



UNIVERSITY OF MALAWI

KAMUZU COLLEGE OF NURSING

**KNOWLEDGE, PERCEPTION AND PRACTICE OF COMMUNITY
MEMBERS ON HIV TESTING AND COUNSELING SERVICES IN
CHILDREN IN PHALOMBE DISTRICT**

By

FELISTAS MPACHIKA

**RESEARCH PROPOSAL IN PARTIAL FULFILLMENT OF THE
REQUIREMENT FOR THE AWARD OF BACHELOR OF SCIENCE
DEGREE IN NURSING**

SUPERVISED BY

MRS M. PINDANI

June 2009

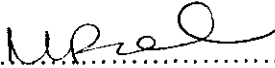
DECLARATION

I hereby declare that this proposal is solely my work and has not been submitted for any degree programme at any other educational institution.

Student: Felistas Mpachika

Signature:  Date: 11 / 06 / 09

Supervisor: Mrs. M. Pindani

Signature:  Date: 12 / 06 / 09

University of Malawi
Kamuzu College of Nursing



31050000516261

DEDICATION

This proposal is dedicated to all those upon whose smiles and well being my own happiness are wholly dependent. I keep it in memory that my inner and outer life are based on the labours of other people, living and dead, and that I should work hard in order to give in the same measure as I have received and am still receiving.

ACKNOWLEDGEMENTS

First and foremost I thank the almighty God for giving me life, protection, and guidance during the course of my four years of study and during the time I was writing this proposal.

I also would like to thank Mrs. Pindani who has been my supervisor during the time I was writing this proposal. I thank her for the positive criticisms and encouragements.

I would like also to acknowledge Mr. Ngwale, a statistics and research seminar lecturer at Kamuzu College of Nursing, for instilling in me the knowledge of how to conduct a research study.

My many thanks should also extend to my guardians, Mr. and Mrs. Piringu and my family members, for their love and support throughout my four years of study, may the good Lord continue blessing them all.

Lastly, my thanks should go to the library staff at Kamuzu College of Nursing for assisting me in sourcing information for this research study.

ACRONYMS AND ABBREVIATIONS

AIDS	:	Acquired immune deficiency syndrome
ART	:	Anti retro viral therapy
ARV's	:	Anti retro viral drugs
CDC	:	Centers for Disease Control and Prevention
D.C	:	District Commissioner.
DHMT	:	District Health Management Team
DHO	:	District Health Officer
FGD	:	Focus Group Discussion
HBM	:	Health Belief Model
HIV	:	Human Immunodeficiency Virus
HSA	:	Health Surveillance Assistant
HTC	:	HIV Testing and Counseling
MACRO	:	Malawi AIDS Counseling Resource Organisation
MDHS	:	Malawi Demographic Health Survey
NGO	:	Non Governmental Organisation
NHP	:	National HIV/AIDS Policy
PCR	:	Polymerase chain reaction
PMTCT	:	Prevention of Mother To Child Transmission.
RPC	:	Research and Publications Committee
T.A.	:	Traditional Authority
TB	:	Tuberculosis
UK	:	United Kingdom
UN	:	United Nations
UNAIDS	:	Joint United Nations Programme on HIV & AIDS
USAID	:	United States Agency for International development
VCT	:	Voluntary Counseling and Testing
WHO	:	World Health Organization

OPERATIONAL DEFINITION OF TERMS USED IN THE STUDY

Attitude: The way one looks at something, the relative positioning of one thing in relation to another.

Children: Persons between the ages of 2 to 5 years.

Community members: Individual members belonging to a group of interacting people in a common location.

Human immune deficiency virus: A retrovirus that causes AIDS, it attacks the immune system (white blood cells known as CD4 cells) gradually deteriorating it until it reaches a point where it can no longer fight off any infection.

HIV testing and counseling: A test done to detect HIV antibodies in the blood. This test include counseling (before and after the test) in order to help one understand the result, how to protect ones own health and to live positively if one is infected.

Knowledge: Scope of information which is gained and preserved by instruction; acquaintance; enlightenment; learning and erudition.

Perception: A way of viewing things or ideas.

Practice: A habitual or customary action or way of doing something.

Satisfaction: Fulfillment of a need or a desire.

TABLE OF CONTENTS

CONTENT	PAGE
Declaration	i
Dedication	ii
Acknowledgements	iii
Acronyms and abbreviations	iv
Definition of terms	v
Abstract	viii

CHAPTER ONE: OVER VIEW OF THE STUDY

1.1 Introduction	1
1.2 Background of the study	2
1.2.1 Global situation	2
1.2.2 HIV & AIDS in the Sub Saharan region	2
1.2.3 Malawi situation of HIV & AIDS.....	3
1.3 Problem statement	4
1.4 Purpose of study	5
1.5 Significance of the study	5
1.6 Objectives of the study	5
1.6.1 Broad objective	5
1.6.2 Specific objectives	5
1.7 Conclusion	6

CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction	7
2.2 Global studies on HIV & AIDS	7
2.3 Studies done in Sub Saharan Africa	8
2.4 Studies conducted in Malawi	9
2.5 Conclusion	12

CHAPTER THREE: CONCEPTUAL FRAMEWORK

3.1 Introduction	13
------------------------	----

3.2 The health belief model	13
3.3 Application of the model	16
3.4 Conclusion	16

CHAPTER FOUR: METHODOLOGY

4.1 Introduction	17
4.2 Study design	17
4.3 Study setting	17
4.4 Sampling	18
4.5 Data collection tool.....	19
4.6 Data collection	19
4.7 Pilot study	19
4.8 Data analysis	20
4.9 Ethical consideration	20
4.10 Conclusion	21

Reference	23
Research budget	27
Budget justification	29
Time line	30

APPENDICES

Appendix 1 – FGD guide (English)	31
Appendix 2 – FGD guide (Chichewa)	33
Appendix 3 – Clearance letter to RPC.....	35
Appendix 4 – Letter to DHO	36
Appendix 5 – Letter to DC	37
Appendix 6 – Information letter to participant (English)	38
Appendix 7 – Consent form (English)	39
Appendix 8 – Information letter to participant (Chichewa)	40
Appendix 9 – Consent form (Chichewa)	41

ABSTRACT

HIV is the most dangerous sexually transmitted disease affecting people of all ages. In children it is mostly transmitted through maternal – fetal transfer. The incidence of the HIV & AIDS is rapidly increasing in women and children. HIV testing is done in order to detect the presence of HIV antibodies in the blood of an individual. The process of testing for HIV includes counseling, before and after the test.

The purpose of this study is to find out what knowledge and perceptions community members have and what practices they are involved in towards HIV testing and counseling. The objectives of this study are to; assess the level of knowledge of community members on HTC in children, to explore the factors that hinder the community from utilizing the HTC services in Phalombe, to assess the community's attitude towards HTC in children and to assess the level of satisfaction with the available HTC services.

A qualitative descriptive design will be used and the study will be conducted in Bokosi village T.A Mkhumba in Phalombe district. Community members of this village will be selected purposively to be participants of the study. A pilot study of 6-10 people from Bokosi village will have a FGD in August 2009. In September 2009, data collection of the main study will be done. Three FGDs of 6-10 people each will be conducted in the same village. The researcher will collect data using an MP3 recorder. Following data collection, data will be analysed manually by the researcher.

CHAPTER ONE: OVER VIEW OF THE STUDY

1.1 Introduction

Human immunodeficiency virus is a virus that weakens the body's ability to fight infection and cause acquired immune deficiency syndrome [AIDS] (Longe, 2006:1306). HIV is the most dangerous sexually transmitted disease, affecting people of all ages (Longe, 2006:1306). HIV is transmitted by sexual contact with an infected person, exposure to contaminated blood (e.g., by sharing needles or accidental exposure to contaminated needles) and maternal – fetal transfer. HIV infection can present no clinical symptoms, cause a spectrum of conditions, or appear as full blown AIDS. The incidence of the HIV & AIDS is rapidly increasing in women and children, too. HIV remains in the body for life, and there is no vaccine against HIV (Longe, 2006: 1306).

Over the past 20 years, voluntary counseling and testing programs (VCT) have helped millions of people learn their HIV status, yet more than 80% of people living with HIV in low and middle-income countries have not tested and do not know that they are infected. Efforts are urgently 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 services for people living with HIV & AIDS and service delivery models need to be expanded to testing in antenatal care, sexually transmitted infection clinics, in-patient wards, as well as free-standing client-initiated testing centers (CDC, 2006).

The HIV-antibody test is the only way to tell whether one is infected. It detects HIV antibodies in the blood. When any virus enters the body, the immune system responds by making proteins called antibodies. Different viruses cause the body to make different antibodies. HIV antibodies are a sign of infection, but, unlike antibodies for many other infections, they do not protect the body from disease. They do not protect one from AIDS, do not make one immune, and do not prevent one from giving HIV to someone else (WHO,2003).

The HIV-antibody test should always include pre-test and post-test counseling. This counseling is to help one understand the result, how to protect ones own health, and

(if one is infected) how to keep from infecting other people. It is a central part of the testing process whether one is infected or not (WHO, 2003).

1.2 Background of the study

1.2.1 Global Situation of HIV & AIDS

Acquired Immune Deficiency Syndrome was first reported in mid-1981 in the United States; it is believed to have originated in sub-Saharan Africa. The human immunodeficiency virus was identified in 1983 and by 1985 tests to detect the virus were available (Info please, Database, 2007). An estimated 370 000 children younger than 15 years became infected with HIV in 2007. Globally, the number of children younger than 15 living with HIV increased from 1.6 million in 2001 to 2.0 million in 2007. Almost 90% of the children live in sub-Saharan Africa (WHO Reports on global HIV/AIDS, 2008). Worldwide, AIDS now ranks as the fourth leading cause of death after heart disease, stroke and respiratory infections (Hung Y.C; Ross F.C; & Luis P. V, 2007:3).

1.2.2 HIV & AIDS in the Sub-Saharan Region

AIDS is one of the most serious public health and development challenges to face sub Saharan Africa. Estimated number of children (ages 0 – 15) living with HIV/AIDS by the end of 2007 was 91 000 (UNAIDS, 2008). Despite these trends, intensive and aggressive prevention programs for behaviour change, condom promotion, voluntary counseling and testing, and blood transfusion safety have lowered prevalence or slowed HIV transmission in several sub Saharan countries (morbidity & mortality week report, 2001). In this region, under-five mortality is two to three times the average for any other region, at 154 deaths per 1,000 births. Poverty, the spread of infectious diseases including an upsurge in TB and HIV/AIDS, increases in levels of malnutrition and limited medical services contribute to the continued high levels of under-five mortality in the sub Saharan Africa (Info Project, 2003: Volume xxxi, Number 2).

AIDS will take the lives of 3.7 million children before age five in Africa between 1995 and 2015, the UN estimates. In countries hit hardest by AIDS—Botswana, Kenya, Lesotho, Malawi, Namibia, South Africa, Swaziland, Zambia, and Zimbabwe—projected under-five mortality rates are as much as two to three times higher than they would be in the absence of AIDS. Even in countries where the full impact of the HIV/AIDS epidemic has yet to be felt, further reductions in child mortality are unlikely as AIDS deaths overwhelm advances made against other causes of death (InfoProject, 2003: Volume xxxi, Number 2).

1.2.3 Malawi Situation of HIV & AIDS

Malawi is one of the countries found in the sub Saharan Africa. Like its neighbors in sub Saharan Africa, has been severely affected by HIV and AIDS. The first case of AIDS in the country was diagnosed in 1985. Since then, epidemiological data show an escalating epidemic (National HIV/AIDS Policy, 2003). The total number of people infected with HIV is estimated to be between 700 000 and one million people in 2003 (Malawi Demographic Health Survey, 2004:185). This figure includes 60 000 – 80 000 HIV positive children under the age of 15 (Malawi Demographic Health Survey, 2004: 185).

Children are infected by the epidemic by contracting the disease from their mothers and are affected by losing a parent to the disease. At the end of 2005, an estimated 91,000 children in Malawi were living with HIV, and more than half a million had been orphaned by AIDS (USAID/MALAWI, 2008).

A national HIV/AIDS policy was developed in 2003, laying down the guiding principles for all national HIV/AIDS programs and interventions. The National HIV/AIDS Strategic Framework for 2000–2004 included prevention and behavior change interventions as well as interventions to expand access to treatment and care and support services, including antiretroviral drugs (ARVs). A national action framework 2005–2009 was developed. Policies and guidelines for voluntary counseling and testing, prevention of mother-to-child transmission (PMTCT) of HIV, antiretroviral therapy (ART), and treatment of sexually transmitted infections have been developed and implemented (USAID/MALAWI, 2008).

VCT was introduced to Malawi at two sites in 1992, and became more widespread in 1995 when the Malawi AIDS Counseling Resource Organization (MACRO, an NGO with the aim of strengthening and developing VCT initiatives) was founded. Rapid blood testing for HIV, which allows people to find out their HIV status the same day they are tested, was introduced in Malawi in 2000 and significantly increased the accessibility of VCT (Graham, 2009). The uptake of HIV testing in Malawi remains below 25 percent in the adult population and data on HIV testing indicate that the most common reasons for seeking testing is concern regarding infection risk and illness (MACRO, 2004; enacted from DHS, 2004:237).

1.3 Problem Statement

The Malawi Government formed the HIV/AIDS policy in 2003. The policy consist of HIV prevention strategies that include the provision of information and education, condoms, sterile injection equipment, voluntary counseling and testing, antiretroviral medications (e.g. to prevent mother- to - child transmission or to provide post – exposure prophylaxis) (National HIV/AIDS Policy,2003). This is to make sure that all Malawians are protected from this epidemic.

Children, like all humans have also been affected by the epidemic. Most infections in HIV positive children are caused by the same pathogens as in HIV negative children, although they may be more frequent or more severe and occur repeatedly (WHO,2000:92). Many HIV positive children die from common childhood illnesses, rather than AIDS. Most of these deaths are preventable by early diagnosis and correct management (WHO, 2000:92). If there are reasons to suspect HIV infection (based on clinical signs or diagnoses in the family) and the child's HIV status is not known, the child should be tested for HIV, where possible (WHO,2000:93). Early treatment of HIV-positive infants reduces the death risk (Kaiser J.H. 2008).

Community members need to utilize the services for HIV testing in children so that infant mortality can be reduced. Knowing the HIV status can be the first step to utilize the available HIV & AIDS services and this is why the study will therefore assess the perception, knowledge, and practice of community members on HTC services in children.

1.4 Purpose of the study

The purpose of this study is to find out how much information the community members have on HTC in children and how the utilization of the HTC services are affected by their perception and knowledge.

1.5 Significance of the study

The conduction of this study will help in the following ways:

- The findings of this study will assist the community members to improve their understanding on the importance of HTC in children.
- The results of the study will also assist health care providers to improve the delivery of the HTC services, through improving their shortfalls.
- The findings will again assist other researchers in the same area of study to research more on the topic depending on the recommendations of the study.
- This research will also assist the government (Ministry of Health) in coming up with other strategies of addressing HTC in children in relation to the views of the community.

1.6 Objectives of the study

1.6.1 Broad Objective

To establish the community member's knowledge, perception and practice towards HTC services in children.

1.6.2 Specific Objectives

1. To assess the level of knowledge of community members on HIV testing in children.
2. To explore the factors that hinders the community from utilizing the HTC services in Phalombe.
3. To assess the community's attitude towards HTC in children.
4. To assess the level of satisfaction with the available HTC services.

1.7 Conclusion

HIV infection progresses faster in individuals with lower immunity than those with higher immunity. Like adults with HIV infection, children with HIV infection develop life threatening opportunistic infections because of their low developing immunity. Because of the risk of developing AIDS, the diagnosis of the HIV infection has to be made at an early stage in order to commence treatment as early as possible.

With the availability of HTC centres in different parts of Malawi, early diagnosis of HIV in children can benefit the nation to reduce the child mortality rate which AIDS is having an impact on. Therefore, there is need to explore the knowledge that the people have on HTC, their perception on having children tested for HIV and what they are practicing in relation to HTC in children so that improvements in provision of HTC services can be made.

CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

Literature review is carried out to ensure that the researcher's enquiry builds on the relevant work previously carried out by others (French S., Reynolds F. & Swain J. 2001:73). It is done in order to help the researcher understand the topic of study thoroughly, to reveal gaps and unresolved issues in other studies done and to provide a rationale for the current study (French et al, 2001:73). This section will reflect on the research studies done on HIV & AIDS in children in different parts of the world and here in Malawi.

2.2 Global studies on HIV & AIDS

HIV/AIDS is one the greatest threats to child development in many parts of the world. Stigma and the sense of hopelessness associated with HIV & AIDS greatly undermine the provision of care to children infected/affected by HIV & AIDS. Discrimination, neglect and isolation of children infected and affected by HIV & AIDS becomes eminent in households with persons suffering from HIV & AIDS (Save the children UK). Below are studies done in the field of HIV & AIDS in children.

In a study conducted in Sao Paulo, Brazil in 2002 on the desire for parenthood among men living with HIV revealed that; participants perceived their doctor's attitudes towards the desire of HIV positive men to become fathers, with as many as 2/3 of the men fearing a response of disapproval, this may explain the insufficient level of information they had with regard to preventing mother- to- child transmission of HIV. Other participants said wanting to have children is a legitimate wish for men and women, whether for religious reasons to give meaning to life, because of gender norms in which they have been socialized, to construct their masculine identity, or because they like children (Reproductive health matters, 2003:97-98).

2.3 Studies done in Sub-Saharan Africa

A study was done in a provincial hospital in Mombasa, Kenya, by Chersisch M.F, Luchters S.M, Othingo M.J, Yard E, Mandaliya K & Temmerman M, on HIV testing and counseling for women attending child health clinics: an opportunity for entry to prevent mother- to- child transmission and HIV treatment. The study assessed the potential for HIV testing at child health clinics to increase knowledge of HIV status, and entry to infant feeding counseling and HIV treatment. HIV testing and counseling were offered to women bringing their child for immunization or acute care services. 95.7% of the women said HIV testing should be offered in these clinics, with many citing the benefits of regular testing and entry to prevent mother –to- child transmission. After 50 participants, point-of –care testing replaced laboratory-based rapid testing. Uptake increased 2.6 times with point-of-care testing. From the study, the researchers concluded that measured by uptake and attitudes, HIV testing in child health clinics is acceptable. This could optimize entry into HIV treatment, infant feeding counseling and family planning services (Chersisch et al, 2008).

Another study done in Nigeria by Adeneye A.K, Salami K.K, Mafe M.A, Adeneye A.A, & Agomo P.U, in 2004 on the community perception of voluntary HIV counseling and testing in Ijebu communities of Ogun State in south west of Nigeria showed that there is urgent need for community mobilization and sensitization to boost knowledge about HIV & AIDS and VCT and its benefits in HIV and AIDS control in the country. In the study, twelve focus group discussions (FGDs) were held among men and women in six communities. All the FGD participants had heard and believed in the reality of HIV/AIDS.

Only a few of them had seen cases of full-blown AIDS. Some of them knew how HIV spreads and its prevention; there were misconceptions among others. There was a low self-perceived susceptibility to HIV infection among the participants. In the communities, the participants had no inclination to relate with HIV positive people. The people were willing in principle to seek VCT services. Those willing to seek VCT reasoned that knowing ones HIV status would give early opportunity of knowing if infected and enable one to seek treatment and care to help cope with the condition, and if negative, it would enable one know how to prevent infection. Almost all the participants advocated for the availability and accessibility of VCT services at

affordable costs in their localities. Some of those not willing to seek VCT highlighted their reasons: the issue of suspicion and its social consequences if the intention to seek testing is made known among couples and relations. Others not interested in seeking VCT had the fears and misconceptions regarding VCT. They were concerned about the confidentiality of test result if tested positive which they feared may predispose them to stigmatization, discrimination and rejection.

The study concluded that the reality of stigma associated with the disease is yet to start manifesting in the study area. It is possible that when services are actually available for use; actual willingness may wane (Adeneye et al, 2004).

De Baets A.J, Sifovo S, Parsons R, & Pazvakavambwa I.E, also conducted a research study on HIV disclosure and discussions about grief with Shona children: A comparison between health care workers and community members in Eastern Zimbabwe. This study investigated perceptions about the acceptability of disclosing the parents' or child's HIV status to a child and talking about grief with children, as well as the preferred time, type, and setting for HIV disclosure. An anonymous survey was taken from 64 primary health care workers and 131 community members from rural Eastern Zimbabwe.

The results expressed a high need and desire for such communications and should be interpreted against a background of high perceived confidence to talk about grief with adults and a high degree of familiarity with child bereavement and foster care. The participants preferred that partial disclosure occurs from the age of 10 years and full disclosure from the age of 14 years. Compared to community members, health care workers were significantly more open to full disclosure and disclosure at a younger age but were slightly less open to discussing grief. The different preferred combinations of persons to initiate such communications included a health care worker in up to 56% of the responses and a family member in up to 52%. The most commonly preferred family members were father's sister (up to 37%) and grandmother (up to 40%) rather than the partner (up to 15%) (De Baets et al, 2008).

2.4 Studies conducted in Malawi

In a survey done in Lilongwe by a non governmental organization, Lilongwe AIDS Counseling and Education Centre (LACE), on HIV antibody test, a community

perception, 900 clients were involved through group interviews. The results were that 562 clients said that positive results mean instant commencement of death. 208 clients said that HIV positive results mean that one was promiscuous. 93 clients (female) said husbands bring the virus into the family, therefore, it is their responsibility to undergo a test. 84 clients said that everyone has the virus, therefore no need to have the test. The discussions from this survey were that HIV & AIDS awareness messages have not influenced people's change of sexual behavior. The responses of people to HIV & AIDS messages depend on level of knowledge. The old HIV/AIDS delivery strategies should be substituted with new realistic ones (Mughogho, 1998).

A cross sectional study was also done in Malawi by Thurstans S., Kerac M., Maleta K., Banda T. & Nesbitt A. on HIV prevalence in severely malnourished children admitted to nutrition rehabilitation units in Malawi: Geographical & seasonal variations. The aim of this study was to collect country wide data on HIV infection patterns in severely malnourished children to guide the development of integrated care in a resource limited setting. 12 representative rural and urban nutrition rehabilitation units, from each of Malawi's 3 regions were involved. All children and their caretakers admitted to each nutrition rehabilitation unit over a two week period were offered HIV counseling and testing. Testing was carried out using two different rapid antibody tests, with PCR testing for discordant results. The survey was conducted once in the dry/post-harvest season, and repeated in the rainy/hungry season. 570 children were eligible for study inclusion.

Acceptability and uptake of HIV testing was high: 523 (91.7%) of carers consented for their children to take part; 368 (70.6%) themselves accepted testing. Overall HIV prevalence amongst children tested was 21.6%. Geographical prevalence variations were significant between the three regions with the highest prevalence being in the south; Northern Region 23.1%, Central Region 10.9% and Southern Region 36.9%. HIV prevalence was significantly higher in urban areas, 32.9% than in rural 13.2%. Nutrition rehabilitation unit HIV prevalence rates were lower in the rainy/hungry season 18.4% than in the dry/post-harvest season 30.9%. The researchers concluded that there is a high prevalence of HIV infection in severely malnourished Malawian children attending nutrition rehabilitation units with children in urban areas most likely to be infected. Testing for HIV is accepted by carers in both urban and rural

areas. Nutrition rehabilitation units could act as entry points to HIV treatment and support programmes for affected children and families (Thurstans et al).

In 1998 Atkinson V., Phiri K., Mulwafu W. & Graham S.M completed 105 surveys on knowledge and attitudes of caregivers to HIV testing of African children. The surveys were done at Queen Elizabeth central Hospital of which 36 were conducted in the inpatient ward and 69 in the outpatient clinic. The majority of the respondents were parents and the remainder of caregivers included grandmothers, aunts and older siblings. The age range of the children was 0-14 years of age. On overall, attitudes towards testing were positive with 98% responding that they would agree to HIV testing and 83% feeling that it was good for parents to know their child's HIV status. Of the caregivers who thought that it was not good for parents to know their child's status, the most frequent response was that parents would feel despair, fear of disappointment if they knew that their child had HIV infection.

Almost all (98%) felt that it was good for the health workers to know a child's status for the reasons of helping the child, making a diagnosis, and to be careful to prevent spread and many others, the commonest reason being that they could help the child. In response to questioning on hospital testing practices, 75% of respondents felt that all children admitted to hospital should be tested for HIV and 59% felt that doctors should obtain parental consent before testing. It was a belief of 27% that all children admitted to hospital are routinely tested and 29% felt that they did not have the right to refuse HIV testing for their child (Atkinson et al, 1998).

Obare F., Fleming P., Anglewicz P., Thorton R., Martinson F., Kapatuka A., Poulin M., Watkins S. and Kohler H.P. did a research study on acceptance of repeat population-based voluntary counseling and testing for HIV in rural Malawi. Behavioral and biomarker data were collected in 2004 and 2006 from approximately 3,000 adult respondents. In 2004, oral swab specimens were collected and analyzed using enzyme-linked immunosorbent assay (ELISA) and confirmatory Western blot tests while finger-prick rapid testing was done in 2006. The authors used cross-tabulations with chi-square tests and significance tests of proportions to determine the statistical significance of differences in acceptance of voluntary counseling and testing by year, individual characteristics, and HIV risk.

First, over 90% of respondents in each round accepted HIV test, despite variations in testing protocols. Second, the percentage of individuals who obtained their test results significantly increased from 67% in 2004 when the results were provided in randomly selected locations several weeks after the specimens were collected, to 98% in 2006 when they were made available immediately within the home. Third, whereas there were significant variations in the socio-demographic and behavioral profiles of those who were successfully contacted for a second HIV test, this was not the case for those who accepted repeat voluntary counseling and testing.

The results from this study suggest that variations in the success of repeat testing might come from contacting the individuals rather than from accepting the test or knowing the results. Repeat HIV testing at home by trained health care workers from outside the local area, and with either saliva or blood, is almost universally acceptable in rural Malawi, and thus likely to be acceptable in similar contexts (Obare et al, 2006).

2.5 Conclusion

HIV testing and counseling is a term well known among individuals but the application of this term in children is something that parents and guardians to the children are willing to do if they have enough knowledge of its importance. From the studies above, people feel the need to have children even if they are HIV positive. This can put the child at a risk of getting the infection from the mother. On the other hand, the parent's willingness for their children to get tested comes in because of the need for the child to get assisted after knowing whether the child is positive or not.

CHAPTER THREE: CONCEPTUAL FRAMEWORK

3.1 Introduction

This chapter will outline the conceptual model used and its application to this study. A study that has its roots in a specified conceptual model, the framework is often called the conceptual framework (Polit & Beck, 2008:118). Conceptual models provide a perspective regarding interrelated phenomena, but are more loosely structured than theories (Polit & Beck, 2008: 116). This study will use the Health Belief Model (HBM).

3.2 The Health Belief Model

The Health Belief Model by Becker, 1978, has become a popular conceptual framework in nursing studies focused on patient compliance and preventive health care practices.

The HBM states that the perception of a personal health behavior threat is itself influenced by at least three factors: general health values, which include interest and concern about health; specific health beliefs about vulnerability to a particular health threat; and beliefs about the consequences of the health problem. Once an individual perceives a threat to his/her health and is simultaneously cued to action, and his/her perceived benefits outweighs his/her perceived barriers, then that individual is most likely to undertake the recommended preventive health action. There may be some variables (demographic, sociopsychological, and structural) that can influence an individual's decision. The components of the HBM are as below:

Perceived susceptibility: a person's perception that a health problem is personally relevant or that a diagnosis is accurate. Each individual has his/her own perception of the likelihood of experiencing a condition that would adversely affect one's health. Individuals vary widely in their perception of susceptibility to a disease or condition. Those at low end of the extreme deny the possibility of contracting an adverse condition. Individuals in a moderate category admit to a statistical possibility of disease susceptibility. Those individuals at the high extreme of susceptibility feel

there is real danger that they will experience an adverse condition or contract a given disease (Polit & Beck, 2008:124).

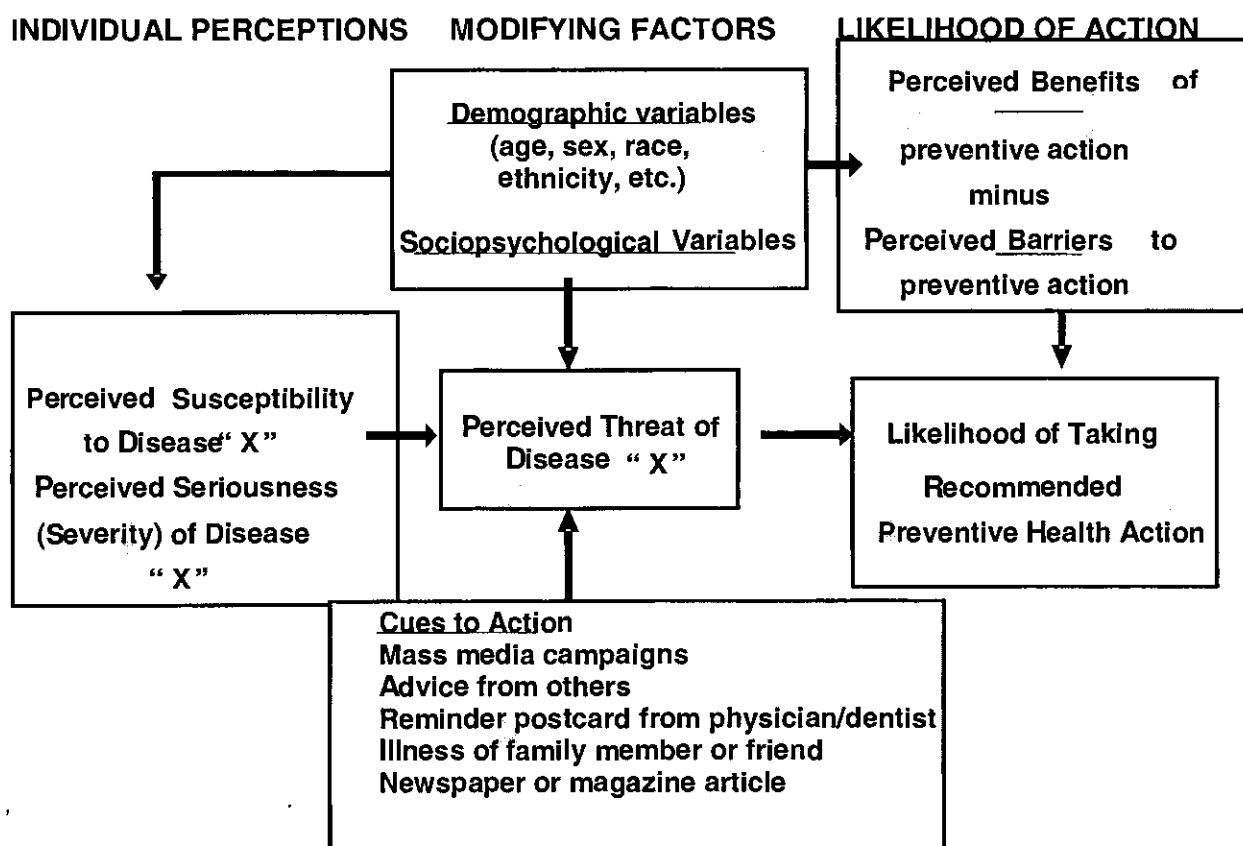
Perceived severity: refers to the beliefs a person holds concerning the effects a given disease or condition would have on one's state of affairs. These effects can be considered from the point of view of the difficulties that a disease would create. For instance, pain and discomfort, loss of work time, financial burdens, difficulties with family, relationships, and susceptibility to future conditions (Clemen-stone S., McGuire S.L. & Eigisti D. G. 2002: 387).

Perceived Benefits: taking action toward the prevention of disease or toward dealing with an illness is the next step to expect after an individual has accepted the susceptibility of a disease and recognized its seriousness. The direction of action that a person chooses will be influenced by the beliefs regarding the action (Clemen-stone et al, 2002:387).

Perceived Barriers: one's opinion of the tangible and psychological costs of the advised action. However, action may not take place, even though an individual may believe that the benefits to taking action are effective. This may be due to barriers. Barriers relate to the characteristics of a treatment or preventive measure that they may be inconvenient, expensive, unpleasant, painful or upsetting. These characteristics may lead a person away from taking the desired action (Polit & Beck, 2008:124).

Cues to Action: strategies to activate "readiness". An individual's perception of the levels of susceptibility and seriousness provide the force to act. Benefits (minus barriers) provide the path of action. However, it may require a 'cue to action' for the desired behavior to occur. These cues may be internal or external (Polit & Beck, 2008:124).

DIAGRAMATIC PRESENTATION OF THE HEALTH BELIEF MODEL



Health Belief Model, adapted from Clemen-stone S., Mc Guire S.L. & Eigisti D. G.
2002: 387

3.3 Application of the Model

The Health Belief Model (HBM) is a psychological model that attempts to explain and predict health behaviors. This is done by focusing on the attitudes and beliefs of individuals.

When parents or guardians (community members) to under five children perceive the children's likelihood of getting the HIV infection (susceptibility) and visualise the effects of the disease on the life of the children (severity), the parents or guardians are likely to utilise the HIV counselling and testing services available (benefits). When community members have perceived the susceptibility and seriousness of HIV to their children, activities within the community in relation to HIV & AIDS, such as; AIDS campaigns, National HIV testing week, or illness of other community members will enhance their perceived threat of HIV on their children.

After understanding how vulnerable children are to infection (due to martenal transmission), community members are likely to perceive the benefits of getting their children tested for HIV so that the children can benefit from the anti retro viral therapy (ART), if found positive. The likelihood of community members getting their children to be tested for HIV will depend on their perceived benefits of getting the children tested over their perceived barriers of getting the children tested. All this together with perceived threat of children having HIV will affect how the community members will utilise the HTC services for under five children

3.4 Conclusion

The conceptual model in research is very important. It helps to show the relationship of different concepts used in the study. From the HBM used, the community member's perception can result in different actions, whether children to be tested or not, depending on the modifying factors that are available.

CHAPTER FOUR: METHODOLOGY

4.1 Introduction

This chapter will give a layout and explain how the researcher will conduct the whole study. It will comprise of the description of the design of the study, the study setting, the sampling method, the data collection method, the pilot study, the data analysis and finally the ethical considerations in this study.

4.2 Study design

Research design is referred to as the overall plan for addressing a research question, including specifications for enhancing the study's integrity (Polit & Beck, 2008:765). This is done in order to come up with a way in which the researcher will formulate a plan to obtain data required to answer the research questions.

The study will be qualitative in nature and a descriptive design will be used. In this design, it focuses on how individuals and groups view and understand the world and construct meaning out of their experiences (Polit & Beck, 2008:763). In this research, the researcher will interact with the community members in order to capture their views and understanding of HTC services in children in Phalombe district. Qualitative research is the investigation of phenomena, typically in an in-depth holistic fashion, through the collection of rich narrative information using a flexible research design (Polit & Beck, 2008:763).

4.3 Study setting

This study will take place in Bokosi village. This village has been selected because of its closeness to Phalombe health centre, a government health facility offering HCT services, and also it is accessible to the community members. Bokosi Village is found in Traditional Authority (TA) Mkhumba in Phalombe district. Phalombe is one of the 28 districts and is in the Southern part of Malawi (National Statistical Office). Bokosi village is one of the 9 villages under TA Mkhumba.

According to Malawi National Statistic Office (2005) projection, Traditional Authority Mkhumba has a population of 72,000 people out of which 12, 700 are under five children. Traditional birth spacing is practiced and many mothers space their children between one to three years. According to DHS (2004) child bearing starts as early as fifteen years and by thirty years most women have an average of six children. This makes parents to have a heavy workload which may influence their health seeking behavior.

In Phalombe district, the District Health Management Team is in charge of health services headed by the District Health Officer (DHO). The DHO reports to the District Commissioner, who is the head of all the government departments in the district. Phalombe is a new district with no government district hospital. There are ten government health facilities, three mission health facilities and one mission hospital. In each facility there is a nurse and a clinician and an average of twenty Health Surveillance Assistants (HSAs) for the catchment area. Each HSA is supposed to look after a population of 1,000 people. Group Village Bokosi is served by one government health facility (Phalombe Health Centre) and one mission hospital (Holy Family). Both facilities offer HCT services to the community. Each site has two counselors who are trained H.SAs, (Phalombe District Profile, 2007).

4.4 Sampling

Sampling is the process of selecting a portion of the population to represent the entire population so that inferences about the population can be made (Polit & Beck, 2008:339). The study will use purposive sampling method. In this method of sampling it involves hand-picking cases that will most benefit the study (Polit & Beck, 2004:294). The aim is to select subjects who are particularly knowledgeable about the issues under study (Polit & Beck, 2004:294). The participants will be parents or guardians to under 5 children. This will be so because they are the ones who make decisions regarding their children's health on whether to seek medical attention or not. The age group of under 5 year olds has been chosen because this is the period when the child is developing its own antibodies and during this period the child is prone to infections. This can be a good period for parents or guardians to decide on

having their child tested to exclude HIV as the cause of the recurrent childhood infections.

4.5 Data collection tool

A focus group discussion guide will be used when collecting data. The guide will be developed by the researcher. Following its development, to ensure the credibility of the data, triangulation (use of multiple referents to draw conclusions about what constitutes the truth) will be used. The researcher will use person triangulation which involves collection of data from different groups of people, i.e. females, males and both females and males together; with the aim of validating the data through multiple perspectives of the phenomenon (Polit & Beck, 2008:431).

4.6 Data collection

The process of data collection has to be planned, the how and in what sequence data will be collected from a single subject (Burns & Grove, 2005:421). The researcher will collect data using the focus group discussion technique. This interactive group discussion will be led by the moderator (the researcher). The discussion will be loosely structured to encourage free flow of ideas. There will be 3 groups of 6-10 participants each. One group will consist of women only, the other one of men only and last group will consist of both men and women. The discussions will last for 45-60 minutes and data will be collected using a recorder, note taking will also be done to capture important points. Data will be collected on a maximum of 4 days in the month of September 2009.

4.7 Pilot study

This is the administration of a newly developed instrument to identify flaws or assess time requirements (Polit & Beck, 2008:762). A pilot study will be conducted to identify parts of the instrument package that are difficult for pretest subjects to understand or that may have been misinterpreted. This study will also be conducted to determine whether the instrument is sensible and also to determine any other needs of the data collector. The pilot study will be conducted in Bokosi village and one focus

group discussion will be conducted in which 6-10 people will be involved. Participants in the pilot study will not be involved in the main study. The pilot study will be carried out in August 2009.

4.8 Data analysis

Morse & Field (1995) in Polit & Beck 2008:508 noted that qualitative analysis is a process of fitting data together, of making the invisible obvious, and of linking and attributing consequences to antecedents. It is a process of conjecture and verification, of correction and modification, of suggestion and defense. The purpose of the data analysis is to organize, provide structure to, and elicit meaning from research data (Polit & Beck, 2008:507). Data analysis will begin after collecting data from the first group and this will involve synthesis of all the collected data. Data will be transcribed word by word from the recorded discussions and then it will be translated into an English version. Then data will be analyzed manually using the editing analysis style. According to Polit & Beck, 2008:508, this style involves the researcher to read through the data in search of meaningful segments and units. Once segments are identified, the researcher develops a category scheme and corresponding codes. This then can be used to sort and organize the data. The researcher will then search for the patterns and structure that connect the categories. The researcher will be the one who will conduct the whole process of analyzing the collected data, thus transcription, translation, and analysis of the data.

4.9 Ethical considerations

In research ethical considerations means that the subjects' rights and the rights of others in the setting are protected (Burns & Grove, 2005:83). Ethical considerations are important in research involving human beings because they provide the basis for moral conduct in respect to human life, dignity, integrity and authority.

Before conducting the study, an ethical approval and study clearance will be obtained from the Kamuzu College of Nursing Research and Publications Committee. Also letters requesting permission to conduct the study will be written to the district commissioner and the district health officer of Phalombe district.

To ensure that the participants are ethically protected, participants will voluntarily participate in the study and they will be required to give an informed consent. Each participant, before participation, will be given an explanation of the nature of the study, that the study will involve the conduction of group discussions and the results of the study will help to improve the delivery of HTC services for better utilization. A description of the benefits of the study will also be explained to the participants, they will be informed that no personal benefits or favours will be provided to them as part of the research study, but the study will help to improve their knowledge on HTC in children. Participants will also be explained that they have freedom to withdraw from the study after accepting to participate if they feel they can not cope with the study. After the participants have understood the nature of the study and have accepted to participate in the study, they will be requested to sign a consent form which will serve as evidence that they have agreed to participate without being forced. The researcher's contacts will be indicated on participants consent forms in case the participants may need clarifications.

In the study, participant's information will be kept in a lockable drawer and it will be accessible to the researcher and her supervisor only. Also the recorded data during data collection will be deleted at the end of the study. All this will be done to ensure that confidentiality is being maintained. To ensure privacy, during data collection each focus group discussion will be conducted in a room where there will be the participants and the researcher only.

Those participants, who will have emotional breakdown during the focus group discussions, shall be confronted and counseled accordingly by the researcher and if further management will be required, they shall be referred to the nearest health facility for further management.

4.10 Conclusion

In a research study, the methodology gives a layout of how the research will be like. This chapter had an overview of the study design; it explained the nature of the study, also the place where this study will be conducted, who will be involved in the study,

how they are to be selected and the instrument to be used when collecting data and how the data will be collected. The chapter also explains of when a pilot study will be conducted and who will be involved in the study, how the data will be analyzed and who will analyze it and finally it looked into which ethical considerations to be ensured in conducting the study.

REFERENCE

- Adeneye A.K, Salami K.K, Mafe M.A, Adeneye A.A & Agomo P.U. (2004). Community perception of voluntary HIV counseling and testing in Ijebu communities of Ogun state in south west of Nigeria. International Conference on AIDS: abstract no. E10831. Nigerian Institute of Medical Research, Yaba, Lagos, Nigeria. <http://gateway.nlm.nih.gov/meetingabstracts/ma?f=102278660.html> -accessed on 16th May 2009.
- Atkinson V., Phiri K., Mulwafu W., & Graham S.M. (1998). Knowledge and attitudes of caregivers to HIV testing of African children. Department of pediatrics, College of Medicine, University of Malawi. Malawi Medical Journal Blantyre.
- Burns N. & Grove S.K (2005). The Practice of nursing Research, Conduct, Critique & Utilization (5th edition). Elsevier Saunders, St Louis.
- Chersich M.F, Luchters S.M., Othigo M.J., Yard E., Mandaliya K. & Temmerman M. (2008). HIV testing and counselling for women attending child health clinics: an opportunity for entry to prevent mother-to-child transmission and HIV treatment. Int J STD AIDS. 2008 Jan; 19(1):42-6.
- Clemen-stone S., Mc Guire S. L. & Eigisti D.G. (2002). Comprehensive community Health Nursing. Family, Aggregate & Community Practice (6th edition). Mosby, St. Louis.
- De Baets A.J., Sifovo S., Parsons R. & Pazvakavambwa I.E. (2008). HIV disclosure and discussions about grief with Shona children: A comparison between health care workers and community members in Eastern Zimbabwe. Soc Sci Med 2008; 66: 479-491. <http://hivthisweek.unaids.net/category/hiv-testing/> -accessd on 16th May 2009.

- French S., Reynolds F. & Swain J. (2001). Practical Research. A guide for therapists (2nd edition). Butterworth Heinemann, Oxford.
- Graham P. (2009). HIV/AIDS in Malawi. www.avert.org-aids/africa - accessed on 18th May 2009.
- Hung Y.F., Ross F.C. & Luis P.V. (2007). AIDS Science & Society (5th edition). Jones & Bartlett publishers, Boston.
- Info Project (2003). HIV/AIDS epidemic in sub Saharan Africa. Volume xxxi, number 2.
- Information please, Database (2007). HIV & AIDS. Pearson Education. www.infoplease.com/sciencs/health/globe-peak-aids-prevalence.html - accessed on 18th May 2009.
- Kaiser J.H. family foundation (2008). Kaiser Daily HIV/AIDS Report.
- Longe J.L. (2006). The Gale Encyclopedia of Nursing & Allied health (2nd edition, volume 2). Thomson Gale, Detroit.
- Prevalence of HIV in sub Saharan Africa. Morbidity and Mortality weekly report, June1, 2001/vol.50/no.21.
- Mughogho. (1998). HIV antibody test, a community perception. International conference on AIDS: abstract no. 43148. Lilongwe AIDS Counselling and Education Centre. Malawi.
<http://gateway.nlm.nih.gov/meetingabstracts/ma?f=102231314.html> -accessed on 24th May 2009.
- National HIV & AIDS Policy. A call to renewed action. Office of President and Cabinet, National AIDS Commission. October 2003.

- Obare F., Fleming P., Anglewicz P., Thornton R., Martinson F., Kapatuka A., Poulin M., Watkins S. & Kohler H.P. (2006). Acceptance of repeat population-based voluntary counseling and testing for HIV in rural Malawi. Sex Transm Infect 2008 Oct 16. <http://hivthisweek.unaids.net/category/hiv-testing/> - accessed on 24th May 2009.
- Polit D.F. & Beck C.T. (2008). Nursing Research, Generating & Assessing Evidence for Nursing Practice (8th edition). Lippincott Williams & Wilkins, Philadelphia.
- Reproductive health matters (2003). HIV/AIDS, sexual reproductive health: intimately related. Volume ii, number 22, November 2003.
- USAID, MALAWI. HIV/AIDS Health Profile (2008). www.usaid.gov/our-work/global-health/aids/countries/africa/malawi - accessed on 12th May 2009.
- Save the children UK (2003). Care for children infected and those affected by HIV/AIDS. A training manual for community health workers. Kampala.
- Thurstans S., Kerc M., Maleta K., Banda T. & Nesbitt A. (2008). HIV prevalence in severely malnourished children admitted to nutrition rehabilitation units in Malawi: Geographical & seasonal variations. a cross sectional study. BMC Pediatr, 2008; 8:22. <http://hivthisweek.unaids.net/category/hiv-testing/> -accessed on 21st May 2009.
- UNAIDS (2008). Report on the global AIDS epidemic. July 2008.
- US Centers for Disease Control and Prevention, 11 august 2006. The global HIV/AIDS Pandemic, 2006. www.thebody.co/content/art1703.html -accessed on 12th May 2009.

- Walker N., Schwartlander B. & Bryce J. (2002). Meeting International Goals in Child Survival and HIV/AIDS. The Lancet, volume 360, issue 9329. Elsevier.
- WHO (2000). Management of the child with a serious infection or severe malnutrition. Guidelines for care at the first- referral level in developing countries. Geneva.
- WHO Reports on global HIV/AIDS situation. 2008 report on the global AIDS epidemic. jc1510-2008-global-report-pp2

RESEARCH BUDGET

ITEM	COST IN MALAWI KWACHA	TOTAL COST IN MALAWI KWACHA
Stationery		
Photocopying papers x 3 reams	800	2,400.00
Printing papers x 2 reams	800	1,600.00
Ball pens x 2	25	50.00
Small envelopes x 5	10	50.00
Large envelopes x 5	30	150.00
Writable CD's x 2	100	200.00
MP3 recorder	5000	5000
Small batteries x 4	25	100
Writing pad x 1	50	50.00
Sub total		9600.00
Secretarial services		
Proposal printing x 4 copies (50 pages)	10	2000.00
Proposal binding x 4 copies	300	1200.00
Printing consent letters x 5	10	50.00
Dissertation printing x 4 copies	10	2000,00
Dissertation binding	300	1200,00
Sub total		6450.00

Communication		
Telephone calls x 5 \$	140	700.00
Transport for data collection	1500	3000.00
Internet services	30	900.00
Sub total		4600.00
Allowances		
Food cost	----	1200.00
Contingency	----	2000.00
Sub total		3200.00
GRAND TOTAL		23850.00

BUDGET JUSTIFICATION

For this research study to be conducted money will be required for the resources needed. Money has been allocated for the stationery because papers will be required for development of the study, typing and printing of the proposal, focus group discussion guide, consent forms and letters and dissertation report. The small envelopes will be used for posting the letters while the large envelopes will be used for posting the dissertation reports. Writable CD's will be required to store information during the development of the study and a writing pad will be needed to take notes during data collection. Some money will be used to buy an MP3 recorder which will be used during data collection and small batteries will be required to keep the recorder running.

Money has also been allocated for secretarial services because at the end of finalizing the proposal and dissertation report, they have to be bound.

Another sum of money has been allocated for communication. Money will be needed to buy airtime to communicate with the supervisor and other influential personnel. Also this money will be used for transport for the researcher to collect the data. Internet services where information for this research study will be sourced from will also require the same money.

Lastly, money for allowances has been set aside. This money will be used for food cost during the period of data collection and some has been allocated for any incidentals that may occur during the study period.

TIME LINE

ACTIVITY	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
Literature Review									
Proposal Writing									
Proposal Submission									
Clearance									
Pre- Testing									
Data Collection									
Data Interpretation									
Report Writing									
Dissemination of Results									

APPENDICES

APPENDIX 1: FOCUS GROUP DISCUSSION GUIDE

ID CODE.....

DATE.....

DEMOGRAPHIC DATA

1. Age

18-28

29-39

40 and above

2. Sex

Male

Female

3. Denomination

CCAP

Roman Catholic

Islam

Other.....

4. Educational level

MSCE

JCE

Other.....

5. Marital status

Married

Widowed

Divorced

Single

KNOWLEDGE, PERCEPTION AND PRACTICE ON HIV COUNSELLING AND TESTING IN CHILDREN

1. What do you know about HIV & AIDS?
 - What do you know about it in children?
2. What do you know about HTC?
 - What do you know about it in children?
3. What is the importance of HIV testing and counseling?
4. Where do people go for HIV testing and counseling in this area?
 - Do you go yourself?
5. How can you describe HTC services in this area?
6. What other services do they provide at the HTC centre?
7. What is the practice like in your family when a child is sick?
8. What do you think are the factors that hinder people from using HTC services in this area?
 - Religion
 - Privacy
 - Waiting hours
 - Culture
9. What is your attitude towards taking under 5 children for HIV testing and counseling?
10. What challenges do you face when you have taken your child to get tested for HIV?
 - How do you overcome the challenges?

APPENDIX 2: FOCUS GROUP DISCUSSION GUIDE

ID CODE..... DATE.....

ZA MOYO WANU

1. Muli ndi zaka zingati zakubadwa?

18-28

29-39

40 kupita mtsogolo

2. Ndinu amuna kapena akazi?

Amuna ☐

Akazi ☐

3. Mumapemphera mpingo wANJI?

CCAP

Katolika

Chisilamu

Zina.....

4. Sukulu munalekeza kalasi yANJI?

Folomu 4

Folomu 2

Zina.....

5. Muli pa banja

Eya ☐

Ayi ☐

ZA MAGANIZO NDI MCHITIDWE WA ANTHU KUMBALI YOTI ANA AZIYEZEDWA MAGAZI KUTI ADZIWE NGATI ALI NDI KACHILOMBO KOYAMBITSA MATENDA A EDZI

1. Mumadziwapo chani za kachilombo ka HIV ndi matenda a Edzi?

-Nanga kumbali ya ana mumadziwapo chani za matendawa?

2. Mumadwiwapo chani pa zolandila uphungu ndi kuyezetsa magari kuti munthu adziwe Ngati ali ndi kachilombo koyambitsa matenda a edzi?

-Nanga nkhani yomweyi kumbali ya ana mukudziwapo chani?

3. Kodi ndi ubwino wanji umene ungakhalepo ngati mwalandila uphungu ndipo mwana wayezedwa magari kuti mudziwe ngati ali ndi kachilombo koyambitsa matenda a edzi ?

4. Kodi ndi malo ati kumene anthu amalandila uphungu ndi kuyezetsa magari m'dera lanu lino?

-Kodi inuyo mumapitako?

5. Mungafotokoze chani za ku malo oyezetselako magari ndi m'mene amapelekela chithandizo m'dera lanu lino.

6. Ndi zina ziti zomwe mumathandizidwa mukapita koyezetsa magari?

7. Mchitidwe wa m'banja mwanu ndi wotani mwana akadwala?

8. Kodi mukuganiza kuti chimawalepheretsa anthu kupita kumalo oyezetsela magari mdera lanu lino ndi chani?

- Chipembedzo

- Chinsinsi

- Kalandilidwe ka anthu ku malowo

- Nthawi yodikila kuti muthandizidwe

9. Maganizo anu ndi otani kuti ana aziyzedwa magari kuti mudziwe ngati ali ndi kachilombo koyambitsa matenda a edzi?

10. Kodi ndi mavuto ati amene mumakumana nawo mukapita ndi ana anu kumalo woti akayezedwe magari?

-Nanga mavuto amenewa mumathana nawo bwanji?

APPENDIX 3: CLEARANCE LETTER TO KAMUZU COLLEGE OF NURSING RESEARCH AND PUBLICATIONS COMMITTEE

University of Malawi,
Kamuzu College of Nursing,
Private bag 1,
Lilongwe
12th June, 2009.

The Chairperson,
Research and Publications Committee,
Kamuzu College of Nursing,
Lilongwe.

Dear Sir/ Madam,

PERMISSION TO CARRY OUT A RESEARCH STUDY IN PHALOMBE DISTRICT

I am a fourth year student at the above college. In partial fulfillment of the Bachelor of Science Degree in Nursing, I am required to carry out a research study on a topic of my choice. The study topic is: **‘Knowledge, perception and practice of community members on HIV counseling and testing services in children in Phalombe district’**.

The purpose of the study is to establish the community members’ knowledge, perception and practice towards HIV counseling and testing in children. The study will be conducted in September 2009. Participants of this study will be community members in Bokosi village.

The purpose of this letter is to request your approval to carry out this study.

Please find attached the proposal to be approved.

Yours sincerely

FELISTAS MPACHIKA

APPENDIX 4: LETTER TO PHALOMBE DISTRICT HEALTH OFFICE

University of Malawi,
Kamuzu College of Nursing,
Private bag 1,
Lilongwe

The District Health Officer,
Phalombe District Health Office,
Post office Box 79,
Phalombe.

Dear Sir/ Madam,

PERMISSION TO CARRY OUT A RESEARCH STUDY IN PHALOMBE DISTRICT

I am a fourth year student at the above college. In partial fulfillment of the Bachelor of Science Degree in Nursing, I am required to carry out a research study on a topic of my choice. The study topic is: **‘Knowledge, perception and practice of community members on HIV counseling and testing services in children in Phalombe district’**.

The purpose of the study is to establish the community members’ knowledge, perception and practice towards HIV counseling and testing in children. The study will be conducted in September 2009. Participants of this study will be community members in Bokosi village.

The purpose of this letter is to seek permission to carry out this study.

Yours sincerely

FELISTAS MPACHIKA

Contacts:

Tel: 0995463200 / 0888678702

APPENDIX 5: LETTER TO PHALOMBE DISTRICT COMMISSION

University of Malawi,
Kamuzu College of Nursing,
Private bag 1,
Lilongwe

The District Commissioner,
Phalombe District Assembly,
Post office Box 78,
Phalombe.

Dear Sir/ Madam,

PERMISSION TO CARRY OUT A RESEARCH STUDY IN PHALOMBE DISTRICT

I am a fourth year student at the above college. In partial fulfillment of the Bachelor of Science Degree in Nursing, I am required to carry out a research study on a topic of my choice. The study topic is: **'Knowledge, perception and practice of community members on HIV counseling and testing services in children in Phalombe district'**.

The purpose of the study is to establish the community members' knowledge, perception and practice towards HIV counseling and testing in children. The study will be conducted in September 2009. Participants of this study will be community members in Bokosi village.

The purpose of this letter is to seek permission to carry out this study.

Yours sincerely

FELISTAS MPACHIKA

Contacts:

Tel: 0995463200 / 0888678702

APPENDIX 6: INFORMATION LETTER TO PARTICIPANTS

I am Felistas Mpachika, a fourth year student at Kamuzu College of Nursing. Currently, I am pursuing a Bachelor of Science Degree in Nursing (Generic). In partial fulfillment of the requirements of the degree programme, I am requested to conduct a research project. The title of the study is **“Knowledge, perception and practice of community members on HIV counseling and testing in children in Phalombe district”**. The results of the study will help the community members to improve their knowledge on HIV counseling and testing in children and also will assist the health workers in improving the delivery of the services for maximum utilization.

I would like to get a consent from you to be included in the study, which will be conducted in September 2009. You will be involved in group discussions where you will be asked questions and you are expected to answer freely and truthfully. You are free to withdraw your consent or discontinue your participation in the study any time you feel like doing so without any penalty.

Be assured that the information collected will be confidential. Only the researcher will have access to the information. There are no specific direct benefits to you personally because of participating in this research but this will benefit the whole community.

Below are my contact details, you can contact me if you require clarifications for the details of the study.

You have been chosen to participate in this study. If you accept please sign the consent form on the next page.

Kamuzu College of Nursing
Private Bag 1,
Lilongwe.
Tel: 0888678702 / 0995463200

APPENDIX 7: CONSENT FORM

I have been informed fully about this research study and I have accepted to participate in the study.

Participant's signature..... Date.....

Researcher's signature..... Date.....

APPENDIX 8: KALATA KWA ANTHU OTENGA NAWO MBALI MUKAFUKUFUKU

Ine ndine Felistas Mpachika, wophunzira wa pa sukulu ya ukachenjede ya unamwino ndi uzamba ya Kamuzu koleji ku Lilongwe yomwe ili pa fupi ndi chipatala chachikulu cha Kamuzu sento. Pofuna kukwaniritsa zolinga zamaphunziro, ndikuyenera kupanga kafukufuku. Mutu wa kafukufuku wanga ndi **“Maganizo ndi mchitidwe wa anthu kumbali yoti ana aziyezetsa magari ndi kulandila uphungu kuti adziwe ngati ali ndi kachilombo koyabitsa matenda a edzi m'boma la Phalombe”**. Zotsatira za kafukufukuyu zidzathandiza anthu kuti awonjezele nzeru zawo pazimene akudziwa kumbali yoti ana aziyzedwa magari, komanso zizathandiza anthu wogwira ntchito ya chipatala kupititsa patsogolo m'mene angathandizile ana kuti aziyzedwa ndipo azatha kupeza njira zoti anthu ambiri azitha kutengere ana awo kumalo woyezetsela magari.

Ine ndikufuna kupempha chilolezo kuti mutenge nawo mbali mukafukufukuyu mosaumirizidwa. Mukhala m'magulu azokambilana ndi anthu ena ndipo ndikufunsani mafunso ndipo muyenera kuyankha momasuka komanso mwachilungamo. Muli ndi ufulu kusiya kutenga nawo mbali mukafukufukuyu nthawi ina iliyonse yomwe mwafuna ndipo simudzaimbidwa mulandu.

Dziwani kuti zokambirana zikhala za chinsinsi. Dzina lanu sililembedwa pa pepala la mafunso. Ndipo ndiyekhayo amene akupanga kafukufuku ndi woyang'anira wake amene akakhale ndi mwayi woona zonse zamukafukufukuyu. Palibenso mphatso ina iliyonse yoperekedwa chifukwa choti mwalowa nawo mukafukufukuyu koma zotsatila zakafukufukuyu zidzathandiza anthu a m'dera lino komanso a m'boma lino. Inu mwasankhidwa kukhala nawo mukafukufuyu. Ngati mwavomera lembani pa tsamba lotsatilalo.

Mukafina kudiwa zambiri funsani ku keyala ili m'musiya:

Kamuzu college of Nursing

P/ Bag 1

Lilongwe

Foni: 0888678702 / 0995463200

APPENDIX 9: CHITSIMIKIZO CHOVOMEREZA KUKHALA
MUKAFUKUFUKU

Ndadziwitsidwa zonse zokhudzana ndi kafukufukuyu ndipo ndavomera kuti nditenge nawo mbali.

Ndine..... Tsiku.....

Wochititsa kafukufuku..... Tsiku.....