

**THE UNIVERSITY OF ZAMBIA
SCHOOL OF MEDICINE
DEPARTMENT OF POST BASIC NURSING**

**THE ATTITUDE AND UTILISATION OF VOLUNTARY
COUNSELLING AND TESTING FOR HIV BY MARRIED
MEN IN GWEMBE DISTRICT**

BY

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To all, I say may the good Lord richly bless you.

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LIST OF ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
BCC	Behavioural Change Communication
CBoH	Central Board of Health
CRAIDS	Community Response to HIV/AIDS
CSO	Central Statistical Office
DATF	District AIDS Task Force
GIMA	Greater Involvement of Men living with or affected by HIV/AIDS
HIV	Human Immune Deficiency Virus
IEC	Information Education and Communication
KAMU	Kubeleka Aba Muchala
STI	Sexually Transmitted Infections
TB	Tuberculosis
UNAIDS	Joint United Nations Programme of HIV/AIDS
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation
ZANARA	Zambia National Response To HIV/AIDS

DECLARATION

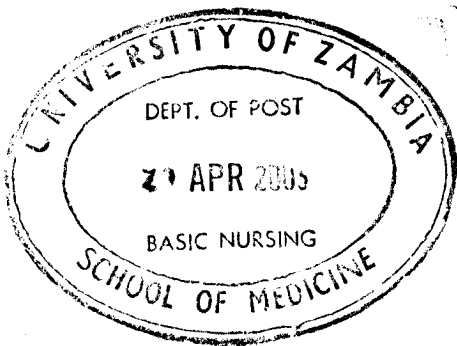
I declare that with the exception of the assistance acknowledged, the work presented in this study for Bachelor of Science in Nursing Degree is the result of my own studies. This work has not been presented either wholly or in part for any other Degree and is not being currently submitted for any other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

Signed: 
CANDIDATE

Date: 02/04/07

Signed: 
SUPERVISING LECTURER

Date: 02/04/07



STATEMENT

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

Signed: *Misheck Mbewe*
CANDIDATE

Date: 02/04/07

DEDICATION

This research study is dedicated to my mum, Esther Mwanza Mbewe.

ABSTRACT

Voluntary Counselling and Testing is important in promoting behavioural change and helps maintain good lifestyles among those who test positive and enhance positive living. Married men who do not utilize the service are bound not to change their behaviour. Failure to target married men (who interact with women as husbands and girls and boys as fathers and educators) in voluntary counselling and testing for HIV has led to many HIV/AIDS interventions not to produce good results.

The study was aimed at determining the attitude and utilization of voluntary counselling and testing services by married men in Gwembe District and with a view to encourage married men to go for voluntary counselling and testing in order to prevent HIV/AIDS and promote behaviour change. Literature from various scholars, globally, regionally and nationally was reviewed on the attitude and utilization of HIV voluntary counselling and testing by married men and other related literature.

A pilot study was conducted in Lukonde ward of Gwembe District and it consisted of one tenth of the total sample for the main study. For the main study, a descriptive study design for both qualitative and quantitative dimensions was used. The study population was married men. A convenient sampling method was used to select the sample population. The study was conducted in Jongola/Khoma and Chibuwe wards in Gwembe District. Data was collected using a structured interview schedule from fifty (50) respondents and later analysed manually by use of data master sheet and a scientific calculator and it has been presented in tables, cross-tabulations, pie charts and bar charts.

The research findings revealed that majority (88%) of respondents had high knowledge on HIV/AIDS and VCT and (12%) had low knowledge. However, majority (76%) of the respondents had negative attitude towards HIV voluntary counselling and testing. Twenty four percent (24%) of the respondents had positive attitude towards the service. The findings also

revealed that 74% of the respondents had poor utilization of VCT, while only 26% had good utilization of the service.

Study findings revealed that most (40%) of the respondents were in the age group 25-34 years and 61% among those respondents with negative attitude towards VCT had primary level of education. Furthermore, the study revealed a relationship between education level of respondents and their attitude towards VCT. There was a larger proportion of the respondents with secondary education (83%) who had a positive attitude than those with primary education (17%). Furthermore, a large proportion of the respondents with negative attitude had primary education (61%) than those with secondary education (21%).

The study findings further revealed a strong relationship between the level of knowledge of HIV and attitude towards VCT by the respondents. The study findings show that all (100%) the respondents with positive attitude towards VCT had high level of knowledge on HIV/AIDS and VCT, while among those with negative attitude 84% had low level of knowledge. There was no relationship between respondents' utilization of VCT and their level of knowledge on HIV/AIDS and VCT. The study results revealed that among the respondents with poor utilization of VCT services, majority (86%) had high level of knowledge, while among those with good utilization most (92%) them had high level of knowledge.

There was a relationship between utilisation of VCT and the attitude of respondents towards VCT. Out of the respondents with negative attitude towards VCT services, majority (92%) had poor utilization of the service. While those with positive attitude most (62%) of them had good utilization.

Although the findings of the study show an increase in knowledge of HIV/AIDS and testing sites by married men, this is not accompanied by a correspondingly increase in the percentage of respondents who have been tested for HIV. Therefore, there is need to increase the uptake of VCT by married men so that the majority of them undergo HIV test.

The major recommendations in view of the study are:

- Gwembe District Health Office should support its staff in terms of allowances and transport in order for them to continue disseminating the information on HIV/AIDS and VCT and door-to-door VCT should be conducted.
- The Ministry of Health should provide a vehicle to the District Health Office to assist in conducting mobile VCT in the whole district.
- Churches should be involved in the dissemination of VCT information in the district

CHAPTER ONE

1.0 INTRODUCTION

1.1 Background

Human Immune Deficiency Virus infection/Acquired Immune Deficiency Syndrome (HIV/AIDS) is a social global problem. The total number of people living with the Human Immunodeficiency Virus (HIV) rose to reach the highest ever-in 2004, with an estimated 39.4 million people worldwide living with the virus. The 4.9 million of these were new infections acquired in 2004 alone. The mortality from the AIDS pandemic in 2004 was estimated at 3.1 million globally (Joint United Nations Programme on HIV/AIDS (UNAIDS), 2002). In ASIA and Eastern Europe HIV/AIDS has affected the countries where the HIV virus was hardly present, for example China, Indonesia and Vietnam. In China it is estimated that 10 million people could be living with HIV within the next six years unless the infection rate is curbed. In Eastern Europe HIV infection is focused on young people who inject drugs and their sexual partners (International HIV/AIDS Alliance Asia and Eastern Europe, 2006).

The sub-Saharan African region is by far the worst affected in the world, with an estimated 25.4 million (23.4 million-28.4 million) people living with HIV by the end of 2004 (UNAIDS, 2002). Since the beginning of the epidemic, more than 15 million Africans have died from AIDS and during 2005 an estimated 2-4 million adults and children died as result of AIDS in Sub-Saharan Africa (AVERT.ORG, 2006). According to Stibbard (2006), the HIV/AIDS prevalence rate in Southern Africa stands as follows: Botswana (38.8%), Lesotho (31%), Zimbabwe (33.7%), Namibia (22.5%), Zambia (21.5%), Malawi (15%) and South Africa (13%). HIV/AIDS is now the leading cause of death in Sub-Saharan Africa. The region's highest level of poverty in the world renders the fight of the pandemic very difficult. As the number of people who fall ill and die from AIDS increases, it creates an impact on

demographic, household, health sector, educational, work place and economic aspects of life.

HIV and AIDS epidemic in Zambia

Zambia is a third world country located in the sub – Saharan region of Africa. It is a land locked country covering an area of 752, 62 kilometres which is about 2.5% of the total space area of the continent of Africa (Central Statistical Office, 2003). It shares borders with the Democratic Republic of Congo (DRC) and Tanzania in the north, Malawi and Mozambique in the east, Zimbabwe and Botswana in the south, Namibia in the south - west and Angola in the west (Central Statistical Office, 2003).

Zambia has a population of 10.3 million people growing at 2.9 percent per annum (Zambia Demographic Health Survey Report, 2001-2002). Majority of Zambians are poor and the situation has further been worsened by the HIV epidemic. At the end of 2003, between 730,000 and 1.1 million Zambians were living with HIV/AIDS. Zambia's HIV/AIDS national prevalence rate stands at 15.6% among adults aged 15 to 49, and one out of five in this age group is HIV infected (National HIV/AIDS/STI/TB Council, 2004). Male HIV prevalence is highest among those aged 35-39. Only in the older age groups is the proportion of HIV- infected men higher than the proportion of HIV-infected women (National HIV/AIDS/STI/TB Council, 2004). The 2001-2002 Zambia Demographic Health Survey reported that out of 2,073 women and 1,734 men aged 15-46 who tested for HIV, 17.8% women and 12.9% men were HIV positive (Central Statistical Office, 2003). The social impact of the pandemic of HIV and AIDS has led to a number of children remaining as orphans with no parental care forcing most of them into the streets. There are about 620,000 orphans due to HIV/AIDS with about 6 percent of these on the streets and only 1 percent in orphanages (National HIV/AIDS/STI/TB Council, 2004). Southern province has the second highest HIV prevalence rate from Copperbelt and Lusaka provinces of Zambia. HIV prevalence rate in

Southern province is at 18% (National HIV/AIDS/STI/TB Council, 2004).

Many reasons have been cited for fuelling HIV/AIDS in Zambia such as high poverty levels, limited resources for prevention and care, gender inequality, denial, stigma and discrimination (University of Zambia Medical Library Med Guide, 2006). The scourge has literally impacted negatively on individuals, families and community. The majority of those infected and affected are in their prime of their productive and reproductive years and in most cases are sole breadwinners of families.

In order to address the HIV/AIDS epidemic issue, Voluntary Counselling and Testing (VCT) is being recognised as a crucial component of effective strategies for HIV/AIDS prevention and care (International HIV/AIDS Alliance Asia and Eastern Europe, 2006). If implemented properly, VCT has the potential of providing multiple benefits. For the individuals, VCT provides an opportunity to enhance one's ability to reduce risk and increase one's access to HIV prevention, care, treatment and support services. For communities, VCT is a means to create awareness, mobilise local resources and reduce denial, stigma and discrimination. VCT provides a link between prevention and care (International HIV/AIDS Alliance Asia and Eastern Europe, 2006). However, VCT initiatives have been slower to develop in Asia and Eastern Europe and have not been adequately prioritised in the past and this has led to a significantly low demand for and poor use of available VCT services (International HIV/AIDS Alliance Asia and Eastern Europe, 2006).

In Zambia, VCT services were established on a larger scale in 1999 with a view of providing quality and friendly counselling and testing services on the same day. It was initiated with the establishment of 21 pilot sites evenly distributed in each of the nine provinces of Zambia. An expansion phase was then undertaken with lessons and

experiences learnt from the pilot. By January 2006, 485 counselling and testing centres were established in all the 72 districts of Zambia. Counselling and testing services have become an important entry point for prevention, care and support in Zambia (National HIV/AIDS/STI/TB Council, 2006).

On the other hand, VCT services at Gwembe District Hospital were implemented in 2005 and since then, outreach VCT programmes are being carried out in the District. However, the statistics at Gwembe District Hospital VCT Centre show that more females than males utilise VCT services (Gwembe District Hospital, 2006). Apart from the District Hospital providing VCT services, Muzeyi VCT programme, which is run by the Roman Catholic nuns in Munyumbwe area of Gwembe District, also provide counselling and testing services and its returns are submitted to Gwembe District Hospital. The District has also programmes like the Community Response to HIV/AIDS (CRAIDS) initiative, which is funded by the Zambia National Response to HIV/AIDS (ZANARA). This programme aims at improving the nutrition status of people living with HIV/AIDS through provision of food supplements. It also encourages people to go for VCT through Information, Education and Communication. Other stake holders in the District that are addressing the issue of HIV/AIDS include the Churches, the Gwembe Tonga Project and the “Kubeleka Aba Muchala” (KAMU) Project. These organisations also encourage people to go for VCT and support those on antiretroviral drugs.

1.2 Statement of the problem

Despite the efforts by the government and other non-governmental organisations implementing VCT services to prevent the spread of HIV, men, especially those that are married have a negative attitude to utilisation of the service.

According to National HIV/AIDS/STI/TB Council, (2004), most adult Zambians have never been tested for HIV despite its importance in

controlling the HIV/AIDS. The goal for the National HIV/AIDS intervention strategic plan was that at least 25% of adult Zambians know their HIV status by 2005. The Zambia Demographic and Health Survey, 2001-2002 reported that 9% of men, married men inclusive and 14% of women had ever been tested (Central Statistical Office, 2003). Testing is more common in urban areas than in rural areas and also more common among the better educated (National HIV/AIDS/STI/TB Council, 2004).

VCT is important in promoting behavioural change and helps to maintain good lifestyles among those who test positive and enhance positive living. Men who are married and who don't utilise the service are bound not to change their behaviour. Those who are HIV positive and don't know their status, may not live a positive life (Central Board of Health, 2002). The resultant would be that they would infect others and also get infected. Worse is in a society like Gwembe District where polygamy is being practiced. The statistics at Gwembe District Hospital VCT Centre showed that from third quarter 2005 to first quarter 2006, 359 clients who are married had utilised VCT services. Sixty six percent (66%) of those who attended VCT during the same period were women and only 34% were men who are married. The negative attitude towards VCT by married men may eventually lead to an increase in morbidity and mortality among the fathers who are in most cases the breadwinners of families. This means that there would be more orphans and street children. VCT can help married men know their HIV status and in turn, they would take measures to keep themselves healthy and reduce the risk of transmitting HIV to others. The knowledge that married men acquire from attending VCT services can also be used to teach their families about the dangers of HIV/AIDS.

1.3 Factors influencing the attitude and utilisation of HIV VCT by married men

Several factors may influence the attitude and utilisation of voluntary counselling and testing for HIV by married men. These include socio-cultural and service related factors.

1.3.1 Socio-cultural and economic factors

The attitude and utilisation of VCT by married men may be influenced by the fear of testing positive and the stigma and rejection that are attached to it. They may feel that if they go for VCT and test HIV positive, they will be blamed by their families, wives and community and probably experience marriage breakdown. Furthermore they may feel that they may be rejected and not supported socially by their families and wives. Men's fear of having their HIV status checked might be further increased by the general blame by society that they are drivers of HIV (University of Zambia Medical Library Med guide, 2006). They may also fear to go for VCT thinking that if their HIV test results came out positive their self-esteem would be undermined by the outcome and therefore may no longer feel as men.

Some men who are married may be aware of their risk of contracting HIV due to the fact that they have several extramarital affairs in which during sexual intercourse with their lovers do not use protective measures such as condoms. Therefore, for this reason they fear going for VCT. In other men, the reason for not going for VCT could be attributed to their ignorance of HIV/AIDS and VCT, which makes them not to appreciate the service as they think there is no HIV. Furthermore, some of the married men have not passed through school and this is a barrier for them to getting adequate information about the dangers of HIV and its interventions, hence may not see the need to go for VCT. On the contrary, those that have passed through certain levels of education or have been to school have access to information on VCT because HIV topics are incorporated in many educational curricula and it gives them a better advantage to accessing

these services because they are better informed. Furthermore, they are able to get more information about VCT from literature and posters since they are able to read.

The other factor that may influence the attitude and utilisation of VCT by married men is the fact that they may be busy working in order to earn a living for their families since most of them are bread winners. Hence they may feel there is no need to go and waste their time on VCT. Furthermore, they may also think that if a spouse or partner tests for HIV then it's enough.

1.3.2 Service factors

Countrywide there are services set up that offer counselling and testing. In Gwembe District there are two centres where one can access these services. These are places where married men can get information on HIV counselling and testing and have a test done on them. These services must be readily available and accessible and must be convenient to men. Various factors can affect accessibility of these services. Clinic working hours may be unsuitable for the men. For example, Gwembe VCT centre only operates from Monday to Friday from 08:00 hours to 16:00 hours every day. Most of the men may prefer weekends due to their busy schedule during working days. Distance is another factor that may hinder men from accessing VCT services. For instance, those married men who stay very far may not be willing to walk long distances to the centre. Long waiting hours before a client is attended to by a health worker or counsellor is another factor contributing to married men shunning visiting counselling centres. At Gwembe VCT centre, there is normally one counsellor attending to clients and so if clients are many they have to wait for too long before they are attended to. Poor infrastructure of the VCT centre, which doesn't even provide privacy to clients, further hinders these men from utilising the services. For instance, the VCT centre at Gwembe District is only an office next to the Maternal and Child Health department and there is no waiting room for clients. This therefore may

compromise privacy and for this reason clients may shun VCT services.

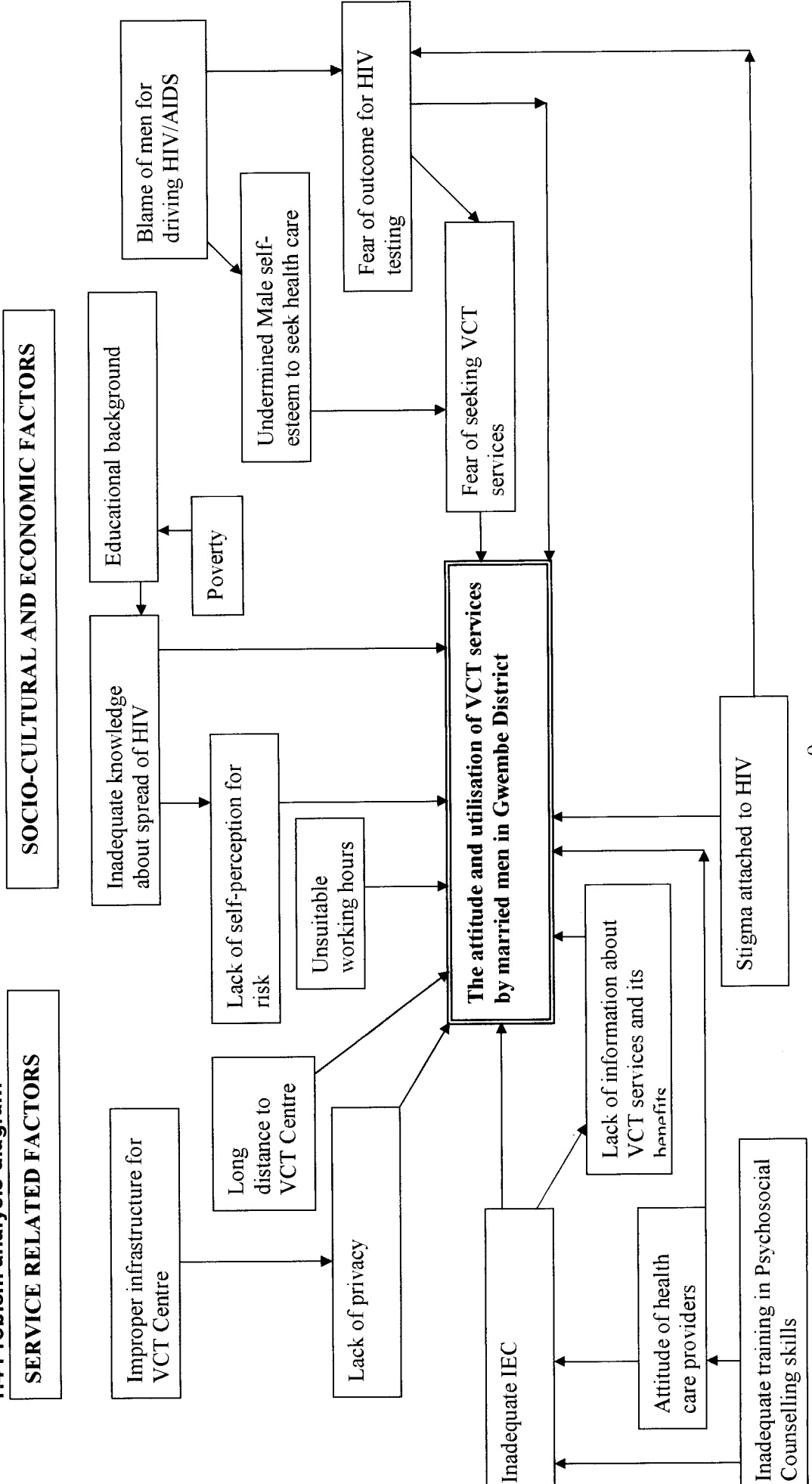
The attitude of health care providers may influence the accessibility of VCT services by married men either positively or negatively. If health care providers assume a condemnation attitude and show no respect and dignity, married men will never go to seek help or information from these centres. Another influencing factor to the attitude and utilisation of VCT by married men may be the way the counsellor provide information to clients during counselling sessions. If the health care providers hurry in giving the information, this may put off these men. At times the married men may not be very sure as to whether the counsellor or health care provider may keep confidential the information they are given. Therefore, this feeling of clients might contribute to a negative attitude towards the services.

Health care providers training may have a bearing on the quality of HIV voluntary counselling and testing services provided and this may influence the attitude of married men toward VCT. A staff that is not adequately trained in the counselling skills may not know how to handle a couple or married men. This may lead to loss of confidence and lack of trust in these counsellors. Gwembe VCT centre has adequate counsellors, however most of them are mostly committed to clinical care duties where there is a shortage and this may impinge on the quality of VCT services offered. Sometimes health care providers may not put much effort in sensitising the communities about the availability of HIV counselling and testing services. For this reason married men may lack information about the availability of VCT services and hence may not access them.

The social life of the counsellor could be another factor that may influence married men's attitude and utilisation of VCT. For instance, if the counsellor is known to be promiscuous, then clients will have no confidence and trust in him or her.

Figure 1

1.4 Problem analysis diagram



1.5 Justification of the study

HIV/AIDS in Zambia is increasingly affecting adults mostly between the age group of 15 to 49 years. This is the productive and reproductive age group. The HIV/AIDS epidemic has negatively impacted the social and economic spheres of the Zambian society and has contributed to the reversal of many of the development gains that were achieved before its advent. According to the National HIV/AIDS/STI/TB Council (2005), gender issues that perpetuate the dominance of male interests and lack of self-assertiveness on the part of women in sexual relations put both men and women at risk. Women are taught never to refuse sex with their husbands regardless of the number of extra-marital partners he may have or his non-willingness to use condoms. This is often the case even when he is suspected of having HIV or other STIs. For this reason, married men are supposed to be the key target in the prevention of HIV/AIDS.

Voluntary counselling and testing is the entry point for HIV prevention and care. The bulk of the studies on HIV/AIDS and its interventions have focused on women, girls, young men, and few on men in general but none have been done on married men to determine their attitude and utilisation of VCT. Married men are seen to be some how perpetuating HIV and at the same time having a negative attitude towards HIV interventions.

Many HIV/AIDS interventions are not producing good results because married men who are assumed to be driving HIV are not targeted. It is assumed that by knowing married men's attitude and utilisation of VCT service, the study will help to find ways of increasing their VCT attendances in VCT Centres. This can be done through incorporating other stakeholders such as churches and men's work places. This intervention would in turn reduce mortality from AIDS related opportunistic infections in the men and thereby reducing the numbers of orphans in the streets.

It is hoped that the findings of this study will help policy makers, health care providers and stakeholders formulate policies that will target men in VCT programmes such as door-to-door HIV/AIDS campaign and mobile VCT.

1.6 Research objectives

1.6.1 General objective

To determine the attitude and utilisation of VCT services by married men in Gwembe District.

1.6.2 Specific objectives

1. To determine the knowledge of married men about VCT.
2. To determine the attitude of married men towards VCT.
3. To assess married men's utilisation of VCT.
4. To establish factors that lead to non-utilisation of VCT services by married men.
5. To identify areas related to HIV/AIDS VCT for further research.
6. To make recommendations to relevant authorities for implementation.

1.7 Hypotheses

1. Married men who are educated have a positive attitude towards voluntary, counselling and testing of HIV.
2. Married men who are educated are likely to utilise VCT services than those married men who are not.

1.8 Operational definitions

Attitude: Positive or negative feelings about VCT services and consists both cognitive and affective aspects of feelings and perception.

Utilisation: Ability of a married man to at least attend voluntary and counselling session.

Knowledge: Level of understanding or awareness of VCT.

Key person or target audience: People who share common characteristics related to the spread of HIV, e.g. a particular risk behaviour, membership of specific institution or reference group or location in a particular geographical area.

Population density: The concentration of a population in a certain geographical area.

Married men: male persons who have a wife or wives.

Voluntary Counselling and Testing: This is when clients willingly go for HIV testing after they have been helped by a health care provider to make such a decision.

Human Immune Virus: This is the virus that causes HIV infection and AIDS.

1.9 Variables and cut off points

Table 1: Variables and cut off points

VARIABLES		QUESTION NO.	SCALE OF MEASUREMENT	
			INDICATOR	CUT OFFPOINTS
1	DEPENDENT Utilisation	27, 30, and 33.	Very good Good Poor	Married men who go for VCT, are counselled, tested for HIV and collect the results. Married men who go for VCT are counselled but decline to be tested for HIV or tested but do not collect the test results. Married men who have never gone for VCT.
	Attitude	16, 20, 22, 24 and 25	Positive Negative	Married men view VCT as having benefits Married men view VCT as having no benefits
2	INDEPENDENT Knowledge	5 to 13	High Low	5 to 9 points 0 to 3 points
	Educational level	3	Highly educated Educated Lowly educated Not educated	Tertiary education Secondary Primary Never been to school

CHAPTER TWO

2.0 LITERATURE REVIEW

2.1 Introduction

There are numerous research studies that have been conducted world wide, in Africa and in Zambia to demonstrate that Counselling and Testing and knowledge of one's serostatus encourages clients to reduce risky behaviour. However, there is also need to conduct studies to determine the attitude and utilisation of VCT services by married men. The need to explore married men's attitude and utilisation of VCT services is crucial in increasing VCT attendances at Voluntary Counselling and Testing Centres and prevent further spread of HIV in the population. Men who are married can be the key people in the prevention of HIV/AIDS because they are among the target audiences who are important in the prevention of HIV/AIDS. There is need for services required to support behaviour change such as provision of HIV VCT (World Health Organisation, 1989). It is against this background that literature on the attitude and utilisation of HIV VCT by married men should be reviewed.

The purpose of literature review is to determine what is already known about the topic being studied so that a comprehensive picture of the state of knowledge on the topic can be obtained. It also gives the researcher clues to the methodology and instruments that people used before and therefore provide information on what has been tried in regard to approaches and methods and what types of data collecting instruments exist and do not work. It also helps the researcher to refine certain parts of the study (Fisher and Foreit, 2002). The literature reviewed is presented and discussed from the works of various scholars from around the globe. The literature is arranged in three parts; global perspective, regional perspective and national perspective.

2.2 Global perspectives

Globally, Voluntary Counselling and Testing of HIV has been accepted as a key factor in the prevention of HIV and it is an entry point to care, prevention and support. Several studies on VCT have been done in special populations such as women, adolescents, young men and men in general about their attitude towards the service. All these studies point to VCT as a cost-effective intervention to prevention of HIV transmission.

2.2.1 Knowledge

Knowledge of HIV/AIDS and VCT by married men is very vital in the fight of HIV/AIDS epidemic. According to Greig (2005), engaging men in achieving gender equality, sexual and reproductive health in the past decade have been translated into many programmes on all continents. Condom education, distribution and VCT initiatives exist in virtually every country and have led to high levels of knowledge among men. Links between gender and inequality, sexual vulnerability and HIV pandemic have spurred a dramatic increase in HIV prevention efforts targeting men's sexual behaviour and the utilisation of VCT centres (Greig, 2005).

2.2.2 Attitude

A case study done by United Nations programme on HIV/AIDS (2001) entitled Greater Involvement of Men living with or affected by HIV/AIDS (GIMA) revealed that the programme has encouraged employment by non-governmental organisations of persons living with HIV/AIDS including men who are heads of homes. This has been accomplished by building skills and confidence among HIV positive clients. While there is no hard information on this, programme staff have observed that the HIV-positive male employees have gained knowledge and skills that have enabled them to change their attitudes and behaviours, while improving their quality of life. Some have become role models in society by "living

positively” and productively, by their involvement in providing care to both fellow men and females and as speakers prepared to give public talks about HIV/AIDS and advantages of VCT. The above study shows that involving men in formal jobs including those married men with HIV/AIDS makes them live positively and talk about it which may help other men change their negative attitude towards the utilisation of VCT services.

2.2.3 Utilisation

Awareness of one’s serostatus is very crucial in the prevention and transmission of HIV. A report by Gilks et al (1998) indicates that men living with HIV are unaware of their HIV status because the majority of the infections have been recently acquired and few seek VCT services. In Thailand and to a lesser extent Cambodia and part of urban India, the epidemic has been in place long enough for HIV/AIDS care to have become a specific issue, but disease data are very limited. Counselling and testing among the males have been piloted in most areas and male trainers in psychosocial counselling trained. How effective such services are is not well documented (Gilks et al, 1998). Therefore, there is need for health care providers to increase awareness of HIV/AIDS in the male folk through door-to-door campaign and mobile VCT.

A report prepared by Sternburg and Hubley (2005) indicates that evidence from many VCT services targeting men show that it is not enough just to offer a service and expect men to use it. The service must be tailored to meet their needs and efforts need to be made to reach out to them. Many HIV/AIDS and VCT programmes that target adult men use their work place as the prime site. Focus for interventions for men include transportation, mining, the military and fisheries. Several strategies applied at the work place or in other settings seem to have promising results on male involvement in VCT. A programme in Honduras used two strategies. One involved training agricultural extension workers to give IEC

sessions on the importance of VCT to their male clients; the other extended an agricultural programme, the “farm management plan”, into areas of VCT training among men through the use of HIV/AIDS booklet. Therefore, the above report shows that there is need to increase male utilisation of VCT through training and giving them IEC in their work places or where ever they are found.

A report done by Sadrizadeh (2006) outlines the main objectives of prevention and control of HIV infection in Iran, to be the prevention for the transmission of HIV infection among males and females, and to promote the utilisation of VCT centres. Strategies for prevention include promotion of safer sexual behaviour including the use of condoms, proper Sexually Transmitted Infection (STI) case management with emphasis on syndromic approach, ensuring safety of blood and blood products, demand and harm reduction in drug abuse, and universal precautions at health care settings. Attention is also being paid to increase the male utilisation of VCT services, with particular attention being given to the client’s human rights and dignity, and avoidance of any form of discrimination. A behavioural surveillance is being carried out to monitor the attitude of males towards VCT.

2.2.4 Factors influencing the attitude and utilisation of VCT by men

A report by Gilks et al (1998) noted that in some countries such as India and Pakistan there is considerable stigmatisation and discrimination. For this reason, people including the married men are reluctant to discuss openly either their HIV status or their particular care needs such as VCT. In others, most noticeably Thailand, there is much more openness and frankness about HIV/AIDS and the utilisation of VCT services at all levels of society, which has greatly assisted the implementation of effective prevention-and-control measures. However, Gilks et al (1998), noted that there appears to have been little effective integration of

care with prevention in South and South East Asia. Such integration of services should be a priority in those communities which suffer high levels of stigmatisation and discrimination and where much can be gained by improving uptake of specific prevention initiatives among men such as intensifying information, education and communication (IEC) on the importance of VCT for HIV.

In a related study done by Verma, et al (2005), it was found that in India, the HIV epidemic is growing, and more than five million people are estimated to be living with HIV and AIDS. He indicated that a key factor contributing to the increasing number of people living with HIV in that country is societal norms that keep women's status low in the home and community and foster men's greater control over resources and decision making. There is increased awareness of the role that inequitable gender norms play in HIV and violence, yet few studies have attempted to influence these norms and measure change in both norms and risk behaviour due to an intervention. The intervention that may change risk behaviour norms of men may include intensifying information education and communication (IEC) on the utilisation of VCT centres by men. Therefore if men acquire this information, they may develop a positive attitude, which may lead them to utilise VCT services. Verma further noted that trained peer educators from low income communities conducted a total of fifty one (51) IEC sessions with young men in the age group sixteen to thirty years on the importance of VCT. This also may have helped men have a positive attitude towards VCT.

2.3 Regional perspective

Most of VCT services in the sub-Saharan Africa have not been well utilised by the people despite the governments and non-governmental organisations' efforts to make the populations be aware about the HIV pandemic. The reason could be that the

campaigns mainly are not targeted on the key population that seem to perpetuate the infection. Married men are not targeted in the fight for HIV and therefore seem to have a negative attitude towards the use of VCT services (World Health Organisation, 1989).

2.3.1 Knowledge

Another report by Medreck (2003) indicates that HIV/AIDS is fast becoming the number one threat to Ethiopian men. Although a relatively large proportion of men have heard of AIDS, specific knowledge about the infection is limited. This has negative implications for adopting safe practices to avoid contracting HIV/AIDS and to help contain the spread of the infection. He reported that much improvement is needed in educating men about HIV/AIDS and in publicizing the risk factors associated with HIV infection. He further reported that Programs should be implemented in health care centres to expand voluntary counselling and testing (VCT) services, to encourage men to go to these centres for testing, and to provide follow-up care for those who tested positive. The general public and especially religious leaders need to be co-opted into designing programs to educate men, that would at the same time tackle some of their own inherent biases about the infection and be a helpful self-educating process, he said. Medrek further reported that the Ethiopian government had taken some initial encouraging steps to address and combat the spread of HIV/AIDS and the utilisation of VCT among males. At the same time it was reported that disclosure and openness to VCT services by men is minimal.

2.3.2 Attitude

A report was prepared by Castle (2003) on a qualitative research carried out in Mali with a view to setting up HIV voluntary testing and counselling (VCT) services and a separate programme to enable men to improve their sexual health. The most striking finding was that a large number of male respondents said they did not

believe in the existence of AIDS. Reasons for disbelief were related to the perceived lack of AIDS cases in China, the inability of the virus to be transmitted by mosquitoes and confusion about mother-to-child transmission. Highly educated males were very sceptical of the existence of the illness, thinking it to be a Western plot to encourage condom use in order to halt the growth of the African population. Those men who were more likely to believe in the existence of the illness were less educated or uneducated who had personally seen someone sick with AIDS. Researchers thought it likely that this scepticism will limit the use of VCT services by men. Other reasons for the potential non-use of services included the fact that some men lacked confidence in the competence of the laboratory technicians and were afraid that those testing positive would be highly stigmatized by the community. The perception portrayed by the subjects of the above research towards AIDS could be similar to that of married men in Gwembe district. Men who are educated may doubt the existence of AIDS, while the uneducated men who had a chance of nursing relatives or friends with HIV/AIDS in the district may believe that AIDS exists

2.3.3 Utilisation

A Post-Campaign Evaluation study in Uganda by Population Services International (2003) focused on increasing the awareness and use of VCT particularly among couples. The study showed that over 95% awareness of VCT was generated and those who reportedly used the service, 89% of males and 94% females admitted to having changed sexual behaviour. Regarding measures adopted in changing sexual behaviour, 71% reported being faithful to one partner while 29%, 27% and 22% reported starting condom use, reduced number of partners and abstinence respectively. Of those who reported using VCT as couples, 50% did so as a means of fostering trust and faithfulness, while 20% were either getting married or planning a family. Of those who did not test with partners the biggest percentage at 38% were men who reported not wanting

their partners to know their status. General barriers for VCT use were given as 51% low risk perception, fear of public opinion and 28% of male respondents reported having fear of positive result. 64% of non users reported interventions to use the service in future" (Population Services International, 2003). Continuous sensitisation of men on the importance of VCT will enable them utilise the service. The sensitisation campaign may be done door to door where married men can be reached and so the service may be utilised.

An article by Abraham (2005) states that more men need to be encouraged to go for VCT in South Africa. This is because statistics show that only a small percentage of men go for Voluntary Counselling and Testing (VCT) of HIV. This is despite the efforts by a number of organisations in Johannesburg and its partners want to change the negative attitude towards VCT utilisation among the males. He further reports that a seminar whose theme was "Men as partners, Increasing men's utilisation of HIV services", was held at the Chris Hani Baragwanath Hospital in Diepkloof, Soweto, on 21 July from 1pm to 4pm. In that seminar topics were presented, and ways to persuade more men to go for voluntary counselling and testing were sought. In the same year a survey of 2 500 men and women between the ages of 15 and 34 in Soweto found that only 28 percent of men had been tested for HIV/AIDS, compared with 55 percent of women.

"We are hoping to apply the research to understand better why men do not undertake testing," said Andrew Levack, a consultant at Engender Health. "We want to use the information to devise better interventions to persuade more men to go for HIV testing". "We hope that through the programme we will be able to encourage more men to utilise City of Johannesburg VCT services," (Abraham, 2005).

According to the above report, there is need to devise some programmes that will increase male utilisation of VCT through IEC, drama, media, and posters.

2.3.4 Factors influencing the attitude and utilisation of VCT by men

Stigmatisation and discrimination may be a major factor contributing to married men in Gwembe district having a negative attitude towards VCT services. Distance also might be a contributing factor to married men not utilising the service. According to Gilks et al (1988), in Sub-Saharan African societies, few men are aware of their HIV status. Access to and availability of VCT centres is one problem. Sick people including men, even those with tuberculosis (TB), are rarely offered HIV testing. Even if tested, a high number of clients fail to return to receive their HIV test results. He further noted that there is considerable stigmatisation and discrimination in the region, problems which clearly impede the establishment of effective groups of people living with HIV/AIDS and often limit individuals from accessing openly whatever care and support services are available. Despite widely available counselling and testing services many people do not want to know their HIV status because they perceive no benefit from this knowledge, or even fear being depressed. A significant number of men fatalistically believe that they are already infected, or are destined soon to becoming infected (Gilks et al, 1998).

2.4 National perspectives

Voluntary Counselling and Testing in Zambia is seen as a way of facilitating behavioural change and hence preventing acquisition and transmission of HIV. VCT is also seen to serve as an entry point to HIV/AIDS care, treatment and support services (National HIV/AIDS/STI/TB Council, 2006). A lot of surveys have been conducted in Zambia to monitor the outcome of the existing interventions on prevention of HIV/AIDS.

2.4.1 Knowledge and attitude

A survey by Family Health International (2003) on the behavioural trends among the male populations namely truck drivers, uniformed personnel, light truck and minibus drivers revealed that of the 93% of men who were successfully interviewed, 78% were married and living with spouses. The majority (70%) had a secondary level of education, and the overall mean age of respondents was 35 years. With regards to knowledge and attitude towards HIV/AIDS, all respondents said they had heard about HIV/AIDS. The means by which respondents thought HIV could be prevented was by abstinence (92%), faithfulness (88%) and use of condoms (78%). The proportion who said were counselled and tested for HIV were 34.4% truck drivers, 22% minibus drivers and 21.9% uniformed personnel. Only a quarter of these respondents actually received the test results. The above survey shows that those men who are educated may have some knowledge about HIV/AIDS. Furthermore, the survey show that a small proportion of men utilise VCT services. Communication on the importance of VCT and availability of the service should be intensified. Health workers and churches can play a role in the promotion of VCT of HIV on married men.

2.4.2 Utilisation

National HIV/AIDS/STI/TB Council (2004) reported that surveys show that one reason many people including married men do not use VCT services is a concern that the results will not be kept confidential and that stigma and discrimination will follow the disclosure of the status. It was also reported that despite VCT being important in the control of the HIV/AIDS epidemic, most adult Zambians have never been tested for HIV. The Demographic Health Survey (2001-2002) reported that nine percent (9%) of men and 14% of women have ever been tested. Another 69% of women and 64% of men want to be tested but have not done so. Testing is

more common in urban areas (14% of women and 17% of men) than in rural areas (6% of women and 12% of men). The difference in the above statistics could be attributed to the fact that in urban areas there are more VCT centres which are easily accessible by the men and women. However, in the rural areas there are few VCT centres and are not easily accessible which may be due to long distances.

2.4.3 Factors influencing the attitude and utilisation of VCT by men

The Health Demographic Survey 2001-2002 reported that VCT is also common among the better educated (Central Statistical Office, 2003). However, in the rural areas where more men and women are not educated, VCT may be uncommon. Stigma and discrimination are some of the factors in Zambia that may lead married men to have a negative attitude towards VCT. According to National HIV/AIDS/STI/TB Council (2004), potential clients are concerned that if found HIV positive, they risk stigmatisation and discrimination in the community. National HIV/AIDS/STI/TB Council (2004) further reported that surveys show clearly that the lack of adequate support services is one of the factors hindering the expansion of VCT use. People, married men inclusive who are potentially HIV positive wonder why they should suffer the trauma of knowing their status when support services are inadequate (National HIV/AIDS/STI/TB Council, 2004).

In Zambia VCT services are more focused on maternal and child health than on men. HIV counselling and testing should be offered routinely to both men and women as part of the strategy to effective management (National HIV/AIDS/STI/TB Council, 2006).

2.5 CONCLUSION

The above discussion generally shows that there is low utilisation of voluntary counselling and testing by men. There is also a negative attitude towards voluntary counselling and testing among the men. In this discussion men seem to be perpetuating the spread of HIV. However, men are not involved in the intervention to stop the infection. The negative attitude towards utilisation of VCT by men could be attributed to inadequate knowledge on the services, unavailability, inaccessible voluntary counselling and testing services, fears or lack of confidence and trust.

However, from the studies done in the developing countries for instance, Uganda shows an increase in demand for VCT amongst the males. It is hoped that the attitude and utilisation of VCT by married men will be determined. The contributing factors to married men's attitude of HIV voluntary counselling and testing will be identified during the study and these will be used to make further recommendations to the relevant authorities and the community on how to improve VCT services.

CHAPTER THREE

3.0 RESEARCH METHODOLOGY

3.1 Introduction

This chapter describes the research methodology that was used in the study. The purpose of the study was to determine the attitude of married men and utilisation of voluntary counselling and testing for HIV in Gwembe District. This was with an aim to come up with recommendations that were presented to the relevant authorities.

3.2 Research design

A research design is the arrangement of conditions for collection and analysis of data in a manner that aims to combine relevance to the research purpose with economy in procedure (Ghosh, 2004). It includes such factors as the research setting, operational definitions, assumptions, relationships between variables, delimitation, sample, sampling procedure, instrument, approach to be used and the method for data analysing, ethical questions concerning subjects' rights and use of data (Treece and Treece, 1986).

The design for this study involved application of a descriptive, cross sectional survey. A descriptive design is a non-experimental research design to discover new meaning and to provide new knowledge when there is little known about a phenomenon of interest (Dempsey and Dempsey, 2000). A descriptive design involves a systematic collection and presentation of data to give a clear picture of a particular situation. The design was chosen for the study because data was collected from the subjects to give a clear account on the attitude and utilisation of VCT by married men. Cross-sectional survey is a design, which is aimed at quantifying the distribution of certain variables in a study population at one point in time (Dempsey and Dempsey, 2000). Data was collected from the respondents in Munyumbwe and Chipepo just once and data was then analysed. The study quantified the following

variables: knowledge, attitude and utilisation of VCT by married men. The design was found suitable because it was less costly.

3.3 Research setting

Research setting is the location where the research is undertaken. The study was conducted in Gwembe District in Jongola, Khoma and Chibuwe wards. Gwembe District constitutes the middle third of the Southern Province's portion of the Zambezi basin/valley that is, from Chirundu in the Northeast to Kafwambila in Southwest. The district shares boundaries with Sinazongwe District in the west and Siavonga District in the east. The two sister valley Districts were, until the early nineties, part of Gwembe District. Gwembe District also shares boundaries with Choma District in the northwest and Monze District in the north. Gwembe District is 200 kilometres from Lusaka. The District covers an area of 12,611 square kilometres of land surface with a population of 41,049 (Central Statistical Office, 2000). Out of this population, 19,704 (48%) are males of all ages while 21,345 (52%) are females of all ages. Jongola and Khoma wards are almost centrally located in Gwembe district while Chibuwe ward is found along Lake Kariba in the southern part of the district. Jongola and Khoma wards, which comprise twenty-three villages, altogether, have a population of 8,955 and out of this population 4,656 are females of all ages while 4,299 are males of all ages. Chibuwe ward on the other hand has a population of 2,984. Out of this population 1,552 are females of all ages and 1,432 are the males of all ages. It has fourteen villages. Lukonde ward where the pilot study was conducted has a population of 5,543 (Gwembe District Hospital Action Plan, 2005 to 2007).

3.4 Study population

A study population consists of the total group of people or objects meeting the desired set of criteria of interest to the researcher. (Dempsey and Dempsey, 2000). The study population comprised all married men in Gwembe District. This group was selected because it is associated with risk taking behaviours related to HIV transmission

and at the same time having a negative attitude towards utilisation of VCT.

3.5 Sample selection

A convenient sampling method was used to select the subjects. In this method, the investigator selects certain items according to his convenience, no pre-planning is necessary for the selection of items and the method is applicable in those cases where the universe is not well-defined, sampling unit is not clear and a complete source list is not available (Ghosh, 2004). The universe is the whole group from which the units or samples are selected. A source list is a list, which contains the names of the units of the universe from which the sample is drawn (Ghosh, 2004). This sampling method was chosen because the sampling units (men who are married) are not well defined in the population and are few. The three wards in the district (Jongola, Khoma and Chibuwe) were selected purposively because there is high population density. The investigator selected respondents conveniently, that is, wherever the respondents were found that had the characteristics the researcher was looking for. The age group between 15 and 49 years of married men was considered in the sample.

3.6 Sample size

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

A sample of 50 married men was used in the study. The sample size was selected because there was limited time in which the study was to be conducted as well as inadequate resources.

3.7 Data collection tool

A data collection tool is an instrument designed to collect information in a form useful to the researcher (Treece and Treece, 1986). A structured interview schedule was used to collect data from the subjects (See annex 1). This tool ensures that all respondents are asked exactly the same set of questions in the same sequence and the interviewer merely reads each question to the respondent (Fisher and Foreit, 2002). The schedule contained questions on all variables under study, which consisted of four sections. The first section obtained demographic data of the subjects. The second section measured the knowledge of married men on voluntary counselling and testing while the third section elicited data on attitude. The last one determined utilisation of VCT. The interview schedule was chosen because it gathered in-depth information that was given spontaneously by the respondents. The disadvantages of using this instrument is that the researcher may not probe the topic in-depth without being lengthy and may also influence how the respondents respond to the interview. Some open-ended questions were used in order to overcome this.

3.8 Data collection technique

Data collection technique is the process of gathering information needed to address a research problem (Polit and Hungler, 1997). A structured interview was used to collect data for this study. The data collection technique was preferred because it was easy to administer to respondents in Gwembe District because the majority of respondents can't read or write in English. The technique was also appropriate because it could collect in-depth information from respondents about the attitude and utilisation of VCT. The questions from the questionnaire were read to the respondent to answer accordingly. The researcher filled in the questionnaire. Each interview took about fifteen to twenty minutes.

3.9 Pilot study

The pilot study for this research was conducted before the actual study. A pilot study is defined as a mini study conducted before the major study in order to make revisions and find flaws in the methodology and it includes every step expected in the major study (Treece and Treece, 1986). The pilot study was done in Lukonde ward, particularly in Gwembe Township for easy accessibility. The pilot study tested the validity and reliability of the instrument in order to detect and solve unforeseen problems. Convenient sampling was used and the sample size was 10% of the actual study sample. This sample size was 5, and these respondents were not part of the actual study. During the pilot study, questions that collected unnecessary data were removed from the questionnaire (Question 3 and 38). The questionnaire was then renumbered.

3.10 Validity and Reliability

3.10.1 Validity

Validity refers to data that are not only reliable but also true and accurate or in other words it is the extent to which a measurement does what it is supposed to do (Fisher and Foreit, 2002). In this study, validity was measured during the pilot study. The investigator measured the ability of the instrument used to see if it was going to bring out desired information. Validity was measured in order to minimise biases. In measuring the validity of the instrument, questions in the questionnaire were checked by experts in HIV VCT to see if they brought out responses on the variables that were measured so that conclusions could be drawn with respect to the sampled population. The instrument was pre-tested to determine whether it collected the desired information. Questions that collected unnecessary data were removed from the questionnaire. The questionnaire was then renumbered.

3.10.2 Reliability

Reliability refers to the consistency, stability or dependability of the data (Fisher and Foreit, 2002). Reliability of the instrument was measured in the pilot study. It was done to establish consistency and dependability in the instrument, that is, if the same information is elicited from the same questions. Reliability of the instrument was measured by pre-testing it. During the pre-testing phase, respondents were interviewed in order to identify ambiguity of questions and problems with comprehension and those that were to be clarified.

3.11 Ethical and cultural considerations

Ethics is defined as "a system of good moral values that is concerned with the degree to which research procedures adhere to professional, legal and social obligations to the study participants" (Polit and Hungler, 1997). Before conducting the study, permission was obtained from the District Commissioner, as well as the Gwembe District Health Office (Refer to annex 2). Permission from His Royal Highness Chief Munyumbwe was obtained to conduct the research in his area. The purpose of the study was explained to the participants before the study and consent was obtained from them. Confidentiality and anonymity of respondent's information was assured, strictly maintained and adhered to through out data collection. Anonymity of respondents was equally maintained through out the analysis and also in this report. Confidentiality and anonymity was also maintained by interviewing the subjects individually and in privacy, ensuring that there names were not written on the interview schedule and by keeping the schedules locked safely in a brief case.

CHAPTER FOUR

4.0 DATA ANALYSIS AND PRESENTATION OF FINDINGS

4.1 Introduction

The data collected and presented in this chapter were gathered from fifty (50) respondents in Gwembe District. The data collected was analysed and presented in frequency tables, cross-tabulations, pie-charts and graphs.

4.2 Data analysis

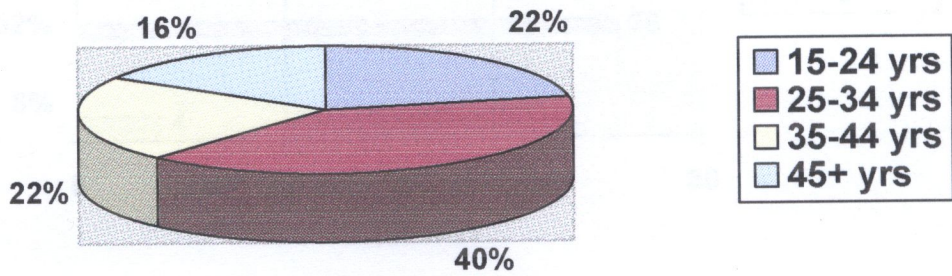
Data analysis is the systematic organisation and synthesis of research data, and testing research hypothesis using those data (Polit and Hungler, 1997). *After data were collected, all the questionnaires were sorted out and checked for completeness and internal consistency and later entered on a data master sheet for manual analysis. A calculator was used to further analyse the data.*

Pie-charts, tables and graphs were found to be more appropriate means of presenting the findings because they are easy to interpret and they accord one with a rough idea and picture about the findings even before they read the discussions of the findings. They are also useful in drawing meaningful inferences. Cross-tabulations were also useful to combine information on two or more variables in order to arrive at positive explanations of the problem. In the tabulation of data descriptive statistics and percentages were used. This enables the reader to understand the intent of the study more easily.

4.3 PRESENTATION OF FINDINGS

4.3.1 Demographic Data

Figure 2: Age distribution of respondents (n = 50)



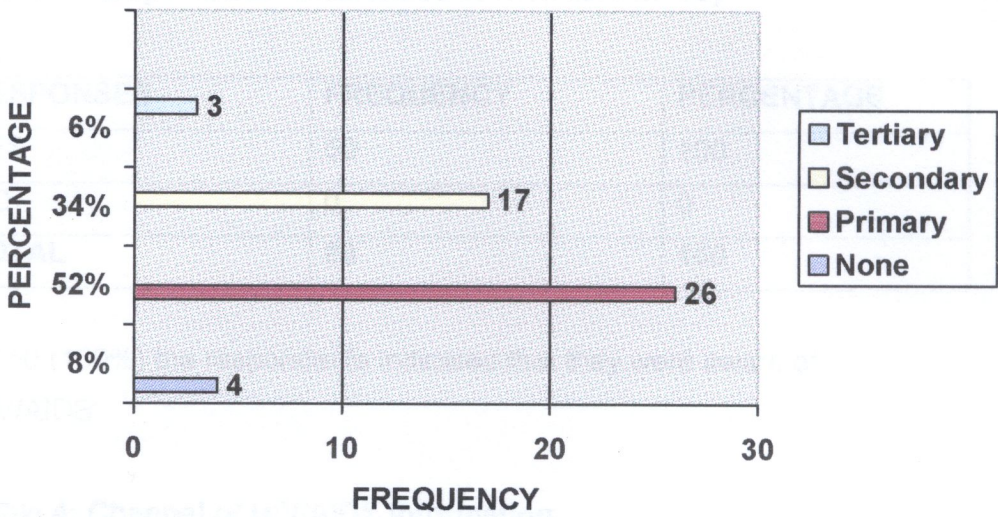
Most 20 (40%) of the respondents were aged between 25 and 34 years.

Table 2: Number of wives for respondents (n = 50)

NUMBER OF WIVES	FREQUENCY	PERCENTAGE
One	39	78
More than one	11	22
TOTAL	50	100

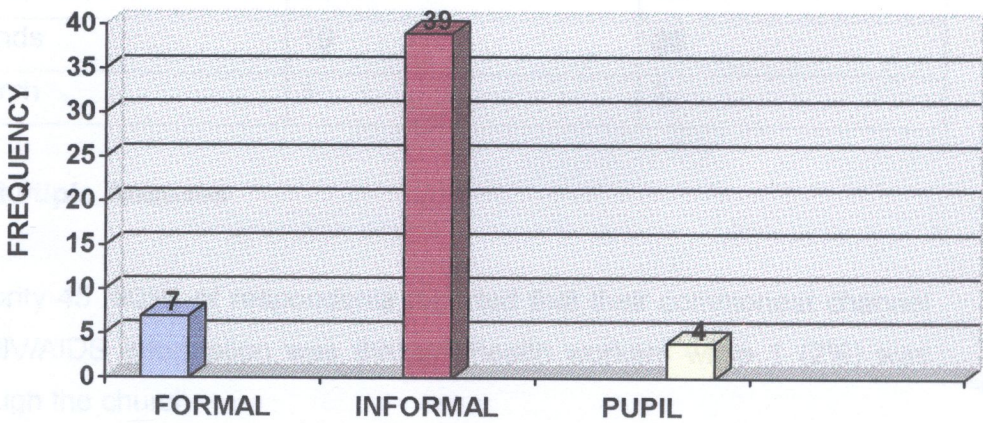
Majority 39 (78%) of the respondents had one wife.

Figure 3: Respondents' level of education (n =50)



Most 26 (52%) of the respondents had primary level of education while 3 (6%) had tertiary education.

Figure 4: Occupational status of respondents (n = 50)



Majority 39 (78%) of the respondents were in informal sector of employment.

4.3.2 Knowledge on VCT and HIV/AIDS

Table 3: Respondents' awareness of HIV/AIDS (n=50)

RESPONSES	FREQUENCY	PERCENTAGE
YES	50	100
NO	0	0
TOTAL	50	100

All 50 (100%) the respondents indicated that they were aware of HIV/AIDS.

Table 4: Channel of HIV/AIDS information

CHANNEL OF HIV/AIDS INFORMATION	FREQUENCY	PERCENTAGE
Radio/TV	33	66
Health Workers	45	90
Books/Posters	9	18
Friends	19	38
Church	1	2

**** Multiple Answers**

Majority 45 (90%) of respondents reported that their commonest channel of HIV/AIDS information was through health workers while 1 (2%) was through the church.

Table 5: Causes of HIV infection (n = 50)

CAUSES OF HIV	FREQUENCY	PERCENTAGE
HIV virus	50	100
Mosquitoes	0	0
Witch craft	0	0
I don't know	0	0
Total	50	100

All 50 (100%) the respondents knew that the cause of HIV infection is the HIV virus.

Table 6: Transmission of HIV

TRANSMISSION OF HIV	FREQUENCY	PERCENTAGE
Sexual intercourse	50	100
Sharing cups and spoons	0	0
Blood transfusion with unscreened blood	33	66
Mosquito bite	0	0
Contaminated razor blade and needles	46	92
Mother to baby through breast milk	15	30
I don't know	0	0

**** Multiple Answers**

All 50 (100%) the respondents knew that sexual intercourse is one of the ways in which HIV is transmitted, and about 15 (30%) indicated that it was

through mother to baby through breast milk.

Table 7: HIV prevention

HIV PREVENTION	FREQUENCY	PERCENTAGE
Abstinence	43	86
Hygiene	0	0
Use of condom	43	86
Having one sexual partner and being faithful	13	26

**** Multiple Answers**

Eighty-six percent 43 (86%) of the respondents indicated that HIV can be prevented through abstinence and another 43 (86%) reported that it can be prevented through use of condoms.

Table 8: Awareness of VCT (n=50)

AWARENESS OF VCT	FREQUENCY	PERCENTAGE
YES	48	96
NO	2	4
Total	50	100

Ninety-six percent 48 (96%) of the respondents had heard about HIV voluntary counselling and testing.

Table 9: Channel of VCT information

CHANNEL OF VCT INFORMATION	FREQUENCY	PERCENTAGE
Radio/TV	31	62
Health Workers	46	92
Books/Posters	10	20
Friends	17	34
Church	10	20

**** Multiple Answers**

Majority 46 (92%) of the respondents indicated that their commonest channel for VCT information was through health workers.

Table 10: Definition of VCT

DEFINITION OF VCT	FREQUENCY	PERCENTAGE
Going to the clinic	6	12
Willingly receiving information on HIV/AIDS, Knowing about HIV/AIDS and being tested	39	78
I don't know	5	10
TOTAL	50	100

Majority 39 (78%) of the respondents knew the definition of VCT, 6 (12%) indicated that VCT is going to the clinic.

Table 11: Knowledge of where to get HIV VCT

KNOWLEDGE OF WHERE TO GET HIV VCT	FREQUENCY	PERCENTAGE
Health centres	43	86
Hospital	10	20
Muzeyi	39	78

**** Multiple Answers**

Majority 43 (86%) of the respondents indicated that VCT services could be obtained from the health centres.

Figure 5: Respondents level of knowledge on HIV/AIDS and VCT as determined from their responses to questions on the causes, transmission, prevention and definition of HIV and where to get VCT services(n=50)

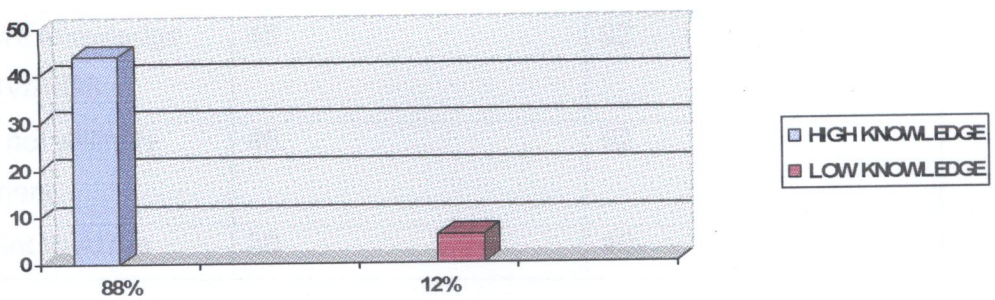
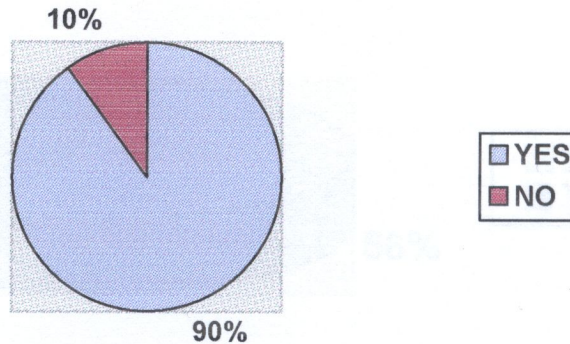


Figure 3 shows that majority 44 (88%) of the respondents had high knowledge on HIV/AIDS and VCT.

4.3.3 Attitude towards VCT

Figure 6: VCT having advantages (n = 50)



Majority 45 (90%) of the respondents indicated that VCT has got advantages.

Table 12: Advantages of undergoing VCT

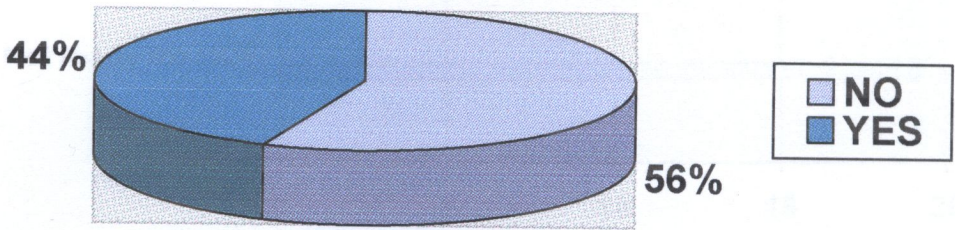
ADVANTAGES OF UNDERGOING VCT	FREQUENCY	PERCENTAGE
To acquire knowledge about HIV/AIDS	46	92
One will not willingly infect others	46	92
Entry point to ARVs	20	40

** Multiple Answers

Ninety-two percent 46 (92%) of the respondents reported that the advantages of taking VCT was that one would acquire knowledge about HIV/AIDS and

another 46 (92%) indicated that one will not willingly infect others, while only 20 (40%) reported that it was an entry point to ARVs.

Figure 7: Discussed VCT with health care provider (n=50)



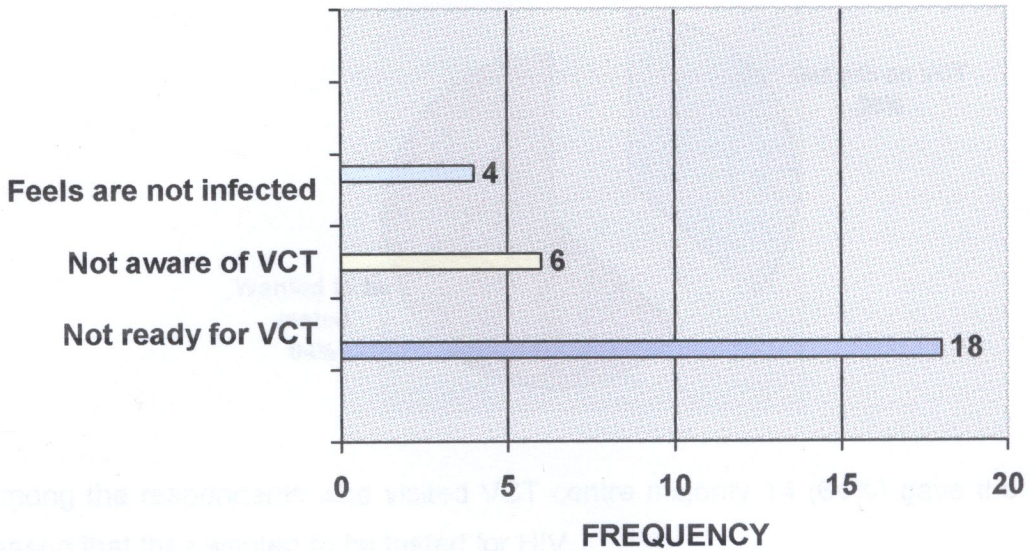
Slightly over half 28 (56%) of the respondents indicated that they had never talked to a health care provider about HIV VCT.

Table 13: Reasons for discussing VCT with health care providers (n=22)

REASONS FOR DISCUSSING VCT WITH HEALTH CARE PROVIDERS	FREQUENCY	PERCENTAGE
Wanted to be tested	14	64
Get information on VCT	8	36
TOTAL	22	100

Among the respondents who discussed VCT with health care providers, 14 (64%) indicated that they wanted to be tested for HIV.

Figure 8: Reasons for NOT discussing VCT with health care providers (n=28)



Out of the respondents who had not discussed VCT with health care providers, thirty-six percent 18 (64%) of respondents mentioned that the reason was that they were not ready.

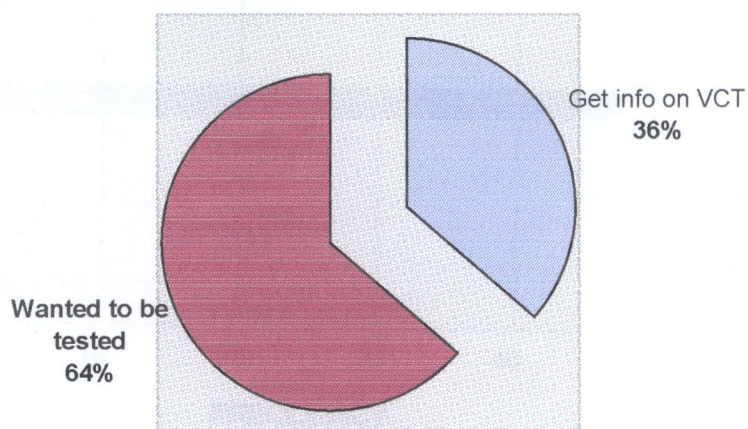
Table 14: Visited a VCT centre before (n=50)

RESPONSES	FREQUENCY	PERCENTAGES
YES	22	44
NO	28	56
TOTAL	50	100

Fifty six percent 28 (56%) of the respondents had never visited a VCT centre before.

Among the respondents who gave reasons for not visiting VCT centres, 12 (43%) indicated that they did so for fear of being stigmatised if their HIV test results came out positive.

Figure 9: Reasons for visiting VCT centre (n=22)



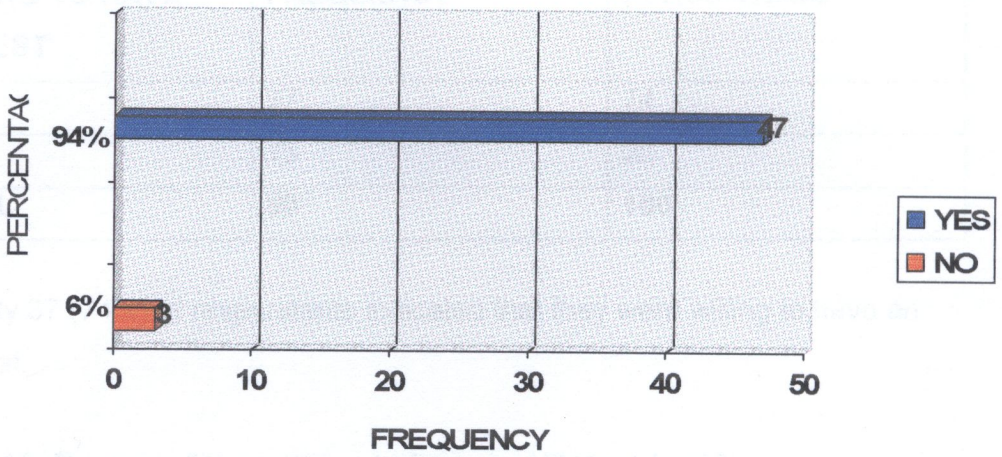
Among the respondents who visited VCT centre majority 14 (64%) gave the reason that they wanted to be tested for HIV.

Table 15: Reasons for NOT visiting VCT centre (n=28)

RESPONSES	FREQUENCY	PERCENTAGE
Not yet decided to go for VCT	3	11
Fear stigmatisation	12	43
Feel they are not infected	4	14
Not willing to go for VCT	3	11
Not aware of the service	6	21
TOTAL	28	100

Among the respondents who gave reasons for not visiting VCT centre, 12 (43%) indicated that they did so for fear of being stigmatised if their HIV test results came out positive.

Figure 10: Willing to be counselled (n=50)



Ninety four percent 47 (94%) of the respondents indicated that they were willing to be counselled for HIV while 3 (6%) were not.

Table 16: Reasons for willingness to be counselled for HIV (n=47)

REASONS FOR WILLINGNESS TO BE COUNSELLED FOR HIV	FREQUENCY	PERCENTAGE
To acquire knowledge on HIV/AIDS	33	70
To know their HIV status	14	30
TOTAL	47	100

Of the respondents who were willing to be counselled, 33 (70%) gave the reason that they wanted to acquire knowledge on HIV/AIDS, while 14 (30%) wanted to know their HIV status.

Table 17: Willing to have an HIV test (n=50)

WILLING TO HAVE HIV TEST	FREQUENCY	PERCENTAGE
YES	37	74
NO	13	26
TOTAL	50	100

Majority 37 (74%) of respondents indicated that they were willing to have an HIV test.

Table 18: Reasons for unwilling to have an HIV test (n=13)

REASONS FOR UNWILLING TO HAVE AN HIV TEST	FREQUENCY	PERCENTAGE
Fear stigma if results are positive	9	69
Feel they are not infected	4	31
TOTAL	13	100

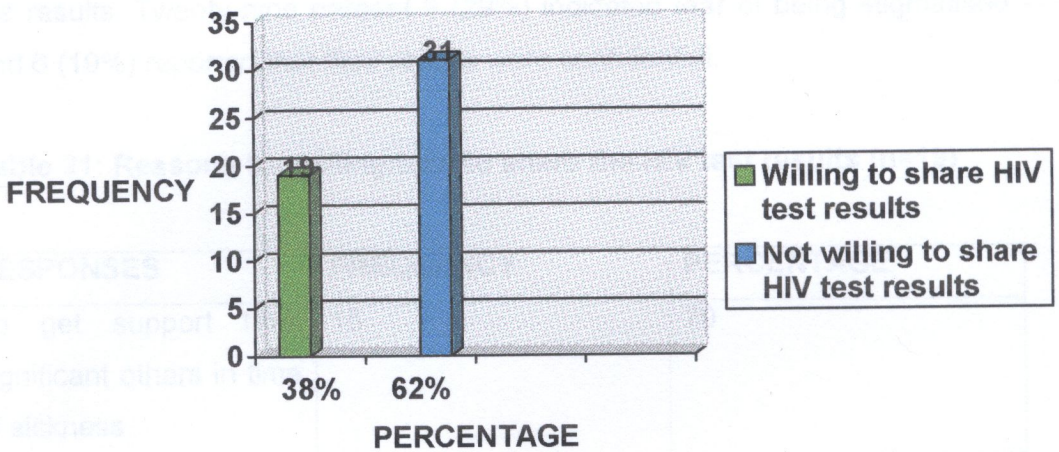
Among the respondents who were not willing to have an HIV test, 9 (69%) gave the reason that they fear stigmatisation if their HIV test results came out positive, while 4 (31%) indicated that they felt they were not infected.

Table 19: Willing to be informed of HIV test results (n=50)

WILLING TO BE INFORMED OF HIV TEST RESULTS	FREQUENCY	PERCENTAGE
YES	19	38
NO	31	62
TOTAL	50	100

Majority 31 (62%) of the respondents were not willing to be informed of HIV test results.

Figure 11: Willing to share HIV test results (n=50)



Majority 31 (62%) of respondents were not willing to share test results.

Table 20: Reasons for unwilling to share the HIV test results (n=31)

REASONS FOR UNWILLING TO SHARE HIV TEST RESULTS	FREQUENCY	PERCENTAGE
Fear being stigmatised	9	29
Confidential	6	19
Not ready to share results	16	52
TOTAL	31	100

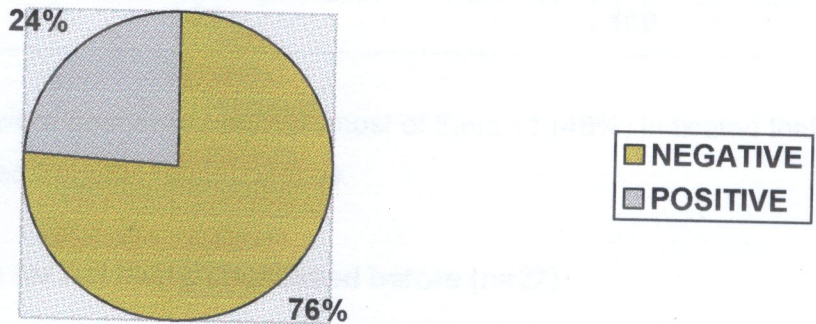
Among the respondents who were not willing to share the HIV test results, slightly over half 16 (52%) gave the reason that they were not ready to share the results. Twenty nine percent 9 (29%) indicated fear of being stigmatised and 6 (19%) reported that their results were confidential.

Table 21: Reasons for willingness to share the HIV test results (n=19)

RESPONSES	FREQUENCY	PERCENTAGE
To get support from significant others in time of sickness	15	79
To encourage other people to go for HIV test	4	21
TOTAL	19	100

Among the respondents who were willing to share the HIV test results 15 (79%) gave the reason that they would do so in order to get support from significant others in time of sickness.

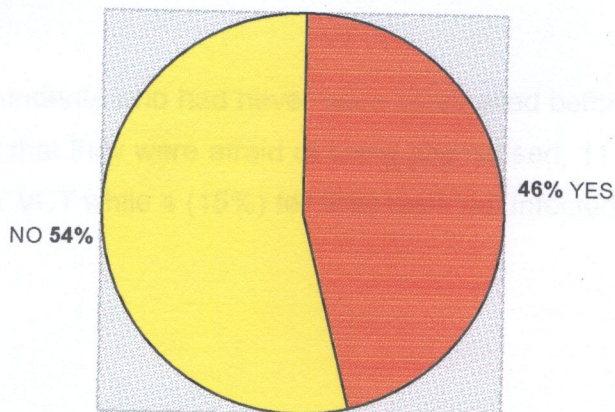
Figure 12: Respondents attitude towards VCT as determined from answers to the following questions; Discussed VCT with health care providers? VCT having advantages? Visited VCT centre before? Willing to be counselled? Willing to have an HIV test? Willing to be informed of HIV results? Willing to share results? (n=50)



Majority 38 (76%) of respondents had a negative attitude towards HIV VCT.

4.3.4 Utilisation of VCT services by the respondents

Figure 13: Counsellled before on HIV/AIDS (n=50)



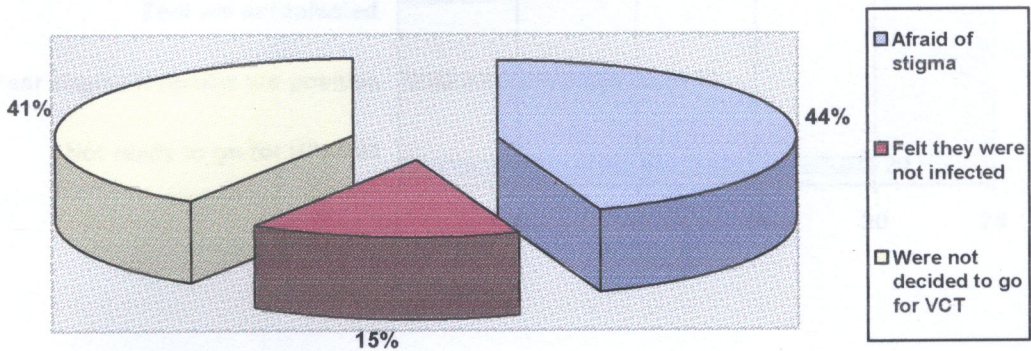
More than half, 27 (54%) of the respondents indicated that they had never received any counselling on HIV/AIDS before.

Table 22: Place where counselled from (n=23)

PLACE WHERE COUNSELLED FROM	FREQUENCY	PERCENTAGE
Health centres	11	48
Hospital	6	26
Muzeyi VCT centre	6	26
TOTAL	23	100

Among those who were counselled on HIV, most of them 11 (48%) indicated that they were counselled from the health centres.

Figure 14: Reason for not being counselled before (n=27)



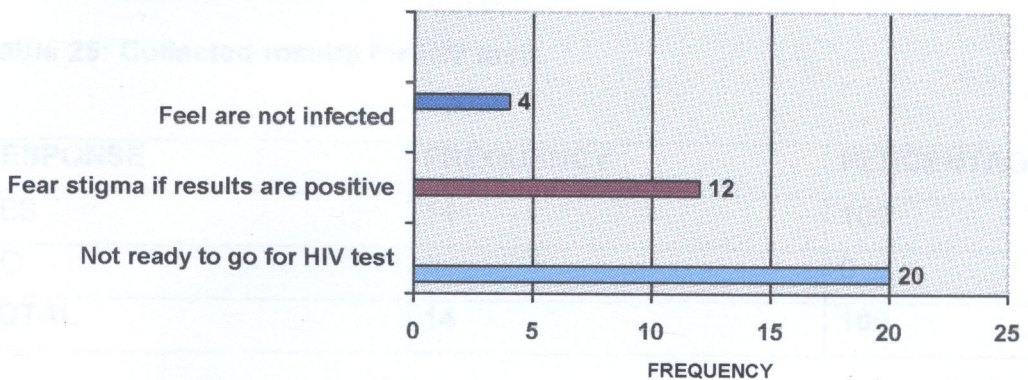
Among the respondents who had never been counselled before on HIV, 12 (44%) gave the reason that they were afraid of being stigmatised, 11 (41%) were not yet decided to go for VCT while 4 (15%) felt they were not infected with HIV.

Table 23: Had an HIV test done (n=50)

HAVING HIV TEST DONE	FREQUENCY	PERCENTAGE
YES	14	28
NO	36	72
TOTAL	50	100

Majority 36 (72%) of respondents had never had an HIV test done while 14 (28%) had.

Figure 15: Reasons for NOT having an HIV test done (n=36)



Of the respondents who had never done an HIV test before, slightly over half 20 (56%) gave the reason that they were not ready to go for HIV test, 12 (33%) reported that they were afraid of stigmatisation in case the test results came out positive and 4 (11%) indicated that they felt they were not infected with HIV.

Table 24: Place where tested from (n=14)

PLACE WHERE TESTED FROM	FREQUENCY	PERCENTAGE
Health centres	5	36
Hospital	6	43
Muzeyi VCT centre	3	21
TOTAL	14	100

Among the respondents who had an HIV test done, majority 6 (43%) reported that they were tested from the hospital.

Table 25: Collected results for HIV test

RESPONSE	FREQUENCY	PERCENTAGE
YES	14	100
NO	0	0
TOTAL	14	100

All 14 (100%) the respondents who indicated that they had an HIV test done on them, collected the results for the test.

Table 26: Factors that hinder men from utilising VCT services

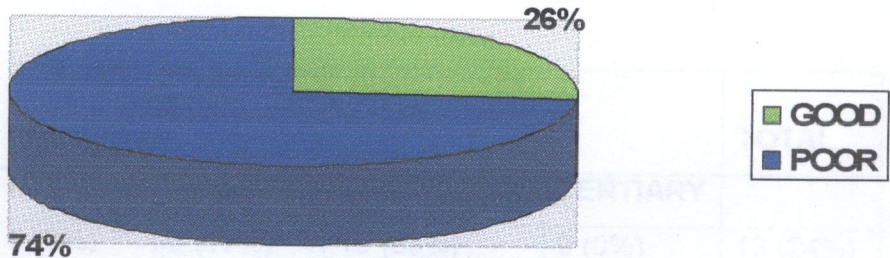
FACTORS THAT HINDER MEN FROM UTILISING VCT SERVICES	FREQUENCY	PERCENTAGE
Long distance to VCT centre	8	16
Stigma from the community and their families	46	92
Fear of divorce if their HIV test results came out positive	29	58
Poor infrastructure for VCT	2	4

without privacy		
Lack of awareness about presence of VCT services	11	22

**** Multiple Answers**

Most 46 (92%) of the respondents reported that factors that hinder men from utilising VCT services is stigma from the community and their families and 29 (58%) indicated fear of divorce if their HIV test results came out positive.

Figure 16: Level of utilisation as determined from respondents' answers to the following questions; Ever counselled before on HIV/AIDS? Ever had an HIV test done before? Collected results for HIV test? (n=50)



The majority 37 (74%) of respondents had poor utilisation of VCT service and 13 (26%) had good utilisation.

4.3.5 Relationship between variables

Table 27: Respondents attitude in relation to age (n=50)

ATTITUDE LEVEL	AGE RANGE				TOTAL
	15-24	25-34	35-44	45+	
POSITIVE	3 (25%)	7 (58%)	2 (17%)	0 (0%)	12 (24%)
NEGATIVE	9 (24%)	12 (31%)	9 (24%)	8 (21%)	38 (76%)
TOTAL	12 (24%)	19 (38%)	11 (22%)	8 (16%)	50(100%)

Among the 38 (76%) respondents with negative attitude towards VCT, majority 12 (31%) were in the age range 25-34 years.

Table 28: Respondents' attitude in relation to level of education (n=50)

ATTITUDE LEVEL	LEVEL OF EDUCATION				TOTAL
	NONE	PRIMARY	SECONDARY	TERTIARY	
POSITIVE	0 (0%)	2 (17%)	10 (83%)	0 (0%)	12 (24%)
NEGATIVE	4 (11%)	23 (61%)	8 (21%)	3 (8%)	38 (76%)
TOTAL	4 (8%)	25 (50%)	18 (36%)	3 (6%)	50(100%)

Majority 23 (61%) of respondents with a negative attitude towards VCT had primary level of education. While majority 10 (83%) with positive attitude had secondary level of education.

Table 29: Respondents attitude in relation to level of knowledge (n=50)

ATTITUDE LEVEL	LEVEL OF KNOWLEDGE		TOTAL
	HIGH	LOW	
POSITIVE	12 (100%)	0 (0%)	12 (24%)
NEGATIVE	32 (84%)	6 (16%)	38 (76%)
TOTAL	44 (88%)	6 (12%)	50 (100%)

All 12 (100%) the respondents with positive attitude had high level of knowledge on HIV/AIDS and VCT while among those with negative attitude, majority 32 (84%) had high level of knowledge.

Table 30: Utilisation in relation to age (n=50)

UTILISATION LEVEL	AGE				TOTAL
	15-24	25-34	35-44	45 and above	
GOOD	4 (31%)	5 (38%)	3 (23%)	1(8%)	13 (26%)
POOR	7 (19%)	15 (40%)	8 (22%)	7 (19%)	37 (74%)
TOTAL	11 (22%)	20 (40%)	11 (22%)	8 (16%)	50 (100%)

Among respondents with good utilisation of VCT, most of them 5 (38%) were aged 25-34 years while those with poor utilisation of the service, 15 (40%) were also aged 25-34 years.

Table 31: Utilisation in relation to education level (n=50)

UTILISATION LEVEL	EDUCATION LEVEL				TOTAL
	NONE	PRIMARY	SECONDARY	TERTIARY	
GOOD	2 (15%)	3 (23%)	7 (54%)	1(8%)	13 (26%)
POOR	1 (3%)	22 (60%)	12 (32%)	2 (5%)	37 (74%)
TOTAL	3 (6%)	25 (50%)	19 (38%)	3 (6%)	50 (100%)

Of the 37 (74%) respondents with poor utilisation of VCT services, majority 22 (60%) had primary level of education, whilst among those with good utilisation, more than half 7 (54%) had secondary level of education.

Table 32: Utilisation in relation to occupation (n=50)

UTILISATION LEVEL	OCCUPATION			TOTAL
	FORMAL	INFORMAL	PUPIL	
GOOD	2 (15%)	9 (70%)	2 (15%)	13 (26%)
POOR	4 (11%)	31 (84%)	2 (5%)	37 (74%)
TOTAL	6 (12%)	40 (80%)	4 (8%)	50 (100%)

Of the 37 (74%) respondents with poor utilisation of VCT services, majority 31 (84%) were in informal employment while those with good utilisation 9 (70%) also had informal employment.

Table 33: Utilisation in relation to level of knowledge (n=50)

UTILISATION LEVEL	LEVEL OF KNOWLEDGE		TOTAL
	HIGH	LOW	
GOOD	12 (92%)	1 (8%)	13 (26%)
POOR	32 (86%)	5 (14%)	37 (74%)
TOTAL	44 (88%)	6 (12%)	50 (100%)

Among the respondents with poor utilisation of VCT services, majority 32 (86%) had high level of knowledge while among those with good utilisation most 12 (92%) of them had also high level of knowledge.

Table 34: Utilisation in relation to attitude (n=50)

UTILISATION LEVEL	ATTITUDE		TOTAL
	POSITIVE	NEGATIVE	
GOOD	10 (83%)	3 (8%)	13 (26%)
POOR	2 (17%)	35 (92%)	37 (74%)
TOTAL	12 (24%)	38 (76%)	50 (100%)

Of the 38 (76%) respondents with negative attitude towards VCT services, majority 35 (92%) had poor utilisation of the service while those with positive attitude 12 (24%) most 10 (62%) of them had good utilisation.

CHAPTER FIVE

5.0 DISCUSSION OF FINDINGS

5.1 Introduction

The findings of this study were based on an analysis of responses of respondents obtained from a sample of fifty (50) married men that live in three wards of Gwembe District. The respondents were conveniently chosen from these wards. The information obtained from the study provided the following highlights in relation to the study objectives.

5.2 Characteristics of the sample

The questionnaire (annex 1) had questions from section A that elicited demographic information from respondents. The results revealed that 40% of the respondents were aged between 25 and 34 years, followed by those in the age group 15-24 (22%) and 35-44 years (22%). Sixteen percent of the respondents were in the age group of 45 years and above (**Figure 2, Page 33**). More respondents were aged 25-34 probably due to the fact that most men in Zambia marry at this age.

The marital status of respondents was investigated and it revealed the following; 78% of respondents had one wife only while 22% had more than one wife (**Table 2, Page 33**). According to Zambia Sexual Behaviour Survey 2005 report that more than half of all male (52.4%) respondents were currently monogamously married and that rural respondents (56.5%) were somewhat more likely to be married than urban respondents (Central Statistical Office, 2006). Most respondents had one wife probably because they are now aware that one of the predisposing factors to HIV transmission is having more than one wife (polygamy).

The research findings revealed that 52% of respondents had primary level of education, followed by 34% with secondary education. Eight percent (8%) of respondents had no education background while only 6% had tertiary level of education (**Figure 3, Page 34**). Majority of respondents had primary education probably because most people in rural areas do not consider education as an important thing in their lives. In addition, male children in Tonga land (southern province) are given the task of looking after cattle and thus if they were schooling do not complete their education. The highest education level they attain mostly is grade seven. According to 2001-2002 Zambia Demographic Health Survey report, 42% males have some primary education (Central Statistical Office, 2003).

A large percentage (78%) of respondents were in an informal employment (**Figure 4, Page 34**). In Gwembe District many people are either peasant farmers, businessmen or involved in elicit beer brewing and selling. Fourteen percent 14% were in formal employment. In Gwembe District the people in formal employment are either civil servants or workers in private companies. Only 8% of respondents were still going to school (pupils) (**Figure 4, Page 34**). Most of the respondents were in informal employment probably due to the economic reform and liberalisation which saw many people lose their jobs due to the Structural Adjustment Programme in the public sector in Zambia. Therefore, most of the people who lost jobs due to this change engaged in informal employment. Fashoyin (1998) reported that a related effect which is associated with economic reform policies and liberalization is the enormous increase in the scale of informal employment. He further reported that though this sector has been a major characteristic of African economies for a long time, economic reform policies have tended to aggravate the informalisation of the labour market. As the formal sector continues to shrink owing to economic reform and liberalization policies, the informal sector is correspondingly growing.

5.3 Knowledge on VCT and HIV/AIDS

Section B of the questionnaire (annex 1) contained questions that were measuring the knowledge of respondents on HIV/AIDS and VCT. Having knowledge about HIV/AIDS and VCT is an important step towards gaining access to VCT services. Majority (88%) of respondents had high knowledge on HIV/AIDS and VCT and (12%) had low knowledge (**Figure 5, Page 39**). These findings are similar to what 2005 Zambia Sexual Behaviour report which showed that majority (97%) of males in Zambia had high knowledge (Central Statistical Office, 2006). Most respondents had high knowledge probably due to dissemination of VCT information by health care providers in the district and also by the Chikuni Community radio station in Monze District.

The study revealed that all the respondents had heard of HIV/AIDS (**Table 3, Page 35**). This agrees with the Zambia Sexual Behaviour (ZSB) 2005 report which showed that the majority of Zambians have heard of HIV/AIDS. The Zambia Sexual Behavioural (ZSB) 2005 reported that the level of knowledge was high among both males (97%) and females (97%), as well as urban (98%) and rural respondents (96%) (Central Statistical Office, 2006).

The research findings revealed that respondents' commonest source of information was through health workers (90%) followed by radio and television (66%). Thirty eight percent (38%) received information through friends, 18% was through books and posters. Only 2% received information through the Church (**Table 4, Page 35**). Health workers were the commonest source of information on HIV/AIDS probably because rural people have no access to other forms of media such as radio or television which are very expensive for them to acquire. Hence health workers are the cheapest channel of information on HIV/AIDS in rural areas. The proportion of respondents who received information on HIV/AIDS was very small probably due to the

fact that the Church in Gwembe District is not very much involved in the fight of the epidemic.

The 2001-2002 Zambia Demographic Health Survey reported that HIV infection is commonly transmitted through sexual intercourse and that 65% of men knew that it can be transmitted through breastfeeding (Central Statistical Office, 2003). From table 5 and 6, the results also revealed that all the respondents (100%) knew the cause of HIV infection and all knew sexual intercourse to be the commonest route of transmission of the HIV infection. Sixty-six percent (66%) of respondents also knew that HIV can be transmitted through blood transfusion with unscreened blood, (92%) reported that it can be transmitted through contaminated razor blades and needles while (30%) indicated through mother to baby through breast milk.

Regarding HIV prevention, the results showed that 86% of the respondents indicated that HIV can be prevented through abstinence and another 86% through use of condoms while 26% indicated through having one sexual partner and being faithful (**Table 7, Page 37**). The study findings are similar to Behavioural Surveillance Survey 2003 report whose findings showed that the means by which respondents thought HIV infection could be avoided were abstinence (92%), faithfulness (88%) and use of condoms (78%) (Family Health International, 2006).

Concerning awareness of VCT, the study findings revealed that (96%) of the respondents indicated that they had heard about VCT while (4%) reported they had not heard about it (**Table 8, Page 37**). When testing respondents' knowledge of where to get HIV VCT, 86% of the respondents indicated that VCT services can be gotten from the health centres, 78% reported that VCT can be gotten from Muzeyi VCT centre in Munyumbwe and 20% indicated that it can be gotten from the hospital (**Table 11, Page 39**). According to 2005 Zambia Sexual Behaviour Report, 83% of all males indicated that they knew a place for testing (Central Statistical Office, 2006). Health workers were the

commonest channel for (92%) respondents' VCT information and 20% received the information through the church (**Table 9, Page 38**). There was very low dissemination of VCT information on HIV/AIDS from the church in Gwembe District probably because it was not fully involved in the fight of the epidemic.

Majority of the respondents (78%) knew the definition for voluntary counselling and testing. This could be due to the increased sensitization by health workers through mobile VCT in the district. Majority of the respondents (92%) reported that they got VCT information through health workers (**Table 10, Page 38**). VCT information in Zambia has reached many people, married men inclusive through various channels. This can be observed by the country's response to HIV/AIDS by introducing Behavioural Change Communication (BCC) strategy which disseminates HIV and VCT information through mass media/mass events, including television/radio serial dramas and talk shows, electronic and print media advertisements, public service announcements, and documentaries (National HIV/AIDS/STI/TB Council, 2004). Behavioural Change Communication is a process by which information and skills are shared and disseminated to people in a specific target audience with the intention of influencing them to adopt sustained changes in sexual behaviour or attitudes, or to engage in other health-seeking behaviours (National HIV/AIDS/STI/TB Council, 2004). The study results also revealed that 62% of the respondents got the information on VCT through the radio (**Table 9, Page 38**). Respondents could have gotten VCT information through Chikuni Community radio in Monze District.

5.4 Attitude towards VCT

With regards to voluntary counselling and testing having advantages, the results showed that the majority (90%) of the respondents indicated that VCT has advantages and 10% reported that it has no advantages (**Figure 6, Page 40**). With regards the advantages of taking VCT, 92% of respondents indicated that VCT helps to acquire knowledge about HIV/AIDS, and another 92% indicated that one will not willingly infect others while 20% reported that it was an entry point to ARVs (**Table 12, Page 40**).

The study results also showed that slightly over half (56%) of the respondents had never talked to a health care provider about HIV VCT. While, 52% had never visited a VCT centre before (**Figure 7, Page 41**). Among the respondents who had discussed VCT with health care providers, 64% indicated that they wanted to be tested and 36% reported that they wanted to information on VCT only (**Table 13, Page 41**). Out of the respondents who had not discussed VCT with health care providers, 64% gave the reason that the reason was that they were not ready to discuss it, 22% were not aware of the services and 14% felt that they were not infected with HIV (**Figure 8, Page 42**).

Slightly over half (56%) of the respondents reported that they had never visited VCT centre before (**Table 14, Page 42**). Despite majority of the respondents acknowledging that VCT has advantages, still they could not utilise the service. The attitude portrayed here by the respondents supports the statement which says that “what people say and what they do may differ widely” (Central Statistical Office, 2006). Among the respondents who gave reasons for not visiting VCT centre, 43% indicated that they did so for fear of being stigmatised if their HIV test results came out positive and 21% gave the reason that they were not aware of the service. Fourteen percent (14%) gave a reason that they felt they were not infected while 11% were not yet decided to go for VCT. Another 11% gave a reason that they were not just willing to go for VCT (**Table 15, Page 43**). However, the findings showed that

(94%) of respondents were willing to be counselled for HIV while only (6%) were not (**Figure 10, Page 44**). From table 17, (74%) of respondents indicated that they were willing to have an HIV test while 26% were not. These study findings agree with National HIV/AIDS/STI/TB Council (2004) report that 64% of men in Zambia want to be tested but have not done so. Among the respondents who were not willing to have an HIV test, 69% gave the reason that they fear being stigmatised if their HIV test results came out positive while 31% indicated that they felt they were not infected with HIV (**Table 18, Page 45**).

The research findings also showed that 62% of respondents were not willing to be informed of HIV test results while another 62% were not willing to share the results (**Table 19 and Figure 11, Page 46**). These findings show that there was some negative attitude by the respondents towards VCT utilization in Gwembe District. According to a report by Gilks et al (1998) many people do not want to know their HIV status because they perceive no benefit from this knowledge, or even fear being depressed if HIV test results came out positive. Similar findings by Family Health International (2003) on the behavioural trends among the male populations in Zambia showed that, among the proportion of men (78.3%) who said were counselled and tested for HIV, only a quarter of the respondents actually received the test results.

From the findings of this study, it was revealed that the majority (76%) of respondents had negative attitude towards HIV voluntary counselling and testing. Twenty four percent (24%) of respondents had positive attitude towards the service (**Figure 12, Page 48**). These findings are similar with what Population Services International (PSI) (2003) reported on a post-campaign evaluation study done in Uganda whose focus was on increasing the awareness and use of VCT particularly among couples.

The following is what was reported on men's attitude towards voluntary counselling and testing service by PSI:

- Men don't bother to go for counselling and testing service since they argue that everybody will die.
- Men who go for testing are most often not ready and decided. They feel scared if proved to be HIV positive and may fail to cater for their families and children.
- Men dislike testing because they have many sexual partners; hence fear embarrassments and negative responses from their spouses /partners and other family members.
- Men have a negative attitude about testing because they feel that the machines used are not accurate.
- Men are ever busy and have no time to go for VCT.
- They also think that if a spouse/partner tests then its enough.

5.5 Utilisation of VCT services by the respondents

Married men's utilization of VCT services was assessed under section D of the questionnaire (annex 1). The findings also revealed that (74%) of respondents had poor utilization of VCT while only (26%) had good utilization (**Figure 16, Page 52**). The study carried out by Population Service International (2003) found that men do not bother to go for counselling and testing service since they argue that everybody will die. This could be one reason why the majority of the respondents were not utilizing the service.

The study revealed that (54%) of respondents had never received any counselling before on HIV/AIDS (**Figure 13, Page 48**). Forty-six percent (46%) received counselling and 28% had been tested for HIV and also collected the results (**Figure 13, Table 23 and 25**). Seventy-two percent (72%) of the respondents never had an HIV test done (**Table 23, Page 50**). The Zambia Demographic Health Survey (2001-2002) Report also indicated that (9%) of men and (14%) women have ever been tested while another (69%) of women and (64%) of men want to be tested but have not done so. Most respondents did not utilize the service very well probably due to some negative attitude towards the service. Some respondents gave the reason that they were not ready to go for HIV test; others reported that they felt they were not infected with HIV (**Figure 15, Page 50**).

Among the respondents who had an HIV test done, 43% reported that they were tested from the hospital, 36% from the health centres and 21% from Muzeyi VCT centre (**Table 24, Page 51**). Majority of the respondents were tested from the hospital probably because the hospital is the only institution in the district which provide antiretroviral therapy and so clients opt to go there for VCT in case they are referred to ART clinic after being counselled.

With regards to factors that hinder married men from utilizing VCT services, (92%) of respondents attributed this to stigma from the community and their families. The findings are similar to the report by the National HIV/AIDS/STI/TB Council (2004) that one reason many people do not use VCT services is a concern that the results will not be kept confidential and that stigma and discrimination will follow the disclosure of the status. Another 58% indicated that it was fear of divorce if their HIV test results came out positive and 22% reported that it was due to lack of awareness about presence of VCT services in the district. Sixteen percent (16%) of respondents relate to the factors that hinder married men from utilizing VCT services as long distance to

VCT centre while only (4%) attributed this to poor infrastructure for VCT without privacy (**Table 26, Page 51**).

5.6 Knowledge, Attitude and Utilisation

The research findings from table 27 revealed that among respondents with negative attitude towards VCT, 31% were in the age range 25-34, 24% were aged between 15 and 24 and another 24% were in the age range 35-44. Twenty-one percent were 45 years old and above. Majority of the respondents with both negative attitude and positive attitude towards VCT were age between 25 and 34 years. Therefore, there is no relationship between attitude towards VCT and the age of the respondents.

The findings in this study revealed that 61% of the respondents among those with negative attitude towards VCT had primary education, 21% had secondary education, 11% had no education at all and only 8% had tertiary education. Among the respondents who had positive attitude, 83% had secondary education and 17% had primary education (**Table 28, Page 53**). There was a larger proportion of the respondents with secondary education who had positive attitude than those with primary education. Furthermore, a large proportion of the respondents with negative attitude had primary education than those with secondary education. Hence from the findings of the study, there is a relationship between respondents' attitude towards VCT and their level of education.

The study results revealed that there is a strong relationship between the level of knowledge of HIV and attitude towards VCT by the respondents. This can be seen from the results on table 29 which show that (100%) of the respondents with positive attitude towards VCT had high level of knowledge on HIV/AIDS and VCT while among those with negative attitude 84% had low level of knowledge. Thus the 2005 Zambia Sexual Behavioural report indicated that the proportion of young people, adult males inclusive who go for testing and know their

HIV status can be influenced by many factors, including access to testing sites, knowledge about the need for HIV testing, attitudes towards HIV/AIDS and level of stigma in society (Central Statistical Office, 2003).

Among respondents with good utilization of VCT, most of them (38%) were aged between 25 and 34 years. While among those with poor utilization of the service, 40% were also in the age range 25-34 years (**Table 30, Page 54**). From the findings it can be concluded that there was no relationship between utilization of VCT and the age of the respondents. However, the study findings revealed that there is a relationship between education and utilization. This can be seen from the results on table 31 that (60%) of respondents with primary education had poor utilization of VCT service and (54%) with good utilization had secondary level of education.

When testing the relationship between utilization of VCT and occupation, the study results revealed that out of the respondents with poor utilization of VCT services, majority (84%) were in formal employment while (70%) with good utilization of the service were in informal employment (**Table 32, Page 55**). Therefore, it can be concluded from the results that there is no relationship between utilization and occupation. The study results revealed that among the respondents with poor utilization of VCT services, majority (86%) had high level of knowledge while among those with good utilization most (92%) of them had also high level of knowledge (**Table 33, Page 56**). Hence forth there is no relationship between respondents' utilization of VCT and their level of knowledge on HIV/AIDS and VCT.

The study findings revealed that there is a relationship between utilisation of VCT and the attitude of respondents towards VCT. Out of the respondents with negative attitude towards VCT services, majority (92%) had poor utilization of the service. While those with positive attitude most (62%) of them had good utilization (**Table 34, Page 56**).

5.7 Implications to the health care system

The health care system is hit particularly hard by the HIV/AIDS epidemic. The treatment of opportunistic infections resulting from AIDS is expensive and is straining the delivery of all health services in the country. HIV/AIDS patients command a disproportionate share of beds at health centres and hospitals. Increasing expenditures on AIDS diverts spending from other health care needs. Health providers are also affected. Some become infected themselves and large numbers suffer from intense physical and emotional strain of dealing with AIDS patients.

Most gender issues perpetuate the dominance of male interests in sexual relations and women are taught never to refuse sex with their husbands regardless of the risk behaviours he may have concerning contracting HIV infection. Targeting married men in HIV/AIDS campaign is preventing the scourge on a woman and her unborn child. This makes the married men to be an important category to consider in the prevention of HIV/AIDS.

Although the findings of the study show an increase in knowledge of HIV/AIDS and testing sites by married men, this is not accompanied by a corresponding increase in the percentage of respondents who say they have ever been tested for HIV. Therefore, there is need to increase the uptake of VCT by married men so that the majority of them undergo HIV test. The most common source of information on VCT noted was through health workers. Information from the church as a source was very low. This means that the church has not done much in the dissemination of information on VCT. Hence there is need for health care system to train key people in the churches who can in turn disseminate VCT information to their fellow members.

In sharp contrast to the proportions of respondents who had ever been tested for HIV, a very large number of married men reported a desire to be tested. However, very few respondents were willing to be informed

of HIV test results and to share those results. The reasons they gave for unwilling to have an HIV test was that they feared that the results may be positive. Furthermore, they said the positive HIV test results may lead to divorce by their wives and also feared stigma from the community and their families. Therefore, there is need for the health care system to protect the rights of people living with HIV/AIDS and to work against stigma, and discrimination. This action will promote openness and tolerance and encourage the involvement of people living with HIV/AIDS in communities in HIV/AIDS prevention and care programmes. This will in turn help limit HIV transmission and improves care and support efforts.

A large proportion of respondents had a negative attitude towards VCT. This negative attitude was seen more in respondents with primary education background. The implication to the health care system is that there is need to involve other sectors such as the Community Development Department to educate married men in the communities so that they can attain a much higher level of education for them to appreciate VCT services. There is also need to intensify information dissemination on HIV/AIDS and VCT in order to increase respondents' knowledge.

It was discovered that there was poor utilization of VCT by respondents in formal jobs. The reason could be due to the timing of the service. Hence, there is need for the health care system to set the time for VCT services in such a way that married men in formal jobs access them, particularly during weekends when they are on off-duties.

5.8 CONCLUSION

This study shows that there is a relationship between attitude and utilization of HIV voluntary counselling and testing. Despite being knowledgeable about HIV voluntary counselling and testing, majority of married men had negative attitude towards VCT and hence poorly utilized the service. Many of the married men were in the age group 25-34 years and most of them had primary education. Majority of the married men with primary education poorly utilized VCT services. Hence the study revealed that there is a relationship between education level of respondents and attitude and utilization of VCT. The researcher therefore rejected the null hypothesis.

It can be therefore mentioned that the main objective of the study has been achieved in that the attitude and utilization of HIV voluntary counselling and testing by married men has been determined.

5.9 Recommendations

5.9.1 Gwembe District Health Office

Since the study results revealed that majority of married men got HIV VCT information through health workers, there is need for Gwembe District Health Office should support its staff in terms of allowances and transport in order for them to continue disseminating the information.

In order for HIV VCT information to reach out to all the married men in the district, the District Health Office should ensure that mobile and door-to-door VCT is conducted in the district.

5.9.2 Ministry of Health

The Ministry of Health should provide a vehicle to the District Health Office to assist in conducting mobile VCT in the whole district.

5.9.3 The District Commissioner's Office

There is need to involve stakeholders, particularly the churches in the dissemination of HIV VCT information. Therefore, the District Commissioner's Office through the District HIV/AIDS Task Force committee should train the leaders of churches in psychosocial counselling so that they assist in the campaign against HIV/AIDS.

5.9.4 Health Workers/Counsellors

Health workers in the district should find ways of assisting married men to disclose their HIV status to their significant others. This would help them get support from the significant others. This also encourages other people to undertake HIV tests.

5.9.5 Further research

Since most married men acknowledged that VCT has got advantages but still could not utilise the service which they were even aware of, there is need to explore more on the cognitive and affective aspects of their feelings and perception about the service.

5.10 Dissemination of findings

Five copies of the report will be printed. A copy will be given to the Post Basic Nursing Department, University of Zambia, Ministry of Health who are the sponsors, Gwembe District Health Office and the other copy to the investigator.

One executive summary will be sent to the District Commissioner's Office and the other to counselling centres. A meeting with the respondents organised by his Loyal Highness, Chief Munyumbwe will be held to discuss the findings of the study and its recommendations.

5.11 Limitations of the study

- Due to a small sample size, the results could not be generalized to all married men in Zambia.
- This research was done in Gwembe District. Therefore, the findings of this study can not be generalised country wide.
- It was not possible to conduct the study on a large scale with a large sample size due to limited resources and time in which the study was to be completed and submitted to the University of Zambia, School of Medicine. This means that the study findings can not be generalised to a larger population of nursing.
- The limitation of this study is also inherent in the research design which has been chosen. In this study design observations are done at a single point in time compared to other designs where observations are carried out several times and allows the research investigator to examine changes over time.
- Non – probability sampling method called convenience sampling was used. This sampling method allows multiple biases that may exist in the sample.

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ANNEX 1

THE UNIVERSITY OF ZAMBIA

SCHOOL OF MEDICINE

DEPARTMENT OF POST BASIC NURSING

STRUCTURED INTERVIEW SCHEDULE FOR MARRIED MEN

**TOPIC: THE ATTITUDE AND UTILISATION OF VOLUNTARY
COUNSELLING AND TESTING BY MARRIED MEN**

INSTRUCTIONS TO THE INTERVIEWER

Serial NO-----Name of interviewer-----

Date of interview-----Place of interview-----

1. Introduce yourself to the respondents.
2. Establish rapport and explain the purpose of the interview.
3. Assure respondents of confidentiality and anonymity.
4. Get verbal consent from the respondent before the interview.
5. Tick in the box corresponding to the correct answer or write response(s) in the space provided.
6. Ensure that all questions are answered.
7. Do not write the name of the respondent on the interview schedule.

SECTION A: DEMOGRAPHIC DATA

**FOR OFFICIAL
USE ONLY**

1. What was your age on your last birth day?

2. How many wives do you have?

3. What is your highest level of education?

A. Primary

B. Secondary

C. Tertiary

--

4. What is your occupation?

A. Formal

B. Informal

--

SECTION B: KNOWLEDGE

5. Have you ever heard of HIV/AIDS?

A. Yes

B. No

--

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

A. Radio/television

B. Health workers

C. Books/posters

D. Friends

E. Others specify-----

--

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

**FOR OFFICIAL
USE ONLY**

- A. Mosquitoes
- B. Witchcraft
- C. HIV virus
- D. I do not know

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

- A. Through sexual intercourse
- B. Sharing cups and spoons
- C. Blood transfusion with unscreened blood
- D. Mosquito bite
- E. Sharing contaminated razor blades and needles
- F. Mother to baby through breast milk
- G. I do not know

9. How can HIV infection be prevented?

- A. Abstain from sex
- B. Hygiene
- C. Using a condom
- D. I do not know
- E. Others specify-----

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

- A. Yes
- B. No

11. Where did you hear it from?

- A. Radio/Television
- B. Health workers
- C. Books/posters
- D. Friends
- E. Church

17. Give reasons to your answer for question 16-----

**FOR OFFICIAL
USE ONLY**

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

A. Yes

B. No

19. Give reasons for your answer-----

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

A. Yes

B. No

21. Give reasons for your answer-----

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

A. Yes

B. No

23. Give reasons for your answer-----

**FOR OFFICIAL
USE ONLY**

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

A. Yes

B. No

25. Would you be willing to share the results?

A. Yes

B. No

26. Give reasons to your answer-----

SECTION D: UTILISATION

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

A. Yes

B. No

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

29. If yes where were you counselled?

- A. Health centre
- B. Hospital
- C. Muzeyi VCT centre
- D. Others specify-----

**FOR OFFICIAL
USE ONLY**

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

- A. Yes
- B. No

31. If no, give reasons-----

32. If yes, where were you tested?

- A. Health centre
- B. Hospital
- C. Muzeyi VCT centre
- D. Others (specify)-----

33. Did you collect your results for HIV test?

- A. Yes
- B. No

34. How can men who are married be encouraged to go for VCT?

35. What do you think are the factors that hinder men from utilising VCT services?

- A. Long distances to VCT centres
- B. Stigma from the community and their families
- C. Fear of divorce if their HIV test results came out positive

D. Poor infrastructure for VCT without privacy

E. Lack of awareness about presence of VCT services

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

THANK YOU FOR YOUR PARTICIPATION

ANNEX 2

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

28th August, 2006.

The District Commissioner
Gwembe District
GWEMBE

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

Dear madam,

**RE: PERMISSION TO CARRY OUT A STUDY ON THE ATTITUDE AND
UTILISATION OF VOLUNTARY COUNSELLING AND TESTING OF
HIV BY MARRIED MEN**

I write to request your good office to allow me conduct a study on the above mentioned subject in Munyumbwe and Chipepo starting from 1st September to 30th September, 2006.

I am a fourth year student at the University of Zambia, School of Medicine, Department of Post Basic Nursing, pursuing a degree course in Nursing. In partial fulfilment of this program, I am requested to conduct a research study. During my study confidentiality will be maintained and informed consent will be obtained from all respondents.

Your favourable consideration of this request will be highly appreciated.

Yours faithfully,

Misheck Mbewe
Fourth Year Student Bsc NRS



REPUBLIC OF ZAMBIA
MINISTRY OF HEALTH
GWEMBE DISTRICT HEALTH OFFICE
P.O. BOX 34
GWEMBE

1ST September, 2006

Mr M. Mbewe
Department of Post Basic Nursing
University of Zambia
LUSAKA

Dear Sir,

**RE: PERMISSION TO CONDUCT A RESEARCH PROJECT IN
MUNYUMBWE AND CHIPEPO**

Reference is made to your letter dated 28th August, 2006 on the above stated subject. I am glad to inform you that my office has granted you permission to carry out the research project in the requested areas.

Yours truly,

A handwritten signature in black ink, appearing to be 'H. Mweemba'.

H. Mweemba
Ag/ Manager Administration
For/District Director of Health

*Property of UNZA Library



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