The role of communication in promoting Voluntary Counselling and Testing for HIV (VCT) in selected clinics around Lusaka district

By

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Declaration

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Abstract

The purpose of this study was to assess the role of communication in promoting Voluntary Counselling and Testing (VCT). The study also aimed at finding out people's knowledge, attitude and practices towards VCT. Further, the study sought to establish the kind of messages that are produced on VCT by the Ministry of Health and the channels used to pass the messages to people. Factors affecting VCT were also established. Lastly, the study aimed at establishing whether messages on VCT are differentiated for different audiences. This study used both quantitative and qualitative research methods. Questionnaires and in-depth interviews were used to collect data from the audience and selected interviewees at the Ministry of Health (MOH), Headquarters and from the selected clinics. Research instruments used were structured questionnaires and interview guide. Data was analysed using the Statistical Package for Social Sciences (SPSS) and narrative form.

This study revealed that communication plays an important role in promoting VCT as reflected by 90% of respondents who felt that messages on VCT could be adopted into behaviour. In addition, most of the respondents knew what VCT was and felt that it was important in the fight against HIV and AIDS. Findings showed that the majority of respondents (93%) knew what VCT is. In spite of 93% of respondents having the knowledge on VCT, the number of people who had accessed the service was low at 37%. Further the study revealed that most respondents accessed VCT information through the media at 71%.

A number of factors including cultural and religious factors were cited as affecting people practices towards VCT. Lastly, the study established that messages on VCT were not differentiated for different audiences thereby hampering active communication. Some of the major recommendations were that there is need for MOH to develop a communication strategy for VCT. In addition, VCT service providers need to scale up communication on VCT by segmenting messages on VCT and reaching out to as many families in communities as possible through intensified door to door sensitization on the benefits of VCT.

Dedication

I dedicate this work to my husband Webster Chisaka, who has been my source of strength and supported me in so many ways throughout my study and in the past 10 years of my life. He motivates and always tells me that I am intelligent and that the sky is not the limit.

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List of Abbreviations

AIDS	:	Acquired Immune Deficiency Syndrome
ART	:	Antiretroviral Therapy
CDC	:	Centre for Disease Control
CSO	:	Central Statistical Office
DOH	:	Department of Health
FNDP	:	Fifth National Development Plan
GBV	:	Gender Based Violence
HBM	:	Health Belief Model
HIV	:	Human Immune Virus
LDHO	:	Lusaka District Health Office
MDG	:	Millenium Development Goal
MISA	:	Media Institute for Southern Africa
MOH	:	Ministry of Health
MP	:	Member of Parliament
NDP	:	National Development Plan
NGO	:	Non-Governmental Organisation
NHCSs	:	Neighbourhood Health Committees
PAZA	:	Press Association of Zambia
PITC	:	Provider Initiated Testing and Counselling

PMO	:	Provincial Medical Office
PMT	:	Protection Motivation Theory
EMTCT	:	Elimination of Mother to Child Transmission
PMTCT	:	Prevention of Mother to Child Transmission
UNFP	:	United Nations Population Fund
UNZA	:	University of Zambia
USA	:	United States of America
VCT	:	Voluntary Counselling and Testing
WHO	:	World Health Organisation
ZNBC	:	Zambia National Broadcasting Corporation

CHAPTER ONE

INTRODUCTION TO THE STUDY

1.0 Introduction

This study was carried out to assess the role of communication in promoting VCT, in selected clinics around Lusaka district. The study was non-experimental, observatory and analytical in nature. The study looked at the messages disseminated, the channels, sources of messages and the factors affecting VCT. The attachment was done at the Ministry of Health, Head Quarters, under the Directorate of Technical Support Services in the area of health education and health promotion. This was for the reason that this is the central coordinating hub at national level and holds the central responsibility for medical care and preventive care services including dissemination of information on health matters and health education. In addition, four weeks were spent at Chainama, Mtendere and Kaunda Square clinics to observe how HIV counselling and testing was done.

The first chapter of this report gives the background information about the study, area of study (Lusaka district), and Ministry of Health, preceded by the background information on VCT in Zambia, followed by the problem statement. It also outlines the objectives and shows the rationale. Furthermore, this report reviewed the available literature on the topic in chapter two. The conceptual and theoretical frame work is dealt with in chapter three. In chapter four, the report elaborates how the study was conducted in terms of methodology. The data collected during the research is analysed in chapter five and discussed in chapter six. The discussion in chapter six was based on the objectives. Lastly, the report will conclude and give the recommendations in chapter seven.

VCT stands for Voluntary Counselling and Testing. VCT is when a person chooses to undergo HIV and AIDS counselling so that they can make an informed decision about whether to be tested for HIV. VCT usually involves two counselling sessions: one prior to taking the test known as “pre-test counselling” and one following the HIV test when the results are given, often referred to as “post-test counselling.” Counselling focuses on the HIV infection, the disease AIDS, the test, and positive behaviour change. VCT centres and counsellors often use rapid HIV tests that require a drop of blood or some cells from the inside of one's cheek; the tests are cheap

and provide accurate results in about 15 minutes. Since VCT is a confidential, direct and inexpensive method to help people receive information, counselling and testing to determine their HIV status, it needs to promoted and enhanced (UNAIDS, 2005).

VCT is important in the fight against HIV and AIDS for the reasons that it serves as an entry point to prevention, care, treatment and support programmes and enables people to confidently understand their HIV status and learn about supportive behaviours for protecting and preventing further spread of HIV. For those that are not infected with HIV, VCT can motivate them to stay HIV negative, and to accept those who are infected. For those that test HIV positive VCT can enable them to take positive measures such as commencement of treatment, exercise and healthy diet so that they can live longer and also prevent further spread of HIV.

According to World Health Organisation (2011) over 90 percent of an estimated 42 million people around the world living with HIV and AIDS reside in Africa, Asia, Latin America and the Caribbean. It is estimated that less than 10 percent are aware of their infected status. In Zambia statistics show that the number of people accessing VCT is low. In the year 2014 only 2.5 million out of 13.2 million Zambians were tested for HIV. It still remains unclear why VCT uptake is low (Mikus, 2015). Some researchers propose that communication can be a significant tool in promoting VCT. According to Dr Corbett a Biomedical researcher at the Biomedical Research and Training Institute, Harare (2012) communication messages such as television and radio advertisements, campaigns, newspaper and magazine advertisement that are designed with a target audience in mind can be used effectively to promote VCT. VCT advertisements that relay messages of hope, incorporating notions of the future, healthy positive attitudes and safety can be well received within the targeted audience and have a positive impact.

1.1 Background information

1.1.1 Area of study- Lusaka District

1.1.1.1 Overview

Lusaka district harbours the capital city of Zambia. It is located in the South Central part of the country and has a surface area of 360 square kilometres. The District is the most populated in the country with a total projected population of 2,281,502 for 2015 and population density of 6,338 people per square kilometre. It has a growth rate of 4.9% per year. The District shares its borders with three districts which are Chilanga to the South, Chisamba to the North, Shibuyunji to the West and Chongwe to the East (LDHO Concept paper, 2015).

1.1.1.2 Demographic Profile

Table 1.1: District Population and Key Health Indicators

Category	2014		2015	
	Number	%	Number	%
Children 0 – 11 Months	84,624	4	91,260	4
<5 Years	423,194	20	456,300	20
5 – 14 Years	592,367	28	638,820	28
Women 15 – 49 Years	465,431	22	501,930	22
All Adults 15 Years+	1,100,100	52	1,186,381	52
Total Male (All ages)	1,015,486	48	1,095,120	48
Total Female (All ages)	1,100,100	52	1,186,381	52
Total Population[\1 CSO]	**2,115, 596**	**100**	**2,281,501**	**100**
Population Growth Rate		4.9		4.9
Expected Pregnancies	114,242	5.4	123,201	5.4
Expected Delivers	110,010	5.2	118,638	5.2
Expected Live Births	103,664	4.9	111,794	4.9

Source: LDHO concept paper (2015)

1.1.1.3 Health services

Lusaka District Health Office (LDCHO) is responsible for providing Primary Health Care Services for the residents of Lusaka. There are 29 public health facilities and 7 Health Posts. 7 first level hospitals, 1 general hospital and 1 University Teaching Hospital. In addition, there are

more than 30 private facilities and hospitals. Almost all these provide Voluntary Counselling and Testing for HIV (VCT) service.

Other health services offered in various facilities include Curative (TB, Leprosy, STIs, ART, dental, Out Patient, In-patient, mental health, pharmacy and nutrition), Preventive and promotive **(**Maternal, neonatal and child health; nutrition, adolescent or youth friendly, Elimination of Mother to Child Transmission of HIV and AIDS (eMTCT which was previously known as PMTCT), HIV, ART, physiotherapy and environmental health) and Supportive **(**laboratory, X-ray and pharmacy).

1.1.1.4 Socio-Economic Profile

Lusaka, being the capital city of the country, is a hive of all international and inter-city trade and commercial investments such as shops, small and medium scale enterprises including street vending. The major industries in Lusaka include manufacturing, farming, and construction. Lusaka is also the headquarters of all government ministries and departments. These institutions are the country's largest employers. Employment opportunities in formal sector are limited resulting in most of the people being involved in informal self-employment like carpentry, catering, trading in consumables and other semi-skilled works.

1.1.1.4 Social and Cultural Environment

Lusaka has a multi-cultural society, characterised by different racial and ethnic groups, religious and traditional groupings, urbanisation, and increasing access to the internet, social media and other sources of information, with significant potential for promoting good health. However, there are some social, cultural and religious beliefs and practices that negatively affect health. These include cultural practices, such as sexual cleansing of surviving spouses, unsafe traditional male circumcision procedures, and some religious beliefs that prohibit blood testing especially for HIV, early marriages for the girl child, and risky traditional health practices that put people at risk of contracting HIV and AIDS and living without knowing their HIV status (National Health Policy, 2012).

The social, cultural and economic environment is a major determinant of health. It includes factors such as the demographic situation and trends, income and socio-economic status, education and literacy, employment and working conditions, and gender. Other factors affecting

health are the physical environment and one's health practices and coping skills. These may also have an effect on VCT uptake.

1.1. 2 Ministry of Health

In the mid-1960s the country had excellent health services though widely spaced. These services were provided by the government and the mines. By 1975, with the dwindling copper prices and the increase in the cost of fuel, Zambia's economy fell and this had a negative impact on the health delivery system (Ministry of Health, 1996, p.1). By 1985, the health sector was barely able to provide basic health care to the people. Though these services were accessed at no cost in a centrally controlled system, the services were inefficient and costly to the government. With the coming of the 1990s, it was realised that the health of the people could only be improved if the system underwent major reforms. The year 1995 saw the provision of health services in Zambia go through massive changes through policy reforms. Through the health reforms, there was decentralization of health services, thereby giving autonomy to the newly established District Health Management Boards. These boards were given authority to plan, allocate and manage funds in the implementation of different district health activities. The boards have since been dissolved and the Ministry of Health has been restructured (Ministry of Health report, 1996, p.2).

1.1.2.1 Role of Ministry of Health and its Programs

Ministry of Health (MOH) is directly run by government. The Ministry holds the central responsibility for medical care and preventive care services through its wide network of public health institutions, countrywide. In this regard, the Ministry undertakes a package of basic health care services through its 11 program areas, namely Epidemic Preparedness, Provision of first level referral services, Roll Back Malaria, HIV and AIDS, Tuberculosis, Integrated Reproductive Health, Child Health, Environmental Health, Mental Health, Oral Health and Nutrition.

1.1.2.2 Vision

The vision for Ministry of Health is to have a healthy and productive nation

1.1.2.3 Mission statement

To provide equitable access to cost-effective, quality health care services as close to the family in Zambia as possible, in a clean caring and competent environment.

1.1.2.4 Objectives

To effectively provide essential drugs to all government health facilities in order to facilitate provision of the basic health services.

To provide quality health services in order to improve the overall health status.

To integrate and harmonise operations of statutory boards, training institutions and other institutions under the Ministry of Health within the mainstream service delivery structures in order to attain better health outcomes.

To provide a comprehensive legal and policy framework for effective coordination, implementation and monitoring of health services

1.1.3 Voluntary Counselling and Testing in Zambia

Many approaches to HIV prevention and care require people to know their HIV status. The importance of VCT has brought about the need for wider promotion and development of VCT services. In the year 1987, Zambia started conducting HIV counselling in centres that had diagnostic capacity in response to the HIV and AIDS epidemic. The Zambian government has been implementing VCT as a vital activity. By June 2007, there were approximately 600 VCT centres in the country and 10,000 trained counsellors. VCT centres have further been increased to over 800 and the VCT National Programme has so far established VCT and Prevention of Mother to Child Transmission (PMTCT) facilities in all the districts in Zambia. In addition, other strategies to promote such as advertisements through media and formation of National HIV and AIDs Council to coordinate all HIV and AIDS activities were put in place (Ministry of Health, 2015).

1.1.3.1 The Media

Although the Ministry of Health plays a major role in distributing health information, the media in their role as watchdogs and conveyors of information are important too. According to Martinson and Hindman (2005:57) the media has a wide coverage and this exposure to information can influence health-related decisions including VCT uptake among people. This in turn can not only encourages the public to seek out medical advice and intervention, but also to do so in a more informed manner. This is where the media and media's coverage of VCT subject and HIV related information could play an important role in informing and educating citizens about their rights and access to health services, as well as what drugs and medication are available to them. Thus media has potential to benefit individuals and society at large.

1.1.4 Statement of the problem

According to the National Health Strategic Plan (2015) HIV and AIDS are currently formidable challenges to human development and social progress in Zambia this is because the country has a generalised HIV epidemic, which cuts across age, gender, geographical, and socio-economic status of the population. The Zambia Demographic Health Survey Report (2013) further reveals that HIV prevalence in adults aged 15 to 49 years stands at 13.3%. This suggests that the people most infected are in their reproductive years. This has a negative impact on families and the labour force. The national burden of HIV and AIDS has brought about the need to halt and begin to reduce the spread of HIV and AIDS by increasing access to quality interventions with VCT being the main intervention and starting point. The concern is that there are still some gaps in this intervention area

Voluntary Counselling and Testing is meant to be voluntary, meaning that people should decide on their own whether to undergo an HIV test or not and this test should only be done when someone has been adequately counselled to psychologically prepare them for the outcome of the test. This is very important as it can help reduce the spread of HIV by encouraging people who are not infected to protect themselves, and those infected to live positively. In this case, the role of the Ministry of Health and health service providers is to provide counselling and communicate with people on the benefits of VCT so that more people can undergo VCT. According to

National Health Strategic Plan (2015:17) the Ministry of Health has continued to expand access to HIV and AIDS prevention especially VCT, PMTC and ART services. In addition, more information on HIV and AIDS and messages to promote VCT have been made available to the public countrywide. Most of this information is accessible at no cost. Despite the efforts made to promote VCT, the number of people accessing this service remains low. Statistics indicate that in 2014 only 2.5 million out of 13.2 million Zambians were tested for HIV of which 68% were female. This situation poses a challenge to HIV prevention, treatment and care. Thus, this study sought to assess the role of communication in promoting VCT.

1.1.5 Objectives of the study

1.1.5.1 Main objective

To examine the role of communication in promoting VCT

1.1.5.2 Specific objectives

To find out people's knowledge, attitudes and practices towards VCT

To find out whether information provided is useful or not

To establish the sources of VCT information

To investigate the channels used to pass information to people

To establish whether messages on VCT are differentiated for different audiences

To explore factors affecting VCT

1.1.6 Research questions

What are people's knowledge, attitudes and practices towards VCT?

How useful is the information provided?

What are the sources of information on VCT?

What are the channels used to pass VCT information to people?

How are messages on VCT differentiated for different audiences?

What are the factors affecting VCT?

1.1.8 Rationale of the study

A number of studies in Zambia have demonstrated factors that affect VCT. However, studies which focus on communication and its role in influencing intention and subsequently the use of VCT are lacking. This study attempted to assess the role of communication in promoting VCT so that the point which requires modification can be identified in order to improve VCT uptake. In addition, the study attempted to investigate how counselling was done, before and after testing and to establish whether people were knowledgeable on VCT and their practices so that people may be helped to make informed decisions about their health and lead better lives.

The study, through its findings and recommendations, may be used as a basis for engaging the Ministry of Health and other VCT service providers to actively carry out counselling and HIV testing in a more professional manner, and to work closely with the media, non-governmental organizations, political and traditional leaders in disseminating VCT information to the public, so that more people can access the service.

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

This chapter presents the relevant literature that was reviewed from around the world including Zambia.

2.1 Role of Counselling and Testing in HIV prevention

According to California State Office of AIDS (2011) HIV counselling and testing is an important part of a continuum of HIV prevention and treatment services. Counselling and testing is one of the main times when a comprehensive individual risk assessment is taken, making it the best opportunity for accurate referrals to more thorough services. The 'five Cs' of good testing practices always apply: informed Consent, Confidentiality, Counselling, Correct test results and Connection to care. HIV counselling and testing is also one of the primary entry points into prevention such as prevention of mother- to- child (PMTC), and Antiretroviral Therapy (ART). Knowing one's HIV status, whether HIV negative or HIV positive is key to preventing the spread of HIV and accessing counselling and medical care in order to delay or prevent a life-threatening situation. Quality VCT can help prevent HIV infection through counselling to discourage high-risk behaviour and support protective behaviour. Counselling also helps people understand their result, how to protect their own health, and (if infected) how to keep from infecting other people.

2.2 The role of communication in promoting HIV counselling and testing

According to Infante (1997, p. 23) it is important to communicate because it helps to create cooperation and interaction with one another, and acquire information which may help in making decisions. He further explains that communication is important because without it, development would not be possible. Even to be aware that development has occurred; one should be able to communicate within self and with others. With regard to VCT, when health care providers do not communicate to people through different means, people would not be aware of VCT and not

act. Thus communication is key in promoting VCT. However, the manner in which a message is communicated is even more important in influencing action.

According to Mwenda who is a researcher at Horizons (2013) valuable communication (before and after testing) by VCT service providers is very important as it can enable people to make informed decisions. Media can also disseminate VCT information effectively in order to encourage more people to access this service. Good Communication depends on how properly trained counsellors are and their level of experience. Counsellors promote VCT by protecting the confidentiality of client information, obtaining informed consent before testing and providing appropriate recommendations. In addition, the US Department of Health (2011) posit that VCT is boosted when counsellors work closely with clients to develop a reasonable risk reduction step and to make sure their clients are actually ready to receive the test results. Counsellors need to establish relationships with key service agencies and cooperating partners to make sure the recommendations they give clients reflect their needs, priorities, culture, age, sexual orientation and language.

2.3 VCT Global perspective

Studies conducted on this topic have shown that counselling is very important before and after undertaking an HIV test. In the year 2005, the Centre for Disease Control and Prevention (CDC) announced an initiative aimed at expanding HIV counselling and testing in the United States of America especially in public health institutions. Their Strategic Plan for 2005 strived to decrease by 50% the number of people who did not know their HIV status. Meeting this goal would have meant that by 2010, an estimated 130,000 new HIV infections may have been prevented. Prior to the initiative of expanding the HIV counselling and testing services, a study was carried out to determine how expansion of HIV counselling and testing services would encourage people to access this service. The study revealed that although public health workers were trained in counselling and testing procedures, most HIV testing in the USA occurred in private doctors' offices or private health institutions. Many people preferred being tested as part of a routine check-up, in private institutions instead of public health sites. 64% of respondents felt that testing in public venues did not offer anonymity, and patients who got tested as part of routine medical care at public institutions may not have received adequate counselling or recommendations.

One of the main recommendations at the end of the study was to promote Rapid Testing which was hoped would change the way counselling and testing was conducted, because the client needs to wait for 20 minutes for the results, the counsellor takes the blood early in the session and has a confined consultation session for risk assessment and counselling on a one to one basis. Counsellors can conduct the blood test themselves, or a separate staff person can do the finger stick and read results. It was felt that counselling with rapid testing could be more intense and client-focused and would dramatically increase the number of persons being counselled and tested for HIV to know their status (US Department of Health and Human Services, 2010).

The study cited above was important because it highlighted the importance of thoroughly training counsellors who are tasked with giving appropriate and adequate information to people before HIV testing to prepare them for the outcome of the test and after HIV testing to guide them on how to protect themselves from HIV and live positively if found to be HIV positive. In addition, the study through its findings and recommendations highlighted the importance of confidentiality in counselling and test results. Confidentiality was an important aspect to the study undertaken. When there is no confidentiality in HIV counselling and testing, people may be discouraged to undergo this process because of fear of undesirable consequences such as discrimination or rejection when one was found to be HIV positive. However, the role of communication by media, and cooperating partners in encouraging HIV counselling and testing through dissemination of messages was left out.

The World Health Organisation (2011) estimated that the majority of people with HIV worldwide are unaware of their infection. Those who do know often test late; and poor linkages from HIV testing and counselling to care mean that many people start antiretroviral therapy (ART) when they are already significantly immune compromised, resulting in poor health outcomes and ongoing transmission. A successful public health response to HIV requires robust VCT services and campaigns. The value of VCT depends on linking people to services that are acceptable, accessible, and effective. Therefore, there is need to identify the models of VCT delivery that are most acceptable, most cost-effective, and best reach the communities most vulnerable to HIV. Most testing takes place when people visit health-care facilities (particularly antenatal care clinics and other reproductive health services) and are tested systematically and

routinely unless they decline, a strategy known as Provider Initiated Testing and Counselling (PITC) can be used.

Couple counselling offers a promising additional approach: Either couples go for testing together or one partner takes the other at a health-care provider's suggestion. Therefore, good communication on the part of counsellors and health workers to the public can promote VCT.in addition, valuable messages can be used to enhance VCT campaigns when addressing general population or specific audiences such as couples, expectant mothers, men, young people, workplaces, schools, for working people and students whose hours do not allow clinic visits.

2.4 VCT African perspective

Research from different African countries has shown that valuable communication by health departments and media can contribute positively to social change and even more so in the promotion of HIV testing and counselling. Total support for HIV testing and counselling campaign can lead to more people undergoing VCT.

A survey was conducted on the Impact of HIV and AIDS Policy Framework on HIV testing and counselling in Namibia, December 2013 by the Testing and Counselling Technical Working Group, USAID-Namibia, and the Namibian Ministry Of Health and Social Services (MOHSS). A combination of qualitative and quantitative methods were used. Namibia has a generalized HIV epidemic. The MOHSS Namibia 2012 Spectrum Modelling presented in the national HIV and AIDS profile estimates HIV prevalence for adults was 13.2 percent between 2010 and 2011. The results of the survey revealed that a little over 50 % of females had ever been tested for HIV and received their results, compared with only 32 % of men. In the 12 months preceding the survey, about 29 % of females were tested and received results, compared with about 18% of males. At the end of the study, data further revealed that the implementation of the National Strategic Framework for HIV and AIDS 2010 to 2015 resulted in increased HIV counselling and testing uptake of over 69%. This was attributed to good communication by MOHSS, policy teaching and law with regard to HIV counselling and testing (USAID-Namibia, 2013).

The survey above raises issues for further evaluation and areas where more in-depth analysis of the existing data could assist in informing decision making around policies, regulations, and implementation approaches for HIV and VCT in particular. The study highlights issues

potentially applicable to Zambia. However the study only focused on policy framework and left out other factors that may affect VCT.

Communication through the use of media may lead to more people accessing VCT service. A study in South Africa on the significance of media campaigns in the fight against HIV showed that between the years 2000 and 2005, the use of HIV campaign branding, billboards, print materials, television and radio advertisements and programs led to increased HIV testing by 28.5% and 40% rates of patients turning up and returning for counselling. Mass media communication increased the likelihood of individuals undergoing voluntary counselling and testing for HIV.

Dr. Lekaba (2005) from the Department of Health South Africa (DOH) put forward that it is important for all countries to get more people to test for HIV through campaigns. The South African National Aids Council (SANAC) has a national HIV Counselling and Testing (HCT) campaign to counsel and test the 1.2 million public servants. It was realized that the Public Service has a crucial role to play in mitigating the impact of HIV and AIDS and as part of its overall focus on the health and well-being of its employees. In addition, large numbers of people are also direct dependents of public servants. As a result, the fate of society as a whole is closely intertwined with the health and well-being of public servants. People in work places are given opportunities to get tested for HIV and be counselled so that they can make informed decisions. Following this, there have been significant improvements in the number of people undergoing VCT. Before the launch of the campaign, some 2.6 million people had gone for counselling and testing, but since its launch with special use of media platforms, 18 million people have been tested.

2.5 VCT Zambian context

In Zambia, minimal research has been done with regard to communication on VCT. A research similar to this study was conducted in the year 2012 at the University of Zambia by Second Year students in the School of Humanities and Social Sciences to specifically determine factors affecting utilisation of VCT services by pre-service trainee Nurses in Zambia. Multistage sampling technique was used. Pre-service training institutions were put into two clusters of pre-service enrolled nursing and pre-service registered nursing and three (3) institutions from each

cluster were conveniently selected for the study. Study units from the selected pre-service institutions were then sampled using systematic random sampling technique.

Results from this study revealed that there was low utilisation of VCT service as only 35.5% of pre-service registered trainee nurses and 36.2% of pre-service enrolled trainee nurses underwent VCT. The study results revealed that pre-service trainee nurses were knowledgeable about HIV and AIDS including VCT.

The study results also revealed that lack of privacy and confidentiality were some of the factors mentioned by pre-service trainee nurses for not undergoing VCT. Other results from this study indicated that most trainee nurses reported that their training institutions did not have HIV and AIDS policy in place and that there were no extracurricular activities like anti AIDS club and youth friendly services which would enhance peer education. The study further revealed that a significant relationship existed between discussing dangers and effects of HIV and AIDS and undergoing VCT among pre-service registered trainee nurses. This research as relevant to this study because it provided insights on some factors such as lack of confidentiality, HIV and AIDS policy and youth friendly services that affect people's attitude towards VCT. In addition, the study included an aspect of communication where dangers and effects of HIV and AIDS were discussed by media, civil society organizations, among health workers and among the general public to promote VCT.

The United Nations Population Fund -Zambia (2008) affirms that the utilisation of VCT services is unacceptably low in Zambia despite the government and Non-governmental organization's efforts to make VCT services available. The media are urged to provide as much information as possible to the public on the importance of this service. In addition, Members of Parliament (MPs), traditional leaders, opinion leaders, the church, civil society and other cooperating partners are urged to mobilise all citizens to access VCT.

Mwenda (2015) notes that though VCT is targeted at individuals, it significantly benefits the general population as it provides information to reduce risk of acquiring and transmitting HIV. Further, wider knowledge of HIV status and its links to interventions may lead to a reduction in denial, stigma and discrimination. In all this, promoting VCT relies on useful communication on the part of service providers. Counsellors must be well trained and equipped with information so

that they work in a professional manner. It is noted that a number of factors may affect VCT such as culture, and religion. Given the fact that Zambia was declared a Christian Nation, some religious groups may not be in favour of VCT. Hence Ministry of Health needs to partner with the church in an aggressive sensitisation campaign on the need to go for VCT.

Stakeholders such as the Press Association of Zambia (PAZA) note that communication is vital in the fight against HIV and AIDS, hence media should always strive to be ethical and focus on covering health issues that greatly affect the nation such as HIV and AIDS. In this way, media can be strongly used in spearheading VCT campaign. Further, MISA Zambia (2011) points out that instead of focusing on politics especially non- issue based political messages, media should report on issues such as health and education that can bring about knowledge, change of unhealthy attitudes and practices of people. The more VCT messages are covered by media, the more likely that people will get the message, and act accordingly.

In addition, research conducted by Horizons (2001) revealed that social relations and interactions, communication patterns in families, among couples and among peers may influence people's decisions regarding HIV testing. This study sought to build upon such information by assessing the role of communication in promoting VCT. Such information was important in order to identify strategies for increasing uptake of VCT by people so that they may take advantage of the prevention and care benefits of knowing their status.

CHAPTER THREE
CONCEPTUAL AND THEORETICAL FRAMEWORK

3.0 Introduction

This chapter consists of two parts. The first part provides the conceptual and operational definitions of the main concepts and how they related to the study. The second part provides theoretical framework within which the study was placed. These assisted in putting the study into perspective.

3.1 Conceptual definitions

Different definitions of communication have been given by different scholars.

3.1.1 Communication: This is defined as the exchange of ideas, thoughts, messages, or information, as by speech, visuals, signals, written, or behaviour. It is the meaningful exchange of information between two or more people in order to promote dialogue, feedback and increase understanding among people. Therefore, communication is about sharing meaning with others (Obonyo; 2011:3).

According to Mefalopulos (2008; 2) communication is the interactive process characterised by the exchange of ideas, information, points of view and experiences between persons and groups. This involves interpersonal communication, group communication and mass communication. It is generation of information and its dissemination and how this information affects individuals and communities. Information influences the receiver's thoughts and actions.

3.1.2 Communication channel: These are the means by which a message travels both vertically and horizontally from a source to the receiver (Berger; 2002).

3.1.3 Communication strategy: This is the what, who, why, when, how and where of transmitting a message. An ideal communication strategy specifies the structure of information flow, the message, the target audience, channels of disseminating information, resources required to accomplish the mission and feedback mechanisms to learn from the entire process (Walker;2004).

3.1.4 Counselling: Jazov (2008) defines counselling as an act of giving out useful information on a particular issue by a trained person to another person who calls for it. This information can be in form of advice, recommendation and guidance. In this report, counselling referred to the process of giving information on HIV by specially trained people to people who called for it before and after an HIV test.

3.1.5 Interpersonal communication: This is communication between two individuals. Type of interpersonal communication vary from verbal to non-verbal and depends on circumstances. Interpersonal communication in this study was understood to mean communication between the lay counsellor and a person accessing VCT service (Miller; 1959).

3.1.6 Media: Berger (2002:22) in defining the media states that "we can designate it as a function in communication that is manifested through a carrier of signs to multi-point destinations. Thus, while language, design, facial expressions and clothing function as vehicles that mediate communication, they become media in a more conventional sense when they appear on a platform (like print, radio, television and billboards) which is dedicated to a communication function."

3.1.7 Mass media: This is the summative of all media that target large populations in propagating messages. For a medium to be part of mass media, it must fulfil the principles of being impersonal in nature, the messages be communicated to a large group of people that is usually heterogeneous in behaviours, attitudes and needs. There must also be a way through which the message is transmitted to the targeted audience (Berger; 2002).

3.1.8 Theory: This is a conceptual representation or explanation of phenomenon. It is a way of explaining the ordering and occurrence of various events. They are stories about what something is, how and why events occur (Benson; 2012:5).

3.2 Operational definitions

3.2.1 Communication: Messages on VCT that people share and receive from Ministry of Health, VCT service providers or the media and react to it.

3.2.2 Communication channel: Banners, fliers, brochures, newspapers, internet, radio and television programs carrying VCT information

3.2.3 Counselling: Useful advice, recommendations or guidance that is given to people before and after undergoing an HIV test

3.2.4 Interpersonal communication: Information, thoughts or ideas on VCT exchanged between two people

3.2.5 Media: Television stations, radio stations, social media, newspaper and magazine publishing companies disseminating information on VCT.

3.3 Theoretical framework

This study was based on one model and one theory. These were Health Belief Model and Agenda Setting Theory.

3.3.1 Health Belief Model

The Health Belief Model (HBM) was significant to this study because it assisted in explaining and predicting health behaviours; and this was done by focusing on the attitudes and beliefs of people. In the case of VCT, the BHM model was used to show why people would want to undergo VCT or not want to undergo HIV counselling and testing. The six constructs of HBM were utilised to show whether they inform decision making process to accept a recommended action that is undergoing VCT in order to prevent or treat HIV. In addition, the HBM helped in developing recommendations that may positively influence people's attitudes and beliefs towards VCT so that healthy lifestyles are encouraged.

The Health Belief Model (HBM) was developed in the early 1950s by social scientists Hochbaum, Rosenstock and Kegel in the United States of America (USA) at Public Health Service in order to understand the failure of people to adopt screening tests for the early detection of disease or prevention strategies. The HBM suggests that a person's belief in a personal threat of an illness or disease together with a person's belief in the effectiveness of the recommended health behaviour or action will predict the likelihood the person will adopt the behaviour.

The HBM derives from psychological and behavioural theory with the foundation that the two components of health-related behaviour are: the desire to avoid illness, or conversely get well if

already ill; and the belief that a specific health action will prevent an illness. In due course, an individual's course of action often depends on the person's perceptions of the benefits and barriers related to health behaviour. There are six constructs of the HBM. The first four constructs were developed as the original tenets of the HBM. The last two were added as research about the HBM evolved (Ibid)

1. Perceived susceptibility - This refers to a person's subjective perception of the risk of acquiring an illness or disease. There is wide variation in a person's feelings of personal vulnerability to an illness or disease. This construct directly relate to this study because people have different perceptions towards HIV testing. For example, some individuals may have undergone VCT because of their realisation that they had engaged in risky sexual behaviour which could have exposed them to the HIV virus. Further, an expectant mother may have undergone VCT in order to protect the unborn baby during pregnancy, at birth and after birth.

2. Perceived severity - This refers to a person's feelings on the seriousness of contracting a disease or leaving the disease untreated. There is wide variation in a person's feelings of severity, and often a person considers the medical consequences such as death, and social consequences in line of family life and social relationships when evaluating the severity. In the case of VCT, an individual may not have been willing to undergo VCT for fear that once they are found to be HIV positive; they would be rejected by family members and stigmatised by society. On the other hand, an individual may want to undergo VCT for fear that he or she may be HIV positive and if not put on the right medication and given the correct advise by health personnel, he or she may have health complications which could lead to death.

3. Perceived benefits - This refers to a person's perception of the effectiveness of various actions available to reduce the threat of disease, treat or to cure disease. The course of action a person takes in preventing or treating a disease relies on consideration and evaluation of both perceived susceptibility and perceived benefit, such that the person would accept the recommended health action if it was perceived as beneficial. This construct was very useful to the study in the sense that VCT is a positive step as it can enable one to commence treatment (Anti-Retro Viral drugs) if found to be HIV positive so that life is prolonged. For one who is found to be HIV negative,

VCT is still beneficial through the counselling provided on how to protect oneself from the HIV virus.

4. Perceived barriers - This refers to a person's feelings on the obstacles to performing a recommended health action. There is wide variation in a person's feelings of barriers, or impediments, which lead to a cost and benefit analysis. The person weighs the effectiveness of the actions against the perceptions that it may be expensive, dangerous (side effects), unpleasant (painful), time-consuming, or inconvenient. In this research, the perceived barriers relate to factors that prevented people from undergoing VCT.

5. Cue to action - This is the stimulus needed to trigger the decision-making process to accept a recommended health action. These cues can be internal for example in the case of VCT; an individual may have experienced some symptoms of HIV that led them to do an HIV test so that they were certain about their status. The cues may also be external, for instance advice from others, illness of a family member, messages from media in form of newspaper articles or adverts on television and radio may have led one to undergo VCT. In this case, valuable information to people was important.

6. Self-efficacy - This refers to the level of a person's confidence in his or her ability to successfully perform behaviour. This construct was added to the model most recently in mid-1980. Self-efficacy is a construct in many behavioural theories as it directly relates to whether a person performs the desired behaviour.

3.3.2 Agenda setting theory

This theory was chosen to support the study because it explains how the media can influence people’s thoughts and actions. The study focused on communication (messages and ideas that influence behaviour and subsequent use of VCT service). The media play an important role in mass communication on different issues including health. Therefore, the Agenda Setting theory was used to establish whether the media had set VCT as one of the important agendas. In addition, this theory was used to develop recommendations so that VCT was promoted.

This theory assumes that it is the media that set the agenda for the public by increasing public’s awareness of an issue at hand. Setting the agenda is one of the ways in which the media have an

effect on the public. This theory argues that agendas are set by how media display the news and other content**.** This in turn determines the issues the public thinks about and talks about. The media do this by giving prominent space and time to issues of their choice. If the media gives an issue a lot of attention, then they will elevate that issue to an important place in society.

Media build agendas by highlighting an issue and making it stand out, providing extensive coverage to bring an issue to public attention, giving an issue meaning which can be understood and by bringing in well-known people to speak on an issue on a radio or television program. This study sought to establish whether the agenda setting theory as proposed here held its legitimacy as regards the Zambian media context in promoting VCT.

CHAPTER FOUR

RESEARCH METHODOLOGY

4.0 Introduction

This chapter looks at the methodology that was used in this study and it consists of four parts. The first part looks at the research design followed by qualitative method (sample size, sampling technique and data collection tools). The third part gives the quantitative method (the sample size, sampling procedure and data collection tool). The fourth part gives the methods of data analysis. Triangulation method was used whereby a combination of qualitative and quantitative methods were used to get an in-depth understanding of the research questions.

4.1 Research Design

The research was non-experimental and analytical in nature by explaining why and how things were done to promote VCT.

4.2 Qualitative Research Method

4.2.1 In-depth interviews

This method was chosen because it allowed the researcher to get deeper insight into the subject matter from the people deemed to be experts in the area of research. Wimmer and Dominick (2014) indicate that the most important advantages of in-depth interviews are; the wealth of detail that it provides and more accurate responses given on sensitive issues. This method helped in getting richer answers to questions put to key informants by the researcher. This gave valuable insights that may have been missed by other methods. Additionally, this method put emphasis on words rather than quantification in the collection of data.

4.1.1.1 Sample size

In-depth interviews were carried out with seven key informants. The Deputy Director- Health Education and Senior Mental Health Officer from the Ministry of Health Headquarters to get an insight on the role they play in promoting VCT and the channels they use for disseminating health information. Then two Heads of Department (VCT and ART) from Chainama and

Mtendere clinics and two Lay Counsellors from Chainama and Kaunda Square clinics were interviewed to get an insight on how they conducted VCT, the communication tools they use and the challenges they faced. In addition, the Director of programs at Zambia National Broadcasting Corporation as interviewed in order to understand the role of media in promoting VCT.

4.1.1.2 Sampling technique

Purposive sampling which entails the choosing of members of the sample deemed by the researcher to be better placed to give relevant information to the study was used. The 7 key interviewees were chosen because they were involved in health communication, and had rich knowledge on the topic of VCT.

4.1.1. 3 Data collection tools

The interviews were semi-structured and the researcher used a question guide in each interview. All interviews were tape recorded. In addition, direct observation by the research during the period of attachment to Ministry of Health Headquarters and field work at the selected clinics was used to gather more data on the subject matter.

4.3 Quantitative Research Method

4.3.1 Quantitative survey

This survey helped to determine the attitudes, knowledge and practices of people towards VCT. The use of this method had many advantages which benefited the study. One of the benefits of using this method was that, it helped to quantify the observed facts hence enhancing the authenticity of the findings. In addition, it involved the collection and analysis of data which necessitated a deductive approach to the relationship between theory and research in which importance was placed on testing theories.

Bryman (2004) put forward that quantitative method incorporates the practices and norms of natural scientific model and represents a view of social reality as an external objective reality. These features are very helpful in reaching at objective conclusions of the study without bias.

Further, this method helps to quantify the observed facts consequently adds to the genuineness of the findings.

4.3.2 Sample size

A total of 90 respondents were considered in this study. This sample was chosen because it was realistic.

4.3.3 Sampling procedure

Proportionate stratified random sample was used to arrive at the total sample of 90 different households. This sampling procedure was beneficial to the study because it catered for divergent views from people of different strata (groups). The researcher targeted a sample from Munali Constituency in Lusaka. This area was chosen because it consists of the high, medium and low density areas that allowed for diversity of views. The low, medium and high density areas were defined as different strata where a random sample was drawn from each stratum (group). In this case, Mtendere, Kaunda Square Stage II and Chudleigh were picked as high, medium and low density areas respectively.

A section was randomly selected in Mtendere. A total of 40 households were systematically picked from streets within the area at an interval of four, where every fourth household was picked in each selected street. For Kaunda Square Stage II, 22 households were systematically picked from streets within the area at an interval of every third house. For Chudleigh, a total number of 28 households were picked systematically from within the streets in the area at an interval of every third household. In all the three townships selected, the head of house for every household sampled was targeted. However, in case of any difficult accessing those, any responsible adult found during the time of visit were allowed to answer the questionnaire.

4.3.4 Data collection tools

Questionnaire with closed and open ended questions was used to collect data from respondents. In addition, books, journals and articles were used to collect data which enabled the researcher to gain a deeper understanding of the topic at hand and consolidate primary data.

4.4 Data Analysis and Interpretation

Data was analysed using both qualitative and quantitative techniques. Narrative analysis, tables and charts were used to present and summarise data. A statistical analysis was also performed to understand some properties of the sample from the study results. The Statistical Package for the Social Sciences (SPSS) was used.

4.5 Ethical considerations

4.5.1 Informed Consent: during the study, the researcher asked for permission from participants before administering questionnaires to them and before conducting interviews. In addition, adequate information was given to participants so that they were made to understand what was involved in the study. As a result, they were able to make an informed decision.

4.5.2 Confidentiality: privacy and identity of all the respondents were preserved. This was achieved by ensuring that respondents were assigned code numbers which were written on the questionnaires.

4.5.3 Objectivity: the researcher ensured that she remained focused without any biases or manipulating the findings because such a thing would undermine the findings of the study.

4.5.4 Permission to conduct research and attachments: permission was obtained from Ministry of Health Headquarters well in advance to conduct the study.

4.6 Challenges

Most respondents for quantitative survey were unable to read and write, however, this challenge as overcome by way of interpreting questions in Bemba and Nyanja. Further, it was difficult to get hold of interviewees despite making interview appointments with them well in advance. In spite of this, the researcher remained persistent and this paid off.

CHAPTER FIVE

PRESENTATION OF FINDINGS

5.0 Introduction

Chapter four described the methodology of the study and how the data was collected. This chapter presents the findings collected using the tools mentioned in the previous chapter. The findings are presented according to the objectives of the study.

The people's knowledge, attitudes and practices towards VCT

The usefulness of the VCT information provided

The sources of VCT information

The channels used to pass information to people

The differentiation of the VCT messages for different audiences

The factors affecting VCT

5.1 Background information of respondents

This section presents the background information of respondents. Age, sex, marital status and residential area were considered.

The table below shows the age of respondents that were categorised in groups.

Table 2: showing age of respondents

What was your age at last birthday?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	below 20 years	8	8.9	8.9	8.9
	20-29 years	39	43.3	43.3	52.2
	30-39 years	25	27.8	27.8	80.0
	40-49 years	15	16.7	16.7	96.7
	50 and above	3	3.3	3.3	100.0
	Total	90	100.0	100.0	

The table above shows that the majority of respondents represented by 43 % were in the age group 20 to 29 years while very few respondents represented by 3% were aged 50 years and above.

Table 3: showing sex of respondents

What is your sex?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	male	50	55.6	55.6	55.6
	female	40	44.4	44.4	100.0
	Total	90	100.0	100.0	

The table above shows that more than half (56%) of the respondents were male while the rest were female (44%).

Table 4: showing marital status of respondents

What is your marital status?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Married	51	56.7	56.7	56.7
	Single	29	32.2	32.2	88.9
	Divorced	2	2.2	2.2	91.1
	Widowed	8	8.9	8.9	100.0
	Total	90	100.0	100.0	

Table 4 above shows that most of the respondents were married represented by 57% followed by 32% for single respondents. Few respondents were divorced and widowed represented by 2% and 9% respectively.

For residential area; low density area had 28 respondents, medium density had 22 while high density area had 40 respondents out of the total of 90.

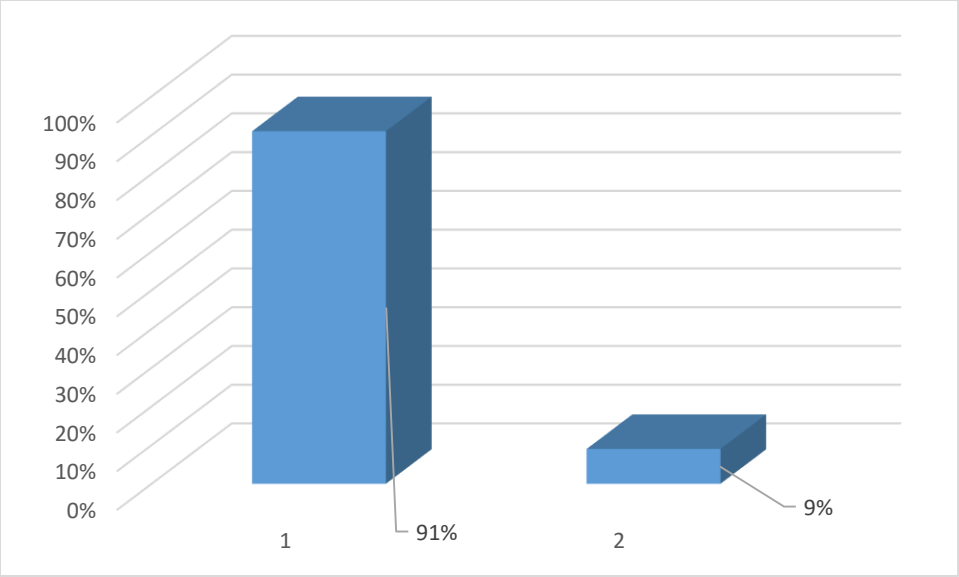
5.2. Knowledge, attitudes and practices towards VCT

This part of the study looked at people's knowledge, attitudes and practices towards VCT. This was done by using three questions which were: what do you know about VCT? Have you undergone VCT? Have you taken any of your children for VCT? The findings are presented in the following charts below.

5.2.1. Knowledge on VCT

In getting to understand whether respondents had knowledge on VCT and its role in the fight against HIV pandemic, the researcher had to ask respondents if they knew what VCT was. Thus the table below clearly shows that the majority of the respondents had knowledge on VCT, this was represent by 91% (82) of the respondents who knew what VCT was while a few respondents represented by 9% (8) of the total respondents did not know what VCT was.

Figure 1: respondents Knowledge on VCT



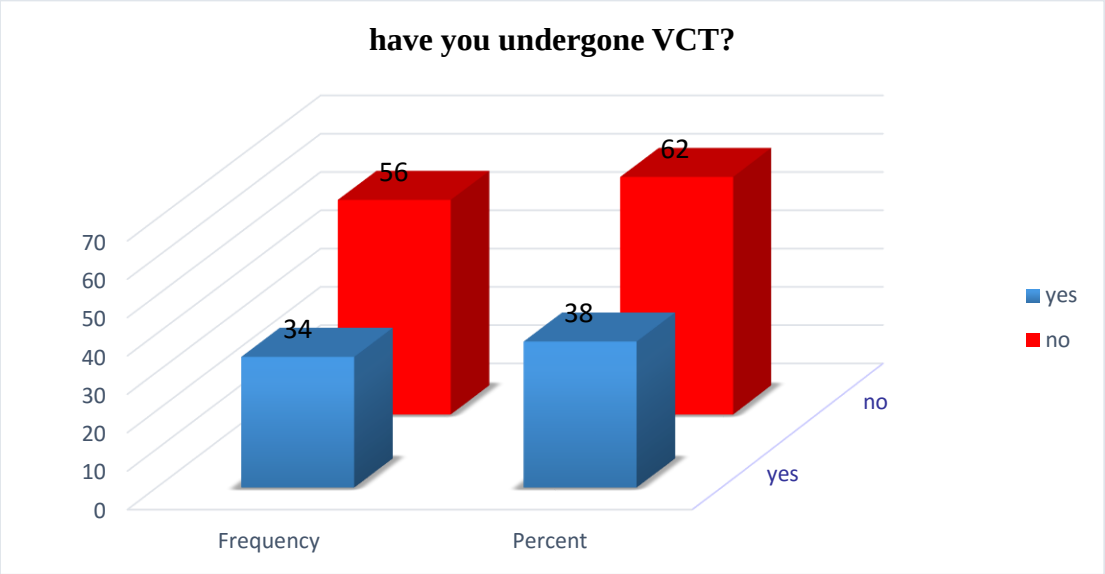
1 Respondents with knowledge on VCT 2 Respondents without knowledge on VCT

Source: field work

5.2.2. Attitudes and practices towards VCT

The researcher went further to understand the practices of people towards VCT. This was done by assessing how many had undergone VCT since most respondents had knowledge on VCT. Thus the question asked was: have you undergone VCT? Responses to this question are presented in the bar chart below and it is clearly observed that despite knowing what VCT was, the majority of respondents did not undergone VCT. The findings show that only 38% (34 out 90) of respondents had undergone VCT while the remaining 62% (56 out of 90) did not undergone VCT.

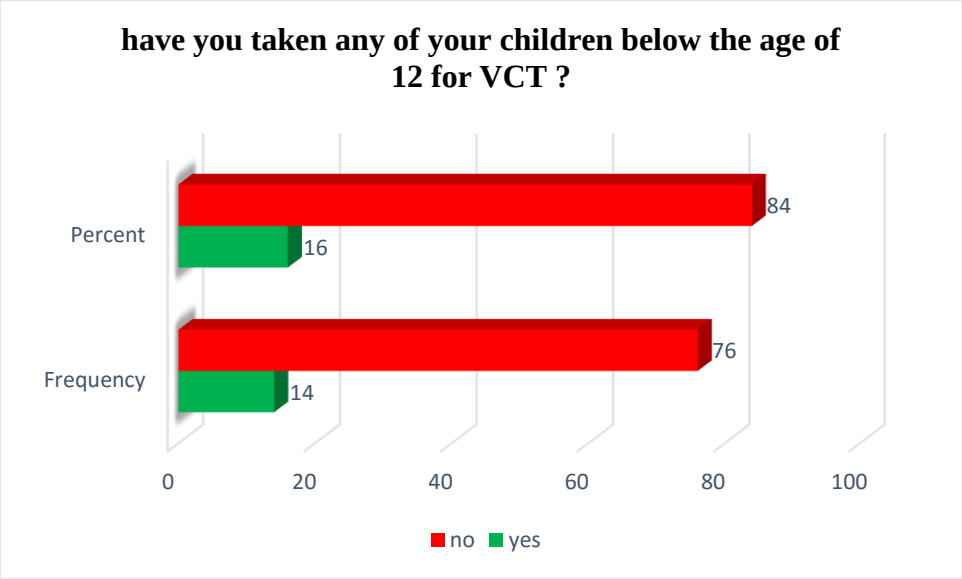
Figure 2: showing percentages of respondents who had undergone VCT and those who did not



Source: field work

The research respondents' practices were also assessed by understanding whether they took responsibility of taking their children (under the age of 12) for VCT. Therefore the respondents were asked if they had taken any of their children (below the age of 12) for an HIV test. The bar chart clearly show that despite having knowledge, the majority of the respondents represented by 84% (76 out of 90) did not take their children for VCT while only 16% (14 out of 90) did

Figure 3: showing whether respondents took their children (below 12 years) for VCT.



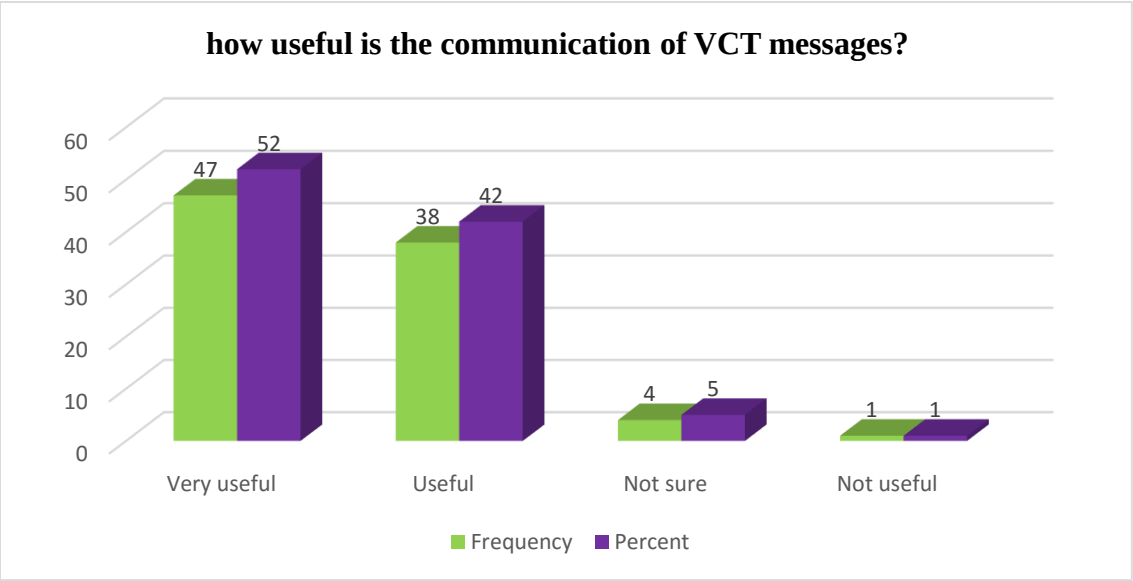
Source: field work

5.3. The usefulness of the VCT information provided

This part of the study evaluated the value of VCT messages in the fight against HIV pandemic. The findings of this section are presented in the bar charts and pie chart. The first part of the bar chart reflects the perception of the respondents on the usefulness of VCT messages in the fight against HIV. The pie chart reflect respondents views on whether VCT should be mandatory as a way of fighting HIV pandemic and the last part bar chart assessed if people had access to VCT information.

The importance of communication was assessed by getting the views of respondents from the question: how useful is the communication of VCT messages in the fight against HIV pandemic? The figure below clearly show that respondents considered communication of VCT messages to be very useful in that the majority represented by 52% (47/90) showed that as very useful, 42% (38/90) stated it was useful. 5% were not sure while only 1% stated that it was not useful.

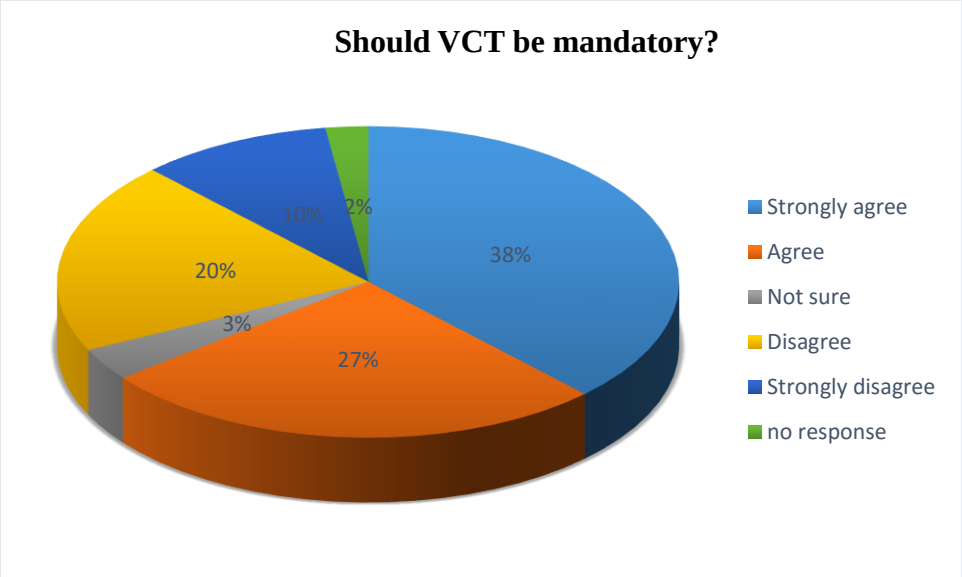
Figure 4: The usefulness of VCT messages in the fight against HIV.



Source: field work

From the above findings, VCT messages were considered useful. The researcher went further to establish whether respondents were of the view that VCT should be mandatory in their communities. In this line, the findings of the study showed that the majority of the respondents were for the view that VCT should be mandatory and this was reflected by 38% of those who strongly agreed and 27% of those who just agreed with this view. Fairly a good number in smaller percentages disagreed and this was reflected by 10% of those who strongly disagreed and 20% of those who just disagreed with the view. Meanwhile the remaining 5% was shared by those who were not sure with 3% and 2% for those who did not respond.

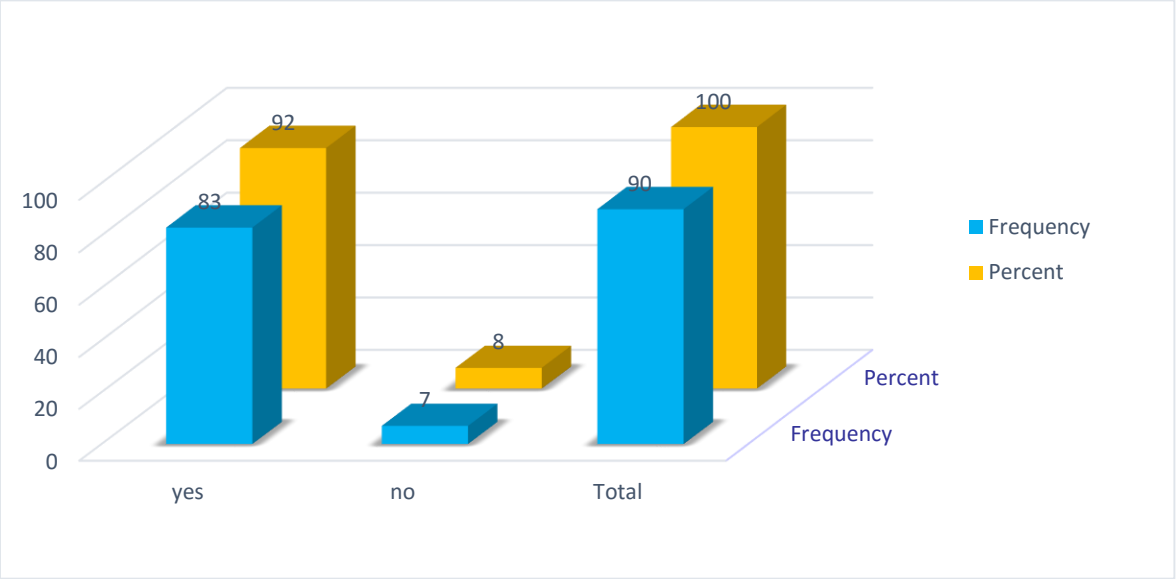
Figure 5: showing whether VCT should be mandatory.



Source: field work

The study also sought to establish whether people had access to information on VCT in their communities. In that line, respondents were asked to respond to the following question: Do you have access to VCT information? The responses were summarised in the bar chart below. The findings showed that, most of the respondents had access to VCT information and this was represented by 92% (83 out of 90) and only 9% (8 out of 90) of the respondents had no access to VCT information in their communities.

Figure 6: showing access to VCT information

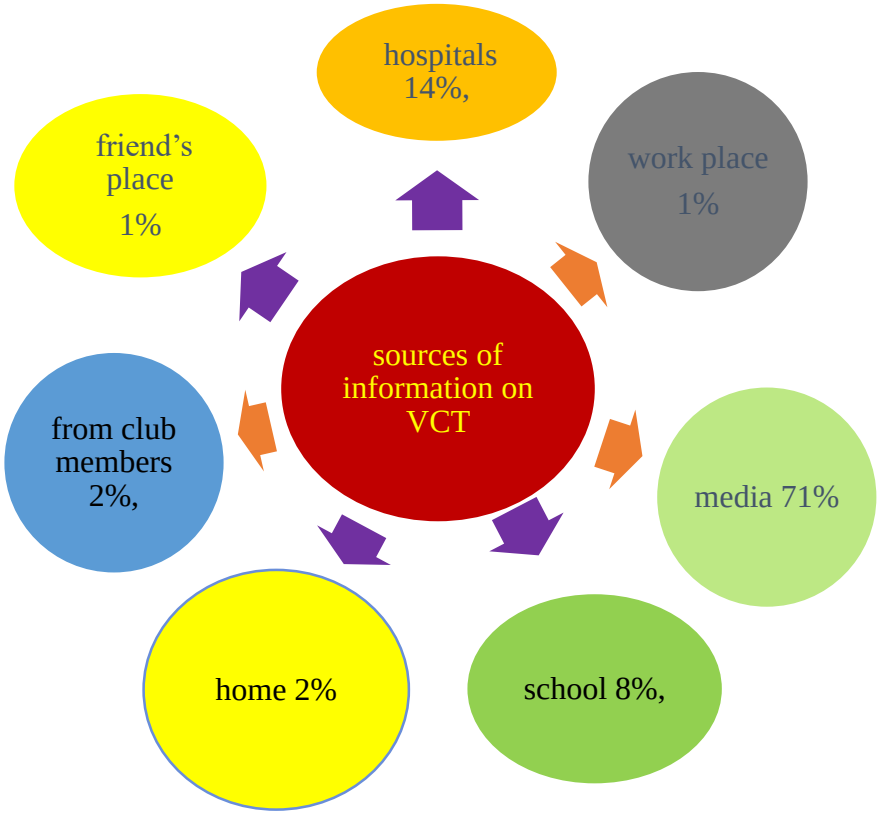


Source: field work

5.4. Sources of VCT information

This part of the study sought to establish the sources of VCT information for respondents in the communities. The study found that most of the respondents represented by 71% got VCT information from the media (television, radio and internet). 14% of the respondents got VCT information from the hospitals mainly women and about 8% of the respondents' accessed VCT information from the schools and these were young people who were often found in learning institutions. Other sources of VCT information were 2% home, 1% work place, 1% friends place and the other 2% from clubs for those who belonged to some clubs. The findings are presented in the figure below.

Figure 7: the sources of VCT information.



Source: filed work

Respondents were asked to state here they got VCT information for the first time. The table below shows the responses given

Table 5: Showing where respondents got VCT information for the first time

Where did you first hear about VCT?

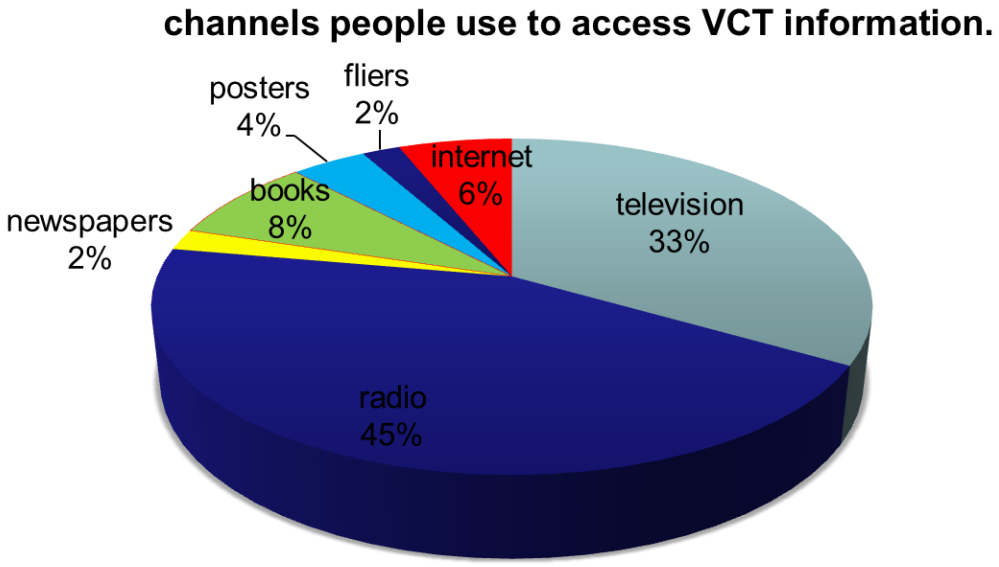
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	At work	1	1.1	1.1	1.1
	At home	2	2.2	2.2	3.3
	At the hospital	14	15.6	15.6	18.9
	At a friend's place	1	1.1	1.1	20.0
	At a member's club	2	2.2	2.2	22.2
	At school	7	7.8	7.8	30.0
	Through the media	63	70.0	70.0	100.0
	Total	90	100.0	100.0	

Source: field work

5.5. Channels people use to access VCT information

Closely linked to the sources above, the study also established the channels used to pass VCT information to people. Channels used to pass information were found to be posters, newspapers, television, radio, fliers and internet. This study found that mass media were the most used channels and source of VCT information. The findings present that the majority (45%) of the participants accessed VCT information from the radio, 33% of them got it from the television, 6% of participants used the internet, 8% read in the books, the posters were also realised to be functional in that at least 4% of the people used them and only 2% of the respondents had accessed VCT information from fliers. See figure below.

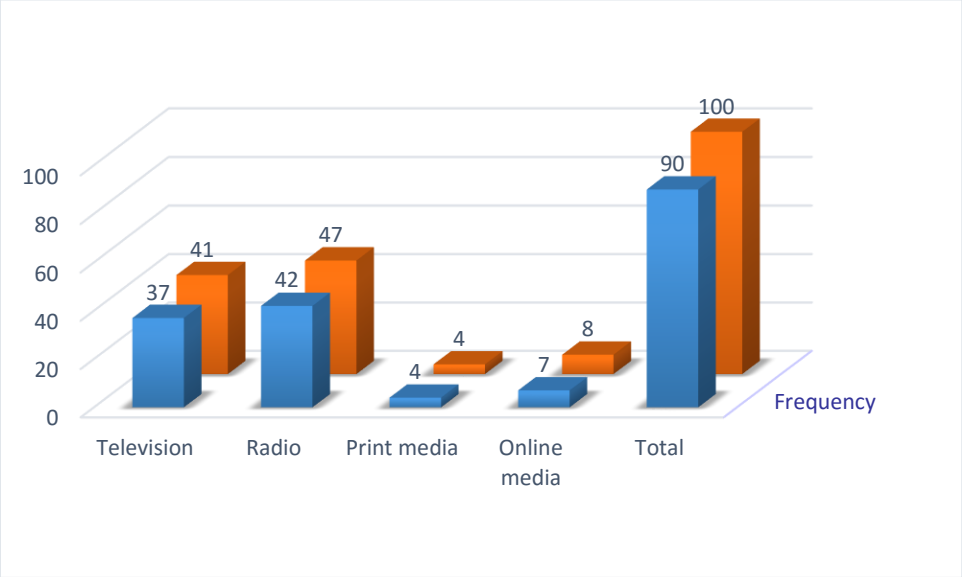
Figure 8: showing the channels used to access VCT information.



Source: field work

Having established that media were the major source of information, the researcher went further to find out the opinions of the respondents on which media platform they thought was most effective in disseminating VCT information. A bar chart was used for the presentation of these findings. The bar chart below shows that most respondents thought of the radio as the most effective media in disseminating VCT information with 47% (42 out 90) followed by television with 41% (37 out of 90) of the respondents while just a few with 4% chose print media and 8% of them thought that online media was the most effective in communicating VCT information.

Figure 9: showing the most effective media in disseminating VCT information.

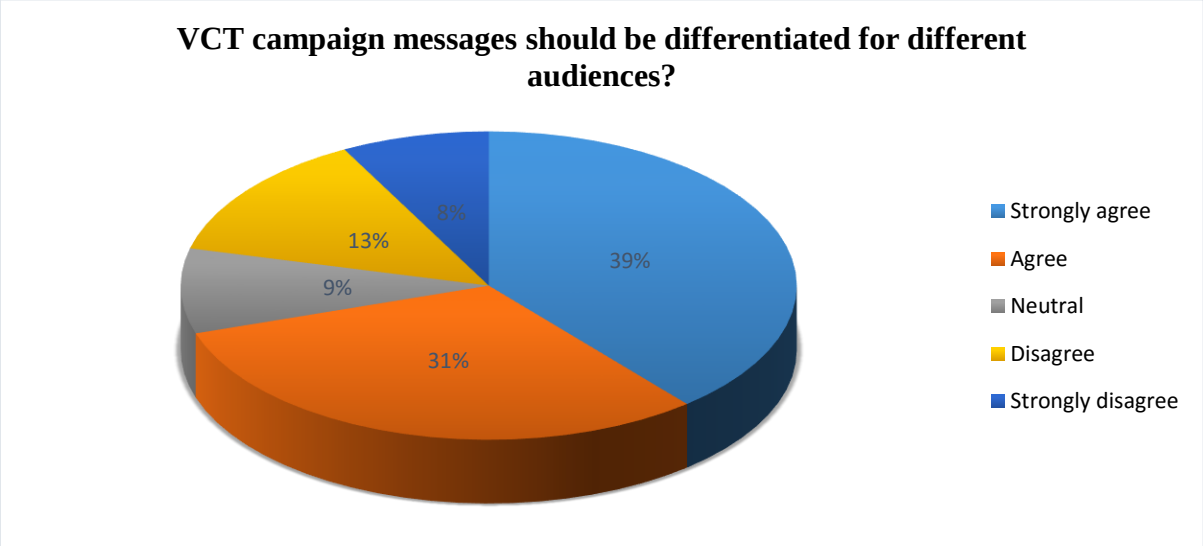


Source: field work

5.6. The differentiation of the VCT messages for different audiences

The study also established the views of the respondents as to whether the VCT campaign messages should be differentiated for different audiences and findings came out as follows; the majority were for the view as reflected by 39% of those who strongly agreed and 31% of those who agreed with the notion. Contrary, a few opposed the idea and these were represented by 8% who strongly disagreed and 13% who disagreed. Others were neutral and are observed with 9% of the respondents.

Figure 10: showing views of respondents on differentiating VCT messages

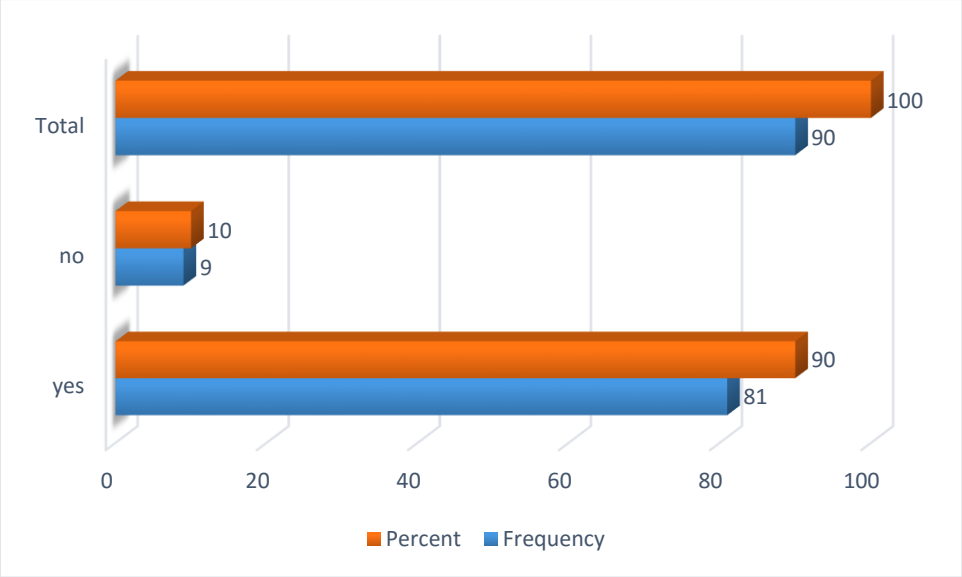


Source: field work

In the quantitative survey, the researcher had to seek understanding of the respondents' views on whether VCT messages that were being communicated could be adopted into behaviour. The findings show that the majority of the respondents believed that people's behaviour could change following the communication of the VCT messages in the communities. The bar chart below puts it clear that 90% (81 out of 90) of the participants were for the view and 10% (9 out 90) of them were against the view.

Figure 11: showing respondents views on whether messages on VCT can be adopted into behaviour

Do you think the message on VCT being communicated can be adopted into behaviour?



Source: field work

Differentiation of the messages on VCT during counselling was considered as a significant part of communication. Supporting the responses given above is the table below demonstrating that the majority of the respondents felt that they were not given enough of necessary information during the counselling. From the table below it can be seen that about 61% of the respondents were not given much of the necessary information during counselling while about 38% received necessary information and just one respondent did not respond.

Table 6: showing whether respondents were given as much necessary information as possible

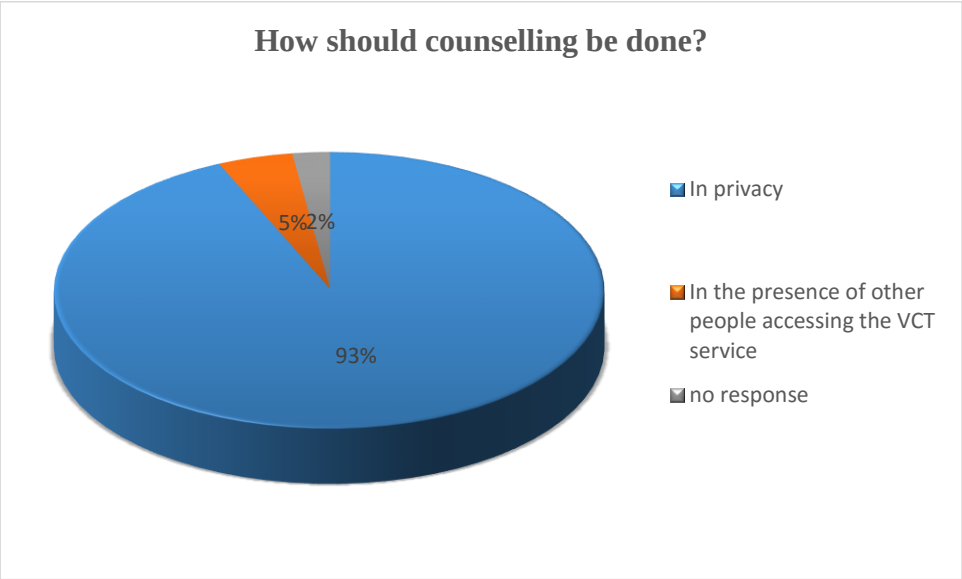
Were you given as much as necessary information during counselling?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	yes	34	37.8	37.8	37.8
	no	55	61.1	61.1	98.9
	no response	1	1.1	1.1	100.0
	Total	90	100.0	100.0	

Source: field work

The researcher went further with the investigations on communication during counselling by asking the respondents to respond to this question: How should counselling be done? The pie chart below show the responses on how counselling should be done. To start with, respondents expressed positive attitudes towards individual counselling and thus 93% of the respondents wanted privacy where counselling was done from. On the other hand only 5% wanted group counselling whereas only 2% were neutral and did not respond. From the in-depth interviews with three lay counsellors, it was stated that most clients preferred being counselled by only one counsellor in one room so that there could be privacy. However privacy in most cases was compromised due to lack of enough counselling rooms. Counselling was mostly done in one room with two or more counsellors each attending to a client.

Figure 12: showing how counselling should be done

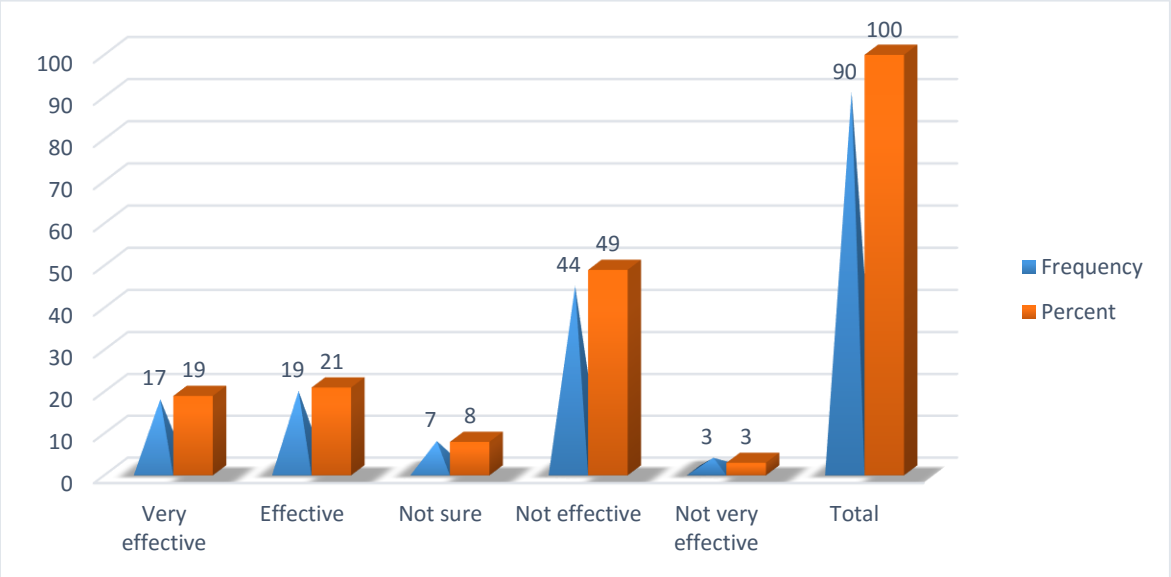


Source: field work

The researcher also sought to establish people's perception on the effectiveness of the counselling services. This was done by asking them; how effective do you think the counselling services offered by VCT service providers are? And the responses to that are presented in the bar chart below. The findings show that most the participants represented by 49% (44 out of 90) indicated that communication and counselling services from the VCT providers was not effective and 3% (3 out 90) stated that it was not very effective. Contrary, 19% (17 out of 90) were of the view that it was very effective, in the same line 21% (19 out 90) stated that it was effective. About 8% (7 out of 90) were not sure.

Figure 13: showing respondents' perception on the effectiveness of counselling services provided.

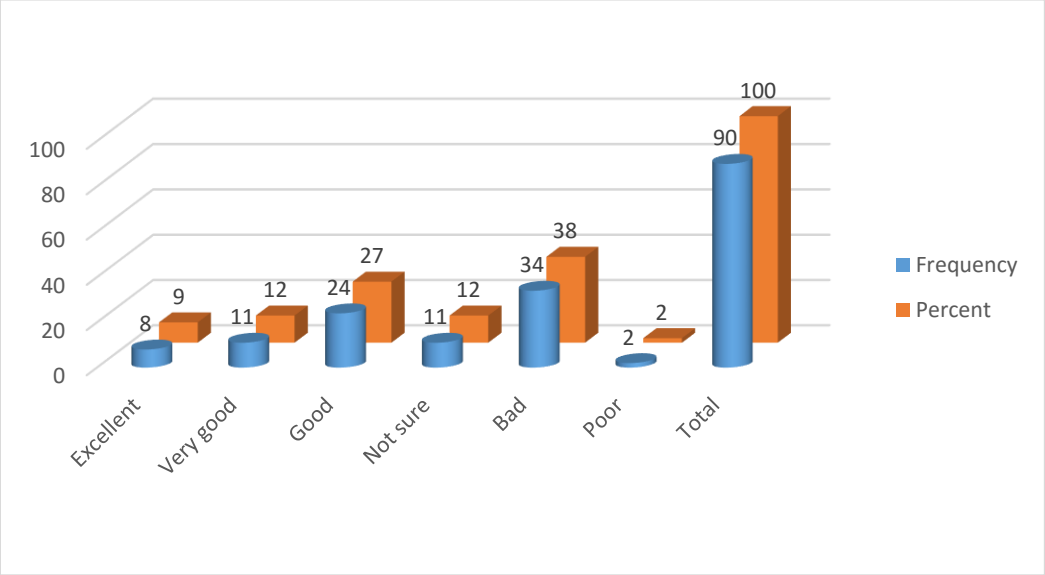
How effective do you think counselling services are?



Source: field work

In addition, the researcher also asked the participants to rate the communication from the VCT providers and the findings are presented in the bar chart below. The ratings were observed as 9% (8) rated it as excellent, 12% (11) rated it as very good and 27% (24) indicated that it was good. Meanwhile 12% (11) were not sure. On the other hand the highest percentage and frequency of 38% 34 out of 90 said it was bad and 2% (2) rated it as poor.

Figure 14: showing the ratings of communication of VCT service providers



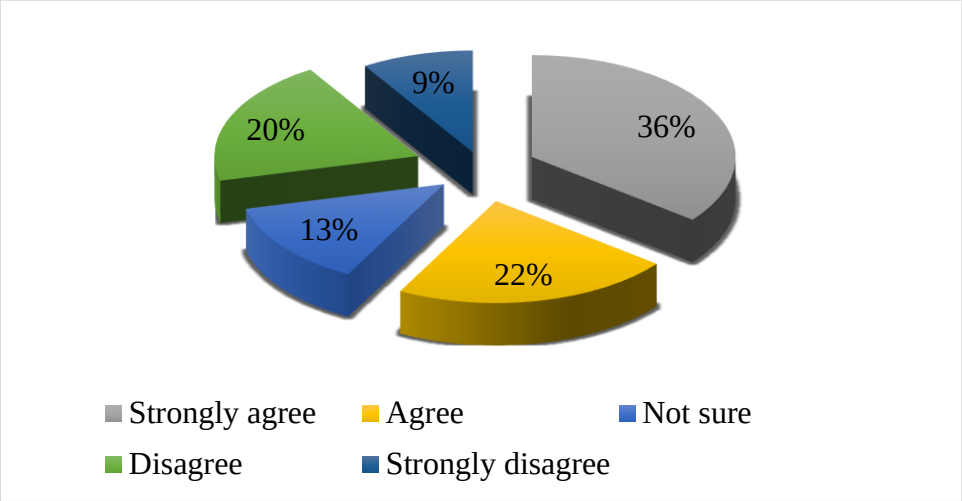
Source: field work

5.7 Factors affecting VCT

This section of the study was intended to bring out the factors affecting VCT. In the quantitative survey, respondents were asked statements that helped to show their perception concerning factors that may affect VCT. One of the statements put forward was; socio-economic status affect ones knowledge and attitude towards VCT. The findings are presented in the segmented pie chart below which show that most of the respondents agreed that socio-economic status affect one's knowledge and attitudes towards VCT, represented by 58%. This 58% composed of 36% of those who strongly agreed and 22% of those who agreed while 13% were not sure. On the other hand 29% opposed the same view and these included 20% of those who disagreed and 9% of those who strongly disagreed.

Figure 15: showing whether socio-economic status affect ones attitude towards VCT

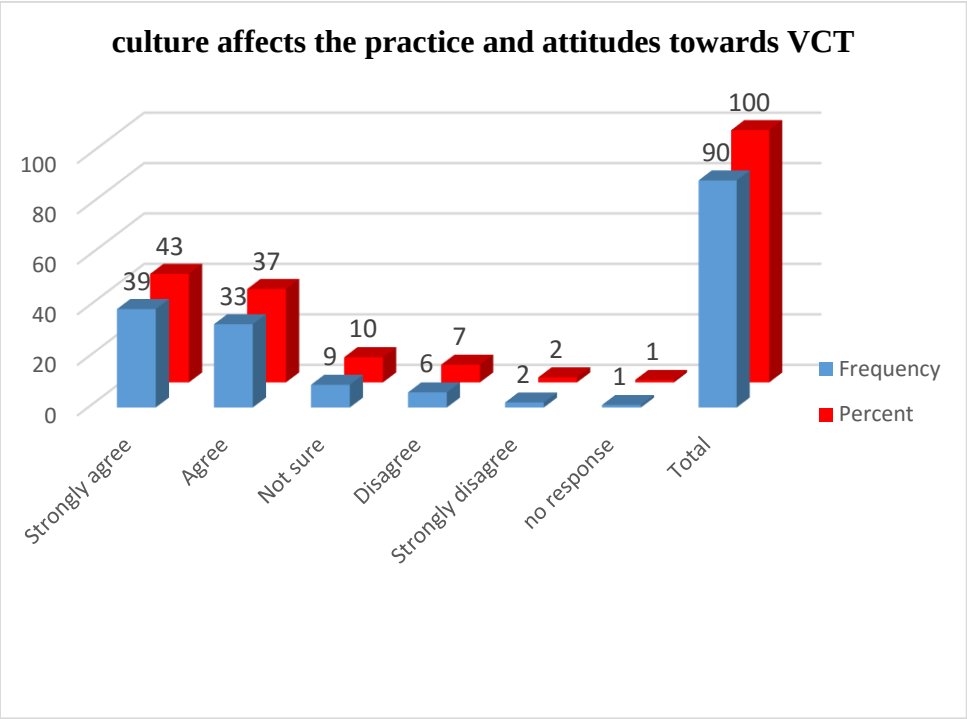
Socio-economic status affects one's attitude towards VCT



Source: field work

In addition, respondents were asked to show whether culture affected one's practice and attitude towards VCT. The bar chart below shows different responses given by respondents.

Figure 16: showing whether culture affected one's practice and attitude towards VCT

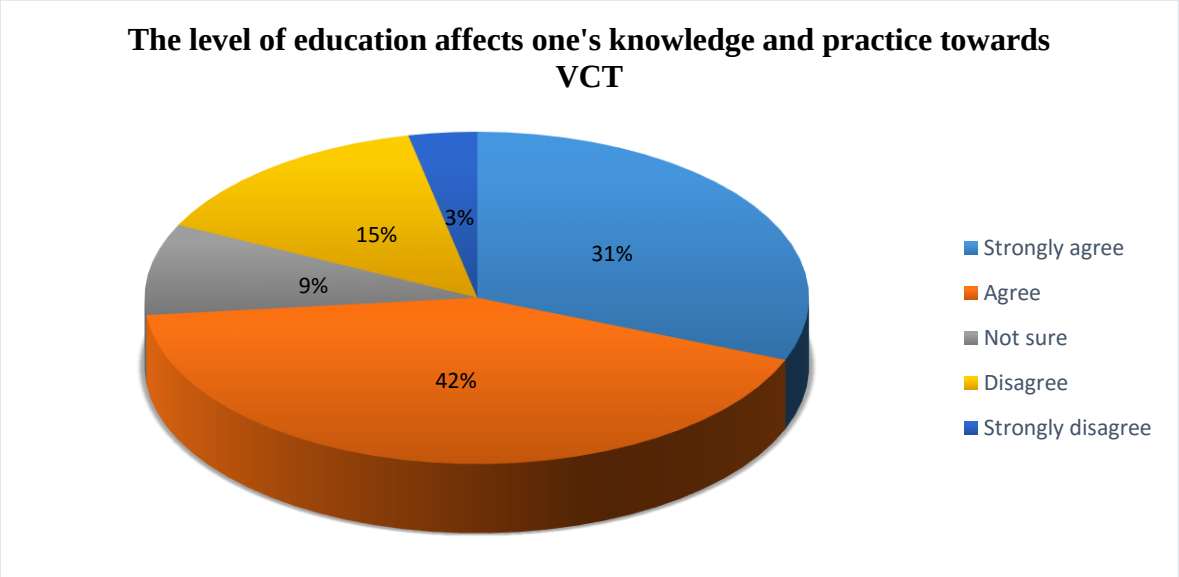


Source: field work

The above bar chart shows that most of the respondents represented by 80% (72 out 90) comprising 43% who strongly agreed and 37% who agreed and believed that culture affects the attitudes and practices towards VCT while only 10% (9) were not sure. On the other hand, only 7% (6 out of 90) disagreed and 2% (2 out 90) strongly opposed the notion.

The study further found that respondents had the impression that one's levels of education also affect their practices and knowledge on VCT. The pie chart below is the reflection of the total responses. The findings show that the majority represented by 73% of the respondents (comprising 31% who strongly agreed and 42% who just agreed) supported the notion while only 9% where not sure. On the opposite side was 18% which comprised 15% who disagreed and 3% who strongly opposed the notion.

Figure 17: showing whether education affected knowledge and practices towards VCT



Source: field work

In addition, the study looked at the aspect of religion affecting attitudes towards VCT. The table below clearly display the views that were produced from the data analysis. In this case, 70% (63) comprising 30% (27) who strongly agreed and 40% (36) who just agreed that religious beliefs affected people's attitude towards VCT. Only 14% were not sure or certain about the notion. Those who disagreed had the same percentage as those who were not sure 14% and only 1% strongly disagreed.

Table 7: showing views whether one's religion affects their attitude towards VCT

	Frequency	Percent	Valid Percent	Cumulative Percent
Strongly agree	27	30.0	30.0	30.0
Agree	36	40.0	40.0	70.0
Not sure	13	14.4	14.4	84.4
Disagree	13	14.4	14.4	98.9
Strongly disagree	1	1.1	1.1	100.0
Total	90	100.0	100.0	

5.8 Cross tabulations

This section considered residential area and marital status of respondents with regard to access of VCT information and actual practice of undergoing VCT

Table 8: showing cross tabulation for residential area and access to VCT information

Which area do you live? Do you have access to VCT information? Cross tabulation

Count				
		Do you have access to VCT information?		
		yes	no	Total
Which area do you live?	Low density	26	2	28
	Medium density	20	2	22
	High density	37	3	40
Total		83	7	90

The table above presents the access of VCT information based on residential areas. From the 90 respondents 26 of those who were from the low density areas said they had access to VCT information in their area, whereas 2 stated that they did not have access to VCT information which accounts for 28 respondents from the low density residential area. 20 of those from medium density agreed to having access to VCT information while 2 stated that they did not have access to VCT information and the rest (40) were from high density residential areas out of which 37 said they had access to VCT information and 3 stated that they did not have access to VCT information within the high density residential area.

Table 9: showing cross tabulation for residential area and undergoing VCT

Which area do you live? Have you undergone VCT? Cross tabulation

Which area do you live?	Have you undergone VCT?		
	yes	no	Total
Low density	3	25	28
Medium density	15	7	22
High density	16	24	40
Total	34	56	90

The above table presents how many respondents other than just having the knowledge on (VCT), but had actually taken time to under-go voluntary counselling and testing (VCT). Out of the 28 from the low density area only 3 had gone for voluntary counselling and testing (VCT) while the other 25 did not undergone voluntary counselling and testing. Furthermore, 15 of the 22 from medium density areas had undergone VCT and the remaining 7 did not undergone VCT. From the high density area there were only 16 out of 40 respondents who indicated that they had undergone VCT while the remaining 24 of the 40 respondents from the high density area did not undergo voluntary counselling and testing. Less than 50% of respondents from low and high density residential areas had undergone VCT. The medium density residential area had more than 50% of respondents who had undergone VCT. The low density residential area had the lowest number of respondents who had undergone VCT

Table 10: showing cross tabulation for residential area and views whether messages on VCT can be adopted into behaviour

Which area do you live? Do you think the messages on VCT being communicated can be adopted into behaviour? Cross tabulation

Which area do you live?	Do you think the message on VCT being communicated can be adopted into behaviour?		
	yes	no	Total
Low density	27	1	28
Medium density	22	0	22
High density	32	8	40
Total	81	9	90

Table above shows the respondents' views on VCT messages being communicated as to whether they be can be adopted into behavior or not by the public in their residential areas. 27 of the 28 from the low density areas said yes while 1 of the 28 showed that VCT information could not be adopted into behavior. All the 22 respondents from the medium density areas thought that the VCT messages communicated through various platforms could be adopted into behavior. In addition, 32 from the 40 respondents in the high density areas said yes while the other 8 of the 40 respondents from the high density residential areas indicated that they did not think that the messages communicated can be adopted into behavior. The majority of respondents from low, medium and high residential areas stated that information on VCT can be adopted into behaviour.

Table 11: showing cross tabulation for marital status and undergoing VCT

What is your marital status? Have you undergone VCT? Cross tabulation

What is your marital status?	Have you undergone VCT?		
	yes	No	Total
Married	14	37	51
Single	15	14	29
Divorced	1	1	2
Widowed	4	4	8
Total	34	56	90

The table above shows the responses as to whether or not respondents had undergone voluntary counselling and testing based on the respondent's marital status. From the total 51 that were married only 14 did undergone voluntary counselling and testing whereas the other 37 had not visited VCT centers for voluntary counselling and testing. Out of the total 29 single respondents, 15 had gone for voluntary counselling and testing whilst 14 did not. Further, of the 2 divorced respondents, 1 had actually undergone VCT while the other did not. From the 8 widowed respondent's, 4 of them had undergone voluntary counselling and testing while the other 4 had not undergone voluntary counselling and testing. Less than 50% of married respondents had undergone VCT and more than 50% of single respondents had gone for VCT. In addition, 50% of divorced and widowed respondents had undergone VCT.

Table 12: showing cross tabulation for marital status and getting as much as necessary Information during counselling session

What is your marital status? Were you given as much as necessary information during counselling? Cross tabulation

What is your marital status?	Were you given as much as necessary information during counselling?			
	yes	no	no response	Total
Married	14	37	0	51
Single	15	14	0	29
Divorced	0	2	0	2
Widowed	5	2	1	8
Total	34	55	1	90

The table above shows responses as to whether or not respondents were given the necessary information on VCT during counselling sessions based on the respondent's marital status. From the total 51 that were married only 14 indicated that they got necessary information on VCT

during their counselling sessions whereas the other 37 stated that they did not get necessary information on VCT during their counselling session. Out of the total 29 single respondents 15 admitted that they were given the necessary information on VCT while 14 showed that they did not get necessary information on VCT during their counseling sessions. 2 respondents who were divorced indicated that they got necessary information on VCT. In addition, of the 8 widowed respondent's 5 of them showed that they got necessary information on VCT during their counselling sessions while 2 were not given the necessary information on VCT and lastly only 1 respondent did not give a response.

The findings of the study indicate that communication plays an important role in promoting VCT. Most of the respondents had VCT and felt that it was important in the fight against HIV and AIDS. In spite of most respondents having knowledge on VCT, the number of those who had accessed the service was low at 37%. The study further reviewed that the main source of VCT information was Ministry of Health, Headquarters and different channels such as booklets, posters, fliers and different media were used to pass information to people. However, most respondents accessed VCT information through the media. Thus the media could play an important role in promoting VCT by influencing the behaviour of people. Additionally, the study established that messages on VCT were not differentiated for different audiences which created a knowledge gap in certain groups of people such as the visually impaired, deaf and the old.

5.9 Qualitative findings

Voluntary counselling and testing for HIV is key to the health sector as it is the first step to HIV prevention and connection to treatment and care. Through VCT, health care providers are able to establish how many clients are infected with HIV and also disseminate information to people who are not infected on how to prevent themselves from HIV. Through the data captured at health facilities on VCT, health care managers and policy makers are able to plan, make decisions and develop strategies to fight HIV and AIDS. Hence, the messages produced by Ministry of Health and health centre staff are very useful to both the public and health care providers. Ministry of Health was the major source of information on VCT because it produced much of this information. The media made it possible for this information to reach a mass audience.

The Ministry of Health Headquarters mainly used the media (television, radio and print media) for advertisements to promote VCT. Print media were cited as the preferred media due to advantages of being less costly compared to electronic media, and printed works or articles could stay for a longer period of time. Television and radio were also used though not very often due to the expensive charge rates. As messages were communicated via radio, it was easy to use local languages rather than English so that many people could listen to the message and act accordingly. In addition, books, billboards, posters and brochures were also used to communicate VCT information to the public. These materials were mainly distributed in schools, market places and health facilities.

Health facility staff conducted health talks every morning in waiting rooms where clients sat and VCT was one of the topics covered on a daily basis. Health facilities also engaged neighbourhood health committees (NHCs) to encourage people in communities to access VCT service. Further, public address system was used to pass VCT information to people in communities. This was mainly done during outreach activities and safe motherhood week. Print materials were also distributed to clients and posters stack around the facilities.

The study also sought to determine whether messages on VCT were differentiated for different audiences. It was observed that messages were not differentiated for different audiences. In other words, messages on VCT were general messages going out to the general public. It appeared that messages on VCT did not have specific audiences. From the in-depth interviews it was stated that the messages on VCT were not differentiated for different audiences though health care providers intended to target people who were mostly in their sexual reproductive age. This was because health workers felt that this group as most vulnerable to HIV.

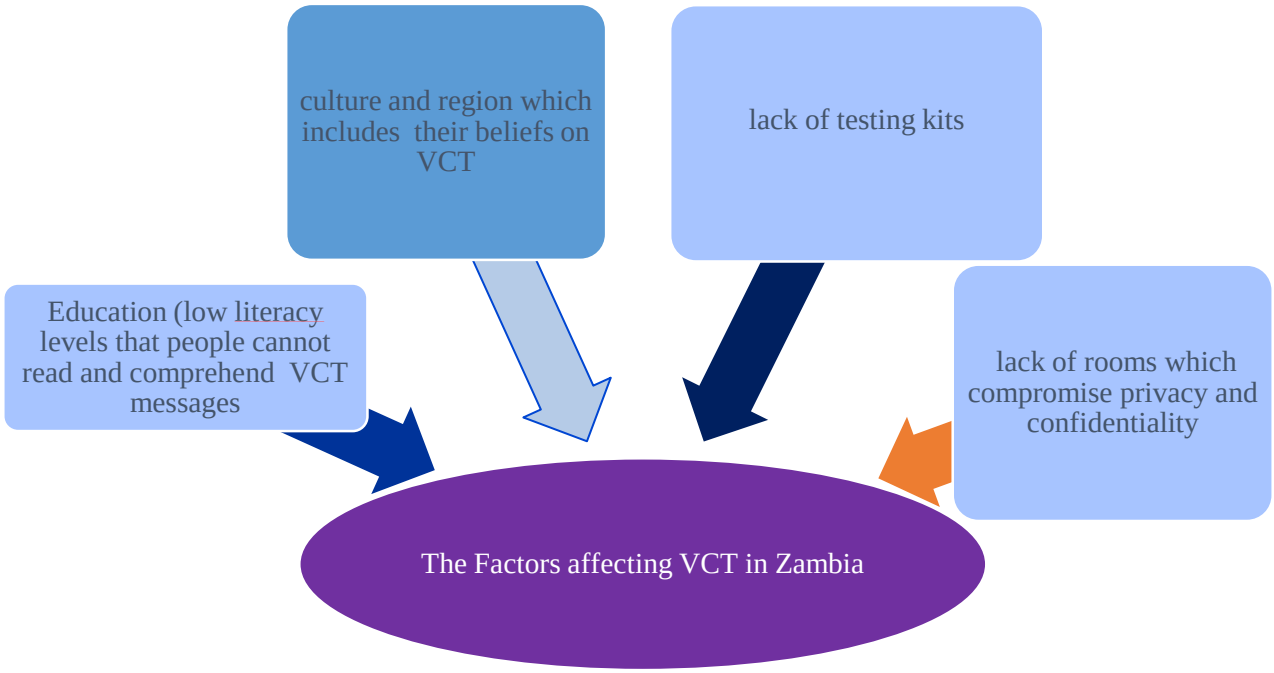
The study established that more and more messages to promote VCT had been disseminated to the public over the years, however, few people had been turning up to access this service. This situation led to health care workers initiating VCT to clients especially those that looked ill or were diagnosed with other diseases or had symptoms of HIV. As a results, health facilities started to record a slight increase in numbers of people undergoing VCT though at a very slow pace.

From the VCT service provider's perspective, a number of factors affected the provision of VCT. Some factors highlighted were lack of testing kits, lack of rooms which compromised privacy and confidentiality, failure by counsellors to use other local languages in counselling sessions, certain cultural practices and some religious beliefs which prohibit blood testing. More and more people in communities had become religious; believing in super natural healing and more spiritual leaders established, who discourage followers from seeking conventional health care.

It was further pointed out that most clients at health facilities were women; who happened to be care givers in most homes. The challenge these women faced when it came to decision making over their health including VCT was that they had to seek for permission from their partners. If their partners did not give consent, the women ignored VCT. Moreover, some women feared that discovery of an HIV positive result could lead to rejection or abandonment by their spouses. Gender based violence (GBV) was also cited as possibly contributing to low numbers of people accessing VCT. This was because victims of GBV would be afraid to ask their partners to be tested for HIV especially where the victims were found to be HIV positive.

From the counsellor's point, people who had very minimal formal education and could barely read and write, appeared to through the counselling process with ease compared to those more educated and professionals. It was put forward that people who were professionals felt that they had read more information on HIV and even tended to self-medicate.

Figure 18: showing the factors affecting VCT



Media were said to be very powerful in getting the messages across to different people and possibly changing their negative attitudes towards VCT. The media played a crucial role in creating an enabling and supportive environment, and platforms where some of the taboo issues and underlying driving forces of HIV were discussed.

News coverage, and programs for discussions through media reinforced information that people received about HIV and VCT in particular from other sources, such as their friends, health care workers and billboards.

CHAPTER SIX

DISCUSSION OF FINDINGS

6.0 Introduction

The previous chapter presented the findings of the study in different forms from the data analysis. This chapter presents the discussion of the findings presented in the previous chapter. As a way of understanding the meaning of the experiences and opinions that the participants had, an interpretation of the emergent themes was done by relating the participants' accounts to the available literature and by making comparisons between and among participants' assertions.

6.1. People's knowledge, attitudes and practices towards VCT

In this section of the study, the themes in relation to people's knowledge, attitudes and practices towards VCT were analysed. This was done by using three questions as presented in the previous chapter which are: what do you know about VCT? Have you undergone VCT? Have you taken any of your children for VCT? These questions helped to understand people's practices towards VCT.

6.2.1. People's knowledge, attitudes and practices on VCT

In this study, the majority of the respondents presented by 91% had knowledge on VCT. The respondents clearly indicated that VCT was an act of undergoing counselling and testing for HIV so that one could know their HIV status. Most respondents went on further to explain the benefits of VCT which showed that they were knowledgeable about VCT. Despite having the knowledge on VCT, the majority of respondents did not visit the health facilities in their areas for VCT as only 38% of respondents had undergone VCT.

These results are similar to those found in a study conducted by Corridors of Hope in Zambia (2011) where 99% of the teenage and adult population had knowledge on VCT and HIV related issues but only 24% accessed the VCT service. Therefore, in this light it as concluded that having knowledge on VCT did not translate into action. Respondents gave different reasons as to why they did not want to undergo VCT. One reason that was common among respondents was lack of confidentiality of test results at public health facilities. From the health care provider's

side, lack of adequate rooms for counselling and testing compromised confidentiality (health facilities only had one room each for VCT services). This is consistent with the findings by Department of Health in USA (2005) which revealed that 64% of respondents felt that there was lack of confidentiality and privacy at public health institutions which made them not to undergo HIV counselling and testing.

6.2 The usefulness of VCT information provided

Turning to the importance of VCT information provided to the community, in this study more than 50% of the respondents indicated that they valued the information provided on VCT. The first part assessed the perception of the respondents on the usefulness of communication in the fight against HIV, the second part showed whether people had access to VCT information and the third part assessed whether VCT should be mandatory as a way of fighting HIV pandemic.

Findings of the study clearly showed that people consider communication of VCT messages to be very useful in that most of the respondents represented by 52% (47/90) indicated that it was very useful in the fight against HIV, 42% (38/90) stated it was useful. These findings support the conclusions of the Department of Health in South Africa (2005) that information on VCT played a key role in the fight against HIV as it helped people lead healthy lifestyles, including knowing one's HIV status and linking people to care and HIV treatment and support.

This study also sought to establish whether people were of the view that VCT should be mandatory in their communities. In this line the results of the study indicated that the majority of the participants were for this view and this was reflected by 70% of the respondents while 30% were against this view. From the health care provider's side at selected clinics, health talks on HIV and the importance of VCT were conducted before clients could be attended to, on a daily basis. After the health talks, patients could be attended to and HIV tests done routinely on clients. HIV tests were extended to children. However, it was noted that most of the clients underwent testing due to the service provider's insistence. Provider initiated counselling and testing was done when clients were hesitant especially for those who appeared to be in bad medical conditions so that extra care was taken when treating their conditions.

This study also sought to establish whether people had access to information on VCT in their communities. The findings show that most of the respondents had access to VCT information

and this was represented by 92%, and only 9% of the respondents indicated that they had no access to VCT information. In addition, the study sought to establish the sources of VCT information provided to the public.

6.3 The sources of VCT information

The study established that the Ministry of Health produced much of the information on VCT and played a major role in disseminating health information to the public through posters, brochures, booklets, adverts on television, radio and mainly adverts on print media which are less costly. The Ministry of Health also worked hand in hand with cooperating partners such as mobile phone network providers such as MTN and Airtel in coming up with messages to meant to encourage people to undergo VCT. However, the media in their role as watchdogs and conveyors of information are important too. According to Martinson and Hindman (2005:57) the media have a wide coverage and this exposure to information can influence health-related decisions including VCT uptake among people. In light of the above statement of Martinson and Mindman, this study found that most of the participants represented by 71% got VCT information from the mass media (television, radio, social media, print media and internet. In addition, 14% of the respondents got VCT information from the hospitals and about 8% of the respondents said that they accessed the VCT information from schools; these are the people who are often found in learning institutions.

Similar to what this study established, Department of Health- South Africa (2005) put forward that communication through the use of mass media may be used to promote voluntary counselling and testing for HIV. This was because a study conducted in South Africa by this department on the significance of media campaigns in the fight against HIV showed that between the years 2000 and 2005, the use of HIV campaign branding, billboards, print materials, television and radio advertisements and programs led to increased HIV testing by 28.5% and 40% rates of patients returning for counselling. Communication about HIV increased the likelihood of individuals undergoing voluntary counselling and testing for HIV.

6.4. The channels used to pass information to people

Closely linked to the sources above the study established the channels used to pass VCT information to people. Channels used to pass information were found to be posters, newspapers, Television stations, radios stations, fliers and internet. This study found that mass media were the most accessible channels of VCT information. The findings present that the majority (45%) of the participants accessed VCT information from the radio, 33% got it from television, while 6% of participants used the internet and 8% read in the books. The posters were also realised to be functional in that at least 4% of the people used it and only 2% of the respondents accessed VCT information from fliers. In addition, the service providers stated that they held public meetings with specific themes to encourage VCT uptake.

The researcher also asked the respondents which media platform they thought was most effective in the sense that the platform conveyed information which was clearly understood and people were able to act on it. Most of the people represented by 47% indicated that radio was the best platform for them , followed by 41% of respondents who were for television while just a few with 4% preferred print media and 8% chose online media as the most effective means of communication of VCT information.

6.5 The differentiation of the VCT messages for different audiences

The study sought to establish whether messages on VCT produced by service providers were designed for specific target groups (establish whether VCT messages were translated into the easily understandable languages for different people to make sense of the VCT information provided in various media and sources mentioned above). From the in-depth interviews conducted with service providers, it was stated that the messages on VCT were not differentiated for different audiences though the focus was on young people below 35 years who were thought to be the most vulnerable to HIV. It was further pointed out that VCT messages that were disseminated to the public through different media were mostly communicated in English. This posed a challenge to those who are unable to understand English. These findings are in contrast with Leslie (2011) who pointed out that different people have different needs. Hence when it

comes to communication, the message must be tailored specifically for a specific audience. Teenagers, young adults, elderly, deaf and visually impaired all have different needs. Communication that promote VCT must come in different languages and forms so as to meet the needs of different people. Regardless of ones' age, physical status, culture, level of education, tribe and religion, there should be an opportunity for them to understand the meaning VCT.

Regarding the role of communication in promoting VCT, the majority of respondents represented by 90% clearly stated that the messages being communicated through different platforms and during counselling sessions could be adopted into behaviour and only 10% indicated that people in their communities could not undergo VCT even if there was communication on VCT. This is in line with Horizons (2013) that communication is key in the fight against HIV and AIDS as it would transform peoples' mind sets and enable them to make informed decision over their health.

6.6 The factors affecting VCT

This section of the study established the factors affecting VCT. From the data analysis the factors affecting VCT in Zambia were found to be lack of testing kits, inadequate rooms for counselling which compromised privacy and confidentiality, education, gender disparity and cultural practices. The above were the most stated responses from the interviews with the key informants from the ministry of health in Zambian and other VCT providers within Lusaka district.

The study shows that most of the respondents represented by 80% comprising 43% who strongly agreed and 37% who agreed that culture affected the attitude and practices of people towards VCT while only 10% (9) were not sure. Contrarily 7% disagreed and 2% strongly opposed the notion. Furthermore the study also found that people were of the view that one's level of education affected the practices and knowledge on VCT in the community. Findings show that the majority represented by 73% of the respondents (comprising 31% who strongly agreed and 42% who just agreed) supported the view while only 9% where not sure. On the other hand, 15% disagreed and 3% of respondents strongly opposed this view.

From the service provider's point of view, factors such as gender disparity played a major role in influencing peoples practices towards VCT especially women. Most women are dependants on men and so they need to seek permission to go for VCT from their partners. Where partners

did not support women, they ended up shunning the VCT service. In communities, people belong to different religious groupings. Some religious groups have discouraged conventional health interventions and group members are advised not to do any blood tests or to seek any medical attention. The religious aspect proved to be a big challenge to service providers because it hampered the implementation of HIV related programs like VCT. Furthermore, stigma affected people's attitude and practices towards VCT as it is still common in communities. Stigma created fear among people in the sense that in case an individual was found to be HIV positive, other people would eventually come to know their status and they would be stigmatised. These findings support the findings by Horizons (2013) that social relations and interactions, communication patterns in families, among couples and among peers may influence people's decisions regarding HIV testing.

Some of the factors discussed above have also affected the nation as a whole as highlighted in National Health Policy, (2012) that Zambia has a multi-cultural society, characterised by different racial and ethnic groups, religious and traditional groupings, urbanisation, and increasing access to the internet and other sources of information, with significant potential for promoting good health. However, there are some social, cultural and religious beliefs and practices that negatively affect health. These include cultural practices, such as sexual cleansing of surviving spouses, unsafe traditional male circumcision procedures, and some religious beliefs that prohibit blood testing especially for HIV, early marriages for the girl child, and risky traditional health practices that put people at risk of contracting HIV and AIDS and living without knowing their HIV status.

CHAPTER SEVEN

CONCLUSIONS AND RECOMMENDATIONS

7.0 Introduction

This chapter has two sections. The first part draws from the lessons and conclusions obtained from the findings. The second part attempt to draw recommendations informed by the findings in the study that may help all VCT service providers and Ministry of Health at large to enhance performance in the area of VCT so that more and more people can access this service thereby closing the gap between knowledge on VCT and the practices towards this service.

7.1 Conclusion

The study shows that the main source of VCT information was Ministry of Health, Headquarters and different channels such as booklets, posters, fliers and different media were used to pass information to people. However, most respondents accessed VCT information through the media. Further, the study established that messages on VCT were not differentiated for different audiences. The study also revealed that communication played a key role in promoting VCT, as noted that 90% of respondents stated that messages on VCT could be translated into behaviour.

The study revealed that most of the respondents knew what VCT was and felt that it was important in the fight against HIV and AIDS. In spite of most respondents having the knowledge on VCT, the number of people who had accessed the service was low at 37%. This showed that there was a gap between knowledge on VCT and actual practice of undergoing VCT. Further, the study established that messages on VCT were not differentiated for different audiences. The lack of differentiation of VCT messages as established as one gaps in communication. Factors such as level of education, religious beliefs, culture, gender disparity and stigma were cited as affecting VCT.

Media have played an important role in disseminating HIV and AIDS information in Lusaka which is highly urbanized with a good number of television stations, radio stations and print media houses including access to internet which avails social media. The majority of people have been able to access this information as shown in the findings. However, the adverts on VCT on media lack proper follow through in that people have not acted on the messages received. In

most cases messages are biased towards young people in the manner that the language is spoken or message written. This has left the audience lacking in content to well written, spoken, researched and in-depth information.

Communication is very vital in the fight against HIV and AIDS. However, when messages do not get across to the target audience, a gap is created. In the case of VCT, messages have been produced and disseminated to people but very few people have acted on this information. There is need to change the packaging of information to suit different audiences. In addition, change in practices could be brought about through support by families, peers and other social relations which would target religious beliefs, gender disparity, stigma and cultural norms. These can drive change in attitude. Good communication practices must be upheld so that there is feedback from communities by having more people undergo VCT. This is important as it serves as a starting point to intervention, treatment and care. Moreover, health care providers need to exercise high levels of professionalism in counselling.

7.2 Recommendations

Based on the findings, the following recommendations were made:

There is need for Ministry of Health to come up with a clearly outlined communication strategy on VCT which should be followed when communicating VCT messages

There is need for Ministry of Health Headquarters to expand infrastructure and the make the supplies of test kits constant and adequate.

VCT service providers at facility level need to scale up communication on VCT by reaching out to communities through health talks, public meetings door to door campaigns and sensitising people on the benefits of VCT. This may assist in reaching out more families.

In addition, there is need to use local languages in posters, fliers, booklets, magazines and advertisements that carry VCT messages and also differentiate these messages for different audiences to cater for their needs. This would help more people to undergo VCT so that they can make informed decisions where treatment, care and prevention of HIV and AIDS are concerned.

There is need for capacity building through in-service training of lay counsellors. This may ensure that VCT service providers remain professional as they offer emotional support to clients

Five Cs should apply in VCT; that is, Consent, Counselling, Correct test results, Confidentiality and Connection to care.

Ministry of Health should lobby for support from cooperating partners and influential leaders in creating social awareness on VCT. This awareness can be done by printing more posters, brochures, booklets and banners to be distributed in strategic places like schools, market places and recreation centers so that more people can come across the information.

Ministry of Health Headquarters and its facilities should work closely with media in disseminating cultural sensitive VCT messages because the media have a wide coverage and potential to change peoples' mindsets towards more positive health practices. Content in adverts should be more appealing to the public and in simplified language.

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APPENDICES

APPENDIX 1. QUESTIONNAIRE FOR AUDIENCE SURVEY

Serial NO……

Introduction

Dear Respondent,

The researcher is a student of Master of Communication for Development at the University of Zambia. As part of the requirement, the researcher is conducting a survey to assess the role of communication in promoting Voluntary Counselling and Testing (VCT).

You have been randomly selected to participate in the research as a respondent. Please answer questions in this questionnaire as accurately as possible. Kindly tick the answer of your choice or write in the spaces provided where your opinion is required. The information you will give will be kept confidential and is strictly for academic purposes. To this effect, you are not required to give or write your name on this questionnaire.

Thank you.

Juliet Mwape.

SECTION A: GENERAL INFORMATION

1. What was your age at last birthday? ……

2. What is your sex?

1. Male

2. Female

3. What is your marital status?

1. Married

2. Single

3. Divorced

4. Widowed

4. What is your occupation? ……

5. Which area do you live?

1. Low density

2. Medium density

3. High density

6. What is your religion? ……..

SECTION B: KNOWLEDGE, ATTITUDES AND PRACTICES TOWARDS VCT

7. What do you know about VCT? .....

8. Have you undergone VCT?

1. Yes

2. No

9. Have you taken any of your children (below the age of 12) for an HIV test?

1. Yes

2. No

10. What do you think of VCT in the fight against HIV and AIDS pandemic?

1. Very useful 2. Useful 3. Not sure

4. Not useful 5. Not very useful

11. VCT should be mandatory

1. Strongly agree 2. Agree 3. Not sure

4. Disagree 5. Strongly disagree

12. Do you think the message on VCT being communicated can be adopted into behaviour?

1. Yes

2. No

SECTION C: COUNSELLING

13. Did you undergo counselling at a VCT centre before and after testing?

1. Yes

2. No

14. Were you given as much as necessary information during counselling?

1. Yes

2. No

15. What do you think of the counselling services offered by VCT service providers?

1. Very effective 2. Effective 3. Not sure

4. Not effective 5. Not very effective

16. How should counselling be done?

1. In privacy

2. In the presence of other people accessing the VCT service

SECTION D: SOURCES AND CHANNELS OF VCT MESSAGES

17. Where did you first hear about VCT?

1. At work 2. At home 3. At the hospital 4. At a friend's place

5. At a member's club 6. At school 7. Through the media

18. Do you have access to VCT information?

1. Yes

2. No

19. Which channels do you use to access VCT information?

1. Television 2. Radio 3. Newspapers

4. Books 5. Posters 6. Fliers 7. Internet

20. Which media platform do you think is most effective in disseminating VCT information?

1. Television 2. Radio 3. Print media 4. Online media

SECTION E: COMMUNICATION STRATEGIES

21. VCT campaign messages should be differentiated for different audiences

1. Strongly agree 2. Agree 3. Neutral

4. Disagree 5. Strongly disagree

22. How do you rate communication of VCT service providers

1. Excellent 2. Very good 3. Good

4. Not sure 5. Bad 6. Poor

23. What improvement can be made to communicate VCT message better?

.....

SECTION F: FACTORS AFFECTING VCT

24. The level of education affects one's attitude towards VCT

1. Strongly agree 2. Agree 3. Not sure

4. Disagree 5. Strongly disagree

25. One's religion affects their attitude towards VCT

1. Strongly agree 2. Agree 3. Not sure

4. Disagree 5. Strongly disagree

26. Culture affects the practice and attitude towards VCT

1. Strongly agree 2. Agree 3. Not sure

4. Disagree 5. Strongly disagree

27. Socio-economic status affects one's knowledge and attitude towards VCT

1. Strongly agree 2. Agree 3. Not sure

4. Disagree 5. Strongly disagree

Thank you for answering the questionnaire

APPENDIX 2. Interview guide - Heads of Department (VCT and ART) at Health Centres

i. Psychographic and organisational information

Name of organisation……

Position or Title of interviewee……..

Date of interview……

Date of transcription…….

i. Guide questions

1. What constitutes good HIV testing and counselling?
2. What is the minimum qualification of a lay counsellor?
3. How useful is HIV counselling at the institution?
4. Who is in charge of producing VCT information?
5. What channels do you use to disseminate VCT information?
6. What do you think are some of the factors affecting people's knowledge and attitudes towards VCT?
7. What are some of the challenges you face as an institution in providing and trying to enhance the VCT service?
8. What can be done better in terms of communication to promote VCT?
9. What is your general view about educated verses uneducated people in accessing VCT service?

Interview guide - Lay Counsellors at health centres

i. Psychographic and organisational information

Name of organisation……

Position or Title of interviewee……..

Date of interview……

Date of transcription…….

ii. Guide questions

1. What are the steps involved in VCT?
2. What constitutes good VCT?
3. How much information do you give clients before and after an HIV test
4. Do you differentiate information during counselling for different age groups and classes of people? Why or Why not?
5. How do you explain to clients the meaning of each possible result (positive or negative)?
6. What are some of the common reactions of people when test results are out?
7. How do you keep confidentiality of counselling session and test results?
8. What are some of the challenges you face in providing VCT service to people?
9. What do you think are some of the factors affecting people's knowledge and attitudes towards VCT?
10. Who are more likely to undergo VCT between males and females?
11. What can be done better in terms of counselling in order to promote VCT?
12. What is your general view about educated verses uneducated people in accessing VCT service?

Interview guide - Ministry of Health Headquarters

i. Psychographic and organisational information

Name of organisation……

Position or Title of interviewee……..

Date of interview……

Date of transcription……

ii. Guide questions

1. What kind of information do you produce as the Ministry in charge of health, to promote VCT?
2. Is the VCT information produced differentiated for different audiences?
3. What channels do you use as a ministry to disseminate VCT information?
4. Do you have a clearly defined communication strategy for VCT information?
5. What challenges do you face in communicating VCT information to people?
6. How can these challenges be overcome?
7. What do you think are some of the factors affecting people's knowledge and attitudes towards VCT?
8. Do you think counselling done by lay counsellors before and after testing is effectual? Why or why not?
9. What is your general view about educated verses uneducated people in accessing VCT service?

Interview guide - Director of Programs at Zambia National Broadcasting Corporation (ZNBC)

i. Psychographic and organisational information

Name of organisation……

Position or Title of interviewee……..

Date of interview……

Date of transcription……

ii. Guide questions

1. What is your role as a national broadcaster in promoting VCT?
2. What are the sources of VCT information aired on television and radio?
3. How frequent are the adverts and discussions on VCT aired?
4. What some of the challenges faced by the organisation in airing VCT or HIV and AIDS related information?
5. What can be done to overcome these challenges?