A STUDY ON FEMALE TEACHER TRAINEES' AWARENESS AND PERCEPTION OF VOLUNTARY COUNSELLING AND HIV/AIDS TESTING: A CASE STUDY OF KERICHO TEACHERS' TRAINING COLLEGE, KERICHO DISTRICT, KENYA.

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A Research Project Report submitted to Graduate School in Partial Fulfillment of the Requirements for the Award of the Degree of Master of Education in Guidance and Counselling of Egerton University.

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DECLARATION

This research report is my original work and has not been previously presented for the award of a degree in any other university.

Cherono Alice Bett — Date: 4TH APRIL 2005

RECOMMENDATION

This research report has been submitted for examination with my approval as a university supervisor.

Dr. Chepchieng M.C — Date: 31/05/05

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DEDICATION

This research project is dedicated to God who, at the beginning of the course, whispered to me, "I will help you". To my beloved husband, Vincent and children Gamaliel, Gideon, Michael and Jean.

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ABSTRACT

Acquired Immune Deficiency Syndrome (AIDS) remains the world's gravest threat to future generations, especially the women population. Currently, there is an indication that women are now infected with Human Immunodeficiency virus (HIV) more than men. This has necessitated studies on women populations. In effect, the main purpose of the research was to investigate female teacher trainees' awareness and perception of Voluntary Counselling and testing in order to establish their HIV status and curb the spread of HIV/AIDS. The study was carried out at Kericho Teachers' Training College, Kericho District of Rift Valley Province, Kenya. The target population was 500 First and Second year female teacher trainees and stratified random technique was applied to draw them from their classes. Out of this population, 218 females students from each stratum were sampled out by using simple random sampling method. Data was collected by the use of a questionnaire which was administered to the selected sample. The questionnaire was tested for reliability by means of Kuder-Richardson (K-R 21) method. Data collected was analysed using the Statistical Package for Social Sciences (SPSS) version 11.5 for Windows. The presentation of the results was in form of frequencies, percentages and means. Also t-test statistical technique was used to test whether significant differences existed between variables. The major findings of the study were as follows: Female teacher trainees had adequate awareness and perception of voluntary counselling and testing having learnt from the media and forums. The year of study, marital status and home location was found to be statistically insignificant in their awareness and perception of voluntary counselling and testing. Religious leaders and college lecturers were found to have contributed a lot to awareness of voluntary counselling and testing in training colleges but Medical and Anti-Aids personnel had a low participation. The study may benefit the Government of Kenya, in particular, the Ministries of Education and Health in the provision of adequate and quality Voluntary Counselling and testing services in the various institutions of learning and health

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LIST OF ABBREVIATIONS

AIDS	-	Acquired Immune Deficiency Syndrome
DEO	-	District Education Officer
HIV	-	Human Immunodeficiency Virus
ICASA	-	International Conference on AIDS and STIs in Africa
KANCO	-	Kenya AIDS NGOs Consortium
NASCOP	-	National AIDS STDs Control Programme
NCPD	-	National Council for Population and Development
PLWA	-	People Living With AIDS
STDs	-	Sexually Transmitted Diseases
TSC	-	Teachers' Service Commission
UNAIDS	-	Joint United Nations Programme on AIDS
VCT	-	Voluntary Counselling and Testing

CHAPTER ONE

INTRODUCTION

1.1 Background of the Study

Acquired Immune Deficiency Syndrome (AIDS) is currently the world's most devastating threat. It has not shown any signs of abating since its emergence at the turn of the last century, and it has consigned millions of people to their graves (Omayio, 2003). In fact, Feacham (2003) has noted that the disease is spreading far faster than global efforts to stop it. Accordingly, the pandemic is galloping out of control. Recent United Nations figures indicate that about 65 million people have contracted HIV/AIDS in the last 20 years and 28 million are already dead (UNAIDS, 2000). Moreover, the global update indicate that women are now more infected with HIV/AIDS than men and well above 40 million people are now living with the disease (UNAIDS, 2003).

Interestingly, it seems that Africa is at the epicentre of the global HIV/AIDS pandemic with an estimated 26.6 million Africans already carrying the killer disease. This, according to UNAIDS (2003) has been exacerbated by a combination of poverty and ignorance. In addition, the Kenya AIDS NGOs Consortium, (KANCO, 2000) has revealed that Sub-Saharan Africa is currently the worst affected region by the HIV/AIDS pandemic in the world. As such, it has been reported that the region is now a home to about 30% of the people living with HIV/AIDS (UNAIDS, 2000). Mai (2003) concur in stating that one in five adults in Sub-saharan Africa is living with HIV/AIDS; this being the highest rate since the epidemic began. The Sub-Saharan Africa situation is clearly observed from table 1 that compares it with other regions of the world.

Table 1: Regional new HIV infections and deaths in 2003

Region	New infections 2003	Adult and children deaths 2003
North America	45,000	15,000
Carribbean	60,000	42,000
Western Europe	30,000	8,000
Eastern Europe and Central Asia	250,000	25,000
Latin America	150,000	60,000
North Africa and Middle East	83,000	37,000
South and South East Asia	800,000	440,000
Sub-Saharan Africa	3,500,000	2,400,000
Australia and New Zealand	500	>100
East Asia and Pacific	270,000	45,000

Source: UNAIDS (2003), Graphic News

Consequent upon this devastating HIV/AIDS situation in Sub-saharan Africa, African leaders have from time to time made concerted efforts to fight against this pandemic (Nation Reporter, 2003). This is because the gains in democracy and stability that Africa is experiencing is lost because of the HIV/AIDS pandemic (Makoki, 2001). Therefore, African leaders must join forces to battle the killer HIV/AIDS virus which is robbing the continent of its future.

In Kenya, the first HIV/AIDS case was recognised in 1984 and by the end of the same year, seven more cases were identified (NASCOP, 1999). In 1985, the National AIDS Committee was established by the Ministry of Health to advise the Ministry on matters pertaining to HIV/AIDS control. But, despite all the efforts made, the epidemic continues unabated with the population growth rate substantially reduced from 4.1 per cent per annum in 1979 to the present 2.3 per cent per annum (NCPD, 1999). Thus, the biggest challenge facing the Kenyan population today remains HIV/AIDS epidemic. Therefore, there is a great need for all Kenyans to be involved in the reduction of HIV/AIDS infection rates. Tengo (2002) has stated that the youth need information to avoid HIV/AIDS

infections. In the same vein, the Family Planning Association of Kenya (FPAK) reported that 50 per cent of young Kenyans have had sex by the age of 15 years yet many still lack information and counsel on the reproductive health (Muganda, 2003). Surprisingly, young females are vulnerable to the HIV/AIDS infections than males because of being uninformed, coerced or raped and to be enticed into sex by older, stronger or richer men (Odei, 2003).

In Kenya, it is paramount to note that AIDS prevalence is higher in rural areas with 62 percent of people infected than in towns (NASCOP, 2003). This has been attributed to the fact that organisations fighting the disease concentrate their activities in towns so that those people in the rural areas lack vital information on HIV/AIDS for instance voluntary counselling and testing. However, many factors and forces may exist that restrict people's autonomy and leave them exposed to HIV infection and are vulnerable to needless suffering once they are infected. This include the following:-

i) Discrimination against people suspected to be with HIV infection.

ii) Lowered status of women, hence abused by wealthier individuals

iii) Scarcity of Voluntary Counselling and testing facilities.

iv) Lack of respect for the human right to information and Education.

It is for this reason that International Conference on AIDS and STIs in Africa (ICASA, 2003) urged Kenyans to go for voluntary counselling and testing to establish their HIV status and to curb the spread of the AIDS epidemic. In effect, this would help in managing the spread and treatment of the scourge. However, the right to information about HIV transmission and prevention is sometimes denied to young people on the grounds that

they should be sexually abstinent (UNAIDS, 2000). Consequently, in some places young people are more vulnerable than the elders because they lack knowledge about HIV/AIDS to protect themselves and in particular the voluntary counselling and testing services (Muganda, 2003). Therefore in the absence of a cure or vaccine of the scourge, education, creation of awareness and the right perception about Voluntary Counselling and testing remains the most effective way to contain this deadly disease (Omayio, 2003). Thus, the need to investigate on awareness and perception of voluntary counselling and testing among college female students.

1.2 Statement of the problem

According to HIV/AIDS global overview 2003, the AIDS epidemic shows no signs of abating. Infact, five million new people were infected with HIV and three million died in the year 2003 alone (Chege, 2004). The pandemic has been observed to rob poor families of bread winners and leaving millions of orphans. It has also been noted that it affects mostly the young and most economically productive, skilful, talented and those with expertise in various fields. This high death rate and economic impact of the scourge could be attributed to people's ignorance of their HIV/AIDS status that has rendered the global efforts to arrest the scourge futile. It is therefore important for people to know their HIV status in order to protect themselves and others hence help curtail the spread of the pandemic as well as counsel the infected ones.

In recent years, basic knowledge of HIV/AIDS has increased among young people. However, this has been observed to be low especially among young women (UNAIDS, 2003). This could be attributed to women's lack of freedom, power and knowledge to make

decisions about their reproductive health, coupled with the perception they may have towards voluntary counselling and testing. Consequent upon this, is the need to carry out an intense research among the female population. Hence, the study aims at investigating the level of awareness and perception of female teacher trainees towards voluntary counselling and testing.

1.3 Purpose of the study

The purpose of the study was to investigate female teacher trainees' awareness and perception of voluntary counselling and testing.

1.4 Objectives of the study

Specifically, the study attempted to achieve the following objectives:-

i) Determine female teacher trainees' level of awareness and perception of voluntary counselling and testing.

ii) Determine whether female teacher trainees' year of study influence the level of awareness and perception of voluntary counselling and testing.

iii) Determine whether differences exist in perception of voluntary counselling and testing between the married and unmarried female teacher trainees.

iv) Find out whether differences exist in perception of voluntary counselling among rural and urban female teacher trainees.

1.5 Research questions

This section presented the research questions.

i) What is the female teacher trainees' level of awareness and perception of voluntary counselling and testing?

ii) Does the female teacher trainees' year of study influence their level of awareness and perception of voluntary counselling and testing?

iii) Does a difference exist in the perception of voluntary counselling and testing between the married and unmarried?

iv) Is there a significant difference in perception of voluntary counselling and testing among rural and urban female teacher trainees?

1.6 Significance of the study

Since women contribute immensely to the Gross Domestic Product of many African countries as Tuju (1996) remarked, the Government of Kenya may benefit from the study particularly in the provision of adequate and quality voluntary counselling and testing services to female and male populations. Therefore, the findings of the study was intended to provide useful information to various institutions and personnel involved in decision making, formulating policies and implementing voluntary counselling and testing services. The counselling unit in the Ministry of Education may also use the findings to come up with HIV sensitization programmes in Teacher Training Colleges.

The student welfare personnel in learning institutions may find the information useful while guiding and counselling students on reproductive health. Also, the Ministry of Health may use the research findings in creating awareness among women on voluntary counselling and testing. This may help to reduce transmission of HIV from infected

mothers to their babies. The counselling staff at the voluntary counselling and Antenatal clinics may also use the study findings to counteract negative perceptions which people may have developed concerning voluntary counselling and testing.

The study may also help increase a person's perception of their vulnerability to HIV infection hence promote behavioural change. Finally, people dealing with community counselling programmes, may use the knowledge to help the local communities in advocacy and fight HIV/AIDS infections.

1.7 Scope of the study

The study was carried out at Kericho Teachers' Training College in Kericho District, Rift Valley Province of Kenya. The respondents whose awareness and perception of voluntary counselling and testing was studied, were female students in their first and second year of study.

1.8 Limitations of the study

The following factors posed as limitations to this study:

i) The research design chosen depended on the cooperation of the respondents. The researcher assured them of confidentiality in order to extract relevant information.

ii) Some of the respondents did not respond to items that sought to reveal their opinions about HIV test. The researcher overcame this by constructing contigency items.

iii) The findings of the study can be generalised only to populations with similar characteristics as the female teacher trainees.

iv) The researcher had no control over the variables hence reported what was already in existence without manipulation.

1.9 Assumption of the study

In this study it was assumed that:

i) The respondents' views reflected their true feelings.

ii) The respondents from the selected Teacher Training College provided the required information.

iii) The respondents selected was a true representation of the larger community of Kenya.

1.9.1 Definition of terms

The following terms are operationally defined as follows:

AIDS: Acquired Immune Deficiency Syndrome. It is a combination of certain diseases such as persistent chest infections, diarrhea, fungal infections and certain cancers.

Awareness: Having adequate information about voluntary counselling and testing.

Forums: Organised meeting at which the teacher trainees express their ideas and opinions.

HIV: Human Immunodeficiency virus; the virus which causes AIDS.

HIV positive persons : These are persons who have been medically examined and found to have Human Immunodeficiency virus.

HIV Testing : refers to the medical laboratory examination to determine the presence and absence of Human Immunodeficiency virus.

Perception : The way a person forms percepts or the things of which he is aware.

Teacher Training College: A College where persons train for the teaching profession.

Teacher Trainees : refers to students who have enrolled in a teacher training institution.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

The purpose of the chapter was to review literature related to the awareness and perception of voluntary counselling and testing. The literature on this topic was reviewed under the following sub-topics: meaning of HIV/AIDS, modes of transmission, sexual behaviour in females, impact of HIV/AIDS, condom use, concept of counselling, voluntary counselling and testing, pre and post test counselling. Also conceptual framework and the summary to the chapter is presented.

2.2 Meaning of HIV/AIDS

AIDS is an abbreviation for Acquired Immune Deficiency Syndrome. It is a disease caused by a retrovirus known as Human Immunodeficiency virus, abbreviated as HIV (K.I.E 1997). The name AIDS tells a lot about the disease. Acquired – it right away tells one that it is received from somewhere; Immune Deficiency - that the condition develops by weakening the body's disease defence system. Syndrome – means that there is a series of symptoms and signs which one has to identify before one can call the disease AIDS (Koinange, 1996). According to Muli (2000) the term was used to describe a disease first recognised in 1981 as being something new. The condition was termed 'acquired' because at that time it occurred in people who had not been born with immunodeficiency. From study of case history records and of stored frozen blood, it has been shown that the virus had been present earlier and was slowly spreading in various parts of the world in the late sixties and seventies. The disease is now seen in almost all countries of the world and blood tests are showing the presence of the virus.

HIV infection occurs when an individual contracts HIV virus. AIDS is that stage of the HIV infection when there is severe immunodepression manifested by the occurrence of life threatening opportunistic infections and malignancies. Mutai (2000) adds that in adults, AIDS usually occurs several years after infection with HIV virus. Dortzbach (1998) concur in stating that AIDS grips the society and spreads silently without people knowing it through a tiny virus HIV.

2.3 Modes of Transmission

The HIV/AIDS epidemic carries within it forces of destruction (Okwatch, 2003). It has the power to tear families apart and causes people to turn away from one another. Personal knowledge of the epidemic, the mode of transmission and experiences of its impact creates concern for the future.

The majority of HIV/AIDS infections (80%) are transmitted through unprotected heterosexual intercourse. Although the probability of transmitting HIV/AIDS in a single act of intercourse can be quite low, a number of factors increase the risk of infection. The most important are presence of a sexually transmitted disease such as syphillis, chancroid or herpes virus. A significant number of Kenyan adults do suffer from STDs and many have a number of sexual partners (Muganda, 2003). Dortzbach (1998) agree that most HIV infections are due to heterosexual contact. Although most women in heterosexual relationship may have one faithful partner, they are not in control of their partner's sexual behaviour (KANCO, 2000).

Transfusion with infected blood will almost always transmit HIV/AIDS. However, in Kenya most blood for transfusion is screened for HIV/AIDS, hence only a few infections are due to blood transfusion. (Dortzbach, 1998). The other way to contract HIV/AIDS virus is through perinatal transmission-mother to child. Many children receive the infection from their infected mothers during pregnancy, at the time of birth or through breast milk. About 30-40% of babies born to infected mothers will themselves be infected. The other 60% may not be infected but are at risk of becoming orphans when their parents die from HIV/AIDS (UNAIDS, 2000).

Transmission through unsteriled surgical and skin-piercing instruments such as contaminated needles and syringes are common. This reflects the interplay of at least four factors. Patients' strong preference for injections, medical services, excessive reliance on parental treatment through injections and lack of adequate sterilization practices compounded by financial and other constraints (Nordberg, 1999).

Rape and domestic violence increases the risk of transmission from male to female. According to Population Report (1999), women are generally at risk of rape with reports reaching alarming rates. Coercive sex is also responsible for the spread of HIV/AIDS in young girls and women. This is perpetrated by masculine beliefs and dominance in sexual decision making without consent from the women. UNAIDS (2000) reports a study in a low-income area of Nairobi, Kenya which illustrates women's reluctance to report sexual violence. Some 30% of women aged over 18 years said they had been sexually abused, as had one-fifth of teenage girls, but the vast majority took no action. The study revealed

many were too shy to report, and others considered it would be a waste of time to do so. This accelerate the spread of the HIV/AIDS in the society.

There are degrading traditional practices that pose a danger to women and puts them on HIV infection. These include; female circumcision, cultural sexual practices like wife inheritance, age differences in pairing men and women, sexual favours in exchange for economic stability and loss of traditions around sex. The most common one being Female Genital Mutilation. This involves the total removal of external genitalia to the narrowing of the vaginal opening. According to Green (1999), one type of this practice is the Sunna or tradition where the prepuce of the clitoris is excised, a times partial or total excision of the clitoris. The second type is clitoridectomy involving the excision of the entire clitoris and the adjacent part of the Labia Minora. Pharaonic circumcision is where all genitalia is excised. This also include the stitching together of the vaginal area with thread or thorns like in the case of Somali women. Ayisi (1992) observed that the practice is common in East Africa, Northern Ghana and Northern Nigeria. Dennitah (2001) concur in stating that female genital mutilation is still practised despite campaigns to stop it. He observed that 100 to 132 million women in the world have undergone the rite while 6,000 girls in Africa are circumcised daily and 2000 annually. In Kenya alone, statistics show that 75 percent of the population practiced it. Such practices are highly treasured in traditional life but they are unhygienic and expose women to HIV infections.

Polygamy is common in most African societies and even where the man is not legally married to more than one woman, he is permitted to have many sexual partners (Tuju, 1996). The more sexual partners a man has, the higher the risk of contracting HIV

and the greater the chances of infecting the many sexual partners. Some stories depict women as weak, untrustworthy and subordinate. Wamue (1996) observed that Kenyan communities view women as possessions of males since they are believed as immature and unstable. Among the Luo, the proverb, "A woman is the middle bone that the clan chews after her husbands death" justify wife inheritance and that she is the property of the clan. Any member of the clan has the right to a sexual intercourse with the widow ((K'Okoul, 1991). The Kipsigis proverb, " *Mokin kanoe kwondo agobo tany ne mi kamanagan*" (Don't let a wife know about a cow that is kept by a friend, portray a negative attitude against women (Towett, 1979). Zastrow (1984) contend in stating that women are socialised to play subordinate roles to their husbands. Their husbands use violence and psychological abuse to make them feel too inadequate to live on their own. Nimkoft (1964) adds that women have been socialized into a state of numbness. Those who are sexually abused expose them to sexually transmitted infections. Culture is dynamic, therefore customs and cultural practices play a role in spreading HIV/AIDS as summarised in the Fig. 1 below.

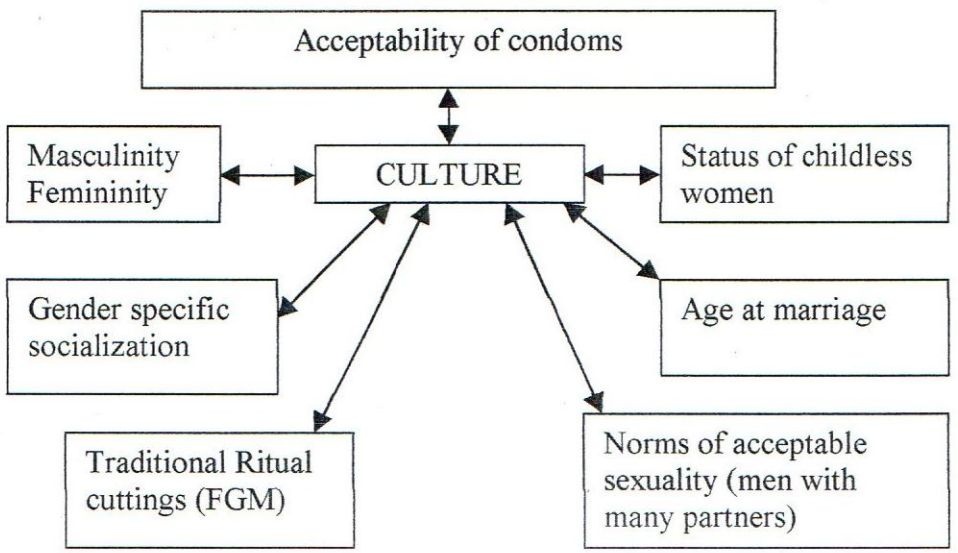


Fig. 1. Model on cultural practices

2.4 Sexual behaviour in females

Although the HIV/AIDS epidemic has swept the entire world, there are significant differences in its prevalence among societies, races and gender. KANCO (2000) has stated that gender plays a crucial role in the HIV epidemic. Risk taking and vulnerability in women is increased by norms that make it inappropriate for them to be knowledgeable about sexuality or to suggest condom use by their male partners.

Physiological differences in genital tracks of men and women, greatly contributes to higher risks in women in acquiring HIV and other STDs. The presence of an untreated STD enhances risk of contracting and transmitting HIV through unprotected sex. UNAIDS (2000) has observed that women are more vulnerable on each sexual encounter because of their biological nature of the process and susceptibility of the reproductive tract tissues to the virus. UNAIDS (2003) agree that HIV is more easily transmitted from men to women due to their biological nature. Women who are exposed to HIV and other STDs or those with the AIDS, face many barriers to getting appropriate treatment. Women are restricted to the house and require permission from their husband to go for any such treatments. Service cost and medicines also restrict women's access to proper treatment since they usually lack independent funds to pay for them. In some societies, it is considered immoral for women to seek information about sex and sexuality (Dortzbach, 1996).

Young women and girls are the target for sex by older men seeking safe sex partners. (Muganda (2003). UNAIDS (2003) concur that young women tend to have sex with much older partners. This accounts for the high number of HIV cases in universities, colleges and other learning institutions. This results in the strong gender difference in the

age-related prevalence of HIV/AIDS. Women also marry or engage in sexual activities with older men who have been sexually active longer and hence are more likely to have become infected themselves. Some men justify the selection of young adolescence girls as sexual partners on the grounds that they are less likely to be infected with HIV/AIDS. Tuju (1996) has agreed in stating that studies show the number of women who are infected surpass the number of men. Odei (2003) has added that results from seven countries in Sub-Saharan Africa that carried out HIV census indicate that women aged between 15 and 49 years were 1.4 times more likely to be infected with HIV than men of the same age. Among the young people aged 15 and 19 years, the difference between sexes were larger with women having an average of 2.7 times higher than men. Muganda (2003) agree that HIV/AIDS prevalence is higher among girls than boys. She gave the ratio as 1:6 in certain parts of Kenya. UNAIDS (2003) states that women are more likely, at least 1.2 times, to be infected with HIV than men. Among young people aged 15-24, this ratio is highest. Women are two-and-a-half times as likely to be infected with HIV as their male counterparts. It is clear from this that young people's ability to deal with these negative consequences of adolescent sexuality is severely constrained by inadequate information, poor access to education and health services and in particular voluntary counselling and testing.

Nyassy (2003) expressed concern that women in the rural areas were more vulnerable to their unfaithful partners who infected them with sexually transmitted diseases and the HIV. Women's status in the family acts as a major constraint to the fight against HIV/AIDS. Women solely depend on male partners for decision making of all aspects including sexuality. They have little or no control over their sexual life leaving them

helpless in terms of opting for safer sex practices. Tuju (1996) has commended that women are disadvantaged because they do not have rights over their sexuality and reproductive health.

African culture emphasize gender roles for women such as child-bearing, household activities and satisfying their husbands sexually. Since they cannot make decisions, they neglect their role in the prevention of HIV/AIDS. The African woman has always persevered humiliation and betrayal in marriage. Her identity and dignity is tied to that of the husband and this forces her to stick to him even if he exposes her to the risk of contracting HIV/AIDS. Pressure to bear children often result to women being forced to have unprotected sex with an infected partner. KANCO (2000) shows that women are economically dependent on their male partners leaving them with little or no powers to make decisions on basic household issues. Even widows have an extra burden to bear children because they are left as destitutes, some are inherited while others are forced into commercial sex as a means to provide for their family as shown in figure 2.

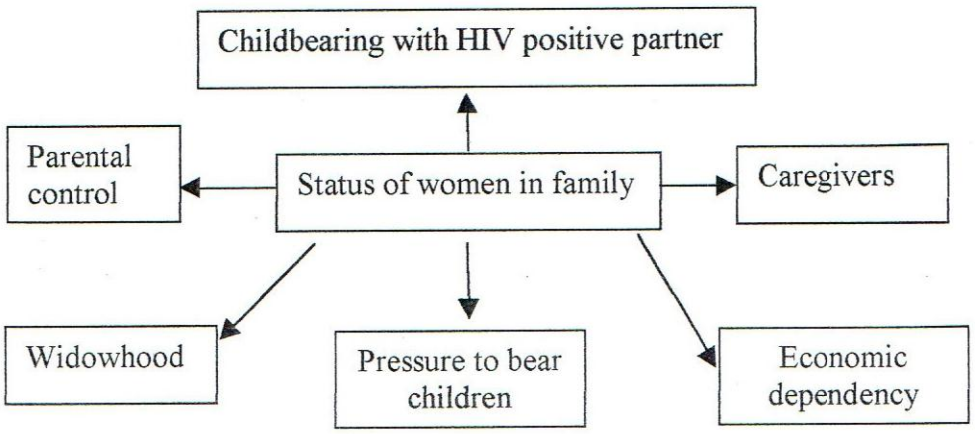


Fig.2. Gender roles for women

Women have a larger soft body surface exposed during sexual intercourse. The soft tissue on female genitals are more likely to get bruises during sexual intercourse since they are the receptive partner. These bruises are easy avenues through which the AIDS causing virus get into the body's blood stream. The male semen also contains a higher concentration of HIV. Vulnerability is increased by the stigma attached to sexually transmitted infections among women coupled with negative attitudes of health workers towards those seeking treatment for such diseases.

Women are also exposed to all forms of violence, physical, psychological or sexual. Children as young as several months old have been raped or sexually molested. A case was reported concerning a school girl who was raped by 10 men and sticks forced into her private parts at Kericho. She was ambushed as she left school in the afternoon at a tea Estate in Kericho (Nation reporter, 1999). Green (1999) reported cases of rape among students in schools. In 1991, 71 girls ages 14-18 years were raped by their classmates at St. Kizito Secondary School in Northern Kenya. The boys were angry because a soccer game had been cancelled and decided to vent their rage on the girls.

Adolescent boys admitted that coercion of female partners is common. In Kenya, boys ages 12 to 14 and 15 to 19 in focus-group discussion observed, "we seduce them at first, but if they remain adamant we force them," including sometimes dragging them or gagging them to prevent screams (Green, 1999). During a focus-group discussion in South Africa, one teenage girl observed that forced sex is the way people interact sexually (Population Report, 1999). Coercive sex is perpetrated by a person who is perceived to hold power over another and occur in the home, school and public place.

2.5 Impact of HIV/AIDS

Kenya's education is already under the threat from HIV/AIDS scourge. It poses a challenge in the realisation of the Education Ministry's mission statement; to provide, promote and coordinate life-long quality education, training and research for Kenya's sustainable development (Mutahi, 2004). The effects of HIV/AIDS on education have been enormous. The most immediate and visible impact is that most of the children infected at birth do not live to enroll in school (NASCOP, 1999). Some of the children enrolled have dropped out of school in order to earn money for their families and for care of ill relatives (Aduda, 2000). Lewis (2003) has noted that the biggest victim is the girl-child who has to take over domestic responsibilities of her mother. Infact whenever someone in a family becomes sick with HIV/AIDS, it is usually the women or the girl-child who act as the caregiver.

UNAIDS (2000) has revealed that HIV related illness is eroding the supply of teachers and therefore increasing class sizes, which is likely to affect the quality of education. Skilled teachers become too sick to work or are dying of HIV-related illness before retirement. TSC (2003) indicated that teacher deaths rose from 450 in 1995 to 1,500 in 1999. There is reduced productivity of chronically ill teachers, school managers, as well as stigma and discrimination of infected teachers and increased workloads for teachers to cover for chronically ill or dead teachers. Some communities refuse to let their children attend school if there are infected teachers. This leads to stigmatization and discrimination of the infected, psychological trauma for the infected and affected as well as the cost of keeping sick teachers on the payroll (Mutahi, 2004).

The impact of HIV/AIDS is also felt in other sectors of the society. There has been an increase in the number of orphans in the hands of older carers (Nhongo, 2003). The implication is that older women have to struggle to meet their own basic needs and that of their grandchildren who may be ailing. This could also lead to an increase in the number of urban street children (NASCOP, 1999). Economically, there is the loss of human capital and skilled high level manpower due to HIV/AIDS related absenteeism and lowstaff turnover (UNAIDS, 2000). There is also a decrease in the agricultural production as noted by Owuor (2000). Life expectancy has been reduced and mortality rate is high. This calls for the need to strengthen the society's solidarity in the fight against HIV/AIDS.

The school is the structure in the society that reaches out to all communities. According to Mutahi (2004), it is logical that school and teachers be the focal points in the war against HIV/AIDS. This require adequate knowledge, awareness and skills to fight the scourge. Teachers have traditionally served as role models and counsellors for the youth. Nzomo (2004) has noted that teachers have a strong influence on the community and the vulnerable young girl in school most of the time. Therefore, this role may diminish if HIV/AIDS infection and death rate among teachers is not stopped.

2.6 Condom use

It is one of the commonest method of prevention. However, condoms are not foolproof. Omayio (2001) has revealed that even when condoms are used correctly, consistently and compliantly, they do not offer 100 percent safety. They do not completely eliminate the risk of becoming infected because they can break, tear or slip off. UNAIDS

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(2000) adds that there are huge misconceptions about the safety of condoms in many populations. Many believe that HIV might be able to pass through a condom, and condoms could even get stuck inside a woman's body. Therefore this contribute to the low levels of use among sexually active youngsters. Violence against women also influences the risk of HIV directly when it interferes with women's ability to negotiate condom use. For many women, asking for condoms can be even more difficult than discussing other contraceptives because condoms are often associated with promiscuity, infidelity and prostitution. Population Report (1999) states that raising the issue of condom use within marriage is difficult. Initiating condom use is simply not practical for many women around the globe. Some women have even been hit for suggesting a condom. For women living with men who are violent, the fear of a negative reaction is enough to cut off discussion of condom. In societies where condom use is discouraged because of cultural or religious reasons, there will be a higher risk of transmission than in those that accept the use of condoms (KANCO 2000).

2.7 Concept of counselling

Counselling encompasses several professional skills hence is not a single activity. Tolbert (1959) defines counselling as a personal face-to-face relationship between two people in which the counsellor by means of this relationship and his special competencies provide a learning situation in which the counsellee is helped to know himself and his present and possible future situation so that he can make use of his characteristics and potentialities in a way that is both satisfying to himself and beneficial to the society. Hoose (1978) concur in stating that the counsellor attempts to help another person in matters of self-understanding decision-making and problem-solving. It is an interactive process

cojoining the counsellee, who is vulnerable and who needs assistance and counsellor who is trained and educated to give assistance to help the counsellee learn to deal effectively with himself and the reality of his environment (Makinde, 1984). The counsellee is stimulated to think through the situation and develop plans and attitudes to help him meet his difficulties.

Bloom or Doom (1999) outline that counselling to people living with AIDS is important because they undergo experiences like loneliness, depression, rejection, denial, shock and anger. The counsellor helps the sick person to understand his or her problems, identify and find out solutions to these problems and make decisions about their future.

2.8 Voluntary Counselling and Testing

Voluntary counselling and testing (VCT) is the situation where a person makes a deliberate effort to establish his or her HIV status. Muhindi (2003) states that VCT is the best intervention for preventing the virus and putting people to care for those infected. Ngacha (2003) concur in revealing that studies give credit to VCT's role in behaviour change. A study in Kenya, Tanzania and Trinidad showed that the proportion of individuals reporting risk reduction behaviour was significantly higher for those who had gone for VCT compared with those who had not. The main argument is that when a person is found to be negative, he or she is counselled on how to avoid contracting the virus. Those found positive are also counselled not to spread the virus and how to get care and support. It help sensitize people on HIV/AIDS and even counselling them on how to live positively once infected. Nordberg (1999) point out that HIV infected individuals undergo a series of emotional crises through which they must be assisted. They have to be helped to cope and

change behaviour in order to continue having a good quality of life and to prevent further spread of the infection.

2.8.1 Pre test counselling

Before taking blood for a test, it is necessary to discuss the possible outcome of the test. If it is negative, this will help in establishing some other diagnosis and seeking a cure but the patient will have to adopt behaviour necessary to stay negative. If it is positive the patient will have to adjust to this bad prognosis and work out the implications for the family and job (Kanel, 1999).

Pretest counselling prepares the individual for the implications and consequences of either a positive or negative test (Nordberg, 1999). Tuju (1996) agree that it is vital for one to go for counselling before an HIV test.

Nordberg (1999) outline the aims of pretest counselling as:

i) Assess the person's risk as to potential infection.

ii) Provide risk reduction information by discussing the facts about HIV transmission and how risk of acquiring or transmitting the infection can be reduced.

iii) Prepare the individual for a possible positive test.

iv) Gain the trust of the individual that the test result will be kept confidential by the counsellor.

Persons prepared in pretest counselling suffer less psychological trauma when informed of the test result than those who are unprepared because they have not received counselling. Tuju (1996) states that patients who fail to embrace counselling tend to do very poorly.

2.8.2 Post test counselling

This revolves around the communication of the test result. Koinange (1996) pointed out that a person must be counselled about the status because only then can one solicit cooperation in appealing to that patient not to spread it to other people. Tuju (1996) adds that those who accept and continue with counselling do very well because they learn to live positively with the virus.

Counselling assists them to be at peace with their inner self. Kanel (1999) reveals that counselling and psychological support is important to the patient with a positive blood test. Symptoms need to be reduced and infections treated where possible. Families have to be given emotional support and advice on how to manage the patient at home. All this is done while ensuring confidentiality. Counselling helps encourage the patient to adopt behaviour which prevents transmission (Muli, 2000).

Those who are informed that they are HIV infected go through shock, anger, guilt, loss of identity, fear, sadness, depression and acceptance. K'okul (1991) states that a counsellor's duty is to "walk" the client through the grief wheel to prolong their lives. Kanel (1999) agree that the crisis worker uses Kubler – Ross's stages as a starting ground and help the client work through each stage. Nordberg (1999) concur in stating that this help them come to terms with this infection status and move on to focus on living rather than dying. This is the ultimate goal of post testing counselling. Those who do not embrace counselling do not survive long enough because they are scared and expose themselves easily to health hazards.

Some of the psychological problems people living with AIDS suffer from include; uncertain future and major adjustment to be made. The long held desires, ambitions, hopes and expectations are also threatened. The complications of full blown AIDS bring problems of financial insecurity, loss of insurance cover or loss of job. There will be worry of quality and length of life they have to live, effects treatment may have and the society's response to them. According to Nordberg (1999) the patient needs to be taught how to communicate the news to loved ones and friends who will be a central pillar of future support care. The counsellor determine the personal resources of the patient to be used for treatment. This helps prevent distress and the patient plan a future within the practical limits.

Recent research indicates that early treatment for people infected with HIV help them live longer and slows down the onset of HIV-related symptoms (American Red Cross, 1992). According to population report (1999), women's fear of men's reaction has kept them away from voluntary counselling and testing. This has implications both for controlling sexual transmission of the virus and for efforts to reduce mother-to-child transmission. Health professionals should consider the implications of encouraging women to reveal HIV infection to their partners.

Researchers in Nairobi explored this among 243 women and found only 66 disclosed their status to their partners; of the 66 women, at least 11 had been chased away from home or replaced by another wife, 7 had been beaten up by their partners and one had committed suicide (Population Report, 1999). Women need to be counseled on the possible risks and benefits of disclosure to an intimate partner. UNAIDS (2000) adds that the hope

of benefiting from early treatment may create a major incentive for women to find out their HIV status. The test results also helps women in reducing their worry about being infected with HIV. It helps them make plans for the future, for example, whether or not to get pregnant.

Nordberg (1999) outlines some of the advantages of a test as:

i) Reducing uncertainty in people involved in risky behaviour and wish to change but are unsure of their status.

ii) It provides motivation for behaviour change for the infected and uninfected.

iii) Allows one to better plan relationships to protect self and others.

iv) Assists women who may have been involved in risky behaviour to make decisions about any possible pregnancy.

v) Screens those wishing to marry or enter into new relationship.

2.9 Conceptual Framework

The conceptual framework of this study was based on the communication model. The main components in this concept include source of VCT message, the mode of transmission, the receiver and the feedback of the message received.

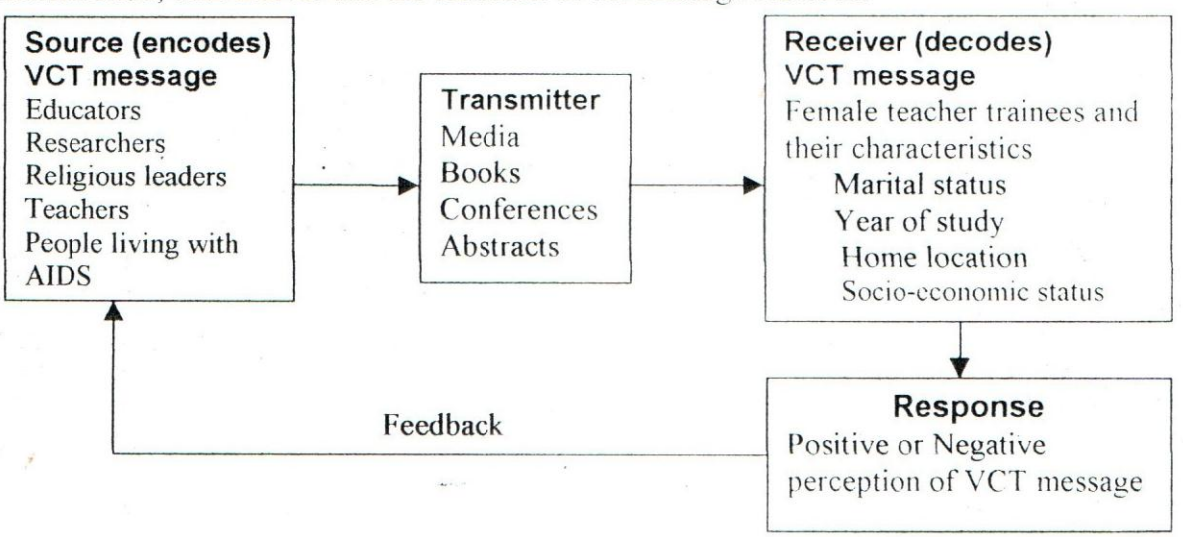


Figure 3: Model showing awareness and perception of voluntary counselling and HIV testing.

In this figure, the source of VCT message include educators, teachers, people living with AIDS researchers and religious leaders, who encodes an idea in the mind into a message to be transmitted to the female teacher trainees. The message is put over on them without their being conscious of it. The symbols of the message are then converted into signals that can be transmitted by means of sound waves and electrical impulses capable of transferring the message. These involve the use of posters, books, mass media, workshops and Barazas. Once the female teacher trainees receive the VCT message which was encoded into symbol by the sender, they make an effort to understand this message. The success of decoding, depends on how well the female trainees recognized the symbols used. The reception of the message is dependent on the female trainees characteristics which are not in the source control such as: marital status, year of study, socio-economic status and their home location.

When the VCT message has been decoded by the female teacher trainees, some meanings and ideas are integrated in their minds. The response points to their awareness and perception of VCT which may be positive or negative. Positive perception may lead to behaviour change while negative perception may cause some female trainees to engage in promiscous lifestyle or even commit suicide. The feedback is useful to the source of VCT message in reinforcing awareness of VCT among the female teacher trainees; depending on their perception of it. Figure 3 gives a detailed summary of the study variables as explained in the theoretical framework.

2.10 Summary

HIV/AIDS is devastating families and communities, overwhelming and depleting health care services and robbing schools of both students and teachers (Nation reporter, 2003). In this view, various interventions such as condom use have not reduced the incidents of HIV/AIDS. Many people in Kenya have basic knowledge on HIV/AIDS transmission but are still vulnerable since they are ignorant of voluntary counselling and testing services. UNAIDS (2000) has reported that vulnerability to HIV/AIDS is mainly due to disrespect for the right to information and education. As such women are prevented or discouraged from obtaining the necessary information and services for self protection. Misinformation could lead women to perceive voluntary counselling and testing facilities negatively. The quality and availability of the testing services would help reduce HIV infection in the society. For this to be achieved, more VCT centres should be opened in the rural areas. Nyassy (2003) has observed that testing centres should be set up in rural areas to be used for constant testing of the rural populations.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

The study investigated Female teacher trainees' awareness and perception of voluntary counselling and testing. The main components of this chapter include; proposed research design, population and sample, research instrumentation, data collection and data analysis procedures.

3.2 Research Design

The study utilized the ex post facto research design. The research design was preferred because the case is a 'naturally occuring' phenomenon (Denscombe, 1998; Kothari, 2003). The study was carried out in a natural setting which implied that the phenomena under study was investigated the way they were without being manipulated and without changing the state of environment under which they operated.

3.3 Location of study

The research was carried out in Kericho Teacher's Training College, Kericho District, Rift Valley Province of Kenya. This institution was chosen because it draws students from various parts of the country and therefore the population was representative since it was drawn from a wider community. The institution was also convenient to the researcher.

3.4 Target Population

The target population was 500 First and Second year female teacher trainees. The population had the characteristics that the researcher considered necessary in the study and also relevant to the awareness and perception of voluntary counselling and testing services. The First and Second year female teacher trainees were chosen because the researcher wished to compare their awareness and perceptions of voluntary counselling and testing. This was because the First years had been in the institution for a short duration of time whereas the Second years had been there for a longer duration.

3.5 Sample and Sampling procedures

The researcher utilized stratified random sampling method in selecting female teacher trainees from the First and Second year classes. Simple random sampling method was used to obtain a sample size of 218 respondents for the study drawn from a population of 500 female teacher trainees. This sample size was arrived at by using the table for determining sample size (Appendix B) as suggested by Kathuri and Pals (1993). The sample served as an adequate representation of the population about which the researcher would generalize the findings (Best, 1981).

3.6 Instrumentation

Data for this study was obtained through a questionnaire. The questionnaire was self administered and composed of closed-ended and open-ended questions. The close-ended items were accompanied by possible alternatives from which the respondents selected the answer that best described their situation. The open-ended items permitted the respondent's freedom to express the response. Therefore, the questionnaire was used to

obtain information on awareness and perception of voluntary counselling and testing from the respondents. The reliability was determined from scores from a single test administered by the researcher to a sample of female teacher trainees. The questionnaire was tested for reliability by means of Kuder-Richardson (K-R 21) method. A test is reliable if it yields consistent results when administered repeatedly to the same individuals. In this study, reliability coefficient of 0.80 was considered reliable. This figure is usually considered respectable and desirable for consistency levels (Koul, 1984).

To validate the research instrument, the researcher utilized content validity whereby a thorough examination of the instrument was done by research experts in HIV/AIDS and from the Faculty of Education and Human resources of Egerton University. The piloting of the research instrument, which enhanced reliability and validity, was done at Mosoriot Teachers Training College. First and Second year students were involved in the piloting. This college was used for piloting the instrument because the respondents were assumed to have similar characteristics with the sample that was used in the actual study. The other advantage of piloting the research instrument is for the researcher to get feedback from the research subjects that leads to improvement of the research instrument that will be used in the main study (Isaac & Michael, 1981).

3.7 Data collection procedures

The researcher sought permission from the Ministry of Education Science and Technology, through the DEO's Office, Kericho. The permission was granted, and the researcher proceeded with an introductory letter to the selected institution and sought permission from the college's principal to carry out the research. Once the permission was granted, the questionnaires were distributed to the selected respondents who responded to

the items as the researcher waited. The researcher collected the completed questionnaires in preparation for data analysis.

3.8 Data analysis

The data obtained was analysed by using descriptive and inferential statistics. The descriptive statistics included frequencies, percentages and means. Inferential statistics involved t-tests. T-tests helped in testing the significant differences between the variables. The data was analysed by using the Statistical Packages for Social Sciences (SPSS) version 11.5 for Windows. This saved time and increased the accuracy of the results (Mugenda & Mugenda, 1999).

CHAPTER FOUR

RESULTS AND DISCUSSIONS

4.1 Introduction

This chapter presents the research results and discussions on female teacher trainees' awareness and perception of voluntary counselling and testing in a selected teachers' training college. The data collected from the respondents was analyzed using Statistical Package for Social Sciences Version 11.5 for Windows. The findings of this investigation are reported in five subsections. The first part presents information of the demographic characteristics of the female students. The second part presents the findings on the level of awareness of voluntary counselling and testing among the female teacher trainees. The third section presents the findings on the influence of female teacher trainees' year of study on voluntary counselling and testing. The fourth section deals with findings on whether marital status influences the students' perception of voluntary counselling and testing.

The fifth section deals with the findings on female teacher trainees' perception of voluntary counselling and testing by home location. Findings are presented in form of frequencies, means, percentages and t-test. A test of significance of the study findings was pegged at $P<0.05$.

The analysis was guided by the following objectives and research questions. The objectives were as follows:

i) Determine female teacher trainees' level of awareness and perception of voluntary counselling and testing.

ii) Determine whether female teacher trainees' year of study influence the level of awareness and perception of voluntary counselling and testing.

iii) Determine whether differences exist in perception of voluntary counselling and testing between the married and unmarried female teacher trainees.

iv) Find out whether differences exist in perception of voluntary counselling among rural and urban female teacher trainees.

The research questions were:

i) What is the female teacher trainees level of awareness and perception of voluntary counselling and testing?

ii) Does the female teacher trainees' year of study influence their level of awareness and perception of voluntary counselling and testing?

iii) Does a difference exist in the perception of voluntary counselling and testing between the married and unmarried?

iv) Is there a significant difference in perception of voluntary counselling and testing among rural and urban female teacher trainees?

4.2 Demographic characteristics of the study's respondents

This section presents the respondents' characteristics such as age group, year of study, marital status and their parental socio-economic status. The analyses of these characteristics are shown in Table 4.1, 4.2, 4.3, 4.4, 4.5 and 4.6.

Table 4.1 Respondents' Distribution by Age.

Age bracket	Frequency	Percentage
18-22	105	48.2
23-27	102	46.8
28-32	10	4.6
38-42	1	0.5
Total	**218**	**100.0**

The findings in table 4.1 reveal that majority of the respondents 105 (48.2%) fall within 18-22 years. The medium group 102 (46.8%) lie within age bracket 23-27. A few (0.5%) female students were at advanced age (38-42 years) compared to the rest of the respondents. The possible reason for the majority of the respondents being within 18-22 age bracket is that the trainees are admitted in the College almost a year after their secondary school education. Thus, most of them are still within the adolescent period age bracket. This age bracket is the one known to have high HIV/AIDS infection levels (Muganda, 2003). Also, adolescents are known to be sexually active and their behaviours may be putting many at risk of HIV/AIDS infections (UNAIDS, 2000).

Table 4.2: Respondents' Distribution by Marital Status

Marital status	Frequency	Percentage
Single	146	67.0
Married	63	28.9
Divorced	1	.5
Separated	7	3.2
Widowed	1	.5
Total	**218**	**100.0**

From table 4.2, it is evident that majority of the respondents 146 (67.0%) were single whereas 63 (28.9%) were married. In effect, it implies that the respondents were still under the care of their parents who are expected to mould their behaviour and make them be aware of HIV/AIDS issues, which include voluntary counselling and testing. According to Dortzbach (1998), youths prefer to be told about sexuality from their parents. However, some young people may not think their parents know enough about sexuality issues. Therefore, parents may become a barrier to adolescent access to both information and services such as voluntary counselling and testing (Muganda, 2003).

Table 4.3: Respondents' Distribution by Home Location

Home location	Frequency	Percentage
Rural	195	89.4
Urban	23	10.6
Total	**218**	**100.0**

Information from Table 4.3 show that 195 (89.4%) of the respondents lived in the rural areas, while 23 (10.6%) came from urban areas. The implications from the findings are that the vast population of the female trainees lived in the rural areas where many people are susceptible to HIV/AIDS (NASCOP, 2003). This could be attributed to the fact that organizations fighting the disease concentrate their activities in urban areas leaving the rural areas to lag behind in vital information such as voluntary counselling and testing (UNAIDS, 2000).

Table 4.4: Respondents' Distribution by family type.

Family Type	Frequency	Percentage
Nuclear	137	62.8
Polygamous	60	27.5
Single parent	19	8.7
Total	**216**	**99.00**

Table 4.4 show that majority, 137 (62.8%) respondents were from nuclear family type. According to K'Koul (1991), nuclear family attach more importance on education and future life that includes discussions on family life and sexuality. The female teacher trainees from nuclear families would be expected to be aware of voluntary counselling and testing.

Table 4.5: Respondents' Distribution by parental Socio-Economic Status

Level of Education	Father		Mother	
	Frequency	Percentage	Frequency	Percent
No schooling	21	9.6	37	17.0
Primary	66	30.3	90	41.3
Secondary	43	19.7	56	25.7
Middle level	64	29.4	30	13.8
University	22	10.1	3	1.4
Total	**216**	**99.1**	**216**	**99.2**

The respondents' parental socio-economic status is explained from the level of parental education and sector of parental employment. Tables 4.5 and 4.6 gives detailed findings on this. As indicated in table 4.5, a high percentage of respondents 66 (30.3%) revealed that their fathers had attained primary education and 64 (29.4%) reported middle level education. The findings further indicated that 90 (41.3%) respondents showed their mothers had attained primary education and 30 (13.8%) had middle level education. There were 56 (25.7%) and 43 (19.7) respondents who revealed that their mothers and fathers had attained secondary level education respectively. Only 22 (10.1%) respondents indicated their fathers had attained university level of education while mothers were 3 (1.4%). A few respondents showed 37 (17.0%) mothers and 21 (9.6%) fathers had no schooling. Most of the respondents had parents with primary level education. This implies that since literate people generally have greater access to information than those who are illiterate and are likely to make well-informed decisions and act on information such as voluntary counselling and testing, female teacher trainees whose parents are literate would have access and be adequately aware of voluntary counselling and testing.

Table 4.6: Respondents' Distribution by Parents' Employment

Sector of employment	Father		Mother	
	Frequency	Percentage	Frequency	Percentage
Formal	112	51.4	50	22.9
Informal	93	42.7	163	74.8
Total	**205**	**94.1**	**213**	**97.7**

As shown in table 4.6, most of the respondents' fathers 112 (51.4%) were employed in the formal sector whereas their mothers 163 (74.8%) were in the informal sector. There were 13 (5.6%) and 5 (2.3%) respondents who did not show their father's and mother's sector of employment. The findings concur with Mbiti (1973) that men pursue education and get employment in the formal sector, while women do not and could be busy in self-employment or agriculture. According to UNAIDS (2000), educated people have better jobs and greater access to money and other resources which can help them support healthier families. Money also make such families to get access to many forms of media such as televisions and radios which are main sources of information on HIV/AIDS and voluntary counselling and testing. Consequently female teacher trainees whose parents are enlightened and with more education, are far more likely to be aware and seek prevention strategies such as voluntary counselling and testing as compared to their counterparts whose parents are uneducated and are not in gainful employment.

4.3 Female Teacher Trainees' Awareness and Perception of Voluntary Counselling and Testing

Research question one aimed at finding out the female teacher trainees' awareness and perception of voluntary counselling and testing. Before presenting analysis on awareness (Table 4.8) and perception Table 4.11, 4.12 and 4.13, it is worth to first present

the sources of information of voluntary counselling and testing as perceived by the female teacher trainees. As such, Table 4.7 gives detailed findings on sources and percentage of respondents perceiving them as vital sources. This section also show resource persons' contributions in making the female teacher trainees aware of VCT as indicated in table 4.9 and 4.10.

Table 4.7: Sources of information about Voluntary Counselling and Testing (VCT)

Sources of VCT information	Frequency	Percentage
Mass media	33	15.1
Forums	29	13.3
Medical agents	4	1.8
Media and forums	149	68.3
College and forums	2	.9
Total	**217**	**99.4**

It is evident from the information presented in table 4.7 that 149 (68.3%) respondents have learned about VCT from media and forums while 33 (15.1%) indicated mass media only as the source of VCT information. A few respondents 29 (13.3%) and 4 (1.8%) perceived forums and medical agents respectively as sources of VCT information. The results portray mass media and forums as indicated by female teacher trainees to be the primary sources of information on VCT. The results concur with Muganda (2003) findings that the most preferred sources of voluntary counselling and testing by the youth, are the televisions and radios.

Table 4.8: General awareness of VCT.

In the study in order to investigate on female teacher trainees' awareness of VCT, items in the questionnaire were to be responded either as true or false. The findings are clearly seen in table 4.8 below.

General awareness of VCT	Respondents' responses to statements of VCT			
	True		False	
	Frequency	Percentage	Frequency	Percentage
1. Aids tests shows presence of virus	203	93.1	11	5.0
2. One is safe in unprotected sex with one showing negative Aids test results	57	26	161	73.0
3. Positive test indicate infection with the virus	194	89.0	24	11.0
4. Whether there is need to practice safe sex by partners in a relationship who have tested positive	54	24.8	164	75.2
5. HIV vaccine, once developed will not reverse one's positive HIV status	151	69.3	67	30.7
6. A positive test result keep one from getting married	106	48.6	109	50.0

The results from table 4.8 indicate that the majority (93.1%) of the respondents were aware of Aids test as an indicator that a person is infected by the HIV virus. According to Koinange (1996), blood tests is the only way which shows that an individual is infected with the virus. Also, as evidenced in the findings, 161 (73.9%) respondents reported that it was not safe to engage in unprotected sex with those who have tested negative. This is attributed to American Red Cross (1992) report that it usually takes from a few weeks to a few months for HIV antibodies to develop after a person becomes infected with the virus. The report adds that if a person was infected recently, the test may not be able to detect any HIV antibodies. Further, as the findings indicate, the respondents were aware for the need to practice safe sex if both partners in a relationship tested positive. The possible reason could be that it might lead to re-infection and complication to manage HIV patients as a result of different strains of the virus from different regions (K.I.E, 1999).

However, it turned out that a substantial number of respondents, 106 (48.6%) indicated that a positive test result could make one to abstain from marriage. The findings depicted a

majority who were not aware of premarital counselling and testing which would be helpful for those entering marriage when already infected (Dortzbach, 1998).

Table 4.9: Resource persons' contribution to the Female Teacher Trainees' awareness of VCT while in college.

Resource persons	Respondents' responses on people who contribute to the awareness of Aids and VCT					
	Often		Rarely		Never	
	Frequency	Percentage	Frequency	percentage	Frequency	percentage
1. Principal and tutors	174	79.8	31	14.2	7	3.2
2. Medical personnel	52	23.9	88	40.4	53	24.3
3. Anti-Aids personnel	53	24.3	76	34.9	65	29.8
4. Religious leaders	178	81.7	26	11.9	8	3.7

As shown on table 4.9, a high percentage of the respondents' 178 (81.7%) revealed that they often got information about VCT from religious organizations, while 174 (79.8%) from the principal and tutors. In the college, students participate in Christian Union and Young Christian students to help them in spiritual and moral development. They also take part in weekend religious rallies and challenges. Resource persons such as church leaders sent to talk to the teacher trainees would impart information on AIDS and VCT. According to Dortzbach (1998), church leaders are equipped to deal with AIDS prevention and care in their communities through a series of pastoral AIDS counselling workshops.

The female teacher trainees also indicated the college principal and tutors as resource persons who have contributed much to the awareness of VCT while in college. This concurs with Mutahi (2004) that teachers have a strong influence on the community since they have traditionally served as counsellors and role models for the youth. This is

also reflected in table 4.10 with 71 (32.9%) respondents who indicated that college tutors effectively disseminate information about HIV testing to them. In contrast, the participation of the medical and Anti-Aids personnel was depicted to be low. This could be attributed to the assumption from those groups that the students are already aware of VCT. In general, various resources persons have played a role in making female teacher trainees aware of VCT.

Table 4.10: Female Teacher Trainees' views on Resource Persons considered most effective in disseminating vital information about HIV testing.

Resource persons	Frequency	Percentage
Parents/Guardians	26	11.9
College tutors	71	32.9
Religious leaders	26	11.9
People living with AIDS (PLWA)	93	42.7
Total	**216**	**99.4**

Information in table 4.10 show that 93 (42.7%) respondents considered People Living with AIDS (PLWA) to be the most effective in disseminating vital information about HIV testing to the teacher trainees. UNAIDS (2000) states that PLWA have played a leadership role in increasing society's acceptance of those living with AIDS, reducing their peers' infection rates, mitigating the personal and social impact of the disease and in fighting for their right to health care. Therefore, involving PLWA is credible especially in learning institutions such as colleges, to make them aware of voluntary counselling and testing.

Table 4.11: Female Teacher Trainees' Perception of HIV testing

Responses	Frequency	Percentage
Strongly Agree	177	81.2
Agree	31	14.2
Uncertain	5	2.3
Disagree	2	.9
Strongly disagree	3	1.4
Total	**218**	**100.0**

As shown in table 4.11, 208 (95.4%) positively agreed that HIV testing enables one to know the HIV status. From these findings, it may be concluded that the female teacher trainees perceive it is through visiting the voluntary counselling and testing that one will know his or her status. The results concur with Muganda (2003) that voluntary counselling and testing is the situation where a person makes a deliberate effort to establish his or her HIV status. Based on these findings, the female teacher trainees have a positive perception of HIV testing and this is the only means to know one's status.

Table 4.12: Reasons given by Female Teacher Trainees why they would accept a blood test.

Reasons	Frequency	Percentage
To know HIV status	123	56.4
Not necessary	6	2.4
Scared of results	24	11.0
Services are available	12	5.5
Organize my life	45	20.6
Total	**210**	**95.9**

As table 4.12 indicates, 123 (56.4%) respondents would go for a blood test to know their HIV status, while 45 (20.6%) respondents revealed they would accept to do so in order to organize their future lives. This concur with UNAIDS (2000) that test results help women make plans for the future, for example, whether or not to get pregnant. This

implies that the female teacher trainees perceived blood testing for HIV virus as being important in planning for the future, hence positive perception of voluntary counselling and testing.

Interestingly, 24 (11.0%) respondents indicated that they would be scared of the results and 6 (2.4%) respondents do not find it necessary to accept a blood test. Therefore, some female teacher trainees may have a negative perception towards voluntary counselling and testing. According to UNAIDS (2003), some could think that positive results means an immediate death sentence. It is also possible that in some areas the stigma maybe so strong that people choose not to know their HIV status even though it is their right.

Table 4.13: Groups of people the Female Teacher Trainees would talk about HIV test.

Groups of people	Respondents' responses on whom they would talk about HIV test					
	Often		Rarely		Never	
	Frequency	Percentage	Frequency	Percentage	Frequency	Percentage
Agemates	185	84.9	23	10.6	4	1.8
Religious leaders	133	61.0	52	23.9	17	7.8
College tutors	122	56.0	65	29.8	19	8.7
Parents	102	46.8	79	36.2	28	12.8

Table 4.13 indicates that 185 (84.9%) respondents often talk with agemates about HIV test, while 133 (61.0%) talked about it with religious leaders. The findings further show that 122 (56.0%) and 102 (46.8%) respondents would talk about HIV test with college tutors and parents respectively. Agemates may influence one another in a group to participate in various activities and share ideas since they trust themselves. It is possible that female teacher trainees discuss or talk freely with religious leaders because they show integrity and concern. According to Dortzbach (1998), religious leaders believe in

wholeness, fullness and sanctify of life for eternity. Therefore, female teacher trainees may view religious leaders to be upright and confidential. Moreover, as pointed out earlier in table 4.9, teachers have been looked to as counsellors and role models for the youth (Mutahi, 2004). This suggest the reason why the female teacher trainees would discuss HIV test with college tutors.

Finally, the female trainees indicated that they would also discuss HIV test with parents. The findings suggest a positive perception towards voluntary counselling and testing as portrayed by the female teacher trainees' willingness to discuss HIV test with various groups of people.

4.4 Female Teacher Trainees' year of study and its influence on level of awareness and perception of voluntary counselling and testing (VCT).

The second objective aimed at finding out whether female teacher trainees' year of study influence awareness and perception of voluntary counselling and testing. Female trainees' awareness and perception mean scores and standard deviations were computed. Also, t-test analysis was performed to test the significance of any existing differences. Table 4.14 and 4.15 gives a summary of the results obtained.

Table 4.14: Means, SDs (Standard Deviation) and t-test analysis of Female Teacher Trainees level of Awareness by year of study.

Year of study	N	Mean	SD	t-value	2 tailed
First	104	2.93	.839	1.963	.051
Second	109	2.71	.842		

An inspection of the results in table 4.14 indicates that some mean differences in the level of awareness of VCT among female teacher trainees existed between those in the first year and those in their second year of study. The mean for first year was 2.93 whereas that of second year was 2.71. This implies that first years seem to be more aware of VCT than the second years. It is possible that the first year students still have the VCT information they received while in the secondary school. Organizations fighting HIV/AIDS may have concentrated their activities in secondary schools where adolescent, who are viewed as vulnerable to AIDS, are found. Adolescent have been known to be sexually active and easily fall prey to sexually transmitted infections (Bett, 2003).

As shown earlier in table 4.9, the participation of medical and Anti-Aids personnel was depicted to be low in teacher colleges. Since second years have been out of secondary school for a longer period, and are assumed to be adults, their level of awareness is likely to be low. In addition, a look at the mean scores and Standard Deviations provides a clue which t-test value would either corroborate or falsify. The obtained t-value, (t-1.963, P>0.05) is indicative of statistically insignificant differences in the level of awareness of VCT between first and second year female trainees. Consequently, the year of study seem not to significantly influence the female teacher trainees' awareness of voluntary counselling testing.

Table 4.15: Means, SDs (Standard Deviation) and t-test Analysis of the difference in the female teacher trainees' perception of VCT by year of study.

Year of study	N	Means	SD	t-value	2 tailed
First	108	60.55	20.93	.772	.441
Second	109	58.94	6.327		

From the results reflected in table 4.15, it is clearly evident that slight mean differences exist in mean perception between the first and second year female teacher trainees. The mean perception for the first year was 60.55 and that of the second year was 58.94. In effect, the differences were 1.61 points. However, this mean difference in perception between the first and second year female teacher trainees was found to be statistically insignificant, (t-0.441, P>0.05). These findings suggest that the year of study did not exert any significant influence on the female teacher trainees' perception of voluntary counselling and testing.

In conclusion therefore, the year of study does not significantly, influence the female teacher trainees' awareness and perception of voluntary counselling and testing. But it should be noted that the first year female teacher trainees seemed to have a higher positive perception and awareness towards voluntary counselling and testing as compared to the second years. The reasons that may be responsible for this difference is beyond the scope of this study hence need further investigation.. However, as noted earlier on table 4.14, the first year female trainees may still remember the information they have learned about voluntary counselling and testing while in the secondary school where adolescent congregate. It is also possible that the media such as newspapers, radio and television, has provided adequate information on voluntary counselling and testing, therefore increasing the female teacher trainees' level of awareness (Table 4.7). Previous studies indicate that young people prefer electronic media as sources of information on voluntary counselling and testing such as televisions, video viewing and radios (Muganda, 2003).

4.5 Female Teacher Trainees' perception of Voluntary Counselling and Testing (VCT) by marital status.

The third objective was to establish whether female teacher trainees' marital status have any influence on perception of VCT. The analyses done by the help of mean scores, standard deviations, t-tests and descriptive statistics are shown in table 4.16.

Table 4.16: Means, SDs (Standard Deviation) and t-test Analysis of the difference in the female teacher trainees' perception of VCT by marital status.

Marital status	N	Means	SD	t-value	2-tailed
Single	146	58.85	6.2	1.117	.265
Married	63	61.49	27.04		

The analysis of female teacher trainees' perception of VCT by marital status is shown in table 4.16. The mean perception for single female trainees was 58.85 whereas the mean for the married female trainees was 61.49. This shows that the mean perception for the married female trainees is 2.64 points higher than that of the single female trainees. The implication is clear that married female teacher trainees have a higher positive perception towards VCT than the single female trainees. However, these mean differences were found to be insignificant, (t-1.117, P>0.05).

Based on the findings shown in table 4.16, female teacher trainees' marital status does not influence perception of VCT. It is likely that the female teacher trainees enter marriage when they are aware and have positive perception of VCT. This findings concur with Ngacha (2003) who stated that youth were comfortable with using VCT services and

would actually go for testing. These suggests a positive perception towards VCT by the female teacher trainees.

4.6 Female Teacher Trainees' perception of Voluntary Counselling and Testing (VCT) by home location

The fourth objective of the study was to determine whether female teacher trainees' home location have an influence in perception of voluntary counselling and testing.

In Kenya, VCT centres are situated mainly in urban and peri-urban areas (Muganda, 2003). This concur with Ngacha (2003) and UNAIDS (2000) that HIV testing facilities in the developing world are still far from adequate. Therefore, the female teacher trainees from urban areas where VCT services are available, may have a positive perception of it as compared with the rural counterparts. Table 4.17 indicates detailed results of this investigation.

Table 4.17: Means, SDs (Standard Deviation) and t-test Analysis of the difference in the female teacher trainees' perception of VCT by home location.

Home location	N	Mean	SD	t-value	2-tailed
Rural	195	59.87	16.10	.301	.208
Urban	23	58.65	6.93		

An examination of the results in table 4.17, reveals that the mean perception for the female teacher trainees from rural areas was 59.87 and for those from urban was 58.65. The mean difference was 1.22 in favour of female trainees from rural areas. However, the mean difference between the female teacher trainees from rural and those from urban areas was

found to be statistically insignificant (t=.301, P> 0.05). It can therefore be concluded that home location does not influence female teacher trainees' perception of VCT. According to UNAIDS (2000), organizations fighting the HIV/AIDS concentrate their activities in urban areas leaving the rural areas lag behind in vital information such as voluntary counselling and testing. However, it is clear from the findings in table 4.17 that home location is not significant in perception of VCT. Therefore, inadequacy of VCT facilities in rural areas has no influence on the female teacher trainees' perception of voluntary counselling and testing.

In conclusion, the media such as radio and television (table 4.7) has been a powerful tool in disseminating voluntary counselling and testing information to people in urban and rural areas. It is possible that female teacher trainees from both rural and urban areas have been influenced by the media and may have developed positive perception of voluntary counselling and testing.

CHAPTER FIVE

SUMMARY, CONCLUSIONS, RECOMMENDATIONS AND SUGGESTIONS

5.1 Introduction

The main purpose of this study was to investigate the female teacher trainees' awareness and perception of voluntary counselling and testing. The study sought to find out whether year of study, marital status and home location influenced their level of awareness and perception of voluntary counselling and testing. This chapter recounts the summary of the major findings, the conclusions reached, recommendations and areas that require further research.

5.2 Summary of Major findings

Based on the results of this study, it can be concluded that the following are the major findings:

(i) In the study, it was found that the female teacher trainees have learned about voluntary counselling and testing from media and forums.

(ii) The study also found that the female teacher trainees had adequate awareness of voluntary counselling and testing.

(iii) Resource persons who have contributed to the awareness of voluntary counselling and testing in the college were found to include religious leaders, the college principal and tutors.

(iv) The medical and Anti-Aids personnel were found to have a low participation in voluntary counselling and testing awareness at the college.

(v) People living with Aids were suggested by the female teacher trainees to be effective in disseminating vital information about HIV testing in teacher training colleges.

(vi) Female teacher trainees were found to perceive HIV testing as enabling one to know the HIV status.

(vii) The main reasons that were given by the female trainees for accepting blood test were to know one's status and to organize for one's future life.

(viii) Some female trainees would not go for blood test because they were scared of the results.

(ix) Female teacher trainees were found to be free with their agemates in discussing HIV test. It was followed by religious leaders, tutors and the least indicated group were the parents.

(x) Female trainees' year of study seem not to significantly influence their awareness level of voluntary counselling and testing.

(xi) The mean difference in perception of voluntary counselling and testing between the first and second year female trainees was found to be statistically insignificant.

(xii) Marital status of the female trainees seem not to influence their perception of voluntary counselling and testing.

(xiii) Female teacher trainees' home location was found to be statistically insignificant in their perception of voluntary counselling and testing.

5.3 Conclusions

The aim of the study was to determine the female teacher trainees awareness and perception of voluntary counselling and testing in a selected teacher training college in

Kericho. From the findings of this study, it can be concluded that female teacher trainees had adequate awareness of voluntary counselling and testing. This is because they have learned about voluntary counselling and testing from media and forums. It was further observed that resources persons, such as religious leaders, the college principal and tutors contributed to awareness of voluntary counselling and testing in college.

Besides, the study findings also revealed that female teacher trainees have a positive perception of voluntary counselling and testing. It was observed that they would accept blood test in order to know their HIV status so as to organize for their future lives. Other factors studied which included year of study, marital status and home location of the female trainees did not have significant effect on their awareness and perception of voluntary counselling and testing.

5.4 Recommendations

From the findings, it is evident that the female teacher trainees have adequate awareness and positive perception to voluntary counselling and testing. In effect, the primary source of information on voluntary counselling and testing is the mass media and forums. Further, resource persons like religious leaders, the college principal and tutors contribute to awareness of voluntary counselling and testing in the college. However, year of study, marital status and home location does not have significant effect on the female trainees' awareness and perception of voluntary counselling and testing. Therefore, based on the findings of this study, the researcher made the following recommendations:

i) The Ministry of Education in conjunction with the Ministry of Health, need to establish educational and communication department for HIV/AIDS awareness and

voluntary counselling and testing in teacher training colleges. This will help in accessibility of the HIV testing services and educational instruction.

ii) The Office of the President should encourage the chiefs in liason with the Ministry of Health, to step up education in various communities about voluntary counselling and testing. It was evident from the findings that media and forums such as barazas were primary sources of voluntary counselling and testing. Open air films should be used to disseminate information on voluntary counselling and testing.

iii) Religious leaders and college lecturers should be educated on voluntary counselling and testing. This is because from the study findings, it was established that they contribute in disseminating information on voluntary counselling and testing in the teacher training colleges.

iv) People living with Aids (PLWA) need to be involved in disseminating vital information on voluntary counselling and testing in the middle level colleges. It was evident from the findings that the PLWA would be effective in educating teacher trainees.

v) Peer counsellors in teacher training colleges should be equipped with counselling skills in order to access vital information on voluntary counselling and testing. Evidently, from the findings, female trainees were found to be free with their agemates in discussing HIV testing.

vi) The medical and Anti-Aids personnel should be encouraged to extend their services to colleges, for the findings indicated low participation in voluntary counselling and testing awareness in the college.

vii) The media should double its efforts in sensitizing the society on voluntary counselling and testing through publications; magazines, tracts, films and videos.

Evidently, the findings noted the media especially television, radios and video viewing as the primary source of VCT awareness.

5.4.1 Recommendations for further research

The study raised up series of questions, which require further investigation. The researcher therefore recommends further research in the following areas.

i) A similar study should be conducted to examine the male teacher trainee's awareness and perception of voluntary counselling and testing for comparison and make conclusion on teacher trainees' awareness and perception of voluntary counselling and testing.

ii) A systematic study adopting cross-sectional design to determine teacher trainees' awareness and perception of voluntary counselling and testing so as to make prediction based on the correlational results for national inference.

iii) A similar study on college lecturers' awareness and perception of voluntary counselling and testing to establish their competence and effectiveness in disseminating information on voluntary counselling and testing to the teacher trainees.

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APPENDIX A

FEMALE TEACHER TRAINEES' QUESTIONNAIRE

Letter of Introduction

Dear Respondent,

I am carrying out a research on female teacher trainees' awareness and perception of Voluntary Counselling and HIV testing. You have been chosen to participate in this study. Any information you give will be very useful in determining how best to make Voluntary Counselling and HIV testing effective. Therefore, I am kindly requesting you to be as honest as possible. May I assure you that the information you give will be treated with confidentiality and will only be used for the purposes of this study. I wish to thank you very much for anticipated cooperation in this endeavour. Honest responses will enable the researcher to complete her study. Please follow the set instructions. Your input will be highly appreciated.

Yours sincerely,

Alice Bett

SECTION A

GENERAL INSTRUCTIONS TO THE RESPONDENTS

i) Your careful, complete and honest answers to this questions will help the Ministries of Education and Health to improve HIV/AIDS awareness in Teacher Training Colleges.

ii) In answering this questionnaire, please bear the following in mind:

   a) The questionnaire is not a test

There is no grade or other mark attached to the answers you will give. The only right answer to the questions are those which best explain your situation or express your views.

b) Your individual identity will not be known:

All your answers will be treated confidentially. Information will be reported only in statistical summaries.

c) Answer every question in accordance with directions. Please note that questions ask you to check only one answer and yet others ask you to give reasons.

d) Please read every question or statement carefully before answering. It will not take you long to answer these questions.

e) Don't indicate your name anywhere on this questionnaire.

THANK YOU

SECTION B

BIO-DATA

This questionnaire is designed to know more about yourself and your views about Voluntary Counselling and HIV testing. Please answer all questions by ticking and filling in the gaps where appropriate.

1. Indicate your age bracket

   i) 18 – 22 [ ]

   ii) 23 – 27 [ ]

   iii) 28 – 32 [ ]

   iv) 33 – 37 [ ]

   v) 38 - 42 [ ]

   vi) 43 and above [ ]

2. Indicate your year of study

   i) 1st [ ]

   ii) 2nd [ ]

3. Indicate your marital status?

   i) Single [ ]

   ii) Married [ ]

   iii) Divorced [ ]

   iv) Separated [ ]

   v) Widow [ ]

4. Where is your home situated?

   i) Rural [ ]

   ii) Urban [ ]

5. If not married, do you live with your parents when at home?

   i) Yes [ ]

   ii) No [ ]

   If NO, at what stage did you live with your parents?

   i) Initial childhood [ ]

   ii) Throughout childhood [ ]

   iii) Until age 18 [ ]

   iv) Never [ ]

6. Indicate your family set up?

   i) Nuclear [ ]

   ii) Polygamous [ ]

   iii) Single parent [ ]

7. How far did your father go in education?

   i) No Schooling [ ]

   ii) Primary [ ]

   iii) Secondary [ ]

   iv) Middle level college [ ]

   v) University [ ]

   vi) Other (specify) _____

8. How far did your mother go in education?

   i) No Schooling [ ]

   ii) Primary [ ]

   iii) Secondary [ ]

   iv) Middle level college [ ]

v) University [ ]

vi) Other (specify) _____

9. What is your father's main sector of employment?

Formal [ ]

Informal [ ]

10. What is your mother's main sector of employment?

Formal [ ]

Informal [ ]

11. What is the major source of your family income?

Salaries [ ]

Business [ ]

Animal rearing [ ]

Crop growing [ ]

12. What is your family income per month?

i) Under 5000 [ ]

ii) 5,001 – 10,000 [ ]

iii) 10,001 – 20,000 [ ]

iv) 20,001 – 30,000 [ ]

v) Over 30,000 [ ]

SECTION C

VOLUNTARY COUNSELLING AND HIV TESTING (VCT) AWARENESS

1. How adequate is the information you have about VCT?

   i) Very adequate [ ]

   ii) Adequate [ ]

   iii) Inadequate [ ]

   iv) Very inadequate [ ]

2. From what sources have you learnt about VCT? (Tick all appropriate sources)

   i) Friends [ ]

   ii) Radio [ ]

   iii) Television [ ]

   iv) Posters [ ]

   v) Newspapers [ ]

   vi) College sensitization programmes [ ]

   vii) Other (specify) _____

3. If there were facilities to test people's blood free of charge, would you accept to be tested for HIV/AIDS?

   i) True [ ]

   ii) False [ ]

   Give reason (s) for your response _____

---

4. Would you like to know the results of your test?

   i) True [ ]

   ii) False [ ]

Give reason (s) for your response _____

_____

5. The AIDS test will tell you if the HIV virus is present in your body

   i) True [ ]

   ii) False [ ]

6. You can be safe in unprotected sexual contact with someone who has shown you his negative AIDS test results.

   i) True [ ]

   ii) False [ ]

7. A 'HIV positive' test indicates that one is already infected.

   i) True [ ]

   ii) False [ ]

8. If both partners in a relationship test positive on the AIDS test, there is no value in practicing 'safe sex'

   i) True [ ]

   ii) False [ ]

9. When a vaccine is developed for the AIDS virus, it will not reverse someone's HIV positive status.

   i) True [ ]

   ii) False [ ]

10. Will a positive test result keep one from getting married?

    i) True [ ]

    ii) False [ ]

11. How have you as an individual tried to increase your knowledge about Voluntary Counselling and HIV testing? Through (Tick all that apply)

i) Visiting community based Counseling Organisations [ ]

ii) Reading newspapers [ ]

iii) College sensitization programmes [ ]

iv) Medical personnel [ ]

v) College Guidance and Counselling department [ ]

vi) Visiting the VCT [ ]

vii) Have not made any effort at all [ ]

12. How often do the students in your college hear about Voluntary Counselling and HIV testing from the following people: Indicate by a [√]

	OFTEN	RARELY	NEVER
i) The principal and tutors	[ ]	[ ]	[ ]
ii) Medical personnel	[ ]	[ ]	[ ]
iii) Anti-Aids Organisation	[ ]	[ ]	[ ]
iv) Religious speakers	[ ]	[ ]	[ ]

13. How often do you discuss about AIDS test with the following groups of people? Indicate with a mark [√]

	OFTEN	RARELY	NEVER
i) Parents	[ ]	[ ]	[ ]
ii) Age mates	[ ]	[ ]	[ ]
iii) Religious leaders	[ ]	[ ]	[ ]
iv) College tutors	[ ]	[ ]	[ ]
v) Medical staff	[ ]	[ ]	[ ]

14. Who among the following would you consider most effective in informing the teacher trainees about HIV testing? Circle ONE answer.

a) Parents/guardians

b) College tutors

c) Religious leaders

d) People with AIDS

15. Does a person with HIV infection have characteristics (symptoms) which can be used to identify him/her?

i) Yes [ ]

ii) No [ ]

If no, how can you tell who has HIV? _____

16. Would you be able to do the following with a first or a new partner?

	YES	NO	DON'T KNOW
i) Ask how many partners he has had	[ ]	[ ]	[ ]
ii) Discuss using codoms before having sex	[ ]	[ ]	[ ]
iii) Ask him to be tested for HIV before having sex	[ ]	[ ]	[ ]

16. If you found results of your blood test to be HIV positive, what would you do? (Tick all that apply).

i) I would commit suicide [ ]

ii) I would tell my family [ ]

iii)I would tell my friends [ ]

iv) I would announce publicly [ ]

v) I would keep quiet [ ]

vi) I would spread the disease

by being promiscuous [ ]

18. What do you think needs to be done to control the spread of HIV/AIDS in teacher training colleges? (please list them in order of preference, using – 1,2,3,4, etc)

i) Visit a VCT centre and know your status [ ]

ii) Avoid sharing sharp objects [ ]

iii) Wear protective gloves when

handling someone who is bleeding [ ]

iv) Through sexual abstinence [ ]

v) Avoid blood transfusions

by untrained personnel [ ]

vi) Insist on tested blood if transfusion is

necessary [ ]

SECTION D

PERCEPTION OF VOLUNTARY COUNSELLING AND HIV TESTING

Read the items carefully and tick the one that corresponds to your feelings towards Voluntary Counselling and HIV testing. Tick [√] only one in each column for each statement.

The choices are: **SA** = Strongly Agree, **A** = Agree, **UN**= Uncertain **D** = Disagree, **SD** = Strongly Disagree

Statement	SA	A	UN	D	SD
1. HIV testing is good because it enables one to know his/her HIV status					
2. It is good to have adequate VCT centres in my District					
3. I don't visit VCT centres because they do not have qualified staff.					
4. Counselling an individual before undergoing an HIV test is important.					
5. Counselling an individual after an HIV test is important					
6. I usually encourage people to visit VCT centres					
7. VCT centres should be integrated within the hospitals so that other people will not know that you have gone for an HIV test.					
8. HIV testing will help in behaviour change in the society					
9. Those planning to join teacher training colleges should undergo HIV test.					
10. More VCT centres should be established in both rural and urban areas.					
11. Counselling helps encourage the patient to adopt behaviour which prevents transmission of the HIV virus.					
12 VCT services is not good for married women because of their husband's reaction if tested positive.					
13. I like going to a VCT centre where the counsellors keep the information confidential.					
14.People should know their HIV status early when the body's defence is still strong to fight back					

APPENDIX B

REQUIRED SIZE FOR RANDOMLY CHOSEN SAMPLE

TABLE FOR DETERMINING SAMPLE SIZE

N	S	N	S	N	S	N	S
10	10	140	103	550	226	4500	354
15	14	150	108	600	234	5000	357
20	19	160	113	650	241	6000	361
25	24	220	140	700	248	7000	364
30	28	230	144	750	254	8000	367
35	32	240	148	800	260	9000	368
40	36	250	152	1200	291	10000	370
45	40	260	155	1300	297	15000	375
50	44	270	159	1400	302	20000	377
55	48	280	162	1500	306	30000	379
60	52	290	165	1600	310	40000	380
65	56	300	169	1700	313	50000	381
70	59	320	175	1800	317	75000	382
75	63	340	181	1900	320	100000	384
80	66	360	186	2000	322		
85	70	380	191	2200	327		
90	73	400	196	2400	331		
95	76	420	201	2600	335		
100	80	440	205	2800	338		
110	86	460	210	3000	341		
120	92	480	214	3500	346		
130	97	500	217	4000	351		

N = Population size; S = sample size

Source: Kathuri, J.N & Pals, D.A (1993). Introduction to Educational Research. Njoro, Kenya: Egerton University press.

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