GENDER DIFFRENTIALS IN HEALTH SEEKING BEHAVIOUR BETWEEN HIV POSITIVE WOMEN AND MEN IN THREE COMMUNITY SUPPORT GROUPS IN LUSAKA URBAN

BY
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DECLARATION

I, Steriah Daka declare that this desertion;

(a) Represents my own work;

(b) Has not previously been submitted for a degree at this or any other University; and

(c) Does not incorporate any published work or material from another dissertation.

Signed : SM

Date : 23-07-2010

APPROVAL

This dissertation of Steriah Daka is approved as fulfilling part of the requirements of the award of the Degree of Master of Arts in Gender Studies of the University of Zambia

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ABSTRACT

As we enter the third decade of the AIDS pandemic, the temptation is great to assume that the epidemic of gender differentials in health seeking behaviour between HIV positive women and men has improved. Most countries have introduced legislative laws and rules protecting people living with HIV and AIDS against gender differentials in health seeking behaviour. Despite these developments anecdotal evidence is showing that differentials in health seeking behaviour still exist. The main aim of this study was to determine factors that influence gender differentials in health seeking behaviour between HIV positive women and men. This was done in order to look at possible interventions community support groups put in place to assist the HIV positive women and men in health seeking behaviour.

The study was carried out in three community support health centres, Kalingalinga Auspices, Mtendere and Ng'ombe. The sample consisted of two government health centres and one Non governmental organisation centre. A total of 267 respondents provided the required information (240 HIV positive women and men, 6 counsellors and 21 additional respondents). To achieve its purpose the study used both qualitative and quantitative techniques such as structured and semi-structured questionnaires and in-depth interview guide were used to collect data.

The study revealed that pulmonary tuberculosis was the most predominant illness most of the respondents had suffered from as an opportunistic infection amongst HIV and AIDS patients. Majority of the respondents sought medical attention when they had opportunistic infections an indication that they seek medical attention regardless their sex. The study also revealed that majority of the respondents whose relatives decided for them to go for testing were females and men accompanied their spouses for testing and not vice-versa. Overall results predominant made as expressions of stigma in the participating communities was through the use of offensive labels. Ninety percent of the respondents did not shun treatment because of stigma and discrimination as compared to only a few of the respondents. Isolation from friends was one prominent type of discrimination respondents encountered within communities.

The study has the following recommendations based on the evidence from the results: the interventions should focus on the increasing awareness about Voluntary Counselling and testing as a starting point to improving access to ART. ; Improvement of access to basic HIV education and prevention facilities such as condoms; strengthening of peer educators to educate the community on HIV issues; increased involvement of male partners as an important feature of the mother-to-child transmission-plus initiative; involvement of communities in design and implementation of HIV initiative is intricate to success, HIV issues and further research to investigate what community activities need to be done in order to increase the uptake of VCT services if more people are to benefit from ART.

DEDICATION

This dissertation is dedicated to my mother, my sisters, my children Manda, Marster and Museta for the unwavering support during my period of study.

ACKNOWLEDGEMENT

I would like to express my gratitude to a number of people and institutions who in different but important ways contributed to the successful completion of this study. My greatest debt of gratitude is to my supervisor Dr. T. Kusanthan who patiently supervised the study and provided continued guidance.

Special thanks go to my Provincial Education officer for sponsoring the research and lightening the burden of the much needed funds. Special thanks to the three institutions Kalingalinga Auspices, Mtedere and Ng'ombe health centres where the research was conducted. Special thanks to Mr. Joseph Simbaya and Mrs. Rebecca Ngulube Chipoya for their unwavering support and vigilant search for literature. Special thanks to the Data analyst Mr. Madalitso Tembo.

Lastly, I would like to thank all the participants who willingly sacrificed their time to provide answers to the questions. Sincere thanks to Lusaka District Health Management Team for permitting me to carry out the research in the district. It is my sincere hope that the information gathered will contribute positively to addressing gender differentials in health seeking behaviour between HIV positive women.

ACRONYMS:

ACE: Community Education and Referral: Supporting Adherence to **ART** and Prevention for people with HIV in Zambia

AIDS: Acquired Immune Deficiency Syndrome.

ANC: Antenatal Care

ARV: Antiretroviral

ART: Anti-Retroviral Therapy.

BCC: Behaviour Change Communication

CBO: Community - Based Organization.

CBOH: Central Board of Health.

CBV's: Community - Based Volunteers

CCC: Comprehensive Care Clinic

CHAZ: Churches Health Association of Zambia

CHW: Community Health Workers

CSG: Community Support Group

CSO: Central Statistics Office.

DAART: Directly Administered Anti-Retroviral Therapy

DHS: Demographic Health Survey

DOTS: Directly Observed Therapy - short course

GIPA: Greater Involvement of people with AIDS

GRZ: Government Republic of Zambia.

HAART: Highly Active Anti-Retroviral Therapy

HW: Health worker

HIV: Human Immunodeficiency Virus.

MOH: Ministry of Health

MTCT: Mother- to- Child -Transmission.

NAC: National HIV/AIDS/STI/TB Council

NGO: Non-Governmental Organization.

NZP+: Network of Zambian People Living with HIV and AIDS.

OI's: Opportunistic Infections.

PLWHA: People Living with HIV and AIDS.

PMTCT: Prevention of Mother-to-Child Transmission

SBS: Sexual Behaviour Survey

SFH: Society for Family Health

STI: Sexually Transmitted Infection.

TB: Pulmonary Tuberculosis

TH: Traditional Healer

UN: United Nations

UNAIDS: United Nations Joint Programme on AIDS

UTH: University Teaching Hospital

VCT: Voluntary Counselling and Testing.

WHO: World Health Organization

ZANARA: Zambia National Response to HIV and AIDS Project

ZDHS: Zambia Demographic and Health Survey

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CHAPTER ONE

BACKGROUND TO THE RESEARCH PROBLEM

1.0 INTRODUCTION

HIV and AIDS is a global public health problem severely affecting millions of people. Sub-Saharan Africa remains by far the region worst affected by the AIDS epidemic. The region has just over 10% of the world's population, but is home to two-thirds of all people living with HIV. It is estimated (UNAIDS 2003) that 25 million people under the age of 50 years are living with HIV and AIDS in sub-Saharan Africa, with 2.7 to 4.1 million new infections in 2004.

Some 40 million people are living with HIV and it is estimated that 6 million of them in developing countries are urgently in need of antiretroviral therapy (ART) in order to stay alive (WHO/UNAIDS 2004). However, fewer than 8% of those who need Antiretroviral drugs (ARVs) are receiving them. This dire lack of access to life-saving treatment has been declared a global health emergency by WHO and UNAIDS. WHO, UNAIDS and many other partners were working to realize the target of providing ART for 3 million people living HIV and AIDS in developing countries by the end of 2005 (the 3 by 5 target).

Globally, the situation of HIV/AIDS epidemic has spread with ferocious speed (UNAIDS 2005). Data on HIV and AIDS highlight the epidemic as a global problem of a great magnitude. A total of 40.3 million people were living with HIV by the end of 2005. Since 1981, more than 25 million people have died of AIDS-related illnesses. In 2005 alone, 3.1 million people died of AIDS, out of which 570,000 were children. Close to five million people were newly infected with HIV in 2005 (UNAIDS,2005).

Sub-Saharan Africa has been the hardest hit by the pandemic. It is accounting for huge reversals in human development on the continent. Nothing else has ever reversed developmental gains so profoundly as the HIV and AIDS in some parts of sub-Saharan Africa. This will have critical long-term impact on human development, economic growth and stability, on society, culture, governance and national capacity, for decades to come (Barnett and Whiteside, 2002). More than

28.5 million people in sub-Saharan Africa were living with HIV/AIDS in 2005 (UNAIDS, 2005). It is estimated that 23.6 to 30 million

Africans are living with HIV/AIDS, with 2.7 to 4.1 million new infections occurred in 2004 (MOH, 2005). In sub-Saharan Africa, HIV infection rates are higher among women than men. Tlou (2002) estimates that over 13 million women in Africa are living with HIV, compared to 11 million men. According to the 2007 Human Development Report (UNDP 2007 p 41), Southern Africa has the highest prevalence ranging from 15% to 35% compared to West Africa (1.5%), North Africa (0.1%) and East Africa (3.7%).

Zambia has a population of 10.3 million people with an annual growth rate of 2.9 percent (CSO, 2000). The ZDHS (2002) estimated that currently, around 920,000 people in Zambia are living with HIV. In 2002, the HIV prevalence rate for the entire country was nearly 16% to the Demographic and Health Survey.

The CSO/ZDHS (2001/2002) indicates that 17% of women in the age range of 15-49 years were HIV positive compared to 13% of men in the same age range and that the prevalence was higher among the female adult population. In urban areas, the prevalence rate among 15-to-49 year-olds was more than 23%; while in rural areas, it was 11%. The overall rate is exceedingly high and shows that Zambia is undergoing one of the worst HIV/AIDS epidemics in the entire world. It means that among those Zambians ages 15-49, about one of six is already HIV-infected and most of those who are currently infected will die from this disease. In addition, more and more adults, as well as children, are becoming newly infected every day and if the current prevalence persists, more than half of today's 15-year-olds will die from this single disease.

Women are disproportionately affected by the HIV/AIDS epidemic. ZDHS (2001/2002) indicates that women (18%) are nearly 1.4 times more likely to be infected than men (14%). This imbalance sex ratio may occur in part because women are more biologically prone to infection than men during unprotected sex intercourse. Similarly, women are more vulnerable to other STIs, the presence of which greatly enhances the risk of HIV transmission. Older men having sexual relations with younger women may also contribute to higher rates of infection among women.

Women and girls are more vulnerable to HIV infection due to social norms that deny them from sexual health knowledge. Not all young people have because they want to, for example, a nation wide study of women 12 to 24 years old in Kenya ,25% said they lost their virginity because they had been forced to. A recently study in Nairobi indicated that 41% of HIV infection in the adolescent 13 to 19 year age group were consequence of rape. Unwilling sex with an infected partner carries a higher risk of infection, especially for girls. Since force is used, abrasion and cuts are more likely and the virus can more easily find its way into the blood streams. What more, condom use is unlikely in such situation.

Research has also shown that in up to 80% of cases of where women in long-term stable relationships are HIV positive, they acquire the virus from their partners (who had become infected through their sexual activities outside the relationships or through drug use).in a variety of contexts, research has shown that women's attitudes towards sex and sexual behaviour differ from considerably from those of men. According to Long and Ankara, (1996), women reported a preference for sexual relations based on mutual fidelity, intimacy and open communication. Studies have also shown that, when women do express a desire for safer sex, men are often obstructive. Perhaps not surprisingly, therefore, the major HIV risk for women is their regular sexual partner or husband (Good ridge and lamptey, 1999). On the other hand, dominant ideologies of masculinity promote the display of sexual prowess and encourage men to have multiple partners (Rivers and Eggleton, 1999).

It is also true that many existing HIV prevention programs fail to take adequate account of the social vulnerability of women or the unequal power relations between men and women in many, if not all Zambian communities. These inequitable relations make it difficult for women to influence in their sexual relationships as well as in the creation of equal social-economic opportunities.

Some of the reasons for high infection rates among women include socio-economic problems, social norms, biological reasons, behavioural reasons, the status of women and their inability to negotiate for safer sex. Young women are also more susceptibly than their peers because they are more likely to have sex with older men already infected with HIV. Early marriages and sexual cleansing are the other factors in sex behaviour.

HIV is the leading cause of deaths in sub-Saharan Africa. Sub-Saharan Africa alone bears an estimated 70% of the current burden of HIV and AIDS; 25.3 of the 36.1 million persons living with HIV and AIDS live in sub-Saharan Africa (WHO/UNAIDS-2004). Of all HIV deaths since the start of the epidemic (17.5 million adults and 4.3 million children), over three-fourths have occurred in Africa. In Africa, the most affected continent, it is estimated that less than 1% of those infected are receiving combination antiretroviral therapy (ART). UNAIDS 2004 in Tlou estimates that over 13 million women in Africa are living with HIV, compared to 11 million men. Sub-Saharan Africa is unique in that it is the only region in the world where more women than men are infected with HIV as in figures indicated above. Not only are women in Africa disproportionately infected, but HIV infection in women often places them at particularly increased risk of rejection, loss of security, stigma and violence. The main argument is that while both women and men are vulnerable to HIV infection. Women are more severely impacted because of their status, roles and limited rights in society.

Zambia has a population of 10.9 million people. The HIV prevalence rate is 14.3% for Zambia.. Approximately 150 people die each day. An estimated 1.6 million Zambians were living with HIV or AIDS in 2003. The Central statistical Office, Zambia Demographic health survey report indicates that 17 of women in the age range 15-49 years are HIV positive compared to 13% of men in the same age range and that the prevalence is higher among the female adult population. It is also estimated (International Labour Organisation 2006) that in Zambia, women are overall 1.4 more likely to be HIV-infected than men (17.8% for women and 12.6% for men).

1.1 STATEMENT OF THE PROBLEM

HIV/AIDS is a gender issue because women and men are affected differently. Every person living with HIV/AIDS has the right to medical care and treatment. Since the discovery of HIV/AIDS in Zambia, efforts have been made by the government and Non-Governmental Organizations NGO's) to sensitize people about the effects of HIV/AIDS. The Zambian government introduced ARVs in the treatment of HIV/AIDS. According to official figures, of the 1,483 people enrolled for treatment in January 2004, only 537 were women (CBoH 3004). Ministry of Health (2006) national uptake by October 2006 shows that of the 60,580 enrolled on ART, only 27,837 (40%) were females while 41,748 (60%) were males. The figures indicated above show that men enjoy

greater access to care, treatment and support. Therefore, this study intends to investigate the gender differentials in health seeking behaviour among HIV positive women and men.

1.2 OBJECTIVES OF THE STUDY

The objectives of the study were:

i) To assess the gender differentials in health seeking behaviour among HIV positive women and men in accessing ARVs.

ii) To asses the effects of gender differentials in health seeking behaviour among HIV positive women and men.

1.3 RESEARCH QUESTIONS

i) What are the gender differentials in health seeking behaviour between HIV positive women and men?

ii) How do effects on gender differentials in health seeking behaviour affect HIV positive women and men?

iii) What interventions had community support groups put in place to assist the HIV positive women and men in health seeking behaviour?

1.4 SIGNIFICANCE OF THE STUDY

The findings of the study will contribute to better understanding of gender differentials in health seeking behaviour between HIV positive women and men. The study could also contribute to the availability of literature on the gender related factors that influence gender differentials in health seeking behaviour. The study could also help development actors with tangible interventions and ways in working to expand women and men possibilities and choices in gender health seeking behaviour.

1.5 LIMITATIONS OF THE STUDY

The study may have some limitations in information because only 80 HIV positive women and men from each of the three community support centres may take part in the study. The rate at which respondents will be recruited for interviews may be slow. As a result, the data may take long to collect. It may also be difficult to get a bigger sample within the time frame of the study though a big number of people on ART may be big this time. The other limitation may be the rate

of visiting the centres by the respondents will be slow depending on how many shall visit the centres within the time frame of the study.

Delimitations of the study

The study shall exclude respondents in the distant places of the three community support groups as the study shall not cover respondents at their residences.

1.6 OPERATIONAL DEFINITIONS OF TERMS

AIDS: Acquired Immune Deficiency Syndrome. AIDS is a result of HIV infection. This occurs when the immune system of a person that is HIV infected becomes so low that they are vulnerable to a variety of illnesses.

ARV: Antiretroviral medicine. These are medicines that interfere with or disturb the life cycle of HIV by slowing down or stopping the processes by which HIV makes copies of it, and increases in the body.

ART: Anti-Retroviral Therapy. A term used to describe the treatment of HIV and AIDS with the use of antiretroviral drugs. ART is what is called a 'Holistic' treatment, which not only involves taking ARV drugs, but understanding HIV, AIDS, preparing for and adhering to ARV Regimens, ensuring proper nutrition, psychosocial support, palliative Care as well as caring for the carers of PLWHA.

CBV's: Community Based Volunteers are a link between people in the Community and the health care providers the prevention and treatment of HIV and AIDS.

CD4 Cell Count: Is a measure of the percentage/number of CD4 cells in the body that helps to determine the degree of immune damage, the need for starting ART and for monitoring response to treatment.

Confidentiality: A term that means any information shared between two people is not revealed to anyone else.

Counselling: A special form of confidential communication between a client (such as a PLWHA) and a care provider, in which thoughts, feelings and attitudes are explored in order to make a person feel good about themselves, or help them make decisions.

Counsellor: A term to describe people who have developed special skills and experience in helping people work through their problems.

Discordant Couples: A term used to describe a situation where one partner is HIV positive and the other is HIV negative.

Empathy: A term used to describe trying to understand a situation from another person's point of view and showing that you care.

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

HIV+: HIV positive describes a person infected with HIV status.

HIV Testing: A blood test can show if a person has been infected with HIV. If the person has been infected antibodies against HIV will appear in the blood. However, for a newly infected person wit time some time to develop enough antibodies to appear in a test. But also in this so called "window period" this person can infect others.

Immune System: Is the body's ability to fight off infections.

NAC: National AIDS Council is the coordinating body for all HIV/AIDS activities in Zambia.

OI's: Opportunistic Infections. Different infections that take advantage When HIV damage the body's immune system. With most of these infections people who have normal immune systems are not infected even when they are exposed. With other infections such as Tuberculosis and bacterial pneumonia, people with HIV infections are more vulnerable to getting infected. Common opportunistic infections seen in Zambia include Tuberculosis (TB), meningitis, Pneumonia, and thrush and diarrhoeal diseases.

PLWHA: People Living with HIV and AIDS.

Positive Living: A term used to describe steps taken by people living with HIV/AIDS that enhance their lives and improve their health.

STD: Sexually transmitted diseases; STDs include diseases as gonorrhea, syphilis and Chlamydia and are spread through sexual intercourse. It is important to treat such diseases immediately to avoid getting infected by HIV.

1.7 STRUCTURE OF DISSERTATION

There are four chapters after the introduction one. Chapter two presents a review of relevant literature while chapter III focuses on the methodology which comprises the data collection and analysis procedures. Chapter IV reports the findings of the study on gender differentials in health seeking behaviour between HIV Positive women and men. Finally chapter V discusses the findings, draws conclusions and makes some recommendations

CHAPTER TWO

LITERATURE REVIEW

2.0 INTRODUCTION

This section presents a review of literature on gender differentials in health seeking behaviours among HIV positive women and men. The use of the term Health seeking behaviours in this study is defined by Scrimshaw and Hurtado (1987) in the sense that it includes what people do individually and collectively in order to maintain and to return to health, what specific steps are taken by and why? The definition includes specific steps taken by the patient, such as self care, asking relatives/friends, use of the pharmacy, health care centre/hospital or the traditional healer and drug vendors (Scrimshaw and Hurtado 1987). Implicit in the definition is the suggestion that people may go back and forth between sources of help or use them simultaneously, and that these decisions are made by individuals influenced by various factors within their environment (Scrimshaw and Hurtado 1987). A survey of literature shows that many studies

Globally, the situation of HIV and AIDS epidemic has spread with ferocious speed (UNAIDS 2005). Data on HIV and AIDS highlight the epidemic as a global problem of a great magnitude. A total of 40.3 million people were living with HIV by the end of 2005. Since 1981, more than 25 million people have died of AIDS-related illnesses. In 2005 alone, 3.1 million people died of AIDS, out of which 570,000 were children. Close to five million people were newly infected with HIV in 2005 (UNAIDS, 2005).

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In urban areas, the prevalence rate among 15-to-49 year-olds was more than 23%; while in rural areas, it was 11%. The overall rate is exceedingly high and shows that Zambia is undergoing one of the worst HIV and AIDS epidemics in the entire world. It means that among those Zambians ages 15-49, about one of six is already HIV-infected and most of those who are currently infected will die from this disease. In addition, more and more adults, as well as children, are becoming newly infected every day and if the current prevalence persists, more than half of today's 15-year-olds will die from this single disease.

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Women and girls are more vulnerable to HIV infection due to social norms that deny them from sexual health knowledge. Not all young people have because they want to, for example, a nation wide study of women 12 to 24 years old in Kenya, 25% said they lost their virginity because they had been forced to. A recently study in Nairobi indicated that 41% of HIV infection in the adolescent 13 to 19 year age group were consequence of rape. Unwilling sex with an infected partner carries a higher risk of infection, especially for girls. Since force is used, abrasion and cuts

are more likely and the virus can more easily find its way into the blood streams. What more, condom use is unlikely in such situation.

Research has also shown that in up to 80% of cases of where women in long-term stable relationships are HIV positive, they acquire the virus from their partners (who had become infected through their sexual activities outside the relationships or through drug use).in a variety of contexts, research has shown that women's attitudes towards sex and sexual behaviour differ from considerably from those of men. According to Long and Ankara, (1996), women reported a preference for sexual relations based on mutual fidelity, intimacy and open communication. Studies have also shown that, when women do express a desire for safer sex, men are often obstructive. Perhaps not surprisingly, therefore, the major HIV risk for women is their regular sexual partner or husband (Good ridge and lamptey, 1999). On the other hand, dominant ideologies of masculinity promote the display of sexual prowess and encourage men to have multiple partners (Rivers and Eggleton, 1999).

It is also true that many existing HIV prevention programs fail to take adequate account of the social vulnerability of women or the unequal power relations between men and women in many, if not all Zambian communities. These inequitable relations make it difficult for women to influence in their sexual relationships as well as in the creation of equal social-economic opportunities.
Some of the reasons for high infection rates among women include socio-economic problems, social norms, biological reasons, behavioural reasons, the status of women and their inability to negotiate for safer sex. Young women are also more susceptibly than their peers because they are more likely to have sex with older men already infected with HIV. Early marriages and sexual cleansing are the other factors in sex behaviour.

2.2 FACTORS THAT INFLUENCE GENDER DIFFERENTIALS IN HEALTH SEEKING BEHAVIOUR AMONG HIV POSITIVE WOMEN AND MEN

2.2.1 Gender perceptions on health seeking behaviour.

Most patients disclose their illnesses to their spouses and parents when they are sick. The household head makes the decision to seek health care in the family. This indicates that family ties are still strong, especially for nuclear families. Therefore, the intervention must look into

strengthening families as support units. Generally, most communities have health and community support group centres within their localities. However, the majority walk to health facilities while others use various transport to seek medical attention.

The behaviours which put people at risk of HIV are rooted in the socio-cultural context. For example, women have less control over their own sexual behaviour and have little real decision power over their own sexual behaviour. Women in particular lack autonomy, and are taught from early childhood to be obedient and submissive to males. In sexual relations, a woman is expected to please her male partner even at the expense of her own pleasure and well being. Dominance of male interests and lack of self-assertiveness on the part of women puts them at risk. For example, women are taught never to refuse having sex with their husbands, even if he has other partners, is unwilling to use condoms, or has HIV or other STIs. Women have limited access to productive resources such as land, credit, skills, capital, technology and information. Because of this, most women are economically dependent on a man, which contributes to their inability to negotiate for safer sex and in some cases, leads to their engagement in commercial sex in order to survive.

2.2.2 Resource Limitations

Resource limitation is one factor that influences gender differentials in health seeking behaviour between HIV positive women and men. While the government of Zambia is making great progress to make ARVs available, PLWHA may lack the resources required to take their ARVs properly and consistently (SAFAIDS 2005).

Although the cost of HIV treatment is a barrier for both men and women, the latter often face additional problems apart from the high cost of ARV drugs, for example, lack of control over family expenditure, a requirement to obtain permission, and the relative poverty of households headed by females (ZARD/SARDC 2005).

Women's economic dependence on their husbands is reinforced by the legal discrimination they suffer in property, inheritance, and divorce laws in many African countries (WHO/UNAIDS 2004). Such matters are of concern in relation to ensuring equitable access to ARVs.

WHO (2000) states that in Zambia, a year's course of ARV treatment costs $480-490 per patient, of which the drug themselves make up 57%, and laboratory tests another 36%. Most of this cost

has always been subsidized, but at least the start of scale-up the government chose to charge each person receiving therapy around $8 per month. In addition, patients had to pay for tests and transportation, which generally raised the cost to $25-30 per month, while most Zambians live on less than a dollar a day, so could not possibly afford to pay. However, currently, ARVs are free of charge in health institutions.

The then selection criteria regarding who will receive free therapy, who will receive subsidized ART and who will pay out of pocket fully should have considered the impact of ART costs on access for women (WHO/UNAIDS 2004). The guiding principle should be fair distribution. As the cost of ART is a major barrier for women in particular, serious consideration must be given to abolishing user fees altogether as part of a strategy for protecting women's access to HIV treatment and care.

ARVs, while present in Zambia, are accessible only to a minority. Individuals who can afford these drugs may access them from private pharmacies or unregistered sources, facing risks that include ineffective and the development of drug resistance (ZARD/SARDC 2005). It is worse with women as they cannot afford to access drugs from these sources because of their poor status. and often have fewer means to cover any direct or indirect costs (such as transport).

2.2.3 HIV Testing and Disclosure

HIV testing and counselling services are an essential part of ART programmes. The HIV prevalence rate is 14.3 for Zambia. Yet less than 1.5 million of our population in Zambia has ever been tested for HIV despite government and NGO efforts to make VCT as widely available as possible (World AIDS Day 2007 District Toolkit). Urban rates for HIV testing are more than twice as high as rural rates (ZSBS 2005). Fear, denial, stigma and discrimination all keep people from taking advantage of the services that are available.

Men and women experience gender differentials to HIV testing and different consequences of disclosure, reflecting gender norms in their community (WHO/UNAIDS 2005). For example, some studies show that women are often not told of their status first-their husbands or in-laws may be told first. Women are also blamed for bringing HIV into the family and are at risk of abuse and ostracism. Men might be unwilling to have an HIV test for fear that they may lose their jobs or be

ostracized at work (WHO/UNAIDS 2005). The reasons commonly given for avoiding HIV testing are lack of perceived need and fear of negative outcomes from disclosing one's HIV status, including fear of stigma, discrimination and violence.

Stigma and negative outcomes of disclosure appear to be more common when a woman is tested prior to their partner, and when the woman is the HIV-positive partner in sero discordant couples (WHO/UNAIDS). Strategies to minimize negative consequences of testing for women include: couple counselling and testing, mediated disclosure by a trained Counsellor and education of communities and family members (men, older women) to reduce discrimination of women and girls who test positive.

Availability of treatment is likely to encourage more people, women and men, to seek HIV testing. However, concerns about stigma and violence (especially experienced by many women) may prevent them from seeking testing and counselling services (WHO/UNAIDS 2005). Similarly, in settings where medical procedures performed on women require their husband's consent (including the need for permission to access health centres), a potential for conflict with confidentiality and informed consent arises. Health providers need training and support on disclosure, confidentiality, informed consent and other ethical, issues related to ART. This training should also include recognition of specific risk for women on HIV disclosure, such as partner violence, which may affect their ability to use HIV services and adhere to ART.

2.2.4 Antiretroviral Treatment (ART) Uptake

The gender difference in health seeking behaviour also affects women's access to and interaction with health services including those for HIV prevention and AIDS care (UNAIDS 2004). To address gender differences in HIV and AIDS treatment, care prevention and support is crucial to consider the different needs and constraints of women and men when accessing HIV services in different settings and design interventions accordingly. For example, women's access is more likely to be affected by restricted mobility, difficulties in accessing transport and childcare and lack of treatment literacy, as compared to men's (SAFAIDS, 2004). In addition, women have special reproductive health concerns which need to be addressed by HIV treatment and care providers.

The gender differences in health seeking behaviour are expressed in the geographical, financial, social and cultural accessibility of health services, including HIV services (UNAIDS 2004). Differentials to accessing health services in terms of cost, location, distance to the facility and clinic scheduling affect women and men differently. For example, men may be unable to take time off to work to approach services for testing and follow up while women may have restricted mobility, be unable to arrange childcare and often have fewer means to cover any direct or indirect costs (such as transport).

According to Network of Zambian People Living with HIV and AIDS (NZP +2005), the present country situation in terms of access to ARVs is one of the immense gender differentials, in which most of the population affected by HIV and AIDS remains without access to HAART. According to CBOH (2004) official figures, Zambia's rollout is reaching disproportionately few HIV positive women than men. Of 1,483 enrolled in treatment in January 2004, only 537 were women. MOH (2006) ART department states that of 69,580 enrolled on ART, 27,832 (40%) were females while 41,748 (60%) were males.

Men, despite higher prevalence among women accessed over 70% of ARVs; Health Minister Brian Chituwo was quoted by United Nations Integrated Regional Networks Plus News, 2004. Women with AIDS received fewer services than men with AIDS. According to AIDS activist, Winston Zulu (2004), public health services are accessed more by women than men only when they are free. Most Zambian women are disempowered (and) disadvantaged; it is part of societal picture. The trend has continued even regarding access to ART.

2.2.5 Social-Cultural Beliefs and Practices

Certain cultural and traditional practices can increase the risk of HIV transmission by contributing to the subordination of women and undermining safe sex practices (National HIV/AIDS/STI/TB Council 2004). For example, when lobola is practiced, it often reinforces the subordinate role of women.

Widow inheritance and sexual cleansing after death of a spouse can create an opportunity for HIV transmission. When family members inherit the property of a deceased husband, the wife can be impoverished and willing to use sexual favours as a survival strategy. According to National HIV/AIDS/STI/TB Council 2004), involuntary and early marriages between young girls and older

men, and formal and informal polygamous marriages often increase the risk of HIV transmission for younger women.

African youth grow up hearing about HIV and AIDS from older adults who share stories and myths that may render all prevention messages useless (Tlou, 2002). This misinformation may lead youth to adopt fatalistic behaviours. For example, a young person who believes that HIV can be transmitted by mosquitoes is likely to see no point to abstain from sex or using a condom.

Some traditional doctors also claim that they can cure AIDS and cite stories of how their clients were healed and went on to live an AIDS-free life (UNAIDS 2001). What seems to happen, is an alleviation of some symptoms such that the client believes he or she has been cured, not an actual eradication of HIV in the body. Such clients, believing they are HIV-free, are not likely to practice safer sex, and thus transmit HIV to their partners (Tlou 2002). Beliefs about HIV transmission and AIDS are also rooted in cultural perceptions of disease being a result of witchcraft or the breaking of social norms and taboos. For example, in Botswana, many older people believe that AIDS is not a new disease, but an epidemic resulting from non compliance with the sexual taboos relating to widowhood.

2.2.6 Care and Support for the Sick

The provision of care and support to sick family members has been traditionally seen as a woman's rather than a man's responsibility, and AIDS care giving is no exception (Tlou 2002). At the same time, the burden of care for the sick and ailing family members falls on the females, who usually lack resources and training to provide adequate home-based care.

Studies on home-based care indicate that older women and girls are the major caregivers of PLWHA, yet they tend to have little access to resources such as good nutrition, transport and healthy support (Tlou, 2002). Furthermore, they often have less access to care and support when they themselves are infected. Very few men and boys share domestic responsibilities, so the burden of providing respite for female adult carers falls on girls.

Rural women increasingly face competing demands to maintain crop production, care for family members suffering from opportunistic infections, and protect their own health. Because an AIDS death of an adult results in the loss of household labour and/or income, children are often required

to leave school and remain at home or go to work to compensate for losses and to avoid school fees. For social and cultural reasons, girls are asked to leave school more often than boys to care for sick family members. Women are also called upon to nurture the growing number of orphaned children, the majority of whom are survivors of AIDS-affected households.

According to Zambia Health Information Digest Volume 7 Number 3, 2000, sick male patients are far much more likely to be looked after by their spouses than is the case for women. The gender gap is 32%. In addition, a husband is far more likely to desert his sick wife, than a wife is likely to desert her sick husband (ZHID 2000). This arises especially from the traditional pattern that the wife is regarded as the caregiver in the home, for both husband and children. When wives become sick, nearly half of them have to seek the assistance of their mothers, or other relatives, to provide care.

The gender discrimination against women in the provision of care shows that female AIDS patients are less likely to be looked after by their spouses (ZHID, 2000). Some women are even 'chased' from their homes by their spouses, and have to seek care in their mother's homes, or with other relatives. Widows of AIDS patients are also discriminated against in various ways. Although often suffering from AIDS themselves, they are often 'chased' from the homes by their deceased husband's relatives, following the (illegal) tradition that the husband's relatives inherit the property left behind. There is need to provide adequate knowledge and to influence socio-cultural attitudes that may create barriers to safe and effective care giving. MOH (2005) indicates the importance of equipping people with basic skills of care giving for the sick. Usually, it is women who bear the burden of caring for the sick, regardless of the type of opportunistic infection. Effective and safe care giving may involve challenging traditional norms, which for example would not allow a married woman to handle a sick husband using gloves. It is essential that men are better informed and more involved in caring for the sick (MOH, 2005).

2.2.7 Health Service Related factors

The present operations of health centres in relationship to HIV and AIDS treatment is perceived as being inadequate. Factors identified as hindrances to utilization of health centres/hospitals are; shortage of drugs, lack of privacy, long queues, poor attitudes of a member of the opposite sex, high medical fees, poor attitudes of staff and demanding that one should bring a partner before being treated (WHO/UNAIDS 2004)

2.2.8 Stigma and Discrimination

The problem of stigma and discrimination is a cross cutting issue as it affects all areas of HIV and AIDS intervention (MOH 2006). Whether affected, or infected, many people avoid any mention of HIV because of the stigma attached to the disease, and the fear of discrimination. The National HIV/AIDS/STI/TB Council, 2004 states that stigma associated HIV and AIDS and discrimination against PLWHA leads to social ostracism and alienation and to a deterioration of civil, economic, and political rights.

HIV and AIDS-related stigma and resulting discriminatory acts create circumstances that fuel the spread of HIV (UNAIDS 1998). Fear of being identified with HIV prevents people from learning their serostatus, changing unsafe behaviour and caring for PLWHA. An International Centre for Research on Women (ICRW) study in Botswana and Zambia found that stigma against HIV-positive people and fear of mistreatment prevented people from participating in voluntary counselling and testing (VCT) and programmes to prevent mother-to-child transmission (MTCT) (Nyblade and Field 2000). Whether it is these programmes, home-based care, or respite support services, stigma prevents individuals and communities from using HIV and AIDS services. Stigma and its resulting discrimination also intensify the pain and suffering of both the PLWHA and their families. With regards to stigma related to HIV and AIDS, in many societies PLWHA are often seen as shameful, while in some societies the infection is associated with minority groups or behaviours, for example, homosexuality. In some cases HIV and AIDS may be linked to 'perversion' and those infected will be punished. Also, in some societies HIV and AIDS is seen as a result of personal irresponsibility. Sometimes, HIV and AIDS are believed to bring shame upon the family or community.

A major problem in attempting to address this epidemic is that people often avoid learning about or admitting to be infected with HIV because of the stigma attached to the disease and fear of discrimination. Such avoidance limits discussion of knowledge about HIV and AIDS in the general population and increases the risk of transmission to loved ones and others. Gender is a critical element in understanding stigmatization of individuals suffering from HIV and AIDS. There is offensive labelling for women suffering from HIV and AIDS as compared to men. (Dustbins, Fimbusu literal translations toilets, Hule (prostitutes for females while terms used to describe males suffering from HIV and AIDS were less offensive such as kubukinsa which in literal translation means just an accident). Stigmatization related to suffering from HIV and AIDS

shared such as gender polarizations to an extent that the girls and women consider suffering from HIV and AIDS worse than having a child out of wedlock.

Stigma and discrimination also affects those who give care and support to the infected (MOH 2005). Because of the stigma associated with the disease, some people may wish not to be seen to be caring for those who are infected with HIV, even when the infected are family members. This may make them discriminate those infected and this has led to some infected people losing hope in life, withdrawing from society and in worst case scenario, even committing suicide (NAC 2004). Therefore, stigma and discrimination as a cross-cutting issue has to be addressed as a barrier to successful intervention in all HIV and AIDS programmes.

2.2.9 Gender-Based Violence

Gender-based violence is a major violation of human rights and a constraint to national development in Africa (Tlou 2002). In most countries women continue to experience severe beating, rape, socio-economic abuse, as well as verbal and emotional abuse. The perpetrators of violence are usually husbands/partners and male acquaintances, as well as male family members, indicating that the home environment may not be necessarily be as safe for women and girls as is often assumed (Tlou 2002). In addition to the psychological consequences of sexual violence, survivors experience physical injuries, unwanted pregnancies, and STDs.

Violence against women is deeply rooted in stereotypical gender beliefs and roles (NAC 2004). Physical violence, the threat of violence, and fear of abandonment act as significant barriers for women who want to negotiate the use of a condom, discuss fidelity with their partners, or leave relationships that they perceive to be risky (Tlou 2002). Fear of violence also inhibits women from living positively with HIV. For example, a study done in Kinshasa, Democratic Republic of Congo found that about 97% of women with HIV were unwilling to inform their sexual partners of their HIV status for fear of violence, physical harm or even murder (Schoep 1992).

The lower status of women in society may affect the HIV-infected women's ability to receive treatment, including ART, and to make decisions about their own care (MOH 2005). Women are especially vulnerable to loss of social and economic support and to domestic violence when they are HIV infected. Violence against women is a problem, for example, in the (ZDHS 2002), over

half of women reported having been physically abused in their lifetime, and almost one in four (24%) reported being beaten in the past years.

Health care facilities providing ART have no systems in place to detect or address gender-based abuses such as domestic violence. Zambia still lacks government protocols on how to deal with violence against women and other abuses within ART programs (Post, 2008). The monitoring systems do not track the effects of such abuse. Similarly, the country's legal framework fails to address these issues adequately. Zambia has no specific law that criminalizes gender-based violence. The penal code does not cover marital rape or psychological abuse. Zambia's ART program is an impressive effort to provide free and universal HIV treatment. For this program to succeed, however, the government needs to introduce reforms in the health and legal systems to end the abuses against women that are obstructing their ability to fully benefit from life-saving HIV treatment programs.

Combating violence against women requires challenging the way that gender roles and power relations are articulated in society (UN 1996). In many countries women have a low status. They are considered as inferior and there is a strong belief that men are superior to them and even own them. Challenging traditional attitudes such as changing peoples attitude and mentality towards women will take a long time-at least a generation, many believe, and perhaps longer (UN 1996).

Nevertheless, raising awareness of the issue of violence against women, and educating boys and men to view women as valuable in life, in the development of a society and in the attainment of peace are just as important as taking legal steps to protect women's human rights. It is also important in order to prevent violence than non-violent means be used to resolve conflict between all members of society. Breaking the cycle of abuse will require concerted collaboration and action between government and non-governmental actors including educators, health care authorities, legislators, the judiciary and the mass media (UN 1996).

2.2.10 Condom Use

Despite increased condom use in Zambia, there are still barriers that prevent correct and consistent use (NAC 2002). The subordinate position of women usually means they do not negotiate for condom use. There are many people who have negative attitudes towards condoms, including

many myths and misconceptions. The ZDHS 2001/2002 reports that 12% of sexually active women and 19% of sexually active men used a condom at last sexual intercourse, a relatively low proportion in an environment of high prevalence. Among those men who paid for sex, 45% used a condom at last sex.

The indicator most commonly used if condom use is increasing is the proportion of women and men who use condoms with non-cohabiting partners (NAC 2005). The National HIV/AIDS Intervention Strategic Plan establishes a goal that 50% of women and 60% of men used condoms with non-cohabiting partners by 2006. The Sexual Behaviour Surveys (2001, 2002, 2003), reported that the proportion of men using condoms with non-cohabiting partners rose from 33% in 1998 to 39% in 2000, but then increased more slowly to 42% in 2003. Among men, the proportion rose from 24% in 1998 to 33% in 2000, and also increased more slowly to 35% in 2003.

More men use condoms with non-cohabiting or non-regular partners than women, and more urban people reported using them than rural people. The Sexual Behaviour Surveys (SBS 2001/2002) reported that the proportion of men using condoms with non-cohabiting partners rose from 33% in 2000 and 34% in 2003. The ZDHS 2001/2002 reported 52% of urban men used condoms with non-regular partners as opposed only 37% of rural men, and 47% of urban women used condoms similarly against only 23% in rural areas.

2.2.11 Mother-to-Child Transmission (MTCT)

WHO/UNAIDS (2002) states that over 90% of the 2.4 million children under the age of 15 who are living with HIV in Sub-Saharan Africa acquired infection from their mothers. In Sub-Saharan Africa, the high rate of MTCT is attributed to a lack of access for women to both HIV care and to ante-and post natal care, together with predominance of breast feeding, and the higher proportion of women in Africa with more advanced HIV disease, chonoa minorities and malnutrition (WHO/UNAIDS 2004).

Although antenatal care is an obvious entry point for women in need of ART, the fears of these services have until recently been limited to preventing transmission from mothers to children, with limited benefits to mothers with HIV (WHO/UNAIDS 2004).

Entry points for non-pregnant women and girls to HIV testing and counselling and to ART need to be readily accessible. The issue of access to drugs for women remains largely focused on MTCT. There is increasing rhetorical attention to the fact that life-saving drugs should not be given to women only in order to protect the health of their infants, but there has been little programmatic change towards increasing women's access to ARVs outside prenatal prevention effort (Gruskin 2000).

2.2.12 CONCLUSION

Women and girls are more vulnerable to HIV and AIDS in Sub-Saharan Africa because of economic and social inequalities that diminish women's abilities to make choices that promote their own health status. The uptake of ART in Zambia still remains low. For example, CBOH (2005) states that there are currently over 23,000 patients on ART. However, GRZ targeted that by the end of 2005, 100,000 patients will be on ART. However, achieving this target and maintaining a successful treatment programme depends on many factors, including effective communication. Communication will be needed to increase the uptake of VCT, increase knowledge on availability of ART; on the importance of strict and continuous adherence; and to tackle stigma associated with ART.

From the above literature it is evident that there are indeed gender differentials in health seeking behaviour between HIV positive women and men.

CHAPTER THREE

METHODOLOGY

3.0 INTRODUCTION

This chapter outlines the methods used and data collection techniques followed by the study to gather and analyse and present both qualitative and quantitative data. It will be presented under the following headings: Study design; Study site and selection, study population, sampling methods, data collection methods and tools pre-testing the methodology, data analysis, and ethical considerations.

3.1 STUDY DESIGN

Since the study sought to identify, examine and explain the effect of gender differentials in health seeking behaviour between HIV positive women and men, it applied both the qualitative and quantitative research designs. The two designs were employed in order to obtain a holistic insight into the objectives of the findings, in the discussions. The quantitative data involves head counting or comparing numbers of women to numbers of men in health seeking behaviour. The qualitative data focuses on the effects of gender differentials in health seeking behaviour and also provides information on actual benefits participants have received in the study. The concept of mixing methods is to improve study validity of psychological trials based on the recognition that any method used on its own has limitations and bias which could be reduced by employing two multiple approaches (Cresswell; 2003). The mixture methods approach made it possible to obtain the gender differentials in health seeking behaviour, the effects and gain an insight into possible interventions to address the effects.

3.2 STUDY SITES AND SELECTION

The study was conducted in three community health centres in Lusaka urban namely; Kalingalinga, Mtendere and Ng'ombe. The sites were identified as severely affected by HIV and AIDS and had the highest prevalence rates in Lusaka. A simple random sampling technique was used to select the respondents who are HIV positive from the three health centres.

3.3 SAMPLE SIZE AND SAMPLING PROCEDURES

The sample was based on the number of HIV positive women and men receiving health care in the three community centres –Kalingalinga Auspice, Mtendere and N'gombe. It was estimated that 1000 people were HIV positive from the three community centres. Total sampling was employed to interview all consenting respondents aged between 15 and 50 accessing treatment at the selected health centres. A total of 261 HIV positive women and men were randomly selected from the three centres and 6 health staff were purposively sampled especially those attracted to ART.

Frequency Interval = $\frac{\text{Total number of population}}{\text{The required number of sample}}$

Which is: $F = \frac{N}{SN}$

$= \frac{1000}{267}$

$= 3.7$

So, the respondents who consented to the request were selected and interviewed. In cases where they refused, they were allowed to continue with other health service related procedures.

SELECTED SAMPLE PER SCHOOL

HEALTH CENTRE	MALE	FEMALE	TOTAL
Kalingalinga	44	43	87
Mtendere	43	44	87
N'gombe	44	43	87
Health Staff	3	3	6
			267

3.4 DATA PROCESSING AND ANALYSIS

The study used triangulation which is the use of multiple tools in data collection in order to complement each other's limitations (Creswell: 2003). The study therefore used four (4) main data collection tools to collect data namely; structured questionnaires (appendix 1), in-depth interview guide (appendix 2), semi- structural questionnaires (appendix 3) and document analysis. These were supplemented by pre-testing of the instruments used.

3.4.1 SEMI – STRUCTURED QUESTIONNAIRES

Both structured and semi-structured questionnaires were used to collect the quantitative data. This tool helped to collect data from a large number of respondents within the study period of time on individuals' background information such as age, sex, marital status, denomination, education attained, occupation, monthly income, which type of opportunistic infections suffered from, and who makes decision to go for VCT; who accompanies him/her for VCT; what problems HIV and AIDS patients face in the community when seeking ARVs; types of domestic violence experienced from spouses; taking ARVs to prevent mother-to-child transmission during pregnancy, who decides when to use condoms; specific effects that hinder women and men in health seeking behaviour.

Secondly, the answers respondents provided could be compared so as to see which effects affected which sex generally. Thirdly, the open ended questions in the questionnaire allowed respondents to freely express themselves and also to raise issues which were conducted in Nyanja, Tonga and partly English in an office provided by the institutions for privacy.

The respondents of Mtendere and Kalingalinga understood English as evidenced in Table 3 and Figure 2. They attained senior primary, Junior and senior secondary level of education while respondents from Ng'ombe attained junior primary education only. The measures taken to ensure accuracy of the translation were two. Firstly respondents were asked to read the questions and if they understood, if not, the researcher spent time reading through the questions first in English and then interpreting in the local Chinyanja language which is widely spoken by many in Lusaka urban. The respondents did not want third person around when being interviewed for confidentiality sake.

3.4.2 IN-DEPTH INTERWIEW

An interview guide was used for in-depth interviews with 21 independent respondents (7 from each centre) on a one to one basis. The respondents were drawn from Kalingalinga auspices, Mtendere and Ng'ombe health centres. Confidentiality of the information to be provided was assured and respondents consent was sought before the interview. The purpose of interviews according to Seideman (1991) is not to get answers, evaluate or test hypothesis, but also to understand people's experiences and meanings they attach to the experiences about the reality being studied. The information that was solicited for included what difficulties patients experience

when they go for VCT and how they felt about their HIV status; knowledge and sources about ARVs; beliefs and perceptions by the community towards people taking ARVs; challenges and benefits of taking ARVs; types of stigma and discrimination experienced from the community about their HIV status; how they are coping up with stigma as people living with HIV and AIDS. Also included were suggestions on how best the community can address the effects on gender differentials in health seeking behaviour within their communities. The in-depth interview was conducted in Nyanja and Bemba.

3.4.3 DOCUMENT ANALYSIS

Research report on gender differential in health seeking behaviour say from books, Journals, published and unpublished documents were used to collect secondary data. Most of the analyzed documents and books provided useful information based on the research subject.

3.4.4 PROBLEMS ENCOUNTERED DURING DATA COLLECTION

Like any other survey, this study experienced some problems which are worth noting. One of the major problems that the researcher encountered whilst in the field was the frequency HIV positive women and men visited the centres was at time erratic. This made it extremely difficult for the researcher to interview a good number of respondents within the stipulated timeframe of data collection.

In many instances, respondents would ask what incentive they would be given at the end of the interview. They were expecting to be given money or food. For ethical reasons, the money and food were not given.

3.4.5 ETHICAL CONSIDERATIONS

Permission to conduct the study was sought from the Ministry of Health District Health Management Team. This was granted and all fields were to be met by the author (researcher). Entry to the health centre was gained through the in-charge of the institution. Doctors and clinical officers attending to people on ART briefly explained the study to the clients and asked if they were willing to participate in the interview. Those willing were then directed to the researcher. A private room at each of the three health centres was used to explain the purpose of the study and to review the consent procedure. After consenting verbally to participate in the study, the questionnaire and interview guide were administered either in Nyanja, Bemba, Tonga or English.

The filed data collector was the researcher alone due to sensitivity of the topic. The consent forms were signed and at the close of each day locked up by the clinical officer. The filled in consent forms were collected at the end of the study.

CHAPTER FOUR

PRESENTATION OF THE FINDINGS

4.0 INTRODUCTION

This chapter presents the findings of the study which are organized in line with the objectives of the study as outlined in chapter one. The presentations begins with findings on whether or not there are gender differentials and effects in health seeking behaviour between HIV positive women and men in the community. Therefore, the chapter reports on findings in retention to interventions communities put in place to assist HIV positive women and men in health seeking behaviour. Finally, the chapter presents results in gender differentials in health seeking behaviour between HIV positive women and men.

4.1. RESPONDENTS VIEWS ON GENDER DIFFERENTIALS IN HEALTH SEEKING BEHAVIOUR AMONG HIV POSITIVE WOMEN AND MEN

Table 1: Age of Respondents in relation to sex

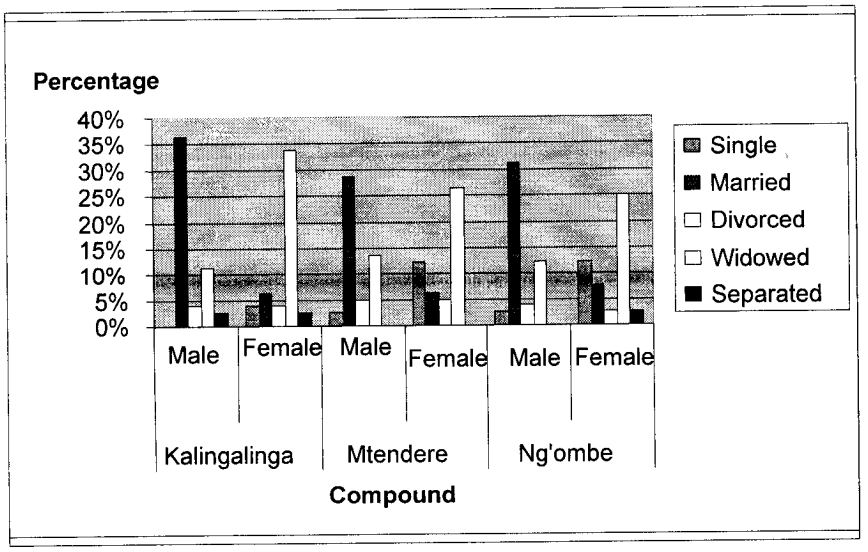
Sex of respondents		Age of respondents						
		15-19	20-24	25-34	35-39	40-44	50 years and above	
Mtendere	Male	4 (5%)	-	12(15%)	11(13.75%)	9(11.25%)	4(5%)	100%
	Female	2 (2.5%)	3(3.75%)	7(8.75%)	21(26.25%)	6(7.5%)	1(1.25%)	
Kalingalinga	Male	7 (8.75%)	-	10(12.5%)	10(12.5%)	6(7.5%)	7(8.75%)	100%
	Female	6 (7.5%)	2 (2.5%)	16 (20%)	11(13.75%)	4(5%)	1(1.25%)	
Ng'ombe	Male	6 (7.5%)	-	8(10%)	11(13.75%)	9(11.25%)	6(7.5%)	100%
	Female	6 (7.5%)	1(1.25%)	15(18.75%)	11(13.75%)	5(6.25%)	2(2.5%)	

Table 1 above show that most of the respondents from all three townships were aged between 25 and 39 years. This can be an indication that the majority of the people with HIV and AIDS were aged between 25 and 39 years.

Table 2: Marital status of the respondents

Sex of respondents		Marital status of the respondents					Percent
		Single	Married	Divorced	Widowed	Separated	
Mtendere	Male	-	26(32.5%)	3(3.75%)	9(11.25%)	2(2.5%)	100%
	Female	3(3.75%)	5(6.25%)	3(3.75%)	27(33.75%)	2(2.5%)	
Kalingalinga	Male	2(2.5%)	23(28.75%)	4(5%)	11(13.75)	-	100%
	Female	10(12.5%)	5(6.25%)	4(5%)	21(26.25%)	-	
Ng'ombe	Male	2(2.5%)	25(31.25%)	3(3.75%)	10(12.5%)	-	100%
	Female	10(12.5%)	6(7.5%)	2(2.5%)	20(25%)	2(2.5%)	

Figure 1: Marital status of the respondents



The findings in Table 2 above show that the majority of males from all the three townships were married and majority of females from all the three townships were widowed/divorced/separated or married and many of these widows/divorced/separated feel that HIV was the cause.

Table 3: Respondents level of education

Sex of the respondents		Respondents' level of education				Percent
		Junior primary	Senior primary	Junior Secondary	Senior Secondary	
Mtendere	Male	-	7(8.75%)	15(18.75%)	18(22.5%)	100%
	Female	-	17(21.25)	19(23.75%)	4(5%)	
Kalingalinga	Male	-	7(8.75%)	7(8.75%)	21(26.25%)	100%
	Female	-	11(13.75%)	6(7.5%)	2(2.5%)	
Ng'ombe	Male	7(8.75%)	5(6.25%)	20(25%)	8(10%)	100%
	Female	11(13.75%)	8(10%)	16(20%)	5(6.25%)	

Figure 2: Respondents' level of Education

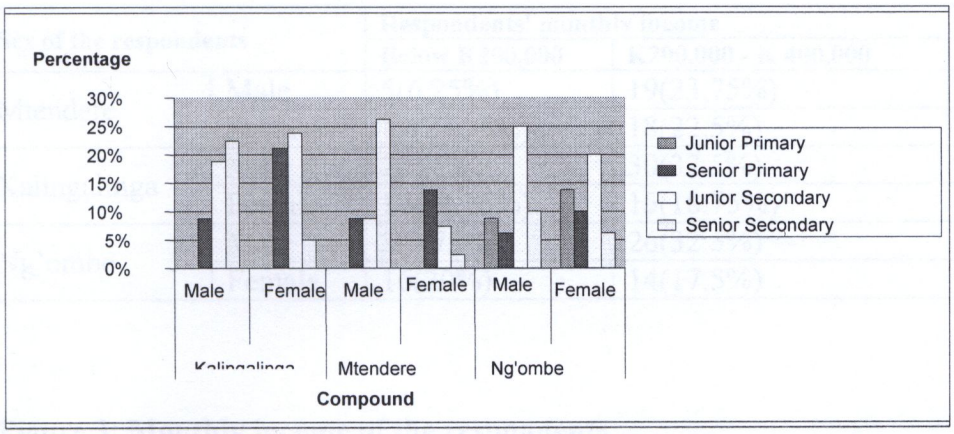


Figure 2 above shows the education profile of respondents in the three study sites. The highest levels of education attained by individuals is presented in figure 2 above; showing Ng'ombe respondents as the only ones who had attained Junior primary education only. The low education levels implied limited formal employment opportunities hence low income levels for households.

Table 4: Respondents' occupation

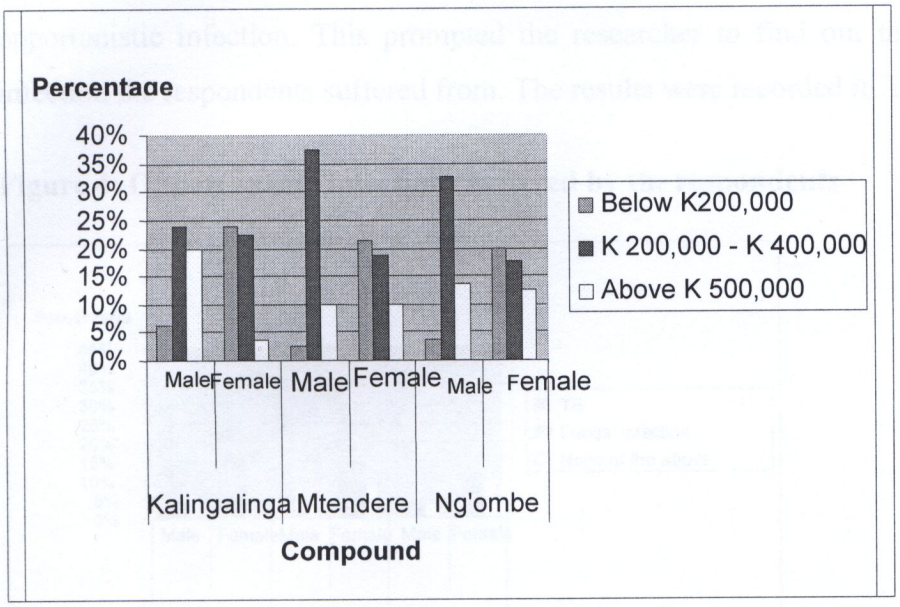
Sex of respondents		Respondents' occupation						Percent
		House wife don't work	Self-employed	Business person	Civil Servant	House Servant	None of the above	
Mtendere	Male	1(1.35%)	16(20%)	4(5%)	5(6.25%)	10(12.5%)	10(12.5%)	100%
	Female	19(23.75%)	9(11.25%)	4(5%)	1(1.25%)	5(6.25%)	5(6.25%)	
Kalingalinga	Male	4(5%)	13(16.25%)	9(11.25%)	-	9(11.25%)	9(11.25%)	100%
	Female	18(22.5)	2(2.5%)	8(10%)	-	2(2.5%)	2(2.5%)	
Ng'ombe	Male	4(5%)	14(17.5%)	7(8.75%)	3(3.75%)	6(7.5%)	6(7.5%)	100%
	Female	16(20%)	2(2.5%)	8(10%)	-	2(2.5%)	2(2.5%)	

The findings in Table 4 above show that a good percentage of the women who were HIV positive from the three townships were either not working or house wives contrary to their male counterparts. These can be an indication that women who were not working or house wives were more vulnerable to the HIV and AIDS infection.

Table 5: Respondents' monthly income

Sex of the respondents		Respondents' monthly income			Percent
		Below K200,000	K200,000 - K 400,000	Above K500,000	
Mtendere	Male	5(6.25%)	19(23.75%)	16(20%)	100%
	Female	19(23.75%)	18(22.5%)	3(3.75%)	
Kalingalinga	Male	2(2.5%)	30(37.5%)	8(10%)	100%
	Female	17(21.25%)	15(18.75%)	8(10%)	
Ng'ombe	Male	3(3.75%)	26(32.5%)	11(13.75%)	100%
	Female	16(20%)	14(17.5%)	10(12.5%)	

Figure 3: Monthly income of the respondents



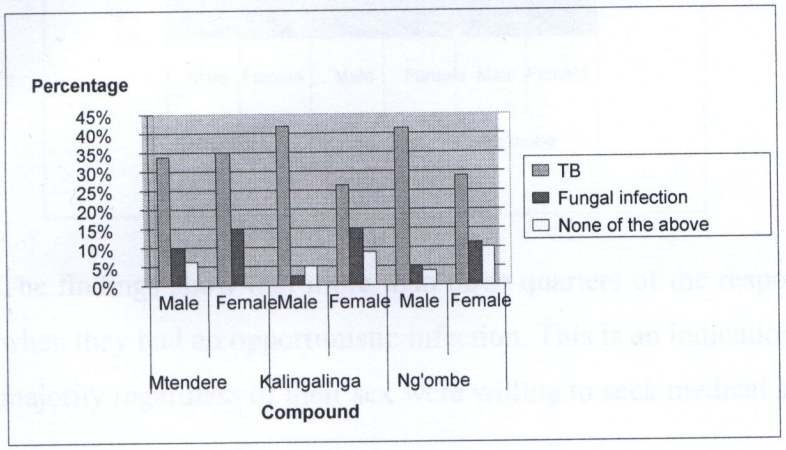
The findings in Table 5 above show that the majority of the male respondents from Kalingalinga and Ng'ombe had a monthly income of between K 200,000 and K 400,000 (37%). While a good percentage of females from all the three townships had a monthly income of below K 200,000. (28%) This shows that males who had at least a good income were more vulnerable to HIV and AIDS and females with low monthly income were more likely to be infected.

Table 6: Responses on opportunistic infection suffered from

Sex of respondents		Respondents' responses to what type of opportunistic infections they have suffered from			Percent
		Pulmonary Tuberculosis (TB)	Fungal infections	None of the above	
Mutendere	Male	27(33.75%)	8(10%)	5(6.25%)	100%
	Female	28(35%)	12(15%)	-	100%
Kalingalinga	Male	34(42.5%)	2(2.5%)	4(5%)	100%
	Female	21(26.25%)	12(15%)	7(8.75%)	100%
Ng'ombe	Male	33(41.25%)	4(5%)	3(3.75%)	100%
	Female	23(28.75%)	9(11.25%)	8(10%)	100%

The findings from all the three townships showed that all the respondents had suffered from an opportunistic infection. This prompted the researcher to find out the kind of an opportunistic infection the respondents suffered from. The results were recorded in Table 6 above.

Figure 4: Opportunistic infections suffered by the respondents

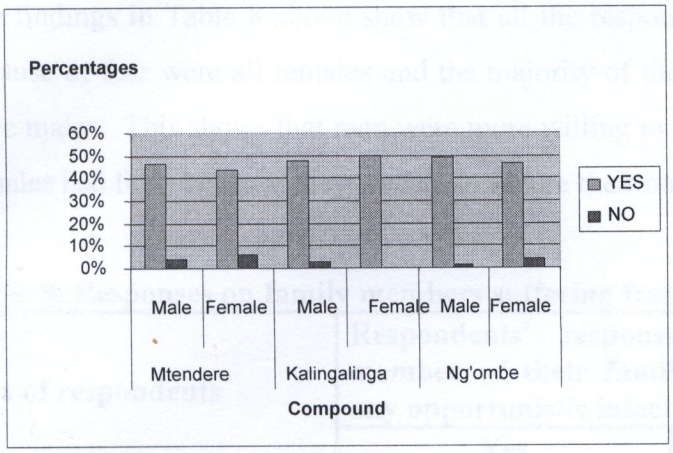


Findings from Table 6 above show that the majority of the respondents from all categories at one point suffered from Pulmonary Tuberculosis (TB). This is an indication that TB is the most dominant opportunistic infection among HIV and AIDS patients.

Table 7: Seeking medical attention for opportunistic infections

Sex of respondents		Respondents' responses to whether they seek any medical attention		Percent
		Yes	No	
Mtendere	Male	37(46.25%)	3(3.75%)	100%
	Female	35(43.75%)	5(6.25%)	
Kalingalinga	Male	38(47.5%)	2(2.5%)	100%
	Female	40(50%)	-	
Ng'ombe	Male	39(48.75%)	1(1.25)	100%
	Female	37(46.25%)	3(3.75%)	

Figure 5: Respondent's responses to whether they seek any medical attention

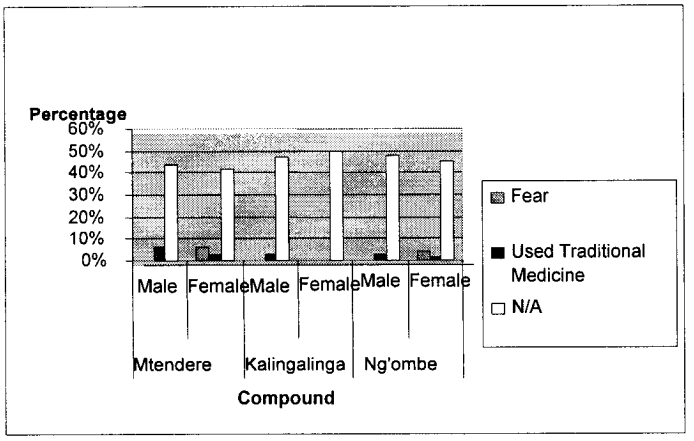


The findings show that more than three quarters of the respondents had sought medical attention when they had an opportunistic infection. This is an indication that more than three quarters of the majority regardless of their sex were willing to seek medical attention.

Table 8: Reasons for not seeking medical attention

Sex of respondents		Respondents' responses to why they don't seek medical attention			Percent
		Fear	Use traditional medicine	N/A	
Mutendere	Male	-	5(6.25%)	35(43.75%)	100%
	Female	5(6.25%)	2(2.5%)	33(41.25%)	
Kalingalinga	Male	-	2(2.5%)	38(47.5%)	100%
	Female	-	-	40(50%)	
Ng'ombe	Male	-	2(2.5%)	38(47.5%)	100%
	Female	3(3.75%)	1(1.255)	36(45%)	

Figure 6: Respondents' responses to why they seek any medical attention

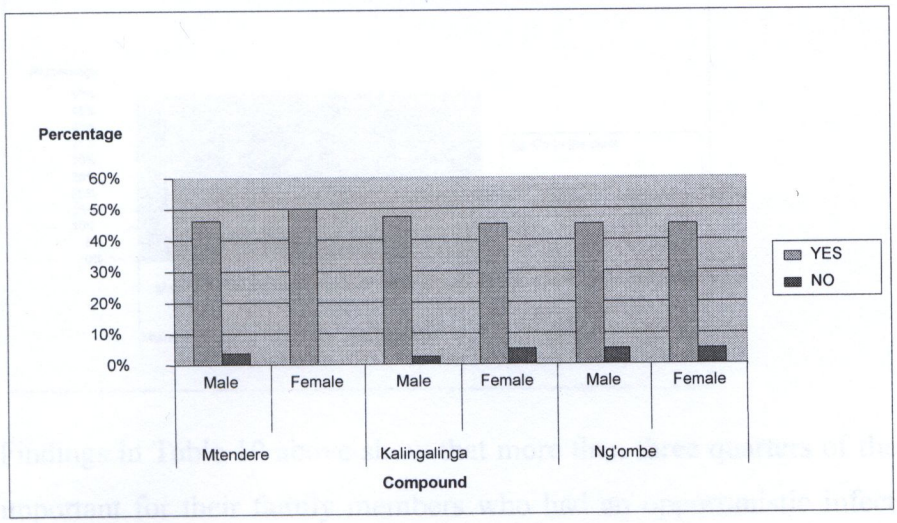


The findings in Table 8 above show that all the respondents who did not seek medical attention because of fear were all females and the majority of those who went to traditional doctor instead were males. This shows that men were more willing to use traditional medicine than women. The females had fears because they wanted to secure their marriages.

Table 9: Responses on family members suffering from any opportunistic Infections

Sex of respondents		Respondents' responses to whether any member of their family has suffered from any opportunistic infections		Percent
		Yes	No	
Mutendere	Male	37(46.25%)	3(3.75%)	100%
	Female	40(50%)	-	
Kalingalinga	Male	38(47.5%)	2(2.5%)	100%
	Female	36(45%)	4(5%)	
Ng'ombe	Male	36(45%)	4(5%)	100%
	Female	36(45%)	4(5%)	

Figure 7: Respondents' responses to whether any member of their family had suffered from an opportunistic infection

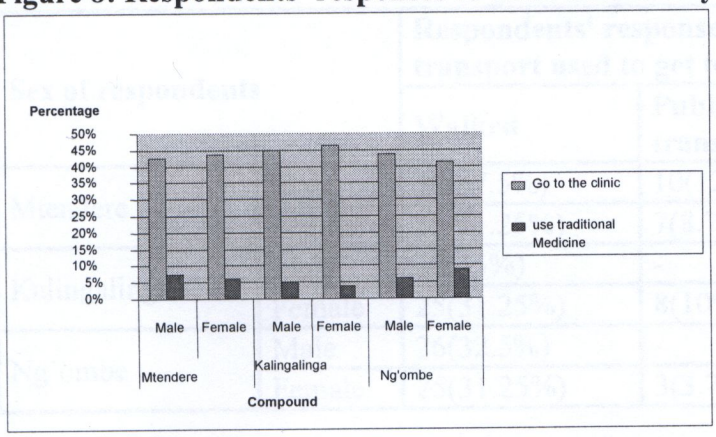


Findings in Table 9 above show that more than three quarters of the respondents from all the three categories had a family member who had suffered from an opportunistic infection. Respondents revealed that when untreated, opportunistic infections can lead to death. Therefore, if a person living with AIDS develops any symptoms, they should see a doctor right away because illnesses waken the body's immune system and allow the HIV virus to multiply more quickly.

Table 10: Advice given to family members suffering from opportunistic infection

Sex of respondents		Respondents' responses to what advice they gave their family members who were suffering from opportunistic infections		Percent
		To go to the clinic	Use traditional medicine	
Mtendere	Male	34(42.5%)	6(7.5%)	100%
	Female	35(43.75%)	5(6.25%)	
Kalingalinga	Male	36(45%)	4(5%)	100%
	Female	37(46.25%)	3(3.75%)	
Mtendere	Male	35(43.75%)	5(6.25%)	100%
	Female	33(41.25%)	7(8.75%)	

Figure 8: Respondents' responses to what advice they gave to their family members



Findings in Table 10 above show that more than three quarters of the respondents felt that it was important for their family members who had an opportunistic infection to go to the hospital or clinic. This means that three quarters of the respondents regardless of their sex felt that it was important for them to seek medical attention when ever they had an opportunistic infection.

Table 11: Type of health facilities respondents went to for health complaints

Sex of respondents		Respondents' responses to what type of health facilities they went for their specific complaints			Percent
		Government clinic/Hospital	Private clinic / Hospital	Traditional medicine	
Mtendere	Male	40(50%)	-	-	100%
	Female	35(43.75%)	3(3.75%)	2(2.5%)	
Kalingalinga	Male	38(47.5%)	1(1.25%)	1(1.25%)	100%
	Female	36(45%)	4(5%)	-	
Ng'ombe	Male	38(47.5%)	-	2(2.5%)	100%
	Female	33(41.25%)	1(1.25%)	6(7.5%)	

The findings in Table 11 above show that more than three quarters (75%) of the respondents from each category went to government hospitals because ARV drugs were free in all the health centres as long as VCT is viewed as the entry point for care and support of people living with HIV and AIDS. The health staff and CBVs are now encouraging clients to visit the health centres for information on ART.

Table 12: Mode of transport used to health facilities

Sex of respondents		Respondents' responses to the mode of transport used to get to a health facility			Percent
		Walked	Public transport	Cycled	
Mtendere	Male	30(37.5%)	10(12.5%)	-	100%
	Female	33(41.25%)	7(8.75%)	-	
Kalingalinga	Male	28(35%)	-	12(15%)	100%
	Female	25(31.25%)	8(10%)	7(8.75%)	
Ng'ombe	Male	26(32.5%)	-	14(17.5%)	100%
	Female	25(31.25%)	3(3.75%)	12(15%)	

The mode of transport respondents used to get to the health facility was walking as evidenced from Mtendere 37.5% males and 41.25% females walk to health facilities; Kalingalinga males 35%, females 31.25% and Ng'ombe males 32.5% and females 31.25%. The respondents who cycled or used public transport came from distant places such as Chawama, Chaisa, Mandevu due to fear of stigma from friends and community at large. They felt comfortable spending money than being known of their status within their locality.

Table 13 below reveals that less than a quarter (25%) of the respondents from all the three study sites covered more than four kilometres to various health facilities. Further probing through interview revealed that they would not want their status be known by the communities. They stated that stigma was still eminent in their localities.

Table 13: Distances to health facilities

		Distances between respondents' residence and the health facilities they visit			Percent
Sex of respondents		Less than 1 Km	1 to 4 km	More than 4 km	
Mtendere	Male	23(28.75%)	14(17.5%)	3(3.75%)	100%
	Female	23(28.75%)	16(20%)	1(1.25%)	
Kalingalinga	Male	17(21.25%)	18(22.5%)	5(6.25%)	100%
	Female	15(18.75%)	18(22.5%)	7(8.75%)	
Ng'ombe	Male	17(21.25%)	17(21.25%)	6(7.5%)	100%
	Female	13(16.25%)	19(23.75%)	8(10%)	

Table 14: Times visited the health facilities

Sex of respondents		Times the respondent has been to the health facilities before being seen for his/her specific complaint			Percent
		1st time	2 times	3 - 5 times	
Mtendere	Male	-	32(40%)	8(10%)	100%
	Female	-	36(45%)	4(5%)	
Kalingalinga	Male	5(6.25%)	25(31.25%)	10(12.5%)	100%
	Female	7(8.75%)	23(28.75%)	10(12.5%)	
Ng'ombe	Male	5(6.25%)	24(30%)	11(13.75%)	100%
	Female	7(8.75%)	23(28.75%)	10(12.5%)	

To assess time the respondents had been to the centres before being seen for specific complaints, majority of the respondents from all the three health sites revealed that they had been to the health facility twice before being seen by a health specialist; about 85% males and females from Mtendere, 50% Kalingalinga , 59% from Ng'ombe.

Table 15: Charges for voluntary Counselling and Testing

Sex of respondents		Respondents' responses to whether they were charged a small fee for VCT services		Percent
		Yes	No	
Mtendere	Male	2(2.5%)	38(47.5%)	100%
	Female	8(10%)	32(40%)	
Kalingalinga	Male	3(3.75%)	37(46.25%)	100%
	Female	4(5%)	36(45%)	
Ng'ombe	Male	4(5%)	36(45%)	100%
	Female	4(5%)	36(45%)	

Table 15 above shows that less than a quarter (25%) of respondents from each compound said that they paid a small amount of money for VCT services rendered to them at their health facilities. The respondents may have done the VCT before the declaration of free VCT services in all health institutions. Further findings revealed that all the respondents from all the three compounds had access to testing facilities and hence the long queues experienced for accessing ARVs.

Table 16: Decision to go for HIV testing

Sex of respondents		Respondents' responses to who decided for them to undergo HIV testing		Percent
		Alone	Relatives	
Mtendere	Male	30(37.5%)	10(12.5%)	100%
	Female	23(28.75%)	17(21.25%)	
Kalingalinga	Male	26(32.5%)	14(17.5%)	100%
	Female	13(16.25%)	27(33.75%)	
Ng'ombe	Male	24(30%)	16(20%)	100%
	Female	8(10%)	32(40%)	

Table 16 reveals that the majority of the respondents whose relatives decided for them to go for testing were females; Mtendere 21.25%. Kalingalinga 33.75% and Ng'ombe 40%. Further probing, the in-depth interview revealed that a few respondents reported that the decision to go for VCT was influenced by members of the family. One respondent said:

> *"I had a wound which was not healing up on my leg. My mother advised me to go for a test because she had her nephew before who was HIV and had a similar wound on the leg. So she suspected it could be a symptom of HIV infection. So I did not refuse, I went for testing and tested HIV positive. I was then referred to Chelstone Clinic for a CD4 Count but instead I went to Kalingalinga Hospice that is where I had my CD4 count and was introduced to ARVs"* (Mtendere woman).

Two respondents reported that the decision to go for VCT was influenced by mother-in-law. One respondent said:

> *"My mother-in-law forced me to go for an HIV test claiming that I was the cause of her son's death. My husband had persistent illnesses but never went for HIV test because the mother believed that he was bewitched. I just wanted to know my status" (Mtendere woman).*

> *"My mother-in-law physically escorted me for an HIV test claiming that I infected her son. I was tested and found positive, then I was referred to Kalingalinga Hospice for a CD4 count and was introduced to ARVs (Ng'ombe woman).*

Table 17: Accompaniment to HIV testing

Sex of respondents		Respondents' responses to who accompanied them for HIV test			Percent
		Alone	Wife/ Husband	A relative	
Mtendere	Male	25(31.25%)	5(6.25%)	10(12.25%)	100%
	Female	12(15%)	1(1.25%)	27(33.75%)	
Kalingalinga	Male	23(28.75%)	-	17(21.25%)	100%
	Female	11(13.75%)	-	29(36.25%)	
Ng'ombe	Male	24(30%)	3(3.75%)	13(16.25%)	100%
	Female	8(10%)	-	32(40%)	

Table 17 above shows that the majority of the respondents from all the compounds who accompanied them when going for testing were males. The reason for this can be attributed to males wanting to blame their spouses having brought the infection in the home while it is the male who seek multiple partners and feel insecure to go for HIV testing, especially in company of their spouses.

Table 18: Length of time for testing

Sex of respondents		Respondents' responses to how long it took for them to be tested		Percent
		Minutes	Hours	
Mtendere	Male	18(22.5%)	22(27.5%)	100%
	Female	2(2.5%)	38(47.5%)	
Kalingalinga	Male	17(21.25%)	23(28.75%)	100%
	Female	15(18.75%)	25(31.25%)	
Ng'ombe	Male	23(28.75%)	17(21.25%)	100%
	Female	15(18.75%)	25(31.25%)	

Table 18 above shows that the majority of the respondents said that it took hours for them to be tested. Further probing during the in-depth interview revealed:

> *"There is an improvement with regards to time spent for testing for HIV now. It now takes about 15-30 minutes to be tested at health centres unlike before where a few centres had the facility".*
> (Kalingalinga, Mtendere, Ng'ombe)

Table 19: Frequency of visiting health facilities

Sex of the respondents		Respondents' responses to how often they visit the health facilities to see counsellors / social workers		Percent
		Monthly	Fortnight	
Mtendere	Male	40(50%)	-	100%
	Female	40950%0	-	
Kalingalinga	Male	38(47.5%)	2(2.5%)	100%
	Female	36(45%)	4(4%)	
Ng'ombe	Male	38(47.5%)	2(2.5%)	100%
	Female	36(45%)	4(5%)	

Table 19 above shows that more than three quarters (75%) of the respondents visit the health centres on a monthly basis. The reason for this can be attributed to distance, since some respondents were not residents of the study sites. The other reason is that the health centres supplied ARVs for a period of 1-2 months and, this only allows them to visit the centre occasionally. However, respondents visit the centre whenever they develop symptoms of opportunistic infections to avoid further weakening the body's immune system.

Table 20: Attitude of health personnel towards HIV patients

Sex of respondents		Respondents' responses to how the would describe the Staffs' attitude towards HIV patient		Percent
		Supportive	Abusive	
Mtendere	Male	37(46.25%)	3(3.75%)	100%
	Female	40(50%)	-	
Kalingalinga	Male	38(47.5%)	2(2.5%)	100%
	Female	40(50%)	-	
Ng'ombe	Male	39(48.75%)	1(1.25%)	100%
	Female	40(50%)	-	

Table 20 above shows that only a few percentage of the respondents felt that the attitude of the health personnel towards HIV patients was abusive. This can be attributed to more campaigns and

collaboration with health centres staff in providing information to the community aimed at behaviour change/modification.

Table 21: Satisfaction with services provided

Sex of respondents		Respondents' responses to whether they were satisfied with the services they were offered			Percent
		Satisfied	Dissatisfied	No response	
Mtendere	Male	36(45%)	2(2.5%)	2(2.5%)	100%
	Female	40(50%)	-	-	
Kalingalinga	Male	38(47.5%)	2(2.5%)	-	100%
	Female	39(48.75%)	1(1.25%)	-	
Ng'ombe	Male	36(45%)	3(3.75%)	1(1.25%)	100%
	Female	39(48.75%)	1(1.25%)	-	

Table 21 shows that only a handful of the respondents from all the three centres were not satisfied with the services that were being offered to them in health centres. The reason for this can be attributed to distances covered by those staying out side the study sites, who have to spend money to reach the health centres. Majority were satisfied with services provided because there is more confidentiality of information by health personnel.

Table 22: Perceptions on how to improve the services

Sex of respondents		Respondents' perception on how the services offered can be improved				Percent
		More staff	Politeness /staff friendlier	Shorter waiting time	Services to be provided on daily basis	
Mtendere	Male	3(3.75%)	5(6.25%)	23(28.75%)	9(11.25%)	100%
	Female	-	-	25(31.25%)	15(18.75%)	
Kalingalinga	Male	12(15%)	2(2.5%)	14(17.5%)	13(16.25%)	100%
	Female	9(11.25%)	-	23(28.75%)	8(10%)	
Kalingalinga	Male	10(12.5%)	1(1.25%)	20(25%)	9(11.25%)	100%
	Female	9(11.25%)	1(1.25%)	24(30%)	6(7.5%)	

Table 22 above shows that the majority of the respondents from all the centres thought that the time they spent waiting for treatment at health services was too long. Because of this, they thought the services could be improved only if the waiting time was reduced to allow respondents to do other works in order to survive since others do business while some work as maids or garden boys.

Table 23: Period lived with HIV and AIDS

Sex of respondents		The time the respondent has lived with HIV/AIDS		Percent
		Months	1 year and above	
Mtendere	Male	8(10%)	32(40%)	100%
	Female	2(2.5%)	38(47.5%)	
Kalingalinga	Male	9(11.25%)	31(38.75%)	100%
	Female	12(15%)	28(35%)	
Ng'ombe	Male	11(13.75%)	29(36.25%)	100%
	Female	11(13.75%)	29(36.25%)	

Table 23 above show that less than a quarter (25%) of the respondents had lived with HIV and AIDS for only a month while about 75% lived for more years. Data in table 23 reveals almost gender balance regards respondents living with HIV and AIDS an indication that people are now accepting their status.

Table 24: Accessibility of ARVs at health facilities

Sex of respondents		Respondents' responses to whether ARVs are easily available at the centre (Hospitals/clinics)		Percent
		Yes	No	
Mtendere	Male	37(46.25%)	3(3.75%)	100%
	Female	40(50%)	-	
Kalingalinga	Male	3847.50%	2(2.5%)	100%
	Female	40(50%)	-	
Ng'ombe	Male	39(48.75%)	1(1.25%)	100%
	Female	40(50%)	-	

Table 24 shows the accessibility of ARVs at health centres, Mtendere had 46.25% males score, 50% females score above the male. Kalingalinga had 47.5% males score while female score was

50%. Ng'ombe had 48.75% males score and 50% females. The general picture from these results is good in that more than three quarters (75%) of the respondents revealed that ARVs were easily accessible in all the three study sites. The other positive response is that all the females in the three study sites scored 50% accessibility of ARV drugs being available and accessible by any at health centres. The result showed that health centres are the main sources of ARVs.

Table 25: Costs for ARVs

Sex of respondents		Respondents' responses to whether they pay for ARVs		Percent
		Yes	No	
Mtendere	Male	4(5%)	36(45%)	100%
	Female	4(5%)	36(45%)	
Kalingalinga	Male	8(10%)	32(40%)	100%
	Female	8(10%)	32(40%)	
Ng'ombe	Male	7(8.75%)	33(41.25%)	100%
	Female	7(8.75%)	33(41.25%)	

Table 25 above shows the cost for ARVs at the three study centres. Respondents were asked whether they pay for ARVs. Mtendere males and females scored 45% no, Kalingalinga males and females scored 40% no and Ng'ombe males and females scored 41.25%. Overall results revealed that three quarters (75%) of the respondents never paid for ARVs, they received from health centres. Respondents who scored yes started ART at private clinics and not government health centres. ARVs were now made widely accessible through sources such as the church especially Kalingalinga respondents.

Table 26: Problems faced by HIV and AIDS patients in the community

Sex of respondents		Problems HIV/AIDS patients face in the community as perceived by respondents					Percent
		Abandonment	Loneli Ness	Stigmatization	Discrimination	N/A	
Mtendere	Male	-	1(1.25%)	25(31.25%)	11(13.75%)	3(3.75%)	100%
	Female	6(7.5%)	3(3.75%)	25(31.25%)	6(7.5%)	-	
Kalingalinga	Male	-	4(5%)	21(26.25%)	10(12.5%)	5(6.25%)	100%
	Female	7(8.75%)	5(6.25%)	9(11.25%)	12(15%)	7(8.75%)	
Ng'ombe	Male	-	5(6.25%)	16(20%)	12(15%)	7(8.75%)	100%
	Female	6(7.5%)	6(7.5%)	11(13.75%)	10(12.5%)	7(8.75%)	

There are significant differences in the stigma scores for the three sites, Mtendere reports highest stigma of 31.25% for both males and females compared to Kalingalinga and Ng'ombe. Kalingalinga had 21(26.25%) males score the higher score than a (11.25%) females score while Ng'ombe males had 16 (20%) score than females 11(13.75%0. The results are reflected on table 26 shows that both women and men in Mtendere had higher stigma scores an indication that there is need for community sensitization through drama and sketches within communities. Furthermore men had significant higher negative self- image disclosure related concerns and public attitude related perceptions than women.

Table 27: Care and support

Sex of respondents		Respondents' responses to what type of care and support they receive				Percent
		Multivitamin supplements	ART	VCT	Palliative care	
Mtendere	Male	11(13.75%)	20(25%)	3(3.75%)	6(7.7%)	100%
	Female	4(5%)	17(21.25%)	11(13.75%)	8(10%)	
Kalingalinga	Male	9(11.25%)	23(28.75%)	6(7.5%)	2(2.5%)	100%
	Female	4(5%)	19(23.75%)	9(11.25%)	8(10%)	
Ng'ombe	Male	9(11.25%)	21(26.25%)	5(6.25%)	5(6.25%)	100%
	Female	4(5%)	19(23.75%)	8(10%)	9(11.25%)	

Table 27 above shows males domination of receiving ARVs; Mtendere had 20 (25%), Kalingalinga 23.(28.75%) and Ng'ombe 21(26.25%) compared to females, 17(21.25%),, 19(23.75%) and 19 (23.75%0 respectively. Females respondents scored higher than males on palliative care as shown in table 27. This can be attributed to the treatment of opportunistic infections as the core of care and support services. Females feel the prompt and effective treatment of opportunistic infections such as pain, cough, skin rashes, fever, diarrhea, for example can help alleviate suffering and improve quality of life.

Table 28: Satisfaction with care and support

Sex of the respondents		Respondents' responses to whether they are satisfied with the care and support		Percent
		No	Yes	
Mtendere	Male	-	40(50%)	100%
	Female	-	40(50%)	
Kalingalinga	Male	2(2.5%)	38(47.5%)	100%
	Female	1(1.25%)	39(48.75%)	
Ng'ombe	Male	2(2.5%)	38(47.5)	100%
	Female	1(1.25%)	39(48.75%)	

Table 28 above shows that all the respondents from Mtendere were satisfied and more than three quarters of the respondents from the two compounds were satisfied with the care and support they received from health centres. All the respondents from all the three compounds said that the care and support they received from health centres was treated with strictest confidence. However the negative scores indicate that the respondents were not satisfied with the care and support rendered at the health centre. They felt that provisions of food supplements can assist their nutritional status as majority cannot afford to have three meals a day.

Table 29: Responses to who cares for patients at home

Sex of the respondents		Respondents' responses to who takes care of them at home				Percent
		Alone	Spouse	Children	Parents	
Mtendere	Male	3(3.75%)	15(18.75%)	12(15%)	10(12.5%)	100%
	Female	3(3.75%)	3(3.75%)	10(12.5%)	24(30%)	
Kalingalinga	Male	10(12.5%)	10(12.5%)	7(8.75%)	13(16.25%)	100%
	Female	10(12.5%)	-	4(5%)	26(32.5%)	
Ng'ombe	Male	9(11.25%)	12(15%)	9(11.25%)	10(12.5%)	100%
	Female	7(8.75%)	1(1.25%)	6(7.5%)	26(32.5%)	

Table 29 on responses to the care for patients at home shows that majority of females or males were taken care of by their females and children indicating a priviledge of being nursed and not vice-versa. Mtendere males scored 15 (18.75%), Kalinganga 10 (12.5%), and Ng'ombe 12 (5%). While female respondents scored; Mtendere 3 (3.75%), Kalingalinga nil, and 1 (1.25%) Ng'ombe.

The general picture in table 29 shows that majority of the female respondents were take care of by their parents and not their spouses. Results show a fairly high level of support from family members (parents) by female respondents, Mtendere 24 930%), Kalingalinga 26 (32.5%) and Ngombe 26 (32.5%).

Table 30: Assistance to take medications

Sex of respondents		Respondents' responses to who helps them take their medications				Percent
		Alone	Wife	Children	Parents	
Mtendere	Male	18(22.5%)	6(7.5%)	14(17.5%)	2(2.5%)	100%
	Female	19(23.75%)	2(2.5%)	10(12.5%)	9(11.25%)	
Kalingalinga	Male	19(23.75%)	4(5%)	11(13.75%)	6(7.5%)	100%
	Female	17(21.25%)	-	4(5%)	19(23.75%)	
Ng'ombe	Male	20(25%)	4(5%)	9(11/25%)	7(8.75%)	100%
	Female	18(22.5%)	-	5(6.25%)	17(21.25%)	

Table 30 above shows that the respondents who were taking medication without anyone's help had the highest percentage for both female and male respondents. The male respondents in Mtendere scored 18(22.5%), Kalingalinga 19 (23.75%) and Ng'ombe 20 (25%) while female score an indications that female respondents find it very easy to take their medication independently. Kalingalinga females scored 17 (21.25%) showing a slight difference between the two sites. It is also worth considering the relatively low percentage of male respondents whose wives assist them take their medications, an indication that HIV patients are now owning the ART and appreciating the services.

Table 31: Participation in household chores

Sex of respondents		Respondents' responses to who does the household chore in their households				Percent
		Children	Husband	Wife	Parent	
Mtendere	Male	13(16.25%)	-	11(13.75%)	7(8.75%)	100%
	Female	24(30%)	9(11.25%)	5(6.25%)	11(13.75%)	
Kalingalinga	Male	12(15%)	-	8(10%)	16(20%)	100%
	Female	10(12.5%)	4(5%)	-	30(37.5%)	
Ng'ombe	Male	12(15%)	4(5%)	8(10%)	16(20%)	100%
	Female	13(16.25%)	-	-	27(33.75%)	

Table 31 above shows that the majority of female respondents from Kalingalinga and Ng'ombe had their household chores being done by their parents and the majority of the female respondents (24/40) from Mtendere had their household chores performed by their children. Further probing in in-dept interview, most female respondents whose household chores were done by their parents revealed that its either spouses chased or abandoned them hence going to stay with parents. The 24/40 (30%) female respondents from Mtendere whose household chores were performed by their children was as a result that they were either too weak or sick to do the chores or they go for piece work for survival.

Table 32: Experiences on domestic violence

Sex of respondents		Respondents' responses to whether they experience domestic violence			Percent
		Yes	No	N/A	
Mtendere	Male	12(15%)	22(27.5%)	6(7.5)	100%
	Female	5(6.25%)	35(33.75%)	-	
Kalingalinga	Male	13(16.25%)	23(28.75%)	4(5%)	100%
	Female	-	40(50%)	-	
Ng'ombe	Male	14(17.25%)	24(30%)	2(2.5%)	100%
	Female	1(1.25%)	39(48.75%)	-	

Table 32 above show that male respondents from all the three compounds were the majority among the respondents who said that they experienced domestic violence. Score Male respondents responses to whether they experience domestic violence shows that Mtendere males scored 12(15%), Kalingalinga 13 (16.25%) and Ng'ombe 14 (17.25%). This is attributed to the culture of silence. Probing further in in-depth interview one female respondent from Kalingalinga stated:

> *"Even men are battered by their wives and they are the worst culprits because they don't report because they feel ashamed to say they have been beaten by a woman"*

Table 33: Types of domestic violence experienced

Sex of respondents		Respondents' responses to what type of domestic violence they experience					Percent
		Insults	Threats	Rejection	Blame	N/A	
Mtendere	Male	3(3.75%)	11(13.75%)		4(5%)	22(27.5%)	100%
	Female	6(7.5%)	1(1.25%)	2(2.5%)	2(2.5%)	29(36.25%)	
Kalingalinga	Male	3(3.75%)	4(5%)	3(3.75%)	7(8.75%)	23(28.75%)	100%
	Female	5(6.25%)	-	-	-	35(43.75%)	
Ng'ombe	Male	2(2.5%)	5(6.25%)	3(3.75%)	6(7.5%)	24(30%)	100%
	Female	3(3.75%)	-	1(1.25%)	-	36(45%)	

The findings in Table 33 above show that the majority of the respondents from all the categories never experienced domestic violence and the majority of those who experience violence, highlighted insults as the major violence they experienced. The researchers' observation is that the culture beliefs are still deep rooted in some communities hence the culture of silence. Comments from some respondents stated that some women have started breaking through the culture of silence by reporting their spouses for any physical violence and threat of violence.

Table 34: Perception on feeling deserted

Sex of respondents		Respondents' responses to whether there are times they feel deserted		Percent
		Yes	No	
Mtendere	Male	15(18.75%)	25(31.25%)	100%
	Female	4(5%)	36(45%)	
Kalingalinga	Male	11(13.75%)	29(36.25%)	100%
	Female	-	40(50%)	
Ng'ombe	Male	8(10%)	32(40%)	100%
	Female	1(1.25%)	39(48.75%)	

Table 34 shows that a good number of males felt deserted as compared to their female counterparts. In the low range Ng'ombe females scored 1 (1.25%), Kalingalinga nil and Mtendere 4 (5%). In the average range males score show Mtendere 15(18/75%), Kalingalinga 11(13.75%) and Ng'ombe 8(10%). This can be attributed to stigma and discrimination still portrayed in some communities.

Table 35: Reasons for feeling deserted

Sex of respondents		Respondents' reasons why they feel deserted			Percent
		Isolation	Torture	N/A	
Mtendere	Male	6(7.5%)	7(7.75%)	27(33.75%)	100%
	Female	2(2.5%)	2(2.5%)	36(45%)	
Kalingalinga	Male	4(5%)	7(7.75%)	29(36.25%)	100%
	Female	-	-	40(100%)	
Ng'ombe	Male	2(2.5%)	5(5.25%)	33(41.25%)	100%
	Female	1(1.25%)	-	39(48.75%)	

Table 25 above shows that respondents who felt deserted felt so because of the torture and isolation they were experiencing. However, most of the respondents did not consider isolation or torture as reasons why they felt deserted. In Mtendere Township about 33% of male and 45% female; in Kalingalinga Township about 36% of female and all male while in Ng'ombe Township about 41% of female and 48% of male did not feel deserted.

Table 36: Shunning treatment due to stigma and discrimination

Sex of respondents		Respondents' responses to whether there are times they shun treatment because of stigma and discrimination		Percent
		Yes	No	
Mtendere	Male	8(10%)	32(40%)	100%
	Female	3(3.75%)	37(45%)	
Kalingalinga	Male	4(5%)	36(45%)	100%
	Female	-	40(100%)	
Ng'ombe	Male	3(3.75%)	37(46.25%)	100%
	Female	1(1.25%)	39(48.75%)	

The research revealed that majority (over 90%) of the respondents did not shun treatment because of stigma and discrimination as compared to only a few of the respondents. This can be attributed to sensitization and campaign strategies such as drama, sketches use of community radio stigma disseminating information to the public. TV, Radio, family members and friends are among the main sources of information.

Table 37: Measures to fight stigma and discrimination

Sex of respondents		Respondents' responses to what measures they have put in place as individuals to fight stigma and discrimination		Percent
		Acceptance	Nothing	
Mtendere	Male	10(12.5%)	30(37.5%)	100%
	Female	5(6.25%)	35(43.75%)	
Kalingalinga	Male	10(12.5%)	30(37.5%)	100%
	Female	1(1.25%)	39(48.75%)	
Ng'ombe	Male	7(8.75%)	33(41.25%)	100%
	Female	2(2.5%)	38(47.5%)	

Most of the respondents responded that nothing had been put in place to fight stigma and discrimination. Of the total respondents interviewed in Mtendere, about 80% said they had done nothing in order to fight stigma and discrimination. This was also true in Kalingalinga and Ng'ombe Townships The research also established that most of the respondents were discriminated by their spouse, friends, workmates, counsellors and others as tabulated below: Further probing in in-depth interview stated that they forced themselves in revealing their status and joining women's clubs within the communities as an indication that even HIV positive people can participate in social development activities and even lead such clubs.

Table 38: Discrimination by spouse/ friends/ workmates/ counsellors

Sex of respondents		Respondents' responses to whether they were at one time discriminated by their spouse/friends/workmates/counsellors		Percent
		Yes	No	
Mtendere	Male	24(30%)	16(20%)	100%
	Female	38(47.5%)	2(2.5%)	
Kalingalinga	Male	29(36.25%)	11(13.75%)	100%
	Female	18(22.5%)	22(27.5%)	
Ng'ombe	Male	24(30%)	16(20%)	100%
	Female	18(22.5%)	22(27.5%)	

Table 38 shows that majority female respondents from Mtendere 38(47.5%) were discriminated by their spouses/ friends workmates/ counsellors. This can be attributed to low sensitization and campaign strategies in the community either by drama, sketches and use of community radio dissemination. However, the scores for respondents who were not at any time discriminated by the above mentioned Mtendere males 16 (20%), Kalingalinga 11 (13.75) and Ng'ombe 16 (20%) indicated an affirmative response.

Table 39: Reason for discrimination

Sex of respondents		Respondents' reasons to why they are discriminated by their spouse/friends/workmates/counsellors			Percent
		Fear of contracting the infection	Embarrassment	Not applicable	
Mtendere	Male	15(18.75%)	5(6.25%)	20(25%)	100%
	Female	17(21.25%)	19(23.75%)	4(5%)	
Kalingalinga	Male	16(20%)	9(11.25%)	15(18.75%)	100%
	Female	9(11.25%)	12(15%)	19(23.75%)	
Ng'ombe	Male	15(18.75%)	6(7.5%)	19(23.75%)	100%
	Female	10(12.5%)	11(13.75%)	19(23.75%)	

Research findings were that about 39% of the respondents in Mtendere pointed out fear of contracting the infection as a reason for discrimination while about 29% pointed out that embarrassment as a reason for discrimination. Of all the respondents in Kalingalinga Township, about 31% pointed out fear of contracting the infection as a reason for discrimination while about 26% pointed out that embarrassment as a reason for discrimination. In Ng'ombe Township, about 30% pointed out fear of contracting the infection as a reason for discrimination while about only 20% pointed out that embarrassment as a reason for discrimination. Overall results in respondents' reasons to why they are discriminated scored averagely in almost all the three study areas. The score did not exceed 50% an indication that people are no longer fearing sharing food, shelter with HIV positive people

Table 40: Type of discrimination encountered

Sex of respondents		Type of discrimination the respondents encountered				Percent
		Isolation from friends	Abandonment	Deserted from	Not applicable	
Mtendere	Male	16(20%)	6(7.5%)	8(10%)	10(12.5%)	100%
	Female	20(25%)	6(7.5%)	12(15%)	2(2.5%)	
Kalingalinga	Male	18(22.5%)	6(7.5%)	9(11.25%)	7(8.75%)	100%
	Female	18(22.5%)	1(1.25%)	10(12.5%)	11(13.75%)	
Ng'ombe	Male	12(15%)	6(7.5%)	11(13.75%)	11(13.75%)	100%
	Female	17(21.25%)	4(5%)	8(10%)	11(13.75%)	

From the table given above, about 45% of the respondents in Mtendere were isolated from friends; 15% were abandoned; 25% were deserted while the rest did not respond. Again, about 45% of the respondents in Kalingalinga were isolated from friends; about 8% were abandoned; about 23% were deserted while the rest did not respond. In Ng'ombe, about 36% of the respondents in Ng'ombe were isolated from friends; 12% were abandoned; 23% were deserted while the rest did not respond. Further probing in in-depth interview stated that friends isolated them because they no longer had resources to give or share with their non- infected friends.

Table 41: Respondents' reaction to discrimination

Sex of respondents		Respondents' reactions to discrimination				Percent
		Embarrassed	Annoyed	Sympathetic	Nothing	
Mtendere	Male	4(5%)	11(13.75%)	5(6.25%)	20(25%)	100%
	Female	20(25%)	11(13.75%)	5(6.25%)	4(5%)	
Kalingalinga	Male	12(15%)	12(15%)	10(12.5%)	6(7.5%)	100%
	Female	13(16.25%)	5(6.25%)	7(8.75%)	15(18.75%)	
Ng'ombe	Male	11(13.75%)	9(11.25%)	3(3.75%)	17(8.75%)	100%
	Female	10(12.5%)	5(6.25%)	3(3.75%)	22(27.5%)	

The research revealed that 30% were embarrassed; about 26% annoyed; 12% sympathetic as compared to only 30% who did not react in Mtendere Township. Of all the respondents in Kalingalinga Township, 31% were embarrassed; about 21% annoyed; 20% sympathetic as compared to only about 25% who did not react. Ng'ombe Township, 25% were embarrassed; about 17% annoyed; only about 6% sympathetic as compared to only about 35% who did not

react. The general picture on respondent's response on reaction to discrimination shows that embarrassment comes out as the major reaction. The in-depth interview guide had the following experience:

> *"People gave me nicknames e.g. (Kana yaka, somebody has put on a jacket), they avoid me and made fun of; people saying things like:' Cinyoni (a bird) 'Look death is walking ('Onani infwa iyenda')"*

> *"The people in the community have ill-feelings toward HIV positive people. They think people with HIV don't reason. People think the illness has made HIV people less reasonable, ('Bana sinka mumathu na AIDS'), It has (HIV) confused them, that is what they think".*

Table 42: Problems faced when accessing ARVs

Sex of respondents		Problems faced by respondents in terms of accessing ARVs				Percent
		Cost	Need for permission	Not applicable	Time	
Mtendere	Male	4(5%)	5(6.25%)	10(12.5%)	21(26.25%)	100%
	Female	2(2.5%)	6(7.5%)	10(12.5%)	22(27.5%)	
Kalingalinga	Male	4(5%)	10(12.5%)	23(28.75%)	4(5%)	100%
	Female	-	11(13.75%)	27(33.75%)	2(2.5%)	
Ng'ombe	Male	3(3.75%)	3(3.75%)	14(17.5%)	20(25%)	100%
	Female	-	3(3.75%)	14(17.5%)	23(28.75%)	

Majority (about 52%) of the respondents in Mtendere Township revealed that time was the problem they faced in accessing ARVs while only about 7% pointed out cost; and 25% said the need for permission was the main problem they faced. In Kalingalinga Township, most of the respondents revealed that need for permission was the main problem they faced while only a few pointed out time problem.

Most of the respondents in Ng'ombe revealed that time was the main problem faced but most of them did not respond.

Table 43: Problems faced due to treatment of HIV and AIDS

Sex of respondents		Problems faced by respondents in terms of treatment to HIV/AIDS			Percent
		Side effects	Non adherence	Not applicable	
Mtendere	Male	17(21.25%)	3(3.75%)	20(25%)	100%
	Female	28(35%)	6(7.5%)	6(7.5%)	
Kalingalinga	Male	31(38.75%)	3(3.75%)	6(7.5%)	100%
	Female	30(37.5%)	-	10(12.5%)	
Ng'ombe	Male	25(31.25%)	5(6.25%)	10(12.5%)	100%
	Female	25(31.25%)	3(3.75%)	12(15%)	

The research showed that most of the respondents in all the townships under the study said that side effects were the main problem faced by respondents in terms of treatment to HIV and AIDS. A minority of the respondents revealed that non-adherence was the problem faced in terms of treatment to HIV and AIDS. The respondents talked about side effects such as persistent, headaches, skin rashes, drowsiness, putting on weight, vomiting and nausea, swelling of feet, lack of appetite. Many respondents revealed during the in-depth interview guide that they mostly experience these side effects during the initial stages of taking drugs. The responses from the health workers category echoed the same comments.

Table 44: Problems faced by patients on care

Sex of respondents		Problems faced by respondents in terms of care as a sick person			Percent
		Abandonment	Loneliness	Isolation from friends and family members	
Mtendere	Male	9(11.25%)	26(32.5%)	5(6.25%)	100%
	Female	2(2.5%)	36(45%)	2(2.5%)	
Kalingalinga	Male	7(8.75%)	28(35%)	5(6.25%)	100%
	Female	-	30(37.5%)	10(12.5%)	
Ng'ombe	Male	5(6.25%)	27(33.75%)	8(10%)	100%
	Female	1(1.25%)	27(33.75%)	12(15%)	

The research revealed that 13% of the respondents were abandoned; most (about 77%) were lonely; while 8% were isolated from friends and family members in Mtendere Township. Of all the respondents in Kalingalinga Township, 8% of the respondents were abandoned; most (about 72%) were lonely; while 18% were isolated from friends and family members. In Ng'ombe Township, 7% of the respondents were abandoned; most (about 67%) were lonely; while 25% were isolated from friends and family members. The overall result revealed that loneliness is the major problem faced by respondents on care. The reason for this can be attributed to believing that they are infected because of their careless sexual behaviour. Probing further in an in-depth interview, one male respondent from Kalingalinga had this to say:

> *"People in the community are happy to see me lonely because they are saying that I am paying for my mischievous sexual behavior. They are calling me a friable maker ('Ba Chitomfwa). This led me to self-isolation." Kalingalinga man.*

Table 45: Sources of drugs for treatment

Sex of respondents		Respondents' responses to where people with HIV/AIDS get drugs for treatment in their communities				Percent
		Government clinics /hospitals	Private clinics	Traditional healer	Don't know	
Mtendere	Male	22(27.5%)	7(8.75%)	7(8.75%)	4(5%)	100%
	Female	17(21.25%)	15(18.75%)	8(10%)	-	
Kalingalinga	Male	26(32.5%)	3(3.75%)	7(8.75%)	4(5%)	100%
	Female	18(22.5%)	7(8.75%)	7(8.75%)	8(10%)	
Ng'ombe	Male	25(31.25%)	5(6.25%)	5(6.25%)	5(6.25%)	100%
	Female	17(21.25%)	8(10%)	6(7.5%)	9(11.25%)	

Table 45 shows that the majority of the respondents in all the three study sites go to government clinics/Hospitals and the minority of the respondents to private clinic/hospital or traditional healers. The result shows that health centres are the main sources of ARVs for treatment . This is also the preferred source for most respondents. Another key source of drugs was the Auspices run by church organization. The ARV drugs were readily accessible at all government health centres and church organization health centres. Many respondents mainly learn about ART and AIDS related information at the health centres, through the radio and TV, from friends and relatives and through peer education.

Table 46: Knowledge of family members on ARVs

Sex of respondents		Respondents' responses to whether any member of their families have received ARVs before			Percent
		Yes	No	Don't know	
Mtendere	Male	4(5%)	13(16.25%)	23(28.75%)	100%
	Female	2(2.5%)	7(8.75%)	31(38.75%)	
Kalingalinga	Male	8(10%)	12(15%)	20(25%)	100%
	Female	13(16.25%)	2(2.5%)	25(31.25%)	
Ng'ombe	Male	9(11.25%)	14(17.5%)	17(21.25%)	100%
	Female	15(18.75%)	4(5%)	21(26.25%)	

The research revealed that most of them did not know whether any member of their families were receiving ARVs or not. Of the total of 240 respondents interviewed. In Mtendere, about 67% of the respondents did not know whether any member of their families were receiving ARVs; about 56% in Kalingalinga and about 47% in Ng'ombe township. Some respondents interviewed revealed that there is still stigma among people in the community in that they travel to other townships or cities for VCT and ART uptake. They would rather spend money travelling outside their location to avoid people knowing their status and ART uptake. However, one male respondent from Ng'ombe stated:

> *"I do not hide swallowing ARV drugs in the presence of my family members and friends and I have become an open cheque to ARV treatment by openly taking the drug in full view of people"*

The respondents were asked about on whether they knew anyone who was currently taking ARVs to prevent mother to child transmission during pregnancy and the responses are tabulated below:

Table 47: Perception on mothers on ARVs to prevent MTCT

Sex of respondents		Respondents' responses to whether they currently have anyone who is taking ARVs to prevent mother to child transmission during pregnancy			Percent
		Yes	No	Don't know	
Mtendere	Male	2(2.5%)	35(43.75%)	3(3.75%)	100%
	Female	2(2.5%)	38(47.5%)	3(3.75%)	
Kalingalinga	Male	4(5%)	29(36.25%)	7(8.75%)	100%
	Female	5(6.25%)	27(33.75%)	8(10%)	
Ng'ombe	Male	5(6.25%)	29(36.25%)	6(7.5%)	100%
	Female	6(7.5%)	26(32.5%)	8(10%)	

The results show that most of the respondents did not know anyone on ARVs trying to prevent mother to child transmission during pregnancy. Of all the respondents in Mtendere, about 90% did not know anyone on ARVs to prevent mother to child transmission; about 70% in Kalingalinga Township; and about 68% in Ng'ombe Township. However, the table 47 shows that all the respondents in Mtendere, about 90% did not know anyone on ARVs to prevent mother-to-child transmission, about 70% in Kalingalinga township and about 68% in Ngo'ombe township. The results in table 47 also revealed that not only did the males not know anyone on ARVs to prevent mother-to-child but females also as they scored Mtendere 38 (47.5%), Kalingalinga 27 (33.75%) and Ng'ombe 26 (32.5%). Response from the interviews with respondents indicated that with males and females should be brought on board on prevention of mother-to-child transmission awareness and benefits of antiretroviral prophylaxis the ARV drug regimens used to prevent mother-to-child.

Table 48: Decision to use condoms

Sex of respondents		Respondents' responses to who decides when to use condoms			Percent
		Husband	Wife	Both	
Mtendere	Male	8(10%)	10(12.5%)	22(27.5%)	100%
	Female	-	2(2.5%)	38(47.5%)	
Kalingalinga	Male	3(3.75%)	17(21.25%)	20(20%)	100%
	Female	-	18(22.5%)	22(27.5%)	
Ng'ombe	Male	4(5%)	14(17.5%)	22(27.5%)	100%
	Female	1(1.25%)	18(22.5%)	21(26.25%)	

Table 48 revealed that about 74% of the respondents in Mtendere Township said that both the husband and wife decides on the use of a condoms; while 15% were wives and only 10% were husband. In Kalingalinga Township, about 47% of the respondents said that both the husband and wife decide on the use of condoms; while about 43% were wives and only 3% were husband. Of all the respondents in Ng'ombe, about 53% of the respondents said that both the husband and wife decide on the use of condoms; while about 40% were wives and only 6% were husband. Overall results on who decided to use a condom in a home revealed affirmative response for both sexes an indication that there is now mutual understanding between women and men.

Results on wives deciding when to use condoms shows that women were now able to use condoms as part of decision making as evidenced in table 48: Mtendere 10 (12.5%), Kalingalinga and Ng'ombe 18 (22.5). Husband decision to use condoms scored low Mtendere 8 (10%), Kalingalinga 3 (3.75%) and Ng'ombe 4 (5%). The respondents reported that they were taught about safer sex and that the use of condom helps to reduce infections. One respondent said that even us who are single and sexually active should learn to use a condom:

> *"We can suffer from other infections if we don't use condoms. If you are having sex without a condom, you will infect each other with diseases because one cannot know if the partner has more viruses than the other" (Kalingalinga woman).*

CHAPTER FIVE

DISCUSSION, CONCLUSION AND RECOMMENDATIONS

5.0 INTRODUCTION

The previous chapter presented the findings on gender differentials in health seeking behaviour between HIV positive women and men in three community health centres in Lusaka urban. The exercise was done in order to provide answers to the research questions in chapter one of this study. The chapter reported the results on gender differentials in health seeking between HIV positive women behaviour between HIV positive women and men. The purpose of the study was to establish whether there were disparities in health seeking behaviour services between HIV positive women and men.

Based on the findings reported in the previous chapter, the present chapter seeks to provide answers by summarizing the findings in line with the objectives of the study. Recommendations based on the findings of the study with regard to gender differentials in health seeking behaviour HIV positive women and women are made.

5.1 DISCUSSION AND CONCLUSION

5.1.1 Sex And Age Differential

Findings reveal that most of the female respondents are widowed or divorced hence the high numbers of women on ART. Most of the respondents from the three townships were aged between 25 and 35 years. Reasons are twofold; VCT uptake among youths (below 25 years) is very low and the time it takes from infection to the time when symptoms appear and people are put on treatment is quite long. This could explain why there are fewer people on ART in the 15 to 25 years age group is confirmed by the high numbers of testing due to opportunistic infections.

5.1.2 Economic Status

Generally people living with HIV and AIDS on ART in the three study sites are very poor with a household income of less than K400, 000. This implies that they have fewer and less nutritive meals than a normal. The poor economic status of most respondents has programmatic implications. There is need for continued support both financial and nutritional, while mechanisms

for empowerment are worked out, until they have been capacitated with sustainable livelihoods that are resilient to household shocks and stresses.

The poor economic status of most respondents has nutritional, while mechanism for empowerment are worked out, until they have been capacitated with sustainable Income Generating Ventures (IGVs) that will enable them to have sustainable livelihoods that are resilient to household shocks and stresses. The lack of adequate food (quality and quantity) for people on treatment must be addressed if adherence is to be maintained or even improved.

Food in proper quantity and quality is also essential for better treatment results. It is therefore important that along with a continuous supply of medication and the means to collect the medication, ways be sought to ensure that people on ART have adequate food to support their treatment. While handouts in form of food supplements are an immediate relief, its sustainability cannot be guaranteed, therefore, efforts must be made to empower vulnerable people on ART to improve their nutritional status (household security) by raising their household income levels. It is also imperative that NGOs mobilize a balanced package or support necessary for people on ART encompassing financial, nutritional, psychological, spiritual, emotional care and other forms of support as community intervention.

5.1.3 Health Seeking Behaviour

Generally, the respondents exhibited good health seeking behaviours. When sick, the majority seek health care mainly from government health centres. Most respondents disclosed their illness to their spouses and parents. However, women can make own decisions to seek health care unlike before where the household made the decision. With the current solution of ART accessed through the clinics, this health seeking behaviour is likely to increase access and uptake of ART. VCT uptakes reported by the three communities are currently at about 42%. However, the differences between the three communities are very meagre. Generally, VCT levels are not very low considering that this was a random sample. However, more effort needs to be targeted at training VCT level in communities.

Majority of female respondents revealed that relatives decided for them to go for testing. Mtendere females scored 17 (21.25%), Kalingalinga 27(33.75%) and Ng'ombe (40%). Some respondents revealed that they were tested because they worried about symptoms and had

unprotected sex, because of marriage or death of spouse. This indicates that few are voluntarily going for testing while still in good health, hence the need to promote VCT as an entry point to ART access. Efforts must be made to ensure that everyone receives pre and post test counselling as an entry to VCT and uptake of ART. Awareness must be raised among communities to increase VCT uptake. It is hoped that will reduce the number of deaths, and eligible people will start their treatment on time.

5.1.4 HIV Testing and Disclosure

Majority of the respondents whose relatives decided and accompanied them to go for testing were females as revealed in tables 16 and 17. Despite this near universality of HIV and AIDS awareness, only minority female respondents reported having gone alone for VCT, while majority of the men went alone. The reasons include fear of results which was associated with apprehensions concerning stigma and discrimination. For women they wanted to safeguard their marriages while others stated that they would have nowhere to go and no one to look after them in consequence of divorce. Stigma is still a big issue despite the efforts directed at eradicating the problem.

However, there is more information available now so people are now disclosing their status to a family member and even spouses.

Community education contributes to the reduction of stigma and can enhance positive living, which in turn can encourage people to come forward for testing and treatment. Effective ways of encouraging people to go for VCT when they are still health must be employed such as increasing awareness about VCT as a starting point to improving access to ART.

5.1.5 Social-Cultural Beliefs and Practices

Social cultural beliefs and practices, which subordinate women in society can make them more vulnerable to HIV infection. Difficulty socio-economic conditions compel women to exchange sex for money or gifts. Other cultural practices such as dry sex and the traditional practice of widow/widower cleansing also facilitate the transmission of HIV. Women lack control of their lives and are taught from early childhood to be obedient and submissive to males who particularly command power as a father, uncle, husband, elder brother or guardian. In sexual relations, a woman is expected to please her male partner, even at the expense of her own pleasure and well

being. Women are taught to never refuse having sex with their husbands, regardless of the number of partners he may have or his non-willingness to use condoms, even if he is suspected of having HIV or another STI. Respondents revealed social norms deny women sexual health knowledge.

Women are biologically more vulnerable than men to HIV infection, their subordinate position to men can make it difficult protect themselves and certain cultural and economic practices can increase the risk of transmission.

5.1.6 Care and Support for the Sick

Majority of respondents from the three sites stated that they were satisfied with the care and support they received from health centres as they were treated with strictest confidentiality. Most of the Zambia's medical institutions provide only clinical care and counselling, while organizations based in the community tend to provide more holistic care, and counselling, social and spiritual support. Majority of the respondents from all the three sites who were taken care of by their parents were females. In order to ensure a continuum of comprehensive care for people living with HIV and ADIS, there needs to be more efficient coordination between the hospitals, clinics and the community based services and support.

Many respondents made it clear that communities already play a significant role in the provision of health care but this has not been sufficiently recognized or utilized. Additionally they state that communities are willing and able to be involved in many different ways in order to support hard pressed health care providers in doing their jobs. It is now accepted that ARV treatment is an essential component of care and support for PLWHA. Additionally, access to ARV treatment offers powerful support for HIV and ADIS prevention.

5.1.7 Health Service Related Factors

Most respondents stated that the present operations of health centres in relationship to HIV and AIDS treatment is perceived as inadequate. Factors identified as hindrances to utilization of health centres/hospitals are: shortage of drugs, lack of privacy, long queue and long waiting time, poor attitudes of staff and also demanding that one should bring a partner before being treated.

5.1.8 Stigma and Discrimination

Data reveals that stigma and discrimination levels are moderate, not very high. Reasons are two fold; availability of treatment and the non-selective nature of the epidemic. HIV and AIDS has been around for over two decades and is part of people's lives. Communities are slowly accepting the epidemic and hence slowing down stigma. Treatment has also led to more disclosure and higher VCT uptake resulting into low stigma. In a nutshell, more people have been sensitized on HIV and AIDS and the dangers of stigma. It is also critical to note that stigma resides within families as much as it does in the communities. There is need for anti-stigma efforts directed at family levels as a way of consolidating the social capital within families.

5.1.9 Condom Use

Knowledge about condoms is quite light, although understanding of the role condoms can play in preventing HIV transmission is lower. The respondents reported that they were taught about safer sex ad that the use of condoms helps to reduce infections. PLWHA get the condoms from community groups, clinics and hospitals. The research revealed that about 74% of the respondents in Mtendere site said that both the husband and wife decides on the use of condoms, while 47% of the respondents both husband and wife in Kalingalinga decides on the use of condoms and in N'gombe 53% both husband and wife respond deciding on the sue of condoms. Although condom use has not been widespread enough to stem the HIV and ADIS epidemic, a significant and increasing proportion of Zambian women and men are using condoms to protect their health. The epidemic would likely to be much worse in the absence of expanded condom availability and use. The correct and consistent use of condoms is an effective way to prevent HI transmission, and promoting access to and use of condoms will remain a cornerstone of HIV prevention strategies in Zambia. Still, much needs to be date to ensure that the National HIV and AIDS Intervention strategic plan goal of making condoms readily available to those couples who choose to use them is achieved.

5.1.10 Mother to Child Transmission

Study revealed that MTCT is an important mode of HIV transmission in Zambia. More than 20% of annual new infections are a result of MTCT. About 50 and 60 babies became newly infected

with HIV each day in Zambia. Since the mothers are already HIV positive, most of these children will become orphans.

Effective prevention of MTCT involves a combination of strategies such as integration of HIV prevention into reproductive and sexual health services, prevention of unintended pregnancies in HIV-positive women, access to comprehensive antenatal care, promotion of voluntary HIV testing and counselling for pregnant women and their partners in antenatal and community-based settings, antiretroviral therapy for mother and newborn and counselling on strategies to reduce the risk of HIV transmission via beast feeding.

5.1. 11. Conclusion

Knowledge levels are reasonably high in view of the low levels of education in the study sites, but do not seem to be translated into action. With the advent of antiretroviral therapy, concerns have been raised about its impact of HIV and AIDS – related behaviours. There is a growing body of evidence that 'treatment optimism' and perceived reductions in infectivity and acceptability of HIV and AIDS due to ARVs may lead to increased sexual risk taking behaviour. More efforts have to be targeted at behaviour change and preventive behaviour. New aspects and manifestations of the epidemic must also be communicated to the community. While community knowledge in general HIV knowledge is high, there are information gaps in relations to treatment. IEC materials and other information communication strategies should aim at reaching current information on health seeking behaviour. This is also likely to influence people's attitudes towards VCT.

While HIV-related services are available, community knowledge about their status needs to be enhanced. VCT uptake is still low, hence an entry point to ART, VCT uptake must be boosted to increase access to ART and reduce ADIS-related mortality. Effective ways of encouraging people to go for VCT when they are still healthy must be employed. Stigma levels are moderate, not very high. However, there is nee dot work at reducing it further.

5.2 RECOMMENDATIONS

5.3 General Recommendations

From the main findings it is recommenced that:

1. Improving health service delivery is an important element of encouraging health seeking behaviours amongst HIV positive women and men in terms of appropriate opening times, improved patient-staff interaction, waiting times, improved partner notification and availability of ARVs.

2. The interventions focus on increasing awareness about VCT as a starting point to improving access to ART.

3. The aim intervention adequately also focuses on activities aimed at behaviour change/modification.

4. IEC materials focus more on treatment information along with new trends in the epidemic and must be translated into four main languages; Bemba Lozi and Nyanja. Also targeted (IEC) Information, Education and Communication materials should empower women and empowerment of women may became critical elements in the reduction of stigma.

5. Collaborate with clinic staff in providing of information to the community to ensure that correct and consistent information is being communicated to all community members.

6. Radio is explored as a channel of information communication to the communities as it is affordable for most community members. Peer educators also be strengthened to educate the community in HIV issues.

7. Establishment of effective community preparedness and mobilization efforts and efficient referral systems would have the full potential of ARVs to be fully realized.

8. Systematic and coordinated engagement of community groups can improve treatment and prevention outcomes as well as generate more effective local responses as efforts to treat tuberculosis.

9. Holistic approaches to fighting HIV must be adopted that are designed to prevent HIV infection, provide affordable and accessible treatment and fight stigma and other barriers to care and access.

10. Involvement of communities in design and implementation of HIV initiatives is critical to success.

11. Access to clear, factual HIV prevention information and to HIV testing should be seen as a right, especially for vulnerable people in high-incidence areas. The government should promote the idea that each person can know his or her HIV status and has access to HIV information, counselling and related services, in a social and legal environment that is supportive and safe for confidential testing and voluntary disclosure of HIV status.

12. Aggressively address stigma and discrimination by enacting laws and policies from national to community levels that protect women and girls against sexual violence, disinheritance of and gender discrimination of all kinds.

13. Women must be adequately represented in policy-and decision-making on AIDS, which at present is driven almost exclusively by men.

14. Changes in laws and policies must be accompanied by adequately funded social mobilization campaigns to protect and promote AIDS-related rights and eliminate HIV associated stigma and discrimination.

15. Access to basic HIV prevention commodities such as condoms must improve.

16. Increased involvement of male partners is also an important feature of the MTC plus initiative. The One MTCT – Plus Site, The Chelstone Clinic in Lusaka urban is using innovative strategies with male partners, reaching out to them at drinking places and sports events and on weekends, to persuade them to make fuller use of treatment services that are available.

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APPENDIX I

THE UNIVERSITY OF ZAMBIA

SCHOOL OF HUMANITIES AND SOCIAL SCIENCES

DEPARTMENT OF GENDER STUDIES

Questionnaire on Gender Differentials in Health seeking behaviour between HIV positive women and men in three community support groups in Lusaka Urban.

SECTION A: DEMOGRAPHIC DATA

QUESTION NUMBER	QUESTIONS AND INSTRUCTIONS	POSSIBLE RESPONSES	CODE NUMBER
1.	What is your age?	15 - 19 years 20 - 24 years 25 - 34 years 35 – 39 years 40 - 44 years 50+ years	1 2 3 4 5 6
2.	Sex	Male Female	1 2
3.	What is your marital status?	Single Married Divorced Widowed Separated	1 2 3 4 5
4.	What is your religion?	Protestant Pentecostal Hindu Moslem Jehovah's Witness Others specify.....	1 2 3 4 5 6
5.	What is your highest level of education?	Junior Primary Senior Primary Junior Secondary Senior Secondary Tertiary University	1 2 3 4 5 6
6.	What is your occupation?	Housewife Self-employed Business person Civil Servant House servant Others Specify	1 2 3 4 5 6
7.	What is your monthly income?	Below K200,000.00 K200,000 – K400,000 Above K500,000.00	1 2 3
8.	How many children do you have?	Number.....	
9.	Have you ever suffered from any opportunistic infections?	Yes No I don't know I am not sure	1 2 3 4
10.	Which type of opportunistic infections have you suffered from?	TB Fungal infection PCP pneumonia Others specify.....	0.1 0.1 0.1 0.1

11.	Did you seek any medical attention?	Yes No	1 2
12.	If no, why?	Fear Stigma Used traditional medicine Others (specify).....	0.1 0.1 0.1 0.1
13.	Has any member of your family suffered from any opportunistic infections?	Yes No	1 2
14.	If yes, what advice did you give him/her?	To go to the clinic Use traditional medicine Others specify	1 2 3

SECTION B: HEALTH SEEKING BEHAVIOUR

15.	What type of health facilities did you visit for your specific health complaint?	Govt clinic/hospitals Private clinic/hospitals Traditional healers Others specify	0.1 0.1 0.1 0.1
16.	What form of transport did you use to get to the facility?	Walked Bicycle Motorcycle Car Public transport Others	0.1 0.1 0.1 0.1 0.1 0.1
17.	How far is your home from this centre?	Less than 1 km 1 to 4 km More than 4 km	1 2 3
18.	How many times have you been to the centre before being seen for your specific complaint?	First time 2 times 3 – 5 times More than 5 times	1 2 3 4
19.	Where you charged a small fee for VCT services?	Yes No a) individual price (K) b) Couple (K)	1 2
20.	Did you undergo HIV testing? If yes, who decided for you to undergo HIV testing.	Yes No Alone Husband Wife Others specify	1 2 1 2 3 4
21.	Who accompanied you for the HIV test?	Alone Husband Wife Others specify	1 2 3 4
22.	How long did it take to be attended to?	Minutes .... Hours	
23.	How often do you visit the centre to see counsellors/social workers?	Monthly 6 months	1 2

		Fortnightly	3
	What are the staff attitudes towards HIV patients?	Supportive Abusive Others specify	0.1 0.1 0.1
24.	On the whole were you satisfied or dissatisfied with the services?	Satisfied Dissatisfied No response	1 2 3
	Give reasons for your response.	....	....
25.	How do you think these services can be improved (probe and tick appropriate category)?	Medication always available More staff Politeness/staff friendlier Shorter waiting time Provide free services Reduce charges Services to be provided on daily basis Privacy Confidentiality Cleanliness Others specify	0.1 0.1 0.1 0.1 0.1 0.1 0.1 0.1 0.1 0.1 0.1
26.	How long have you been living with HIV and AIDS? How long have you been taking ARVs?	Months ..... Years ..... Months ..... Years	
27.	Are ARVs easily available at the centre? If no, what are the problems you face in accessing ARVs?	Yes ..... No	1 2 ....
28.	Do you experience long queues when getting ARVs? Do you pay any fees for ARVs? If yes, how much do you pay?	Yes No Yes No	1 2 1 2
29.	What problems do HIV and AIDS patients face in your community?	Abandonment Loneliness Stigmatization Discrimination Others specify	0.1 0.1 0.1 0.1 0.1
30.	What are the misconceptions about receiving ARVs in the community? (probe any misconceptions)	....	....
31.	What are the certain beliefs associated with the management of HIV and AIDS in the community (Probe for more beliefs).	....	....
32.	Do you think you have easy access to	Yes	1

	testing facilities. If yes, do you think all the information is kept confidential?	No Yes No	2 1 2
33.	What type of medication do you follow for your treatment of HIV and AIDS?	....	....
34.	Where else do HIV patients get treatment from? Why?	Traditional healers Herbalists Diviners Clinics/hospitals Others specify	0.1 0.1 0.1 0.1 0.1 ....
35.	What type of care and support does the centre offer to HIV and AIDS patients?	Multivitamin supplements ART VCT PMCT Palliative Care	0.1 0.1 0.1 0.1 0.1
36.	Are you satisfied with the care and support offered at the centre? Is it confidential?	Yes No Yes No	1 2 1 2
37.	Who takes care of you as a sick person at home?	Alone Husband Wife Children Others specify	0.1 0.1 0.1 0.1 0.1
38.	Who helps and supports you in taking your medications?	Alone Husband Wife Children Others specify	0.1 0.1 0.1 0.1 0.1
39.	Who does main household chores in your household?	Children Husband Wife Others specify	0.1 0.1 0.1 0.1
40.	Do you experience any domestic violence from your spouse in providing care and support?	Yes No	1 2
41.	What type of violence have you experienced in your care and support from your spouse?	Abandonment Insults Threats Rejection Blame Others specify.....	0.1 0.1 0.1 0.1 0.1 0.1
42.	Did you at any time feel like deserting your spouse because of him or her not caring and supporting you? If yes, why?	Yes No Isolation Torture Others specify.....	1 2 0.1 0.1 0.1
43.	Do you at times shun away from receiving treatment because of stigma and	Yes No	1 2

	discrimination?		
44.	If yes, what measurers have you put in place as an individual to mitigate the problem?	Acceptance Adherence Others specify.....	0.1 0.1 0.1
45.	Has your spouse/friends /workmates/ counsellors ever discriminated you because of your HIV status? If yes, why?	Yes No Fear of contracting infection Embarrassment Others specify.....	1 2 0.1 0.1 0.1
46.	What kind of discrimination have you experienced?	Isolation from friends Abandonment Deserted from Others specify.....	0.1 0.1 0.1 0.1
47.	What was your reaction?	Embarrassed Annoyed sympathetic Others specify.....	0.1 0.1 0.1 0.1
48.	What kind of problems are you faced with in terms of access to ARVs?	Cost Need for permission from husband Others specify	0.1 0.1 0.1
49.	What kind of problems do you face in terms of treatment to HIV and AIDs?	Side effects Non adherence Others specify.....	0.1 0.1 0.1
50.	What kind of problems do you face in terms of care as a sick person?	Abandonment loneliness Isolation from friends and family members Others specify.....	0.1 0.1 0.1 0.1
51.	Does the centre segregate in terms of gender preference when attending to patients?	Yes No	1 2
52.	What type of segregation have you observed/experienced?	Men served first Husband's consent Others specify.....	0.1 0.1 0.1
53.	What do people in the community do when they have signs and symptoms of opportunistic infection of HV and AIDS?	....	....
54.	Where do people living with HIV and AIDS get drugs for treatment in your community?	Govt Clinics/hospitals Private clinics/hospitals Traditional healers Vendors Pharmacy/drug stores Others specify	0.1 0.1 0.1 0.1 0.1 0.1
55.	Has anyone in your household ever received ARVs during pregnancy to prevent mother to child transmission of HIV and AIDS?	Yes No Do not know	1 2 3
56.	Is anyone in your household currently taking ARVs to prevent mother to child transmission during pregnancy? If no, has anyone in your household ever received ARVs for treatment outside of pregnancy?	Yes No Yes No Do not know	1 2 1 2 3
57.	Who decides when to use condoms in	Husband	1

	your home?	Wife	2

APPENDIX II

THE UNIVERSITY OF ZAMBIA

SCHOOL OF HUMANITIES AND SOCIAL SCIENCES

DEPARTMENT OF GENDER STUDIES

QUESTIONNAIRE FOR KEY INFORMANTS – HEALTH STAFF AT KALINGALINGA AUSPICES, MTENDERE AND NG'OMBE COMMUNITY SUPPORT GROUP CENTRES.

INSTRUCTIONS

PLEASE TICK CORRECT ANSWERS IN THE BOX AND WRITE ANSWERS IN THE SPACES PROVIDED.

SECTION A: HEALTH SEEKING BEHAVIOUR

1. Are HIV positive women and men aware of ARV treatment at your health centre?

Yes ☐
No ☐

2. If yes, how do they know about the centre?
   a. Health campaign programs ☐
   b. Sensitization ☐
   c. Church gatherings ☐
   d. Friends ☐

3. Which gender often seeks ARV treatment at your centre?
   Male ☐
   Female ☐

4. Why?.....
   .....

5. Do they come as partners for HIV testing before being put on ART?
   Yes ☐
   No ☐

6. If no, why?.....
   .....

7. Are HIV positive women and men able to disclose their HIV status?
   Yes ☐
   No ☐

8. If no, why?.....
   .....

9. How does the centre encourage more HIV positive women and men to disclose their status before accessing ART treatment?.....

.....

.....

10. Do the HIV positive women and men understand the reasons for taking ARVs?

    Yes ☐

    No ☐

11. If no, what information do you give them about these treatments?.....

.....

.....

12. What factors affect women and men's access to ART treatment?.....

.....

.....

13. Are there instances where women are denied access to ART treatment because of no consent from husbands or senior household members?

    Yes ☐

    No ☐

14. If yes, what help do you offer as a support group centre?.....

.....

.....

15. Do you explain the reasons for taking ARVs/how they work/what benefits they have?

    Yes ☐

    No ☐

16. What type of care and support does the centre offer to HIV positive women and men?.....

.....

.....

17. Are the HIV positive women and men satisfied with the care offered to them at the centre? Is it confidential?.....

.....

18. If no, how do you intend to improve the care and support to satisfy them?.....

.....

.....

19. Which gender often cares and supports the spouse as they visit the centre for ART?

    Male ☐

    Female ☐

20. Why is it like that?.....

.....

21. What advice do you recommend on health seeking behavior to HIV patients?

.....

22. How many of the HIV patients take regular exercises, healthy diet, hygiene?

.....

23. Does the centre offer CD4+count as part of antenatal care?
.....

24. What type of nutritional support does the centre offer to the patients?
.....

25. Is there stigma and discrimination amongst people living with HIV/AIDS in accessing ARVs at the centre?

Yes ☐
No ☐

26. If yes, why?.....
.....
.....

27. Which gender is more vulnerable to stigma and victimization when accessing treatment for HIV/AIDS?

Male ☐
Female ☐

28. Why is it like that?.....
.....

29. What personal experiences of stigma and discrimination do you notice on people living with HIV/AIDS regards treatment?.....
.....
.....

THANK YOU FOR TAKING THE TIME TO ANSWER THIS QUESTIONNAIRE. THE INFORMATION IS GOING TO BE USED TO HELP MAKE PROGRAMMES FOR PEOPLE TAKING HIV MEDICATIONS BETTER.

APPENDIX III

THE UNIVERSITY OF ZAMBIA
SCHOOL OF HUMANITIES AND SOCIAL SCIENCES
DIRECTORATE OF RSEARCH AND GRADUATE STUDIES

In-depth guide on gender differentials in health seeking behaviour between HIV positive women and men in three community support group centres in Lusaka Urban.

(a) PREVENTION BEHAVIOUR

1. How did you make the decision to go for VCT?
2. What difficulties did you experience when you went for VCT?
3. What preventive measures were you given on access and use of condoms?
4. In your opinion what are the methods (Western and traditional) used to prevent the spread of HIV/AIDS?
5. How do you feel about your HIV status?

(b) ART EXPERIENCE

6. What do you know about ARVs?
7. What are the belief and perceptions by the community towards people taking ARVs?
8. What benefits and challenges do you face when taking ARVs?

(c) STIGMA AND DISCRIMINATION

9. What type of stigma and discrimination about your HIV status have you experienced from the community?
10. What changes in stigma and discrimination against people living with HIV and AIDS?
11. How are you coping with stigma as a person living with HIV and AIDS?
12. What is your view about the attitude by the community that most people living with HIV and AIDS are responsible for their illness?

APPENDIX IV

INFORMED CONSENT FORM.

TITLE: Gender differentials in health seeking behaviour among HIV positive Women and men. A case of Mtendere, Kalingalinga and N'gombe Community Support Group Centres in Lusaka urban.

My name is Steriah Daka; I am collecting data on gender differentials in health seeking behaviour among HIV positive women and men in Lusaka urban. If you have any questions about any aspects of the study, please feel free to contact Steriah Daka, Cell No. 0977365163 / 0955772746 or The Director, Postgraduate Studies P. O. Box 32379. Lusaka.

Before you answer any questions I would like you to know that:

(1) Your participation in this study is entirely voluntary. They are no risk or Harm to you by virtue of your participation.
(2) Even if you did not participate in this study, you will still receive care in The community support group centre just like anybody else.
(3) You are free to terminate this interview at any time
(4) There is no direct benefit to you but the information will be helpful in The prevention of HIV/AIDS.
(5) During the interview we seek your permission to record proceedings.

The data collected in the interview will be kept strictly confidential and will be available only to members of the research team. Excerpts from individual interviews may form part of the final research report, but under no circumstances will your name or any identifying characteristics be included in the report.

May I seek your consent to interview? (If the respondent declines to be interviewed) please thank the respondent and discontinue the interview.

Thank you for agreeing to take part in this study. I will now declare that you have given written consent for the interview.

NAME OF INTERVIEWER:.....

SIGNATURE/THUMB PRINT OF RESPONDENT.....

APPENDIX V:

THE UNIVERSITY OF ZAMBIA
SCHOOL OF HUMANITIES AND SOCIAL SCIENCES
DEPARTMENT OF GENDER STUDIES

QUESTIONNAIRE TO ESTABLISH THE GENDER DIFFERENTIALS IN HEALTH SEEKING BEHAVIOUR AMONG HIV POSITIVE WOMEN AND MEN IN LUSAKA URBAN.

RESEARCHER: STERIAH DAKA: MASTER OF GENDER STUDIES RESIDENT STUDENT. UNIVERSITY OF ZAMBIA 2008.

Dear Respondent,

I am a research student at UNZA undertaking a master in Gender Studies degree. This research, which is an important part of my programme, seeks to gather pieces of information on your knowledge on gender differentials in health seeking behaviour among HIV positive women and men in Lusaka urban.

Please help me to bring the true picture by being honest and open in responding to the questions in the interview guide. Your responses and identity are guaranteed the confidentiality they deserve.

Thanking you in anticipation.

STERIAH DAKA
MGS. RESIDENT STUDENT

THE UNIVERSITY OF ZAMBIA
SCHOOL OF HUMANITIES AND SOCIAL SCIENCES
GENDER STUDIES DEPARTMENT

1 April 2008

TO WHOM IT MAY CONCERN

This is to introduce Ms Steriah Daka, a student at the University of Zambia in the School of Humanities and Social Sciences, Gender Studies Department. She is carrying out a research entitled "**Gender differentials in health seeking behaviour among HIV positive women and men in Lusaka urban.**"

The main objective of the study is to examine factors that influence gender differentials in health seeking behaviour among HIV positive women and men in Lusaka urban.

We would appreciate very much your assistance in helping her carry out the research. We thank you for your cooperation.

Dr. T. Kusanthan
Acting Head, Gender Studies Department
UNZA

DEPARTMENT OF GENDER STUDIES
SCHOOL OF HUMANITIES &
SOCIAL SCIENCES

01 APR 2008

UNIVERSITY OF ZAMBIA
P.O. BOX 32379, LUSAKA

P.O. Box 50827
Lusaka
Tel: +260-211-235554
Fax: +260-211-236429

In reply please q

No.....

Republic of Zambia

MINISTRY OF HEALTH
LUSAKA DISTRICT HEALTH MANAGEMENT TEAM

09/04/.....2008

The In-Charge
NTENDERE/ NGOMBE....Health centre
BOX 50827
LUSAKA

Dear Sir.

PRACTICAL ATTACHMENT / RESEARCH
MR/MS...STERIAH DAKA.....

Be informed that permission has been granted to the above named student to be attached to your health Centre for practical/research.

However this must be done with minimal disruption to the day to day activities at the health centre.

Your usual cooperation will be appreciated

Yours faithfully,

DR. M KABASO
CLINICAL CARE EXPERT
FOR/DISTRICT DIRECTOR OF HEALTH