable age in Lampanq Province had ever tested and the prevalence of HIV among them was an alarming 9%. Furthermore, only 44% of those tested received pre-test counselling and only one third received post-test counselling. Clearly, a more effective strategy of VCT was needed. Part of the reason for the apparent public health failure of the intervention may have been the extensive public health education programme on HIV and AIDS and the relatively high prevalence of AIDS cases, such that most young people in Lampanq were already aware of the risk factors for HIV. On the other hand, surprisingly few of them felt they were themselves personally at risk for HIV. This confidence may have undermined the message of the need to get tested. It is probable that the intervention was not successful at making the population of marriageable youths feel vulnerable and therefore in need of testing. Promoting a feeling of vulnerability, however, can also foster a negative feeling of hopelessness and the futility of getting tested. The challenge, then, is to induce sufficient anxiety to promote testing but not so much anxiety as to induce hopelessness (Guilford Publications. 2002).

2.6.4 South Africa

In 2002, the Horizons Programme, in conjunction with South Africa's state owned Power Company ESKOM and Development Research Africa, initiated a research project at several of ESKOM's technical centers in kwaZulu - Natal Province to gain a more in-depth understanding of workers' perceptions of and experiences with HIV and AIDS.

ESKOM's HIV and AIDS programmes for employees stand out among South African businesses. The company has declared HIV and AIDS a strategic priority and created work groups to develop strategies to mitigate the impact of the epidemic on its workers and productivity. The Company supports peer-educator training, VCT, counselling and Greater Involvement of People Living with AIDS (GIPA) principle, and has implemented awareness campaigns, including road shows, presentations, theatre and community choirs. Condoms are available free of charge.

Although ESKOM's HIV and AIDS policies and programmes are progressive, there is little documentation about its success in encouraging employees to use its HIV and AIDS services and their impact on employees. Within a larger research goal of improving ESKOM's prevention and support

programmes, the Horizons study examined HIV and AIDS-related stigma and discrimination in the workplace to inform stigma-reduction activities.

Findings were revealed in three categories. First category - institutional-level interactions included employee perception, understanding of and experience with workplace HIV and AIDS policies and programmes. Almost a quarter of workers reported a fear of being fired if they had AIDS.

The second category - employee interactions that relate to the physical job requirements - included potential stigma from workers concerned about the ability of HIV-positive workers, and about the risks of casual on-the-job contact. Fear of transmission through casual contact was found to be a potential source of stigma at the workplace.

The third category - was based on social interactions that take place at the workplace. This included those that occur during downtime at work such as during meals or travel. Three quarters of

respondents said that HIV positive workers experienced social isolation and nearly half said that they would be subject to rumours, gossip and verbal abuse.

"These fears likely influenced workers' willingness to undergo VCT or opinions about disclosure of HIV status. While workplace strategies to reduce HIV prevention activities are important, interpersonal aspects, such as isolation, must also be directly addressed" (WORLDWIDE JOURNAL. 2006).

There is clear evidence of the fact that VCT is effective in modifying the sexual attitudes and risk behaviour of those who test HIV positive. While there is contradictory evidence regarding the capacity of VCT to facilitate significant and consistent behaviour change in those testing negative, the evidence does suggest that VCT significantly reduces unprotected sex with non-primary partners. "On the basis of evidence such as this, it has been predicted that 356,000 new infections will be prevented by VCT programmes in South Africa between 2001 and 2015" (WORLDWIDE JOURNAL. 2006).

The effectiveness of VCT is however, largely dependent upon the perceived desirability and uptake of VCT services. "In the face of overwhelming stigma and the absence of proper treatment and support, the advantages of knowing one's status are often seen to be outweighed by the negative effect of emotional trauma, not only on one's psychological wellbeing, but also on one's immune status and physical health" (WORLDWIDE JOURNAL. 2006).

The acceptance of HIV testing depends on improved protection from stigma and discrimination as well as access to integrated services for prevention, treatment and care. UNAIDS and WHO encourage the use of rapid test so that results are provided quickly and can be followed up immediately with post-test counselling for both HIV-negative and HIV-positive persons, and with treatment if necessary. Counselling, including appropriate referral and prevention messages, should be an essential part of a care and support programme for workers with HIV/AIDS (ILO/WHO. 2005).

2.6.5 Cote D'Ivoire

In Cote D'Ivoire, VCT services are available at several centers in Abidjan at ante-natal care (ANC) clinics. In an attempt to look at the effect on behaviour change, 208 sero-positive people were interviewed from seven different AIDS care centers. Basic knowledge about HIV was good, however, there was no pre-test behavioural information, so the impact of VCT on sexual behaviour could not be adequately assessed (UNAIDS. 2005).

2.6.6 Burkino Faso

A study aimed at studying HIV-infected women's experience with sharing sero-status with their partner in Burkina Faso in 1995 revealed that only one third of HIV infected women had shared their HIV sero-status with their partner. Sharing sero- status was associated with educational level. Fear of being rejected or abandoned was the main reason limiting sharing sero-status with partner (WHO. 2004).

2.6.7 Kenya

In Kenya, VCT services are available at several Non-governmental Organisation and government sites and in association with MTCT projects. In a study, Kenyan women were offered VCT as part of their ANC. Women who tested positive and a comparison group of uninfected women were followed up for one year. They had each received one session of post-counselling where HIV, family planning and sexual behaviour were discussed. Family planning use, condom use and pregnancy rates were similar in both groups. The authors concluded that this single session of counselling was therefore ineffective in this setting, in influencing decisions on subsequent condom use of reproductive behaviour. However, it may be difficult for women to influence safer sex behaviour in their relationships since in the majority of cases their sexual partners were unaware of their HIV status. Furthermore, in Kenya, as elsewhere, women often have difficulties in discussing HIV and sexual behaviour and insisting on condom use, especially with long-term partners (UNAIDS. 2001).

2.6.8 Uganda

Aids Information Centers (AICs) are stand alone VCT sites in Uganda, offering VCT. Opened in 2001, these centers also offer services such as reproductive health services which include diagnosis and treatment of STIs, family planning, pregnancy testing and counselling and antenatal and postnatal care.

AICs provided initial technical and material support including training peer counsellors to do pre and post counselling, orienting laboratory staff, implementing a client monitoring system and supplying testing kits while the government provided the personnel (Horizons Publications. 2004).

2.6.9 Zimbabwe

In some countries such as Zimbabwe, VCT is approached as a franchise. Zimbabwe's pioneering "New Start" programme, for example, integrates counselling and testing services into existing delivery points – such as NGOs and private and public health service providers – and provides a few stand alone VCT sites in densely populated urban areas. VCT services are easily replicated across the national network, linked by a common brand that signifies quality. The "New Start" brand is promoted using proven social marketing techniques to increase demand and reduce stigma around the use of VCT services. Mobile VCT units are used to reach those located in remote areas where a static VCT site would be cost prohibitive. High quality VCT services across the net work are assured through standardised protocols and training and constant compliance monitoring (AIDSMark. 2007).

AIDSMark and PSI (Population Services International) initiated VCT social marketing in Zimbabwe in 1999 and in just seven years the project has developed into a franchised network of 20 VCT centers branded and promoted under the unifying name New Start, testing 15,000 clients per month. As of January 2007, PSI implements VCT projects in 21 countries world wide and has tested 1.7 million clients. In addition to Zimbabwe, PSI has branded VCT services in Zambia, Namibia, Lesotho, South Africa and Swaziland under the New Start logo. PSI runs VCT centers in Mali and Cote D'Ivoire under the name centre L'Eveil (a French word meaning "Awaken"). VCT and prevention from Mother-To-Child transmission services in Mozambique are branded with the name Renascer (a Portuguese word meaning "Rebirth"). PSI also implements VCT programmes in Benin, Cambodia, El Salvador, India, Haiti, Madagascar, Nigeria, Rwanda, Togo and Uganda. In addition, Vietnam and Kenya implement VCT social marketing (AIDSMark. 2007).

2.6.10 Zambia

The major objective of VCT services in countries which have a severe problem of HIV and AIDS is the need to know the burden of the disease. Zambia currently features among the seven top countries in the sub-Sahara Africa worse affected by HIV infection. VCT, if used correctly, is considered to be an intervention that would motivate both the infected and those not infected to know their status and if necessary commence ART. Currently, the MOH is trying to reach the Millennium Development Goals (MDGs) by screening as many people as possible and put at least 100,000 HIV positive people on ART. However, due to stigma, hesitation and logistical problems only 26% of this target has come forward for VCT.

In Zambia, VCT services have been available in Lusaka since 1992, when Kara Counselling and Training Trust developed them in conjunction with support services for PLWHA. Several studies and projects have been developed associated with hospitals or home-based care programmes. In 1999 a country-wide VCT service was started and is being introduced throughout Zambia. VCT services have evolved from 22 sites to 500 by 2005. Following successful pilot projects of VCT associated with MTCT interventions, this service is also being expanded (MoH. 2005).

Studies from Kara have demonstrated some changes in sexual behaviour following VCT. Reports indicate that those testing sero-positive and sero-negative were more likely to use condoms and reduced their number of casual sexual partners, when compared with reported behaviour prior to testing. However, some women expressed difficulties about using safer sex methods because of poor communication with their sexual partner/s (MoH. 2002). Zimbabwe's AIDSMark and PSI also initiated VCT social marketing in Zambia in early 1999 with the "New Start" programme. Currently all districts have benefited from this programme (AIDSMark. 2007).

Women also hear about and discuss HIV issues, including PMTCT, through various mechanisms, including a group talk for clients waiting for ANC services and during pre and post test counselling (USAID. 2003).

Meanwhile, the Ministry of Defence has drafted a comprehensive five year HIV and AIDS prevention, care and support programme. Proposed activities include VCT, home-based care, condom distribution, training of psychosocial counsellors, peer educators and care givers for different target groups including the youth and women in the military, military dependants and civilian populations. The Defence Force Draft Policy on HIV and AIDS requires that only confirmed HIV sero-positive clients should be considered for ART (ZDF. 2002).

Similarly the National HIV and AIDS policy urges the Defence and Security Sector to provide enhanced counselling service and peer-education programmes in all military hospitals and clinics (MoH. 2005).

Fear of discrimination is preventing people from seeking treatment for AIDS. People can be deterred from utilising VCT services, a linchpin in prevention, treatment and care programmes. Those living with HIV can therefore be left isolated, and deprived of the care and support that could lessen the epidemics' impact. "Even when seeking care and support, people infected with HIV can experience

the harsh repercussions of stigma and discrimination. Those seeking care or counselling may be rejected by the very services that should help them" (ILO/WHO. 2005).

A number of cases have been reported in which people living with HIV have been criminally charged for a variety of acts that transmit HIV and risk transmission. "In some cases, criminal charges have been laid for conduct that is merely perceived as risking transmission, sometimes with very harsh penalties imposed. Some jurisdictions have moved to enact or amend legislation specifically to address such conduct" (Mclellan 2002).

Given the stigma that surrounds HIV and the persistence of HIV-related discrimination, there is a risk that criminal sanctions will be directed disproportionately at those who are socially, culturally and/or economically marginalised. "Policy makers must ensure that the law is not to target or punish people simply because of their HIV positive status, their sexual orientation, their work as prostitutes, their use of illegal drugs or other disfavoured status such as being a prisoner (or ex-prisoner) or immigrant" (UNAIDS. 2002).

Action must be taken to prevent stigma and to challenge discrimination when it occurs, as well as to monitor and redress human rights violations. Clearly, everyone - from political and social leaders to community members and entertainers - has a role to play in fighting stigma and discrimination and human rights abuses. "Some of the most powerful efforts to curb HIV and AIDS-related stigma and discrimination are driven by the involvement of people living with or affected by HIV and AIDS. Examples abound - from programmes for leadership training in Zambia, to media and advocacy activities in newspapers and television programmes organised by the Ministry of Health and other Non-Governmental Organisations" (WHO. 2004).

The Community-centered approach taken in Zambia, for example, prompted chiefs in the district of Lundazi to lead by example and take an HIV test, successfully mobilising community members into following their lead. They went further decreeing against widow inheritances and other practices that discriminate against women and girls, leaving them more vulnerable to infection (WHO. 2003).

The 2005 ZDF unpublished research findings on HIV and AIDS prevalence in the Zambian Defence Force revealed that the overall HIV sero-prevalence was 29% broken down as follows;

Zambia Army	-	**33.9%**
Zambia Air force	-	**16.7%**
Zambia National Service	-	**28.2%**

These figures are very high compared to the National prevalence rate of 16% (MoH & CSO. 2001-2002).

The study further revealed that several interventions have already been instituted and that these interventions are backed by a strategic plan drawn up in 2002. The study says that about 58% respondents had attended HIV and AIDS awareness sessions within their barracks; an average of 3.73 VCT counsellors per Unit/Camp have been trained, with 85% of the Units having an active VCT service for a mean of 11.9 months; a total of 174 new VCT clients had been attended to in the one month preceding the survey in all the study Units (mean 13.4 clients per Unit, with a cumulative total of 1346) giving a mean of 79 clients per Unit since inception of the service in 2000 (ZDF. 2005).

However, despite there being trained staff for specific interventions in the ZDF, these remain poorly utilised, or are shunned by military personnel may be because of stigma attached to them or lack of confidence and trust in the staff. The report states that because of this the uptake of VCT services remains low although the majority of personnel are aware of a VCT centre within Camps/Units. Besides stigma, there appears to be lack of confidence among the clients over the quality of services provided at the centers resulting in them resorting to indigenous methods such as seeking treatment for HIV and AIDS related ailments from herbalists, rather than going for VCT (ZDF. 2005).

The report further recommends that the VCT programme should be made accessible and user-friendly by providing the VCT services outside usual clinic hours as well as off Clinic/Hospital premises and to train more senior VCT managers who are more professional and discreet in their approach and who can inspire confidence in their clients.

Another recommendation was the need to broaden the scope of services to provide extended follow up care beyond a single post-test counselling session, and that emphasis must be laid on prevention of HIV transmission for HIV positive and remaining negative for the HIV negative through couple testing and partner notification (ZDF. 2005).

It is clear from the problem outlined above that there are serious problems concerning the utilisation of VCT services in the ZNS that need to be identified by the users of the service themselves in order to increase the uptake of VCT services.

.Utilisation of VCT services can only be enhanced if HIV and AIDS-related stigma and discrimination are reduced. This can be achieved if it is challenged simultaneously on several fronts:

- Inside communities, where media-based efforts can be directed at public opinion to improve the environment of people living with HIV and AIDS;
- In settings such as the workplace, hospitals and clinics, places of worship and education establishments, where equitable policies and educational strategies can counter stigma, discrimination and human rights violations; and

In the courts, where people can invoke legal rights and duties in order to promote and protect the human rights of people seeking VCT, treatment or people living with HIV and AIDS (UNAIDS. 2005).

This protocol is trying to look at VCT acceptability, ignorance, lack of interest in VCT due to peer pressure or fear of losing jobs among the ZNS personnel. The emphasis would be to motivate all Soldiers and Officers that VCT services are aimed at assisting those who are sick with HIV through appropriate counselling and then putting them on appropriate therapy thereby giving them a longer life-span and avoiding premature deaths among the ZNS personnel.

2.7. Review of concepts

2.7.1 Location of VCT Services

Location of VCT services can lead to under utilisation of VCT services because Camps located nearer to Zambia National Service Headquarters may be at an advantage in getting a larger share of resources such as health workers, equipment and supplies than Camps in rural areas. If resources are not available personnel cannot access these services and so there may be under or lack of utilisation of the VCT services.

2.7.2 Operating hours of VCT services

Currently, all VCT services in the Zambia National Service Camps operate between 08.00hrs and 17.00hrs. These timings may restrict personnel who would like to under-go VCT in the privacy of the night when there are no colleagues watching them, in order to cut down on risk of stigma.

2.7.3 Superiority complex

The Defence Force has a culture or way of life where Officers are extremely respected and held in high esteem by Non-Commissioned Junior Officers. As a result, Officers may be unwilling to be seen going for VCT. Because of this superiority complex which they develop, an Officer would rather die

than be seen going to the Camp Clinic for treatment, let alone for VCT. This is because of the military belief that "An Officer must be smart and free from diseases at all times". An Officer, it is believed, must not suffer from "Funny diseases (e.g HIV and AIDS, and other Sexually Transmitted Infections)"

except "real diseases like malaria, diabetes mellitus, heart diseases etc". It is believed that the "Funny diseases" must only be suffered by junior Non-Commissioned Officers. This notion is further compounded by the fact that it is a chargeable offence for Soldiers and Officers to contract or conceal sexually transmitted diseases.

There is a like a likelihood in the ZNS that those who are poor or poverty stricken acquire the disease faster, and mortality among them is higher. Therefore they need to be protected and convinced that there is a facility which they must not fail to use.

It must not be forgotten that life prevails irrespective of whether one is an Officer or Soldier or whether one is rich or poor. All people have an equal chance of acquiring HIV infection. Therefore, everyone must have access to treatment, care and support, irrespective of colour, rank, race or creed

2.7.4 Fear of stigma, discrimination and divorce

Defence Force personnel mainly live in barracks and Camps/Units. This makes privacy very difficult to achieve. Illnesses, family living standards and marriage settings are closely observed by the whole community. Any change in the health of Officers, Soldiers and their families triggers a lot of speculation and rumour mongering. Some married personnel that contracted HIV have ended up in divorce due to these pressures.

Discrimination may be caused by unsensitised Commanding Officers. Sickly employees may be removed from beneficial incentives e.g attending workshops, international peacekeeping, promotion etc. All these may put a lot of stress on Soldiers, Officers and their families and may lead to shunning VCT services in order to conceal HIV infection.

2.7.5 Poor leadership

In Zambia National Service, big Camps are commanded by a Commanding Officer (CO) while small Camps are commanded by an Officer Commanding (OC). Most of these leaders have been educated about HIV and AIDS. But some of these leaders continue to fan stigma by uttering disparaging remarks against personnel that are chronically ill, those exhibiting signs and symptoms of HIV and AIDS or those living with HIV and AIDS. These leaders may threaten personnel who become inactive in duties like farming, sentry duties, operations etc, with early retirement through medical boards. This

may create a lot of fear and stress in personnel and may further discourage personnel from utilising VCT services.

2.7.6 Job insecurity and lack of willingness for VCT

The poor leadership may instill fear in personnel and may result in personnel being unwilling to undergo VCT in order to avoid being found HIV positive and being medically boarded out of employment in the event of developing AIDS.

2.7.7 Attitudes and cultural beliefs

Traditional and cultural backgrounds may influence personnel perceptions of HIV and AIDS. In spite of massive sensitisation on HIV and AIDS, personnel may still harbour other beliefs about how HIV is contracted, how it can be traditionally prevented, how it can be traditionally treated etc. The extent of these beliefs may determine acceptability of HIV and AIDS messages and VCT utilisation.

2.7.8 Intimidation by supervisors

Leaders in Camps/Units may fan stigma and discrimination of chronically ill personnel or those showing signs and symptoms of HIV and AIDS which may result in personnel feeling intimidated by these Senior Officers who have the power to recommend them for medical retirement. Fear of losing one's employment if discovered HIV positive can lead to non-utilisation of VCT services.

2.7.9 Lack of motivation

The hostile Camp environment, the poor Camp leadership, fear of stigma, discrimination and the intimidation by Senior Officers may all result in lack of motivation for personnel to utilise VCT services in Camps.

2.7.10 Personal Acceptance for VCT

Personnel may not under-go VCT if they are intimidated, threatened, discriminated against or ridiculed. People need respect and privacy, so if they are going to be publicly ridiculed, they may stay away from these services or seek help outside the Camps.

2.7.11 Accessibility of ART

Personnel may not be encouraged to under-go VCT if at the end of it all there is no treatment to help them get better. Currently ZNS only supplies ART at one Urban Camp. In the rest of the Camps, personnel must travel to Lusaka for tests and treatment. This may promote stigma and may result in personnel opting to go to government or private centers for these services.

CHAPTER THREE

2.0 Study design

This was a descriptive cross-sectional study aimed at evaluating the extent of utilization of VCT services by uniformed personnel in the ZNS Camps. Both quantitative and qualitative research methods were used to collect data.

3.1 Review of theories informing choice of design and methodology

The choice of design was informed by the need to have both qualitative and quantitative design. A triangulation of data collection techniques used increased confidence in the validity of findings. The study used questionnaires, focus group discussions and in-depth interviews and checklists with clinic VCT managers in the four Camps. Structured closed ended questions were used to collect quantitative information on utilisation of VCT services while open ended questions were used to collect data from the respondents in the focus group discussions to reveal needs, barriers and attitudes of the personnel in ZNS Camps in accessing treatment care and support for HIV and AIDS.

3.2 Data collection procedures

Quantitative data was collected by a questionnaire of perceptions towards VCT services and through staff interviews using a VCT clinic record checklist. The questionnaire was applied to one hundred and forty nine participants in each Camp. The VCT clinic record checklist was applied to staff managing VCT services in each Camp.

Qualitative data was collected through Focus Group Discussions (FGDs). A total of four focus group discussions were held; one in each Camp. Participants were conveniently drawn from the study population in each Camp. The FGDs consisted of six participants comprising two Senior Officers, two Senior Non-Commissioned Officers and two junior Non-Commissioned Officers.

The review of records and interviews of VCT centre staff covered the period 2000-2007 of VCT services in ZNS.

Data was collected from two Urban Camps and two Peri-Urban Camps (restricted disclosure) to provide for a wider scope of views. Data collection was carried out from 2nd January 2008 to 5th January 2008. The language used was a mixture of English, Nyanja and Bemba. The research Assistants used in each Camp, were staff from the clinic and the Commanding Officers in each Camp. Research Assistants were trained by the researcher for one day. All activities were completed on the same day to prevent participants and clinic staff from comparing or discussing questionnaire answers or the VCT record checklist, which would have influenced the outcome of the study.

3.3 Research setting

This study took place in four ZNS Camps in Lusaka District (restricted disclosure). Lusaka is the Capital City of Zambia. Due to limitation of resources and time only four Camps; Two Urban and Two Peri-Urban were included in the study. Peri-Urban areas are those areas located 30 kilometers from the radius of the City of Lusaka (restricted disclosure).The Camps had each a population of 300 personnel. The information was collected from a selected total population of 596.

3.4 The Study Units

The study included male and female Commissioned and Non-Commissioned Officers of the Rank from Private to Lieutenant Colonel aged between 18 to 49 years, who had not previously utilised the Camp VCT services.

3.5 Inclusion criteria

The inclusion criteria of participants were as follows;

- One currently working for the Zambia National Service
- Of the Rank of Private to Lieutenant Colonel
- Aged between 18 to 49 years
- One who had not previously utilised Camp VCT services
- One who willingly accepted to participate in the study

3.6 Exclusion criteria

The exclusion criteria were as follows;

- One not serving as a military person in the Zambia National Service
- Military personnel below 18 years or above 49 years
- Above the rank of Lieutenant Colonel (above target group)
- Who had previously utilised Camp VCT services
- Who refused to participate in the study

3.7 Sample Size

The study included male and female Commissioned and Non-Commissioned Officers of the rank of Private to Lieutenant Colonel aged between 18 to 49 years who previously had not utilised Camp VCT services.

Each Camp sampled consisted of 300 personnel. The prevalence rate of VCT utilisation was 79. Therefore the calculation was as follows;
79/300 = 149 plus minus 5% at 95% confidence interval using the STAT-CACL computer calculation. The total study population was therefore 596 participants.

FGDs consisted of 6 participants per Camp and were drawn from the same sample of 149 participants in each of the four Units. The total number of participants for the FGDs was therefore 24. However, special consideration was made to include as many female participants in the study as possible because the service has more males to a large extent.

3.8 Sampling technique

Selection of male participants was done randomly through simple sampling technique. For Non-Commissioned Officers, small papers that bore the letter "R" and others blank were distributed during the normal parades. Those that picked papers with the letter "R" were eligible for the study. For Commissioned Officers, meetings were held in the Unit halls where the same procedure was repeated. However due to the low ratio of female to male personnel in ZNS, all female personnel who were interested in the study, Officers and Non-Commissioned Officers, in all the four Camps were purposely included in the study.

3.9 Fieldwork procedures and data collection

Data collection was carried out in four days starting from 2nd January 2008 to 5th January 2008. The researcher worked with the Camp Commanders/Commanding Officers, Registered Civilian Nurses and the VCT Managers in the four Camps as research Assistants. On the survey date participants in each Camp voluntarily assembled in a hall. A further detailed explanation about the study was made by the researcher. Questions were answered and clarified and confidentiality assured. A written and signed consent was obtained from each participant.

The structured questionnaire was given, filled and collected. This took forty five minutes, thereafter the FGDs were conducted. Participants for the FGDs were selected through the methods of convenience sampling; participants were hand picked from the main research group. Focus Group Discussions lasted for one hour in each Camp.

Information on the VCT programme was then collected from the clinic records and staff interviews. This took one hour. All activities were conducted on the same day in each Camp to prevent participants discussing and comparing questionnaire answers which may have prejudiced the outcome of the study and also to cut down costs.

3.10 Pre-testing of questionnaire and training of research assistants

Pre-testing of the questionnaire was done on 28th December 2007 at ZNS Headquarters to make sure that questions were clear, concise and consistent. The questionnaire was applied to five Commissioned Officers and five Non-Commissioned Officers. These comprised three Senior Officers, two Junior Officers, three Senior Non-Commissioned Officers and two Junior Non-Commissioned Officers. No problems were experienced with the questionnaire, therefore no adjustments were made.

Training of research assistants was also done on 28th December at ZNS Headquarters and was aimed at orienting research assistants on the use of research tools to ensure that all research assistants used the tools in a standardized manner to ensure valid results.

3.11 Data analysis

Data collected from the questionnaires and interview schedules was checked by the researcher for completeness and consistency before entering it in EPI INFOR Version 6 statistical package. Analysis was later done using the same package and the CHI square statistical test was used to determine associations between variables. The multivariate logistic regression was used to determine independent predictors for congregation use. The cut off point for statistical significance was set at 5%. Responses from FGDs were analysed according to the interview questions. Feelings, concerns and suggestions were reported as expressed by the participants, while some feelings were quoted as expressed by participants.

3.12 Limitations of the study

The study had the following limitations:

- The sample size was only limited to uniformed personnel who had not utilised the Camp VCT services.
- The study was also only limited to two Urban and two Peri-Urban Camps in Lusaka District leaving out other Camps in Lusaka as well as other Camps in the many Provinces of Zambia. This was due to inadequate funding and limited time.

CHAPTER FOUR

4.0 Data Analysis and Presentation of results

The results of the study which was looking at the utilisation of VCT services by uniformed personnel in the ZNS are presented as follows:

1. Information obtained from the questionnaire
2. Information from FGDs
3. Information from VCT Checklist (obtained from the four Camp clinic considered for the study)

According to the chosen sample size, a total of 596 participants fulfilled the selection criteria of which 309 were selected from the urban sites and 287 from the peri-Urban sites. The names of these Camps are not mentioned for confidentiality purposes and in compliance with the Defence Force regulations.

4.1 Results of the questionnaire

Table1: Frequency distribution of location of unit whether Urban or Peri-Urban

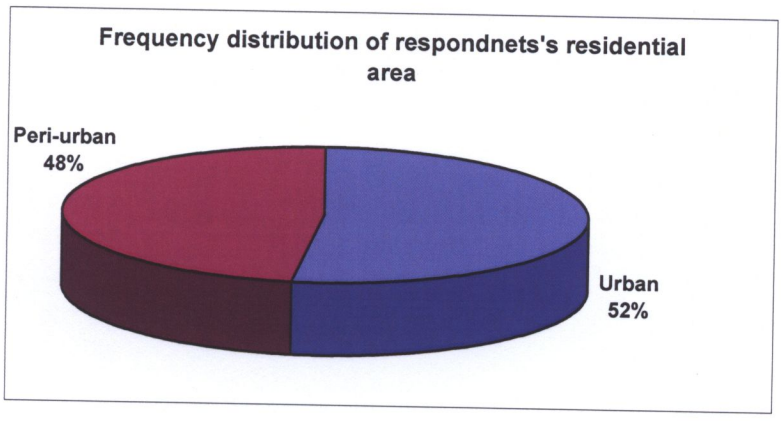


Table 1 shows the distribution of participants from the four selected Camps. There were 309 (51.8%) participants from the two Urban Camps and 287 (48.2%) participants from the Peri-Urban Camps. The results show that there was more enthusiasm for the study from personnel from Urban Camps than from the Peri-Urban Camps

Location of Units/Camps

Location of Unit	Number	Percent
Urban	309	51.8%
Peri-Urban	287	48.2%
Total	**596**	**100%**

* Each Camp had a total of 300 personnel. The two Urban Camps had more personnel (309). This was because some personnel had been posted in from other Camps while those posted out were still in Camps waiting for transport to take them to their new destinations.

TABLE 2; Distribution of Rank and Location

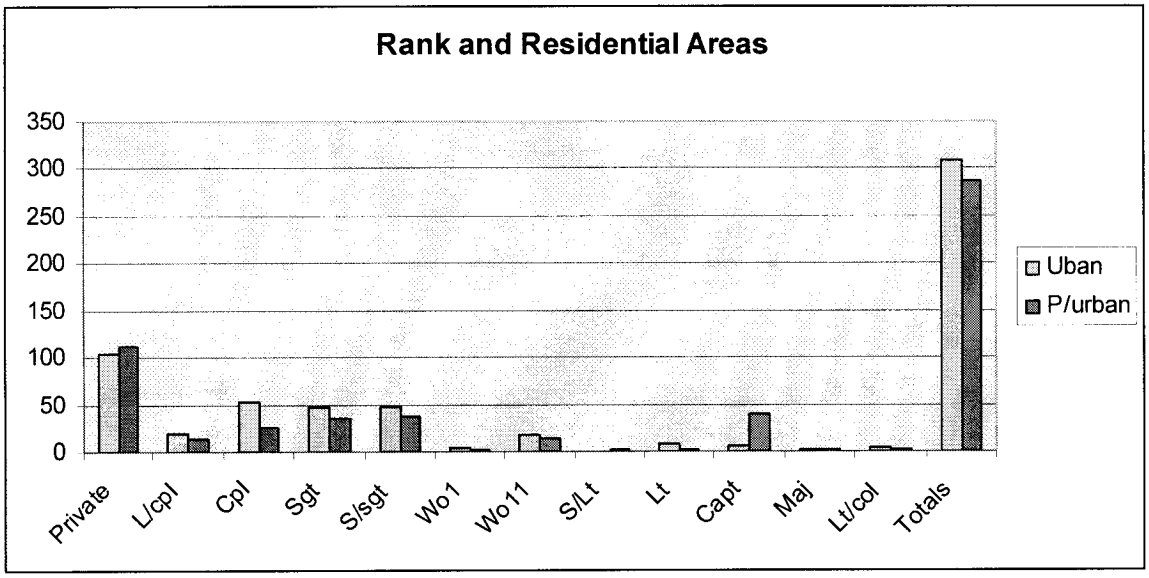


Table 2 above shows the distribution frequency of participants by rank. Of the total number of participants (596) there were 217 (36.4%) Privates, Lance Corporals 34 (5.6%), Corporals 79 (7.9%), Sergeants 82 (13.8%), Staff Sergeants 85 (14.3%), Warrant Officers Class Two 32 (5.4%), with 5 (0.8%) being of the rank of Warrant Officers Class One. The rest of the respondents ranged from the ranks of, 2 (0.3%) Second Lieutenants, 8 (1.3%) Lieutenants, 45 (7.6%) Captains, 3 (0.5%) Majors and 4 (0.7%) Lieutenant Colonels

*Each Camp had the following total number of personnel in each category:
Private – 85
Lance Corporal – 40
Corporal – 55
Sergeant – 39
Staff Sergeant – 40
Warrant Officer Class Two – 10
Warrant Officer Class One – 5
2Lieutenant - 6
Lieutenant – 10
Captain – 18
Major – 1 (one Camp had no Major)
Lieutenant Colonel – 1

* The total number of female personnel out of 300 personnel in each Camp was as follows:
Urban Camp one – 70
Urban Camp two – 08
Peri-Urban Camp one – 55
Peri-Urban Camp two – 44
Total – 177 female personnel in the four Camps
Ratio Male to female – 177 females to 1023 male personnel

Table 3a: Social Demographic features of participants

Age (years)	Urban Camps % (n)	Peri Urban Camps % (n)	Total	Total %
18 – 30	154	75	229	38.4
30 – 40	169	77	246	41.2
40- 49	96	25	121	20.3
Marital status	**%(N)**	**%(N)**		**%(N)**
Currently married	209	194	403	57.6
Single	100	61	161	37
Divorced	7	25	32	5.3
Widowed				
Ranks of respondents				
Private	104	113	217	36.4
Lance Corporal	20	14	34	5.4
Corporal	53	26	79	13.7%
Sergeant	47	35	82	13.8
Staff sergeant	47	38	85	14.3
Warrant Officer 11	18	14	32	5.4
Warrant Officer 1	3	2	5	0.8
Second lieutenant	0	2	2	0.3
Lieutenant	7	1	8	1.3
Captain	6	39	45	7.6
Major	1	2	3	0.5
Lieutenant Colonel	3	1	4	0.7
Level of education	**%(N)**	**% (n)**		**%(N)**
Primary	28	17	53	7.6
Secondary	169	135	304	51.0
Tertiary	112	135	247	41.4
Never attended school			-	-

Table 3a above represents socio demographic data of participants. As can be seen from the table, the majority of respondents were of the age group 30-40 years (41.2%) and 18-30 (38.4%). Very few respondents were of the age group 40-49 years (20.3%). The most common rank found amongst the respondents was that of Private (36.4%), while the next highest was that of Sergeant (13.8%) and Staff Sergeant (14.3%).

The distribution of participants by educational level shows that 53 (7.6%) attained primary education, 296 (51.0%) secondary level and 247 (41.4%) tertiary level. This shows the ZNS has personnel that have attained reasonable levels of education to be able to understand issues affecting their health.

The study also found that 161 (37%) were single, 403 (57.6%) were married and 32 (5.3%) were divorced. There were no participants who were widowed.

Frequency of distribution of age groups of respondents

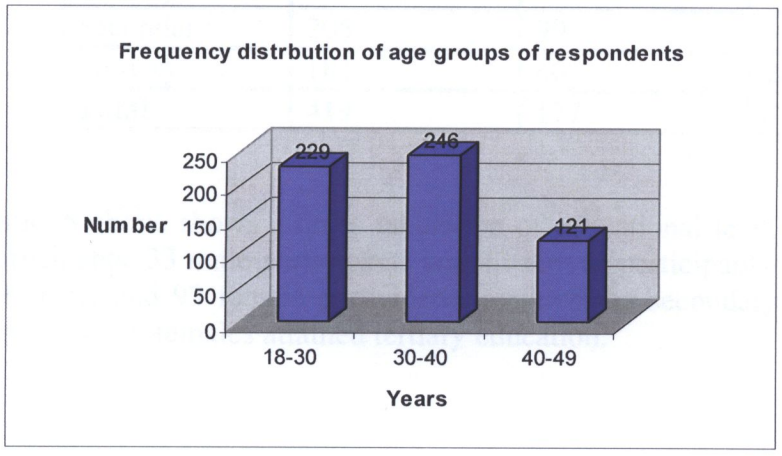


Table 3 b

Table 3b above shows that the majority of participants were between 30-40 years of age (246) followed by 18-30 years (229) with only 121 participants in the age group 40-49 years. According to the selection criteria the youngest age was 18 years (the military entry age in ZNS, at the rank of Private for Non-Commissioned Officers) while 49 was the oldest. The entry rank for Commissioned Officers is Second Lieutenant (2Lt) for non professionals while professionals come in as Lieutenant (e.g nurses, agriculturists etc) or Captain (e.g Doctors).

Table 4: Sex distribution of respondents

Gender	Number	Percent
Male	419	70.3%
Female	177	29.7%
Total	**596**	**100%**

Table 4 above shows sex distribution by gender. The total number of male participants was 419 (70.3%) and that of females 177 (29.7%). The ZNS consists of more males to a larger extent. In spite of a deliberate effort to ensure gender balancing and including more females in the study, the number still falls far less than that of their male counterparts.

Table 5: Shows a cross tabulation of educational level and sex of respondents

Educational Level	Male	Female	Total
Primary	33	12	45
Secondary	205	99	304
Tertiary	181	66	247
Total	**419**	**177**	**596**

Table 5 above shows a cross tabulation of educational level of participants with sex of participants. 33 male participants and 12 female participants attained primary education, 205 male and 99 female participants attained the secondary education level while 181 males and 66 females attained tertiary education.

Table 6: Knowledge of HIV and AIDS

Knowledge about HIV and AIDS	Number	Percent
YES	590	97 %
NO	6	3%
Total	**596**	**100%**

The general knowledge of HIV by the respondents was very good with over 90% of respondents possessing good knowledge about HIV and AIDS.

Table 7; Knowledge about availability of VCT services

Awareness of VCT services	Number	Percent
YES	519	87.0%
NO	76	12.8%
Don't know	1	0.2%
Total	**596**	**100%**

Table 7 shows the distribution of participants who had knowledge about the availability of VCT services in the Camps. 519 (87%) of the respondents were aware of VCT services, 76 (12.8%) didn't know that the services were available and 1 (0.2%) said they were not sure of any such services being offered in the Camps.

Table 8; Distribution of respondents wanting to know their HIV status compared with Educational level

Educational Level	Knowledge Of HIV status		Total
	Yes	No	
Primary	23	122	144
Secondary	145	59	204
Tertiary	152	96	248
Total	**419 (74%)**	**177 (21%)**	**596**

Table 8 above shows that most of the respondents 419 (74%) stated that they wanted to know their status and only 177 (21%) stated that they did not want to know their status. One would wonder therefore why Testing is so low.

Table 9; Knowledge of one's HIV status

Knowledge of one's HIV status	NUMBER	PERCENT
YES	320	53.7%
NO	276	46.3%
TOTAL	**596**	**100%**

Table 9 shows that slightly over 50% of respondents 320 (53.7%) had undergone VCT and knew their HIV status while 276 (46.3%) did not undergo VCT despite the fact that 519 (87%) were aware of the availability of VCT services in their Camps (Table 7).

Table 10; Distribution of respondents' responses as to whether they would share their HIV positive results with their spouses, best friend, parents or supervisor

Shared HIV results with	Number	Percent
Spouse	309	57.8%
Best friend	77	12.3%
Parents	23	4.4%
Supervisor	25	5.0%
Non of the above	162	**20.5%**
TOTAL	**596**	**100%**

Table 10 above shows that respondents stated they would share their
HIV positive results with their spouses (57.8%), 76 (12.3%) said they would share with their best friend, 23 (4.4%) said they would share their results only with their parents while 25 (5.0%) said they would share their result with their Supervisor only. This poses a problem because if HIV positive spouses (42.2%) hide results they will infect their HIV negative spouses and other sexual partners thereby worsening the burden of disease in the ZNS.

Table 11; whether attended to by a professional Counsellor at private or government clinic

Attended by a professional Counsellor	Number	Percent
YES	291	49.4%
NO	57	9.7%
I Don't Know	248	40.9%
TOTAL	**596**	**100%**

Table 11 shows the distribution of respondents who had accessed the VCT services outside the Camps, only 49% stated they had been attended to by a professional counsellor at the private or government clinic which they attended. Almost half of the respondents did not know who provided VCT to them.

Table 12; Distribution of responses as to whether ZNS has adequate administrative structures to support HIV and AIDS Programmes

Adequate administrative structures	Number	Percent
YES	193	32.4%
NO	359	60.2%
I don't know	44	7.4%
TOTAL	**596**	**100%**

Table 12 above shows that the majority of respondents 359 (60.2%), stated that ZNS had no adequate administrative structures to support HIV and AIDS Programmes, 193 (32.4%) said that there were adequate structures, while 44 (7.4%) said they did not know whether ZNS had adequate structures to support HIV and AIDS Programmes. Administrative structures mean facilities for HIV and AIDS Services such as VCT centres, manpower etc in the ZNS.

Table 16; Frequency distribution of whether Health workers keep VCT results Confidential

Confidentiality by Health Workers	Number	Percent
YES	251	42.1%
No	345	57.9%
Total	**596**	**100%**

Table 16 above shows that 251 (42.1%) respondents felt that health workers kept client VCT results secret while 345 (57.9%) felt that health providers did not keep secret client VCT results. This means that health providers violate the principle of confidentiality. This contributes to the reasons why clients do not utilise the VCT services in ZNS (Table 9; page 37). This Table indicates that despite respondents being aware of the availability of VCT services in ZNS Camps 519 (87%) only 320 (53.7%) knew their HIV status while 276 (46.3%) did not know their HIV status. Because of lack of confidentiality, three hundred fifty four respondents (57.4%) feared that they would be stigmatised if they underwent VCT (Table 17).

Table 17; Reasons for shunning VCT services by uniformed personnel in the Zambia National Service

Reasons	Number	Percent
Fear of stigma	354	57.4%
Fear of intimidation by Senior Officers	88	14.1%
Cultural beliefs	21	3.9%
Lack of motivation	83	13.9%
Fear of dismissal	8	1.3%
Job security	29	5.9%
Any other	13	3.5%
Total	**596**	**100%**

Table 17 above shows that 354 respondents (59.4%) stated that stigma was a barrier to utilisation of VCT, 88 (14.8%) attributed it to fear of intimidation by Senior Officers while 83 (13.9%) stated lack of motivation as a barrier to VCT utilisation in ZNS. Other barriers stated were job insecurity (4.9%), cultural beliefs (3.5%) and fear of dismissal from employment (1.3%).

Table 18; Distribution of responses as to whether PLWHA were ridiculed, persecuted, threatened with dismissal or discriminated against in the ZNS

	Number	Percent
Ridiculed	128	22.1%
Persecuted	Nil	Nil
Threatened with dismissal	123	20%
Discriminated against	345	57.9%
Total	**596**	**100%**

Table 18 shows that most respondents 345 (57%) said that PLWHA were discriminated against, 128 (42.1%), said that they were ridiculed while 123 (20%) said they were threatened with dismissal.

Table 19; Distribution of responses as to whether the ZNS was doing enough in the prevention of HIV and AIDS

Whether ZNS was doing enough in HIV/AIDS	Number	Percent
YES	554	**93.9%**
NO	42	6.1%
I don't know	Nil	Nil
TOTAL	**596**	**100%**

Table 19 above shows that the majority of respondents 554 (93.9%) felt that the ZNS was doing enough about HIV and AIDS, 42 (6.1%) said that ZNS was not doing enough about HIV and AIDS.

Table 20; Frequency distribution of ART

ART	Number	Percent
YES	42	6.1%
No	554	93.9%
Total	**596**	**100%**

Table 20 indicates the number of personnel who stated that they were on ART, (6.1%) while 554 (93%) respondents said they were not on ART. Despite the 28.2% HIV prevalence rate in the ZNS (ZDF.2005), it is incredible that only 6.1% of the ZNS workforce could be on ART!!

Table 21; Frequency of distribution on whether ZNS was providing adequate Care and Support for PLWHA

Adequate care and support	Number	Percent
YES	291	49.4%
NO	24	19.7%
I don't know	248	30.9%
TOTAL	**596**	**100%**

Table 21 shows that the most respondents 291 (49.4%) said that ZNS provides adequate care and support, 248 (40.9%) said that ZNS did not provide adequate care and support while 24 (19.7%) did not know whether the ZNS provides adequate care and support for PLWHA. Almost half of the respondents did not know whether the ZNS provide adequate care

Table 22 Frequency distribution of accessibility of laboratory services in the Zambia National Service

Accessibility of Laboratory services	Number	Percent
YES	359	60.2%
No	193	32.4%
Don't know	44	7.4%
Total	**596**	**100%**

Table 22 shows the number of respondents who stated that there was easy access to laboratory services 359 (60.2%) while 193 (32.4%) stated that there was no easy accessibility to laboratory services and 44 (7.4%) said they did not know whether it was easy or not to access laboratory services. This contradicted the above findings (table 21) where almost half of the respondents said that the ZNS was not providing adequate care or they did not know whether the ZNS provides adequate care and support for PLWHA. This proves that laboratory services are not accessible in the ZNS.

4.2 Results from Focus Group Discussions (FGDs)

Participants for the Focus Group discussions were picked from the main research group in each Camp. Six personnel took part in these discussions comprising two Senior Commissioned Officers, two Senior Non-Commissioned Officers and two Junior Non-Commissioned Officers. Participants in the focus group discussions were asked questions from an interview schedule to solicit information on their knowledge of HIV and AIDS and find out their reasons for not utilising the VCT services located in their Camps.

4.2.1 Definitions of HIV and AIDS

Ninety seven percent of the participants were able to define the two words. Most of the participants were able to go further to explain at what stage one would be found with the virus in the blood and what stage an individual would develop a full fledged disease. All participants were able to explain modes of infection and how HIV infection can be prevented. So knowledge about HIV and AIDS was good.

4.2.2 Number of people who had undertaken HIV test in the FGDs

All the participants had undergone VCT but at government or private clinics, outside the Camp. The reasons given were largely fear of stigma from colleagues and discrimination by their Senior Officers.

4.2.3 Reasons why personnel opted for VCT services outside the camp

Seventy percent of the participants said they feared to be stigmatised if they underwent HIV test in the Camp and were found positive. The majority of the participants said that the staff at the clinic leaked HIV results. This meant that all the colleagues in the Camp would come to know about the problem and would start talking about them behind their back. One participant went on to say, "You become the topic in Camp. You see friends who were close to you start distancing themselves from you. They avoid using your cups at work and start locking up their cups and plates to avoid you using them. You just start feeling unwanted and going for work becomes so difficult".

4.2.4 Sharing of positive results with spouse, parents, best friends or supervisor

Sixty percent of the participants said they had shared their results with their spouses. However most of them said that it was difficult to share with supervisors because they too did not keep secret the HIV positive results. One participant said "They will start ridiculing you in front of colleagues just to embarrass you. They even tell their wives who are not workers in ZNS about what is going on at work. You just hear women gossiping about you ati baja kanayaka (that one is HIV positive)". They also felt sharing with friends was risky because of the rampant rumour mongering that is going on in ZNS about who is HIV positive and who is not.

4.2.5 Opinions on utilisation of VCT services by uniformed personnel in ZNS

All the participants expressed concern at the low utilisation of the VCT services by uniformed personnel in ZNS. This was attributed to lack of confidentiality by staff, stigma, fear of being ridiculed or discriminated against and fear of being retired on medical grounds. One participant said that as soon as an individual tested HIV positive supervisors will leave the victim out of duties like peace keeping abroad. He said that peace keeping duty was the only way personnel could earn enough money to build houses, send children to decent schools and buy a car, which were basic needs of a worker. Another participant who gave an example of herself said that when she tested HIV positive, a Commanding Officer told her he could not keep her in his Camp because she was going to be sick all the time. She said he told her,"I don't keep sicklers in my Camp". The next day she was issued with forms for medical board and told to fill in and submit them to him for recommendation for medical retirement. She said that she was shocked and heart-broken and could not believe she could be treated like that after serving the Organisation for twenty two years. One participant narrated how he was removed from the list of personnel going for peace-keeping duties in Sudan, when he tested HIV positive during medical examinations. His CD4 Count was 350 but authorities decided he had AIDS and could not be allowed to undertake such duties even though he had no symptoms of AIDS. He said that the results were put on his file and the file was going round offices and that his status became known by all personnel at ZNS Headquarters. He said that this caused him a lot of pain and embarrassment and that if

there was a way of undoing what had happened he would have opted to do his VCT outside the Camp and kept secret his results.

4.2.6 Opinions on whether the location of VCT services prevented utilisation.

Seventy percent of the participants said that utilisation of VCT services was low because they were located in the Camps. They argued that there was careless record keeping at clinics making it easy for non-medical personnel accessing records. This resulted in leakages of confidential information. One participant said "Staff at the clinic use the same clinic record book to keep VCT results. These books are left on the tables carelessly thereby exposing the results to people who go to the clinic. Once HIV positive results are seen the gossip starts and you wonder how these people came to know about these results. And yet the counsellors tell us that the results will be kept confidential. You start wondering what type of counsellors they are. You should be training people that are mature and committed to the profession instead of training every Jim and Jack. Counselling must be treated as a profession with ethics and people who break these ethics must be severely punished". Other participants said that clinic personnel were obliged to inform Commanding Officers and Supervisors about the HIV results of personnel especially if they had developed AIDS so that these individuals could be excused from duty for longer periods to enable them recover. However, instead of maintaining confidentiality, these Commanding Officers and Supervisors started to pass embarrassing comments about the patients' HIV status to other personnel. The majority of participants objected to having VCT at the Camp Clinic because it brought gossip and a lot of speculation. They suggested that mobile VCT would be a better option in order to provide for privacy.

4.2.7 Opinion on best time for VCT

Most participants suggested that if VCT services were to continue in Camps they should be offered 24 hours a day so that personnel could access them in the privacy of the night. Most of the participants felt that the clinics should be manned by mature health providers who would be able to keep results confidential. They suggested that the current staff in all Camps should be re-trained on the importance of confidentiality and that stiff punishment should be meted out to those that leaked results. The majority of participants expressed

the need for affiliating ZNS Counsellors to Zambia Counsellors' Council which enforces Ethics of counselling and deals with counsellors breaching confidentiality.

4.2.8 Opinion on whether Commanding Officers encouraged personnel to undergo VCT

Most of the participants said that some Commanding Officers who were sensitised on HIV and AIDS encouraged personnel to undergo VCT and supported personnel living with HIV and AIDS while those that were not sensitised did not show leadership in HIV and AIDS programmes and discouraged personnel with their attitude.

4.2.9 Opinion on ART services in ZNS

Ninety percent of participants said that there was need to decentralise ART and laboratory services in the ZNS. Currently all personnel who require ART and laboratory services have to travel to Lusaka to access ART. This discouraged personnel from utilisng the services because of the stress of travelling and the risk of being stigmatised at ZNS Headquarters. One participant said "Madam, when you go to Headquarters people want to know why you have come. If you look thin and you enter the DMS's office colleagues start talking. If you are given laboratory forms to go to MSMH it is even worse because they now conclude you have AIDS. If you have to start treatment, ARVs are not given in privacy. Even a cleaner knows who is on ARVs. Medical records are not locked away. That's how bad it is. So it is better to go to private or government institutions to avoid being talked about".

4.2.10 Opinion on whether the ZNS was doing enough in the prevention of HIV among personnel

Most participants felt that ZNS was trying hard to prevent HIV infection among its personnel. However, participants suggested that the Commandant should go further to encourage and support formation of support groups for People living with HIV and AIDS to enhance care. Another recommendation was the need to reduce the time for local Operation Duties from six months to three months and international Operation Duties from one year to six months, as this was too long a time for one to stay away from a regular sexual partner. They further argued that when one was sexually starved one took "whatever was available or offered" thereby increasing the risk of getting infected with

HIV. Most participants expressed the need for partnership with Co-operating partners such as Project Concern International (PCI) and JHPIEGO in the area of supply of nutritious food because they felt that good nutrition played a very critical role in ART in PLWHA. Participants suggested that sensitisation of soldiers and Officers on HIV and AIDS should continue and should be done on a monthly basis in all Camps in order to update Officers and soldiers on the HIV and AIDS pandemic. One participant said, "Please include Commanders and Commanding Officers in Sensitisation so that these people understand when their juniors are sick. Some Commanding Officers are in the fore front of stigmatising personnel who have AIDS and threaten them with medical retirement. How can you go for VCT when you know that you will be the centre of discussion at parades and Indabas"?

4.2.11 Other issues

Participants felt that medical personnel in ZNS had concentrated on prevention and treatment for HIV and AIDS but not on support for people living with HIV and AIDS (PLWHA). They said that if this was done it would encourage personnel to live positively and would also encourage those who would like to come out openly to teach colleagues on the dangers of HIV and AIDS.

Participants suggested that medical personnel should privately advise ailing patients to go for VCT instead of doing it in public, embarrassing the clients. They also said that medical personnel should exhaust all investigations before settling for HIV testing.

Another suggestion was that ZNS should dedicate a day each month for PLWHA so that these people could encourage each other thereby encouraging other personnel who were reluctant to know their status to undergo VCT, knowing that they will be supported. Participants were of the opinion that VCT was an entry point to Support and Care so health providers should encourage patients and treat HIV and AIDS as any other illness instead of passing damaging remarks. Participants also suggested that personnel suffering from AIDS which did not respond to ARVs should be considered for retirement on medical grounds in order to enable personnel to receive their pension which would assist them provide for their families in terms of shelter, school fees etc. before they passed on.

4.3 RESULTS OF THE VCT RECORD CHECKLIST

4.3.1 Year of commencement of VCT services

VCT Services commenced in 2002 in all the Camps.

4.3.2 Type of VCT facility

All the VCT facilities in the four Camps were modern with modern equipment such as fridges, tables and HIV testing kits. However, only one Urban Camp clinic was equipped with ARVs.

4.3.3 Number of trained psychosocial counsellors

Two Urban and one Peri-Urban clinics had five trained psychosocial Counsellors each. One Peri-Urban clinic had three trained Counsellors.

4.3.4 Number of personnel utilising VCT services since the inception of the service.

Urban Camp one: 20

Urban Camp two: 22

Peri-Urban Camp one: 19

Peri-Urban Camp two: 16

:

4.3.5 Type of referral systems for clients found to HIV positive

HIV testing was being carried out at all the four Camps. However, all clients found HIV positive were referred to Director of Medical Services (DMS) at ZNS Headquarters who in turn referred the client to Maina Soko Military Hospital (MSMH) for further tests such as Liver Function Test, Heamoglobin test, Full Blood Count and CD4 Count. Clients that had a CD4 Count of less than 350 were referred back to the DMS at ZNS Headquarters, who then opened a file for the client and commenced the client on ART. Apart from ZNS Headquarters, only one Urban clinic was authorised to dispense ARVs. Clients from this Camp were referred from MSMH back to their Camp to commence ART.

4.3.6 Number of clients on ART

Urban Camp one:	15
Urban Camp two:	20
Peri-Urban Camp one:	15
Peri-Urban Camp two:	10

4.3.7 Sources and frequency of supply of HIV testing

ZNS Headquarters supplies all Camps monthly.

4.3.8 Sources and frequency of supply of ARVs

ZNS Headquarters supplies one Urban Camp with ARVs while clients from other Camps were supplied on demand.

4.3.9 Other HIV and AIDS activities being carried out in camps

All Camps had records of activities going on in the following areas:

- PMTCT
- Peer Education
- Home-Based Care
- HIV and AIDS sensitization

However, there was need to expand these services so that all Officers, Soldiers and their families could have equal accessibility to these services.

All the Camps did not have activities in the area of Care of Orphans and Vulnerable Children (OVC) or HIV and AIDS support group.

CHAPTER FIVE

5.0 Discussion of results

As part of scaling-up HIV services in the ZNS and indeed in the country, increasing emphasis is being placed on the collection of information to improve patient management and monitoring as well as programme or service monitoring and evaluation. Such data allow individuals to be tracked over time and between places and enable the development of longitudinal patient-level information for clinical management. Patient-level information becomes even more important when used for programme or service monitoring or evaluation.

The provision of VCT services for military personnel was key to the improvement of quality of life for military health personnel in Zambia and will ultimately contribute to the country's overall programme for the prevention, treatment, care and support of PLWHA. The study sites consisted of peri-Urban and Urban areas with 51.8% of the sites being in the Urban and the rest in the peri-Urban areas. Seventy percent of the respondents were male, with a secondary level of education. Only 30% of the respondents were female. Over 97% of the respondents were aware that VCT services were available at the Camp clinics. The study findings demonstrated that the overall knowledge of HIV and AIDS was very high (97%). This finding was similar to findings of other parts of the Southern African region and the country as a whole, where the knowledge levels were high (International HIV/AIDS Alliance. 2004; Zambia Demography and Healthy Survey. 2001-2002; WHO. 2001; MoH. 2006; UNAIDS. 2004; USAID. 2000). This could be attributed to numerous programmes that have been undertaken by various government and donor agencies where a lot of information and education had been disseminated to inform the population at large on HIV and AIDS. HIV testing was being undertaken in all the four Camps that were part of the study sample.

HIV testing centers were established in all Camps in 2002 (ZDF. 2005) and it was found that all the sites visited were well equipped centers. The total number of VCT centers found was 42% for Urban and 35% for peri-Urban (ZDF. 2005). Currently these sites are supplied with testing kits monthly from the ZNS Headquarters. However, this study revealed that clients that needed treatment were referred to Maina Soko Military Hospital (MSMH) for CD4 Count and other investigations. Compliance to this would depend on the ability and sense of responsibility of the client to cover the long distance from the Camp to the hospital, which would usually be at his own

cost due to the erratic provision of transport system in the Camps. This would be compounded by the long queues that clients have to endure at MSMH which adds to the frustration. This study also found that although ZNS Headquarters supplied all Camps monthly with HIV testing kits, the supply of ARVs was undertaken from ZNS Headquarters for all Camps except one. However all Camps had records of VCT, Home Based Care, PMTCT, Peer education and HIV and AIDS Sensitisation activities being implemented which were currently being funded by various partners.

5.1 Determine the factors associated with lack of utilisation of VCT services

Despite the high levels of knowledge of the availability of the VCT services in the Camps, only 74% of the participants said they would want to know their status and only 53.7 % knew their HIV status. Among some of the factors that were associated with shunning of VCT services by uniformed personnel in the Zambia National Service, fear of stigma ranked the highest (59.4 %). Fifty eight percent of the respondents stated that they were not going for VCT because health providers did not keep secret HIV results, while 14.8% feared intimidation by Senior Officers. Fourteen per cent of respondents indicated that they did not utilise VCT services in Camps because they were not motivated to utilise these services. What was interesting was that 4.9% stated job insecurity as another reason for shunning VCT. However cultural beliefs were not a reason that people shunned VCT services in the military as only 3.5% of the respondents stated that as a reason. The majority of respondents from FGDs and the majority of responses from the questionnaire indicated that lack of confidentiality of HIV and AIDS information by health providers and the centralised laboratory and ART structures were the biggest barriers to VCT utilisation in ZNS.

The respondents in this study had ranks ranging from Private to Lieutenant Colonel with the largest number of respondents being Privates (36.4 %) and Sergeants, 13.8%. The rank of Private was the lowest rank of Officers. Respondents felt that VCT services were attached with stigma (70%). This view was further echoed by participants from the Focus Group Discussions (FGDs) who also expressed concern at the low utilisation of the VCT services by uniformed personnel. They said this was also compounded by lack of confidentiality by Staff. Stigma, fear of being ridiculed, discriminated against and fear of being retired on medical grounds were also cited by FGDs as the biggest barriers to utilisation of VCT. One participant in the FGDs stated, "as soon an individual tested HIV positive, supervisors will leave the victim out of duties like peace keeping abroad". He said that peace keeping duty was the only way personnel could earn enough money to build a

house, send children to decent schools and buy a car, which were basic needs of a worker. Another participant, who was talking from personal experience, stated that when she tested positive, a Commanding Officer told her he could not keep her in his Camp because she was going to be sick all the time. She said he told her "I don't keep sicklers in my Camp". The very next day she was issued with forms for medical board and told to fill and submit the forms to him for recommendation for medical retirement. The participants also felt that VCT services should be offered as a 24 hour service so as to encourage personnel to seek the VCT services in the privacy of the night.

The respondents also felt that personnel in the ZNS were ridiculed (22.1%), threatened with dismissal (20%) and discriminated against (59.7%), when they were found to be constantly ill. However, forty nine percent of respondents said that the ZNS was providing adequate care and support for PLWHA and only 19.7% of the respondents stated that the ZNS was not doing enough for people living with HIV while 30% said that they did not know whether the ZNS was providing adequate care and support for PLWHA.

Respondents felt that the ZNS should be providing food and vitamin supplements to enhance nutrition for patients, improving health facilities, providing leadership and support to HIV support groups, ensuring light duties for those who were constantly ill and providing more community care through services such as Home Based Care (HBC), for all personnel who were HIV positive and living positively. A few of the respondents from the FGDs stated that the Adjutants, Commanding Officers and Officers Commanding Camps did not provide support to personnel when they were ill. However there were others who felt that there were Officers who had knowledge on HIV and AIDS who encouraged their personnel to undergo VCT and supported personnel living with HIV and AIDS while those who were not sensitised did not show any leadership on HIV and AIDS.

Respondents from the FGDs also felt that ZNS did not have adequate administrative structures to support HIV and AIDS programmes. The respondents felt that the ZNS should decentralise laboratory services and other HIV and AIDS programmes and further made recommendations that the ZNS should build modern health facilities. However, respondents strongly felt that the ZNS had undertaken a number of activities in the area of prevention of HIV and AIDS infection. Sixty percent of the participants felt that it was easy for the personnel to access laboratory and ART services in the ZNS. Respondents from the FGDs who felt that it was not easy mainly cited the lack

of laboratory services in the Camps, the need for decentralisation of ART and laboratory services and the inadequate number of trained health personnel at the health facilities as the major barriers to utilisation of these services. The current management of ART services was strongly criticised, where personnel were required to be tested in Camps then referred to ZNS Headquarters for referral to MSMH for CD4 Count and other investigations, and then referred back from MSMH to ZNS Headquarters for commencement of treatment.

The study findings also revealed that participants strongly suggested urgent improvement in the access to VCT, laboratory and ART services if ZNS was to succeed in reducing the HIV and AIDS prevalence rate of 28.2%. Some of the suggestions on the improvement of HIV and AIDS Programme management were the need to decentralise laboratory services and the provision of ART and the employment of more mature health providers who would bring credibility to the issue of confidentiality of all HIV information for personnel in the ZNS.

Participants felt that the issue of HIV and AIDS was being defeated by the health providers who did not keep secret clients' results, resulting in personnel losing trust in them and shunning Camp VCT and other HIV and AIDS services, preferring private or government services where they were assured of confidential services.

5.2 Evaluate knowledge and perception of VCT services

Although the majority of respondents (97%) were aware of the availability of VCT services in Camps they expressed reluctance to utilising these services due to fear of stigma. Fifty eight per cent of the respondents stated that Lack of confidentiality by health providers was one of the reasons they did not utilise VCT services. This finding is similar to other findings done in the region, as will be illustrated later in the discussion. Lack of confidentiality has been cited as a major reason why access to VCT services is not increasing. This may be attributed to many reasons such as the lack of mature and qualified health providers at health facilities due to the human resource crisis that is currently affecting the African Continent. This scenario has not spared Zambia or the Zambian Military.

At the time of this study the ZNS had about 137 trained counselors to offer HIV and AIDS services, a number falling far short of the required number on the establishment necessary to carry out such a mammoth task and meeting the demands of the ZNS large workforce (restricted disclosure).

Lack of confidentiality of personal HIV information was also cited as a major area of concern by the FGDs. One participant recalled how he was removed from the list of personnel going for peace keeping duties in Sudan, when he tested HIV positive during the medical examination. He said that his CD4 Count was 350 and had no signs and symptoms of HIV infection but authorities decided he had AIDS and could not be allowed to go for these duties. He said his results were put in his file and the file was going around the offices and his status became known by all personnel at ZNS Headquarters.

Other factors promoting this scenario in the military is the need to inform Senior Officers and the hierarchy in the Military about such results, which might force a Junior Health provider to release confidential HIV information of soldiers and Officers. However other members in the FGDs felt that despite the ZNS doing so much for the personnel in prevention activities, the Commandant should go further to encourage and support formation of support groups for people living with HIV and AIDS in order to enhance care.

5.3 Access to VCT and ART services

The study found that VCT services were readily available in all the Camps. In all of the sites visited whether Urban or per-Urban, it was found that the services were made available since 2002. This finding echoed the findings of the Joint Health Sector Review that found that VCT and PMTCT services had been scaled up country-wide and that most centers had started promoting routine counselling and testing (MOH. 2006).

However despite the services being available in the sites, the FGDs revealed that the majority of the participants opted for services outside the Camp because they feared being stigmatised and discriminated against. One participant said "you become a topic in the Camp. You see friends who were close to you start distancing themselves from you. They avoid using your cups at work and start locking up their cups and plates to prevent you using them. You just start feeling unwanted and going for work becomes so difficult". This only goes to prove the breach of confidentiality existing among health providers in ZNS which results in indiscriminate attacks on those who are sick or PLWHA.

The participants of the FGDs felt that there was need to decentralise the provision of ART and laboratory services in the ZNS. The current practice is that personnel who require ART and laboratory services have to travel to Lusaka to access ART. This was felt to be a barrier to personnel utilising the services because of the stress of travelling and the risk of being stigmatised at ZNS Headquarters. One respondent stated "the Staff at Administration at Headquarters are very inquisitive as to why you have come. The people want to know why you have come. If you look thin and you enter the DMS's office, colleagues start talking. When you are given a laboratory form to go to MSMH it is even worse because they now conclude that you have AIDS". This is unethical and requires attention if the ZNS want to improve the service.

Another reason stated for the low utilisation of the VCT services was the careless record keeping that was at the clinics making it easy for non-medical personnel accessing records. One participant stated, "Staff at the clinic used the same client medical record for keeping VCT results. These books are left on tables carelessly, thereby exposing the results to people who go to the clinic".

The study also revealed that in 49.4 % of the sites, it was possible to be seen by a professional Counsellor when a client went for VCT. This finding was critical as it demonstrated the great strides that the Military and the country as a whole, had made towards the provision of professional counselling at most of the health facilities. However, various organisations provide counselling training in Zambia which is not monitored. This has resulted in fragmented training that may not be comprehensive and of low standard thereby compromising the field of professional counselling, hence the problem of lack of confidentiality. Currently the Military relies on government and NGOs for training of its personnel in most health-related training including psychosocial counselling.

Seventy four percent (74.3%) of the Respondents also felt that the best time for VCT services was during normal hospital or clinic hours so as not to attract too much attention when one was going for counselling. However, others opposed this view with twenty five percent (25.7%) stating that counselling should be undertaken outside the normal clinic hours. However, in order to improve this scenario the National AIDS Council has provided guidelines for community counselling and

testing. These guidelines released in 2006 allow lay counsellors to provide counselling and testing services within the confines of a clients home and then to link them to care, treatment and support.

It would be prudent for the Military to research this area and analyse the pros and cons of such a service for the improvement of VCT services.

The findings of this study are similar to the findings in the study that was done by Horizons Programme, in conjunction with South Africa's Power Company ESKOM and Development Research Africa in 2002. The research was done on ESKOM workers and was aimed at gaining a more in-depth understanding of workers' perceptions and experiences with the HIV and AIDS pandemic. Findings were revealed in three categories. First category – institutional-level interactions included employee perception, understanding of and experience with workplace HIV and AIDS policies and programmes. Almost a quarter of workers reported a fear of being fired if they had AIDS. The second category – employee interactions that related to physical job requirements – included potential stigma from workers concerned about the ability of HIV-positive workers of infecting HIV negative employees, and about the risks of casual on-the-job contact. Fear of transmission through casual contact was found to be a source of stigma at the workplace. The third category – was based on social interactions that took place at the workplace. This included those that occurred during downtime at work such as during meals or travel. Three quarters of respondents said that HIV positive workers experienced social isolation and nearly half said that they would be subject to rumours, gossip and verbal abuse. These fears likely influenced workers' willingness to undergo VCT or opinions about disclosure of HIV status just like what is happening in the ZNS.

Another study done by WHO and UNAIDS in 2000 in Windhoek, Namibia on "Opening up the HIV AIDS epidemic", concluded that people everywhere have great difficult in openly facing issues involving sex, disease and death. The study concluded that in many countries, the stigma and discrimination surrounding HIV and AIDS adds to the fears that many people who are HIV positive or have AIDS feel about informing spouses, lovers, family, friends, colleagues – and even health providers – about their HIV status. In resource poor countries, particularly, the fear of stigma, lack of treatment options, and the very limited access to VCT have led to only a small number of people voluntarily testing for HIV and then disclosing their HIV status for prevention of transmission or for care and support services.

The study revealed that the fact that only a small number of people know they have HIV and an even smaller number disclose that they are HIV positive to their spouses, has added to the difficulty faced by governments and communities in creating greater awareness of the HIV and

AIDS epidemic, encouraging people to come forward for testing, preventing further HIV infections and accurately monitoring HIV and AIDS, on an on-going basis.

It is now accepted that ARV treatment is an essential component of care and support for people with HIV (WHO. 2001). Additionally, access to ARV treatment offers powerful support for HIV and AIDS prevention. Although it cannot cure HIV and AIDS, ARV treatment has dramatically reduced the morbidity and mortality, prolonged lives and improved the quality of life of many people with HIV (WHO. 2001)

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It is clear that much more needs to be done to "open up" the epidemic so that conditions are created where HIV and AIDS become what they are – a viral infection and related illnesses that deserve, like any similar condition, a response involving compassion, support, respect and access to effective prevention, care and support – for both the infected and uninfected. This will require adherence to principles of confidentiality and informed consent, not only as valid ethical principles but also as pragmatic means by which to engage people in effective prevention and care efforts. At this late stage, but crucial of the epidemic, it becomes ever more important for communities, health authorities, governments and international agencies to work in partnerships to encourage HIV testing and Counselling, disclosure of status, notification of partners, and reporting on the epidemic in appropriate ways. This will involve a significant evaluation of the use of resources, and may involve re-orientation from traditional HIV programmes.

A serious shift must now be taken towards creating a social environment where people can feel confident and safe to test for HIV and inform others that they have HIV. This will mean different sorts of activities, such as public education campaigns on tolerance and non-discrimination, training of care providers, enactment of laws and policies protecting against discrimination, support for community-based services that encourage VCT and follow-up support and promotion of innovative concepts such as "shared confidentiality" and "positive living".

It is time now for countries, Institutions, governments and communities everywhere to move out from the darkness of secrecy into the light of effective individual and community action. This can only be possible if one makes a holistic approach towards the prevention and control of HIV

disease and treat it like any other disease found in the clinics. It should be an approach which is not based on status, cast, creed or colour. Freedom from stigma is the best way to handle the most complicated health situation which saves life.

CHAPTER SIX

6.0 Summary and Conclusion

As part of scaling-up HIV services in the ZNS and indeed in the country, increasing emphasis is being placed on the collection of information to improve patient management and monitoring as well as programme or service monitoring and evaluation. Such data allow individuals to be tracked over time and between places, and enable the development of longitudinal client-level information for clinical management. Client-level information becomes even more important when used for programme or service monitoring and evaluation. This will require information systems, whether paper-based or electronic, which ensure client confidentiality at both the individual and organisation level yet allow relatively easy access to the information.

The findings of this study demonstrated that there were various barriers attributed to the low utilisation of the VCT services in the ZNS but mainly, lack of confidentiality by the service providers. Other contributing factors were the curiosity of Commanding Officers to know the status of the personnel. Lack of a well oriented leadership on HIV and AIDS in the ZNS led to some Commanding Officers and Supervisors in stigmatising and discriminating HIV positive personnel. The study also revealed that the current system of centralised treatment and care of HIV positive personnel has greatly contributed to the barriers in utilisation of VCT services in the ZNS.

The respondents said that the barriers which were preventing VCT utilisation in ZNS Camps were fear of stigma (59.4%), intimidation by Senior Officers (14.8%), dismissal from employment (4.9%) and lack of confidentiality of VCT results by health providers (58%). Respondents felt that VCT services were attached with a lot of stigma and discrimination (70%).

The findings (Table 16) indicate that 345 (57.9%) of the participants felt that health providers did not keep VCT results confidential. This means that health providers violate the principle of confidentiality. The findings (Table 7; page 37) also indicate that despite respondents being aware of the availability of VCT services in ZNS Camps 519 (87%), only 320 (53.7%) knew their HIV status while 276 (46.3%) did not know their HIV status. Because of lack of confidentiality, three hundred fifty four respondents (57.4%) feared that they would be stigmatised if they underwent VCT (Table 17). All these contribute to the reasons why clients do not utilise the VCT services in the ZNS.

The study results (Table 10) illustrate that the majority of respondents stated they would share their HIV positive results with their spouses (57.8%), 76 (12.3%) said they would share with their best friend, 23 (4.4%) said they would share their results only with their parents while 25 (5.0%) said they would share their result with their Supervisor only. These results indicate that 42.2% will hide HIV positive results from their spouses. This poses a problem because if (42.2%) HIV positive spouses hide results they will infect their HIV negative spouses and other sexual partners thereby worsening the burden of disease in the ZNS.

The findings further revealed that although the overall knowledge of HIV and AIDS was very high (97%) and that over 97% of the respondents were aware that VCT services were available in Camps only 74% of the respondents said that they would like to know their HIV status but only 53.7% knew their status. The respondents that knew their status had done the HIV test at government or private facilities.

Focus Group Discussions strongly criticised the centralised structure for ART in ZNS which lacked confidentiality.

Results of the VCT clinic audit revealed that only 77 personnel had utilised VCT services and that only 60 personnel were on ART in the four Camps from 2002 to 2007. The HIV prevalence rate in ZNS is 28.2%. If personnel do not utilise the VCT services and treatment, this rate will continue rising since the HIV infection will not be controlled. The ZNS workforce will continue to suffer heavy morbidity and mortality rates leading to a Security Wing that will be unable to perform their national and international tasks. The crunch will not only be felt by the ZNS but by the country as a whole.

A number of organisational procedures need to be followed in ZNS to ensure safeguards for the collection, transfer, storage, use, dissemination and disposal of personal identified data and other HIV related information. Policies and procedures developed must cover both paper-based and electronic systems.

Whenever possible, release of HIV-related data must be kept to a minimum. A written data policy should exist in ZNS and be reviewed at regular intervals. This needs to define the purpose and uses of HIV data, outline which data elements can be released and for which purpose.

Security breaches and loss of confidentiality on the part of Health providers should be thoroughly investigated and appropriate sanctions imposed.

Despite the major breakthrough the ZNS has made in the field of HIV and AIDS, there is still room for improvement especially in Care and Support for HIV positive personnel. Ensuring that correct leadership on the fight against HIV and AIDS is provided for personnel is of paramount importance for the welfare and morale of Officers and Soldiers.

6.1 Recommendations

Results of this study show that there is discrimination and gross breach of confidentiality in the way HIV and AIDS matters are managed in the ZNS (pages 41 and 42; Tables 17 and 18). According to the Zambia National Policy on the prevention and treatment of HIV and AIDS, all HIV positive patients should be treated equally, just like any other patients seeking treatment at hospitals. The Policy states that HIV patients should not be sidelined or discriminated against because of their HIV positive status. The attitude of health providers in the ZNS is unethical and needs to be changed. Health providers need to develop more friendly and sympathetic attitudes towards those suffering with HIV and AIDS. Sympathetic attitude will generate trust in clients and further motivate clients to utilise HIV and AIDS services that are being provided free in Camps. Given the 28.2% of the prevalence rate of HIV infection in the ZNS, Utilisation of VCT services by personnel will enhance ART which will in turn improve the health of Officers, Soldiers and their families thereby reducing the disease burden for the ZNS. This will lead to a Security Wing that will be fit for national and international tasks.

1. Access to antiretroviral treatment should be scaled up as a key component of the Zambia National Service response to the threat of HIV and AIDS. Treatment must go hand-in-hand with preventive efforts targeted at HIV-positive people. Improving access to treatment may help to reduce stigma, by mitigating fear, which is one of the sources of stigma. Access to treatment also demonstrates that the lives of PLWHA are valued.
2. The ZNS should decentralise ART services and essential laboratory testing services (e,g CD4 Count, Liver Function Test, Haemoglobin test, Full Blood Count etc) in order to ensure equity and fairness of access.
3. In order to increase uptake of VCT, the ZNS should make these services more accessible and user-friendly by providing VCT during and outside usual clinic hours or introducing mobile VCT clinics to enable personnel undergo VCT when it is convenient for them.
4. The ZNS should train VCT and ART managers who are mature and more professional and discreet in their work. They should be people who motivate and inspire their clients that they would not leak their HIV results or other information that may lead to clients being sacked or retired on medical grounds.

5. The ZNS Medical Directorate should work at strengthening follow up care beyond a single post-counselling session to sustain care and support for HIV positive personnel and to prevent infection in the negative personnel.

6. The ZNS Medical Directorate should conduct HIV Sensitisation campaigns in all Camps every month to ensure that personnel are constantly reminded about the threat of HIV and AIDS

7. The ZNS should have a written policy that defines security procedures concerning the way personnel confidential data in the healthcare system is collected, stored, transferred and released. The policies need to be implemented at all relevant levels, and staff must understand the policies and to have signed an agreement stating that they will implement them as part of their work. This will require training new staff and updating all staff on the relevant procedures.

The purpose of defining health information confidentiality and security principles is to ensure that health data are available and used to serve the improvement of health, as well as the reduction of harm, for all personnel, healthy and not healthy. Pursuing this goal involves an on-going process of refining the balance between maximizing of benefits, which can and should come from the wise and fullest use of data and protection from harm, which can result from either malicious or inadvertent inappropriate release of individually identifiable data. Appropriate policies, procedures and technical methods must be balanced to protect both individual and public rights.

8. The ZNS should at all levels of the health care system identify a Confidentiality and Security Officer (CSO) to be ultimately responsible for the confidentiality and security of all HIV information within ZNS.

9. Development and review of confidentiality and security laws and procedures should be done with active participation from relevant stakeholders, including people living with HIV, healthcare professionals, information technology specialists, legal and ethical experts.

10. If old records are to going to be kept, they will need to be stored ensuring full confidentiality and security of HIV information.

11. If HIV information records are to be destroyed, both paper and electronic records should be destroyed, including all data backups.

12. Individuals authorised to access HIV-related information should receive appropriate training and should be responsible for protecting confidentiality. Security breaches and loss of confidentiality should be thoroughly investigated and appropriate sanctions imposed.

13. Security strategies and related laws and policies should be continuously reviewed, independently assessed and changed when required.

14 The ZNS should reduce the time of local Operations from six months to three months and International Operations from one year to six months if the HIV prevalence rate of 28.2% is to be reduced. Six months or one year was too long a time for personnel to be away from their regular, faithful sexual partners.

15. The ZNS should establish a department of research to periodically carry out research in the many areas of need so that social and health problems which affect personnel could be adequately identified and dealt with in order to improve the productivity of the Organisation. The issue of lay Counsellors providing counselling services to personnel in their homes should be researched so that it could be used as another way of providing confidential VCT services which may reduce the fear of stigma and discrimination which have been identified in the current VCT services.

The study findings have proved that there is a big distance between the service providers and the recipients (Soldiers and Officers), that is why accessibility of VCT is poor. This can be best tackled by the Zambia National Service, by wining the confidence of the soldiers with sympathetic gestures.

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NAME OF PARTICIPANT_____ **Date**_____

SIGNATURE OF PARTICIPANT/THUMBPRINT_____ **Date**_____

SIGNATURE OF RESEARCHER_____ **Date**_____

WITNESS_____ **Date**_____

Please use the space below for the right-thumb print if participant is unable to sign the consent.

Signed copies of this consent form must 1) be retained by the principal investigator and 2) given to the participant.

VALID FROM_____**TO**_____

6.3.2 QUESTIONNAIRE

Evaluation of Utilization of VCT services by uniformed personnel in the Zambia National Service Units in Lusaka District

1. Questionnaire No.

2. Location of Unit (tick)

Urban OR Peri- Urban

3. Unit/Camp_____

4. Rank_____

5. Age (tick)

AGE	TICK
18- 30 years	
30-40 years	
40-49 years	

6. Sex (Tick)

MALE ( )

FEMALE ( )

7. Education

PRIMARY

SECONDARY

TERTIARY

8. Marital Status (tick)

Single ( ) **Married ( )** **Divorced ( )**

Widowed ( ) **Separated ( )**

9. Profession (skills) .....

.....

10. Are you aware of VCT services in your Unit? (Tick)

YES ( ) **NO ( )**

11. Would you like to know your HIV status voluntarily (tick)

YES ( ) **NO ( )** **DON'T KNOW ( )**

12. Do you know your HIV status? (Tick)

YES ( ) **NO ( )** **DON'T KNOW ( )**

13. If no, please give reasons.....

.....

14. If yes, who have you shared results with (You may Tick more than one answer)

Shared with Spouse ( )

Shared with best friend only ( )

Shared with parents only ( )

Shared with Supervisor ( )

15. Were you attended to by a trained Counselor when you underwent VCT at the private or government clinic you went to?

YES ( ) **NO ( )** **DON'T KNOW ( )**

16. Do you think that you have adequate knowledge about HIV and AIDS to be able to protect yourself against HIV and AIDS infection (What HIV and AIDS is, its mode of transmission and its effect on the human being)?

YES ( ) NO ( ) DON'T KNOW ( )

17. Where should VCT be conducted? (tick)

- Camp Hospital/ Camp Clinic ( )

- Outside Camp Hospital/ Camp Clinic ( )

18. If outside Camp Hospital/Camp Clinic, suggest where you would like VCT to be done?

.....

.....

19. What time do you think is best for carrying out VCT? (tick)

During normal Hospital/Clinic hours ( )

Outside normal Hospital/ Clinic Hours ( )

20. Is VCT attached with stigma and discrimination? (tick)

YES ( ) NO ( ) DON'T KNOW ( )

21. Do health workers keep VCT results confidential (tick)?

YES ( ) NO ( ) DON'T KNOW ( )

22. If no, suggest ways of improving confidentiality

.....

.....

23. What do you think are reasons why uniformed personnel do not go for VCT (tick one or more)?

Fear of stigma	( )
Fear of intimidation by Senior Officers	( )
Cultural beliefs	( )
Lack of motivation	( )
Fear of dismissal	( )
Superiority complex	( )
Job insecurity	( )
Any other	

.....

.....

24. Do you think HIV positive or chronically ill personnel are ridiculed, persecuted, threatened with dismissal or discriminated against in ZNS (Indicate YES or NO). You may pick more than one answer)

- **Ridiculed** ( )
- **Persecuted** ( )
- **Threatened with dismissal** ( )
- **Discriminated against** ( )
- **Non of the above** ( )

25. Do you think ZNS has adequate administrative structures to support the HIV/AIDS Programmes (Such as HIV and AIDS Policy, Legal services, adequate manpower and VCT centers)?

YES ( ) **NO** ( ) **DON'T KNOW** ( )

26. Do you think ZNS is doing enough in the prevention of HIV and AIDS infection for personnel? (tick)

YES ( ) **NO ( )** **DON'T KNOW ( )**

27. If no, suggest what else the ZNS should be doing in the prevention of HIV and AIDS.

.....

.....

.....

.....

28. Do you think the ZNS provides adequate Care and Support for people living with HIV and AIDS? (tick)

YES ( ) **NO ( )** **DON'T KNOW ( )**

29. If no, suggest what the ZNS should be doing for people living with HIV and AIDS

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30. Are you on ART?

YES ( ) **NO ( )** **DON'T KNOW ( )**

31. Is it easy for you to access laboratory services and ARVS/ART in the ZNS?

YES ( ) **NO ( )** **DON'T KNOW ( )**

32. If no, suggest ways in which the ZNS can make it easy for personnel to access laboratory services and ARVS/ART

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33. Any other comments?

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THANK YOU FOR YOUR PARTICIPATION