

**KNOWLEDGE, ATTITUDE AND PRACTICES OF HOUSEHOLD HEADS ON
HIV/AIDS IN NJILAH AND NJIPNKANG SLUMS OF NDU HEALTH
DISTRICT- NWR CAMEROON**

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Abstract

Introduction

The incidence of HIV/AIDS has been on the rise since the discovery of HIV as the cause of AIDS in 1984. In Ndu District, the HIV prevalence at 10% is higher than that of the whole country of 3.3%.

The study objectives: To establish the knowledge, attitude and practices among the household in Njilah and Njipnkang towards HIV/AIDS in Ndu District.

Study design: Descriptive cross-sectional study.

METHODS: Structured questionnaires were administered to 341 household heads in both Njilah and Njipnkang slums. Two Focus Group Discussions were conducted one for men in Njilah and another for Women in Njipnkang. Two in-depth interviews were also done. Data was analyzed by the SPSS 18.0 version.

RESULTS: Out of the 341 respondents, 56.3% were females. Majority (75.7%) was married and most of them knew what HIV/AIDS is. Unprotected sexual intercourse was known by many (94.3%) as the major route of HIV/AIDS transmission, other modes included sharing of needles, MTCT, and unsafe-blood transfusion. Although many (91.2%) said that they knew how to prevent themselves, they still had multiple sexual partners (50.1%) with low use of condom (48.3%). Age, income, education and number of sexual partners were tested against condom use and showed no association.

Conclusion and Recommendation

People in these slums knew what HIV/AIDS is, modes of transmission and how to prevent themselves. However, the practices, behaviors and their attitudes were contrary to this. There is need for intensive health education on behavior change, promotion of condom use and provision of VCT Services.

Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ARV	Anti-retroviral
CI	Confidence Interval
DHMT	District Health Management Team
FGD	Focus Group Discussion
HC	Health Centre
HIV	Human immune deficiency Virus
MSM	Men having Sex with Men
NASCOP	National AIDS and STD Control Programme
NCAPD	National Coordination Agency for Population and Development
RCO	Registered Clinical Officer
STD	Sexually Transmitted Diseases
STI	Sexually Transmitted Infections
UNESCO	United Nations Educational Scientific and Cultural Organization
UNAIDS	United Nations Agency for International Development
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
VCT	Voluntary Counseling and Testing

Chapter 1: Introduction and Literature Review

1.1 Introduction

The number of people living with HIV has risen from around 8 million in 1990 to 37.4 million today, and is still growing. Around 67% of people living with HIV are in sub-Saharan Africa. 31.4 million being adults and 2.1 being children. Out of the total adults, 15.7 million are women. The total adults deaths as a result of HIV/AIDS in 2021 alone was 2.0 million while children AIDS deaths was 0.28 million. Twenty-five million people have died of AIDS since 1981. At the end of 2021, women accounted for 50% of all adults living with HIV worldwide. As a result, Africa has over 14 million AIDS orphans (UNAIDS, 2020).

Over 22.4 million people are living with HIV/AIDS in Sub-Saharan Africa. In developing and transitional countries, 9.5 million people are in immediate need of life-saving AIDS drugs; of these, only 4 million (42%) are receiving the drugs (UNAIDS, 2020).

Though the population of the Eastern and Southern Africa region currently represents only about 6 percent of the world's population, 32 percent of all new HIV infections around the world in 2007 occurred there. Without widespread accessibility to antiretroviral drugs, many of those people infected will continue to develop AIDS, and the number of deaths resulting from the disease will not abate. In fact, in the same year, 3 out of every 4 people who died were from Eastern and Southern Africa (UNAIDS, 2020).

Over two decades since the first AIDS case was described in Cameroon, HIV/AIDS still remains a huge problem for the country in its efforts for social and economic development. Responses to the pandemic have evolved over time as people became aware of this new disease, as they experienced illness and death among family members, and as services have developed to confront this epidemic (NASCO, 2015).

Today in Cameroon, the HIV epidemic is better understood. New information on the level of HIV infection comes from the national HIV prevalence survey, the Cameroon demographic and health survey (CDHS, 2018) which estimated that 4.3% of adults age 15 to 49 years in Cameroon are infected with HIV and that rates in women are nearly double the rates in men. Annual sentinel surveillance at selected sites has demonstrated significant declines of HIV prevalence in pregnant women. Using these and other sources of information, prevalence of HIV infection in adults appears to have peaked at 10% in the late 1990s and has been declining in many parts of the country (NASCOP, 2015).

The number of people living with HIV in Cameroon includes about 550 thousand adults between 15 and 49 years, another 60,000 age 50 and over, and approximately 100,000 children. Urban populations have higher adult HIV prevalence (10%) than do rural populations (6%). Regional variation is significant (NASCOP, 2015).

More than 56% of Cameroonians currently live below the poverty line and have less than a dollar per day to spend on everything needed to live. Discussion over the rising poverty level in Cameroon and how it has resulted in negative economic growth over the last two decades is the subject of many forums. Poverty in Cameroon is a function of a number of interrelated factors: untapped or poorly used human resources, low levels of industrialization, inadequate or poorly maintained infrastructure, issues of governance and economic policy, and socio-demographic factors.

The intricate relationship between poverty and HIV continues to be a vicious cycle in the national response to the pandemic. While increasing poverty levels continue to fuel the spread of HIV, the pandemic itself exacerbates those levels in households and families with people living with HIV/AIDS. Families in vain spend huge percentages of their resources searching for cure or better health for their infected loved ones. Until 2003, when the Industrial Properties Act removed legal barriers to importing generic drugs, bringing down the cost of ARVs significantly, their cost was beyond the reach of most Cameroonians (UNGASS, 2008).

Over the last 20 years, the socio-economic impact of HIV/AIDS has manifested itself in key areas of the economy. Health expenditures have risen and will continue to rise and productivity will be adversely affected. Controlling the HIV epidemic is a key part of strengthening the economy in the 21st century (NAS COP, 2015).

In the year 2001, Donga Mantung Division had over 110 health facilities spread across the district. The average distance to a health facility is 5 Km. The most prevalent diseases are Malaria and Skin diseases while the childhood diseases include anaemia, marasmus, eye infection, pneumonia, malaria and Kwashiorkor (NHDP, 2016)

One of the reproductive health concerns that have continued to affect a large population of Cameroonians in their reproductive ages is STI/HIV/AIDS. In Ndu Health District, HIV prevalence is of great concern. In year 2014, HIV prevalence rate was estimated to be 15%. The impact of the scourge has been felt at all levels of the district's economic and social circles. An increase in the number of HIV/AIDS orphans and street children has been noted. HIV/AIDS in Ndu is a major health problem with the prevalence averaging 15%. With regard to bed occupancy, about 50% of the hospital beds are occupied by patients with HIV/AIDS related diseases. HIV/AIDS in the district was diagnosed in June 1989 and 4 males and 5 females tested HIV positive. In December of the same year, 42 cases had been reported and since then the numbers have continued to increase ((NHDP , 2016).

Majority of HIV/AIDS patients are found in Ndu Town and its environs and in all towns along the Ndu – Nkambe High ways. Cases are being reported in the small up-coming towns in the district like Nwa. HIV/AIDS incidences along the major highway and upcoming towns are attributed to the long distance truck drivers\trucks and, the commercial, sex workers. The biggest challenge facing the district is the increasing cases HIV/AIDS in spite of the awareness level of over 85 per cent. It also faces the challenges of providing medical care for the infected and support for the affected. Currently the district estimates that there are over 15,000 children who are in need of special care (CSP) and this numbers is expected to rise due to the increasing number of HIV/AIDS orphans (NHDP, 2016).

The labour force in Ndu District is increasing rapidly. According to the 2013 Population and Housing Census the total population of this age group represented 47.6% (465,432) of the total population and comprised 221,403 males and 244,029 females. This number is projected to increase to 542,379 comprising of 258,006 males and 284,373 females by year 2022. The high increase in labour force has led to increase in unemployment and this could lead to escalation of crimes as a result of non-absorption of this active population in services of gainful employment, which may as well lead to the HIV infection. During the poverty assessment exercise carryout in year 2013, the district was estimated to have 66.2 percent of the population as poor (NHDP, 2016).

High unemployment rate, high rate of school dropout, high rate of early marriages and pregnancies and high rate of HIV/AIDs prevalence are the major concerns affecting youth and children. Child labour, orphans and street children are on the increase. In Ndu District, gender disparities are manifested through school enrolment, property ownership, access to credit and discrimination in places of work among others. In Ndu District gender disparities are manifested through school enrolment, property ownership, access to credit and discrimination in places of work among others (NHDP, 2016) It is generally accepted and well-documented that long distance truck drivers have been and remain one of the key forces in the spread of HIV/AIDS pandemic across the African continent. The role of truck drivers in the transmission of HIV/AIDS and other sexually transmitted diseases is rooted in the lifestyle that comes with the profession, as well as the broader social and economic societal factors.

Truck drivers are highly mobile and spend long hours on the road away from their families. Their need for entertainment and female companionship, coupled with relative solvency compared to the rest of the population, makes them very likely to use the services of commercial sex workers in stop-over towns near major transportation routes. These truck stop towns have developed an entire infrastructure of networks and services meeting the business and recreation needs of truck drivers, including gas stations, inspection points, lodges, bars and brothels, and a high population of commercial sex

workers. The resulting co-mingling of the two mobile, sexually active, high-risk populations explains high prevalence of HIV and STI rates in truck drivers and the subsequent spread of the disease through the African continent. In addition to having sex with Female Sex Workers, most truck drivers have regular girlfriends or wives at home who are likely to become infected with HIV by their husbands and boyfriends, and continue spreading the virus in their local communities (Hudson, 1996).

A survey of truck drivers visiting sex workers at truck stops in KwaZulu-Natal found an overall HIV prevalence of 56% - staggering, but hardly surprising considering the findings of a related study by the same authors (Ramjee *et al.* 1998) that found similar rates of infection in sex workers servicing the same truck stops along the major road between Durban and Johannesburg in summer 1996/spring 1997. Half of the women were HIV seropositive, and the occurrence of various STIs was between 14% and 71% (Ramjee *et al.*, 2002).

A high HIV prevalence is, of course, not limited to truck drivers only in Southern African countries. A survey of 236 truck drivers in Burkina Faso in 1994 found HIV prevalence rates of approximately 18% (Lankoande *et al.*, 1998). In Eastern Africa, several studies reported HIV prevalence rates of 25% to 32% among truck drivers in Kenya and Uganda. (Mbugua *et al.*, 1995; Bwayo *et al.*, 1994). Truck drivers along the Mombasa-Nairobi high way were enrolled at a road side research clinic near Nairobi between 1989 and December 1991. A total of 952 truck drivers, from eight countries were enrolled. The sero-prevalence was 26.7% for HIV and 5.6% for syphilis. This is an important group for the spread of HIV within and across borders and should be targeted for health education and control programs for STDs/HIV. Conditions for employment contribute to their high risk sexual behavior (Job *et al.*, 1992).

1.2 Problem statement

World wide, AIDS has already taken some 20 million lives, created 15 million AIDS orphans and caused enormous personal, social and economic losses. HIV infection is now a major cause of disease and the death among persons aged 25-44 years. Among young people aged 15-24, some 10 million are currently living with HIV/AIDS and every day, some 6,500 new infection, that is half of all new infections occur among people in this age group. Unfortunately only a fraction of the young people currently infected knows about it. The lack of information and/or misinformation about HIV and AIDS fuel a great deal of prejudice, causing individuals to fear contact with people who are infected or whose friends or relatives are infected. Stigma and discrimination discourage people from being tested and disclosing their HIV status. This contributes to the spread of the virus, and delays treatment that can reduce the suffering of persons living with HIV/AIDS (UNESCO, 2002). The incidence of HIV/AIDS has been on the rise since the discovery of HIV as the cause of AIDS in 1984. In Ndu District, the HIV prevalence at 10% is higher than that of the whole country of 3.3%.

and in 2006, 85,000 people died from AIDS related illnesses. Cameroon's HIV prevalence peaked during 2000 and according to the latest figures the prevalence has dramatically reduced to around 3.3%. This decline is thought to be partially due to an increase in education and awareness, and high death rate. Many people in Cameroon are still not being reached with HIV prevention and treatment services. Only 1 in 4 children needing treatment are receiving it. These demonstrates that Cameroon still has a long way to go in providing universal access to HIV treatment, prevention and care (NHDP, 2016).

Lack of knowledge and misconception about HIV/AIDS, are the key factors contributing to the inadequate prevention efforts and it has been shown that people need a solid factual understanding of HIV and its transmission, access to relevant services and social power to initiate and sustain behavior change in order to prevent the spread of HIV/AIDS (Cindy 1998, Gupta and Wiess, 2000). Although knowledge alone does not change and there is no significant relationship between sexual knowledge and safer sex, knowledge of the fact of

HIV transmission plays obvious role in increasing the likelihood of safe sex through perception of individual risk mediate action based on knowledge (Camlim and Chibwete, 2003)

1.3 Justification

Cameroon's HIV epidemic has been categorized as generalized – meaning that HIV affects all sectors of the population. Nearly half of all new infections were transmitted during heterosexual sex while in a relationship and 20% during casual heterosexual sex (NHDP, 2016).

HIV prevalence is higher amongst specific groups and tends to differ according to location, gender and age. Various studies have revealed high HIV prevalence amongst a number of key affected groups, including sex workers, injecting drug users, men who have sex with men (MSM), truck drivers and cross-border mobile populations. Some of these groups are marginalized within society. Therefore these groups are difficult to reach with HIV prevention, treatment and care, and the extent to which HIV is affecting these groups has not been fully explored. Up to 33% of new infections in 2008 were within these most at risk populations (NHDP, 2016).

Women are disproportionately affected by HIV. In 2008/2009 HIV prevalence among women was twice as high as that for men at 8% and 4.3% respectively. This disparity is even greater in young women aged 15-24 who are four times more likely to become infected with HIV than men of the same age. Cameroon women experience high rates of violent sexual contact, which is thought to contribute to the higher prevalence of HIV. In a 2003 nationwide survey, almost half of women reported having experienced violence and one in four women aged between 12 and 24 had lost their virginity by force. Adult HIV prevalence is greater among urban areas 8.4% than rural areas 6.7% of Cameroon. However, as around 75% of people in Cameroon live in rural areas, the total number of people living with HIV is higher in rural settings 1 million adults than urban settings 0.4 million adults (NHDP, 2016).

There was scanty or no information available on the level of knowledge in Ndu district on HIV/AIDS. This called for a study to be carried out in order to establish the level since lack of awareness can increase transmission. HIV being a problem of global concern, the study was intended to help provide policy makers and other key stakeholders with information in developing prompt and viable interventions. HIV/AIDS was declared a national concern in Cameroon. Douala was characterized by several high risks groups of because the place is an industrial area as well as a stopover for the truck drivers, which attracts the influx of commercial sex workers. To effectively control the spread of HIV in the Njilah and Njipnkang slums, health care providers therefore needed information to understand not only the gaps in knowledge but also the attitudes and practices that may have a bearing in the control of infection in the community they serve. This study was designed to provide information on the knowledge, attitude and practices related to HIV/AIDS among the households in Njilah and Njipnkang Slums in Ndu District.

1.4 Research Questions

1. What was the level of knowledge on HIV/AIDS among house hold heads in Njilah and Njipnkang slums?
2. What were the attitudes of house hold heads towards HIV/AIDS in Njilah and Njipnkang slums??
3. What were the practices of house hold heads towards HIV/AIDS?

1.5 Objectives

Broad Objectives

To establish the knowledge, attitude and practices among household heads in Njilah and Njipnkang slums towards HIV/AIDS.

Specific Objectives

1. To establish the level of knowledge of HIV/AIDS among household heads in Njilah and Njipnkang slums
2. To establish the attitude of the household heads towards HIV/AIDS in the slums
3. To establish the practices in the community towards HIV/AIDS.

1.6 Hypothesis

There was no relationship between knowledge and attitude in regard to the practices associated with HIV/AIDS among the household heads.

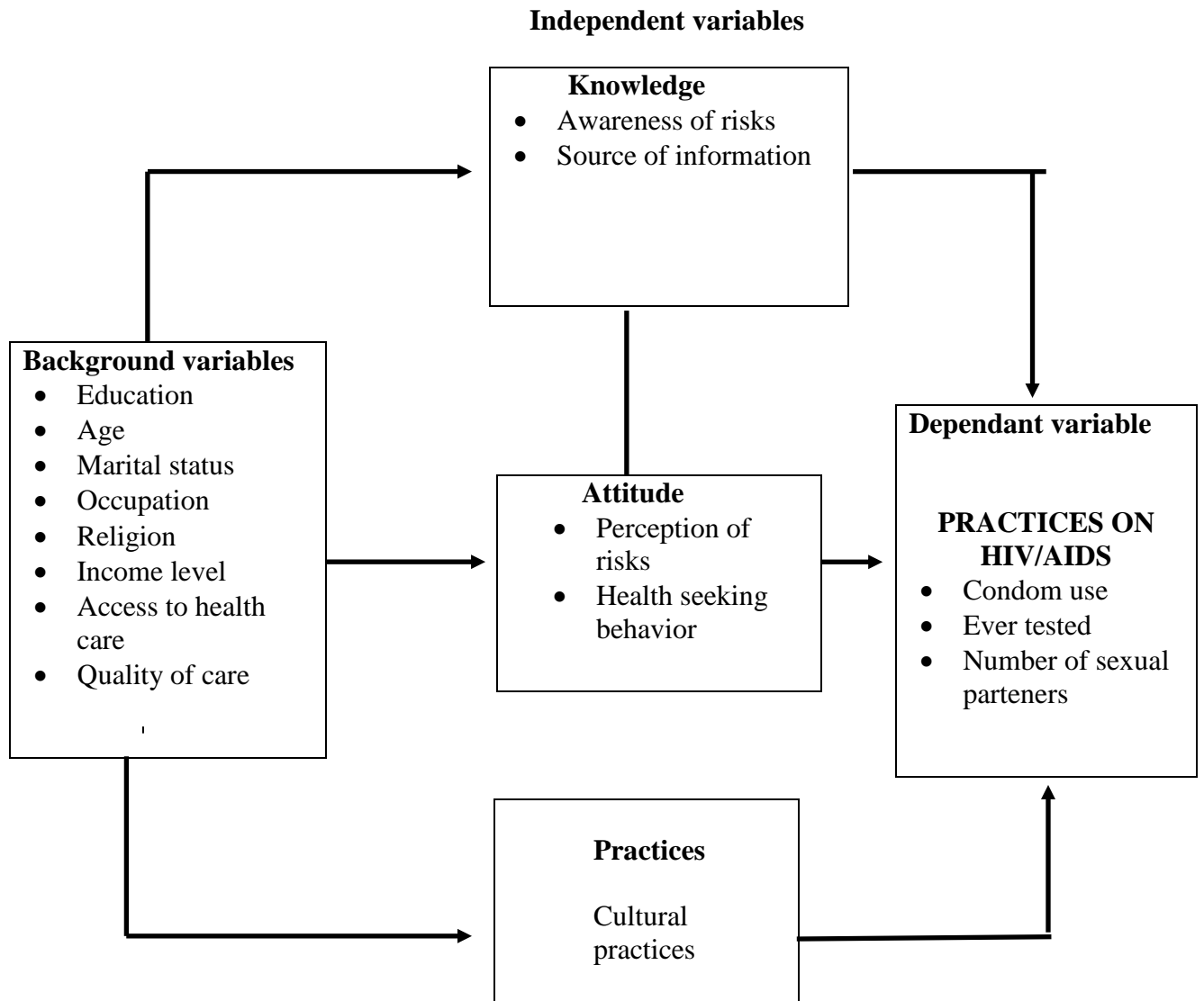


Figure 1: Conceptual Framework

1.7 Study area

Ndu District is one of the 52 districts that form North West Regions. The district borders the city of Kumbo and Nkambe District to the northwest, Nwa District to the east, Magba District to the west, Mbiame District to the south and Nfumte District to the north. It stretches from latitudes 0° 45' south to 1° 31' south and longitudes 36° 45' east to 37° 45' east. The district covers an area of 6,281.4kms most of which is semi-arid. It has a total population of 276,576 in year 2008 (NHDP, 2016)

In Ndu District, the population of females of reproductive age group (15-49) was estimated to be 214,759 in 2020 and is projected to increase to 250,264 by year 2023. Although High and medium potential areas where rain fed agriculture is carried out consist of a District Hospital, 2 dispensaries and 23 private health facilities, 3 VCT centres with over 1000 registered clients. There are 4000 households in Njilah and Njipnkang slums with Malaria, Diarrhoea, URTI, and Skin diseases as the top diseases. It has 3 Government health facilities, Ndu Municipal Council. They have fertile soils that support other cash and food crops and receive moderate rainfall (NHDP, 2016)

CHAPTER TWO: METHODOLOGY

2.1 Study Design

A cross sectional study was done to establish the knowledge, attitude and practices related to HIV/AIDS among the household members living in Njilah and Njipnkang slums. Both qualitative and quantitative data was collected.

2.2 Study Population

The target population was household heads who were present at home during the time of data collection.

2.3 Sampling Technique

NDU district was purposefully selected due to the high HIV prevalent rate of 10% in Njilah and Njipnkang slums. The households was put in clusters then systematic sampling was used to get to the households.

2.3.1 Sample Size Determination

Sample size was calculated as follows: $n = \frac{z^2 pq}{d^2}$

Where n = maximum desired sample size,

z = standard normal deviation set at 1.96, which corresponds with 95% CI

P= proportion of the target population estimated to have a particular characteristics of Interest (50%)

d= Minimum error (degree of accuracy desired) set at 0.05.

q= the proportion of the remaining population (1-P)

That is $q=1-0.5=0.5$

$$n = \frac{z^2 pq}{d^2} = \frac{1.96^2 * 0.5 * 0.5}{0.05^2} = 385 \text{ respondents}$$

Number of household heads in Njilah and Njipnkang slums =4000

$$nf = \frac{n}{1 + \frac{n}{N}} = \frac{385}{1 + \frac{385}{4000}} = 352$$

Desired sample size (n) is 352 household heads

2.4 Data collection methods and tools

In this study both qualitative and quantitative data were collected. Questionnaires were administered to respondents from households and it generated quantitative data while focus group discussions and in-dept interviews were conducted which generated qualitative data. Selection for inclusion in the focus group discussion were based on the willingness of the respondent to participate.

2,4.1 Tools

The tools used in collection of qualitative data were key informants guides and focus group discussion guides for women at the slum. While structured interview schedule were used to collect quantitative data and were administered to household heads.

2.5 Quality Control

The interview schedule were pretested and the necessary adjustments made before actual data collection. The research assistants were recruited and trained before the onset of data collection. The questionnaires were checked on daily basis including field editing and data cleaning through running frequencies for errors and inconsistencies.

2.6 Ethical considerations

Authority to undertake this study were obtained from the District Medical Officer. The Ndu District Health Management Team showed interest in the study and ready to facilitate the process. Members of the community will be consulted in the planning of the research. Verbal consents was sought from each household head before interviews was conducted. Research participants was considered partners, not research subjects and their daily work schedules was respected

2.7 Study variables

Table. 1 operational definition of variables

SN	VARIABLE	DISCRIPTION	SCALE OF MEASURE
1.	Socio-demographic Age Sex Marital status Religion	Age in complete years Sex of the respondent Marital status of the respondent Religion of the respondent	Continuous Binary Nominal Nominal
2.	Socio-economic Occupation Income level Educational level	Occupation of the respondent Source of income of the respondent Level of education of the respondent	Categorical Categorical Ordinal
3.	Knowledge on HIV/AIDS	Level of knowledge of the respondent on HIV/AIDS prevention and transmission	Binary
4	Attitude towards HIV/AIDS	Perception and opinion of the respondent towards HIV/AIDS	Categorical
5.	Practices related to HIV/AIDS	The practices of the respondents that increase or reduce the spread of HIV/AIDS	Binary

2.8 Data processing and analysis

Data was analyzed using SPSS Version 23.0. Categorical data was analyzed and presented in frequencies, proportions and percentages while numerical data was also analyzed and presented in measures of central tendency and dispersion.

2.9 Limitations and constraints

The time period set for the study was short to collect the desired sample size. Some of the researchers could not speak the local language which delayed the process of data collection. The availability of the research assistants and the hard work of the researchers helped in combating these constraints.

CHAPTER 3: FINDINGS AND INTERPRETATIONS

This chapter presents findings from Njilah and Njipnkan slum areas. There were 242 respondents from Njipnkang and 99 respondents from Njipnkan respectively. The study findings from the two areas are combined and presented as a single document. It is in the form of text, tables and figures.

3.1: Section A: Socio-Demographic Characteristics

More than half (56.3%) of the respondents were females and the rest males. The majority (75.7%) of the respondents were married followed by single (19.4%) and the rest were either separated, widowed or divorced. About fifty two percent (51.9%) attained formal education up to primary level, 42.2% acquired secondary education and 5.0% attained tertiary level of education. Over two thirds (61.6%) of the respondents were Christian protestants, followed by Catholics (32.0%) and the rest were either Muslims or others who said they had no religion. The findings showed that 30.5% of the respondents were self employed, 20.5% formerly employed receiving salaries while 13.2% were engaged into business. The rest were house wives, students and Casual workers.

Table 2: Socio-Demographic characteristics of respondents (n=341)

Marital status of respondents	Frequency	Percent
Single	66	19.4
Married	258	75.7
Separated	8	2.3
Divorced	6	1.8
Widowed	3	0.9
Total	341	100
Educational level of respondents		
None	3	0.9
Primary	177	51.9
Secondary	144	42.2
Tertiary	17	5.0
Total	341	100
Sex of respondents		
Male	149	43.7
Female	192	56.3
Total	341	100

Religion of respondents		
Christian protestant	210	61.6
Catholic	109	32.0
Muslim	6	1.8
Others	16	4.7
Totals	341	100.0
Occupation of respondents		
Employed	70	20.5
Self employed	104	30.5
Business	45	13.2
Housewife	76	22.3
Student	12	3.5
Casual workers	34	10.0
Total	341	100

3.1.1 Age and income level of the respondents

Out of the 341 people interviewed, 267 respondents gave out their ages and income levels. The mean age of the respondents was 31.04 years with a standard deviation of ± 9.4 years (95% Confidence Interval 29.91-32.18). The youngest respondent was 17 years while the oldest was 67 years old.

Age of respondents (N=267)

Age	Frequency	Percent
<24yrs	111	32.6
25-34yrs	143	41.9
>35	87	25.5

3.1.2 Income of respondents

The average income level of the respondents per month was 38,484 FCFA with a standard deviation of FCFA 30,226.8 (95% Confidence Interval 24842.12—42126.42).

The lowest earner had FCFA 1,200 and the highest FCFA 180,000.

Income level of the respondent (N=267)

	Frequency	Percent
<3500	92	34.5
4000-9000	120	44.9

>10000	55	20.6
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3.2: Section B: Knowledge of Respondents

3.2.1: Knowledge on HIV /AIDS

Nearly all (97.0%) the respondents had knowledge on HIV/AIDS with regards to understanding what it is. In a focus group discussion HIV/AIDS was termed as a very dangerous disease with no cure. As to where the respondents received information on HIV/AIDS, 82.8% said from the radio, 66.6% said from the health centre and 41.9% from the church. The other respondents received the information from newspapers (42.2 %), conferences (35.5 %,) while 35.2% said they received the information from their peers and 6.9% mentioned other sources such as television. Other studies conducted concluded that, accurate knowledge regarding possible routes of transmission is not only critical for decreasing the infection rate, it is also important to dispel persistent myths (Babakin *et al*, 2004).

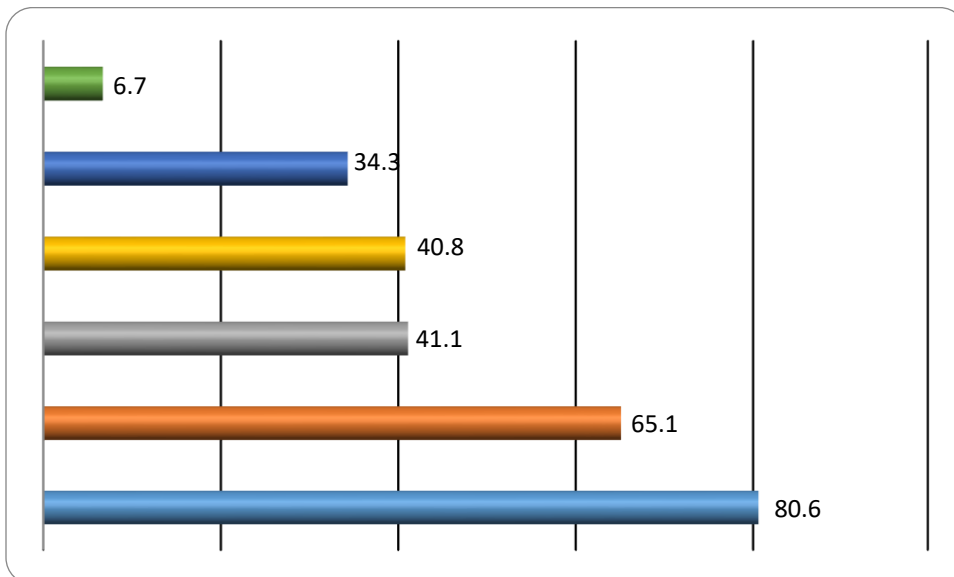


Fig 2: Highlighted Sources of information on HIV (multiple response in percentages)

3.2.2: Knowledge on mode of HIV Transmission

The study found that the highest mode of transmission was through unprotected sexual intercourse with 94.3% and sharing of sharp objects (58.3%). More than half (55.0%) of the respondents mentioned unsafe blood transfusion and 43.8% said through breastfeeding. Other mode of mother-to-child transmission was known by 38.4% while kissing and other ways represented 13.0% and 3.9% respectively. However, 1.8% did not know any mode of transmission. During a focus group discussion the men confirmed that unprotected sex was the highest mode of transmission of HIV/AIDS. According to Camlim and Chibwete, (2003), knowledge alone does not change behaviour and there is no significant relationship between sexual knowledge and safer sex. As per the result of the study the slum dwellers had knowledge on the modes of transmission however, this did not conform to their practices.

Table 3: Knowledge on mode of HIV Transmission (*multiple responses)-n=341

Mode of transmission	Percentage*
Unprotected sex	94.3
Unsafe blood transfusion	55.0
Sharing of sharp objects	58.3
Breastfeeding	43.8
Other modes of mother to child transmission	38.4
kissing	13.0

3.2.3: Known ways of HIV prevention

Most (91.2%) of the respondents knew how to prevent themselves from HIV while 8.8% mentioned they did not know. Of those who knew how to prevent themselves 58.2% said they avoid multiple sexual partners and a little below half (48.3%) use condoms as a means of prevention. Avoiding sexual intercourse was said by 14.8% while 5.2% mentioned other ways of prevention such as not sharing sharp objects. Although most of the respondent knew how to protect themselves, one man said **“it’s very difficult to use a condom when you get a young girl and especially a school girl”**. Another one mentioned that young girls and boys rent rooms for selling local brews “SHAA” chew guts and once they are drunk they end up having unplanned and unprotected sex. Although this was mentioned by the older men, it was found to be true as young men were found drinking indiscriminately

and using drugs in the communities. This implies that the spread of HIV/AIDS could be high in these slums unless people change their sexual behavior. Other studies have confirmed that drug abuse is positively associated with high sexual behavior among the truck drivers and young men and women. (Zamani *et al*, 2005)

Table 4: Known ways of HIV prevention (*multiple responses)-n=341

Preventing one self	Percentages*
Avoiding sexual intercourse	14.8
Use of condom	48.3
Avoiding multiple sexual partners	58.2
Avoiding Sharp Objects	5.2

3.2.4: Knowledge of identifying someone with HIV

With regards to whether the respondents knew someone in their communities who has HIV/AIDS, 72.1% indicated that they know and 27.9% mentioned that they did not know anybody with HIV. The respondents gave the following as signs of HIV/AIDS; Weakness (59.6%), sickling (56.2%), thinness (54.5%). Prolong cough was also mentioned by 42.4% of the respondents while others such as diarrhea and rashes accounted for 13.1%. %. This was confirmed during a FGD where the participants said they have all once seen persons with HIV/AIDS within the community or in their families. They further gave information people living with HIV/AIDS are very thin, prone to opportunistic diseases and many of them lose appetite. Others were saying that, the use of ARVs is increasing the spread of the disease in a way that if someone tests HIV positive and start using the drugs immediately, he/she will not be recognized and may continue spreading HIV/AIDS.

Table 5: Knowledge on Identifying Someone with HIV/AIDS
 (*multiple responses)- n=338

Knowing one with HIV/AIDS	Percentages*
Thin	54.5
Sick-ling	56.2
Weak	59.6
Prolong cough	42.4
Diarrhea and Rashes	13.1

3.3: Section C: Attitude Towards HIV/AIDS

3.3.1: Expressed Attitude about persons most vulnerable

Slightly more than half (52.5%) of the respondents highlighted that anybody can get HIV/AIDS, followed by commercial sex workers 21.7%. The truck drivers formed 15.5% of those at risk of getting HIV/AIDS as per the research findings. The rest of the respondents mentioned women, men, adolescents respectively as those who are at lower risk. It also came out from the FGD that anybody can get HIV/AIDS, however commercial sex workers were mentioned as those at higher risk than other groups in the slums. It was also mentioned that socio economic factors for example, low income level influence the young girls and married women to go into unprotected sexual behavior.

This is supported by a study done by Hudson (1996) which found out that in addition to having sex with Female Sex Workers, most truck drivers have regular girl friends or wives at home who are likely to become infected with HIV by their husbands and boyfriends, and continue spreading the virus in their local communities.

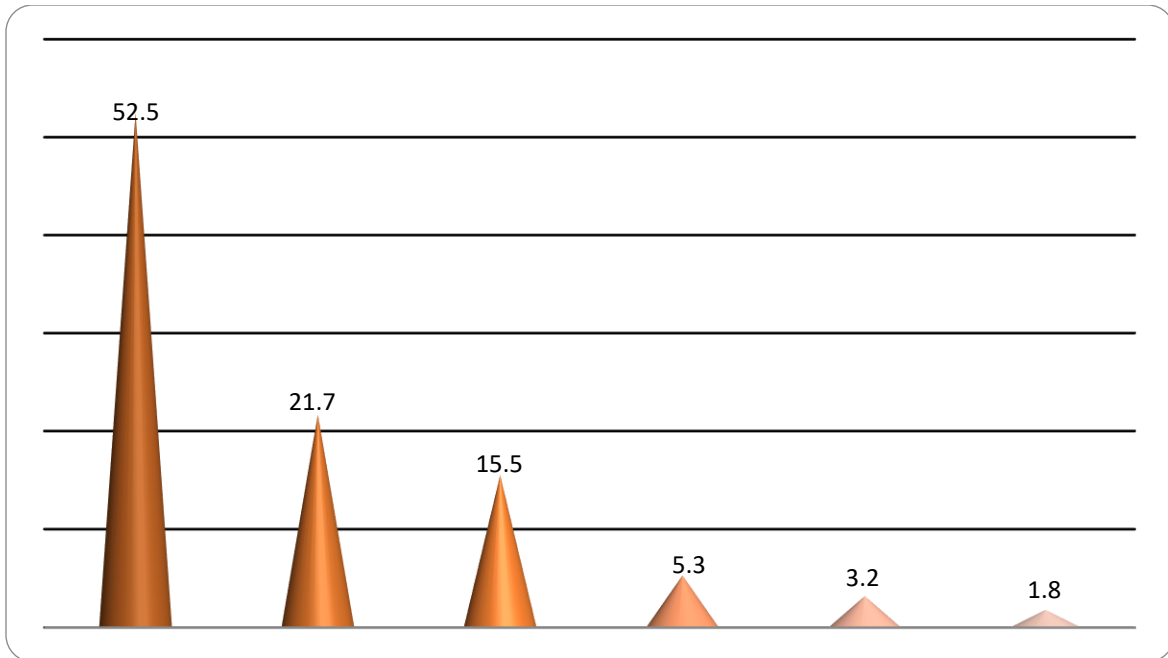


Figure 3: Expressed Attitude about most vulnerable persons in percentages

3.3.2: Known Attitude towards HIV Testing

Approximately all (92.1%) the respondents were willing to be tested while (7.9%) were not ready to be tested. Most people during the focus group discussion stated that they wanted a mobile VCT service in the slum so that they can be tested. For those who were willing to be tested, 89.3% mentioned that they will accept the situation even if they turn positive, 6.7% said they will blame their partners and 2.1% indicated they will attempt suicide. The rest (1.8%) said they don't know how they will feel. On the other hand, out of 58 respondents who said they will not go for HIV testing, 27.6% mentioned fear of death as the reason while 12.1% fear of stigmatization and another 12.1% said lack of self and partner trust. The rest (48.2%) were others such as self trust/confidence.

Table 6: Known attitude towards HIV testing (N=341)

Feeling of the respondent	Frequency	Percentage
Accept the situation	292	89.3
Attempt suicide	7	2.1
Blame my partner	22	6.7
Don't know	6	1.8

3.3.3: Expressed Attitude towards People Living with HIV/AIDS

Figure four below shows the attitude of the community towards people infected with HIV/AIDS. A total of 47.6% indicated that they perceive them as normal while 28.4% discriminate them. However, 15.0% perceive those infected with HIV/AIDS as prostitutes and the rest isolate or see them as sinners. During a focus group discussion, most of the people said they perceive people living with HIV/AIDS as normal. How the findings indicated that stigma and discrimination was still high.

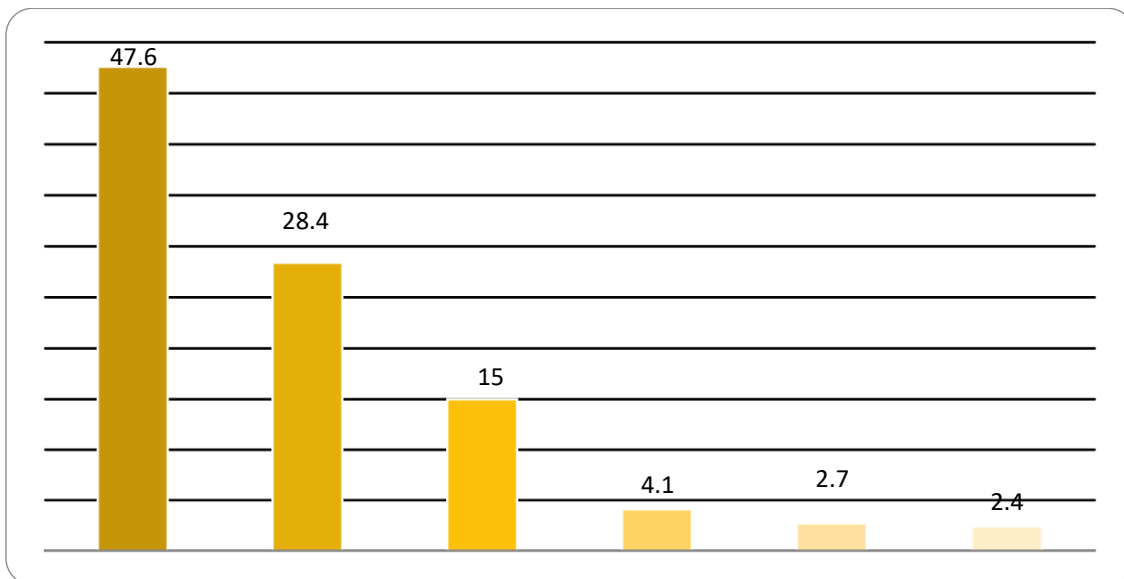


Fig 4: Expressed Attitude towards people living with HIV/AIDS in percentages

3.3.4: Expressed opinion towards condom Use

Over two thirds (64.0%) of the respondents said condoms are good, 20% mentioned that it was bad while 14% felt that it was immoral to even have it in our society and 2% mentioned discomfort. During a focus group discussion, one man said **“I don’t trust a condom because they are not 100% they even burst sometimes”**.

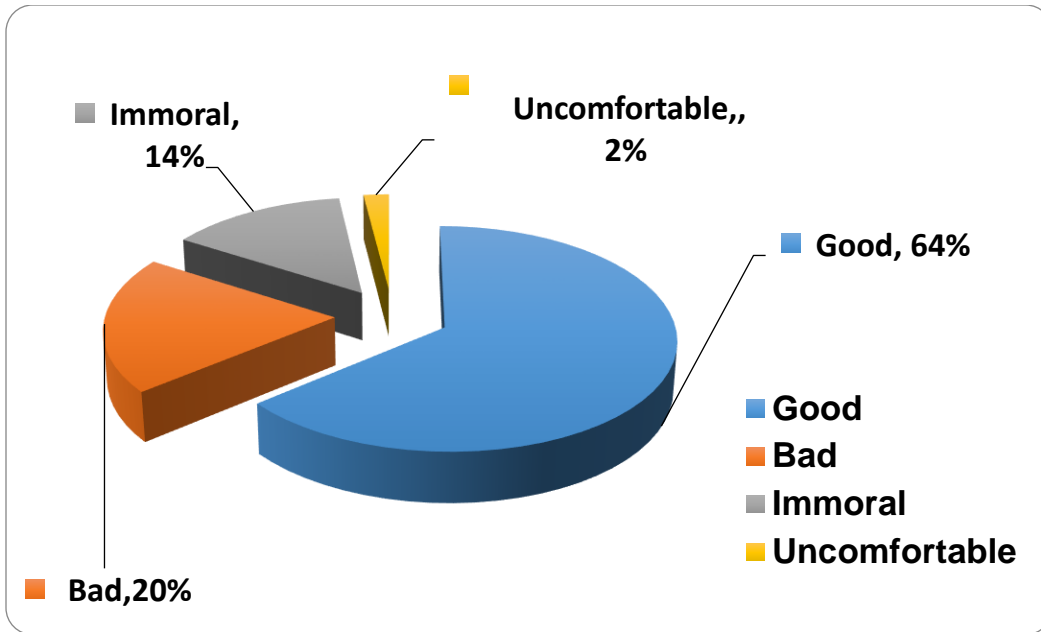


Figure 5: Expressed opinion towards Condom Use

3.4: Section D: Practices towards HIV/AIDS

3.4.1: Risky cultural practices established during the study

Among the cultural practices mentioned by respondents, multiple sexual partners was the most (86.2%) practice that could increase the spread of HIV/AIDS. A little over sixty percent (60.4%) said wife inheritance, 51.9% stated having many wives. The other practices included circumcision (29.9%), tattooing (19.9%) and 4.1% said they didn't know. Drug abuse, alcohol consumption and idleness were other practices that were mentioned during a focus group discussion as risky behaviours.

Table 7: Risky cultural practices established during the study (*multiple response) (n=341)

Practices	Percentage*
Multiple sexual partners	86.2
Wife inheritance	60.4
Many wives	51.9
Circumcision	29.9
Tattooing	19.9

3.4.2 Number of Sexual Partners

The study found out that 48.1% had one, 52% had two or more sexual partners while 3.8% had none. During the focus group discussion, men stated that it is normal to have more than one sexual partner even for those who are married furthermore; they stated that **“it is very difficult for a man to stay with one sexual partner and women were made for men.”** However, a study done by Kapiga (1996) suggested that the tendency to engage with multiple sexual partners is considered as a critical factor for the high rate of HIV/AIDS infection.

Table 8: Number of Sexual Partners (n=341)

Sexual partners	frequency	percent
0	13	3.8
1	164	48.1
2	141	41.3
3	17	5.0
4	6	1.8

3.4.3: Response on Condom use

The research results showed that the use of condoms is not apparent as more than half (54.3%) of the respondents do not use condoms at all, be it with their wives or outside marriage. However, for those who said they use condoms, which accounts for 45.7%, gave reasons such as protection against sexually transmitted infections (32.3%), to prevent HIV (32.9%), for family planning purposes (23.4%) and 11.4% mentioned others such as using it for both family planning, preventing sexually transmitted diseases and prevention of HIV/AIDS. In a focus group discussion, one man said it is very important to take care when you are having **‘ma-ndap-** (*meaning extra marital sexual intercourse*) because one can get infected so it is very vital to use a condom during the intercourse.

With regards to where those who use condoms get it, 56.5% buy from shops, 34.5% from the health center and the rest (9.1%) from dispensers, workshops and seminars. In a focus group discussion it was said that condoms are not available and someone one said that, **“if the condoms were placed at strategic locations, it will be easy for people to pick when**

the need arise". For those who don't use condom, one of them said it reduces sexual pleasure and **"I can't eat a sweet inside its paper"**.

Table 9: Actual Response on Condom use (n=341)

Reason for use of condoms	Frequency	Percentage
For protection	54	32.3
To prevent HIV	55	32.9
Family Planning	39	23.4
Where respondents get condoms		
Health centre	61	34.5
Buy	100	56.5
Dispensers	9	5.1
Workshops/ seminars	7	4.0
Ever tested		
Yes	282	82.7
No	59	17.3
Total	341	100.0

3.4.4: People already tested

Majority (82.7%) of the respondent said they have been tested while 17.3% have never been tested. The results showed that more than half (52.2%) of them were tested at VCT centres, 34.7% at the health centre and the rest were done at both places. An in-depth interview conducted with the chief revealed that there were three VCT centers in Ndu District location but not within the slum area. All the respondents requested for VCT services to be located within the village. Of those who said they were tested, 88.5% stated that they did it voluntarily while 11.5% indicated that it was not voluntary. This is confirmed by a study done by UNESCO (2002) stating stigma and discrimination discourage people going in for VCT and disclosing their HIV status.

Table 10: Where the respondent was tested (n=341)

Where been tested	Frequency	Percentage
VCT centre	164	52.2
Health centre	109	34.7
Both HC and VCT centre	41	13.1

3.5: Factors Associated with Condom use

The table below shows the association test of variables against condom use, it showed that: there is no relationship ($P > 0.05$) between the age of the respondent, level of income, educational level and number of sexual partners and the use of condom. This means that the different variables did not influence condom use.

Table 11: Factors associated with Condom use

Dependent variable	Age of the respondent			$x^2=0.911$; 2df; P=0.634 P>0.05
Condom use	≤24	25-35	35+	
yes	46.8%(n=52)	47.6%(n=62)	41.4%(n=31)	
no	53.2%(n=51)	52.4%(n=58)	58.6%(n=30)	
Dependent variable	Income level of the respondent			$x^2=1.224$; 2df; p=0.542 p>0.05
Condom use	≤3500ksh	4000-9000ksh	10000ksh+	
yes	44.6%(n=41)	51.7%(n=62)	47.9%(n=25)	
No	55.4%(n=51)	48.3%(n=58)	54.5%(n=30)	
Dependent variable	Education level			$x^2=0.633$; 1df; p=0.426 p>0.05
Condom use	≤Primary	≤secondary		
Yes	47.8%(n=86)	43.5%(n=70)		
No	52.2%(n=51)	56.5%(n=58)		
Dependent variable	No of sexual partners			$x^2=2.799$;1df; p=0.094 p>0.05
Condom use	1(one)	≤2		
Yes	23.1%(n=3)	46.6%(n=253)		
No	79.9%(n=10)	53.4%(n=175)		

CHAPTER 4: CONCLUSION AND RECOMMENDATIONS

4.1 Conclusion

Knowledge:

The knowledge of HIV/AIDS among the slums dwellers is high as almost every respondent knew what HIV/AIDS is. The respondents also had knowledge on the modes of transmission and how to prevent themselves.

Attitude

Although HIV/AIDS was termed as a disease for everybody people still associated it with commercial sex workers and truck drivers. Stigmatization of PLWHA was still evident from the findings among the slum community. This brings into question the ability of the people to care for the infected and support the affected. The condom was perceived as bad and associated with immorality. Many people were willing to be tested and majority of them were ready to accept the situation if they test positive.

Practice

An in-depth interview conducted with the chief revealed that there were three VCT centers in Ndu District location but they were not within the slum area. Many respondents were at least once tested. Multiple sexual partners was one of the cultural practices that could increase the spread of HIV/AIDS, worsened by the influx of commercial sex workers. Drug abuse, alcohol consumption was evident within the slum. Findings revealed that men had more multiple sexual partners.

4.2: Recommendations

- The DHMT need to plan for intensive health education on behavior change, condom promotion
- DHMT need to strategize on ways of supplying condoms to the slums.
- Mobile moonlight VCT need to be conducted periodically as most people go for casual work during the day and could strengthen confidentiality.

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APPENDIX

Appendix 1: Household Interview Schedule

MASTER IN PUBLIC HEALTH STUDENT AT TEXILA AMERICAN UNIVERSITY

HOUSEHOLD INTERVIEW SCHEDULE

Code.....

I am a Master in Public Health Student at Texila American University, India in collaboration with the Ministry of Public Health undertaking a study on knowledge, attitude and practices on HIV/AIDS among house hold heads. The information collected will be treated with utmost confidentiality and will help government and partners to design and implement programs geared towards HIV/AIDS in Ndu District.

BACKGROUND INFORMATION

District Location
Village
Name of Interviewer..... Date of interview.....

SECTION: A SOCIO-DEMOGRAPHIC INFORMATION

- 1. What is your marital status?
 - 1. Single
 - 2. Married
 - 3. Separated
 - 4. Divorced
 - 5. Widow/widower
- 2. Highest level of education?
 - 1. None
 - 2. Primary
 - 3. Secondary
 - 4. Tertiary
- 3. Occupation of the respondent?
 - 1. Employed
 - 2. Self employed
 - 3. Business
 - 4. Housewife
 - 5. Student
 - 6. Others(specify)-----
- 4. What is your average income?_____

5. Religion of the respondent?
1. Christian Protestants
 2. Catholic
 3. Muslim
 4. Hindu
 5. Others (specify).....

6. Age of the respondent.....

7. Sex of the respondent.....

SECTION: B KNOWLEDGE ABOUT HIV/AIDS

8. Do you understand what HIV/AIDS is?

1. Yes
2. No

9. If yes, what was your source of information? (multiple choice)

1. Radio
2. Health facility/health worker.
3. Church/mosque
4. Newspaper/book
5. Conferences
6. Peers
7. Others specify.....

10. What do you think are the modes of HIV/AIDS transmission in this community?

(Multiple answers)

1. Unprotected sexual intercourse
2. Unsafe blood transfusion
3. Sharing of sharp object
4. Mother to child transmission during delivery
5. Breastfeeding from an infected mother
6. Kissing
7. I don't know
8. others

11. Do you know how to prevent yourself from HIV/AIDS?

1. Yes
2. No

12. If yes, how can you prevent HIV/AIDS
1. Avoiding sexual intercourse
 2. Use of condom
 3. Avoiding multiple partners
 3. Others (specify).....

13. Do you know what a condom is?
1. Yes
 2. No

14. Do you know someone with HIV/AIDS?
1. Yes
 2. No

15. How do you know that one has HIV/AIDS? (Multiple response)
1. Thin
 2. Sick ling
 3. Weak
 4. Prolong Cough
 5. Others.....

16. Can one partner be HIV positive while another negative?
1. Yes
 2. No

SECTION C: ATTITUDES TOWARDS HIV/AIDS

17. Who do you think can get HIV/AIDS?

1. Truck drivers
2. Men
3. Women
4. Adolescents and youth
5. Commercial sex workers
6. Others.....

18. Would you like to be tested HIV/AIDS?

1. Yes
2. No

19. How would you feel if tested positive?

1. Accept the situation
2. Attempt suicide
3. Blame my partner
4. Others (specify).....

20. If no, why?

1. Fear of death
2. I don't trust myself or my partner
3. Stigmatization
4. Others.....

21. How do people perceive someone with HIV/AIDS?

1. Discriminate
2. Normal
3. Isolate
4. Prostitutes
5. Sinners
6. Others.....

22. What is your opinion about condom?

1. Good
2. Bad
3. Immoral
4. Other

SECTION C: PRACTICES TOWARDS HIV/AIDS

23. Which cultural practices do you think can contribute to the spread of HIV/AIDS?

(Multiple Choice)

- 1. Multiple sexual partners
- 2. Wives inheritance
- 3. Having many wives
- 4. Circumcisions
- 5. Tattooing
- 6. Don't know
- 7. Others.....

24. How many sexual partners do you have?

- 1. None
- 2. One
- 3. Two
- 4. Three
- 5. Others.....

25. Do you always use a condom?

- 1. Yes
- 2. No

26. Why do you use it?

- 1. For protection of sexually transmitted diseases
- 2. To prevent HIV
- 3. For family planning
- 4. Others.....

27. Where do you get the condom?

- 1. Health centre
- 2. Buy
- 3. Dispensers
- 4. Others

28. Have you ever been tested?

- 1. Yes
- 2. No

29. If yes where (Multiple Choice)

- 1. VCT centre
- 2. Health centre

3. Others specify.....

30. Was the test voluntary?

1. Yes

2. No

31. Have you ever been treated for an STI?

1. Yes

2. No

Thank you

Appendix 2: Focus Group Interview Guide

MASTER IN PUBLIC HEALTH STUDENT AT TEXILA AMERICAN UNIVERSITY

FOCUS GROUP DISCUSSION GUIDE

Code.....

I am a Master in Public Health Student at Texila American University, India in collaboration with the Ministry of Public Health undertaking a study on knowledge, attitude and practices on HIV/AIDS among house hold heads. The information collected will be treated with utmost confidentiality and will help government and partners to design and implement programs geared towards HIV/AIDS in Ndu District

BACKGROUND INFORMATION

District Location

Village

Name of Interviewer..... Date of interview.....

We will begin by answering some questions:

1. What is HIV/AIDS?
2. What do you think about the truck drivers and the spread of HIV/AIDS in this community? h
3. What are some of the practices
4. How can one prevent him/herself from HIV/AIDS?
5. Are people in this community aware about using condom to prevent HIV/STI?
6. Which age group do you think is at high risk of spreading HIV/AIDS and why?
7. Are there any VCT centers in this community, if yes, do people go for testing.
8. Are there any particular occupations that people do which is highly related to exposure to HIV infection? Which ones?
9. How do people perceive someone with HIV/AIDS?

Thank You

Appendix 3: Interview Guide for the Chief

MASTER IN PUBLIC HEALTH STUDENT AT TEXILA AMERICAN UNIVERSITY

IN-DEPTH INTERVIEW GUIDE FOR THE CHIEF

Code.....

I am a Master in Public Health Student at Texila American University, India in collaboration with the Ministry of Public Health undertaking a study on knowledge, attitude and practices on HIV/AIDS among house hold heads. The information collected will be treated with utmost confidentiality and will help government and partners to design and implement programs geared towards HIV/AIDS in Ndu District

BACKGROUND INFORMATION

District Location

Village

Name of Interviewer..... Date of interview.....

I will ask you the following questions:

1. What can you say about HIV/AIDS situation in your location.....
.....
.....
.....
2. What do you think about the spread of HIV/AIDS here.....
.....
.....
.....
3. What are the benefits for someone knowing his/her HIV status?.....
.....
.....

- 4. Are condoms available in this community? where do people get them from?.....
.....
.....
- 5. Is there any information about HIV/AIDS provided in this community?.....
.....
.....
- 6. Are there any VCT services in this area?.....
.....
.....
.....
- 7. What are some of the ways of HIV/AIDS prevention.....
.....
.....

Thank You

Appendix 4: In-depth Interview Guide for the Truck Driver

MASTER IN PUBLIC HEALTH STUDENT AT TEXILA AMERICAN UNIVERSITY

IN-DEPTH INTERVIEW GUIDE FOR THE TRUCK DRIVER

Code.....

I am a Master in Public Health Student at Texila American University, India in collaboration with the Ministry of Public Health undertaking a study on knowledge, attitude and practices on HIV/AIDS among house hold heads. The information collected will be treated with utmost confidentiality and will help government and partners to design and implement programs geared towards HIV/AIDS in Ndu District.

BACKGROUND INFORMATION

District Location

Village

Name of Interviewer..... Date of interview.....

I will ask you the following questions:

1. What do you understand about HIV/AIDS?.....
.....
.....
2. What do you think can spread HIV/AIDS?.....
.....
.....
3. How can one prevent him/her self from HIV/AIDS?.....
.....
.....
4. Does your work affect your family if yes, how.....
.....

.....
.....
5. Have you ever used a condom? Yes or no

6. If yes, why do you use
condoms?.....
.....
.....

7. Where do you get
condoms?.....
.....
.....
.....

8. Have you ever gone for HIV
testing?.....
.....
.....
.....

Thank You

Appendix 5: In-depth Interview Guide for the Health Worker
MASTER IN PUBLIC HEALTH STUDENT AT TEXILA AMERICAN
UNIVERSITY

IN-DEPTH INTERVIEW FOR THE HEALTH WORKER

Code.....

I am a Master in Public Health Student at Texila American University, India in collaboration with the Ministry of Public Health undertaking a study on knowledge, attitude and practices on HIV/AIDS among house hold heads. The information collected will be treated with utmost confidentiality and will help government and partners to design and implement programs geared towards HIV/AIDS in Ndu District

BACKGROUND INFORMATION

District Location

Village

Name of Interviewer..... Date of interview.....

I will ask you the following questions:

1. Are people in this area aware of how HIV/AIDS is transmitted?.....
.....
.....
2. How can one prevent himself/herself from HIV/AIDS?.....
.....
.....
3. Is there any VCT center in this facility?.....
.....

-
-
4. Are people using VCT in this area?.....
.....
.....
 5. How many clients do you attend to in a day?.....
 6. Do you issue condoms in this facility?
 7. Is this an authorized HIV treatment centre? Yes/No
 8. Approximately how many people are on ARVs?
 9. According to your records who are the most affected people with HIV/AIDS?
 10. Apart from giving AVR's do you give HIV people any support? If yes, What support?.....

Thank you for your valuable responses