KNOWLEDGE, ATTITUDES AND EXPERIENCES OF CLIENTS REGARDING VOLUNTARY COUNSELLING AND TESTING AT MANKWENG PRIMARY HEALTH CARE FACILITIES CAPRICORN DISTRICT LIMPOPO PROVINCE

by

MANKU MAGDELINE RAMORASWI

A mini- dissertation submitted in partial fulfilment of the requirements for the degree

MASTER OF PUBLIC HEALTH

in the School of Public Health

T 361.329 RAM

at the

UNIVERSITY OF LIMPOPO - TURFLOOP CAMPUS

SUPERVISOR: DR M E LEKHULENI

i12738189

CO- SUPERVISOR: DR MBL MPOLOKENG

JUNE 2009

205021

DECLARATION

I declare that **"KNOWLEDGE, ATTITUDES AND EXPERIENCES OF CLIENTS REGARDING VOLUNTARY COUNSELLING AND TESTING AT MANKWENG PRIMARY HEALTH CARE FACILITIES, CAPRICORN DISTRICT LIMPOPO PROVINCE"** is my own work and that all the sources that I have used have been indicated and acknowledged by means of complete references and that this work has not been submitted for any other degree at other institution.

MM RAMORASWI

10/03/2010

DATE

Dedication

I would like to dedicate this work to my late parents, Monene and Moshita Ramoraswi, my late grandmother Motjatji Lekala Kgofelo, my children Mologadi, Tebogo, Lefa, my grandchild Lebone and all the nurses in the world.

Acknowledgements

I would like to thank God for giving me the strength and patience to complete this study.

I want to thank my children whom I missed so much when I had to be away from home to work on this project.

I would like to acknowledge the following people, who contributed to the success of this work,

- My supervisor Dr. ME Lekhuleni for her academic and professional guidance
- My co-supervisor Dr MBL Mpolokeng for his constructive contribution
- The community of Nobody, Makanye, Mankweng and Evelyn Lekganyane for their participation and contribution to this project.
- My colleagues for their encouragement and assistance
- The Department of Health and Social Development Limpopo Province, for the permission granted to me to conduct this study
- The clinics management for giving me permission to collect data from their clients and assistance during data collection
- Mrs. R Olwagen for helping with compiling and analyzing the statistics.

ABSTRACT

Voluntary counselling and testing (VCT), has emerged as a major strategy for prevention of HIV infections. Knowing one's HIV status, whether it is positive or negative, is instrumental in effecting behaviour change and the adoption of safer sex practices. Depending on the results of VCT, people usually take steps to avoid becoming infected or infecting others. VCT should therefore be a key component of HIV and AIDS prevention programmes.

The purpose of this study was to describe knowledge, attitudes, and experiences of clients regarding voluntary counselling and testing at Mankweng Primary Health Care facilities, Capricorn District, Limpopo Province. Quantitative descriptive design was used in this study to assess knowledge, attitudes and experiences of the clients regarding VCT in four health care facilities; namely, Makanye, Mankweng, Nobody, and Evelyn Lekganyane clinics. A self administered, structured questionnaire was used to collect data from clients aged 17-49 years old. A sample of 200 clients participated in the study, 60% drawn from each of the four health facilities. Data analysis was carried out by using descriptive statistical test. The findings revealed that lack of knowledge, negative attitudes and negative experiences towards VCT was a problem in all age groups of participants.

The study recommended that there should be effective utilisation of the VCT programs in all Primary health care facilities. Regular health awareness should be conducted and education of the community according to HIV health calendar days.

Table of contents **Page**

Table of contents **Page**

CHAPTER 3

Research Methodology

Table of contents **Page**

Table of contents **Page**

List of tables **Page**

List of appendices

List of figures **Page**

List of abbreviations

The following abbreviations were used in the study:

AIDS	Acquired Immune Deficiency Syndrome
ARVs	Antiretroviral Drugs
CBO	Community Based Organisation
CDC	Centre for Disease Control
DOH	Department of Health
HIV	Human Immune Virus
NGO	Non Government Organisation
PHC	Primary Health Care
PMTCT	Prevention of Mother to Child Transmission
SADC	Southern Africa Development Community
STI	Sexually Transmitted Infections
UK	United Kingdom
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation

CHAPTER 1

OVERVIEW OF THE STUDY

1.1 INTRODUCTION AND BACKGROUND

Voluntary Counselling and Testing (VCT) services require community awareness, education and mobilisation to ensure that clients wishing to be tested understand the test process. Health providers should ensure that those who are tested and found infected with HIV should be supported and not discriminated against.

According to The Henry Kaiser Family Foundation (2006:46), HIV testing is integral to HIV prevention, treatment, and care efforts. Knowledge of one's status is important for prevention of HIV. Furthermore, those who test HIV positive should modify their behaviour to reduce the risk of transmission. Knowledge of HIV status is also important to link those who are HIV positive to medical care and services for reduction of morbidity and mortality. However, some clients refuse to be tested for fear of learning that they may have a life threatening condition. Furthermore, clients may mistrust HIV testing for fear of stigma and discrimination if tested HIV positive.

According to Granich and Mermin (2001:78), HIV testing provides a special opportunity for counselling and a chance to speak to clients in depth about the ways HIV is spread. VCT attracts clients to other HIV services, such as treatment for sexually transmitted diseases, family planning, or social services. According to World Health Organization (WHO) (2002:17), VCT should be widely accessible through innovative, ethical and practical models of delivery. WHO (2003:3) recommends that VCT should be offered whenever the client shows signs and symptoms of HIV infection or AIDS.

WHO (2007:1) indicated that efforts are needed to increase the provision of HIV testing through a wider range of effective and safe options. HIV testing is a critical entry point to life sustaining healthcare service for clients living with HIV and AIDS.

Bennett and Erin (2001:18) indicate that it is possible to protect others from infection by avoiding activities that expose them to risk of infection. However, unlike HIV associated with sexual contact or drug use, it may not be possible for a pregnant woman to protect her future child from HIV infection without knowing that she is HIV positive. Granich and Mermin (2001:78) support the view that it is necessary to identify HIV positive mothers through VCT so that they can be given an option to take preventative drugs in pregnancy. These measures would save the lives of children. Granich and Mermin (2001:78) further stated that other benefits of VCT include identifying infected partners and helping the HIV positive persons to remain healthy and productive for a longer period. VCT can also help to break the vicious circle of fear and stigmatizing beliefs about HIV and AIDS.

According to Igumbor, Pengpids and Obi (2006:395), some clients who come for VCT and test HIV positive do not return to clinics for follow-up visits or fail to take the prescribed drugs. This could be due to negative experiences in interacting with clinic staff or being poorly informed about HIV transmission and its prevention. Clients may choose not to attend HIV clinics to avoid revealing their HIV positive status.

According to Philpott and Warren (2001:968), the traditional model of voluntary counselling and testing which is being implemented in many places with excellent results requires significant commitments in terms of time, resources, infrastructure, and trained staff. One to one counselling and the time required to provide it are possible disincentives for people who wish to be tested on a more routine and perhaps less conspicuous basis.

Bennett and Erin (2001:16) claim that a test for HIV antibody has been available in the UK since 1985 on request. It has been the policy of the UK Department of Health that the offer of HIV test should be accompanied by appropriate pre and post test counselling and that the issue of informed consent and confidentiality are fully addressed. These issues of VCT were also fully endorsed by the British Medical Association and the UK Central Council for Nursing, Midwifery and Health Visiting.

The Henry Kaiser Family Foundation (2006:47) stated that, the United States Centre for Disease Control (CDC) and Prevention released revised recommendations for HIV testing in health settings in 2006. CDC recommended HIV screening for all people aged 13 to 64 years and repeat screening at least annually for those at high risk of HIV infection.

Van Dyk (2002:58) found that VCT has emerged as a major strategy for the prevention of HIV infections in African countries. It is preferable to use rapid HIV antibody test because distance from clinics and lack of transport often make it difficult for clients to come back to the clinic for their test results. If VCT services do exist, the community should be well informed about such services. VCT should be widely advertised and health care professionals and the community workers should be sensitised and trained in pre and post HIV testing and counselling.

UNAIDS (2006:12) stated that HIV prevention works and should be focused and sustained. Increased HIV prevention programmes that are focused to reach those most at risk of HIV infections are making inroads. Positive trends in young client's sexual behaviour, increased use of condoms, and fewer sexual partners, have been observed over the past decade in many countries.

A decline in HIV prevalence among young clients between the years 2000 and 2005 was evident in Botswana, Burundi, Kenya, Malawi, Rwanda, and Zimbabwe

According to Darkoh (2004:7) since the beginning of 2004, HIV tests have been offered as a routine part of checkups in public and private clinics in Botswana. The testing is part of the standard routine, but clients who do not want to be tested can opt out. Botswana was the first country in Africa to have a national policy of routinely offering VCT at clinics. Health officials in Botswana believe that routine testing is a good way of prevention programmes to lessen the burden on hospitals by aiding HIV positive clients to access treatment at an earlier stage of the disease as there is a stigma attached to sexually transmitted infections.

Van Dyk (2002:94) found that although most South Africans are aware that VCT services are available, only one in five people who have knowledge about VCT have been tested for HIV. The reasons for South Africans not seeking VCT could be that they have negative attitudes towards VCT services. However, the relationship between the attitude and seeking VCT in South Africa has thus far received limited attention. HIV/AIDS News (2006:2) indicated that some nurses, HIV and AIDS advocates and not-for-profit groups recently showed that many HIV-positive clients in South Africa could live longer and healthier lives if VCT services were improved. According to the Department of Health (DoH) (2006:7), counsellors were employed at 474 VCT sites across the country. The DoH database shows that about 12,000 counsellors have been trained to help HIV-Positive people and that the department offers refresher courses for practicing counsellors. Despite the efforts of the DoH, VCT appears not to take up well in the PHC facilities of the Capricorn District. According to the Department of Health (2000:2), VCT is one of the key prevention strategies used to slow down the spread of HIV and AIDS in South Africa. According to Department of Health (2006:2), VCT in Limpopo Province started in 2001 following the rollout plan of the South African National Government. Pilot studies regarding VCT were conducted in several Limpopo hospitals and in a number of PHC facilities.

Among those facilities took part were Makanye, Mankweng, Nobody and Evelyn Lekganyane clinics. According to the Department of Health (2006:2), HIV prevalence in Limpopo during 2004 was 19.3% and 21.5% in 2005. Less than 10% of the population knew their status while below 5% of the population voluntarily undertook HIV testing.

1.2 PROBLEM STATEMENT

Farrel (2006:4) indicated that, HIV is a world pandemic. 40 million people worldwide are living with HIV/AIDS. In Africa, Sub- Saharan Africa is the most affected region, with infected people unaware of their HIV status. Kalichman and Simbayi (2003:29) showed that a South African National Survey conducted in 2002 revealed that 26% of respondents would not be willing to share a meal with a person living with AIDS, 18% were not willing to sleep in the same room with someone with AIDS, and 6% would not talk to a person whom they know has AIDS. Lack of knowledge, attitudes and lack of experiences might be a barrier to seeking VCT in the four facilities namely: Makanye, Mankweng, Nobody and Evelyn Lekganyane PHC Facilities in the Capricorn District of Limpopo Province.

1.3 RESEARCH QUESTIONS

The following research questions guided this study:

- What is the knowledge of clients regarding VCT?
- What are the attitudes of clients towards VCT?
- What are the experiences of clients in relation to VCT?

1.4 AIM OF THE STUDY

The study aims to determine the knowledge, attitudes, and experiences of clients attending the Mankweng PHC facilities in relation to HIV/AIDS and VCT in March and April 2008.

1.5 OBJECTIVES OF THE STUDY

The objectives of this study were to:

- Determine the knowledge of the clients aged 17-49 years regarding VCT.
- Identify the attitudes of clients aged 17-49 years towards VCT.
- Assess the experiences of clients in relation to VCT.
- Compare knowledge attitudes and experiences of clients aged 17-49 years regarding VCT.

1.6 METHODOLOGY

Quantitative cross sectional descriptive design was used in this study for the purpose that quantitative scales provide the magnitude of the attribute under investigation for any particular person.

According to Uys and Basson (1995:75), a quantitative scale is considered to be a true scientific scale, since it is used in scientific experiments where attempts are made to establish causal relationships between variables. This study is also descriptive in that the researcher collected detail descriptions of knowledge, attitudes, and experiences of clients regarding VCT. Mouton (2005:152) refers to descriptive studies as studies that are usually quantitative in nature and which aim to provide a broad overview of a representative sample of a large population.

According to Uys and Basson (1995, 86) population includes all the members or units of some clearly defined group of people, objects or events while sampling is the process whereby the sample is drawn from the population. Population and sampling used in this study comprised of clients 17-49 years old who attended health care facilities namely; Makanye, Mankweng, Nobody, and Evelyn Lekganyane clinic.

A self administered questionnaire was used to collect data to determine knowledge, attitudes and experiences regarding VCT.

The details of the methodology will be discussed in chapter 3 of the study.

1.7 SIGNIFICANCE OF THE STUDY

The study could contribute towards improvement of VCT services in Primary Health Care facilities at Mankweng, Capricorn district. Furthermore, the study could benefit HIV positive clients to access treatment and the health care providers to improve service delivery.

1.8 LIMITATIONS OF THE STUDY

The study was limited to clients age 17 - 49 years who came for any consultation at Mankweng Primary Health care facilities. The responses could be maximized if the clients from age 12 years and above 50 years were included in the study, as these age groups are also exposed to HIV.

1.9 ORGANISATION OF THE SUBSEQUENT CHAPTERS

The subsequent chapters of this study were organised as follows:

Chapter 2 describes review of relevant literature pertaining to HIV and VCT.
Chapter 3 outlines the methodology used in the study.
Chapter 4 presents data analysis and discussion of findings.
Chapter 5 contains the conclusions and recommendations for future research.

1.10 SUMMARY

Chapter 1 discussed introduction, problem statement, research question, methodology, aim of the study, objectives, significance of the study, limitations of the study and organisation of the subsequent chapters.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

Chapter 2 provides a detailed discussion of literature relevant to the concepts; knowledge, attitudes, experiences, and voluntary counselling and testing. The researcher obtained information that contributed to writing of this dissertation from book chapters, reports, journals and electronic databases.

2.2 REASONS FOR DOING LITERATURE REVIEW

According to Uys and Basson (1995:17), a literature review puts the research project into context by showing how it fits into a particular field by identifying knowledge gaps. A literature review assisted the researcher to develop a research problem, identify a theoretical framework, and it identifies issues and variables related to the research topic. A literature review also ensures that the researcher does not duplicate a previous study, discover what the most recent and authoritative theorising about the subject is and it identifies the available instrumentation that has proven valid and reliable (Uys and Basson, 1995:17).

The review of literature about knowledge, attitudes and experiences of clients regarding VCT assisted the researcher to find out about accepted empirical findings in the field of study. The literature review also helped the researcher to ascertain the accepted definitions of the concepts used in the study.

2.3 THE CONCEPTS KNOWLEDGE, ATTITUDES, EXPERIENCES AND VOLUNTARY COUNSELLING AND TESTING

The review of literature revealed the following important concepts related to the research topic:

- Knowledge
- Attitudes
- Experiences
- Voluntary counselling and testing

The discussion of the above concepts appears related to each other. Clients should have knowledge of Voluntary Counselling and Testing to develop positive or negative attitudes. Clients may refuse VCT due to lack of knowledge, or due to negative attitudes towards health services, or negative experiences from partner, family or the community.

2.3.1 KNOWLEDGE REGARDING VCT

In this study knowledge means the clients' level of information about HIV and VCT. Information acquired through experience and awareness or familiarity gained by experience.

According to WHO (2007:12), over the past 20 years VCT programme helped millions of people to learn their status. Many countries were encouraged to increase VCT services as well as to standardise and expand provider initiated counselling and testing so that people learn about their HIV status. According to WHO (2002:7), more than 80% of people living with HIV in low and middle income countries do not know that they are infected. People have a right to knowledge of their HIV status. VCT should be widely accessible through innovative, ethical, and practical models of delivery.

HIV testing and counselling are entry points to HIV related care and prevention services. VCT provide opportunities for people to reduce their risk of acquiring or transmitting HIV. According to WHO (2002:4), knowledge of HIV status has been beneficial by enabling people to access care, support, and treatment, in the form of psychological support, home based care, nutritional support, palliative care, treatment for opportunistic infections, tuberculosis, sexually transmitted infections and antiretroviral therapy. WHO (2002:4) further stated that new approaches to HIV testing and counselling must be implemented in more settings, and on a larger scale. Health care workers should offer VCT to all people who might benefit from knowing their HIV status. VCT should only be performed in accordance with the guiding principles.

According to WHO (2003:5), the changing face of HIV/AIDS epidemic has resulted in new opportunities, as well as new imperatives, to increase access to HIV testing and counselling and to knowledge of HIV status. Increased access to care and treatment, and decreased stigma and discrimination present new opportunities associated with taking an HIV test. Painter (2001:1411) indicated that there is a need for improved basic knowledge that has implications for the development of prevention interventions; for example, concerning how couples negotiate HIV risk reduction and cope during the post test period.

WHO (2007:16) indicated that VCT provides clients the opportunity to confidentially explore their HIV risks and know their HIV test result. VCT services can be provided in freestanding sites or embedded within other facilities such as health centres, workplace settings, and military facilities.

2.3.2. ATTITUDES REGARDING VCT

According to Louw and Edward (1998:180), attitudes refer to a hypothetical construct that represents a client's like or dislike for information about VCT or the negative or neutral views of VCT.

Most attitudes in individuals are a result of observational learning from environment. The link between attitudes and behaviour exists but depends on human behaviour, some of which is irrational.

According to Van Dyk (2002:46), people must be equipped with positive self esteem and self confidence in order to develop solid values that will guide their decision making to prevent negative attitudes regarding VCT. Dreyer, Hattingh and Lock (2000:147) indicated that the attitudes of health workers, situations in contemporary community health care can raise some difficult ethical questions. Community nurses should be familiar with ethical principles and their application to advice and support clients when value related or conflicting decisions have to be taken to prevent attitudes towards health services. Arthur and Pool (2001:122) stated that although people believed that it is a good idea for the people to know their HIV serostatus, it is also evident that a lack of trust in the public health system is a stumbling block in the provision of comprehensive VCT services in South Africa. Arthur and Pool (2001:122) further revealed that people may fear that, if their HIV positive and their status become known, health care professionals would discriminate against them and refuse them treatment. The clients also fear that health care workers would not keep their results confidential. Most people who wish to participate in the VCT would choose to go to a clinic where nobody knows them. Fear of rejection by their loved ones and community is one of the stumbling blocks of opting for the VCT.

According to Weiss (2000:86), African heads of state, Prime ministers, Ministers of health, and other key lay and religious leaders must play a supportive role in creating national and local environment that empowers HIV prevention efforts. According to Wiktor and Grant (1999:1472), acceptance and support for persons who have been tested for HIV and disclosure of test results is needed from health workers, the partner, the family, and the community.

According to Campbell (2000:1399), there will be some cases where an HIV positive person does not wish to, and may refuse to inform the partner(s) or allow them to opt for counselling. Such refusal might be due to fear of rejection by partners and family members. There could also be fear of stigma and discrimination, being blamed for the infection of others, feelings of despair, remorse and guilt. Refusal to notify their partners might be due to a desire by the HIV positive person to place another person deliberately at risk of HIV infection. Painter (2001:1389) stated that VCT facilities in sub-Saharan Africa are infrequently attuned to partners needs, few couples present together for VCT. Diaby (2000:115) indicated that most VCT facilities address individual clients who request HIV testing. In the case of antenatal clinics in the sub-Saharan Africa, women frequent the facilities primarily for medical consultations, not because they seek HIV testing. Many pregnant women do not know about the VCT testing opportunities. The women may be surprised by the offer of HIV test, refuse telling counsellors that they wish to postpone their decisions and this often amounts to a deferred refusal.

Shin, Kang and Moneyham (2007:2) indicated that many Koreans avoid making use of HIV testing and related services because of concerns about confidentiality, attitudes, and fear of being discriminated against by their family, and society. Parker (2004:120) showed that the scope of the challenge in scaling up VCT in terms of human resources and physical infrastructure is raising awareness and changing attitudes. It is essential to understand attitudes to VCT including misconceptions and fears. This understanding could enable communication and advocacy campaigns to be effective in encouraging people to test. Mandel (2000:461) associates VCT with a broader range of health services. Increased international interest and support for VCT in sub-Saharan Africa is to address the severe social stigma associated with HIV/AIDS. Mandel further support that, VCT increases the acceptability of HIV testing as prevention tool, therefore it should be made available as part of a broader range of services that focus on mother and child, reproductive, and family health issues.

WHO (2002:18) revealed that improvements in quality of life and the associated savings will only be realized if efforts to expand HIV testing and counselling services are linked to care, treatment and support programmes. The lack of needed human, technical, and financial capacity must be addressed. Furthermore, disincentives to HIV testing and counselling due to denial, stigma, discrimination, and the unequal status of women must be countered. Wherever possible, the use of rapid HIV test method should be an important component in the expansion of testing and counselling services. There is also urgent need to increase the capacity of health care workers to deliver quality counselling, for example by developing cadres of professional counsellors, using lay counsellors, and improving the counselling ability of health care professionals such as clinical officers and nurses.

According to Rose, Violari, Bolton and Gray (2005:9), other reasons for the slow uptake of VCT could be wide spread fear of taking the test; concerns that confidentiality will be breached; stigma attitudes and discrimination; and the costs associated with the service. The World Bank (2001:1700) found that integrating VCT with other health services can serve multiple objectives including the reduction of social stigma. Significant progress with destigmatising HIV/AIDS will require robust efforts at the highest levels of African government. Farham (2003:36) demonstrated that through positive attitudes there is improved uptake of VCT in Botswana. The demand for VCT in Botswana has increased since their antiretroviral treatment programme was started. Many of those seeking testing were in self reported monogamous relationships. According to Wiktor and Grant (1999:1471), the VCT programs target individuals and occasionally couples.

Wiktor and Grant (1999:1471) further indicated that people of shared experience and knowledge may result in broader social impacts, including changes in community values and norms that affect persons beyond those who have participated directly in VCT.

These changes may include improved communication, openness about HIV prevention, advice on risk reduction and decreased denial about the existence of AIDS.

It was found that in African countries where breastfeeding is considered standard practice, women who do not breastfeed may be presumed to be infected by the virus (Taegtmeyer & Tincobald 2006:17). Women fear HIV testing because some still fear that status disclosure to the partner might put them in both physical and mental danger. Domestic violence has also been noted as a major concern of some women in developing countries. According to Lawoyin and Adewole (2004:167), counselling is important to prepare clients to come to terms with their HIV status and includes dealing with fear, quilt, stigma, and discrimination. It is also important to help people devise or strengthen ways of staying HIV negative, if they test HIV negative.

2.3.3. EXPERIENCES REGARDING VCT

According to Fowler and Fowler (1970:287), experiences are the effect upon the judgement or feelings produced by any event whether witnessed or participated in. Experiences are personal acquaintances, actual enjoyment or suffering, knowledge based on personal observation, contact or incident that affects one state of personal emotion.

Swanepoel (2003:126) indicated that HIV and AIDS pose a threat to South Africans. The extent of HIV and AIDS infections in South Africa and its impact on demographic trends, the economy and society at large, is still a subject of debate and uncertainty. Swanepoel (2003:126) further showed that the National HIV and AIDS Conference of South Africa in 2003 stated that South Africa was heading for Uganda with fast growing infections of HIV. The epidemic in South Africa is growing at a rate faster than in other African countries.

The South African Cabinet approved funds for the implementation of an integrated response to HIV and AIDS epidemic in 1999. One of the components of the integrated plan is to strengthen the efforts to make VCT facilities available.

According to Eden and Taegtmeyer (2003:293) there is a need to critically examine the problems with current approaches and look at how to improve interventions in this changing context of an evolving epidemic and new interventions to reduce HIV transmission. VCT depends on the voluntary entrance of at risk groups to the health services. In the absence of public health strategies that encourage VCT among the population, it could have limited impact. Routine testing is a necessary measure to allow health care services to identify greater number of those who are already infected. According to Philipott and Warren (2001:900), VCT has been available within the mine health service since 1991. However, spontaneous uptake of VCT has been low and many did not return for the results of their test. In 2000, the VCT service at the mines was evaluated; counsellors and clients identified key areas in which improvements could be made. Philipott and Warren (2001:900) further stated that efforts were made to increase the trust and confidence of potential clients and counsellors by providing same day results using rapid test kits, anonymous record keeping, lay counsellors and peer educators. Those who tested positive for HIV were offered referral to a specialist clinic for further counselling, education and preventive therapy.

Van de Perre (2002:406) indicated that VCT has been given low priority as a possible strategy for combating HIV in developing countries. The view that individuals have low motivation to know their test results to modify behaviour and the non existence of medical care that could make a difference. According to Machekano, Dube, and Mandel (2006:63), HIV/AIDS presents a major crisis that is increasingly affecting the most productive segments of the population across development sectors in Tanzania.

The basic education sector, which is vital to the creation and enhancement of human capital, is equally affected. The loss of skilled and experienced teachers, due to HIV/AIDS related deaths and long term illnesses, is increasingly compromising the provision of quality primary education. The situation demanded VCT that would reverse the trend of education and was documented as a viable strategy of HIV prevention. Van Dyk and Van Dyk (2003:118) claim that VCT programmes are regarded as important strategy in the management of HIV/AIDS pandemic worldwide. Such programmes have experienced various problems and barriers, which limited their successful implementation. These barriers may relate to problems with facilities and services or psychological obstacles that negatively impact on people's willingness to participate in programmes.

UNAIDS (2006:8) argues that the existence of VCT services is not in itself enough to get people to come forward for HIV testing. There must be incentives, and these should take the form of greater availability and affordability of care, treatment, and support. In resource poor settings, treatment in the form of drugs, and care options are limited. However, these obstacles can in part be overcome by innovative and far reaching community based programmes. UNAIDS (2006:8) further stated that such programmes offer outreach to affected families, voluntary and confidentiality counselling and testing, support groups, home visits, follow up and involvement of people living with HIV/AIDS in prevention and care activities.

According to Theobalds (2006:590), increasing access to treatment is a critical intervention in the epidemic, but it should be at the expenses of preventing further transmission of the virus. There is a need for both public health and human rights to have common goals, to ensure the uptake of VCT. Testing without counselling will not have beneficial impact on either prevention or treatment that it seeks. Routine testing to succeed as either prevention or treatment strategy it will depend upon the quality of counselling.

2.3.4 VOLUNTARY COUNSELLING AND TESTING

According to Sweat (2000:87), VCT is a combination of two activities counselling and testing into a service that amplifies the benefits of both. VCT is an approach that is useful in all settings resource: rich, poor, urban and rural. VCT is adaptable to clients' need, it can be done for individuals and couples, for people of all ages and of all backgrounds. With proper training, members of the clients' local community, regardless of their educational level, can do the counselling component. According to WHO (2002:4), VCT commitments is in terms of time, resources, infrastructure, and trained staff. One to one counselling and the time required to provide it are possible disincentives for people who wish to be tested on a more routine and perhaps less conspicuous basis. Young people in particular may not have adequate access to the VCT services; innovative services should now be expanded to provide for them and to overcome the legal and cultural obstacles to testing and counselling they face. WHO (2003:17) recommended that VCT be widely accessible on a voluntary and confidential basis. VCT services should include pre test counselling to explain the purpose and possible implications of the test, informed consent on the part of the client, and post counselling to discuss the test results. Kilewo (2001:459) supports that VCT provides a significant prevention opportunity, for dissemination of accurate information about HIV/AIDS, for risk assessment regardless of serostatus, and referral to medical services such as specific treatment of associated infections like sexually transmitted diseases and opportunistic such infections as tuberculosis.

Van de Perre (2002:407) outlined that the challenge is no longer the need to show the efficacy of VCT but to make it accessible to those who desperately need it. VCT is more acceptable, innocuous, and less expensive. Since VCT is principal entry point for both prevention and care, access should first be provided in existing community health services. The voluntary HIV-1 Counselling and Testing Efficacy Study added to the list of standards of quality necessary for the implementation of VCT services.

UNAIDS (2000:22) outlined that VCT involves individuals actively seeking HIV testing and counselling at a facility that offers these services. Client initiated HIV testing and counselling emphasizes individual risk assessment and management by counsellors. VCT addresses issues such as the desirability and implications of taking an HIV test and the development of individual risk reduction strategies. UNAIDS (2006:19) supported that client initiated approaches have been the primary model for providing HIV testing and counselling. Coverage of client initiated HIV testing and counselling services is inadequate in both high income and resource constrained settings.

Sherr and Lopman (2001:176) support the view that VCT is an effective method of reducing high risk sexual behaviour in sub-Saharan Africa, by identifying infected persons early in HIV disease. The development and expansion of VCT centres has been associated with reductions in HIV seroprevalence. Sherr and Lopman (2001:176) further indicate that research in Kenya, Trinidad, and Tanzania revealed that unprotected sex with a non primary partner decreased from 30% to 18% in men and from 22% to 12% among women receiving VCT. Those found to be HIV infected may be more likely to protect themselves. Clients found to be HIV positive may seek medical attention for early symptoms of AIDS related illnesses. Those who test negative are more likely to change their behaviour to maintain their negative status by using condoms or by encouraging their partners to test for HIV. According to Taegtmeyer and Tincobald (2006:100), another key strategy in Kenya's fight against HIV has been the rapid scale up of VCT services. To this end, over 650 VCT sites have been registered nationally.
A standard 126 hour training package for VCT counsellors has been compiled followed by a period of observed practice.

Parker (2004:120) indicated that VCT is a central component of the South African government's strategy to prevent the spread of HIV and to provide care and support to those living with HIV/AIDS.

Government's commitment to expanding access to VCT for people across the country creates a policy framework for increased uptake of VCT services in South Africa.

According to the DoH (2000:3), there are key issues surrounding VCT in South Africa. Several key issues must be addressed in expanding VCT services in South Africa, including:

- Developing and Strengthening the human and infrastructural resources required to deliver VCT services;
- Promoting VCT among target audiences and encouraging large numbers of people to test;
- Monitoring, evaluating and ensuring quality control of VCT programmes.

The DoH (2000:3) further indicated that a report on public sector VCT services in South Africa, commissioned by the Department of Health, provided an interim assessment of the government expansion of VCT, in terms of access, infrastructure, organization of VCT services, marketing of VCT, routine data collection, and policy planning and management.

The findings were that:

- Access to VCT within the public sector is overly reliant on PHC services, which may discourage some people from testing;

- VCT services tend to be provided during standard working hours only, which may deter employed people and students from testing

- Some VCT sites face environmental/infrastructural challenges, such as a lack of privacy, inadequate storage, and waiting space.

The Department of Health (2000:2) outlined the government's national policy on VCT for HIV guides, the administration of HIV tests in both public and private facilities in South Africa. It further provides guidelines on the circumstances under which VCT may be conducted with the client's informed consent, the instances in which informed consent is not required, and specific circumstances in which HIV testing may not be undertaken. It also provides definitions of pre and post test counselling and informed consent, and sets forth standards for how the procedure should be undertaken. Parker (2004:120) observed that VCT is a central component of the South African government's strategy to prevent the spread of HIV and to provide care and support to those living with HIV/AIDS. Government's commitment to expanding access to VCT for people across the country creates a policy framework for increased uptake of VCT services in South Africa.

According to Rose et al (2005:8), at Chris Hani Baragwanath Hospital, VCT services have been available to pregnant women who attend antenatal services since 1998. In1999, on site rapid testing was introduced with the option to be tested and counselled on the same day. UNAIDS (2006:2) support that VCT has functioned as an effective and ethical public health tool. In the standard model of VCT, the overall objective has been prevention with emphasis of confidentiality and voluntary individual decision making, including protecting the individual's decision not to be tested and/or not to learn the results. UNAIDS (2001:2) elaborated by indicating that, VCT has tended to attract those who might otherwise shy away from HIV intervention. From a public health perspective, VCT has served to connect many people to paths related to HIV prevention and care.

According to WHO (2003:19), WHO is developing strategies for expanding access to VCT and for ensuring that they are carried out in accordance with appropriate ethical and technical standards.

WHO (2003:19) further indicated that WHO has convened a series of international consultations on the approaches now needed for VCT, and has identified the priority tasks in expanding the provision of HIV testing and counselling services, including:

- Advocating for expanded access to testing and counselling services, especially in the context of accelerating access to treatment, efforts to prevent infection to mothers and their infants.

- Setting standards and providing guidance to support and improve the quality of testing and counselling in clinical and antenatal care settings.

- Providing technical support with key partners to countries, and at the regional and global levels.

- Strengthening partnerships in the implementation of testing and counselling, particularly within communities most affected by HIV/AIDS.

- Documenting currently effective models from which lessons can be learned and transferred.

WHO (2003:19) elaborate by indicating that enormous numbers of people need to know their HIV status and WHO is committed to working with governments and their partners to help bring about marked and rapid increases in access to VCT services across a much broader range of setting. In the near future, millions of people must be offered VCT under conditions that will benefit their health, enhance their lives, lead to greater access to the care, support and treatment. WHO (2003:19) further elaborated by saying, the changing landscape of the HIV/AIDS epidemic has resulted in new opportunities as well as new imperatives to increased knowledge of HIV status.

WHO (2002:26) indicated that in order to support the primary prevention of HIV infection among women of reproductive age, and the reduction of unintended pregnancies among HIV positive women, VCT should be offered to women in free standing clinics or in conjunction with other services, for example; family planning where HIV infection is prevalent.

Mandel (2000:461) asserts that the routine offer of VCT in public health facilities should continue to create opportunities for patients to make an informed, confidential decision to test or not. Clients should be encouraged to disclose their HIV status and to encourage others in their lives to test. A routine offer of HIV testing should not undermine VCT but rather promote access to it.

Turyagyenda (2000:16) supports the view that HIV testing and counselling services should be routinely offered in antenatal care clinics as the standard of care. Such services showed standards of best practice if they involve the provision of pre test information in a group setting, followed by the offer of an HIV test as standard procedure. In "opt-in" approaches, women have to request the test specifically and decline the test if they do not want it to be performed. Both of these approaches are acceptable if women are individually informed that they have the right to refuse the test and are given the opportunity to do so.

According to Creek (2006:222), VCT allows sexual partners to learn their HIV status together as a unit. Couple HIV Counselling is an important intervention because as many as 30% of the couples in high HIV prevalence countries are serodiscordant, or have one partner who is infected with HIV and one who is not. Counselling sessions focus on discussing risk issues and concerns, risk reduction, and linkages to care, treatment, and support.
Pre and post test counselling sessions focus on recommending and offering the HIV test, obtaining informed consent, using the test results to make medical care decisions or recommendations, and providing appropriate referrals.

Bartlett and Theilman (2005:691) indicate that by promoting behaviour change, VCT can also serve as point of referral for preventive services. These services include the prevention of mother to child transmission. VCT can also serve as an entry point for treatment of sexually transmitted infections, prophylaxis of opportunistic infections, diagnosis and treatment of tuberculosis and initiation of active antiretroviral therapy. It is estimated that less than 1% of sexually active urban population have been tested for HIV, highlighting the urgent need to increase access to VCT.

2.4 Summary

Chapter 2 discussed the reasons for doing literature, and focused on the concepts knowledge, attitudes, experiences and voluntary counselling and testing. The literature review shows that VCT is an innovative approach to preventing the spread of HIV/AIDS. Although the significance of the VCT services receives appraisals from researchers and health organizations, attitudes, knowledge, and experiences of clients undergoing VCT are virtually unknown in Limpopo Province. It is against this backdrop that the current study seeks to investigate these aspects in Mankweng Primary Health Care Facilities and fill in this knowledge gaps.

CHAPTER 3

RESEARCH METHODOLOGY

3.1 INTRODUCTION

In chapter three the research design is discussed in terms of methods, population, sampling, instruments, data collection and analysis procedures as these pertain to the present research. The research design enabled the researcher to achieve the aim and the objectives of the study. The aim of the study was to determine association between knowledge, attitudes and experiences of clients in relation to VCT.

3.2 OBJECTIVES OF THE STUDY

The objectives of this study were to:

- Determine the knowledge of the clients aged 17-49 years regarding VCT;
- Identify the attitudes of clients aged 17-49 years towards VCT;
- Assess the experiences of clients in relation to VCT; and
- Compare knowledge attitudes and experiences among the clients aged 17-49 years regarding VCT.

3.3 RESEARCH DESIGN

A quantitative descriptive and cross sectional design was used to determine knowledge, attitudes and experiences of clients regarding VCT in Health Care Facilities.

3.3.1 Quantitative

A quantitative design was used in this study as the strategies used by the researcher were in numeric form. Terre Blanche and Durrheim (2004:42) described quantitative research as when a researcher collects data in a form of numbers and use statistical types of data analysis. According to Knapp (1998:136), a quantitative approach is research that uses quantitative methods by studying phenomena that are relevant to the goals of a discipline. The approach is used to classify research efforts that use traditional methods exemplified by experiments, survey or correlation studies of various types. Burns and Grove (1993:27) refer to quantitative research as a formal, objective, rigorous, systematic process for generating information about the world. Quantitative research was conducted to describe new situations, events, or concepts in the world, such as describing new illnesses like AIDS or HIV and to examine relationships among concepts or ideas.

3.3.2 Cross sectional

The study was cross sectional. According to Bless and Higson-Smith (2000:153) cross sectional design is a research design where all data is collected at a single point in time. It is also referred to as cross sectional study.

3.3.3 Descriptive

The study was descriptive in that the researcher collected detailed descriptions of knowledge, attitudes and experiences of clients regarding VCT. Mouton (2005:152) defines descriptive studies as those that are usually quantitative in nature and aim to provide broad overview of representative sample of a population. Polit and Hungler (1999:700) defines descriptive research as studies whose main objective is the accurate portrayal of the characteristics of persons, situation or groups and the frequency with which certain phenomena occur.

4.4 POPULATION AND SAMPLING

3.4.1 The study Population

The population in this study comprised 17-49 years old clients who attended health care services at four PHC facilities; namely, Makanye, Mankweng, Nobody, and Evelyn Lekganyane clinics.

Table 3.1: Population of Makanye, Mankweng, Nobody, and Evelyn Lekganyane PHC facilities age 17-49 years

Name of facility	Total target population
Makanye clinic	5505
Mankweng Clinic	7278
Nobody Clinic	5974
Evelyn Lekganyane clinic	5856

Table 3.1 shows the population of the four PHC facilities namely Makanye, Mankweng, Nobody, and Evelyn Lekganyane clinics.

3.4.2 Sampling

According to Mouton (2005:120) sampling refers to a process of selecting things or objects when it was impossible to have knowledge of a larger collection of objects. In social research, sampling refers to procedures which involve some form of random selection of elements from target population. The aim of sampling in social research was to produce representative selection of population elements. In this study a sample of 60% clients was drawn from each of the four health care facilities. The participants comprised males and females aged 18 to 49 years who never took part in VCT. Systematic sampling was used where every third person of the target group from the queue attending the PHC facility was chosen to participate in the research.

The selection of the research sample was discussed with a statistician. (see appendix 2). The statistician recommended that 60 percent of the clients from each of the four PHC facilities should participate in this study to find equal percentages of participants from each facility according to head count. Every third person in the queue was invited in a private area away from the view of other client to create privacy and was requested to complete the questionnaire. The researcher enquired from the clients and administered the questionnaire to the clients who never tested for HIV.

3.4.3 Criteria for the inclusion of participants

To ensure inclusion in the sample, the participants met the following criteria:

Males and females aged 17-49 years who visited Mankweng PHC facilities and did not know their HIV status.

3.4.4 Study Site

The study site was at Mankweng Primary Health Care facilities; namely, Makanye, Mankweng, Nobody, and Evelyn Lekganyane clinics at Polokwane municipality, Capricorn District, Limpopo Province. These PHC facilities are situated about 35 km east of Polokwane City. The four PHC facilities were the first roll-out sites to pilot VCT in the Capricorn District of Limpopo Province.

3.5 DATA COLLECTION

3.5.1 Data collection instrument

The researcher used a self administered questionnaire for data collection with the purpose of collecting data to determine knowledge, attitudes, and experiences of clients regarding VCT at PHC facilities.

After intensive literature review the researcher designed the questionnaire with guidance of the supervisors and statistician. The final questionnaire was discussed with the supervisors and statistician and was accepted in terms of face and content validity.

3.5.2 Advantages of questionnaire

The advantages of using a questionnaire in this study were as follows:

- Questionnaire was less expensive and had the advantage of involving large number of participants.

- The questionnaire was structured and questions were arranged in a definite order according to the researcher's choice.

- Questionnaire was a suitable instrument for gathering information from the target group age, 17-49 years.

- Questionnaire saved time for both the researcher and the participants as it required 15-20 minutes to complete.

3.5.3 Disadvantages of questionnaire

The disadvantage of using a questionnaire in this study was that there was no opportunity for the researcher to clarify items that could be misunderstood by the participants during data collection.

3.5.4 Format of questionnaire

The questionnaire consisted of five sections as follows:

- Section A: related to biographic data of the respondent.
- Section B: Questions related to knowledge of clients regarding HIV and VCT.
- Section C: Questions related to attitudes of clients regarding VCT.
- Section D: Questions related to experiences of clients regarding HIV and VCT.
- Section E: Questions related to additional opinions of participants regarding VCT.

3.6 PRETESTING THE RESEARCH INSTRUMENT

According to Uys and Basson (1995:103), a pilot study is a small-scale study using a small sample of the population, but not the same group who will eventually form part of the sample group. The researcher should aim to collect data as quickly as possible without jeopardizing the accuracy and validity of the investigation. The researcher should also avoid any inconvenience to the respondents prior to, during or upon completion of data collection.

The researcher administered fourty questionnaires to 17-49 years old clients, males and females, who were not identified to form part of the research for them to respond.

The following aspects of the questionnaire were corrected:

- The response of true or false not known and very high, high, medium, low, very low and yes or no, were changed to strongly disagree, disagree, not known, strongly agree, and agree

- Number of items reduced from 57 to 47.

The duration of completing questionnaire was decreased from 20 minutes to 15 minutes.

3.6.1 Data collection

The researcher made appointment with supervisors and managers of clinics to conduct research. The researcher explained the purpose of research to the clients, invited every third client in the queue to a private room to complete the questionnaire. The researcher administered the questionnaire to the clients for completion.

Table 3.2: Questionnaires administered and returned

Respondents	Administered	Returned	Across%
Makanye clinic	56	56	100%
Mankweng clinic	48	48	100%
Nobody clinic	34	34	100%
Evelyn Lekganyane	62	62	100%
Total	200	200	100%

Table 3.2 reveals that 100% of the questionnaires administered were returned.

The high response of the participants might be due to the simple, well designed understandable questionnaire which was easy to complete and due to the presence of the researcher in the research setting.

3.6.2 Reliability and Validity

3.6.2.1 Reliability

According to Terre Blanche and Durrheim (2004:63), reliability refers to the dependability of a measuring instrument and consistency over time. Furthermore, reliability refers to the fact that different research participants being tested by the same instrument at different times should respond identically to the instrument.

To test the reliability of the study during pilot study, the researcher used the split-half method, where the researcher constructed two different tests, only one of which was retained as a true measure, then divided items randomly, to make two parallel halves. Since the halves should be equivalent, in bar random error people who scored high on the one half should also score high on the other half, the correlation between two halves of the test represented the reliability of half of the test, and it was an underestimate of the reliability of the whole test.

3.6.2.2 Validity

Creswell (2003:36) defines validity as the degree to which an instrument measures what it is suppose to be measuring. Validity is regarded to be the main requirement for a data-collecting instrument and is considered to be the main criterion by which the quality of the instrument is evaluated.

In this study to test validity the questionnaire was reviewed by the supervisors of the study and two researchers independently to test content validity.

A pre test was conducted to test the validity and reliability of the questionnaire. The questionnaire was also discussed with the statistician and the researcher's supervisors. Ten clients were drawn from each PHC facility that was not selected for the study, within Capricorn District of Limpopo Province.

The researcher developed the questions from the literature review, from researcher's own work experience and from consultation with other health workers who are experts on content and also involved in VCT program.

3.7 ETHICAL CONSIDERATIONS

The proposal was submitted to the University of Limpopo Ethics Committee for ethical clearance before starting with data collection. The researcher observed relevant ethical and legal guidelines governing research with human participation and procedures for data collection and analysis.

The researcher further considered some ethical issues concerning the study as follows:

3.7.1 Confidentiality and anonymity

According to Uys and Basson (1995:98), confidentiality entails that no information provided by a patient should be divulged or made available to any other person. Confidential information provided by research participants must be treated as such by researchers. The obligation to respect confidentiality also applies to members of research organizations, coders, and clerical staff who have access to information.

According to Mouton (2005:243), the research subject has the right to anonymity and the right to assume that data collected kept confidential. Participants have the right to remain anonymous.

In this study participant's identities were not linked, even by the researcher, with the responses.

- The researcher did not collect more data particularly of a private nature for achieving the objectives of the study.

- The researcher took the necessary precautions to ensure that the self-respect and dignity of the client is maintained by inviting participants in a private room away from the view of other clients.

3.7.2 Permission to collect data

The researcher requested permission to conduct research from Capricorn District, Limpopo Province Department of Health and Social Development.

The managers of institutions were contacted telephonically to secure appointment dates for data collection at specific venues. This was followed up with a written confirmation. The researcher further requested permission from clinic manager, health provider, the counsellor, and the clients. The permission was also asked from the clients, an appointment was made to meet them after finishing from consulting.

Participants were informed about the purpose of the study, data collection method and the participation needed from them. The participants were informed verbally that participation was voluntary; they would receive no monetary benefits from participating in the study and that they could withdraw from the study without fear of being penalized by the researcher or the institution.

Information was given to the participants that they were not expected to provide information when they were disinclined to do so, or to act in any way contrary to their beliefs or principles.

According to Mouton (2005:244), the aims of the investigation should be communicated to the informant. There is an obligation to reflect on the foreseeable repercussion of research and publication on the general population being studied. The anticipation consequences of research should be communicated as fully as possible to the individuals and groups likely to be affected.

3.8 ANALYSIS OF DATA

Descriptive statistics were used to analyse data from section A, B, C and D. Frequency distributions and percentages were calculated. Data from section E were analysed by grouping common concepts together to obtain frequencies. No data were fabricated and data were keyed into the computer as presented by participants. In addition the researcher involved a qualified statistician to ascertain that statistical calculations done were applicable to the type of data namely; frequency and percentages, tables, cross tabulation, the Chi-square test and t-test.

Detailed presentation of data analysis will be presented in Chapter 4.

3.9 SUMMARY

Chapter 3 discussed the methodology followed in conducting the research. The study design, population and sampling, data collection, ethical consideration, pre-testing the research instrument, and analysis of data were described. Reliability and validity of data collection procedures were also discussed.

CHAPTER 4

ANALYSIS AND PRESENTATION OF DATA

4.1 INTRODUCTION

This chapter deals with the analysis and presentation of the data collected. The aim of this study was to determine association between knowledge, attitudes, and experiences of clients in relation to VCT. Furthermore the study aimed to determine relationship of demographic characteristics of clients, their knowledge, attitudes and experiences regarding VCT at Mankweng Primary Health Care facilities.

The objectives of this study were to

- Assess the knowledge of the clients age 17-49 years regarding VCT;
- Identify the attitudes of clients age 17-49 years towards VCT;
- Describe the experiences of clients in relation to VCT; and
- Compare knowledge, attitudes and experiences regarding VCT among clients.

Questionnaire with five sections were administered to participants in the study. The questionnaires were marked on return. The marking was not to identify participants, but to enable the researcher to review the questionnaire if the needs arise, when computing the data. Participants were required to respond to questions in section A, B, C and D of the questionnaire by marking with "X".

The participants were required to indicate the extent to which they agreed or disagreed with statements by marking their responses on five points scale using an "X". Section E had open-ended questions where participants were requested to write additional opinions regarding HIV and VCT.
The following key was used to guide the participants;

SD= strongly disagree, D= disagree, KN= not known, SA= strongly disagree, A= agree

"Agree" and "strongly agree" were summed as agree and indicated positive response to knowledge, attitudes and experiences of participants. "Disagree" and "strongly disagree" were summed as disagree and indicated negative response to knowledge, attitudes and experiences. Views of less than 50% implied negative responses which indicate lack of knowledge of the participants, negative attitude and experiences towards VCT. Descriptive statistics involving frequency and percentages were used to compare knowledge, attitudes and experiences of participants. Tables, cross tabulation and the Chi-square tests were used to determine association between variables.

Findings of this study are presented according to the section of questionnaire.

- Section A: biographic data of the participants
- Section B: knowledge of clients regarding HIV and VCT
- Section C: attitudes of clients regarding and VCT
- Section D: experiences of clients regarding HIV and VCT
- Section E: additional opinions regarding HIV and VCT

In section B, C, D, and E each category "count" indicates the total number of participants. However, all participants did not answer each question. Consequently, count could be fewer for any item than indicated for the specific category of participants. Percentages were calculated on the number of participants to the item not to total count.

Data obtained from section E were analysed by grouping common concepts together to obtain frequencies.

4.2 SECTION A: ANALYSIS OF BIOGRAPHIC DATA: AGE, GENDER, LEVEL OF EDUCATION, MARITAL STATUS, RESIDENTIAL PLACE AND EMPLOYMENT

Section A consists of six biographic items from item 1 to 6 namely: clients age 17-49 years, gender, level of education, marital status, residential place, and employment status.

Item 1: Age group and gender of participants

Table 4.1 shows the age and gender distribution of the three age groups of participants; 17-23 years, 24-33 years and 34-49 years

Table 4.1: Age group and gender distribution

Age	Females		Males	
	Count	%	Count	%
17-23	55	35	12	27
24-33	54	35	14	31
34-49	46	30	19	42
Total	155	100	45	100.

Table 4.1 reveals that 35% participants were females aged 17-23 years, and 35% aged 24-33 years and 30% age 34-49 years. The age groups 17-23 and 24-33 years are young adults in child bearing stage at risk of contracting HIV infections and should have knowledge regarding HIV and VCT. In all age groups females participated more than males. This finding reveals that females use health services more than men.

Item 2: Education and gender of participants

Table 4.2: Education and gender distribution

Education	Females		Males	
	Count	%	count	%
None	6	4	0	0
Primary	11	7	11	24
Secondary	110	71	25	56
Tertiary	27	18	9	20
Total	154	100	45	100

Table 4.2 reveals that 71% of the female participants and 56% of the males had secondary education. Few (4%) of the females had no education while 7% had primary education and 18% tertiary education. Twenty four percent (24%) of the male participants had primary education and 20% tertiary education. Van Dyk (2002:195) support that schools have a very important role to play in empowering children with the necessary knowledge, attitudes, values, and life skills to protect themselves against HIV infection and AIDS. The need to intensify health education and health awareness should be addressed in all age groups.

Item 3: Marital Status and gender of the participants

Table 4.3: Marital status and gender distribution

Marital status	Females		Males	
	count	%	count	%
Single	113	73	28	62
Married	37	24	16	36
Divorced	3	2	1	2
Widowed	2	1	0	0
Total	155	100	45	100

Table 4.3 reveals that the majority of participants (73%) were single females and 62% were males. Only 23% were married females and 36% married males.

Item 4: Residence and gender of the participants

Table 4.4: Residence and gender

Residence	Females		Males	
	count	%	count	%
Rural	139	90	38	84
Urban	16	10	7	16
Total	155	100	45	100

Table 4.4 reveals that 90% of the females and 84% of the males who participated in this study were from rural areas, while 16% of the males and 10% of the females were from urban area.

Item 5: Employment and gender of the participants

Table 4.5: Employment and gender distribution

Employment and gender	Females		Males	
	count	%	count	%
Employed	26	17	21	47
Unemployed	129	83	24	53
Total	155	100	45	100

Table 4.5 reveals high (83%) unemployment in females and 53% in males.

4.3 Summary

Section A consisted of analysis of biographic data of participants related to age group and gender, education and gender, marital status and gender, residence and gender, and employment and gender.

SECTION B

4.4 SECTION B: KNOWLEDGE OF CLIENTS REGARDING HIV AND VCT

Section B consists of 26 items from item 7 to 17. All items consist of questions and responses of the participants related to knowledge of VCT and HIV.

Table 4.6: Respondents' knowledge regarding HIV and Voluntary Counselling and Testing																		
Items from the questionnaire	17-23						24-33						34-49					
	Disagree		Not Known		Agree		Disagree		Not Known		Agree		Disagree		Not Known		Agree	
	Count	%	Count	%	Count	%	Count	%	Count	%	Count	%	Count	%	Count	%	Count	%
7. Where did you get the information about HIV?																		
7.1 Parent	22	34			43	66	34	52	2	3	30	46	42	68			20	32
7.2 Sibling	21	34	2	3	39	63	32	47	2	3	34	50	37	58	1	2	26	41
7.3 Church	22	35	3	5	38	60	21	32	2	3	43	65	28	45	1	2	33	53
7.4 School	5	8			60	92	11	16			56	84	26	41			38	59
8. HIV is transmitted through:																		
8.1 Unprotected sex	1	2			63	98	4	6	1	2	63	93	1	2			64	99
8.2 Getting in contact with infected blood	4	6	3	5	58	89	9	13	4	6	55	81	3	5	1	2	60	94
8.3 Kissing a person	47	75	6	10	10	16	47	71	4	6	15	23	38	59	9	14	17	27
8.4 Shaking hands with infected person	58	94	2	3	2	3	49	77	6	9	9	14	47	73	5	8	12	19
9. HIV is prevented through?																		
9.1 Using condoms	5	8	1	2	59	91	2	3	1	2	64	96	3	5	1	2	61	94
9.2 Abstain	3	5	3	5	56	90	6	9	3	5	57	86	4	6	1	2	59	92
9.3 Being faithful	6	10	2	3	55	87	11	16	1	2	55	82	7	11	3	5	53	84
9.4 Washing after sex	47	76	6	10	9	15	43	65	10	15	13	20	40	64	15	24	8	13
10. HIV can be contracted through:																		
10.1 Eating with infected person from the same plate	53	83	6	9	5	8	53	79	5	8	9	13	50	79	5	8	8	13
10.2 Having sex with infected person without condom	4	6			63	94	5	7.	4	6	59	87	3	5	1	2	60	94

10.3 By sharing needles with infected person	9	14	2	3	54	83	12	18	3	5	52	78	8	12	1	2	56	86
10.4 Sharing toilet with infected person	51	79	8	12	6	9	54	81	2	3	11	16	49	78	8	13	6	10
11 More women than men are infected with HIV	16	24	19	29	31	47	10	15	14	3	44	65	11	17	13	20	41	63
12Person's risk of HIV infection increases when is infected with other STI'S	6	9	11	17	49	74	4	6	5	7	59	87	5	8	9	14	51	79
13 According to the law HIV test may not be done without person's consent	13	20	7	11	44	69	8	12	8	12	52	77	13	20	8	12	44	68
14 Even if both partners are HIV positive , it is still necessary to use condoms when they have sexual intercourse to prevent infection	6	9	3	5	57	86	3	5	5	8	59	88	8	12	5	8	52	80
15Aperson who is HIV positive is equally Contagious through all stages of infection	10	16	16	25	38	59	3	5	14	21	49	74	5	8	12	19	47	73
16.Taking HIV Test one week after sex will show if a person is infected	20	30	18	27	28	42	16	24	19	28	33	49	16	25	19	29	30	46
17A person can get HIV through getting in contact with a person who is Cough or sneezing	47	71	7	11	12	18	48	71	9	13	11	16	40	62	8	12	17	26

Item 7: Where did you get information about HIV?

Item 7.1: Parents

Sixty-six percent (66%) of the participants aged 17-23 years agreed while 34% disagreed. In the age category of 24-33 years, 52% of the participants disagreed and 45% agreed while 3% did not know. In the age category of 34-49 years, 68% of the participants disagreed and 32% agreed. Age 24-33 years and 34-49 years groups disagreed with the statement with high percentage. The disagreement from age 24-49 might be due to mature age not staying with parents. Kibel and Wagstaff (1995:246) stated that educating children about becoming infected during sexual contact is controversial. Young people need to understand the HIV pandemic and the specific actions they can take to prevent the HIV infection, especially during adolescence.

Item 7.2: Siblings

Fifty percent (50%) of the participants aged 17-23 years agreed, 47% disagreed, and 3% did not know. Most 63% of the participants age 24-33 years agreed, 34%disagreed and 3% did not know. Fifty eight percent (58%) of the participants aged 34-49 years disagreed, 41% agreed and 1% did not know. Age 17-23 and 24-33 years group responded agreed while age 34-49 years participants disagree. The high percentage of disagreed in age 34-49 groups indicate that in older group brothers and sisters do not give each other information about HIV.

Item 7.3: Church

Sixty percent (60%) of the participants aged 17-23 years agreed 35% disagreed and (5%) did not know. Sixty-five percent (65%) of the participants aged 24-33 years agreed 32% disagreed and 3% did not know. Fifty-three percent (53%) of the participants aged 34-49 years agreed 45% disagreed and 2% did not know. These findings imply that churches can play a role in contribution of HIV knowledge.

Van Dyk (2002:320) indicates that all religious institutions should be encouraged to become involved in HIV counselling team.

Item 7.4: School

Ninety-two percent (92%) of the participants aged 17-23 years agreed that the information about HIV they found it from school. 8% disagreed with the statement. Eighty-four percent (84%) of the participants aged 24-33 years agreed and 16% disagreed. Fifty-nine percent (59%) of the participants aged 34-49 years agreed with the statement while 41% disagreed. These findings indicated that in 17-23 and 24-33 age groups, high number of participants agreed that they got HIV information from schools and little above fifty 34-49 agreed due to average knowledge of HIV. The reason might be that in their time of schooling HIV information was not given at school. According to Van Dyk (2002:318) a comprehensive prevention programme that addresses the various aspects of HIV/AIDS in different context like schools will prevent the stigma and discrimination often associated with HIV specific programmes.

Item 8: HIV is transmitted through:

Item 8.1: Unprotected sex

Ninety-eight percent (98%) of the participants aged 17-23 years agreed that HIV is transmitted through unprotected sex and 2% disagreed. Ninety-three percent (93%) of the participants aged 24-33 years agreed with the statement and 6% disagreed while 1% did not know. Almost all 98% of the participants aged 34-49 years agreed that HIV is transmitted through unprotected sex while (2%) disagreed. These findings indicated that nearly all the participants have knowledge that condom is the best reliable method to prevent HIV.

Taegtmeyer and Tincobald (2006:100) indicate that integral to the VCT protocol, condoms are discussed as a routine part of pre test counselling process, with the focus mainly on male condoms.

Item 8.2: Getting in contact with infected blood

Eighty-nine percent (89%) of the participants aged 17-23 agreed that HIV is transmitted through getting in contact with infected blood while 6% disagreed and 5% did not know. Eighty-one percent (81%) of the participants aged 24-33 years agreed with the statement while 13% disagreed and 6% did not know. Ninety-three percent 93% of the participants aged 34-49 years agreed while 5% disagreed and 2% did not know. These findings revealed that majority of people have knowledge that coming in contact with infected blood or having open wound without protective measure like gloves put one at risk of HIV infection.

Item 8.3: Kissing a person

Participants aged 17-23 years 75% disagreed that HIV is transmitted through kissing a person, while 16% agreed and 9% did not know. Seventy-one percent (71%) of the participants aged 24-33 years disagreed with the statement. Twenty-three percent (23%) agreed and 6% did not know. Fifty-nine percent (59%) of the participants aged 34-49 years disagreed, 27% agreed and 14% did not know. The findings reveal that the participants disagree with the statement and the disagreed percentages decreases with age. These findings reveal that the participants know that for a person to get infected through kissing is when they engaged in deep kissing and having sores in mouth. Van Dyk (2002:142) indicates that deep wet kissing with HIV infected person should be avoided. Possible trauma to the mouth may occur which may result in an exchange of blood.

Item 8.4: Shaking hands with infected person

Ninety-four percent (94%) of the participants aged 17-23 years disagreed that HIV can be transmitted through shaking hands with infected person. Three percent (3%) agreed and 3% did not know. Seventy-seven percent (77%) of the participants aged 24-33 years disagreed, 14% agreed and 9% did not know. Most 73% of the participants aged 34-49 years disagreed 19% agreed and 8% did not know. The high number of the participants who disagreed indicates that most people have knowledge that a person can only contract HIV by coming in contact with infected person's body fluids not ordinary touch.

Item 9: HIV is prevented through

Item 9.1: Using condom

Ninety-one percent (91%) of participants aged 17-23 year agreed that HIV can be prevented through using condom. Eight percent (8%) disagreed with the statement and 1% did not know. Ninety-six percent (96%) of participants aged 24-33 years agreed with the statement, while 3% disagreed and 1% did not know. Ninety-four percent (94%) of people aged 34-49 years agreed 5% disagreed and 1% did not know.

These findings revealed that high percentage of participants in all age groups have knowledge that HIV is prevented through using condoms. According to Stadler, Delany and Mntambo (2007:189) condoms are one of the most effective method for HIV prevention if used consistently and correctly.

Item 9.2: Abstinence

Participants aged 17-23 years 90% agreed that HIV can be prevented through abstinence, while 5% disagreed with the statement and 5% did not know.

Eighty-six percent (86%) of the participants aged 24-33 years agreed with the statement 9% disagreed and 5% did not know 92% of the participant's age 34-49 years agreed 6% disagreed and 2% did not know. These findings showed that high percentage of participants have knowledge that HIV can be prevented by abstaining from sex. Van Dyk (2002:134) indicates that the only totally reliable way of preventing oneself from being infected by HIV is total abstinence from sex.

Item 9.3: By being faithful to your partner

Eight-seven percent (87%) of the participants aged 17-23 years agreed that HIV can be prevented through being faithful to your partner 10% disagreed and 3% did not know. Eighty-two percent (82%) of the participants aged 24-33 years agreed, 16% disagreed and 2% did not know. Eighty-four percent (84%) of the participants aged 34-49 years agreed, 11% disagreed and 5% did not know. The high percentage of all age groups responses reveal that most people have knowledge that HIV can be prevented by not changing partners.

Item 9.4: Washing after sex

Participants aged 17-23 years (76%) disagreed that HIV can be prevented by washing after sex, 14% agreed with the statement and 10% did not know. Sixty-five percent (65%) of the participants aged 24-33 years disagreed, 20% agreed and 15% did not know. Sixty-three percent (63%) of the participants aged 34-49 years disagreed, 13% agreed and 24% did not know. The disagreed percentages decrease with age. The disagreed 63-76% percentage of all age group responses revealed that participants do understand HIV's mode of infection that virus is in blood stream not superficial. Once infected washing will not help. Van Dyk (2002:145) clarify the statement by indicating that, cleansing after sex is positively not advised because it is likely that such cleansing may facilitate HIV infected semen deeper into the vagina or anus.

Item 10: HIV can be contracted through

Item 10.1: Eating with infected person from the same plate

Seventy-nine percent (79%) of the participants aged 17-23 years disagreed that eating with infected person from the same plate one can contract HIV, 13% agreed and 8% did not know. Eighty-three percent (83%) of the participants aged 24-33 years disagreed with the statement, 8% agreed and 9% did not know. Most 83% of the participants aged 34-49 years disagreed, 13% agreed and 8% did not know. These findings indicated that most of the participants have knowledge that eating with infected person from the same plate would not transmit in the HIV, as it is transmitted through blood via open wound.

Item 10.2: Having sex with infected person without condom

Participants aged 17-23 years 94% agreed that one can contract HIV by having sex with infected person without condom, 6% disagreed. Eight-seven percent (87%) of the participants aged 24-33 years agreed with the statement, 7% disagreed and 6% did not know. Ninety-three percent (93%) of the participants aged 34-49 years of age agreed, 5% disagreed and 2% did not know. These high percentages of agreed responses from participants reveals that participants have knowledge that using of condoms are one of the best methods that prevent HIV. According to Van Dyk (2002:145) scientific evidence shows that latex condoms are highly effective in preventing HIV and other STI'S.

10.3: By sharing needles with infected person

Eighty-three (83%) of the participants aged 17-23 years agreed that HIV can be contracted through sharing needles with infected person, while 14% disagreed and 3% did not know. Seventy-eight percent 78% of the participants aged 24-33 years agreed, 18% disagreed and 4% did not know.

Most 86% of the participant's age 34-49 years agreed with the statement, 2% disagreed and 2% did not know. These findings revealed that participants have knowledge that sharing needles is one of the risks factors of HIV infection. Strode, Van Rooyen, and Heywood (2005:46) indicated that sharing needles can transmit HIV. Injecting drugs does not directly cause HIV but sharing needles with other people is what cause the spread of HIV from person to person.

Item 10.4: Sharing the toilet with infected person

Most (79%) of the participants aged 17-23 years disagreed that HIV can be contracted by sharing the toilet with person, 9% agreed and 12% did not know. The majority 81% of the participants aged 24-33 years disagreed, 16% of the participants agreed and 3% did not know. Most 78% of the participants aged 34-49 years disagreed, 9% agreed and 13% did not know. These findings reveal that participants have knowledge that HIV can not transmitted by using the same toilet with infected person. These findings further revealed that most participants understand how to leave with people who are HIV positive. People do not contract HIV if they take necessary precautions such as adhering to the rules of basic hygiene.

Item 11: More women than men are infected with HIV

Fourty-seven percent (47%) of the participants aged 17-23 years agreed that more women than men are infected with HIV, 24% disagreed and 29% did not know. Sixty-five percent (65%) of the participants aged 24-33 years agreed. Fifteen percent (15%) disagreed and 20% did not know. Sixty-three percent (63%) of participants aged 34-49 years agreed, 17% disagreed and 20% did not know. Low percentage of age 17-23 years showed lack of knowledge of the statement, though the other ages also scored average.

According to Van Dyk (2002:20) women as the recipients of semen, are exposed to semen for a longer time, semen remains in the body of a woman for few hours while a man is exposed to the body fluids of a woman for a short time during sexual intercourse.

Item 12: Person's risk of HIV increases when he or she is infected with other sexually transmitted diseases

Participants aged 17-23 years 74% agreed that person's risk of contracting HIV infections increases when she is infected with other sexually transmitted diseases, 9% disagreed and 17% did not know. Eighty-seven percent (87%) of the participants aged 24-33 years agreed with the statement while 6% disagreed and 7% did not know. Seventy-eight percent (78%) of participants age 34-49 years agreed, 8% disagreed and 14% did not know. This finding showed that most of the participants understand the relationship between HIV and sexually transmitted infections, that HIV get entry through open wound like genital sores. According to Creek (2006:46) the presence of a sexually transmitted infection (STI) can increase the risk of HIV acquisition or transmission.

Item 13: According to the law, an HIV test may not be done without a person's informed consent

Sixty-nine percent (69%) of the respondents aged 17-23 years agreed that HIV test may not be done without a person's informed consent, 20% disagreed and 11% did not know. Most 76% of the participants aged 24-33 years agreed, 12% disagree and 12% did not know. Sixty-eight percent (68%) of the participants aged 34-49 years agreed with the statement, 20% disagreed and 12% did not know. The finding revealed high 68%+ of agreed shows that participants have knowledge about HIV law because in VCT client is counselled first when agrees to test, given consent form to sign before being tested.

Corbitt (2001:97) indicates that Informed consent, which includes pre-HIV test counselling, is compulsory before HIV testing may be carried out. Post test counselling takes place as part of the process of informing an individual of an HIV test result.

Item 14: Even if both partners are HIV positive, it is still necessary for them to use condoms when they have sexual intercourse to prevent re-infection

Participants aged 17-23 years 86% agreed that it is necessary for partners to use condom even if they are both HIV positive while 9% disagreed with the statement and 5% did not know. Eighty-eight percent (88%) of the participants aged 24-33 years agreed with the statement, while (5%) disagreed and (8%) did not know. Eighty percent (80%) of the participants age 34-49 years agreed while 12% disagreed and 8% did not know. The high percentage of agreed response in all age groups indicate that the participants have knowledge that even if infected one can be re-infected if engage in unprotected sex. Van Dyk (2002:29) maintains that it is important for HIV infected person to protect themselves against re-infections because each new infection can cause an increase in the viral load in the blood.

Item 15: A person who is HIV positive is equally contagious through all stages of infection

Fifty-nine percent (59%) of participants aged 17-23 years agreed that a person who is HIV positive is equally contagious through all stages of infection, 16% disagreed and 25% did not know. Seventy-four percent (74%) of the participants aged 24-33 agreed with the statement, 5% disagreed and 21% did not know. Seventy-three percent (73%) of the participants aged 34-49 agreed with the statement while 8% disagreed and 19% did not know.

These findings indicated that most participants have knowledge about the statement as all age groups agreed with more than 50%.

Item 16: Taking HIV test one week after sex will show if a person is infected

Fourty-three percent (43%) of the participants aged 17-23 agreed that taking HIV test one week after sex will show if a person is infected, 30% disagreed and 27% did not know. Fourty-eight percent (48%) of the participants aged 24-33 years agreed with the statement 24% disagreed and 28% did not know. Fourty-six percent (46%) of the participants aged 34-49 years agreed while 25% disagreed and 29% did not know. The low percentage of agreed of less than fifty percent in all age groups in this statement indicated that on this item participants lack knowledge about window period. According to Van Dyk (2002:78) before three to four weeks after HIV infection antibodies does not react to the test. That means that before the indicated time the test may not reveal the status.

Item 17: Person can get HIV through a person who is coughing or sneezing

Seventy-one percent (71%) of the participants aged 17-23 and 24-33 years disagreed that person can get HIV through coughing or sneezing. Sixty-two percent (62%) of the participants aged 34-49 years disagreed, 26% agreed and 12% did not know. These findings indicated that the participants have knowledge that HIV is transmitted through body fluids not cough or sneezing.

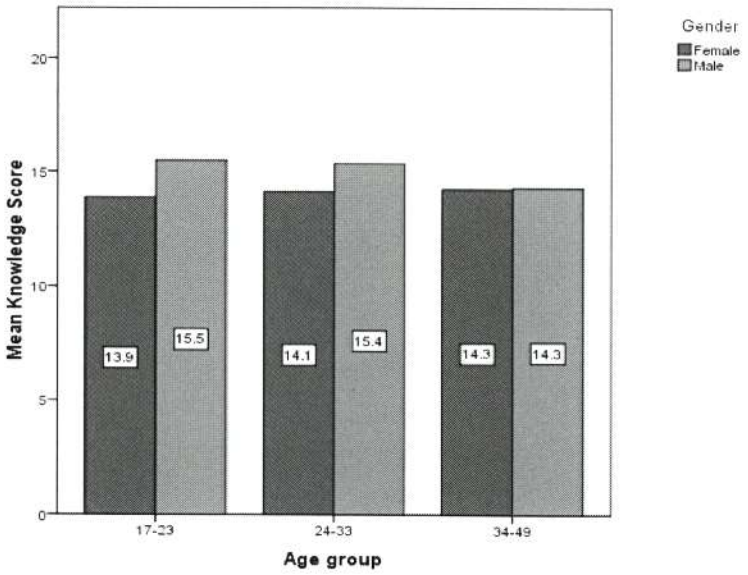

Figure 1: Mean Knowledge Score Age Group and Gender

Figure 1 reveals mean knowledge score in age groups and gender. In age group 17-23 years females scored 14% and males scored 16%. In age group 24-33 years females scored 14% and males scored 15%. In age 34-49 years females and males scored 14%. The findings indicate that in all ages females scored the same percentages regarding knowledge towards VCT. Males in age 17-23 and 24-33 years scored nearly the same and higher than females. In age 34-49 years both females and males mean knowledge score were the same.

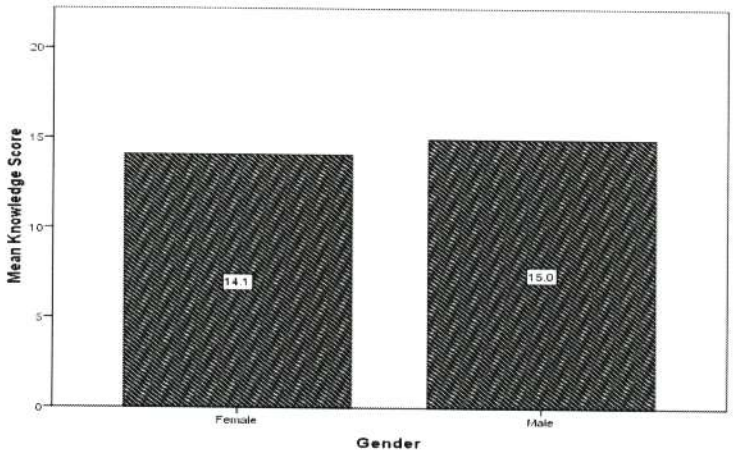

Figure 2: Mean Knowledge Score and Gender

Figure 2 shows mean knowledge score and gender. Female participants mean knowledge score 14% while males mean knowledge score is 15%. The finding reveals only one percent difference between males and females regarding knowledge towards VCT.

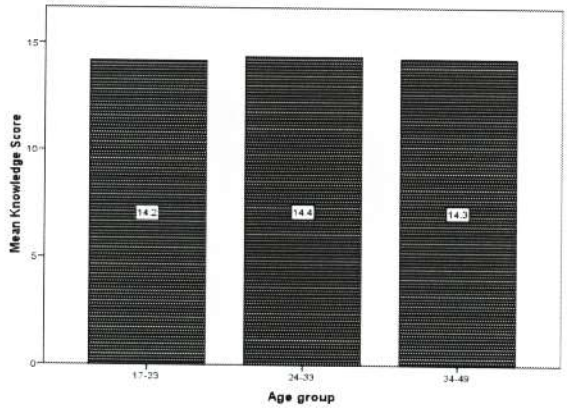

Figure 3: Mean Knowledge Score and Age Group

Figure 3 reveals mean knowledge score and age groups in age 17-23, 24-33 and 34-49 years. In all age groups mean knowledge score is nearly the same. The findings reveal that all age groups have almost the same knowledge about VCT.

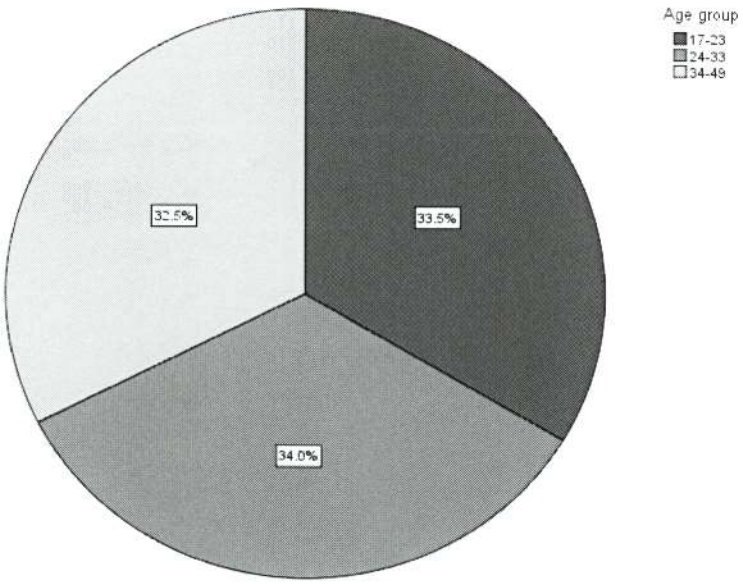

Figure 4: Knowledge According to Age Group

Figure 4 reveals 34% for both participants age 17-23 and 24-33 years have knowledge of VCT and participants age 34-49 years 33% have knowledge of VCT. The findings indicate that younger age groups have more knowledge of VCT than older age group.

4.5. Summary

In section B, in most items participants of the three groups showed to posses knowledge in HIV and VCT, however in item 16 regarding testing of HIV one week after sex participants lack knowledge.

Section C

4.6 SECTION C: ATTITUDES OF CLIENTS REGARDING VCT

Section C consists of 16 items, from 18 to 32. The questions and the responses from the participants in section C relate to attitudes of the clients towards HIV and VCT. A frequency table was done for section C data. The findings are as indicated in Table 4.7.

4.3 Section C: Attitudes of clients regarding VCT

Table 4. 7: Attitudes of clients regarding HIV and Voluntary Counselling and Testing

ITEMS FROM THE QUESTIONNAIRE	17-23 Years						24-33 Years						34-49 Years					
	Disagree		Not Known		Agree		Disagree		Not Known		Agree		Disagree		Not Known		Agree	
	Count	%	Count	%	Count	%	Count	%	Count	%	Count	%	Count	%	Count	%	Count	%
18. People are afraid to go for VCT	7	11	2	3	56	86	8	12	2	3	58	85	4	6	4	6	57	88
19. More women than men takes part in VCT	4	6	16	25	45	69	6	9	13	19	49	72	4	6	11	17	50	77
20. People feel that VCT is not helpful for there is no cure for HIV	26	40	4	6	35	54	27	40	9	13	32	47	25	39	8	12	32	49
21. What is the attitude of the community towards HIV infected people?																		
21.1Treat like any other person	30	48	1	2	31	50	20	30	2	3	45	67	17	27	3	5	42	68
21.2 People gossip about them	16	25	2	3	46	72	20	32	2	3	41	65	13	21	2	3	47	76
22.It is important to know his/her status	3	5	1	2	61	94	1	2	2	3	65	96	2	3	1	2	61	95
23.VCT should be marketed to every client	3	5	9	14	51	81	7	10	4	6	57	82	2	3	4	6	59	91
24. Most men see VCT as issues of women only	11	18	9	14	46	70	12	18	6	9	50	74	9	14	4	6	52	80
25. HIV positive persons get support from their families	3	5	2	3	59	92	5	8			62	93	6	9			58	91
26. Most couples divorce if one party test HIV positive	18	27	4	6	44	67	8	12	11	16	49	72	12	19	7	11	45	70
27. People who have HIV/AIDS are cursed	35	53	10	15	21	32	19	29	8	12	38	59	27	42	6	9	31	48
28. It is safe for people who are infected with HIV to work with children	33	50	4	6	29	44	26	38	5	7	37	54	28	43	4	6	33	51
29. It is known in the community that people who have HIV are dirty	37	56	8	12	21	32	27	40	9	13	32	47	27	42	5	8	33	51
30. People who have HIV should be ashamed of themselves	51	77	2	3	13	20	33	49	5	8	29	43	36	55	1	2	28	43
31. People who are HIV positive must be isolated	49	74	6	9	11	17	44	68	3	5	19	29	44	69	4	6	16	25
32. Disclosing one's HIV positive status can help to reduce the stress of oping on his/her own	17	26	5	8	44	68	14	21	5	7	49	72	6	9	9	14	50	77

18: People are afraid to go for VCT

Eight-six percent (86%) of the participants aged 17-23 years agreed that people are afraid to go for VCT, 11% of the participants disagreed and 3% did not know. Eight-five percent (85%) of participants aged 24-33 years agreed with the statement while 12% disagreed and 3% did not know. Eighty-eight percent (88%) of participants aged 34-49 years agreed with the statement, 6% disagreed and 6% not known. The majority 85%+ of the three age groups agreed that people are afraid to go for VCT. The findings imply that participants in this study displayed negative attitudes in HIV testing. Turyagyenda (2000:71) support that people fear HIV testing, especially women, because even if testing is done there is still fear of status disclosure which might put them in both physical and mental danger from the partner and the family.

Item 19: More women than men take part in VCT

Participants aged 17-23 years (69%) agreed that more women than men take part in VCT; those aged 24-33 years (72%) and 34-49 years (77%) agreed as well. These findings show that women visit health facilities regularly than men, and they take health issues positively than men. These findings link with those of item 1 in section A of this study wherein 78% of the participants were women.

Item: 20 People feel that VCT is not helpful for there is no cure for HIV

Fifty-four percent (54%) of the participants aged 17-23 years agreed that people feel that VCT is not helpful for there is no cure for HIV while 40% disagreed and 6% did not know. Fourty-seven percent (47%) of the participants aged 24-33 years agreed, 40% disagreed and 13% did not know. Fourty-nine percent (49%) participants aged 34-49 years agreed, 39% disagreed and 12% not known.

According to UNAIDS (2001:13), Voluntary counselling and testing is regarded as priority area in strategies to prevent the spread of HIV and to provide care, support and treatment to people already living with HIV. By allowing people to learn their HIV status and be counselled about its implications, VCT may help to curb the further spread of HIV. UNAIDS further indicate that VCT also represents a mechanism for referral into care, treatment and support systems. These include treatment for opportunistic infections, post exposure prophylaxis (PEP), and access to anti retroviral (ARV) as well as longer term counselling and support for positive living. Evian (2003:83) support that ART is likely to be more effective and successfully maintained if begun before the patient is severely immune deficient. There is now various choices available for ART. This therapy can prevent the deterioration of the disease.

Item 21: What is the attitude of the community towards HIV infected people?

Item 21.1: Treat like any other person

Fifty percent (50%) of the participants aged 17-23 years agreed that HIV infected people are treated like any other person, 48% disagreed and 2% did not know. Sixty-seven (67%) of the participants aged 24-33 years agreed, 30% disagreed and 3% did not know. Sixty-eight percent (68%) of the participants aged 34-49 years agreed 27% disagreed and 5% did not know. The findings revealed that all age groups have positive attitudes towards HIV positive people as they feel they should be treated like any other person. Evian (2003:286) revealed that people affected by HIV/AIDS are often subjected to discrimination and rejection by their family, friends, colleagues and even insurance schemes. Support and counselling is needed.

Item 21.2: People gossip about them

Seventy-two percent (72%) of participants aged 17-23 years agreed that people gossip about people who are HIV positive while 25% disagreed with the statement and 3% did not know. Sixty-five percent (65%) of participants aged 24-33 years agreed, 32% disagreed and 3% did not know. Seventy-six percent 76% of participants aged 34-49 years agreed, 21% disagreed and 3% did not know. These findings revealed that average percentage of participants agreed that the community gossip about HIV positive people. These findings show that average participants have negative attitudes towards HIV infected people. It shows that the HIV positive people are still stigmatised in the community. UNIAIDS (2001:13) indicated that widespread uptake of VCT within communities can help to normalize HIV/AIDS, to reduce AIDS related stigma, and to raise awareness of the epidemic.

Item 22: It is important for a person to know his/her status

Ninety-four percent (94%) of the participants aged 17-23 years agreed that it is important for a person to know his/her status. Five percent (5%) disagreed and 1% did not know. Ninety-six percent (96%) of the participants aged 24-33 years agreed and 1% disagreed and 3% did not know. Ninety-five percent (95%) of the participants aged 34-49 agreed with the statement, while 3% disagreed and 2% did not know. These findings indicate that more participants have positive attitudes towards VCT and they like to know their status. According to UNAIDS (2006:6), it is estimated that up to 90% of HIV positive people in low income countries do not know their HIV status due to few VCT facilities.

However, even where VCT facilities are available, many people do not want to be tested because of a perception that "nothing is to be gained" by knowing an HIV status.

Sherr and Lopman (2001:176) show that those found to be HIV infected may be more likely to protect themselves and others found to be HIV positive may seek medical attention for early symptoms of AIDS related illnesses. Those who test negative are more likely to change their behaviour to maintain their negative status by using condoms or by encouraging their partners to test for HIV.

Item 23: VCT should be marketed to every client

Participants aged 17-23 years (81%) agreed that VCT should be marketed to every client. 5% disagreed with the statement and 14% did not know. Eighty-four percent (84%) of the participants aged 24-33 years agreed, 10% disagreed and 6% did not know. In participants aged 34-49 years 91% agreed with the statement while 3% disagreed and 6% did not know. These findings indicate that more participants have positive attitudes towards VCT program and they wish everybody could know about the program. According to Weiss (2000:86), health providers, media, community, and home based programs need to tailor their messages and support VCT. African political and health leaders need to speak more often and more convincingly about the importance of HIV prevention, including VCT, for the citizens.

Item 24: Most men see VCT as issue for women

Seventy percent (70%) of the participants aged 17-23 years agreed that most men see VCT as issue of women. Seventeen percent (17%) disagreed and 14% did not know. Seventy-four percent (74%) of the participants aged 24-33 years agreed with the statement, while 18% disagreed and 9% did not know. Eighty percent (80%) of the participants aged 34-49 years agreed that most men see VCT as an issue of women. Fourteen percent (14%) disagreed and 6% did not know. These findings reveal that men are not keen to know their status; they give women the responsibility of health issues that imply that men have negative attitudes towards VCT.

Diaby (2000:11), agrees that effective prevention requires cooperation from women's partners. This gives an added urgency to the need for health facility based VCT programs that incorporate women's sexual partners targeted recruiting efforts and community outreach to couples.

Item 25: HIV positive person get support from their family

Participants aged 17-23 years (92%) agreed that HIV positive person get support from their family, (5%) disagreed and (3%) did not know. Ninety-three percent (93%) of the participant's age 24-33 years agreed, (7%) disagreed with the statement. Ninety-one (91%) of the participant's age 34-49 years agreed 9% disagreed.

These high percentage responses of agreed in all age groups indicate that most families accept and support their HIV infected family members. The responses indicate positive attitudes towards HIV positive persons. According to UNAIDS (2001:13) support for positive living people from family may play a role in promoting greater social acceptance of the HIV/AIDS infections.

Item 26: Most couples divorce if one party test HIV positive

Sixty-seven percent (67%) of the participants aged 17-23 years agreed that most couples divorce if one party test HIV positive, (27%) disagreed and (6%) did not know. Seventy-two percent (72%) of the participants aged 24-33 years agreed with the statement that most couples divorce if one party test HIV positive, 12% disagreed and (16%) did not know. Seventy percent (70%) of the participants aged 34-49 years agreed, (19%) disagreed and (11%) did not know. The responses revealed that most partners have negative attitudes towards HIV infected partners, while HIV positive partner need support from his/her partner.

Item 27: People who have HIV/AIDS are cursed

Participant's age 17-23 years (53%) disagreed that people who have HIV/AIDS are cursed, (32%) agreed wit the statement and (15%) did not know. Fifty-nine percent (59%) of the participants age 24-33 years agreed, (29%) disagreed and (12%) did not know. Fourty-eight percent (48%) of the participants aged 34-49 years agreed (42%) disagreed and (10%) did not know. The responses are controversial in age 17-23 years and in age 24-33 years and 34-49 years. Age 17-23 and 24-33 years disagreed with above fifty percentages that people who have HIV/AIDS are cursed while age 34-49 disagreed with below fifty percentages that people who have HIV/AIDS are cursed.

Item 28: It is safe for people who are infected with HIV to work with children

Fifty percent (50%) of the participants aged 17-23 years disagreed that it is safe for people who are HIV positive to work with children while (44%) agreed with the statement and (6%) did not know. Fifty-five percent (55%) of the participants aged 24-33 years agreed that it is safe for people who are HIV to work with children, (38%) disagreed and (7%) did not know. Fifty-one percent (51%) of the participants aged 34-49 years agreed (43%) disagreed and (6%) did not know. The disagreed responses in category of age 17-23 years are contradictory to age 24-33 years and age 34-49 years which agreed with the statement. Van Dyk (2002:414) indicates that it is of opinion that an HIV infected person generally does not pose a risk to children and there is no need to withdraw self from care activities.

Item 29: It is known in the community that people who have HIV are dirty

Participants aged 17-23 years 56% disagreed that it is known in the community that people who have HIV are dirty, 32% agreed with the statement and 12% did not know.

Fourty-seven percent (47%) of the participants aged 24-33 years agreed, 40% disagreed and 13% did not know. Fifty-one percent (51%) of the participants aged 34-49 years agreed, 42% disagreed and 8% did not know. The responses age 17-23 years is disagreed while age 24-33 years and 34-49 years is agreed which shows controversial response, the findings indicate that there is stigma regarding HIV positive people mostly from older age groups and the agreed increases with ages.

Item 30: People who are HIV positive must be ashamed of themselves

Seventy-seven percent (77%) participants aged 17-23 years disagreed with the statement, while 20% agreed and 3% did not know. Fourty-nine percent (49%) of the age 24-33 years participants disagreed, 43% agreed and 8% did not know. Fifty-five (55%) of the participants age 34-49 years agreed, (43%) agreed and (2%) did not know. The responses shows gap in percentages age 17-23 years rated high while age 24-33 and 34-49 years rated low. It is surprising that age 24-33 years group is doubtful about the above statement.

Item 31: People who are HIV positive must be isolated

Seventy-four percent (74%) of the participants aged 17-23 years disagreed that people who are HIV positive must be isolated, 17% agreed and 9% did not know. Sixty-seven percent (67%) of the participants aged 24-33 years disagreed. Twenty-nine (29%) agreed and 4% did not know. Sixty-nine percent (69%) of the participants aged 34-49 years disagreed, 25% agreed and 6% did not know.

Item 32: Disclosing one's HIV positive status can help to reduce the stress of coping on his/her own

Of the participants aged 17-23 years 67% agreed with the statement, 26% disagreed and 7% did not know. Most 72% of the participants aged 24-33 years agreed that disclosing one's HIV positive status can reduce the stress of coping on his/her own, 21% disagreed and 7% did not now. Seventy-seven percent (77%) of the participants aged 34-49 years agreed, 9% disagreed and 14% did not know. The finding reveals that high percentages of participants have positive attitudes towards accepting and disclosing of HIV positive status. According to Wiktor and Grant (1999:1472), acceptance and support for persons who have tested HIV positive and greater support for disclosure of HIV positive status is highly needed. Van Dyk (2002:138) supports that disclosure help people to accept their HIV status and reduce the stress of coping on their own.

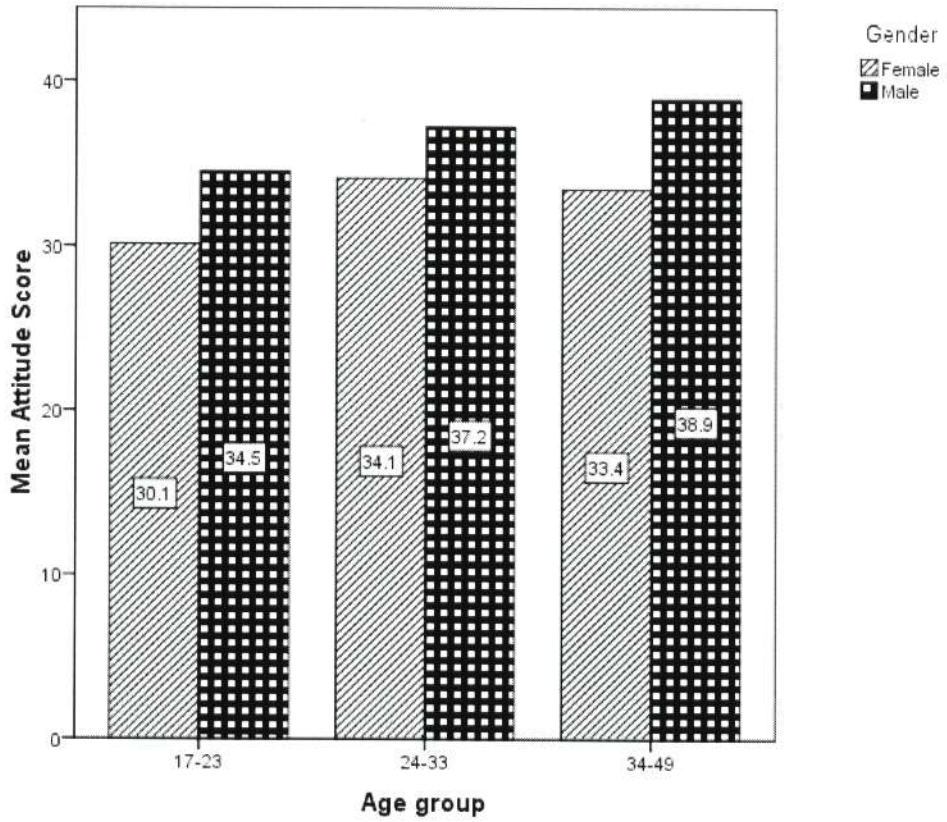

Figure 5: Mean Attitude Score Age Group and Gender

Figure 5 reveals mean attitudes score of females and males by age groups. Age 17-23 years females mean score 30% and males mean score 35%. Age 24-33 years females mean score 34% and males 37%. Age 34-49 years females mean score 33% and males mean score 39%. The findings reveal males have higher score of attitudes towards VCT than females. In age groups, mean score reveal that older age groups have higher score of attitudes towards VCT.

Group Statistics

	Employment	N	Mean	Std. Deviation	Std. Error Mean
Knowledge	Employed	47	14.34	2.944	.429
	Unemployed	153	14.26	3.238	.262
Attitude	Employed	47	34.91	9.791	1.428
	Unemployed	152	33.14	8.841	.717

4.7 Summary

In section C the three groups were presented with 15 items, from 18 to 32, to respond to. All three groups responded in agreed and disagreed in positive and negative statements. In some of the statements there were controversial responses, in some negative statements the groups agreed with statements, like in items 27, 28 and 30. The differences in attitudes were revealed in different age groups.

Table 4.8 Independent Sample Test

Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means						
									95% Confidence Interval of the Difference	
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	Lower	Upper
Knowledge	Equal variances assumed	.546	.461	.149	198	.881	.079	.529	-.964	1.122
	Equal variances not assumed			.157	83.079	.876	.079	.503	-.921	1.079
Attitude	Equal variances assumed	.492	.484	1.169	197	.244	1.770	1.514	-1.216	4.756
	Equal variances not assumed			1.108	70.750	.272	1.770	1.598	-1.417	4.957

P<0.05 > there is significant difference in the mean attitude score between males and females

Mean	SD	Mean	SD	p-value
14.96	3.052	14.08	3.179	0.104

Section D

4.8: SECTION D: EXPERIENCES OF CLIENTS REGARDING HIV AND VCT

Section D consists of twelve items from item 33 to 44 the questions and the responses of the participants relating to experiences of clients regarding HIV and VCT. Data in section D was presented in table 4.9.

Table 4.9: Experiences of clients regarding HIV and Voluntary Counselling and Testing

ITEMS FROM THE QUESTIONNAIRE	17-23						24-33						34-49					
	Disagree		Not Known		Agree		Disagree		Not Known		Agree		Disagree		Not Known		Agree	
	Count	%	Count	%	Count	%	Count	%	Count	%	Count	%	Count	%	Count	%	Count	%
33. According to your experience the following group of people are at risk of contracting HIV infections																		
33.1 Sex workers	10	15	5	8	51	77	8	12	2	3	57	85	3	5	3	5	58	91
33.2 Poor	35	54	3	5	27	42	22	33	7	11	37	56	25	39	4	6	35	55
33.3 Elderly	45	70	4	6	15	23	33	50	6	9	27	41	42	66	1	1	21	33
33.4 Illiterate	22	36	16	26	24	39	23	37	11	18	29	46	30	47	5	8	29	45
33.5 Drug users	14	12	5	8	44	70	15	22	6	9	46	69	13	20	7	91	44	69
33.6 Young	6	9	2	3	57	88	9	14	3	5	54	82	6	9	3	5	55	86
33.7 Males	13	20	4	6	48	74	10	15	6	9	50	76	2	3	3	5	59	92
33.8 Females	11	17	4	6	50	77	9	14	2	3	55	83	5	8	4	6	54	86
34. Most woman find it difficult to discuss sex with their partners	9	14	8	12	48	74	10	15	2	3	55	82	7	11	2	3	55	86
35. People carry own razorblades when visiting traditional healers	14	22	24	37	27	42	9	13	13	19	45	67	13	21	7	11	42	68
36. Women are at risk of HIV infection when menstruating	30	46	17	26	18	28	19	29	18	27	39	44	20	32	19	31	23	37
37. There is a vaccine that prevent HIV infection	33	52	18	28	13	20	42	64	11	17	13	20	44	70	7	11	12	19
38. VCT is a must for pregnant women to protect their children	8	12	4	6	54	82	8	12	2	3	57	85	3	5	3	5	57	91
39. One of the methods to prevent HIV is to use condoms	2	3			64	97	5	8	1	2	61	91	3	5	2	3	59	92
40. It is important for a person to know his/her status			1	2	63	98	6	9			60	91	2	3	4	6	57	91
41. In health facilities people get tested without their consent	41	62	13	20	12	18	43	64	7	10	17	25	33	52	14	22	17	27
42. People who test HIV positive become depressed	8	12	8	12	50	76	6	9	9	13	52	78	4	6	2	3	57	91
43. A sense of self worth is needed even if one test HIV positive	7	11	10	15	49	74	8	12	6	9	53	79	6	9	6	9	52	81
44. HIV is a man made diseases	26	39	15	26	25	38	25	38	14	21	27	41	21	33	20	32	22	35

Item 33: According to your experience the following group of people are at risk of contracting HIV infection

Item 33.1: Sex workers

Most 77% of the participants aged 17-23 years agreed that sex workers are at risk of contracting HIV infections, 15% disagreed and 8% did not know. Eighty-five percent (85%) of the participants aged 24-33 years agreed that sex workers are at risk of contracting HIV infections, 12% disagreed with the statement and 3% did not know. Ninety percent (90%) of the participants aged 34-49 agreed that sex workers are at risk of contracting HIV infections. Five percent (5%) disagreed and 5% did not now. The findings revealed that all age groups of participants support that sex workers are at risk to contract HIV infections.

Item 33.2: Poor people

Fifty-four percent (54%) of the participants aged 17-23 years disagreed that poor people are at risk of contracting HIV infection, 41% agreed with the statement and 5% did not know. Fifty-six percent (56%) of the participants aged 24-33 years agreed that poor people are at risk of contracting HIV infection, 33% disagreed and 11% did not know. Fifty-five percent (55%) of the participants aged 34-49 years agreed that poor people are at risk of contracting HIV infection. 39% disagreed and 6% did not know. These findings reveal that 42% of the participants aged 17-23 years agreed that poverty could contribute to HIV infection while 56% age 24-33 years and 55% age 34-49 years agreed with the statement. The findings reveal that the older age groups have experiences that if a person is poor and hungry, would go for anything irrespective of how dangerous it is to put food on the table. Van Dyk (2002:33) observes that depressed socioeconomic conditions and poverty are contributory factors to the spread of HIV.

Item 33.3 Old people

Participants aged 17-23 years (70%) disagreed that old people are at risk of contracting HIV infection, 24% agreed and 6% did not know. Fifty percent (50%) of the participants aged 24-33 years disagreed that old people are at risk of contracting HIV infection, 41% agreed and 9% did not know. Sixty-six percent (66%) of the participants aged 34-49 years disagreed that old people are at risk of contracting HIV infection, 33% agreed and 1% did not know. These findings revealed that all age groups disagreed with the statement.

Item 33.4 Illiterates

Participants aged 17-23 years (39%) agreed that illiterate people are at risk of contracting HIV, while 36% disagreed with the statement and 26% responded that they did not known. Fourty-six percent (46%) of the participants aged 24-33 years agreed, 37% disagreed and 18% did not know. The age group 34-49 years, (47%) disagreed while (45%) agreed and (8%) responded that did not know whether illiterate people are at risk of contracting HIV infections. The findings reveal low percentages of below 50% for age group 17-33 years while participants aged 34-49 agreed with the statement. The findings reveal that older groups have no experiences that illiterate people are at risk of contracting HIV. The findings link with those of item 2 on education and gender wherein 71% female participants and 56% males have secondary education, revealing that lack of education expose one to contract HIV. Hunter (2003:32) indicated that the simplest and cheapest form of HIV intervention is to inform people susceptible to infection about VCT and the use of condoms especially for largely illiterate population with limited health resources.

Item 33.5 Drug users

All the age groups (69% and 70%) agreed that drug users are at risk of contracting HIV infection. These findings reveal that high percentages from all age groups of participants support that drug users are exposed to HIV infections, especially those who share needles. WHO (2002:4) indicated that in high prevalence settings, it is recommended that VCT be offered as a priority service to all those considered to be at high risk of HIV infection, especially to vulnerable and marginalized populations such as injecting drug users because they usually share needles and their at risk to contract HIV.

Item 33.6: Young people

Of the participants aged 17-23 years 88% agreed that young people are at risk of contracting HIV, 9% disagreed and 3% responded not known. Eighty-two percent (82%) of the participants aged 24-33 years agreed that young people are at risk of contracting HIV, 14% disagreed with the statement and 5% did not know. Eighty-six percent (86%) of the participants aged 34-49 years agreed that young people are at risk of contracting HIV. Nine percent (9%) disagreed and 5% responded did not know. These high percent of agreed in all age groups indicates that participants have support that young people are the most group at risk of contracting HIV infection. According to Van Dyk (2002:181) young people develop the ability to consider hypothetical risks and the possible benefits of various kinds of behaviour, as well as the potential consequences of such behaviour, and this ability helps them to make good or bad decisions.

Item 33.7: Males

The majority of participants in the three age groups of 74% to 92% agreed that males are at risk of contracting HIV infection.

These findings imply that the participants support that most men are at risk of contracting HIV infection. The high percentage in agreed for all age groups reveal that the participants support that males are at risk to contract HIV infection. Van Dyk (2002:137) support that most men engage in unprotected penetrative sex which create a very high risk for HIV transmission.

Item 33.8: Females

Seventy-seven percent (77%) of the participants aged 17-23 years agreed that females are at risk of contracting HIV infection. Seventeen percent (17%) disagreed with the statement and 6% did not know. Eighty-three percent (83%) of the participants aged 24-33 years agreed that females are at risk of contracting HIV infection. Fourteen percent (14%) disagreed and 3% responded not known. Eighty-six percent (86%) of the participants aged 34-49 years agreed that females are at risk of contracting HIV infection, 8% disagreed and 6% did not know. These findings reveal that participants in all categories agreed with 77% + that through experiences females are at risk to contract HIV. Van Dyk (2002:20) supported the statement and indicated that women poses large surface area of mucosa in vagina and cervix which are exposed to their partner's secretions during sexual intercourse. That is why women are more easily infected by HIV.

Item 34: Most women find it difficult to discuss sex with partners

Of the participants aged 17-23 years 74% agreed that women find it difficult to discuss sex with their partners, while 14% disagreed with the statement and 12% responded not known. Eight-two percent (82%) of the participants aged 24-33 years agreed that women find it difficult to discuss sex with their partners. Fifteen percent (15%) disagreed and 3% did not know. Eighty-six percent (86%) of the participants aged 34-49 years agreed that women find it difficult to discuss sex with their partners. Eleven percent (11%) disagreed and 3% did not know.

These findings show that all age groups of participants agreed with 74% + that through experiences women have problem to communicate with their partners regarding sexual choice like protected sex. Van Dyk (2002:21) support that most women are not in position to negotiate safe sex practices with their partners because of fear of violence and abandonment.

Item 35: People carry own razor blades when visiting traditional healer

Participants aged 17-23 years (42%) agreed that people carry their own razorblades when visiting traditional healers. Twenty-two percent (22%) disagreed with statement and 37% did not know. Sixty-seven percent (67%) of the participants aged 24-33 years agreed that people carry their own razorblades when visiting traditional healers 13% disagreed while 19% did not know. Sixty-eight percent (68%) of the participants aged 34-49 years agreed that people carry their own razorblades when visiting traditional healers, 21% disagreed and 11% responded not known. These findings reveal that age 17-23 have less experiences of traditional healers while the older ages 24-33 and 34-49 years has experiences of using traditional healers and that shows that the youth might not be visiting traditional healers.

Item 36: Women are at risk of HIV infection when menstruating

Participants aged 17-23 years 46% disagreed that women are at risk of HIV infection when menstruating. Twenty-eight percent (28%) agreed and 26% responded that not known. Fourty-four percent (44%) of the participants aged 24-33 years disagreed that women are at risk of HIV infection when menstruating. While 29% disagreed with the statement and 27% did not know. Thirty-seven percent (37%) of participants age 34-49 agreed while 32% disagreed and 31% did not know.

The findings reveal that in this statement all the age groups had no experiences about the statement. Van Dyk (2002:21) indicate that women are likely to be infected with HIV before, during and immediately after menstruation because of the large, raw area of inner uterine lining that is exposed to semen.

Item 37: There is vaccine that prevent HIV infection

Fifty-two percent (52%) of the participants aged 17-23 years disagreed that there is vaccine to prevent HIV infection. Twenty percent (20%) agreed and 28% did not know. Sixty-four percent (64%) of the participants aged 24-33 years disagreed that there is vaccine to prevent HIV infection, 20% agreed with the statement and 17% responded not known. Seventy percent (70%) aged 34-49 years disagreed that there is vaccine to prevent HIV infection. Nineteen percent (19%) agreed and 11% did not know. These findings reveal that participants experienced that there is no vaccine or cure for HIV. Van Dyk (2002:72) clarified that the researchers are unable to develop HIV vaccine that actually prevents HIV infections. They might be able to develop a vaccine that will be able to make the virus less infectious.

Item 38: VCT is a must for a pregnant woman to protect their unborn children

All age groups had overwhelming agreement of 83% to 92% that VCT is a must for a pregnant woman to protect their unborn children. The high percentage of agreed from participants in all age groups shows that participants have experiences and they support that VCT is a must for a pregnant women to protect the unborn babies. WHO (2003:23) mentioned that VCT as early as possible during pregnancy enables pregnant women to benefit from prevention, treatment and care and to access interventions for reducing HIV transmission to their infants.

Item 39: One of the methods to prevent HIV is to use condoms

All most all (97%) participants age 17-23 and 92% aged24-33 and 34-49 years agreed that one of the methods to prevent HIV is to use condoms. These findings indicate that (92% +) of the participants in all age groups have experiences that the best available method to prevent HIV is use of condoms.

Granich and Mermin (2001:63) indicated that the effective method to prevent HIV is use of condom. Hunter (2003:32) support that HIV can be prevented with less radical measures, such as consistent and correct use of a condom.

Item 40: It is important for a person to know his/her status

All most all 98% participants age 17-23 and 91% age 24-33 and 34-49 years agreed that it is important for a person to know his/her status. These high percentages of agreed responses indicate that over 91% of the participants have experiences regarding VCT. Sherr and Lopman (2001:176) indicated that the important of knowing ones' HIV status is that those found to be HIV infected may be more likely to protect themselves and others if found to be HIV positive and may seek medical attention for early symptoms of AIDS related illnesses. Sherr and Lopman (2001:176) further indicated that, those who test negative are more likely to change their behaviour to maintain their negative status by using condoms or by encouraging their partners to test for HIV.

Item 41: In health facilities people get tested without their consent

In the age group 17-23 years 62% disagreed that in health facilities people get tested without their consent, 18% agreed and 20% did not know. The age group 24-33 64% and age 34-49 years 52% participants disagreed with the statement. The findings reveal that participants have experiences regarding VCT procedure that clients get pre-counselling.

If the clients agree to test, they should complete consent form then get tested. After testing either negative or positive results they should get post-counselling.

Van Dyk (2002:118) explains that during VCT individuals undergo counselling to enable them to make informed decision about being tested for HIV antibodies.

Item 42: People who test HIV positive become depressed

Participants aged 17-23 years 76% agreed that people who test HIV positive get depressed, while 125 disagreed with the statement and 12% did not know. Seventy-eight percent (78%) of the participants aged 24-33 years agreed.

Nine percent (9%) disagreed and 13% did not know. Ninety-one percent (91%) of the participants aged 34-49 years agreed that people who test HIV positive get depressed. The findings reveals that in all age groups participants have experiences of emotional respond of a person after bad news, though in HIV after continues counselling the individual accept the status and overcome the depression. According to Van Dyk (2002:258) HIV infected individuals often experience depression because they feel that they have lost much in life and that they themselves are to blame for it.

Item 43: A sense of self worth is needed even if one tested HIV positive

Seventy-four percent 74% of the participants aged 17-23, 79% age 24-33 and 81% 34-49% years agreed that a sense of self worth is needed even if one tests HIV positive. These finding shows average agreement of 74% from all age groups. These indicate that the participants have experiences that even if a person is HIV positive should maintain self-esteem as is still worth living. Van Dyk (2002:258) indicates that the self worth of HIV infected person is often severely threatened. Rejection by colleagues, friends and loved ones can cause loss of confidence and a sense of social identity, leading to reduced feeling of self-worth (Van Dyk, 2002:258).

Item 44: HIV is a man made disease

Participants aged 17-23 years 39% disagreed that HIV is man made disease, while 38% agreed with the statement and 22% did not know. Fourty-one percent 41% of the participants aged 24-33 years agreed. Thirty-eight percent (38%) disagreed with the statement and 21% did not know. Thirty-five percent (35%) of the participants aged 34-49 years agreed 33% disagreed with the statement and 32% responded not known.

4.9 Summary

In section D the three groups were presented with 19 items from 33 to 44 to respond to. All three groups responded in agree and disagree in columns and not known in positive and negative statements. In some of the statements there were controversial responses. In item 36 the participants showed lack of experiences. In item 44 the participants in all age groups showed doubtful experiences. In item 33.3 all the age groups disagreed with the positive statement and that also indicated lack of experiences.

Section E

4.10: SECTION E: ADDITIONAL OPINIONS REGARDING HIV AND VCT

Section E consists of three items from item 45 to 47 the questions and the responses of the participants relating to additional opinions regarding HIV and VCT. Data in section E was presented in table 4.9, 4.10 and 4.11.

Item 45: What is VCT?

Table 4.10 Additional opinion regarding clients knowledge towards HIV and VCT

	17-23		24-33		34-49	
	Count	%	Count	%	Count	%
Not know	7	10	9	13	4	6
HIV testing	47	70	47	70	50	79
Blood test	10	15	4	6	4	6
HIV education	3	5	7	10	5	8
Total	67	100	67	100	63	100

Seventy percent (70%) of the participants aged 17-23 and 24-33 and 79% age 34-49 year responded that VCT is HIV testing. Ten percent (10%) age 17-23, (13%) age 24-33 and 6% age 34-49 years did not know the meaning of VCT. Fifteen percent (15%) age 17-23, 6% age 24-33 and 34-49 years responded that VCT is testing of blood. Five percent (5%) of participants age 17-23, 10% age 24-33 and 8% age 34-49 years responded that VCT is HIV education.

Item 46: If one of your friend, brother, or sister can test HIV positive, how will you feel.

Table 4.11: Additional opinion regarding clients attitudes towards HIV and VCT

	17-23		24-33		34-49	
	Count	%	Count	%	Count	%
Feel sorry	1	17	0	0	0	0
Acceptance	4	66	5	50	6	60
Antiretroviral	1	17	5	50	4	40
Total	6	100	10	100	10	100

Age 17-23 years (66%), age 24-33 years (50%) and (60%) age 33-49 stated that if a friend, brother or a sister can test HIV positive, they will be sorry but reassure the person and advise him/her to accept. Seventeen percent (17%) age 17-23 years, 50% age 24-33 years and 40% age 34-49 indicated that they will tell the person that even if tested HIV positive at least there is antiretroviral treatment to prolong life. Seventeen percent (17%) of the participants age 17-23 will feel sorry if a friend, brother or sister can test HIV positive while age 24-33 years and 34-49 years did not respond to the question. The responses showed that the participants have positive attitudes towards HIV positive person.

Item 47: What are the situations which can put you at risk to contact HIV?

Table 4.12: Additional opinions regarding clients experiences towards HIV and VCT

	17-23		24-33		34-49	
	Count	%	Count	%	Count	%
Sharing needles	0	0	1	3	0	0
Unprotected sex	6	14	11	4	8	3
Touching blood	27	64	22	58	23	11
Changing partners	9	21	10	26	10	26
Sex workers	0	0	1	3	2	5
Total	42	100	45	94	43	45

Participants aged 17-23 years 64%, 24-33 (58%) and 34-49 years 11% indicated that touching blood with bare hands having open wound can put one at risk of contracting HIV infections.

Age 24-33 years group 3% of the participants indicated that the situations which can put one at risk to contract HIV is sharing of needles. Age 17-23 years and 34-49 years did not respond. Age 17-23 years (14%), 24-33 years 4% and 34-47 years 3% indicated that the situation which can put one at risk to contract HIV is to engage in unprotected sex. (21%) of age 17-23 years, 26% age 24-33 years and (26%) within age 34-49 participants indicated that changing partners put one at risk of contracting HIV infections. Three percent (3%) age 24-33 years and (5%) age 34-49 indicated that sex worker put a person at risk to contract HIV, while age 17-23 years did not respond to. The findings reveal that age group 17-23 and 24-33 support that one can contract HIV by touching infected blood without wearing gloves.

4.11 Summary

Chapter 4 discussed analysis of responses to knowledge, attitudes and experiences of participants regarding HIV and VCT. There were positive and negative responses in some of questions regarding knowledge in section B, but the participants showed knowledge of VCT. In section C, the findings revealed both positive and negative attitudes towards VCT programme and people living with HIV. In section D, the findings revealed that people have positive and negative experiences about VCT and HIV. In section E, the study showed lack of knowledge in the meaning of VCT, positive attitudes towards HIV infected person and the participants have experiences regarding HIV mode of spread.

CHAPTER 5

CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

The aim of this study was to determine knowledge, attitudes and experiences of clients regarding VCT. The research questions were as follows:

- What is the knowledge of clients regarding VCT?
- What are the attitudes of clients towards VCT?
- What are the experiences of clients in relation to VCT?

5.2 OBJECTIVES

The objectives of the study are subsequently evaluated to determine whether they have been attained.

Objective 1

To assess the knowledge of the clients age 18-49 years regarding VCT

In section B there was congruence in the knowledge of the three age groups of respondents: ages 17-23, 24-33, and 34-49 years. There were positive responses on knowledge of the clients regarding VCT. The summary showed that the participants in all age groups have knowledge about VCT.

Objective 2

To identify the attitudes of clients age 17-49 years towards VCT.

In section C, there was correlation in the responses of the three categories of participants aged 17-49 years. These imply positive attitudes towards VCT. These positive attitudes are essential to community to accept VCT programs and to live positively with the people living with HIV.

Objective 3

To describe the experiences of clients in relation to VCT

In section D, there was congruence in the experiences of the three groups of respondents aged 18-49 years. Some participants agreed while other disagreed with the statements to show lack of experiences. These experiences might enable the participants to understand myths about HIV, cultural influence on HIV, safe sexual practices, and other community beliefs in relation to HIV.

Objective 4

To compare knowledge attitudes and experiences regarding VCT among clients.

In section B, biographic data of the participants in education of respondents in secondary education females scored (71%) while males scored little above half (56%) on education in the same category. In marital status and gender of the respondents in age 17-23 years single females scored (71%) while single males scored 62%. In residence and gender of the respondents (79%) of females and 70% were from rural area. Employment gender of respondents, high number of females were unemployed (83%) while (53%) of males were unemployed.

There was positive and negative response in statement relating to knowledge in section B. In the majority of questions regarding attitudes in section C the findings revealed negative attitudes regarding VCT and HV.

In section D, the majority of statements revealed lack of experiences. Despite having knowledge, some participants displayed negative attitudes towards HIV positive people. Some participants lacked experiences regarding HIV irrespective of having knowledge regarding VCT.

5.3 CONCLUSIONS

The study revealed that participants have knowledge though having negative attitudes and lack experiences regarding HIV and VCT. However there is a need to intensify HIV education to all categories of clients, starting from home, schools, churches and other public settings. With proper information giving about HIV, there will be positive attitudes towards VCT programs and to people living with HIV. Van DyK (2002:156) indicated that for HIV education to be successful, there should be balance between knowledge, life skills, values, and attitudes.

5.4 RECOMMENDATIONS

The recommendations based on this study relating to Knowledge, attitudes and experiences of clients aged 17-49 years regarding VCT are as follows:

- VCT programs should be marketed in all health facilities and that may be done in a form of health education, handing of pamphlets and posters.

- Regular health awareness campaign to the community in relation to HIV and VCT to empower the community with HIV information and to make them aware of the importance of knowing their HIV status.

- Observing of health calendar dates for HIV for example; world AIDS day, condom week and candle light day.
- Forming of HIV support groups to encourage people living with HIV to accept the condition, for the infected to learn how to cope with opportunistic diseases and to learn how to prevent re-infections to increase their life span.

- Further research should be conducted on attitudes of clients who visit Primary Health Care facilities.

- Effective referral system of clients who tested HIV positive with low cell count of less than 200 to start with Anti-retroviral therapy.

- DoH should be engaged in extensive promotion of VCT services use in PHC facilities at Mankweng.

5.5 SUMMARY

Chapter 5 discussed the objectives of the study, to assess the knowledge of the client age 18-49 years regarding VCT, to identify the attitudes of the client's age 18-49 years towards VCT, to describe the experiences of clients in relation to VCT, to compare knowledge attitudes and experiences regarding VCT among clients. Conclusions and recommendations of the study were also presented.

REFERENCES

Arthur, E & Pool, A. 2001. **Confidentiality in VCT. South African Journal of Psychology.** 33 (2): 122-123.

Bartlett, JA & Theilman NM. 2005. Socio demographic and clinical characteristics of client presenting for HIV counselling and testing in Moshi Tanzania. **International journal of STD AND aids.** 16(7): 691-696.

Bennett, R & Erin, CA. 2001. **HIV/AIDS testing, screening, and confidentiality.** New York: Oxford University Press.

Bless, C & Higson-Smith, C.2000. **Social research methods.** Juta Education (Pty) Ltd. Lansdowne.

Burns, N & Grove, SK. 1993. **Understanding Nursing Research.** Philadelphia: Saunders.

Campell, S. 2000. Strengthen VCT procedures, staff capacity and performance. Couples in VCT recruitment efforts. **The Lancet. South African Journal of Psychology.** 53 (11): 1397-1411.

Creek, TL. 2006. Acquired Immunodeficiency Syndrome. **Centre for diseases control and prevention.** 25 (43) 210-218.

Corbitt, G. 2001. **HIV Testing and Screening Current Practicalities and Future Possibilities**. New York: Oxford University Press.

Creswell, J.W. 2003. **Research Design, Qualitative, Quantitative and mixed methods approaches.** London: Sage Publication.

Darkoh, E. 2004.**HIV/AIDS in Botswana** (http:/www.avert.org/aidsbotswana.htm) accessed on 2007/01/09.

Department of Health 2000. **Strategic Plan for South Africa, 2005-2006.** Pretoria: Government Printers.

Department of Health. 2000. H**IV/AIDS & STI Strategic Plan for South Africa, 2000-2005.** Pretoria: Government Printers.

Department of Health. 2006 Directorate Report Review

Diaby, N. 2000. Efficacy of Voluntary Counselling and Testing in individual and couples in Kenya and Trinidad. **The Lancet.** 356 (24): 113-121.

Dreyer, M, Hattingh, S & Lock, M. 2000. **Fundamental aspects in community health nursing,** Cape Town, Kobler Carton 7 print.

Eden A & Taegtmeyer M, A. 2003. Kenya National Manual for Training Counsellors in Voluntary Counselling and Testing for HIV. **National AIDS and STD Control Programme,** 63 (3): 292-300.

Evian, C. 2003. **Primary HIV/AIDS care.** Fishwicks the Printers, Durban.

Farham, B. 2003. Aids briefs improved uptake of VCT in Botswana. **Continuing Medical Education**. 25 (1):36.

Farrell, R. 2006. **The Real Truth, the AIDS Pandemic 25 Years Later.**http://www.realtruth.org, accessed on. 11/28/2006.

Fowler, FG & Fowler, HW.1970. **Oxford Dictionary**. Oxford University press. Great Britain.

Fawler, FG & Fawler, HW. 1970. **Oxford Dictionary.** Oxford University Press. Great Britain.

Granich, R & Mermin, J. 2001. **HIV Screening.** Great Britain: Sage Publications. HIV/AIDS News. 2006. http:/www.medical news today.com, accessed on. 2007/01/09)

Hunter, S. 2003. **Who cares? AIDS in Africa**. Palgrave Macmillan. New York.

Igumbor, OJ. Pengpids S & Obi CC, 2006. Effect of exposure to clinic- based education intervention on HIV infection. **Journal of Social Aspects of HIV/AIDS.** 3 (1): 394-402.

Kalichman, SC & Simbayi, LC. 2003. HIV testing attitudes, and voluntary HIV Counselling and testing. http://www.sti.bmj.com 2007/01/09.

Kibel, MA & Wagstaff, LA. 1995**. Child Health for all**. A manual for South Africa. Oxford University Press. South Africa.

Kilewo, C. 2001. Acceptability of VCT by pregnant women in developing countries. **The Lancet.** 28 (9):458-462..

Knapp, TR. 1998. **Quantitative nursing research.** London: Sage Publication.

Lawoyin, TO & Adewole, DA. 2004. Predictor of maternal HIV infection at the primary care level in inner city Ibadan. **International Journal of STD & AIDS.** 15 165-168.

Louw, DA & Edward, DJA. 1998. **Psychology, Introduction for students in Southern Africa**. Sandton Himamann Higher and further Education (Pty) Ltd.

Machekano, R. Dube, M & Mandel, E, 2006. Improving Sexual and Reproductive health in poor and vulnerable population. **Reproductive Health Matters 2006. Elsevier Ltd.** 4 (1): 63

Mandel, E. 2000. VCT as a component of HIV/AIDS preventative strategies in Sub-Sahara Africa. **Journal of Social Science & Medicine**. 28 (5): 458-462.-70.

Mouton, J, 2005. **How to succeed in your Masters Doctoral Studies.** Pretoria: Van Schaik.

Painter, TM. 2001. VCT for couples a high leverage intervention for HIV/AIDS prevention in sub-Saharan Africa. **Social science and medicine.** 53 (11): 1397-1411.

Parker, W. 2004. VCT in South Africa Centre for AIDS Development Research and Evaluation, Counselling and testing. John Hopkins University Centre. **Journal of Psychology**, 33 (4): 118-125.

Pearsall, J. 1999 **Concise Oxford Dictionary** .Great Britain: Oxford University Press.

Philpott, A & Warren M. 2001.Expanding safer sex opinions. **Reproductive Health Matters.** 95 (12): 968-970.

Polit, DF & Hungler, BP. 1999. **Nursing Research Principles and Methods.** Philadelphia: Lippincott Company.

Richards, EP. 2001. **HIV Testing, Screening and Confidentiality an American Perspective.** New York: Oxford University Press.

Rose, P, Violari, A, Bolton, C & Gray, GE. 2005. Feasibility and acceptability of postpartum Voluntary Counselling and testing. **The SA journal of HIV medicine.** 10 (6): 8-6.

Sherr, L. & Lopman W. 2001. **Counselling and HIV Testing, Ethical Dilemmas.** New York: Oxford University Press.

Shin, S, Kang, HS & Moneyham, L. 2007. **Characteristics of individual seeking VCT for HIV infections in South Korea.** http://www.sciencedirect.com/science accessed on 2007/10/26.

Stadler, J, Delany,S, & Mntambo M. 2007. **Women's perceptions and experiences of HIV prevention trials in Soweto, South Africa.** http://www.sciencedirect.com/science accessed 2007/10/26.

Strode, A, Van Rooyen, H, & Heywood, M. 2005. Scaling up HIV testing in resource constrained settings. **The SA Journal of HIV medicine.** 32 (1): 45-47.

Swanepoel, BJ. 2003. **The Management of Employment Relations.** Durban: Butterworths.

Sweat, M. 2000. Cost-effectiveness of Voluntary HIV-1 counselling and testing in reducing sexual transmission of HIV in Kenya and Tanzania. **The Lancet.** 356 (2): 86-92.

Taegtmeyer, M & Tincobald, S. 2006. **Reproductive Health matters promoting female condoms in HIV.** EL Selvier Ltd.

Terre Blanche, E & Durrheim, K. 2004. **Research in practice.** Cape Town: Eppindust.

The Henry Kaiser Family Foundation, 2006. **HIV/AIDS Policy fact sheet.** 28 (30): 47-82.

The World Bank, 2001. Greater International Support for VCT. **Journal of Social Science & Medicine**. 61 (8): 1689-1700.

Theobalds, S. 2006. Improving sexual and reproductive health. **Reproductive Health Matters.** 10 (10): 589-601.

Turyagyenda, S. 2000. Knowing your HIV status the first step to care and preventing further infection. **Reproductive Health Matters.** 3(5): 68-78.

UNAIDS 2001, **Southern African Developed Community (SADC) Regional BLNS STI/ HIV and AIDS. Strategy and Program of action 2003-2006.**

UNAIDS, 2000. **Opening up the HIV/AIDS epidemic Joint United Nation programme on HIV/AIDS.** Geneva Switzerland.

UNAIDS, 2000. **Voluntary Counselling and Testing** Technical update. http://www.unaids.org/ countries/ mozambique.esp 2007/01/09.

UNAIDS, 2006. **Social marketing, an effective tool in global response to HIV/AIDS.** http//www.unaids.org/publications/documents/human/law/ 2006

UNAIDS 2007 http://www.who.int/hiv/topcs/vct/en/index.html.7/2/2007

UNAIDS 2006 http/data.unaids.org/Publications/IRC-publ/JC301-FemCondGuide-en.pdf> August 2006.

Uys, HHM & Basson, AA. 1995. **Research Methodology in Nursing.** Pretoria: Penrose Book Printers.

Van de Perre, P. 2002. HIV VCT in community health science. **The Lancet**. 179 (4): 405-407.

Van Dyk, A. 2002. **HIV AIDS Care and Counselling.** Cape Town: Maskew Miller.

Van Dyk, AC & Van Dyk, PJ. 2003. **What is the point knowing psychosocial barrier to HIV/AIDS VCT programmes in SA South Africa Journals of Psychology.** 33 (2): 118-125.

Weiss, N. 2000. Insufficient social behavioural knowledge about HIV risk and risk management by couples. **The Lancet.** 356 (10): 86-87.

WHO, 2002. **Increasing Access to HIV testing and counselling.** Geneva Switzerland. http//www.who.int/entity/hiv/pub/vct/hiv accessed on 2002-09 -en.pdf

WHO, 2003. **The right to know, New approach to HIV testing and counselling.**

WHO 2007 **HIV, Testing and Counseling.**
http:/www.who.int/hiv/topcs/vct/en/index.html. Accessed on 7/2/2007

WHO 2007. **The female Condom.** http//www.data.unaids.org/Publication/IRC-publ/JC301-FemCondGuide-en.pdf>August 2006

Wiktor, SZ & Grant, AD. 1999. Efficacy of prophylaxis treatment to disease morbidity and mortality in HIV-1 infected patients. **The Lancet.** 353 (9): 1469-1475.

APPENDIX 1: QUESTIONNAIRE

CLINIC			
Makanye	**1**	**Mankweng**	**2**
Nobody	**3**	**Evelyn Lekganyane**	**4**

SECTION A: BIOGRAPHIC DATA

1. Age at last birthday.....

2. Gender

0= Female	1=Male

3. Level of Education

0 No Education	1 Primary	2 Secondary	3 Tertiary

4. Marital status

1 Single	2 Married	3 Divorced	4 Widowed

5. Residential place

1 Rural	2 Urban

6. Employment

1 Employed	2 Unemployed

SECTION B

Knowledge of clients regarding HIV and VCT

Please respond by 1= strongly disagree 2= disagree 3= not known

4= strongly agree 5= agree.

7. Where did you get the information about HIV?	SD	D	NK	SA	A
7.1 Parents	1	2	3	4	5
7.2 Brother/ Sister	1	2	3	4	5
7.3 Church	1	2	3	4	5
7.4 School	1	2	3	4	5
8. HIV is transmitted through:					
8.1Unprotected sex	1	2	3	4	5
8.2 Getting in contact with infected blood	1	2	3	4	5
8.3 Kissing a person	1	2	3	4	5
8.4 Shaking hands with infected person	1	2	3	4	5
9. HIV is prevented through:					
9.1 Using condom	1	2	3	4	5
9.2 Abstinence	1	2	3	4	5
9.3 Being faithful to your partner	1	2	3	4	5
9.4 Washing after sex	1	2	3	4	5
10. HIV can be contracted through:					
10.1 Eating with infected person from the same plate	1	2	3	4	5
10.2 Having sex with infected person without condom	1	2	3	4	5
10.3 By sharing needles with infected person	1	2	3	4	5
10.4 Sharing the toilet with infected person	1	2	3	4	5

11. More women than men are infected with HIV.	1	2	3	4	5
12. Person's risk of HIV infection increases when he or she is infected with other sexually transmitted diseases.	1	2	3	4	5
13. According to the law, an HIV test may not be done without a person's informed consent.	1	2	3	4	5
14. Even if both partners are HIV positive, it is still necessary for them to use condoms when they have sexual intercourse to prevent re-infection.	1	2	3	4	5
15. A person who is HIV positive is equally contagious through all the stages of infection.	1	2	3	4	5
16. Taking HIV test one week after sex will show if a person is infected.	1	2	3	4	5
17. Person can get HIV through getting in contact with a person who is coughing or sneezing.	1	2	3	4	5

SECTION C

Attitudes of clients regarding VCT

Please respond by 1= strongly disagree 2= Disagree 3= not known 4=strongly agree 5= agree.

	SD	D	NK	SA	A
18. People are afraid to go for VCT.	1	2	3	4	5
19. More women than men take part in VCT.	1	2	3	4	5
20. People feel that VCT is not helpful for there is no cure for HIV.	1	2	3	4	5
21. What is the attitude of the community towards HIV infected people?					
21.1 Treat like any other person	1	2	3	4	5
21.2 People gossip about them	1	2	3	4	5
22. It is important for a person to know his/her status.	1	2	3	4	5
23. VCT should be marketed to every to client.	1	2	3	4	5
24. Most men see VCT as issue of women only.	1	2	3	4	5
25. HIV positive person get support from their families.	1	2	3	4	5
26. Most couples divorce if one party test HIV positive.	1	2	3	4	5
27. People who have HIV/AIDS are cursed.	1	2	3	4	5
28. It is safe for people who are infected with HIV to work with children.	1	2	3	4	5
29. It is known in the community that people who have HIV are dirty.	1	2	3	4	5
30. People who have HIV should be ashamed of themselves.	1	2	3	4	5
31. People who are HIV positive must be isolated.	1	2	3	4	5
32. Disclosing one's HIV positive status can help to reduce the stress of coping on his/her own.	1	2	3	4	5

SECTION D

Experiences of client regarding HIV AND VCT

Please respond by 1= strongly disagree 2= disagree 3= not known

4= strongly agree 5= agree.

33. According to your experience the following group of people are at risk of contracting HIV infections:	SD	D	NK	SA	A
33.1 sex workers	1	2	3	4	5
33.2 poor people	1	2	3	4	5
33.3 old people	1	2	3	4	5
33.4 Illiterates	1	2	3	4	5
33.5 Drug users	1	2	3	4	5
33.6 young people	1	2	3	4	5
33.7 males	1	2	3	4	5
33.8 females	1	2	3	4	5
34.Most woman find it difficult to discuss sex with partners	1	2	3	4	5
35. People carry own razorblades when visiting traditional healer.	1	2	3	4	5
36. Women are at risk of HIV infection when menstruating	1	2	3	4	5
37. There is vaccine that prevent HIV infection.	1	2	3	4	5
38. VCT is a must for pregnant women to protect their children.	1	2	3	4	5
39. One of the methods to prevent HIV is to use condoms.	1	2	3	4	5
40. It is important for a person to know his/her status.	1	2	3	4	5
41. In health facilities people get tested without their consent.	1	2	3	4	5
42. People who test HIV positive become depressed.	1	2	3	4	5
43. A sense of self worth is needed even if one test HIV positive.	1	2	3	4	5
44. HIV is a man made disease.	1	2	3	4	5

SECTION E

Additional opinions regarding HIV and VCT

45. What do you understand by VCT?

.....
.....
.....
.....

46. If one of your close friend, brother, or sister can test HIV positive, how will you feel, and what supporting message can you give to him/her?

.....
.....
.....
.....

47. What are the situations which can put you at risk to contact HIV?

.....
.....
.....
.....
.....

APPENDIX 2: LETTER TO REQUEST PERMISSION

APPLICATION FORM FOR PROPOSED RESEARCH PROJECT UNIVERSITY OF LIMPOPO
Medunsa Campus

MEDUNSA CAMPUS RESEARCH ETHICS COMMITTEE

A. **PARTICULARS OF APPLICANT/CHIEF RESEARCHER**

Title: Ms First name: Manku Magdeline Surname: Ramoraswi

Department: Public Health Tel: 0152683507

School: Public Health

B. **DETAILS OF RESEARCH PROJECT**
(Tick appropriate block(s) with a 'x'

1.a New project [x] or : Continuation of project [ ]

1.b Independent research : [ ] or : Contract research: [ ]

Post-graduate research: [x] or : Undergraduate research : [ ]

Degree: Master of Public Health

At which university is the degree registered? University of Limpopo-Turfloop Campus

2.a. Title of project: Knowledge, attitudes and practices of clients regarding voluntary counseling and testing at Mankweng primary health care facilities

b. Co-workers (Not for post-graduate research. See Guidelines)

Name	Department/Institution	Signature
Not applicable		

c. Research Co-ordinator (In the case of independent or contract research)

Name	Department/Institution	Signature
Not applicable		

Reviewing
Received 09/07/2007

1

d. Supervisor (In the case of post-graduate research)

Name	Department/Institution	Signature
Mrs M E Lekhuleni	Nursing	

e. Co-supervisor (In the case of post-graduate research)

Name	Department/Institution	Signature
Dr MBL Mpolokeng	Public Health	

f. Hospital Superintendent/Health Care Manager

Name	Department/Institution	Signature

g. Other involved departmental heads

Name	Department/Institution	Signature
Not applicable		

C. **SPECIAL REQUIREMENTS**

Will the research involve the following:

	Yes	No		Yes	No
Experimental animals		x	Approval from Animal ethics Committee attached (separate application form required)		x
Special apparatus		X	Is it available at Medunsa?		
Special drugs (medicaments)			Explanation of who will supply the drugs attached		
Radio isotopes		X	Completed radio Isotopes form attached (Appendix 4)		
Special laboratory facilities		X	Is it available at Medunsa? If no, attach a statement of requirements		
Electron microscopy		X	Completed Electron microscope form attached (Appendix 3)		
Health care services	X		Signature of health care manager attached	x	
Statistical analysis	X		Has a statistician been consulted? If yes, attach form. (Appendix 2) If no explain.	x	

2

D. ETHICAL ISSUES

1. *Indemnity*

If a hospital (human, dental or veterinary) will be involved, please attach the written approval of the Superintendent. Should the use of the service laboratories be required, attached a letter of consent of the hospital management that this is in order.

2. *Consent*

Will patients/human volunteers form part of the experiment/trial/survey? If so, kindly modify the attached form, specifically for your project. (Appendix 1)

E. BUDGET

Who will finance this project? (Tick appropriate block with a "x")

University of Limpopo (Medunsa Campus)		Health Department		Self	X	Other (specify)	

Please indicate the institutions where application has been made for financial support or where it is intended to apply for financial support.

MRC		NRF		CSD		Other (specify)	

NB: Approval of the research project does **NOT** imply that the requested funds will be made available to the applicant.

G. DECLARATION BY RESEARCHER(S)

Should this project be approved, I/we fully understand the conditions under which I am/we are authorized to carry out the above-mentioned research. I/we guarantee to ensure compliance with these approved conditions. Furthermore, I/we undertake **not to change the procedure as detailed in the protocol but will submit a further application to the Research Committee if changes become necessary**

SIGNATURE: _____ _____ DATE: _____
CHIEF RESEARCHER:

SIGNATURE:_____DATE:_____
HEAD OF DEPARTMENT

SIGNATURE:_____DATE:_____
DIRECTOR OF SCHOOL

APPENDIX 3: LETTER FROM STATISTICIAN

STATISTICAL ANALYSES

The Chairperson,
Medunsa Campus Research Ethics Committee
Box 163
UNIVERSITY OF LIMPOPO
Medunsa Campus

Dear Sir/Madam

STATISTICAL ANALYSES

I have studied the research protocol of Manku Magdeline Ramoraswi

titled: Knowledge, attitudes and practices of clients regarding voluntary counselling and testing at Mankweng primary health care facilities

and I agree/~~do not agree~~ * to assist with the statistical analyses.

Yours sincerely,

Signature: Statistician

R. OLWAGEN
Name in block letters

09/07/2007
Date

* Please delete which is not applicable. If you do not agree to assist with the statistical analyses, please provide reasons on a separate sheet.

5

APPENDIX 4: LETTER FROM MEDICAL RESEARCH ETHICS COMMITTEE

UNIVERSITY OF LIMPOPO

Medunsa Campus

MEDUNSA CAMPUS RESEARCH & ETHICS COMMITTEE

FACULTY OF HEALTH SCIENCES

CLEARANCE CERTIFICATE

P O Medunsa
Medunsa
0204
SOUTH AFRICA

Tel: 012 521 4000
Fax: 012 - 560 0066

MEETING: 05/2007 **PROJECT NUMBER: MCREC/PH/93/2007: PG**

PROJECT

Title:	Knowledge, attitudes and experiences of Clients regarding voluntary counseling and testing at Mankweng Primary Health Care facilities
Researcher:	Ms MM Ramoraswi
Supervisor:	Mrs ME Lekhuleni
Co-supervisor:	Dr MBL Mpolokeng
Hospital Superintendent:	MM Manabile (Polokwane Municipality PHC)
Department:	Public Health (Turfloop Campus)
School:	National School of Public Health
Degree:	MPH

DATE CONSIDERED: October 30, 2007

DECISION OF THE COMMITTEE:

REPC approved the project.

DATE: November 15, 2007

UNIVERSITY OF LIMPOPO
2007 -11- 15
RESEARCH
Medunsa Campus

PROF GA OGUNBANJO
DIRECTOR: RESEARCH & CHAIRPERSON

Note: i)	**Should any departure be contemplated from the research procedure as approved, the researcher(s) must re-submit the protocol to the committee.**
ii)	**The budget for the research will be considered separately from the protocol. PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES.**

African Excellence – Global Leadership

APPENDIX 5: LETTER FROM LIMPOPO DEPARTMENT OF HEALTH AND SOCIAL DEVELOPMENT

LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HEALTH AND SOCIAL DEVELOPMENT

Enquiries: Malomane EL

Ref: 4/2/2

6 December, 2007

Ms MM Ramoraswi
University of Limpopo Medunsa Campus

Dear Ms MM Ramoraswi

"Knowledge, attitudes and experiences of Clients regarding voluntary counselling and Testing in Mankweng Primary Health Care Facilities "

- Permission is hereby granted to **Ms MM Ramoraswi** to conduct the study as mentioned above Mankweng Primary Health Care Facilities Capricorn District Limpopo Province, South Africa
- The Department of Health and Social Development will expect a copy of the completed research for its own resource centre after completion of the study.
- The researcher is expected to avoid disrupting services in the course of his study.
- The Researcher/s should be prepared to assist in interpretation and implementation of the recommendations where possible
- The Institution management where the study is being conducted should be made aware of this,
- A copy of the permission letter can be forwarded to Management of the Institutions concerned

HEAD OF DEPARTMENT
HEALTH AND SOCIAL DEVELOPMENT
LIMPOPO PROVINCE

Private Bag X9302 Polokwane
18 College Str., Polokwane 0700 • Tel: 015 293 6000 • Fax: 015 293 6211 • Website: http/www.limpopo.gov.za
The heartland of southern Africa - development is about people

APPENDIX 6: LETTER FROM EDITOR

Division/Faculty: Humanities
School/Section: Languages and Communication Studies
Department: English Studies

Private Bag X1106
Sovenga
0727

Tel: +27 15 268 3199/3069
Fax: +27 15 268 2868/3299
E-Mail: johnm@ul.ac.za
Tryforcerun@ul.ac.za

21 January, 2009

To whom it may concern

Re: Proof of editing: Mrs MM Ramoraswi

This is to certify that I have edited Manku Madgeline Ramoraswi's mini dissertation entitled, "Knowledge, attitudes, experiences of clients regarding voluntary counseling and testing at Mankweng Primary Health Care Facilities, Capricorn District Limpopo Province."

I trust that the edited version will be of acceptable language standard.

Should you have any questions, please do not hesitate to contact me at the above contacts.

Sincerely,

Dr L Makalela