KNOWLEDGE, ATTITUDE AND PRACTICES OF HIV/AIDS PREVENTION AMONG FIRST YEAR DIPLOMA STUDENTS DOING CLINICAL MEDICINE AT KAMPALA INTERNATIONAL UNIVERSITY, WESTERN CAMPUS.

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DCM/0145/143/DU

DECLARATION

I NAMBUBI ANNE MARY declare that this work presented in this report is from my own findings and that it has never been presented to any university or college before. Therefore it should not be reproduced by anybody else without permission from the author.

Signature……

Date……

APPROVAL

This research report has been approved by my supervisor below.

Signature……..Date……..

Dr. ODWEE AMBROSE

DEDICATION

This research report has been dedicated to my beloved Daddy Mr. Kibuka Lawrence.

The values I have for life and eternity are the heritage of the influence you have extended in my life.

ACKNOWLEDEMENT

I would like to express my gratitude to God for being with me through the process of writing this report and also for giving me the gift of patience, perseverance especially when things did not go the way I had planned. A great lesson I learnt.

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TERMS AND DEFINITION

Attitude: Is an option or general feeling about something.

Commercial sex: Sexual intercourse without the aim of producing a child but for monetary gains.

Epidemic: occurrence to an increase in the number of cases of a disease beyond past experience for a given population time and place

Heterosexual contact: Sexual intercourse between two different sexes

Knowledge: A clear awareness of fact or situation. In this study it is defined as a clear and certain understanding of HIV/AIDS mode of transmission and prevention as condom use.

Morbidity: Inability as a result of having suffered from a particular condition such as HIV/AIDS

Myth: A wrong belief about something

Opportunistic disease: It is an infection that takes the opportunity of the reduced body's defenses mechanism to flourish

Pandemic: Spread of the disease worldwide or across several countries

Prevalence: Is the occurrence of both new and old cases of a particular disease in agiven population at a specific given time

Risky sexual practice: Unprotected sexual intercourse (Sex without condom use consistently) with non-regular partner(s).

Safe male circumcision: A surgical procedure which involves removal of a fore skin from the man's penis under aseptic techniques

Safer sex: practice where the sexual partner has a right not to have sex with an HIV infected person or be allowed to use a protective measure like condoms

Sexual practices: These activities associated with sexual intercourse.

Sexual trafficking: A situation where women are taken to outside countries and sexually abused for monetary gains

Stigma: Feelings of disapproval that people have about a particular illness

Vertical transmission: transmission of HIV from mother to the baby during pregnancy, during birth and during breast feeding

Vulnerability: Being at high risk of acquiring a disease

LIST OF ABBREVIATIONS

ABC Abstinence, Be faithful to one partner, Condom use

AIDS Acquired Immune Deficiency Syndrome

ART Anti-Retroviral Therapy

ENT Ear, Nose and Throat

HCT HIV Testing and counseling

HIV Human Immune Deficiency Virus

HSSP Health Sector Strategic Plan

IEC Information, Education and Communication

KAP Knowledge, Attitude and Practices

KIU Kampala International University

KIU-TH Kampala International University Teaching Hospital

NDP National Development Plan

NSP National HIV/AIDS Strategic Plan

PMTCT Prevention of Mother to Child Transmission

SMC Safe Male Circumcision

SSA Sub Saharan Africa

TASO The AIDS Support Organization

TB Tuberculosis

UBOS Uganda Bureau of Statistics

UNAIDS the Joint United Nations Program on HIV&AIDS

UNDP United Nations Development Program

UNICEF United Nations International Children's Emergency Fund

VCT Voluntary Counseling and Testing

WHO World Health Organization

ABSTRACT

Background: Good knowledge, attitude and practices (KAP) of HIV/AIDS prevention are essential in order not to acquire HIV infection and to prevent the disease from spreading. A proper and well-functioning prevention of HIV requires clear and relevant information and instruction from health care providers who have been trained in that field.

Study objective: To assess the knowledge, attitudes and practices of HIV/AIDS prevention among first year diploma students doing clinical medicine at Kampala international university, western campus and compare these between the genders.

Methodology: A descriptive cross sectional study design was used, the data was presented in form of tables and graphs where descriptive statistics put in percentages for each response and the results were analyzed manually for accuracy of results. A sample of 138 students was drawn by use of simple random sampling but only 125 questionnaires were returned, as it was considered appropriate for the reason of increasing the accuracy of the findings and also for it to ensure high percentage

involvement by the subject. Students participated by answering a questionnaire on knowledge, attitude and practices of HIV/AIDS prevention among first year diploma students doing clinical medicine.

Results: All the respondents responded with 100% response that they had ever had about HIV/AIDS although there was poor response of those who had heard about HIV/AIDS from church/mosque with 20% total response. As concerns the students' attitudes towards HIV/AIDS prevention13% still believe that students who are HIV positive should be removed from school. 24% responded that they abstain from sex, 10% responded that they use sterilized needles as HIV preventive measure and finally all the students had ever tested for AIDS, 40% once, 28% twice and 25% more than twice.

Conclusion: All the students reported that they had received information on HIV/AIDS. There were significant differences in gender in several statements concerning knowledge, attitude and practices though the males' participation was greater than that of the females. The male and female students in KIU-WC had different knowledge, attitudes and practice of HIV/AIDS prevention

Recommendation: Peer Educators, parents, teachers/lecturers and Health care professionals should consider gender and religion when providing intervention programs to the student

CHAPTER ONE:

1.0 Introduction

This chapter presents the background, problem statement, study objectives both the broad and specific objectives, research questions significance of the study, study scope and conceptual framework.

1.1 Background

Acquired Immune Deficiency Syndrome (AIDS) is caused by a human immunodeficiency virus (HIV) that weakens the immune system, making the body susceptible to opportunistic diseases that often lead to death. The predominant mode of HIV transmission is through heterosexual contact, followed by prenatal transmission, where the mother passes the virus to the child during pregnancy, delivery or breastfeeding. Other modes of transmission are through infected blood and unsafe injections (Gideon, 2011)

HIV/AIDS is a global challenge that has threatened the very existence of the human race. At present, there is no country in the world without HIV cases (WHO, 1995). The African continent is said to hold the vast majority of the world's HIV infected population. It is estimated that in 2007, of the 33.0 million people living with HIV/AIDS, 22.0 million of them lived in sub-Saharan Africa, (UNAIDS, 2008). More than 25 million people had died of AIDS worldwide since 1981. Africa had 11.6% AIDS orphans. Women accounted for 50% of all adults living with HIV worldwide and for 59% in sub-Saharan Africa. Young people (under 25 years old) accounted for half of all new infections worldwide(UNAIDS, 2008).

HIV/AIDS remains a significant development problem in sub-Sahara Africa (SSA), and understanding the factors that can halt the spread of the disease is both an economic and a public health priority. According to the joint United Nations Program on AIDS (UNAIDS), at the end of 2011, an estimated 34 million persons were infected with HIV globally, and at least 69% of victims were in SSA—a region with only 12% of the global population (UNAIDS, 2012)

Uganda has experienced a severe and devastating epidemic of HIV infection and AIDS for more than a quarter of century. The epidemic started on the shores of Lake Victoria in Rakai District. Thereafter, HIV infection spread quickly, initially in major urban areas and along highways. By 1990s, HIV had reached all districts in the country, resulting in what is classified as a generalized

epidemic. As in other countries in sub-Saharan Africa, Uganda's HIV/AIDS epidemic is predominantly spread through heterosexual contact.(Nambatya, 2010)

Uganda's was the first government on the continent to recognize the danger of HIV to national development. Acknowledging an explosive epidemic in the general population very early on, President Yoweri Museveni took active steps to fight its spread through action by the government and other groups in society, including religious leaders and community development organizations, which were encouraged to tackle HIV and AIDS in ways that made best use of their particular skills. This broad based approach to the epidemic contributed to a reduction in HIV infections among young pregnant women living in towns and cities, as recorded in the 1998 Report on the global HIV/AIDS epidemic**.** Gratifyingly, data from a large community-based study now show a similar fall in infection rates in rural Uganda. The HIV prevalence rate among 13–19-year-old girls has fallen significantly over an eight-year period, while the rate in teenage boys – always much lower because boys are less likely than girls to have partners in the older, more heavily infected age groups – has remained roughly stable. A large increase in condom use UNAIDS, 2000)

1.2Problem statement

According to the young people and HIV/AIDS opportunity in crisis a joint report by UNICEF, UNAIDS, and WHO, worldwide about 50% of all new infections occur among people 15-24 years old .(UNAIDS, 2002)

According to Davidson's principles and practices of medicine (Davidson, 2004) the cumulative death number since the epidemic is 20 million in the whole world, the majority of the cases occurring in Sub-Saharan Africa.

According to Davidson's principles of medicine, the dominant routes of transmission are hetero-sexual and from mother to child (vertical transmission)

The disease is not curable and prevention is therefore crucial, but for a successful prevention an improved knowledge about the disease is needed. Lack of preventive knowledge increases the risk of acquiring the disease and transmitting it to others (WHO, 2011). In order to realize greater success of programs in Uganda, it is necessary to address the reason for the observed reluctance. Proper and functioning HIV prevention for students require good knowledge about the disease

and also access to health care. To inform the students about the disease should be considered a major issue for health care provider to pay attention to.

Although there have been major inroads and achievements in the thematic area of prevention, there is evidence that the pace of behavioral change has either been slow or stagnant. Studies have shown that people have knowledge/information but the response in terms of behavioral change has not been encouraging. Further, although significant strides have been made in the area of prevention, the services remain inadequate in scope and coverage. For instance, there is high unmet need for HCT, low coverage for PMTCT and challenges in addressing infection control and infection safety especially in the context of TB-HIV. Some of the policies that can help curb the spread other are yet to be implemented and rolled out e.g. MMC (Uganda UNGASS, 2010)

Good knowledge, attitudes and practices (KAP) of HIV prevention are essential in order not to acquire HIV infection and to prevent the disease from spreading. A proper and well-functioning prevention of HIV requires clear and relevant information and instructions from healthcare givers. Therefore, it is important to increase knowledge and understanding among health care providers, to be aware about this risk group (students) and to prepare information and intervention programs of HIV prevention for the students.

1.3 Study objectives

1.3.1Broad objective

To assess the level of Knowledge, attitude, and practice of HIV/AIDS prevention among first year diploma students doing clinical medicine at KIU Western Campus

1.3.2 Specific objective

1) To assess the level of knowledge of HIV/AIDS prevention among first year diploma students doing clinical medicine at KIU Western Campus.
2) To determine the attitudes of HIV/AIDS prevention among first year diploma students doing clinical medicine at KIU Western Campus.
3) To determine the various practices concerning HIV/AIDS prevention among first year diploma students doing clinical medicine at KIU Western Campus.

1.4 Research question

1) What is the level of knowledge of HIV/AIDS prevention among first year diploma students doing clinical medicine at KIU Western Campus?

2) What is the attitude of HIV/AIDS prevention among first year diploma students doing clinical medicine at KIU Western Campus?

3) What are the various practices concerning HIV/AIDS prevention among first year diploma students doing clinical medicine at KIU Western Campus?

1.5 Significance of the study

This is divided into significance to the academic body and to the community.

1.5.1 Significance to the academic body.

This research report is a partial fulfillment for the award of Diploma in Clinical Medicine and Community Health. This will enable the researcher to acquire knowledge, skills and attitude necessary for conducting research.

This study is also to build confidence to the researcher as more knowledge about HIV is discovered and as well will be able to discover his or her own attitude and practices of HIV prevention so that in the future can be able to sensitize others.

1.5.2 Significance to the community

1.The study findings will raise awareness of the current national HIV prevention strategy for Uganda, access to and the cost of health services can be a major hindrance in adopting safe sex practices. For instance, students from well-to-do households are more likely to be tested for HIV than poorer students.

2.The research will contribute knowledge that will help the ministry of health and other stake holders involved to fight against HIV/AIDS

3.The study will provide data for the future researchers since the HIV scourge is a life threatening epidemic.

1.6 Scope of the study

1.6.1 Geographical scope

This study was carried out from Kampala International University Western campus, Bushenyi district which is located in the south western part of Uganda. The university has a population of 5000 students and of which 182 students are first years doing diploma in clinical medicine both 1.1, January intake 2017 and 1.2, August intake 2016 classes

1.6.2 Content scope

This research included chapter one having introduction, background, problem statement, study objectives, research questions, significance of the study, scope of the study and conceptual frame work.

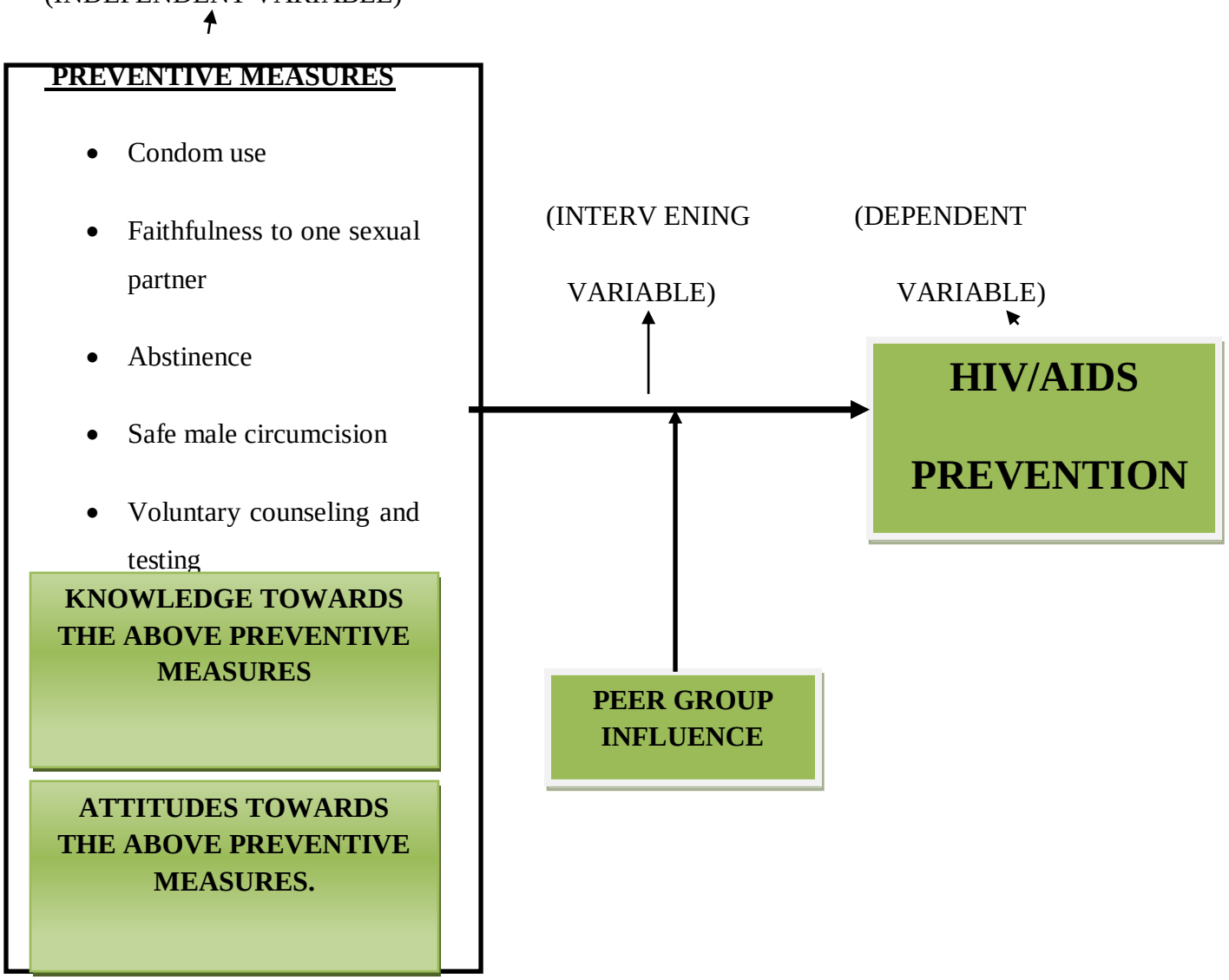
It also included chapter two having literature review showing knowledge of HIV/AIDS, attitudes towards HIV/AIDS and HIV prevention.

The study also included chapter three having the methodology showing introduction, study design, study area, sample size determination, sampling methods, study variables, inclusion and exclusion criteria, data collection methods, study analysis plan, and ethical considerations.

1.6.2 Time scope

The research was conducted from the month of December 2017 to July, 2017.

1.7 Conceptual framework



CHAPTER TWO

LITERATURE REVIEW

2.0 **Introduction**

This chapter introduced the knowledge of HIV/AIDS prevention, attitudes towards HIV/AIDS prevention and HIV/AIDS preventive practices.

2.1**Knowledge of HIV/AIDS prevention**

Knowledge of how HIV is transmitted is one of several factors that enable youth to protect themselves from the virus. Correct knowledge can also reduce stigma and discrimination against people living with HIV/AIDS(Nambatya, 2010)

Students with comprehensive knowledge are those who agree with prompted questions that individuals can reduce their chances of contracting HIV by having sex with only one faithful, uninfected partner and by using condoms, those who know that a healthy-looking person can have the HIV virus, and those who know that HIV cannot be transmitted by mosquito bites or sharing food with a person who has HIV(Nambatya, 2010)

HIV/AIDS knowledge among young people globally constitutes a major challenge to the control of this scourge. Most people become sexually active in adolescence. The need to admit that young people are having sex but lack the proper knowledge to protect themselves; is important in the fight against HIV/AIDS. Young people are now the epicenter and bear a disproportionate burden of this pandemic.(WHO/UNICEF/UNAIDS, 2002)

In 2007, national surveys found that 40% of young men and 36% of women had accurate HIV knowledge. Both in sub-Saharan Africa and globally, women had lower levels of HIV knowledge. Most youth were aware that being in monogamous relationship with a person of the same sero-status is an effective prevention strategy. (UNAIDS, 2007)

Knowledge on how HIV is transmitted is one of the several factors that enable youth to protect themselves from the virus. Correct knowledge can also reduce stigma and discrimination against people living with HIV/AIDS. Several studies have shown that health related knowledge has

power to change people's attitudes and health care behaviors in different health contexts, including, oral and dental health (Kin irons and Stewart, 1998). Widespread evidence shows that knowledge about HIV/AIDS and STIs and reproductive health are key strategies for empowering young people to delay the onset of sexual activity and to make their sexual behaviors safer(Jackson, 2002)

In addition to knowing about effective ways to avoid contracting HIV/AIDS, it is also useful to be able to identify incorrect beliefs about AIDS to eliminate misconceptions. Common misconceptions about AIDS include the idea that all HIV infected people appear ill and the belief that the virus can be transmitted through mosquito or other insect's bites, by sharing food with someone who is infected or by witch craft or other supernatural means. In sub-Saharan Africa, surveys continue to indicate that young people between 15-24 years harbor serious misconceptions about HIV and how it is transmitted (Cohall *et al.*,2001). Even though it is now common knowledge that the HIV agent cannot be transmitted through mosquito bites, many people still believe that mosquitoes are a good vehicle for HIV transmission. In sub-Saharan Africa where mosquitoes are endemic, this misconception is significant because it implies a defeatist attitude that regardless of what one does, one is subject to HIV infection as a resident of a mosquito infested region. It also poses a compliance challenge for any educational intervention effort targeted at this group. (Wodi, 2005)

Individuals that suddenly learn of their positive HIV status and begin acts of personal vendetta by engaging in unprotected sex have also been implicated in the spread of the disease (Guardian,2002) .It is clear that this degree of ignorance and attitude relative to sexuality must be addressed if the disease is to be controlled in the region.

2.2 Attitudes towards HIV/AIDS prevention

Socio-economic factors including women's lack of access to education or personal income and unequal property rights perpetuate women's greater vulnerability to HIV infection. Many women fear their husbands or partners to abandon them if they try to control how and when they have sex and whether their partners use condoms. More over poverty drives some women into the sex industry when sexual trafficking and commercial sex promote continued exposure to HIV. Cultural traditions such as male dominance and older men's preference for young women contribute to women's vulnerability(UNAIDS, 2006).

People who inject drugs are among the population groups most severely affected by HIV infection. In virtually all countries reporting data in 2012, the prevalence of HIV infection is higher among people who inject drugs than among the general population. In addition to extraordinary burdens on people who use drugs, drug- related transmission also undermines global efforts to lay the foundation for the eventual end of AIDS(*UNAIDS, 2012*)

In South Africa, several factors contribute to the spread of HIV for one stigma attached to admitting to HIV infection and to using condoms. For another, many deny that HIV causes AIDS. Thabo Mbeki and Robert Mugabe have both suggested that AIDS stems from poverty rather than HIV infection. And finally many myths attached to the use of condoms such as the ideas that a conspiracy wants to limit the growth of the African population and that condoms stifle for the traditional power of the man in his community(UNAIDS, 2006)

While condoms are the best weapons against HIV infection, studies continue to show limited use of condoms in sub-Saharan Africa (Eaton et.al,2008).These studies implicate socio-cultural and religious factors in negotiating for safer sex. Knowledge about HIV transmission and ways to prevent it are less useful if people feel powerless to negotiate safer sex with their partners. To gauge attitudes towards safer sex, there is need to know if people think a wife is justified in refusing to have sex with her husband when she knows he has a disease that can be transmitted through sexual contact. There is also need to know whether a woman in the same circumstances is justified in asking her husband to use a condom.

Families that will not discuss sexuality issues with their children fearing that it will make them more promiscuous, religious organizations and community activists that preach chastity education and abstinence only, political leadership that would not infuse available resources to match the magnitude of the problem, all contribute to the etiology of HIV transmission in Kenya.

Negative attitudes regarding people living with HIV may be abating somewhat over time. From 2003 to 2008 and 2009, increases were reported in the percentage of both women and men who expressed willingness to care for a relative with HIV, a willingness to buy food from an HIV infected vendor and a belief that HIV-positive teachers should be allowed to continue to teach. However, stigmatization attitudes persist. Nearly half of all Kenyan women surveyed in 2009 they said that they would want to keep a family' HIV infection secret ((KNBS), 2009)

In 2012, 61% of countries reported the existence of anti-discrimination laws that protect people living with HIV. Thus, in the epidemic's fourth decade, nearly 4 in countries worldwide still lack any specific legal provision to prevent or address HIV-related discrimination. Even when such laws exist, they provide little meaningful protection(*UNAIDS, 2012*)

2.3 Preventive practices

2.3.1 Abstinence

The term abstinence can refer either to a situation in which a young person who has never had sex delays starting sexual activity (primary abstinence), or to a person who decides to stop sexual activity after initiation (secondary abstinence).While reliable data are unavailable to determine the impact of secondary abstinence on HIV transmission, there has been a strong focus on promoting primary abstinence for young people in Uganda through such innovative means such as Straight Talk and Young Talk. These monthly sexual health newspapers target the youth, with print runs of 155 000 and 280 000respectively; and the increase of the median age of sexual debut in the country from 14 to 17 years is indicative of the cumulative success of programs. (Okware *et al*, 2005)

2.3.2 Being faithful one sexual partner

In its purest sense, the B of ABC entails practicing sex with just one partner, in a long term or lifelong relationship such as marriage and only after determining that both partners are not infected with HIV. Shades of grey do exist, however, with, for example, polygamous marital relationships and also those who engage in serial monogamy. (Okware *et al*, 2005)

2.3.3 Condom use

When used consistently and correctly, the male condom is effective for the reduction of sexual transmission of HIV and of other sexually transmitted infections.18–20 however, the extent to which condoms have been embraced by the Ugandan public has fluctuated considerably over the years, and they have recently become the focus of an increasingly bitter public debate. (Okware et al, 2005)

2.3.4 Safe Male circumcision (SMC)

Uganda adopted SMC as part of the broader strategies for HIV prevention in the National Safe Male Circumcision Policy 2010, following results of the three randomized controlled trials in

2007 showing that medical male circumcision is effective in reducing HIV acquisition among men by approximately 60 percent. Based on these results, World Health Organization (WHO) and the Joint United Nations program on HIV/AIDS (UNAIDS) issued a set of recommendations for the use of MC as one of the HIV prevention strategies in countries with low male circumcision rates like Uganda, where only 26 percent of its men aged 15-49 years are circumcised and has a high HIV prevalence of 7.2 percent (WHO, 2007). The guidelines however highlight that SMC does not provide complete protection against HIV, it should be considered only as part of a comprehensive package to prevent HIV.(Ahaibwe et al, 2011).

2.3.5 Voluntary counseling and Testing.

Awareness of HIV status can motivate individuals to further protect themselves against infection or to protect their partners from acquiring the disease. It is particularly important to measure testing behavior among youth. Not only are they especially vulnerable to infection, but they also may experience barriers to accessing testing services because of their age.

As alluded to earlier, a big percentage of the adult population in SSA has never been tested for HIV/AIDS since the outbreak of the disease more than 20 years ago. The fact that fewer than half of those living with HIV do not know it is a huge barrier to treatment scale up and realizing the benefits of treatment for prevention. Limited knowledge about HIV/AIDS status exacerbates the spread of the disease, as mentioned earlier (Kasirye, 2013)Indeed, many studies have found that VCT is effective as a strategy for facilitating behavioral change around both preventing HIV and early access to care and support (Ahaibwe et al , 2011)

In Uganda, HIV testing coverage has increased tremendously in the past seven years from 15% for women and 12%for men aged 15-49 years in 2004/5 (Kasirye, 2013) to over 69%for women and 47%for men by 2011.

CHAPTER THREE:

METHODOLOGY

3.0Introduction

This chapter looked at the methodological procedures that were followed in the development and conduct of the study. The study site was described in respect of the population demographics; the concepts of study design, study population and study sample are discussed and elucidated comprehensively. The chapter also dealt with issues of the data collection instrument, study variables validity and reliability, data analysis plan and research ethics.

3.1 Study Design

The study was a descriptive cross sectional that employed a quantitative method. The quantitative component of this sequential mixed methods study was reflected in open ended questions regarding Knowledge, attitude and practices of HIV/AIDS prevention among first year diploma students doing clinical medicine at KIU Western Campus Bushenyi district. All participants were provided the opportunity to provide personal comments, reflections, or stories of their experiences with documentation in the questionnaires.

3.2 Study area

The study was conducted from KIU which is located in Bushenyi-Ishaka municipality, Ishaka town in Bushenyi district. Bushenyi-Ishaka municipality is composed of 3 divisions i.e. Ishaka, Nyakabirizi and central division and each division is divided into wards which are further divided into cells.

3.3Study Population

The target population included all first year diploma students doing clinical medicine both 1.1, January intake 2017 and 1.2, August intake 2016 classes at Kampala International University, Western campus.

3.4Sample Size determination

This sample size was obtained using Fitcher's et al (1990) formula i.e.

$n = Z^2PQ/D^2$.This formula was valid for a population approximately 182 students

Where; n = desired sample size

Z = standard normal deviation taken as 1.96 at confidence interval of 95%.

P = proportion of the target population estimated to have similar characteristics, 90% = 0.9

D = degree of accuracy (0.05).

Q = population without the desired characteristics (1-P).

P+Q = 1

$$n=\frac{Z^2 X P X 1\text{-}P}{D^2}$$

$n = (1.96^2 \times 0.9 \times 0.1) / (0.05^{2)}$

n = 138

Therefore the sample size was 138 respondents

3.5 Sampling Techniques

Simple random sampling was used in selecting students of Kampala International University Western campus, Bushenyi district, to take part in the study.

3.6.0 Study variable

3.6.1 Independent variable

Knowledge, attitudes and preventive practices of HIV/AIDS prevention

3.6.2 Dependent variable

The prevention of HIV/AIDS

3.7.0 Inclusion and exclusion criteria

3.7.1 Inclusion Criteria

Inclusion criteria included all first year diploma students doing clinical medicine both 1.1, January intake 2017 and 1.2, August intake 2016 classes Kampala international University, Western campus to participate in the study.

3.7.2 Exclusion Criteria

This included all those students who were sick, those discontinued from the university and all other classes that were not in the inclusion criteria at Kampala international university, western campus Bushenyi district

3.8 Data collection method

3.8.1 Data collection instrument

A self-administered questionnaire was used to conduct the study among all first year diploma students in clinical medicine at Kampala International University Western campus, Bushenyi district.

3.8.2 Pre-test for the questionnaire

A pre-test for the questionnaire was conducted among all first year diploma students in nursing at from the nursing faculty at KIU. This was to determine the extent to which the questions in the questionnaire address the variables of interest.

3.8.3 Data collection procedure

The data collection process was performed in a period of two months. The data for the study was collected by use of self-administered questionnaires. Based on an in-depth literature review, a three part self-administered questionnaire was designed.

3.8.4 Reliability

A pilot test was carried out to check appropriateness of the instrument. All the first year diploma students from nursing faculty were used in testing reliability of the questionnaire.

3.9Data Analysis plan

Both qualitative and quantitative data was collected. This was analyzed manually for accuracy of results. Typing was done by computer to enable formatting drawing of figures if found appropriate.

3.10Data Quality Control

The quality of data was enhanced by using questionnaires and use of trained research assistants. Pre-testing the questionnaires and checking for their completeness was done daily to sort out all the confusing questions.

3.11 Data Presentation Methods

Data was presented in form of tables and figures. Descriptive statistics was used where percentages for each response were calculated to give the lesson learnt and conclusion from the response.

3.12 Ethical Consideration

An introductory letter was obtained from KIU-TH Faculty of Allied health after approval of the proposal by Research and Ethics Committee of the Department of Health Studies, KIU-TH and then taken to the dean of students at KIU for further approval for collection of data.

Informed consent was obtained from the respondents after explaining the nature and purpose of the study. It was emphasized that participation is voluntary and that they can withdraw from the study at any time without penalty.

The interviews were conducted privately and the respondents were assured that their information was to be treated as being strictly confidential.

The principle of autonomy was practiced where by all participants received enough information about the study and this made them exercise their rights during decision making whether to participate or not.

Students (respondents) were thanked for their contribution)

CHAPTER FOUR

DATA PRESENTATION AND ANALYSIS

4.0: Introduction

This chapter provides statistical presentation and analysis of data collected. The data has been presented in tables and figures with summaries being given for each table and figures.

From the study population target of 138 students, a total of 125 questionnaires were returned representing a response rate of 91%.

4.1.1: Social demographic data of the respondents

The study analyzed to see the effects of the students' demographic information on their knowledge, attitude and practices towards HIV/AIDS prevention among prevention among first year diploma students doing clinical medicine at KIU Western Campus (KIU-WC)

The total number of respondents was 125, majority were males with (77) 62% while the females constituted only (48) 38% of the respondents.

The ages of the respondents was between 18-20 years representing 20%, and the majority lie under 21-23 years representing 54.4% ,then 16% representing 24-27 years,6.4% representing 28-30 years and then finally 3.2% representing those respondents above 31years.

Among the respondents interviewed, 16% were married while 84% were not married students and of all the respondents were students from KIU-WC.

As regards the respondents' religions, Catholics were identified as the majority with 32%, Anglicans with 26%, Muslims with 16%, born again with 16% and finally with others (SDA) 10%.

According to the respondents' tribes, the Basoga were the majority with 40%, the Baganda followed with 32%, the Banyankole were 15(12%) then finally the others (Bagishu and the Bagwere) were 8(6%)

Table 1: Respondents' background information

AGE (YEARS)	**FREQUENCY**	**PERCENTAGE (%)**
18-20	25	20.0
21-23	68	54.4
24-27	20	16.0
28-30	08	6.4
Above 31	04	3.2
TOTAL	**125**	**100**
GENDER		
Males	77	62
Females	48	38
TOTAL	**125**	**100**
MARITAL STATUS		
Married	20	16
Not married	105	84
TOTAL	125	100
RELIGION		
Catholic	40	32
Anglican	32	26

Muslims	20	16
Born again	20	16
Others(Seventh Day Adventists	13	10
TOTAL	**125**	**100**
TRIBE		
Banyankole	15	12
Baganda	40	32
Basoga	50	40
Luo	12	10
Others (Bagishu and Bagwere)	08	06
TOTAL	**125**	**100**

4.2.0 Section 2: knowledge about HIV/AIDS prevention

All the students had ever heard about HIV/AIDS representing 100%.

Table 2: Distribution of respondents by their knowledge about HIV/AIDS

RESPONSE	FREQUENCY	PERCENTAGE (%)
YES	125	100
NO	0.00	0.00
TOTAL	125	100

0ut of the 91%(125 students)who received information concerning knowledge about HIV/AIDS prevention ,56% representing 70 students had ever heard from parents while 44% representing 55 students answered no to their source of information from parents.

20% representing 25 students received from church while 80% representing 100 students answered no to information from church.

44%(55 students) received from media(radios, TV) while56%(70 students) answered no. 64%(80 students) heard information from friends while 36%(45 students) answered no and finally 72%(90 students) heard the information from health care provider campaigns while 28%(35 students) answered no.

Table 3: Distribution of respondents by their knowledge from where or whom (source of information) about HIV/AIDS prevention

Source of information	Frequency	Total percentage (%)
a)parents		
yes	70	56
No	55	44
b)church		
Yes	25	20
No	100	80
c)media(radio, TV)		
Yes	55	44
No	70	56
d) friends		
Yes	80	64
No	45	36
d)Health care provider campaigns	90	72
Yes		28
No	35	

No student answered YES about a cure for AIDS while 62% of them answered NO about AIDS cure representing 78 students and 38 %(47 students) of them didn't know whether there is a cure for AIDS.

74 %(92 students) answered YES that a person can be infected with HIV and not have AIDS while 18 %(23 students) answered NO and then 8 %(10 students) didn't know whether a person can be infected with HIV and not have the disease AIDS.

90.4% (113 students) answered yes that a healthy looking person can have HIV/AIDS, 3.2% (04 students) answered NO while 6.4% (08 students) didn't know.

All the respondents answered that HIV causes AIDs (100%, 125 students) and none answered witchcraft

Table 4: knowledge of HIV/AIDS prevention

QUESTIONNAIRE	**TOTAL**		**GENDER**			
KNOWLEDGE OF HIV/AIDS PREVENTION.			**MALES**		**FEMALES**	
	FREQENCY	**(%)**	**FREQENCY**	**(%)**	**FREQUENCY**	**(%)**
8) Is there a cure for AIDS?						
Yes	0.00	0.00	0.00	0.00	0.00	0.00
no	78	62	48	62	30	38
don't know	47	38	29	62	18	38

9) **A person can be infected with HIV and not have disease AIDS?**						
Yes	92	74	52	57	40	43
No	23	18	18	78	05	22
Don't know	10	08	07	70	03	30
10) Can a healthy looking person have HIV/AIDS?						
Yes	113	90.4	71	63	42	37
No	04	3.2	O3	75	01	25
Don't know	08	6.4	04	50	04	50
11**) What causes AIDS?**						
HIV	125	100	77	62	48	38
Witch craft	0.00	0.00	0.00	0.00	0.oo	0.00

All the students (125 students) responded that HIV/AIDS is transmitted through unprotected sex, mother to child transmission, infected blood transfusion, sharing sharp instruments and none answered transmission through mosquito bites and sharing utensils.

Table 5: Respondents' knowledge on how HIV/AIDS is transmitted

How HIV/AIDS is transmitted	Frequency	Percentage (%)
Unprotected sex	125	100
Mother to child transmission	125	100
Infected blood transmission	125	100
Sharing sharp instruments	125	100
Mosquito bites	0.00	0.00
Sharing utensils	0.00	0.00

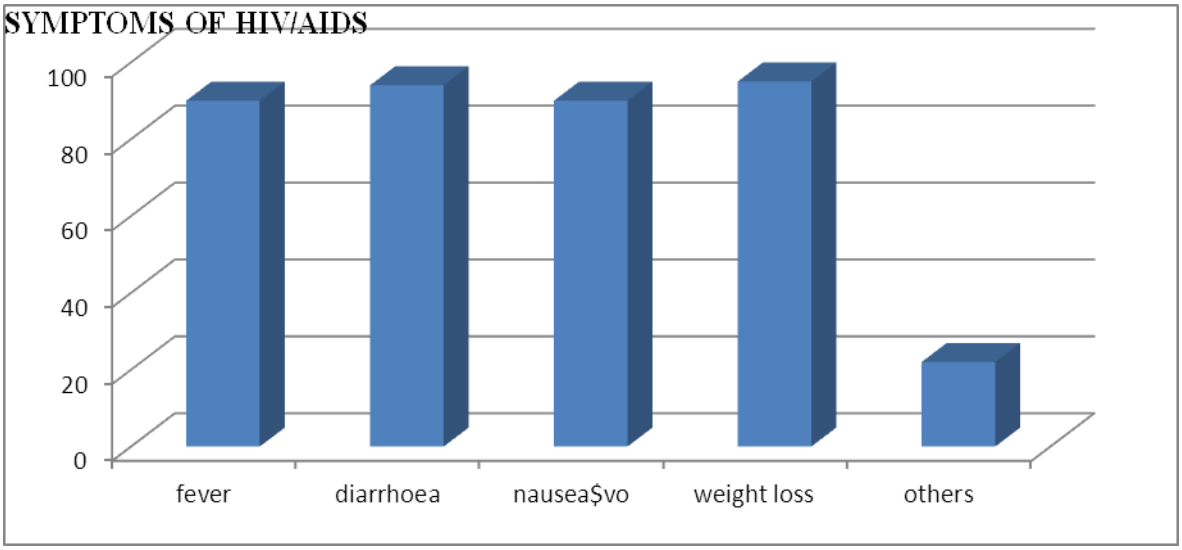


Figure 1: Respondents knowledge about HIV/AIDS symptom

90% (113 students) had knowledge of fever as a symptom of HIV/AIDS, 94% (117 students), 94% (117 students) answered diarrhea , 90% (113students) answered nausea and vomiting, 95% (119 students) answered weight loss and finally 22% (28 students) answered other symptoms which was persistent skin rash

4.3.0 SECTION C: ATTITUDES OF STUDENTS TOWARDS HIV/AIDS PREVENTION.

Among the students interviewed concerning their attitudes towards HIV/AIDS prevention, 99% (79 students) agreed that most youths who have HIV/AIDS have only themselves while 21%(26 students) disagreed to it.

34 %(43 students) agreed that most youths who have HIV/AIDS deserve what they get while 66% (82 students) disagreed. 13% (16 students) agreed that students should be removed from school if positive, 87 (109 students) disagreed.

114 students (91%) agreed that they feel more sympathetic towards students who get HIV/ AIDS from blood transfusion than those who get it from drug abuse however 9% (11 students) disagreed.

92 % (115 students) agreed that students with AIDS should be treated with same respect as other students while 8% (10 students) disagreed.

70% (87 students) agreed that they are worried about getting HIV/AIDS through social contact with fellow students but 30% (38students) disagreed.

92% (115 students) agreed that people with HIV/AIDS should tell their sexual partners that they are infected while 8% (10 students) disagreed.

61% (76students) agreed that they are sympathetic towards the misery that students with HIV/AIDS experience while 39% (49 students) disagreed.

90% (113students) agreed that they comfortable discussing with someone about HIV/AIDS while 10% (12 students) disagreed and finally 64 %(80 students) agreed that they have heard enough about HIV/AIDS and they don't want to hear about it anymore while 36 %(45 students) disagreed.

Table 6: Attitudes of students towards HIV/AIDS prevention

ATTITUDES TOWARDS HIV/AIDS PREVENTION	TOTAL		GENDER MALES		GENDER FEMALES	
	FREQENCY	PERCENTAGE (%)	FREQUENCY	(%)	FREQUENCY	(%)
Most students who have HIV/AIDS have only themselves to blame						
Yes	99	79	67	68	32	32
No	26	21	10	38	16	62
Most students who have HIV/AIDS deserve what they get						
Yes	43	34	20	47	23	53
No	82	66	57	70	25	30

Students should be removed from school if positive Yes No	16 109	13 87	11 66	69 61	05 43	31 39
I feel more sympathetic towards students who get HIV/AIDS from blood transfusion than those who get it from drug abuse Yes No	114 11	91 09	73 04	64 36	41 07	36 64
Students with AIDS should be treated with same respect as other students.						

Yes No	115 10	92 08	73 04	63 40	42 06	37 60
I am worried about getting HIV/AIDS from social contact with fellow students Yes No	 87 38	 70 30	 48 29	 55 76	 39 O9	 45 24
People with HIV/AIDS should tell their sexual partners that they are infected Yes No	 115 10	 92 08	 70 07	 61 70	 45 O3	 39 30
I am sympathetic						

towards the misery that students with HIV/AIDS experience						
Yes	76	61	41	54	35	46
No	49	39	36	73	13	27
I am comfortable discussing with someone about HIV/AIDS						
Yes	113	90	73	65	40	35
no	12	10	04	33	08	67
I have heard enough about HIV/AIDS and I don't want to hear it anymore						
Yes	80	64	45	56	25	31
No	45	36	32	71	23	51

4.4.0 SECTION 4: HIV/AIDS PREVENTIVE PRACTICES

Of the 125 students interviewed about how they protect themselves against HIV/AIDS, they suggested as follows; 24% (30 students) abstain from sex, 88% (110 students) use condoms, 74% (92 students) have only one sex partner, 16% (20 students) agreed that they use safe male circumcision and 28% (35 students) disagreed while 56% (70 students) disagreed that it is not applicable to them and finally 10% (12 students) use sterilized needles.

Table 7: The distribution of respondents' practices of how they protect themselves against HIV/AIDS

PRACTICES WHICH STUDENTS USE TO PROTECT THEMSELVES AGAINST HIV/AIDS	**TOTAL**		**GENDER**			
			MALES		**FEMALES**	
	FREQUENCY	**(%)**	**FREQUENCY**	**(%)**	**FREQUENCY**	**(%)**
Abstain from sex	30	24	20	67	10	33
Always use condoms	110	88	74	67	36	33
Have only one sex partner	92	74	50	54	42	46

Safe male circumcision **Yes** **No** **N/A**	 20 35 70	 16 28 56	 12 30 35	 60 86 50	 08 05 35	 40 14 50
Use sterilized needles	12	10	10	83	02	17

88 %(110) respondents said that their culture accept condom use however 12% (15) respondents said that their cultures don't allow condom use.

Table 8: The distribution of respondents whether their cultures accept condom use

Whether culture accepts condoms use	**Frequency**	**Percentage (%)**
Yes Females Males **Total**	 39 70 **109**	 36 64 **87**

No		
Females	09	56
Males	07	44
Total	**16**	**13**

48%(60 respondents) agreed that they believe that safe male circumcision reduces the risk of HIV by 60% while 52% (65 respondents) didn't believe it, 87% (109 respondents) agreed that their cultures accept safe male circumcision while 13% (16 respondents) disagreed to it, 93% (116 respondents)agreed that their religions accept safe male circumcision while 7% (09 respondents) disagreed, 97% (121 respondents) agreed that they believe that safer sex avoids HIV/AIDS while 3%(4 respondents) disagreed and finally 93% (116 respondents) had ever tested for HIV/AIDs however, 7% (9 respondents) had never tested.

Table 9: The respondents' preventive measures

Questionnaires about preventive measures	**Frequency**	**Percentage (%)**
Do you believe that safe male circumcision reduces the risk of HIV infection by 60%		
Yes	60	48
No	65	52

Does your culture accept safe male circumcision Yes No	 109 16	 87 13
Does your religion accept safe male circumcision Yes No	 116 09	 93 07
Do you believe that safer sex avoids HIV/AIDS Yes No	 121 04	 97 03

40% (50 respondents) had ever tested once, 28% (35 respondents) had ever tested twice and finally 25 %(31 respondents) had ever tested for HIV/AIDs more than twice.

Table 10: The distribution of the respondents for the number of times they had ever tested for those who said yes

Number of times that students tested for HIV/AIDS	**Frequency**	**Percentage (%)**
Once		
Females	20	40
Males	30	60
Total	50	40
Twice		
Females	10	29
Males	25	71
Total	35	28
More than twice		
Females		
Males	10	32
Total	21	68
	31	25

CHAPTER FIVE

DISCUSSION OF FINDINGS, CONCLUSION, WEAKNESS, STRENGTHS AND RECOMMENDATIONS

5.0 INTRODUCTION

This chapter draws a summary of the discussion and conclusion plus weaknesses, strengths and recommendations based on the findings which attempted to answer the research questions.

5.1 Discussion of the findings

5.1.1 What is the level of knowledge of HIV/AIDS prevention among prevention among first year diploma students doing clinical medicine?

Level of knowledge of HIV/AIDS prevention can be explained on how well the students are aware of HIV/AIDS, the difference between HIV and AIDS, source of where they heard the information about HIV/AIDS, the symptoms and how HIV/AIDS is transmitted.

In table 2, the study found out that the level of knowledge of the students on HIV/AIDS was good with 100% response. They had all heard about HIV/AIDS however there was a difference between genders where 62% males had received the information and 38% females which shows that more males than females received this information which is similar to the information by (UNAIDS, 2007)which stated that both in sub Saharan Africa and globally ,women had lower levels of HIV knowledge. This be could that there are more males attending school than the males as per Africa tradition and it could also be due to lack of access to the information about HIV/AIDS.

In table 3, at least every student had received information on HIV/AIDS from various sources as discussed below. The majority had the information from health care providers 'campaigns with 72% total response. This could be due to the intense health care provider by TASO during secondary schools and also the intensive sensitization and mobilization about HIV /AIDS by most Health centers. This was followed by access of information about HIV /AIDS from friends with 64%, this could be due to the good peers with whom the students socialize with and probably they have known more about the dangers of having the infection. 44% heard from media (TV, radios) this could be due to the high level of literacy and modern technology among students .56% agreed to have heard from parents, this indicates that parents are playing a role in

sexual education of their children which is different from (Nambatya, 2010) which stated that families will not discuss sexuality issues with their children fearing that it will make them more promiscuous. A few students comprising of 20% agreed they heard from church /mosque. This could be because a few students attend prayers or the religious leaders don't preach about how to prevent the spread of HIV /AIDS and have no information about it.

In table 4, all the students agreed that there is no cure for HIV/AIDS .This could be to the wide knowledge that students have towards chronic illnesses that do not cure and it could be that the students had seen people with HIV/AIDS being managed for it but do not cure but continuously swallow drugs to prolong life. However, 62% of students disagreed that there is a cure for HIV/AIDS. This could be due to lack of proper information, poor sensitization and mobilization of the youth about HIV/AIDS. 38% of them responded that they do not know whether there is cure, this shows the misconception that students have towards the virus.

About 74% agreed that a person can be infected with HIV and not have AIDS .This shows how informed and intelligent these students are concerning HIV/AIDS.18% disagreed to it which could be due to lack of information about HIV/AIDS. However 7% responded contrary to the rest which shows the misconception that they have which could be due to lack of adequate information about the disease and lack of access to various sources of information about the disease.

90% agreed that a healthy looking person can have HIV/AIDS. This percentage is still as per regards to the various campaigns which the government of Uganda has put in the mobilizing about HIV/AIDS, this could be due to lack of proper information from TASO, Uganda about HIV/AIDS. 3.2% disagreed to it could be due to the high information about the infection. This answers (Cohall, 2001)desire for the people to identify the common misconceptions about AIDS include that all the HIV infected people appear ill. This shows that these students do not have information about infection. However, 6.4% responded that they did not know whether a healthy looking person can have HIV/AIDS. This could be that they lack access to information about HIV/AIDS.

All the students with 100% response agreed that HIV causes AIDS and not witchcraft which is a clear indication that they all know the cause of the AIDS. This is different from(Cohall et al,

2001)'research that the virus can be transmitted through mosquito or other insect's bites, by sharing food with someone who is infected or by witch craft or other supernatural means. This common misconception about HIV/AIDS could have been stopped because the students have been well equipped with knowledge about the cause of the infection.

In table 5, 100% of the students responded that HIV/AIDS can be transmitted in various ways as identified, un protected sex, mother to child transmission, infected blood transfusion and sharing of sharp instruments as the only ways of transmission of the virus which is an indication that all of them know how the disease is contracted and the respondents being medical students shows that they had prior information about HIV/AIDS although they are first years in the medical school however there is no student who responded that HIV is transmitted through mosquito bites and sharing utensils which clears the misconception as noted by (Wodi, 2005) . According to the author sub-Saharan Africa being where mosquitoes are endemic this misconception is significant because it implies a defeatist attitude that regardless of what one does, one is subject to HIV infection as a resident of a mosquito infested region. Therefore it's important to know this misconception.

In figure 1, all the respondents identified the symptoms correctly with others suggesting fever 90%, diarrhea 94%, nausea and vomiting others responded weight loss (95%) and finally others responded to persistent skin rash. Looking at the above results all the students had proper knowledge about the symptoms of HIV/AIDS.

5.1.2: What is the attitude of the students towards HIV/AIDS prevention?

In table 6, enough time was allocated to measure the respondent feeling towards HIV/AIDS. The respondents expressed empathic attitudes towards people with HIV/AIDS and the males were more empathic compared to the females.

79% agreed that most students who have HIV/AIDS only blame themselves. This could be that some students engage in sexual intercourse with people even when they come to know their sero-status being positive but still have it for the sake of getting money from them. 21% disagreed to it because some students acquire the virus from their parents through breastfeeding while others get the virus through blood transfusion hence have no reason to blame themselves for having it.

About 34% agreed that most students who have HIV/AIDS deserve what they get. This could be that some people are deliberately having sex just to feel their ego due to their unsatisfiable desires for sex and they end up getting the disease hence they deserve what they get. However, 20% disagreed that these students do not deserve what they get which could be that these students a times acquire the infection from being pierced by sharps on wards during their ward rounds in their various hospitals and others could have got through a massive road traffic accidents.

16 students with a response rate of 13% agreed that students should be removed from school if HIV positive. This is similar to the information by(Wodi, 2005) where he noted that in Sub Saharan Africa, overt discrimination against HIV positive youth could cause dropping out of school for the victims. This could be due to the lack of information about the HIV/AIDS. However, the majority with a response rate of 87% disagreed to it, it could be that these students have been oriented that these students are normal like any other student and can carry on their daily activities.

91% agreed that they felt more sympathetic towards students who get HIV/AIDS from blood transfusion than those who get it from drug abuse. This could be that these students get the virus innocently when they did not engage in sexual activity as compared with those who get from drug abuse. This could be that these students despite of the various sensitizations about stopping drug abuse still continue with using them and end up sharing the same syringe for injecting themselves hence acquiring the virus.

92% responded that students with AIDS should be treated with the same respect as other student. This could be that these students have proper information and have been educated against discrimination of those infected; however, 8% disagreed that students with AIDS should be treated with same respect as other students. This difference could be due to the attitudes that the students attach to those who contracted the disease through prostitution hence those people are considered prostitutes and do not need respect.

About 70% were worried about getting HIV/AIDS from social contact with fellow students in school which is different from what ((KNBS), 2009) reported that from 2003 to 2008 and 2009, increases were reported in the percentage of both women and men who expressed willingness to

care for a relative with HIV, a willingness to buy food from an HIV infected vendor and a belief that HIV-positive teachers should be allowed to continue to teach. This could be due to the negative attitudes that students attach to those infected and also could be due to lack of information of how HIV/AIDS is transmitted while 30% both female and male students disagreed to it. This could be that these students are aware of how HIV/AIDS is transmitted and not any how through social contact like handshaking with one infected.

92% responded that people with HIV/AIDS should tell their sexual partners that they are infected which is different from (Wodi , 2005) who explained that many youths fear to disclose their HIV status because of the fear to be discriminated by the community. This could be that students have understood the importance of results disclosure as this would make them prompt for better methods of HIV/AIDS prevention. However, 8% disagreed that to it. This could be that these students fear the discrimination which could come in once the sexual partner comes to know the spouse' HIV/AIDS sero status.

61% felt more sympathetic towards the misery that students with HIV/AIDS experience. This could be that these students have come to understand that these students are so innocent for the disease they have which has no hope of it curing and the complication and demands attached to the infection. However 39% disagreed to it, this could be that some students no dangers of HIV/AIDS but still do not involves taking precaution by using condoms while having sex or by being faithful to one sexual partner.

90% disclosed that they are comfortable discussing with someone about HIV/AIDS. This indicates that the people having it have had better experience and have known about the effects of the infection and could be that they are ready to educate others on how to prevent acquiring it and encourage those who are positive to live positively while happy but 10% disagreed to it which could be that these people are scared of the community discriminating them or they are scared of their own sero status and are in denial.

64% responded that they have heard enough about HIV/AIDS and they don't want to hear about it anymore. This could be due to the stigma they attach to HIV/AIDS patients in the clinical manifestations at late stage of the infection and it could also due to doubt or guilt about their sexual behaviors. This makes them reluctant to understand more about HIV virus. However 36%

disagreed to it which could be that these students are inquisitive and want to know more about the virus so that they can protect themselves against it.

5.1.3What are the various practices concerning HIV/AIDS prevention among first year diploma students doing clinical medicine have?

About 24% responded that they abstain from sex of 33% (females) were females and the majority were males with 67% which indicates that most females start practicing sex early in their lives which is different from (Okware *et al*, 2005) who found out that the strong campaigns being put in educating girl child about the importance of primary and secondary abstinence is fluctuating among the students. This could be due to poverty girl child where they are involving in early sex to attain basic needs.

88% responded that they always use condoms which is still low as compared with the current prevalence of HIV/AIDS which is similar to that found by(Nambatya, 2010) who stated that adolescent in particular may not know where to get them or fear to approach health workers about them. This could also be low due to the negative attitude that students attach to condoms such low sexual pleasure when having sex with a condom.

About 74% agreed that they have sex with one sexual partner; this indicates a good sign that those who are married are not practicing polygamy hence controlling the spread of HIV/AIDS. This could be that that the students are informed about the importance of having one sexual partner.

16% agreed that they use safe male circumcision which indicates that the majority of the males are not are aware of the significance of it in controlling the spread of HIV/AIDS as discussed by (WHO, 2007) which stated that in Uganda only 26 percent of its men aged 15-49 years are circumcised and has a high HIV prevalence of 7.2 percent This shows that the majority of them are still ignorant about circumcision and its relevance in HIV prevention.

48% agreed believed that safe male circumcision reduces the risk of HIV infection by 60%. This shows that the people know about safe male circumcision and are not going for it due to poverty and lack of access to health facilities for the procedure to be carried out.

10% agreed that they use sterilized needles which indicate that there is still little precaution taken about sharing of sharp instruments with infected people. This being medical school students could be that students lack proper information about how HIV/AIDS is transmitted through use of unsterilized needles.

About 88% agreed that their culture accept condom use, 87% agreed that their cultures accept safe male circumcision (SMC) and 93% agreed that their religions accept SMC this indicates that both the cultures and religions have done a lot in the fight of HIV/AIDS. This could be that these cultures like the Bagishu and Islam religious leaders are well informed about the relevance of circumcision in the prevention of HIV/AIDS.

97% believed that safer sex avoids HIV/AIDS this indicates that the students have taken a higher step in knowing more of those safer methods to be used while having sex. This could be that these students are well informed about safer sex in the prevention of HIV/AIDS.

About 93% 0f the students had ever tested for HIV/AIDS though 40% had ever tested once, 28% tested twice and 25% had tested more than twice. This is different from (Kasirye, 2013) who stipulated that a big percentage of adult population in SSA have never tested for HIV/AIDS since the outbreak of the disease more than 20 years ago. This could be due to lack of access to the healthy facility.

5.2 CONCLUSION

5.2.1 Knowledge

The research showed that most of the students both the female and male have a good level of knowledge regarding HIV/AIDS especially about the cause, sources of information and how it is transmitted, which is a good sign; however, the male had overall better results than the female concerning knowledge, attitude and practices of HIV/AIDS prevention. Although there are some who are still confused whether there is cure for AIDS and some few about 18% don't believe that a person can be infected with HIV and not have the disease AIDS.

5.2.2 Attitude

Although most of the students showed to have a good attitude towards HIV/AIDS prevention, about 16% students still believe that students who are HIV positive should be removed from

school. This shows that there is still some degree of stigmatization and discrimination among towards those who infected.

5.2.3 Various sexual practices

A majority of the respondents showed that they are taking precaution while having sex and didn't feel they are at risk of HIV infection. This shows the wide rate of knowledge that the students have towards HIV /AIDS prevention although abstaining from sex for those who are not married showed to be low with 24% total response which means that many of them are sexually active. Use of sterilized needles with a response rate of 10%and the use of safe male circumcision in reduction of the risk of HIV infection by 60% reported to be poor. This indicates that the students have low knowledge about the use of those methods in the control of the spread of AIDS.

5.3.0 WEAKNESSES AND STRENGTHS

5.3.1 Weaknesses

While collecting data, I printed out 138 questionnaires as my target sample size to be distributed to students but only 125 questionnaires were returned reducing the degree of accuracy of the results.

During analyzing data I faced big challenge with electricity as it was not stable leading to the delay in the accomplishment of the report.

While collecting data I faced a challenge with persuading students to answer the questionnaires as they were always busy preparing for their examinations which prolonged the process of data collection.

I faced a financial challenge while working on the report as it needed a lot of money to be accomplished.

Lastly I faced a challenge in balancing writing the research report with reading other course units as we preparing for the final examinations.

5.3.2 Strengths

Despite the busy schedule I was able to convince some students who gave me time allocations to meet them so that they could answer the questionnaire especially during weekends and during their free times.

I wrote questionnaires which were easy to interpret by the students hence overcame the research fatigue by the students.

I was able to plan my time for accomplishing the research report and balance with reading other course units which became a success.

My friends and parents supported me financially hence a success in printing out the final report amidst all the struggles.

5.4.0 RECOMMENDATIONS

5.4.1 To the academic body (students)

The academic body should carry out a qualitative study to understand more deeply why the female have poorer knowledge on HIV and its transmission compared to the male.

In the future it would be interesting to investigate and compare what information and recommendations the students believe they have received from health care givers and what information health care providers believe they have given to the students. This could show if there if there is lack of information from health care givers or if there are any area concerning KAP of HIV prevention that needs to be improved.

It's important for future research to focus on the level of knowledge of the staff or other educators on HIV/AIDS prevention in order to ensure that they impart right knowledge and methods which help the students to realistically assess their risk for HIV/AIDS.

5.4.2 To the community

The Ministry of Health (MoH) should make health service more youth friendly may lead to an increased use of facility by young people in Bushenyi. Many young people lack access to services such as condoms and voluntary counseling and testing (VCT). Sensitizing staff on young people' need is critical to make sure they get the service package they need.

The parents should also play a role in educating their adolescent children about sex education. This shall help the youths not to discover some bad sex habits out of ignorance.

Targeted media and social marketing campaigns should be used in communities to improve young peoples' knowledge about HIV and AIDS. Programs that use a mix of media show significant outcomes on HIV knowledge.

The MoH should train health workers who shall in turn educate peers to be positive role models that can positively influence young people' behaviors, facilitating access to and creating trust among young people.

APPENDIX 1: REFERENCES

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APPENDIX 2: CONSENT FORM

Dear respondent,

I am NAMBUBI ANNE MARY a student of KIU-WC in the faculty of Allied Health Sciences. Am carrying out a research under the topic:

The assessment of the level knowledge, Attitude and HIV/AIDS prevention among first year diploma students doing clinical medicine at KIU Western Campus (KIU-WC)

You have been chosen to participate in this study. The main purpose of this study is to clear information about the knowledge, attitude and behavioral practice of the students towards HIV/AIDS prevention. Your response will be very useful in designing ways to ensure control measures of HIV/AIDS and the related stigma attached to it.

_____

Signature of Respondent

The information will be treated confidentially

APPENDIX 3: QUESTIONNNAIRE FOR RESPONDENTS

Questionnaire to assess the knowledge, Attitude, practices of HIV/AIDS prevention among first year diploma students doing clinical medicine at KIU Western Campus (KIU-WC)

Instructions;

Please fill in the space provided or tick the right answer

Section 1: social demographic data

1 .How old is you (in years)

a) ☐ 18- 20 ☐ b) 21-23 ☐ c) 24- 27 ☐ d) 28-30 e) above 31.

2. What is your gender?

a) Male ☐ b) Female ☐

3. Are you married?

a) Yes ☐ b) No ☐

4. What is your Religion/ denomination?

a) Catholic ☐ b) Anglican ☐ c) Muslim ☐ d) born again ☐ e) others ☐

5. Ethnicity (tribe)……

Section 2: Knowledge related to prevention

6. Have you ever heard about HIV/AIDS? .....

7. If yes, from where/whom

Parent'ss ☐

Church ☐

Media (radio, television) ☐

Friends ☐

School ☐

Health care provider ☐

Campaigns ☐

7. Is there a cure for AIDS?

a) Yes☐ b. No ☐c. Don't Know ☐

8. A person can be infected with HIV and not have the disease AIDS

b) Yes☐ b. No ☐c. Don't Know/Don't Remember ☐

9. Can a healthy looking person have HIV/AIDS?

c) Yes ☐ b. No☐c. Don't Know/Don't Remember ☐

10. What causes AIDS?

a) HIV ☐

b) Witch craft ☐

6. How is HIV transmitted?

a) Un protected sex ☐

b) Mother to child transmission ☐

c) c) Infected blood transfusion ☐

d) d) Sharing of sharp instruments ☐

e) e) Mosquito bites ☐

f) f) Sharing utensils ☐

11. Which are the symptoms of HIV/AIDS? Kindly tick the relevant ones.

a) Fever ☐

b) Diarrhea ☐

c) . Nausea and Vomiting ☐

d) d. Weight loss ☐

e) e. persistent skin rashes ☐

f) f. Fatigue ☐

g) g. Others (Specify) ☐

Section 3: Attitudes of students towards HIV/AIDS prevention

12. Most youth who have HIV/AIDS have only themselves to blame

Yes ☐

No ☐

13. Most youth who have HIV/AIDS deserve what they get

Yes ☐

No ☐

14. Students should be removed from the school if they are HIV positive

Yes ☐

No ☐

15. I feel more sympathetic towards students who get HIV/AIDS from blood transfusion than those who get it from drug abuse

Yes☐ No ☐

16. Students with AIDS should be treated with the same respect as other students

Yes ☐

No ☐

17. I am worried about getting HIV/AIDS from social contact with fellow students in school

Yes☐ No ☐

18. People with HIV/AIDS should tell their sexual partners that they are infected

Yes☐ No ☐

19. I am sympathetic towards the misery that students with HIV/AIDS experience s

Yes☐ No ☐

20. I am comfortable discussing with someone HIV/AIDS

Yes☐ No ☐

21. I have heard enough about HIV/AIDS and I don't want to hear about it anymore.

Yes☐ No ☐

Section 4: HIV/AIDS prevention

22. What do you use to protect yourself against HIV/AIDS?

a. Abstain from sex ☐
b. Always use condoms ☐
c. Have only one sex partner ☐
d. safe male circumcisions yes☐ no ☐ N/A ☐
e. Use sterilized needles ☐
f. routine testing ☐

23. Does your culture accept condom use?

Yes☐ No ☐

24. Do you believe that safe male circumcision reduces the risk of HIV infection by 60%?

Yes☐ No ☐

25. Does your culture accept safe male circumcision?

Yes☐ No ☐

26. Does your religion accept safe male circumcision?

Yes ☐ No ☐

27. Do you believe that safer sex avoids HIV/AIDS?

Yes☐ No ☐

28. a) Have you ever tested for HIV AIDS

Yes☐ No ☐

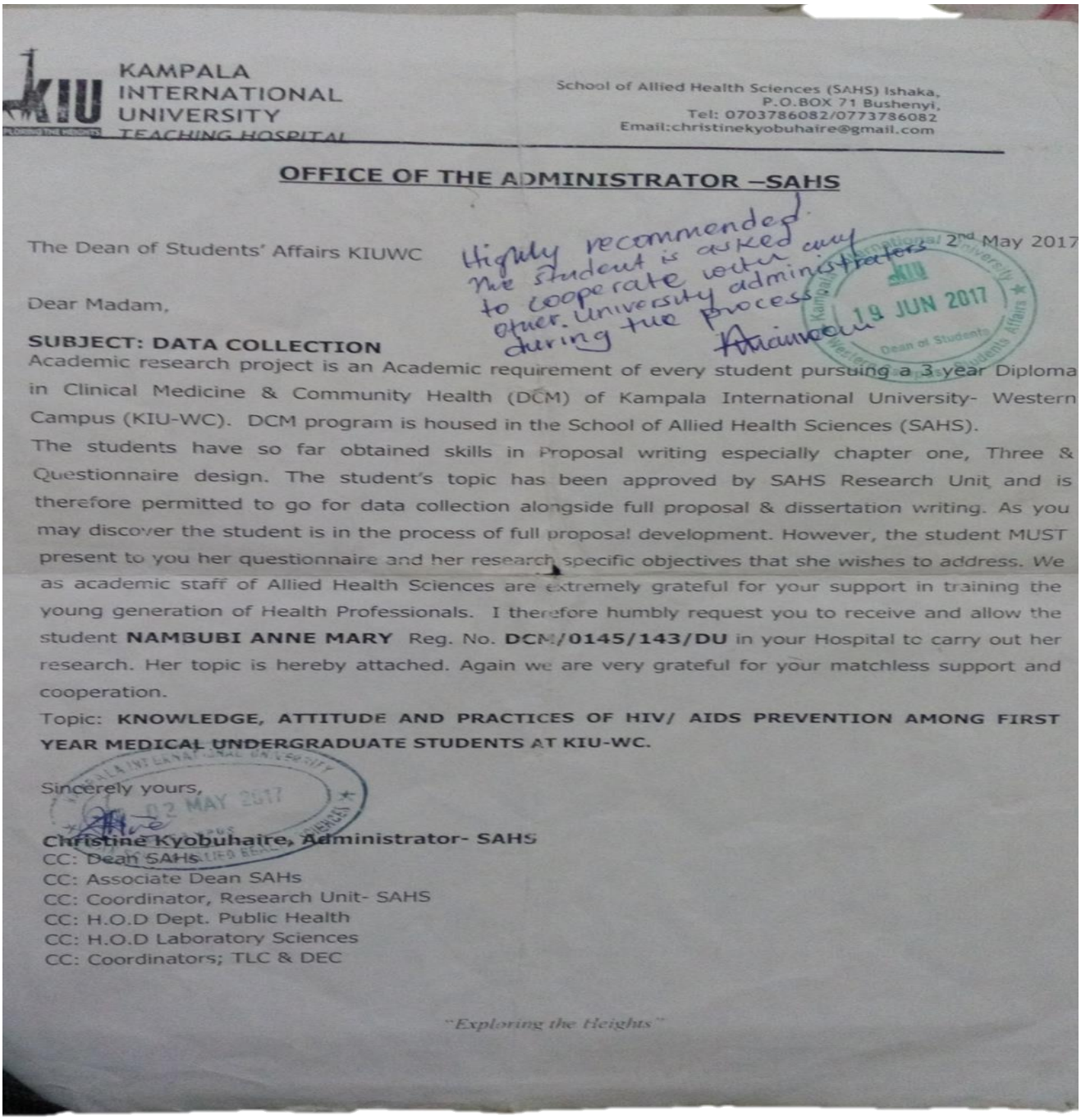
b) If yes, how many times

Once☐

Twice ☐

More than twice☐

APPENDIX 4: APPROVAL LETTER FOR DATA COLLECTION



KAMPALA INTERNATIONAL UNIVERSITY
TEACHING HOSPITAL

School of Allied Health Sciences (SAHS) Ishaka,
P.O.BOX 71 Bushenyi,
Tel: 0703786082/0773786082
Email:christinekyobuhaire@gmail.com

OFFICE OF THE ADMINISTRATOR –SAHS

The Dean of Students' Affairs KIUWC

Highly recommended. The student is asked to cooperate with other University administrators during the process

2nd May 2017

Dear Madam,

SUBJECT: DATA COLLECTION

Academic research project is an Academic requirement of every student pursuing a 3 year Diploma in Clinical Medicine & Community Health (DCM) of Kampala International University- Western Campus (KIU-WC). DCM program is housed in the School of Allied Health Sciences (SAHS).

The students have so far obtained skills in Proposal writing especially chapter one, Three & Questionnaire design. The student's topic has been approved by SAHS Research Unit and is therefore permitted to go for data collection alongside full proposal & dissertation writing. As you may discover the student is in the process of full proposal development. However, the student MUST present to you her questionnaire and her research specific objectives that she wishes to address. We as academic staff of Allied Health Sciences are extremely grateful for your support in training the young generation of Health Professionals. I therefore humbly request you to receive and allow the student **NAMBUBI ANNE MARY** Reg. No. **DCM/0145/143/DU** in your Hospital to carry out her research. Her topic is hereby attached. Again we are very grateful for your matchless support and cooperation.

Topic: **KNOWLEDGE, ATTITUDE AND PRACTICES OF HIV/ AIDS PREVENTION AMONG FIRST YEAR MEDICAL UNDERGRADUATE STUDENTS AT KIU-WC.**

Sincerely yours,

Christine Kyobuhaire, Administrator- SAHS

CC: Dean SAHs
CC: Associate Dean SAHs
CC: Coordinator, Research Unit- SAHS
CC: H.O.D Dept. Public Health
CC: H.O.D Laboratory Sciences
CC: Coordinators; TLC & DEC

"Exploring the Heights"

APPENDIX 5: MAP OF BUSHENYI DISTRICT SHOWING KIU LOCATION