ASSESSMENT OF THE FACTORS AFFECTING UPTAKE OF VOLUNTARY COUNSELING AND TESTING (VCT) SERVICES AMONG YOUTH IN CENTRAL DISTRICT, ZANZIBAR

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A DISEERTATION SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE AWARD OF MASTERS DEGREE OF ARTS IN SOCIAL WORK OF OPEN UNIVERSITY OF TANZANIA.

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CERTIFICATION

I, **Prof. Hosea Rwegoshora**, certifies that he has read and hereby recommends for acceptance by the Open University of Tanzania a dissertation titled ***"Assessment of Factors affecting uptake of Voluntary Counseling and Testing among Youth in Central District, Zanzibar"*** submitted in partial fulfillment of the requirements for the Degree of Social Work of the Open University of Tanzania.

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Prof. Hosea Rwegoshora

(Supervisor)

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Date

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DECLARATION

I, **Said KassimMoh'd**, do hereby declare that this dissertation is my own original work and it has never been presented before its submission to Open University of Tanzania and will not be presented to any University for a similar or any other degree award.

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Signature

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Date

DEDICATION

This work is dedicated to the beloved members of my family. First in the list is my beloved father who passed away on 12/08/2015 while this work had already started May almighty God rest their souls in eternal peace.

Secondly, I dedicate this work to my beloved mother Asha Suleiman Ameir, who in spite of not having had chance to excel much in education, but really blossomed and treasured education on me.

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Last, but by all means not the least, I feel deep gratitude to all those who in one way or the other, were connected to this project, even those who well wished me for this endeavor. Nonetheless, I remain exclusively responsible for any or all the shortcomings that will be observed from this work.

ABSTRACT

Globally, an estimated 11.8 million young people aged 15-24 are living with HIV/AIDS. In Tanzania in 2003, among the 1.6 million people with HIV/AIDS, 15% were 15-24 years old, and 60% of new infection occurred among youth. Therefore, considering such rate of HIV infection, youth deserve to be the focus of HIV prevention efforts. The VCT is among of HIV intervention measures that are implemented in Zanzibar, youth are among of the targeted group whose attendance has been reported low, hence the needy of this study.

This study adopted a descriptive research design. Qualitative and Quantitative methods were also used in this study. Data were collected through reviewing documents, questionnaires, interviews, focus group discussion (FGD). Only quarter of the youth in the district have had voluntary counseling and testing services Therefore measures are needed to promote uptake including raising awareness to youths.

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OPERATIONAL DEFINITIONS

Confidentiality - obligation not to reveal youth HIV test results of a youth without his/her consent (McCauley, 2004).

Discrimination – According to Coovadia, (2000)is an action that results from stigma. It occurs when a distinction is made against persons that result in their being treated unfairly on the basis of HIV/AIDS status. This does not only occur to the infected persons but also to their families, relatives and friends.

Informed consent - an agreement the youth makes with the service provider or researcher after having received and understood the purpose of the procedure or the exchange of information.

Post-test counseling- a discussion held between a provider and a youth with the aim of informing the youth of their HIV test results and assisting them to cope with the results. The discussion consists of giving the test results, assessing the youth's emotional and mental understanding of the results and making plans for care (Horizon, 2004).

Pre-test counseling- a discussion held between a provider and youth aimed at preparing the youth for the HIV test. It consists of clarifying the youth's knowledge about HIV/AIDS, informing the youth about the test procedures and how HIV test results are managed, preparing the youth for the outcome of the test, assisting them to make a decision about testing , obtaining the informed consent of the youth and counseling about safer sex(Horizon, 2004).

Stigma – Stigma refers to the negative thoughts about a person or group based on prejudiced.(McCauley, 2004).

Voluntary Counseling and Testing - Process whereby a person undergoes counseling to enable him/her make an informed choice about being tested for HIV. This decision must be entirely the choice of the individual and must be assured that the process is confidential.(Horizon, 2004)

Youth - Any persons aged between 15-24 years, for the purpose of this study only those who are in school were selected.

ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ART	Anti –Retroviral Therapy
AMREF	Africa Medical and Research Foundation
ANGAZA	Voluntary Counseling Centers under AMREF
FGD	Focus Group Discussion
HIV	Human Immunodeficiency Virus
HIV/AIDS	The two terms constitute the disease continuum, from HIV infection to AIDS
NACP	National Aids Control Program
NGO	Non-Governmental Organization
PMTCT	Prevention Mother To Child Transmission
STI	Sexually Transmitted infection
STD	Sexually Transmitted Disease
USAID	United States Agency for International Development
USA	United States of America
VCT V	Voluntary Counseling and Testing
DHO	District Health Office
FGD	Focus Group Discussion
FHI	Family Health International
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HSD	Health Sub-District
STD	Sexually Transmitted Diseases

UNDP	United Nations Development Program
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations Children's fund
WHO	World Health Organization

CHAPTER ONE

1.0 THE STUDY AND ITS SETTING

1.1 Introduction

This chapter presents background information on HIV/AIDs and VCT services on youths. The chapter further presents a statement of the problem, main objectives and specific objectives of the study, conceptual framework, research questions and significance of the study.

1.2 Background Information

HIV/AIDS is a global pandemic that affects individuals, families, and entire communities around the world and has profound social and economic implications; its impact has been and is to be felt decades to come. Various interventions have been seen in recent years in global efforts to address the AIDS epidemic, including increased access to effective treatment and prevention programs, (UNAIDS & WHO 2006); Despite all these efforts, the number of people living with HIV continues to grow as does the number of death due to AIDS and the HIV epidemic continues to be the a major challenge for global health,(UNAIDS & WHO 2008a).

UNAIDS Statistics for the end of 2009 indicate that around 33.3 million people (31.4-35.5 million people) are living with HIV globally,(UNAIDS & WHO 2010). The UNAIDS further estimated that each year around 2.7 million more people are infected with HIV and 2 million die of AIDS every year UNAIDS/WHO2009, November). Although HIV /AIDS prevail in all parts of the world, some areas are more affected

than others; the worst affected region is sub-Saharan Africa, where in some countries at least more than one in five adults is infected with HIV,(CDC 2005).

In Sub-Saharan Africa, an estimated 22.5 million people are living with HIV,(UNAIDS & WHO 2010), in 2008, around 1.4 million people died of AIDS in sub-Saharan Africa and 1.9 million people were infected with HIV. Over this period, more than 14 million children have lost one or both parents since the beginning of the epidemic; the largest epidemics in sub-Saharan Africa are in Ethiopia, Nigeria, South Africa, Zambia, and Zimbabwe(UNAIDS & WHO 2009b).

In Tanzania like any other affected country, HIV/AIDS continues to be a major national health priority. Although important progress has been achieved in preventing new HIV infections and in lowering the annual number of AIDS related deaths, the number of people living with HIV continues to increase. AIDS-related illnesses remain one of the leading causes of deaths and are projected to continue hence causing increased premature mortality in the coming decades, (UNAIDS & WHO 2008a).

The first cases of HIV/AIDS in Tanzania were reported in1983, although for sub-Saharan Africa as a whole the problem began to surface in the late 1970s. The epidemic has evolved from being rare and new disease to a common household problem, which has affected most Tanzania families. (National HIV/AIDS Policy, 2001:12) The development of the HIV/AIDS epidemic have its clear impact on all sectors of development through not only pressure on AIDS cases care and management of resources, but also through debilitation and depletion of economically active population

especially young women and men. Zanzibar is not severely affected as the Sub Saharan Africa neighbours. The first HIV/AIDS cases in Zanzibar were diagnosed in 1986 at Mnazimmoja hospital, since then there has been a marked increase in reported cases cumulatively from 3 in 1986 to 2500 by the end of 2002. (Zanzibar multisectoral HIV/AIDS Policy, 2005: 9).

Surveillance data provide evidence that unlike mainland Tanzania, which has a relatively high HIV prevalence of 5.3% in the general population, an estimated 1% of the general population of Unguja and Pemba islands is infected with HIV (THMIS, 2012: 46). Furthermore, periodic HIV surveillance activities among pregnant women in Zanzibar also indicate low prevalence of 0.6% in 2008 (Zanzibar ANC surveillance Report, 2010:2).While HIV prevalence in the general population remains low, it is known that certain populations, referred to as key populations at risk (KPs), are at increased risk for HIV infection, including people who inject drugs (PWID), men who have sex with men (MSM), and sex workers (SWs). Data from integrated behavioural and biological surveys (IBBS) conducted among KPAR in 2007 support this knowledge, having found HIV prevalence rates of 16.0%, 12.3% and 10.8% among PWID, MSM and female sex workers (FSW), respectively (RDS report, 2007).

According to Zanzibar's Ministry of Health, the number of people living with HIV (PLHIV) in Zanzibar had reached 11,000 by 2012. Because AIDS is spreading both in numbers and geographically, it is viewed as a major public health threat and strategies are underway to increase AIDS awareness and knowledge among the general public. In February-March 2008, the 2008 Survey, which analyses knowledge, attitudes,

behaviour, and practices related to HIV risk perception of contracting HIV, and people living with HIV. More than 6,000 youth were interviewed, out of 424 youth they have enough knowledge and skills on how to use condom and effects of engaging into risk behaviour activities which results into HIV infections yet they are still ignoring.

Despite collective preventive interventions such as community sensitizations and education, yet the HIV Infection prevalence had dramatically increase in Zanzibar from 0.6 in 2007 THMIS to 1% in 2012 THMIS.To date there is no cure for HIV/AIDS and prevention still remains the main strategy for combating HIV/AIDS. Many approaches to HIV prevention and care require people to know their HIV status. In many low and middle income countries, the primary model for HIV testing has been of client-initiated VCT **(**WHO, 2004). The provision of voluntary confidential counseling and testing is first and foremost based on the intent that everyone who wishes to has a right to know the test result, and that services are provided on confidential basis (Temmerman et al., 1997).

Voluntary Counseling and Testing (VCT) presents an entry point for important intervention opportunities in terms of prevention, support and medical care (Lippincott &Wilkins, 1999).

Voluntary Counseling and Testing is HIV testing provided to individuals who seek the service out of their own will without any coercion. A health provider, sexual partner or friend may refer these persons, or they may have learned of the service through hearsay or public media. The emphasis is that the person makes their conscious decision to seek

the service without coercion; this can be an effective behavior-change intervention since it offers a holistic approach that can address HIV in the broader context of peoples' lives, including the context of poverty and its relationship to risk practice (Boswell & Baggaley, 2002).

Youth particularly those still in their teens are underrepresented among those accessing VCT services (McCauley, 2004), in spite of most HIV infections being estimated to occur among young people 15–24years (UNAIDS, 2004). Young people require special attention to their needs through the provision of confidential youth friendly health services. In Zanzibar, HIV counselling and testing services are provided in 79 sites, including 54 public health facilities, 13 NGOs, 2 FBOs, 4 parastatal and 6 private hospitals/dispensaries. The sites are distributed in all districts of Zanzibar and among them, 53 are in Unguja and 26 in Pemba. Out of these 79 sites, 34 provide VCT services alone, 18 provide PITC services alone and 27 provide both VCT and PITC services. In addition, these services are also provided in outreach activities and during special events such as World AIDS Day, Zanzibar International Film Festival, village health days and other events.

1.3 Statement of the Problem

HIV/AIDS continue to be one of the most important health problems facing Tanzania today. As of 2011, an estimated 1.6 million people in Tanzania are living with HIV, and among them, about 1.3million under the age of 15 and older (UNAIDS, 2012).The impact of HIV/AIDS has been devastating. It has affected all spheres of life. The demographic consequences of the epidemic are reflected in the country's quality-of-life

indicators, including the infant mortality rate and life expectancy. HIV infection has resulted in a surge of opportunistic infections, such as tuberculosis and some forms of cancer. HIV/AIDS morbidity and mortality of women and men in their prime years of productivity has had a serious social and economic impact on all sectors, and at community and individual levels. The epidemic has necessitated the diversion of resources from other areas to HIV prevention, care, and treatment.

The economy has been adversely affected by the loss of the most productive segment of society.

Loss of human capital also affects the development of institutional capacity, which requires skilled workers and leaders. Professionals in medical care, education, agriculture, and engineering are not easily replaced. The reduction of income due to HIV/AIDS morbidity and mortality leads to poverty, which in turn increases the suffering of individuals and communities. At the community level, poverty imposes enormous strains on the extended family structure, leading to a substantial burden of orphans and vulnerable children (OVCs). A social consequence is the growing number of households headed by children and widows. Morbidity and mortality among parents has severely affected children, especially those supposed to be in school, who are forced instead to stay home and take care of sick parents

Since the first HIV/AIDS cases in Zanzibar were diagnosed in 1986 at Mnazimmoja hospital, emphasis has been placed on the development of strategies and approaches to scale up interventions, and care and treatment service. The government, civil society

organizations have adopted strategies to contain the HIV/AIDS epidemic, primarily by promoting sexual abstinence, mutual faithfulness among married or cohabiting partners, and condom use, especially in higher-risk sex. Zanzibar's strategy also includes voluntary testing and counseling (VCT), prevention of mother-to-child transmission of HIV, antiretroviral treatment, and care and support services for people living with HIV and AIDS, advocating for attention to People Having AIDS (PHAs) and reduction of stigma and discrimination

Despite the above mentioned measures, the HIV/AIDs prevalence in Central District has increased significantly, where as in (2011) the prevalence rate was 1% among 6,166 people tested for HIV compare to the prevalence rate of 1.4% among 10,110 people tested for HIV in (2013). Therefore, this study seeks to assess factors affecting uptake of Voluntary Counseling and testing services as one of the HIV intervention measure. For the purpose of this study, **up take** means the action of taking up or making use of voluntary counseling and testing services. Due to the fact that youths are more vulnerable to HIV infection and other sexually transmitted infections, there is a need therefore, to explore the youths feeling on the HIV problem and utilizing the VCTs. Their responsive attitude behavior towards VCT services would promote a better utility of the offered services and give grounds of safer life, hence the need of this study

1.4 General Objective of the Study

The overall objective of the Study is to assess the factors affecting uptake of voluntary counseling and testing among youth in Central District.

1.4.1 Specific Research Objective

This study was guided by the following specific objectives.

a) To examine individual factors affecting uptake of voluntary counseling and testing among youth.
b) To assess community factors as perceived by youth that affect uptake of voluntary counseling and testing among youth.
c) To find out health services barriers as perceived by youth that affect uptake of voluntary counseling and testing among youth.

1.5 Specific Research Questions

a) What are individual factors influence VCT uptakes among youth?

b) What is the community's attitude towards youth VCT uptake in Central district?

c) What are the health service related barriers to VCT uptake by the youth in Central District?

1.6 Significance of the Study

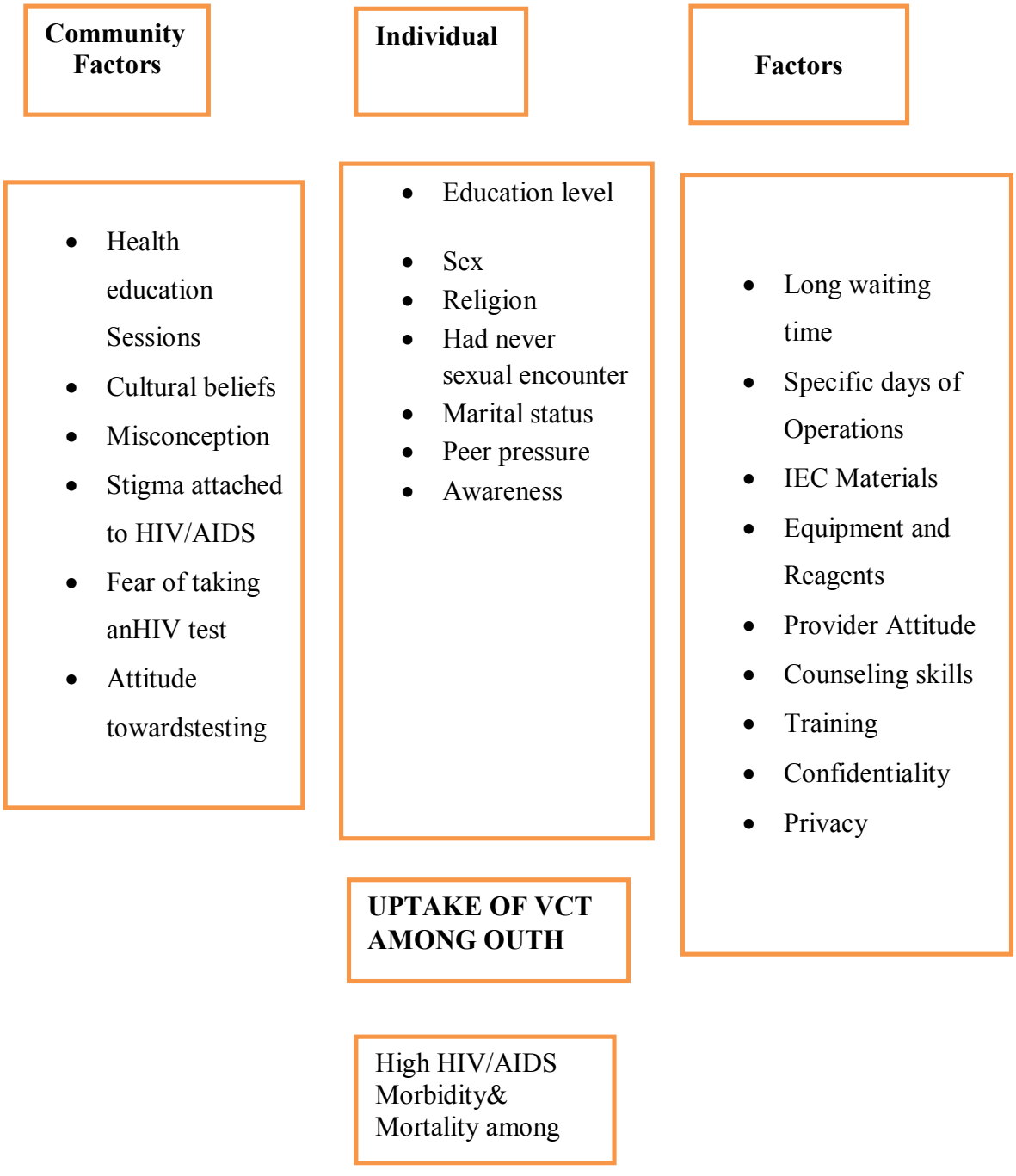
Due to the fact that efforts to influence them to regularly attend VCTs services have not been productive, the findings from this study will give an opportunity to learn more on what are the barriers from youths using the services. The government and NGOs working in this sector will gain insights from the findings that may help in identifying the necessary changes in making VCTs attractive, more appropriate and acceptable to

youth. The changes to be made should be geared to explore various ways that would promote the increase use of VCTs among young people.

Service delivery organizations in Zanzibar will be availed with the findings of the study to design VCT programs that are youth-friendly and provide high-quality voluntary which aim at raising their awareness on the susceptibility of being HIV infected severity of AIDS, efficacy of counseling centers, self- efficacy, and protective motivation as means towards protective sexual behavior. As an end result young people who are vulnerable to HIVAIDS, their life quality will be improved or prolonged. The findings also will be used by academicians and other researchers as additional sources of knowledge on the study of HIV/AIDs prevention approaches.

1.7 Conceptual Framework

Figure 1.1 : Conceptual Framework of Uptake of VCT Services among Youth



(Source: Field Data, 2015)

The conceptual framework in Figure 1.1 highlights the Individual factors, Community factors and Health service factors that affect uptake of VCT services among the youth. The community factors such as stigmatization, cultural beliefs and misconceptions may negatively influence youth uptake of VCT services. This may be influenced by service delivery factors like counselors attitudes, waiting time, equipment, costs and specific days of operation and the individual characteristics like education level, sex, awareness and peer influence that could affect Uptake of VCT among youth. This low VCT uptake will result in increased HIV/AIDS morbidity and mortality among the youth.

1.7.1 Dependant Variable

Voluntary Counseling and testing uptake

1.7.2 Independent Variable

a) Individual factors like age, religion, sex, education level, occupation, level of awareness, peer pressure.
b) Community factors as perceived by the youth like cultural beliefs, Stigma and fear of taking an HIV test.
c) Health service barriers as perceived by the youth like Health education sessions, Provider attitude and Poor counseling skills and confidentiality observed, availability of IEC materials , privacy at the health facility, specific working days.

CHAPTER TWO

2.0 LITERATURE REVIEW

2.1 Introduction

This chapter presents the review of literature regarding the matter discussed; presenting some concepts and theories relevant to the research topic, views of other scholars in the field may also be discussed.

2.2 Global Trends of HIV/AIDS

The HIV/AIDS epidemic continues to be a major health challenge of the 21st century. The global HIV/AIDS prevalence was estimated to be 33.3 million people in 2009; Sub-Saharan Africa still bears an excessive share of the global HIV burden(UNAIDS & WHO 2010). Although the rate of new HIV infections has decreased, the total number of people living with HIV continues to rise. In 2009, that number people living with HIV/AIDS in Sub-Saharan Africa reached 22.5 million [20.9 million–24.2 million], 68% of the global total and Sub-Saharan Africa has more women than men living with HIV(UNAIDS & WHO 2010). The epidemic continues to have a huge impact on households, communities, businesses, public services and national economies in the region.

Since 1999, the year in which it is thought that the epidemic peaked, globally, the number of new infections has fallen by 19%. Of the estimated 15 million people living with HIV in low and middle-income countries who need treatment today, 5.2 million have access resulting into fewer AIDS related deaths. For the estimated 33.3 million people living with HIV after nearly 30 years into a very complex epidemic, the gains

are real but still fragile. Future progress will depend heavily on the joint efforts of everyone involved in the HIV response.(UNAIDS & WHO 2010)

In December 2007, UNAIDS and the World Health Organization (WHO) released updated estimates of prevalent and incident HIV infections worldwide. In 2007, an estimated 33.2 million people were living with HIV, approximately 2.5 million people became infected, and 2.1 million people died (UNAIDS & WHO 2007). These estimates represent notable downward revisions of estimated global HIV prevalence and incidence. Based on the best available evidence, it now appears that the global epidemic stabilized in the late 1990s and that the annual number of new infections may have since modestly declined.

However, the UNAIDS 2010 global report indicates that in seven countries, five of them in Eastern Europe and Central Asia, HIV incidence increased by more than 25% between 2001 and 2009. The dimensions and pace of the epidemic remain staggering. The news is especially terrible in southern Africa, where little progress has been made in curbing the rate of new infections; HIV infections continue to increase in a number of countries, including China, Indonesia, Mozambique, Russia, Ukraine, Vietnam, and several high-income countries(PWG 2008)

The first cases of HIV/AIDS in Tanzania were reported in1983, although for sub-Saharan Africa as a whole the problem began to surface in the late 1970s. The epidemic has evolved from being rare and new disease to a common household problem, which has affected most Tanzania families. (National HIV/AIDS Policy 2001:23) The

development of the HIV/AIDS epidemic have its clear impact on all sectors of development through not only pressure on AIDS cases care and management of resources, but also through debilitation and depletion of economically active population especially young women and men.

Zanzibar is not severely affected as the Sub Saharan Africa neighbours. The first HIV/AIDS cases in Zanzibar were diagnosed in 1986 at Mnazimmoja hospital, since then there has been a marked increase in reported cases cumulatively from 3 in 1986 to 2500 by the end of 2002. (Zanzibar multisectoral HIV/AIDS Policy 2005: 29). Surveillance data provide evidence that unlike mainland Tanzania, which has a relatively high HIV prevalence of 5.3% in the general population, an estimated 1% of the general population of Unguja and Pemba islands is infected with HIV (THMIS, 2012:46). Furthermore, periodic HIV surveillance activities among pregnant women in Zanzibar also indicate low prevalence of 0.6% in 2008 (Zanzibar ANC surveillance Report, 2010:6).

While HIV prevalence in the general population remains low, it is known that certain populations, referred to as key populations at risk (KPs), are at increased risk for HIV infection, including people who inject drugs (PWID), men who have sex with men (MSM), and sex workers (SWs). Data from integrated behavioural and biological surveys (IBBS) conducted among KPAR in 2007 support this knowledge, having found HIV prevalence rates of 16.0%, 12.3% and 10.8% among PWID, MSM and female sex workers (FSW), respectively(RDS report, 2007).

2.3 Sexuality among Young People

The emerging sexuality during teenage years together with lack of necessary information has made the young people to be vulnerable to many diseases such as AIDS. According to Runeborg (2002), sexuality is a super force without which sexual drive, explained as important for intimacy and pleasure would mean no life existence. However, human beings are not sex machines but they have many other aspirations in life. On contrary, adolescents and young people tend to place sexuality, love and sexual feelings very central in their lives.

It is a fact that also young people have sex, thus there is a need for displaying correct factual information related to them as a protection from health hazardous. Silber Schmidt (1994), states that, sex and sexuality have a powerful influence during teenage life as well as in adults. The only way forwards is to speak out to provide factual information on sexuality, prevention of sexually transmitted infections (STIs) and sexual behavioral change. Furthermore, young people irrespective of gender need self-supportive environments in which they can talk friendly and be informed about their healthy behavior and sexuality. Also young people should be able to talk freely to adults about their problems, not only to their friends and through the media, which sometimes are not reliable channels of information.

Youth's misinformation from mostly unreliable sources of sexual matters in African societies;

Peers and media programs remain the big problem.(Bohmer and Kirumari1997)This phenomenon is contributed by, elders quietness on over their sole responsibility of

informing young people about the important changes in their physiological, biological psychological beings that would render them vulnerable for incurable HIV/AIDS. Young people would continue to lack this important component of their progress towards adulthood because of the most African cultural practice whereby youth's exposure to sexual matters is considered immoral before marriage, as a result sex is perceived as a top secret in most of the societies. The fact that HIV has its major root of transmission through sex, apart from contact with the HIV infected body fluids etc; the traditional African sexual dormant perception has more risk and damages. This makes hard for young people to disclose their sexual life since that behavior may be socially unacceptable e.g. Ugandan mother who argued that, *"as a parent, especially for the boy, I would start imagining he has started moving around with women and I would get much worried*.(Horizon, 2004)

Due to such beliefs, young people have fear to share their sexual experience with their parents or elders who could be of help in their sexual behaviors change. This would mean, it is even worse if the young people would attempt sharing with their parents about their ideas of going for the HIV tests e.g. male community members from Kenya argued that:-

"*Within the age group under discussion, (11-24 years), there is fear, according to African culture, that a child in that group cannot tell his father that he wants to go for an HIV test. You know this will mean that he is indulging in immoral behaviors and this is not acceptable".* (Horizon, 2004)

Such argument may not be entirely relevant to this generation, these cultural practices and beliefs need to change. In order to facilitate and improve the sexual life of our young people; parents; guardians and adults need to be fully involved. The idea that talking with youths will stimulate them into early sexual debut is not much valid to date because young people have sex in one way or another. Therefore, right to information, counseling and testing are necessary without which they will go ahead for their alternatives and often under influence of unreliable sexual

2.4 HIV/AIDS Counseling and Testing

Voluntary counseling and testing facilitates early referral for care and support of HIV-infected individuals and is an effective method of preventing infection. Provision of voluntary confidential counseling and testing is an entry point to other HIV services and an opportunity for individuals to learn their HIV status, and knowledge about accurate risk perceptions thereby encouraging safer behaviors therefore testing and counseling must be scaled up for universal access (UNDP, 2007).

Counseling, both before and after the test distinguishes VCT from other HIV testing services. HIV testing must be voluntary, the decision to test or not to test being based on an understanding of accurate, objective and relevant information; post-test counseling & services are crucial; confidentiality must be protected; non-discrimination in service delivery is critical. The provision of voluntary confidential counseling and testing is first and foremost based on the intent that everyone who wishes to has a right to know the test result, knowledge of HIV zero status has been advocated as a prerequisite for access to support and care (Zoysa et al, 1995) and increasingly as a

prevention measure in its own right (Summers et al., 2000; Cock et al., 2002, 2003). It can motivate an individual to practice safer sexual behavior thereafter avoiding transmitting the virus to others (UDHS, 2006).

The Voluntary HIV Counseling and Testing Centre (VCT) is among of HIV intervention measure with the purpose of giving education about living with HIV and avoiding infecting others, and to uninfected ones on how to maintain their zero negative status. It assist in early detection of the of HIV infection. It also assists individuals in accessing intervention and support services including management of infectious diseases. Moreover, it assists infected individuals in assessing their personal risks and adopting risk reduction behaviors. It does not work at individual level only, but also provides strength to prevention efforts particularly at the community level.(Campbell, Jr. et al. 1997)

In many countries, young people actively seek VCT. However patterns of health service use differ, for instance young people in industrialized nations often do not attend formal health services for reproductive health and STI/HIV health services (Mirza et al., 1998) for their preventive health needs where as in some developing countries like in Zambia Kara clinic there are increasing number of youth seeking VCT, especially in the context of premarital testing (Chama & Kayawe 2000; UNAIDS, 2002). Marital status has also been found to affect uptake of HIV/AIDS health care services. In a study carried out in Bushenyi District, South western Uganda by Nuwaha et al., 2002, it was found that sexual partner influence were among the factors that affected acceptability of VCT for HIV the same was found in other studies

however the decision to undertake VCT was mainly a personal decision though it was also influenced by other people such as spouses, sexual partners and prospective marriage partners.

A study done in Zimbabwe on lifetime uptake of VCT showed that knowledge of HIV, increasing education and age were associated with VCT uptake with an increase from under 6% to 11% at follow-up. Women who took a test were more likely to be HIV positive and to have greater HIV knowledge and fewer total lifetime partners; sexual behavior was not independently associated with VCT uptake. Motivation for VCT uptake was driven by knowledge and education rather than sexual risk (Sherr et al**.,** 2007)**.** Voluntary counseling and testing services can result in positive behavior change including a decrease in unprotected sexual intercourse (Youth net, 2007). It is part of health seeking behavior which refers to those entire things humans do to prevent diseases and to detect diseases in asymptomatic stages or even when they become symptomatic to seek care.

Other evidence given out by Coovadia, for a positive impact of VCT services includes facilitating decision-making, accepting and coping with HIV, improving family and community acceptance, increasing condom use, and reducing gonorrhea rates and HIV transmission.(Coovadia, 2000). As a response to the above facts, Tanzania formed HIV/AIDS testing policy, which aims at promoting early diagnosis of HIV infection through voluntary testing with pre-and post-test counseling. The main objective is to reassure and encourage the 85-90% of the population who are HIV negative to take definitive steps not to be infected and for those who are infected, to cope with their

status, prolong their lives and not to infect others. (Tanzania Prime Minister's Office, 2001)It is important therefore, for young people to use this service because they are among the risk group in this HIV/AIDS era, and they have all rights to information about their own HIV status and the right to use VCT services.

Several studies have been carried out to establish the relationship between uptake of VCT with age; a randomized trial conducted in Zambia on acceptability of voluntary counseling and testing revealed that acceptability varied greatly with age with about 47% of the respondents in the young age group of 20-24years accepting to take VCT services compared to only 18% of those in age group of 40-49 years (Fylkensnes et al., 2004).

Voluntary counseling and testing services should be accessible, unrestricted by geography, economic, social and cultural or language barriers. Geographic access may be measured by modes of transport, distance, travel time and any other physical barriers that could keep the client from receiving the services. Social or cultural access relates to service acceptability within the context of the clients' cultural values, beliefs and attitudes (Lori et al., 1999). Studies conducted revealed that Stigma, fear of receiving an HIV-positive status, lack of confidentiality, long distances to VCT sites, and long delays in returning HIV test results limit people's access to VCT services (Matovu etal.,2007)

The Tanzanian government through her Ministry of Health established the National AIDS Control Programmed (NACP) in 1985 to coordinate all HIV activities in the

country. NACP has been establishing counseling services in the hospitals. It has trained hospital-based counselors to provide counseling to HIV/AIDS patients in hospitals.(World Bank, 1992)**.**Apart from those centers that have been established by NACP, other centers are being run by NGOs and other organizations like African Medical and Research Foundation (AMREF). By the year 2004, the numbers of VCT sites in Tanzania were 521. AMREF, with support from USAID and other donors has established VCT services at 45 sites in 21 Tanzania regions.(World Bank, 1992) (WorldHealth Organization (WHO) However, most of the VCT centers are located in urban areas leaving the rural areas from not knowing what is going on with ultimate unbearable impact on sexually active youth.

2.5 Reasons for Undertaking VCT

In order to know factors behind youths accepting or not accepting the VCTs services, it is important to know what other countries have come out with in their findings on this issue. In an exploratory study conducted in Nairobi, Kenya, and Uganda with in addition to the anonymous, random, digital-dial survey done in Massachusetts in USA, main reasons for adolescents seeking VCT services or having HIV test were; for blood donation, pregnancy case, hospital procedures, health insurance, life insurance, job requirement, and military recruitment. Other reasons identified were for immigration requirement, fear of having had sex without condom, use of injecting drugs, influence by physicians, knowing the HIV status in general, distrust of partners, exposure to HIV risk, and due to service providers' referrals. Moreover some, reasons were due to marriage plans, having HIV symptoms, and using VCT centers to get accurate information about HIV.(Samet et al. 1997)

As well as in the qualitative study done in Malawi and population-based HIV survey in Zambia, reasons for getting tested were not much different from what had been found from the above mentioned countries. Various reasons were associated as the reasons of getting HIV test in Malawi that the test could be due to long sickness with HIV symptoms that they have been sick over a long of period of time and they are losing weight. To some individuals is after the death of spouse whose cause of death is associated with HIV/AIDS. To some, whenever they feel that they are vulnerable to infection, for example someone with several partners or with unfaithful partners they will opt getting tested. Others are doing the test due to certain events in their life, for example, getting married, plans of having a child, requirement in a new job, scholarship application.(Younde PS and Priscila M, 2004)

In Zambia the main factor associated with readiness of testing among young people (15-24 years) was due to self – perceived risk of being HIV infected. (Fylkesnes K and Siziya S. 2004).

With all of the above reasons that make youths be among the important group in utilizing the VCT, they encounter various barriers that can mark as among the reasons for youths not using the services. In the same studies (above) they came out with the barriers young people face in terms of seeking VCT services; some youths did not believe if the result were kept confidence, others wanted to avoid social stigma that other HIV positive people suffer, some did not think if the HIV positive result were accurate and reliable, others who wanted to undergo test did not know where to go for

HIV testing and some did not want other people to know that they have undergone the test.

The low rate of youths attending VCTs services found in Tanzania has also been reported in other countries. In the Massachusetts survey, the HIV testing among sexually active adolescents was found not to be common. Adolescents who were interviewed were knowledgeable that they can contract AIDS and believed that the likelihood of them being HIV positive was there; still they did not want to access VCT services and at a time of interview only 10% had pursued voluntary HIV testing. (Samet et al, 1997) Therefore, this survey supports the observation that young people do not seek HIV testing regardless of them knowing that they are at risk.

Findings on why youths access or not access VCTs services including HIV testing are more or less the same to different countries with different social, cultural and economic backgrounds. Some of the findings above could be true to the country the study is going to be conducted (Zanzibar). However, it is very hard to give out a conclusion without any research findings.

Some of the reasons I find to be not applicable to the study area. For example, on the issue of accessibility and cost of the services, these are among of the things which are within youth reach in the area. There are VCTs in the district which provides free services to the age group of this study (15-24 years).

2.6 Benefits of Voluntary Counseling and Testing

High quality voluntary counseling and testing not only enables and encourages people with HIV to access appropriate care but has been demonstrated to be effective in HIV prevention. Research over the last decade has demonstrated the public health benefit of VCT in terms of reductions in risk behavior that are both significant and cost effective (Marks & Crepaz, 2001; Sweat et al., 2000; Forsythe et al., 2002). Studies of VCT impact among youth in the United States do provide evidence that some youth adopt safe behaviors after testing. Although the U.S. studies often focus on high-risk individuals such as drug-users, runaways, and those in high-prevalence areas, they do look at the behavior of young people.

In Lusaka, Zambia it was also reported that most people found VCT a useful experience, particularly in making decisions on sexual behavior; sero-positive people valued the role of VCT in helping them cope with their status and its link to support services while sero negative people valued the assistance that VCT provided in remaining sero-negative. The importance of VCT for both prevention and care is increasingly recognized which includes prevention of HIV transmission from positive tested people to un-tested, mother to child; prevention of HIV acquisition by negative tested people from positive or untested partners leading to early and appropriate uptake of service for both positive tested and negative-tested people**.**

Voluntary counseling and testing is the platform for facilitating early management of HIV-related infections and STIs, identifying the need for prophylaxis and effective use of HIV antiretroviral therapy ,medical care family planning, emotional care, counseling

for positive living, social support, improved coping and planning for the future. Societal benefits like challenging stigma, promoting awareness, supporting human rights enabling psychosocial support through referral to social and peer support groups increases the visibility of HIV in the communities. This fosters the enhancement of stigmatization of those with HIV/AIDS (WHO, 2004).

The study conducted in three countries, Kenya, Tanzania, and Trinidad, provided a strong evidence to support the fact that VCT is effective and cost –effective as a strategy in facilitating behavior change. VCT also is an important entry point for care and support. (The Voluntary HIV-1Counseling and Testing Efficacy Study Group (2000) Efficacy of Voluntary HIV-1counseling and testing in individuals and couples in Kenya, Tanzania, and Trinidad: a randomized trial.

2.7 Youth Friendly VCT Services

Youth friendly services means that the counselor will not scold them for being sexually active or be judgmental (Juma et al., 2004c; Likwelile, 2004). A study conducted among adolescents in Mpigi District of Uganda revealed that many of the males and females were interested in HIV testing but concerned about confidentiality, the testing process, the accuracy of test results, and the cost of VCT services (Bohmer & Kirumira, 1997). This was similar to a study carried out in Zambia which found that privacy and service quality were also important to youth and they stressed the need for privacy in testing and the availability of complete and accurate information (UNAIDS 2002).

Among surveyed youth (14 to 21), in Kenya and Uganda, 41 percent of untested youth and 38 percent of tested youth reported that they would prefer to test at a youth friendly facility rather than at adult facility, where they might encounter adults they know (Horizons, 2001). Youth also want staff who are kind and who understand youth issues. Untested Kenyan and Ugandan youth wanted to be sure that they saw qualified staff that used reliable testing equipment. Youth want counselors who can give them accurate information in a friendly way. In Ugandan clinics, tested youth participating in exit interviews rated the skills and friendliness of the providers as what they liked most about the VCT service. They mentioned long waits as what they liked least, and reported that the wait as each person received their results privately was a particularly stressful time (Juma et al., 2002; Kirumira et al., 2003).

2.8 Barriers to Seeking Voluntary Counseling and Testing

Apart from positive achievements the VCT services have made, often they encounter various constraints because of anticipated and or actual stigma experienced by those who want to go testing and or living with HIV respectively. According to Nyblade et al in his study, te came out with the fact that, those going for blood tests prefer anonymity to avoid social avoidance and fear of being finger- pointed. In addition to this, clients fear some of the immoral professional practices such as counselors and health workers who do not keep secretes and gossip with other people on health states of their clients. Moreover, some people fears from being seen on the waiting benches at the VCT centers or clinics which would be translated as having sexually misbehaving in the eyes of the passersby,(Nyblade, 2003).

Waiting time and cost- sharing, even though it is small amount of penny to adults, prohibits some youths from seeking HIV test, worries of the positive results to be informed to their sexual partners and or parents were among of the barriers in use of VCTs services. (Samet, 1997).

In Uganda and Nairobi, youths didn't feel at risk, the fear that they could not handle the result if they tested positive. Some youths argued that the positive results might easily lead to negative social and psychological consequences. Lack of information and misinformation was a barrier for youths accessing VCT services. Youths would like access to HIV testing and counseling services if the services are confidential, honest and inexpensive.

In Malawi young people felt that they were not at risk then they did not see an importance of testing. Other did not want to be seen going to VCT centers, for people will know that their HIV positive and they were worried about the meaning to their future. To some were ready to attend service whereby VCT service is free, the provision of result is rapid, if they are assured of privacy and anonymity and if they give enough time to have conversation with counselors, (Younde and Priscila, 2004).

Also in Zambia confidentiality was among the reasons behind negative response to VCT services. Individuals preferred to attend services whereby they are not known by VCT service providers and privacy was assured. Worries of meeting anybody whom you know at the clinic were among the barrier to young people accessing VCT services, (Younde andPriscila2004).In a qualitative study conducted in rural areas of Uganda, some participants in FGDs commented on having counselors who were not

residents of the area, for they were considered more credible and would offer a greater confidentiality than residents. They even gave their suggestion that counseling should take place at neutral sites where confidentiality can be assured, for example, having private rooms. Few individuals thought that community centers like schools, churcheshomes, trading centers can be used to maintain anonymity. (Kipp ,Kabarambe, and Konde- Lule J, 2002)

Among other things found as barriers to access VCT services was poor perception of the health services marked as an obstacle to youth going for the health care. Easy access that was explained in two ways being among of the barriers, not only in distance but also easy to be visited by counselor that will make hard to maintain the anonymity. Even time spent when waiting for the result was among of the barrier for youths gong for VCT services, (Fylkesnes and Siziya , 2004)

In Mali disbelief in AIDS marked as barrier to the potential use of VCT Services. In a qualitative study conducted in Mali various reasons were given out as reasons for those who did not belief in the existence of HIV/AIDS. In one of the Focus group discussion, young men argued that,

"*I have heard about AIDS but I don't believe in it because I have never seen anyone ill with my own eyes. It is for this reason that I don't believe in it"*

[Bamako, man, 17 years old, trader, no education].

A similar comment was given by young woman who argued that:-

"*In my opinion, AIDS is not a reality because they have not been able to find a treatment. For me, AIDS is a complication of another illness. If it gets to a very advanced stage, people say that it is AIDS".*

Bamako, woman,20 years old, student, higher education, (Castle, 2003).

According to Boswell (2002), barriers to VCT for young people include availability and acceptability of services, including waiting time, costs and pressure by health staff to notify partners, worries about confidentiality and fears that results would be shared with parent(s) or partner(s). Inaccurate risk perception, fear of being labeled and stigmatized by their families, friends and communities perceptions of the consequences of living with HIV ,inadequate responses from health care providers, including counselors, to effectively meet the HIV prevention, care and support needs of youth.

AIDS related stigma is another factor that probably influences seeking VCT as indicated by a study done in South Africa. Stigmatizing beliefs about AIDS and their associated fears of discrimination can influence decisions to seek HIV testing and HIV treatment services (Kalichman&Simbay, 2003).In a report by International information support centre on implementing HIV testing for individuals revealed that costs affected whether or not people sought HIV counseling and testing. Deborah & Rachel, (2002) found that barriers to VCT for the young people included costs attached to the services which were similar to a study conducted by Nuwaha et al., (2002) in Bushenyi district which found cost and physical accessibility of VCT services was among the factors that influenced acceptability of HIV testing.

A study carried out by Matoro, (2002) found that health-seeking behavior of youth with regard to VCT was low mainly because of different kinds of fear, this is similar to a survey done among urban youth in Kampala Uganda, which revealed that only 9% were involved in VCT activities although 81% of youth 16-28 had ever heard of VCT (Muganzi, 2002). This was due to being scared of results, fear of psychological effects and stigma which is in agreement with a study carried out in South Africa that indicated only one in five people who know about VCT have been tested for HIV however the reasons that South Africans gave for not seeking HIV testing were negative perceptions of testing services (Kalichman, 2003).This study explored why there is still low VCT uptake in the district despite the availability of youth friendly services.

Research conducted by Horizons and partners, (2001) revealed that social relationships, including family interactions may influence young people's decisions regarding HIV testing (Denison et al., 2006) but doesn't consider how factors at the individual, relational, and environmental levels interact and influence adolescent test-taking behaviors. This study attempted to explore this area.

A study in Zimbabwe revealed that young people are less likely to ask questions about these issues without prompting, appear more embarrassed and shy to talk about sexual matters and they have concerns about privacy and confidentiality in counseling situation (Kim, 1997). There seems to be mixed feelings in communities regarding the value of VCT (Kayawe, 1998). There is lack of qualitative information about young people's attitude to VCT for HIV in East Africa (Amuyunzu-Myamongo, 2005).Thus

whether or not a youth seeks treatment with the appropriate providers and at the appropriate time depends on various factors, including the client's socio-economic status, perceived severity of illness and symptom recognition, distance and physical access, and perceived quality and cost of health service provision (Tipping 1995).

2.9 Theoretical Discussions

"Social work is a practice-based profession and an academic discipline that promotes social change and development, social cohesion, and the empowerment and liberation of people. Principles of social justice, human rights, collective responsibility and respect for diversities are central to social work. Underpinned by theories of social work, social sciences, humanities and indigenous knowledge, social work engages people and structures to address life challenges and enhance wellbeing.(IASSW July 2014). Therefore, through this study youths who are more vulnerable to HIV infection and other sexually transmitted infections, are encouraged to use voluntary counseling and testing services as part of the measure in the prevention of HIV/AIDS. Theoretical framework used in this study is borrowed from the AIDS Risk Reduction Model and the social cognitive or social learning theory (SCT)

2.10 AIDS Risk Reduction Model

The AIDS Risk Reduction Model (ARRM), introduced in 1990. This provides a framework for explaining and predicting the behavior change efforts of individuals specifically in relationship to the sexual transmission of HIV/ AIDS. A three-stage model, the ARRM incorporates several variables from other behavior change theories,

including the Health Belief Model, "efficacy" theory, emotional influences, and interpersonal processes,(Catania, Kegeles & T.J. (1990).)

This model is based on three stages and influenced by hypothesized factors, the first stage is known as Recognition and labeling of one's behavior as high risk; this stage is influenced by knowledge of sexual activities associated with HIV transmission; believing that one is personally susceptible to contracting HIV; believing that having AIDS is undesirable; social norms and networking.

The second stage also known as making a commitment to reduce high-risk sexual contacts and to increase low-risk activities and is influenced by the perceived cost and benefits; enjoyment; response efficacy, self-efficacy; knowledge of the health utility and enjoy ability of a sexual practice, as well as social factors (group norms and social support), are believed to influence an individual's cost and benefit and self-efficacy beliefs.

The third stage, action stage is broken down into three phases: 1) Information seeking; 2) obtaining remedies; 3) enacting solutions. Depending on the individual, phases may occur concurrently or phases may be skipped. This stage is influenced by social networks and problem-solving choices (self-help, informal and formal help); prior experiences with problems and solutions; level of self-esteem; resource requirements of acquiring help; ability to communicate verbally with sexual partner; sexual partner's beliefs and behaviors.

2.11 Social Cognitive (Learning) Theory

The premise of the social cognitive or social learning theory (SCT) states that new behaviors are learned either by modeling the behavior of others or by directs experience.

Social learning theory focuses on the important roles played by vicarious, symbolic, and self-regulatory processes in psychological functioning and looks at human behavior as a continuousinteraction between cognitive, behavioural and environmental determinants (Bandura, 1977). Central tenets of the social cognitive theory are:-

- self-efficacy – the belief in the ability to implement the necessary behaviour ("I know I can insist on condom use with my partner")
- Outcome expectancies - beliefs about outcomes such as the belief that using condoms correctly will prevent HIV infection.

Programmes built on SCT integrate information and attitudinal change to enhance motivation and reinforcement of risk reduction skills and self-efficacy. Specifically, activities focus on the experience people have in talking to their partners about sex and condom use, the positive and negative beliefs about adopting condom use, and the types of environmental barriers to risk reduction. A met analysis of HIV risk-reduction interventions that used SCT in controlled experimental trials found that 12 published interventions with mostly uninfected individuals all obtained positive changes in risk behaviour, with a medium effect size meeting or exceeding effects of other theory-based behavioural change interventions (Greenberg, 1996).

2.12 Empirical Finding

Unfortunately, there is no any study so far in particular aimed at assessing factors affecting the uptake of VCT services among youth in Zanzibar, though studies have been conducted in relation with this study in other countries. On Individual factors that affect uptake of VCT, this study found out that youth in the age group (20-24) were more likely to go for an HIV test than those 15-19 years.. This means that age is an important factor enabling the youth to test. Older youth are more likely to have more knowledge. The finding closely relate to the results in Zimbabwe where age was associated with uptake for VCT (Ikechebelu, 2006).

The findings were similar to another longitudinal study carried out in a rural area in Uganda (Matovu ,2005) with a high HIV prevalence which found that those with higher than primary education accepted to test while UNAIDS ,2001, report revealed that young people in secondary schools showed high willingness to test for HIV. This can be explained by the fact that increasing in level of education increases the knowledge and awareness of the advantages of knowing your zero-status.

On the other hand Knowledge of youth on the routes of transmission and prevention of HIV was high this issimilar to a study done by Matoro, 2002.A cross sectional population study carried out in Hong Kong by Lam et al, 2003 found that youth had good knowledge about correct modes of HIV transmission and prevention. These findings were similar to this study probably because of increasing awareness programmes and campaigns on HIV/AIDS that are conducted in the country. Knowledge of the youth about an HIV VCT was high, awareness of the place for VCT

and the benefits of VCT were found to be associated with uptake of the services. Sixty three percent of the undergraduate students in Nigeria were aware and had heard of VCT with 59.1% having heard of it at least one year prior to the study (Ikechebelu, 2006).

Majority of youth were willing to have an HIV test done and willingness to go for HIV test was statistically associated to uptake for VCT. This is consistent with findings in a study on knowledge , attitudes and practices on VCT where majority of the respondents were willing to go for VCT and among those who were not willing to go for VCT the commonest reason given was that they were certain they were not infected (Ikechebelu, 2006).

Peers played a role in encouraging the youth to go for testing and majority who have tested were encouraged by their peers and this was significant. Local leaders as well encourage youth to go for testing but this was not statistically significant. When youth were asked whether their parents would be willing to have them tested, majority said that their parents were willing however not many said that their parents would facilitate them to have the test for example giving them money for transport**.**

There was no significant association between costs and uptake for VCT. Most of the youth said the services were free and those who had tested didn't pay. This is because the majority of facilities offering VCT are Government units. This is consistent with a report from youth friendly services Uganda, 2005 which noted that majority of the

youth had reported that services were free and only a few said that the services were affordable.

This differs from a study by Deborah and Rachel, 2002, carried out among youth which found that costs was a barrier to VCT. According to Damesyn et al study carried in Kenya, Zambia, Zimbabwe and United States, cost factors significantly affected uptake and acceptability of VCT services by young people. In order to reach most young people, VCT must be free.

2.13 The Knowledge Gap

The reviewed literatures in this study have focused on the assessment of the factors affecting uptake of Voluntary Counseling and Testing (VCT) services among youth for African countries. In Zanzibar Islands, such assessment of Voluntary Counseling and Testing uptake has so far not given priority. This create gap which this research in going to fill specifically in Zanzibar environment.

CHAPTER THREE

3.0 RESEARCH METHODS AND PROCEDURES

3.1 Introduction

This chapter gives a vivid description of the methodology used in this study. It highlights the concerned investigation to obtain answers to the research. This chapter is comprised of the research design, research approach, study area, study population, and sampling procedures. This chapter also deals with data collection techniques, analysis and gives account of validity of instruments.

3.2 Research Design

A research design is a detailed plan of activities to be done in order to achieve the research objectives. It is a conceptual structure within which the research process is to be undertaken (Adam and Kamuzora 2008).Kothari (2004) shares the above view but elaborates further by arguing that, a research design is a plan that constitutes a blue print for the collection, measurement and analysis of data. This study adopted a descriptive research design. Descriptive research studies are those concerned with describing the characteristics of a particular individual, or of a group, events or situations. It is primarily concerned with describing the nature or conditions and degree in detail of the present situation. This design was chosen because it defined clearly what is supposed to be measured and found adequate methods for measuring it along with a clear cut definition of population to be studied. Since the aim is to obtain complete and accurate information in the said study, the research design provided

protection against bias and maximized reliability, with due concern for the economical completion of the research study.

This study used both qualitative and quantitative approaches. Qualitative research is a type of formative research that offers specialized techniques for obtaining in-depth responses about what people think and how they feel (Padgett). It enables a researcher to gain insight into attitudes, beliefs, motives, and behaviors of the target population. The reason for using the qualitative research in this study is that it provides greater depth of response and greater understanding. According to (selltiz et al. 1965), the purpose of quantitative research is to discover answers to questions through the application of scientific procedures. These procedures have been developed in order to increase the likelihood that the information gathered will be relevant to the question asked and will be reliable and unbiased.

3.3 Study Area

The study was conducted three Shehias in the Central District namely Uroa, Marumbi and Chwaka whereby three Secondary schools available in those she hias were involved. These are Uroa Secondary School, Marumbi Secondary School and Chwaka Secondary School. This study was conducted in Central district; it is located on a (640)-acre of piece of land Sub County in South Region, South of Zanzibar Capital. South Region has two districts (Central and South).The selection of the Central District as a study area based on the fact that it is among the places where accessibility of VCT services is undoubtedly good. Central District is a pluralistic society consisting of people from different countries around the globe. The Social economic activities done

in the district are fishing activities, tourism, spice farming, and trade. These social economic activities can also influence the HIVAIDS epidemic due to the interaction of people taking place in the area.

3.4 Study Population

Central district has a population of 76,346(Census 2012). The target population for this study was divided into two groups. Firstly, youths who are in school involving both female and male secondary school within the age of 15-24 years from three secondary schools in Central district namely Uroa, Marumbi and Chwaka. The second target populations were officers from government such as she has and counselors and. Youths aged 15-24 years old were chosen because they are within the age range anticipated to be highly sexually active and at high risk of contracting HIV/AIDS. The total population in three Shehias under the study is 9092.

The study involved 100 respondents and its summary is presented in the table below:-

Table 3.1 : Respondents' Distribution

S/NO.	Respondents Category	Number	Method
1	Students	87	questionnaire
2	Students	08	FDGs
3	Counselors	02	Interviews
4	Local community leaders/Shehas	03	Interviews
	Total		**100**

Source: (Field Data 2015)

3.5 Sampling Procedure

According to Manheim (1977), 'a sample is a part of the population which is studied in order to make inference about the whole population'. The reason for sampling is that in many cases the population is so large and scattered that complete coverage may not be possible. It also offers a high degree of accuracy because it deals with a small number of persons. This study applied both purposive and random sampling to get answers from respondents.

3.5.1 Purposive Sampling

In this sampling the researcher purposely chooses a person who, in his judgment about some appropriate characteristics required of the sample members, is relevant to the research topic and easily available to him. Churchil et al, (2002), states that purposive sampling enables the researcher to use judgment to select cases that best answered the research questions and objectives. In this study purposive sampling was used to identify only those people who can answer the technical questions which cannot be answered by anybody else. These people were such as she has and counselors.

3.5.2 Random Sampling

Simple random sampling was used in this study. It is a subset of a statistical population in which each member of the subset has an equal probability of being chosen. A simple random sample is meant to be an unbiased representation of a group. This focused mainly on students who can respond to the general questions they were asked. The lottery method was used to complete this task. One teacher was selected from each three selected schools; teacher assisted the researcher in gathering students'i.e

respondents. Firstly the sampling frame i.e students' list was constructed followed by writing number listed in sampling frame on small piece of paper and placing them in box after that all papers were mixed and given to the students until the required number of students from each school is reached.

3.6 Sample Size

Sample size is the number of observations in a sample (Evans *et al.* 2000). It is commonly denoted n or N. According to Cohen et al (2000), the knowledge gained from the sample is representative of the population under study. The size of the population was consulted using calculation based on the formula below. The total population from selected She has to be contacted is 9092 and sample of 100 was selected. This figure included both students and Government officials.

$$n = N/(1+Ne^2)$$

Where, n=Sample Size

N=Total Population

E=Marginal Error =0.1

$$n = N/(1+Ne^2)$$

$$n = \frac{9092}{1+(9092)(0.1)^2}$$

$$n = \frac{9092}{1+90.92}$$

$$n = \frac{9092}{91.92}$$

$$n = 98.9$$

3.7 Data Collection Techniques

Data Collection is an important aspect of any type of research study. Inaccurate data collection can impact the results of a study and ultimately lead to invalid results.Data collection is the process of gathering and measuring information on variables of interest, in an established systematic fashion that enables one to answer stated research questions, test hypotheses, and evaluate outcomes. It is argued that for a research to deliver the desired and reliable results, more than one data collection methods to be used. The significance of using combination of data collection techniques is emphasized since no single technique is necessary superior to any other. (Kalton et al, 1971).In this study data were collected from both primary and secondary sources. Secondary information was gathered from the available literature. This involved reviewing numerous documents like textbooks, journals, newspapers, national and international policy documents, reports and bulletins containing relevant information to this study. Primary data was collected through questionnaires, focus group discussion and Interviews.

3.7.2 Questionnaire

Questionnaire is a list or a set of questions addressed to a group of people who must respond and return to the sender in a given period of time(Goldbell, 2003). Researchers have noted significant advantages of using questionnaires techniques. They are of relatively of low cost and that respondents have adequate time to give well thought out answers (Kothari, 2004). Among other advantages of Questionnaire is that it provide coverage of a large area of study, it is free from external influence and provide

reliability and validity of the information. The researcher used questionnaire method to collect both quantitative and qualitative data from the respondents who time can read and write. Both open ended and close ended questions were designed so as to give freedom to the respondents to write what they feel about the various components in the study. This tool is advantageous as it enabled respondents to give information freely without fear. Questionnaires were prepared in English language and translated into Kiswahili and distributed to students to collect information.

3.7.3 Focus Group Discussions

A focus group discussion (FGDs) is another data collection technique adopted in the field. Powell (1996) et al. defines a focus group as a group of individuals selected and assembled by researchers to discuss and comment on, from personal experience, the topic that is the subject of the research. It involves interviewing a number of people at the same time, the emphasis being on questions and responses between the researcher and participants. Focus groups however rely on interaction within them based on topics that are supplied by the researcher (Morgan 1997).

A focus group discussion was geared towards obtaining in-depth information on concepts, perceptions and ideas of a group of interest. One Focus group discussion was conducted with students. The FGD was carried out in Uroasecondary School which were of mixed gender and included participants who attended the VCT services and those who had not used the services. Participants in focus group discussion were 8 students.

3.7.4 Interviews

An interview is a data-collection technique that involves oral questioning of respondents, either individually or as a group. The answer to the questions posed during an interview can be recorded by writing them down (either during interview itself or immediately after the interview) or by tape –recording the responses, or by a combination of both. Varkevisser et al., (2003)Young (1983) defined an interview as a systematic method whereby one person enters more or less into the inner life of another who is comparative stranger to him. He argues that, an interview is a research instrument used to collect primary data in field by interrogating a discrete or a group of individuals on a particular subject matter. As far as this study is concerned structured and unstructured interviews were used.

3.7.4.1 Structured Interview

This is a type of interview in which the form is already structured. That is to say the interviewer has only to carry out the instructions. This type of interview has the following characteristics:

i) The interviewer has to act according to the instructions written in the interviewing guide (schedule). He has no liberty or freedom.

ii) In these types of interviews, the direction or the focus of the interview is specified and so the uniformity of the study findings are more fulfilled.

iii) These types of interviews as highlighted above are standardized. Because of their structured and formal nature, the objectivity is more reliable and dependable.

iv) Since structured interviews are recorded, there is no problem for the field worker regarding language and phraseology. The field worker has only to use language that has been prescribed to him (Rwegoshora, 2014)

In this study structured interview were administered to counselors to enable the researcher clarify issues with the respondents and ensure that the respondents give clear information so as to carry out an in-depth investigation. The respondents were given chance to express their opinions, knowledge and experiences.

3.7.4.2 Unstructured Interviews

It is an interview without any set format but in which the interviewer may have some key questions formulated in advance. Unstructured interviews allow questions based on the interview's responses and proceeds like a friendly, non-threatening conversation. (lindlof et al, 2002).In this study, unstructured interview was conducted whereby through dialogue and conversation the informants were encouraged to express their knowledge and views on the subject of VCT services in Central District.

3.8 Data Analysis

Initial data analysis and processing was conducted daily at site, where collected data were organized and summarized, edited, coded and classified to facilitate easy further analysis. Data analysis captured both qualitative and quantitative aspects. The findings were then presented in tables and diagrams. Also the data from relevant secondary sources were analyzed in order to verify their consistency and reliability with the primary data. Analysis of quantitative data was by the use of content analysis method

whereby, generalization of key issues emerged from the discussions were summarized and analyzed to draw conclusion. Quantitative data were analyzed using the Microsoft Excel.

3.9 Ethical Consideration

Conducting research that is ethical requires a commitment that lasts not only throughout the life of the research project but also afterwards, at the dissemination stage and even beyond Permission to conduct the study was obtained from the Open University of Tanzania, Faculty of Arts and Social Sciences. Permission was obtained from Central District administrative officials who were consulted for requesting their permission to conduct the study in their areas, this was easily accessed. Introductory letters were provided to selected areas for this study. Confidentiality was maintained throughout the study.

CHAPTER FOUR

4.0 DATA PRESENTATION, ANAYLSIS AND DISCUSSION

4.1 Introduction

In this chapter, results are presented and discussed based on specific objectives of the study. Results include characteristic of respondents, individual factors affecting Voluntary Counseling and Testing,

4.2 Characteristics of the Respondents

The total number of respondents involved in the study was 100 youth. The respondents were in the age range of 15-24 years. Majority of the respondents were aged 20-24, 67/100 (67%). About 95% were Muslims and the remaining 5% percent were Christians. The analysis revealed that among 100 respondents 59% were male and female respondents were 41%. Respondents between the age group 15 – 17 were 16%, Respondents Aged 18 – 20 were 31% and 53% Respondents were aged 20 – 25 years.

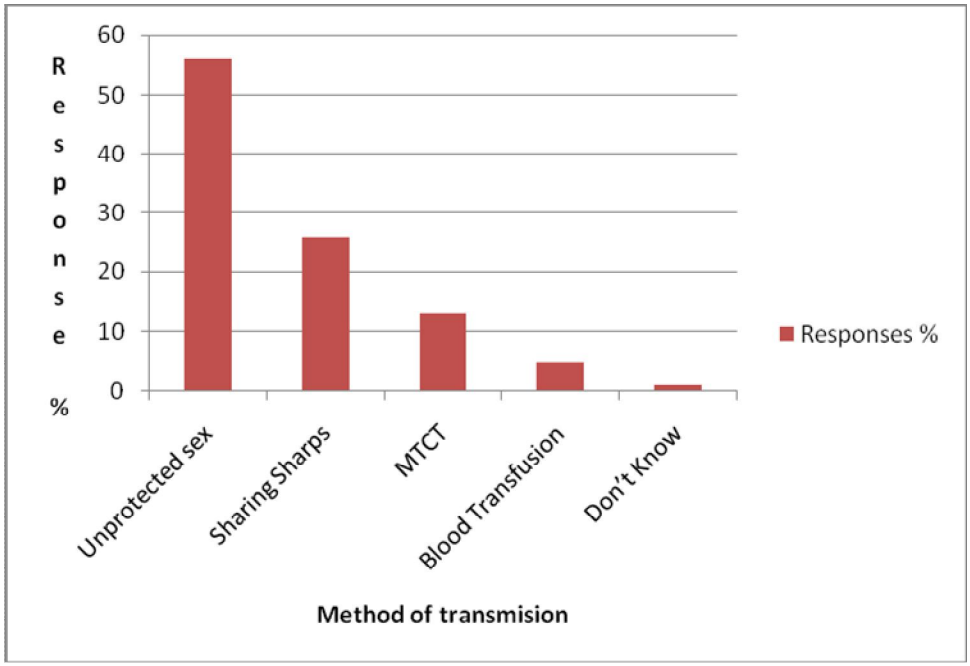
4.2 Individual Factors Affecting VCT Uptake

These individual factors affecting uptake of Voluntary Counseling and Testing were described in detail in the field by focusing on knowledge of youth about mode of HIV/AIDs transmission, Knowledge of methods of detecting of HIV/AIDs, Sources of information used by youth to get news on Voluntary counseling and testing services, Advantages of Voluntary Counseling and Testing and individual factors associated with uptake of VCT among youth.

4.3 Knowledge of Youth about Mode of HIV/AIDS Transmission

On this theme, the purpose is to assess the understanding of the respondents on the ways in which HIV/AIDs transmit from one person to another. Knowledge of transmitting is a key issue towards taking precaution against the disease.

Figure 4.1 : Knowledge of Youth about Modes of HIV Transmission



Source (Field Data, 2015)

Knowledge of youth about mode of transmission was generally high with 56 of the 100 respondents (56%) indicated having unprotected sex with an infected person as the main mode of acquiring HIV/AIDS, 26 of 100 respondents (26%) indicated sharing shape objects while 13 of 100 (13 %) indicated mother passing it to the unborn baby, 5 of 100 (4%) mentioned blood transfusion while only 1 of 100 (1%) could not mention any mode of transmission. This therefore implies that respondents are knowledgeable about HIV/AIDS transmission by indicating having unprotected sex with an infected

person as the main mode of acquiring HIV/AIDs. Knowledge is important if the individuals/groups or communities are to change their behaviors, the current prevention approaches have not fully addressed the knowledge needs of communities

4.4 Knowledge of Methods of Detection of HIV

It is impossible to detect someone with HIV through naked eyes, Therefore several methods were put forward to measure students ability to identify those methods as seen in the table 1 below:-

Table 4.1 : Knowledge of methods of detection of HIV

No	Diagnostic Method	Frequency	Percent %
1	Taking an HIV test	60	60
2	Signs and symptoms	24	24
3	Doctors exam	11	11
4	Don't know	5	**5**

(Source: Field Data, 2015)

More than half of youth, 60 /100 (60%) mentioned taking an HIV test as diagnostic method while 24/100 counts (24%) mentioned signs and symptoms as a method of detection of HIV , 11/100 (11%) mentioned doctors examination and 5/100 (5%) were not knowledgeable of any method. Though young people were very aware HIV and AIDS they used the two terms interchangeably. This was also confirmed by counselors

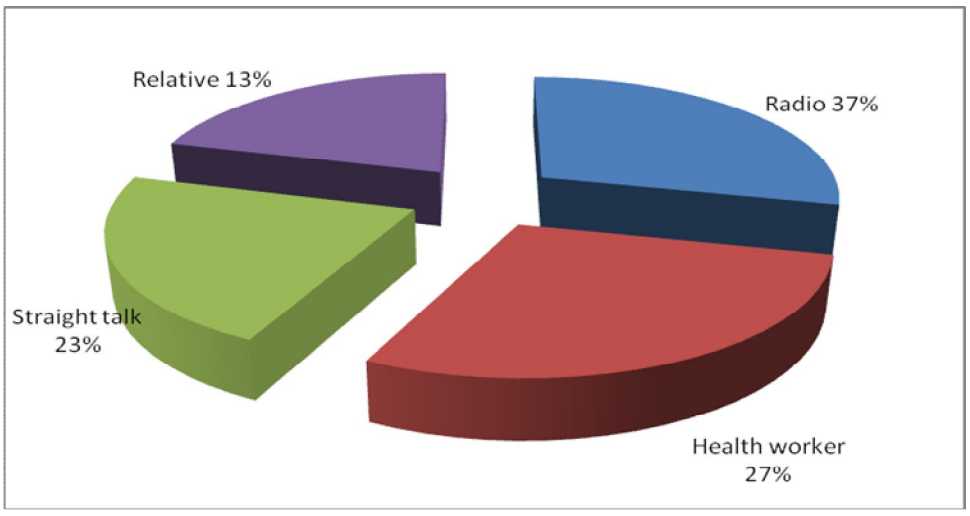
who reported using much of their time providing students with more knowledge on the differences between the two. One of the young informants, who had visited VCT services, narrated what she knew as the differences between the two terms as follow:-

"About HIV, I know is a situation whereby a person starts to be sick and AIDS is situationwhereby a person may have the disease but he/she has not started to get sick." (FGDs female student, 2015)

4.6 Sources of Information on VCT

In this section sources of the VCT services information are mentioned and discussed. These are such as radio, health workers, relative and Straight talk.

Figure 4.2 : Sources of Information About VCT



(Source: Field Data 2015)

Findings on figure 4.3 shows that the main sources of information about VCT were radio 37/100 (37%), followed by health workers 27/100 (27%). Straight talk magazines

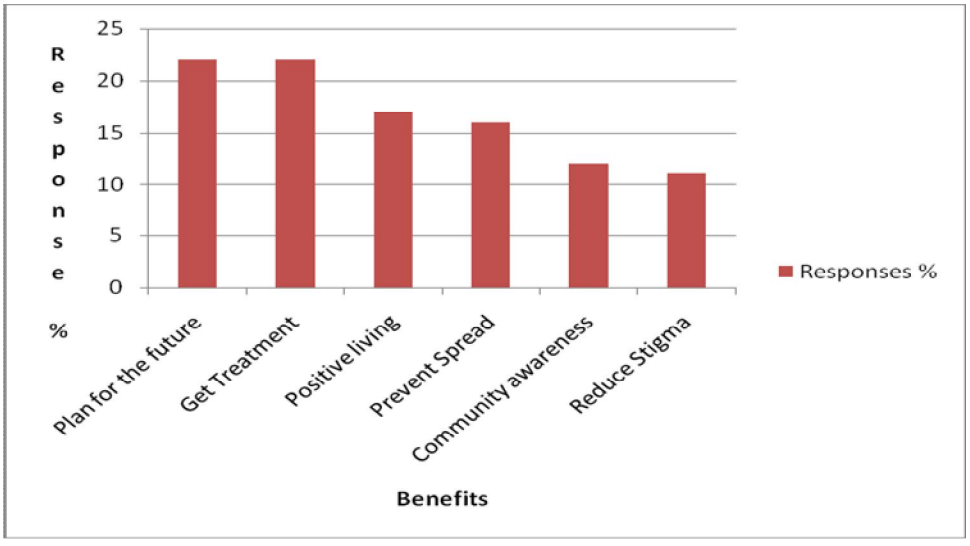
23/100 (23%) were another source that youth get the information while some respondents said that they learnt of VCT from their relatives 13/100(13%).In addition, all FGDs conducted participants mentioned that the radio was the main source of information i.e. informed them of the places to go for VCT.

'We youths enjoy listening to music over the radio and any adverts that are between music intervals can be clearly heard so that's how we get to know where VCT services are offered' (FGDs, Male student, 2015).

4.7 Knowledge about Advantages of VCT

Respondents were asked on the advantages behind seeking out VCT services. Their responses can be put into the following categories: - plan for the future, get treatment, positive living, prevent the spread of Aids, community awareness and reducing stigma.

Figure 4.3 : Knowledge about Advantages of VCT



(Source: Field data, 2015)

The data from figure 4.4 indicates that some youth mentioned that when one gets to know their status they are able to plan for the future 22/100 (22%) while others mentioned get treatment 22 /100 (22%) if found positive, live positively 17 /100 (17%), prevent spread 16 /100(16%),increases community awareness 12/100 (12 %) and reducing stigma 11/100 (11 %) as a benefit of VCT. Furthermore, as consequences to some youth who want to initiate new sexual relationship, find themselves in a trend of seeking HIV testing. In such situation girls are seen as initiators in seeking VCT services as a prerequisite for starting the new sexual relationships. This is vividly shown in the FGDs:-

"We go to *(VCT center) because we want to establish a new sexual relationship, you may find that a boy seduces a girl and if that girl is aware of the risk involved with acquiring HIV/AIDS then she will tell him that we must go for the HIV testing before we indulge into sexual affair (we should check our HIV status first then I will be ready to have sex with you)". (FGD NO. 1 female Students, 2015)*

Moreover, counselors talked about youth who attend VCT services specifically when they have a certain future event plan such as getting married, having a child, and requirement to the job application. Other reasons were due to scholarship requirements, and when initiating a new sexual relationship. Counselors said that, out of these reasons, initiation of new sexual relationship was the more prominent reason related to young people than the rest.

"There are those who come because they want to get married we test them, to few individuals are coming for the test because the test results are needed in places where they look for employment opportunities, or to others when they go for studies abroad or among the requirement to scholarship they are entitled with."(Interview, Female Counselor, 2015)

4.8 Personal Factors Associated with the Uptake of VCT

In this section three variable named age, sex and education are discussed to check their association with the uptake of Voluntary Counseling and Testing services

Table 4.2 : Individual factors associated with uptake of VCT

No	Variable on VCT	Tested (Yes)	Tested (No)
1.	**Age**		
	15-19	12	31
	20-24	35	22
2.	**Sex**		
	Male	25	35
	Female	17	23
3	**Education level**		
	Primary	11	45
	Secondary	32	12

Source: (Field Data 2015)

a) AGE

Findings on table 4.3 show that age range is a very big determinant for the youth to participate in the services. Only 12% of youth aged15-19 participated in voluntary counseling and testing services more compare to the other age group of 20-24 who form the 35% of the population. Another disappointing experience mentioned by young people was about the accepted age an individualized consent for HIV test. Some informants reported having being denied the services when they were 15 years old, some when 14 years. The acceptable age for HIV test according to Tanzania policy is from 16 onwards. Any one below this age being interested to attend the services must by law, be accompanied by a parent or guardian to the services that would consent on behalf. It was noted by counselors and young people that such policy results to some interested youth's being pushed away from access. This young informanthad encountered such experience, and besides all her interest, she ended up denied the service.

"She (the counselor) told the researcher that first to tell her what was my age. It was last year; I told her I was fourteen. She told me I was too young to test for HIV; it will not be possible; because I was below the accepted age they considered me that I was a child." (FGDs. Female Student,2015)

When counselors were asked about their consideration on young people who are below the legible age for the VCT services, they agreed that sometimes the application of this policy denies youth who are below 16 years freedom to access the services. They also talked about them being aware of young people who are less than 16 years that they are

sexually active hence HIV test is important to them. One counselor described what is happening to young people under 16:-

"It is true we are aware that there are some young people who are below sixteen years are sexually active or may be already they are in risk of HIV infection. What I want to say about this is that, this is due to the government policy. They argue that psychological maturity is from the age of sixteen and above and to someone who is below that age it means has not reached the maturity age and he/she is not grown up enough to receive such results". (Interview with male Counselor, 2015)

b) GENDER

Results from table 4.3 shows that among the youth interviewed had taken an HIV test, majority being male 25 % while female form 17%. This indicates that male students are more aware in relation to their health and have big confidence in expressing themselves. Another counselor narrated his experience on this issue as follow:-

"In my experience, young male are freely to express themselves in details depending on the problem that has brought him here. They express themselves well and more freely without fear compared to girls. Many females are apprehensive and fearful as if they are not confident. When they come here they must be having a very touchy issue to bring her here as compared with boys. Boys can even come in groups. A large group of boys but girls come one by one". (Interview with Counselor, 2015)

c) Education

Data from the figure 4.3 indicates that youth with secondary level of education were more likely to have been tested for HIV/AIDs compared to those in primary level of education. The data shows that 32% of the secondary students have been tested while 11% of primary School students tested. This shows the presence of gap in of HIV/AIDS education given at different levels. HIV/AIDS is not taught from primary schools and it starts from secondary up to colleges and universities. Therefore these students in primary level don't see the importance of attending VCT services. Some respondents' went further in proposing possible age to which HIV information should be given by saying:-

"I think the services should start from the beginning when just as one starts learning "A" when it starts entering his ears, so the information should penetrate the brain. These information could develop a person that he knows such a thing (HIV/AIDS) exist, it reside into the brain and not someone hearing it say, when in form one, form four, name anywhere." (FGDs, Male Student, 2015)

4.9 Parents/Guardians Attitude on VCT

This section is aiming to show perceived guardian's attitude towards Voluntary Counseling and Testing to their youth. The table 4.4 below summarizes their responses by considering six aspects such as Parents/Guardian Willingness Test

Table 4.3 : Response from youth regarding their guardian's attitude towards Voluntary Counseling and Testing

No	Responses	Number of Respondents	Percentage (%)
1.	**Parents/Guardians Willingness Test**		
	Yes	40	40
	No	52	52
	I don't know	8	8
2	**Parents/ Guardians provide financial support**		
	Yes	30	30
	No	37	37
	I don't know	33	33

(Source: Field Data 2015)

In the above table 4.4 Parents/Guardians were seen to be barriers as only 40% of them were willing to have them tested and 52% would not convince their sons and daughters to test. On the other hand parents would not provide financial support for their children to go for test as only 30% would be facilitated by their parents. In some occasions youth were motivated to attend services but whenever they shared such information with their parents or family members they were blocked from use. Youth are generally encouraged by peers to go and test. What has been observed in the findings about this that fear and lack of information to parents and relatives were perceived as triggers of negative attitude towards VCT services.

"They have their own way of understanding on this matter and so long they are in the same environment then they have a certain common belief to HIV/AIDS that it is for prostitutes. This can cause many young people not using the services" (Interview with male Counselor, 2015)

Respondents commented that it is not the same for every family member because there are some parents and Guardians who are very positive with the services. Family member who had access to HIV/AIDS education were said to be more positive. Counselors talked about programs that are in initial stages and few parents attend seminar and share the knowledge gained to other people from their areas. The notion of young age was not only to young people but also to parents. Parents were said to have that notion by considering their children that they are still young even if their age allow to decide independently without parental or guardian consent. From the findings parents and relatives associated VCT services with prostitution and it was found that due to such understanding prohibit them and other people around them accessing the service. An example of parent response given to her child when she told her intention of undergoing VCT services.

...a child like me when I tell my mother that I have heard about HIV/AIDS and I would like to test, mother will start saying my child since when you are able to say you known about HIV/IDS, and what have you done you are still a child. (FGDs, male student 2015)

4.10 Community Factors Associated with Uptake of VCT

In this section three questions were set to identify community factors that are associated with the uptake of voluntary counseling and testing services. These are Youth willingness to test, Encouragement of peer group and encouragement of local leaders as seen in the table below:-

Table 4.4 : Community factors on VCT

No	Response	Frequency	Percentage (%)
1.	**Willing to test**		
	Yes	79	79
	No	21	21
2.	**Have your peers encouraged you to test**		
	Yes	47	47
	No	53	53
3	**Encouraged by local leaders**		
	Yes	57	57
	No	43	43

(Source: Field data, 2015)

a) Youth willingness to test

Table 4.5 showed that most youth (79%) mentioned that they were willing to test for HIV/AIDs, while 21% of the students showed resistance. This shows some courageous

acts of the students to understand their health status at that early period. Young people decision on accepting the Voluntary Counseling and testing services is important component if the target is geared to have successful results.

b) Peer influencing factors

The table shows that youth who had encouragement from their youth registered 70% likelihood of getting tested for HIV/Aids. This means that in times when they meet for socialization, young people share various experiences including VCT information. Young people who have been to VCT services are sharing their experience with others; young people are attracted and decide to undergo VCT services. Furthermore, those who test negative were said to be proud of their results which influences other youth into thinking that may be if they go for HIV testing, result will also be negative. Counselor's experiences towards youth influencing each other:-

"Some youth simply like to share there experiences, when they are in a group a fellow who had HIV testing might say it that I have been to HIV testing and others will be interested.(Interview female Counselor 2015)

"Some youths are proud towards each other in the streets that they have tested and had negative results, others might be attracted to go, they will go as a reference got from their fellow by thinking that if she/he has done the HIV testing why not us". (FDGs. male student, 2015)

c) Local leaders influence

The data from table 4.5 revealed that local leaders i.e She has play a vital role in encouraging youth to participate in HIV/Aids testing. 57 % respondents said agreed that she has use their time to encourage them to go for testing while 43% were against the idea. From this data it is clear that the government have done its best to provide HIV/AIDs education to local leaders in the villages. One respondent suggested that there should be joint efforts between the government and local leaders in providing HIV/AIDS education to young people. The following opinion was raised by respondent as follow:-

"For me I see that there is a need for a marked cooperation between the Government and local leaders in educating youths and boosting counseling and testing services among young people. It will be better if the Government and She has will be working in cooperation when giving education to us (young people) might result into young people being positive to the services. By accepting VCT services and attending in such facilities we (youths) can have more knowledge on HIV/AIDS, (FGDs, male student, 2015)

4.11 Health Services Barriers on VCT

In the table 4.5 below respondents were asked to do the estimations in percentage on health related barriers to VCT services. Various reasons were brought forward about them not using the services these are fear, never had sexual encounter, need time to make decision and testing site being far.

Table 4. 5 : Reasons for not being tested

No	Variable	VCT uptake	Percentage (%)
1.	Never had sexual encounter	22	22
2.	Fear	36	36
3.	Have one faithful partner	12	12
4.	Need more time to make a decision	11	11
5.	Testing site is far	8	8
6.	Don't know where testing site is	5	5
7.	Don't have time	6	53

(Source: Field Data 2015)

a) Sexual Reasons

From the table 4.5 above, the reasons youth mentioned for not getting tested were that they had never had sexual encounter 22 /100 (22%), Previously Sexuality among young people has been identified as major route of HIV transmission. However, in this context it can also act as an obstacle to some attending the VCT services. For those who had sexual intercourse with many partners they were said to have fear to undergo VCT services. Self-assessment to the prevailing health of an individual leads to some not attending the services by saying already they know their status that, they are HIV negative therefore, they believe that attending the HIV test is wastage of time.

b) Fear

Most of respondents (36%) mentioned fear as the reason behind low attendance of VCT services. During the FGDs and interviews youth and counselor reported about fear being among of the reasons to some youth's not attending the VCT services. The quotes below from some of the respondents are typical of what many individuals have stated.

i) They talked of fear which is based on the HIV positive, fear related to anxious to HIV positive results.

"Majority fear, a person feels that after knowing my status that I am HIV positive I will be in doubt then he/she may decide that whatever will be let it be, he/she will not attend VCT services due to such fear". (FGDs, male student, 2015)

"My Blood Pressure will rise or the pressure might go down if I know that I am HIV positive, I don't want to die because of this." (FGDs, female Student, 2015)

ii) Other respondents identified fear which is associated with being denied parent support if results are HIV positive. Youth are worried to be rejected by their family members, and the society at large.

"A person gets worries of attending HIV testing that, if I test HIV positive, what I am going to tell my parents? He/she will be thinking of being denied or chased away from home. Therefore, that is another reason limiting youths from attending VCT services. (FDGs, male student2015)

iii) Informants said that other fear is based on HIV positive results that they might be known to other people. Therefore, people who have such fear are troubled with how confidential results can be, that may be they can be accessed by other people. This respondent had this to say:-

"Youths do not believe if results to their testing will be accessible only by them and their counselors, they think information's will spread out, and this is so due to lack of trust to counselors, as a result they don't use the services". (FGDs, Female student 2015)

iv) Another form of fear mentioned was concerning the whole process of drawing blood for testing. Counselor experience to this:

"To others their worries based on the process of taking blood sample for screening, their worries are associated with those syringes when they are pieced into their bodies, really you can see them worried". (Interview with Counselor, 2015)

v) Fear to stigmatization was said to be among of the obstacle to young people accessing the VCT services. Argument from the counselor about this was:-

"They are afraid of the HIV positive results that will lead them into rejection and facing stigma from people surrounding them (society)". (Interview with Counselor,2015)

c) Faithfulness

As noted in the table 4.5 above, 12% of the respondents who rated themselves to avoid Voluntary and Counseling and Testing services claimed that they have only one faithful partner therefore there was no need to seek such services. It is however noted that even respondents who had multiple sexual partners rated themselves to have a low/no risk of HIV/AIDS, some of these respondents informed the researcher that although they had multiple partners they used condoms.

d) Location of the VCT Centers

From the table 5.4 only 8% respondents said that location of the VCT centers were barriers to attending the services. Respondents talked about the location of the VCT centers whereby various thoughts were aired. Some were not pleased with the location of the available VCT centers which are mostly found within health facilities. Some argued that this is not a proper place because people will begin to think that you went there attending treatment related to AIDS. They talked about stigma, that people are still not well informed about this problem of HIV/AIDS. Furthermore, centers around health facilities are not suitable because you are likely to meet several people. While some respondent were against with the VCT centers being located in hospital compounds others were for it. One respondent has this to say:-

"To me I think these sites are located in accessible areas for example; those which are within hospital compounds, because I see some of them there, personally I see no obstacles concerning their location". (FGDs, female student, 2015)

4.12 Suggestions Provided by Youth on VCT

In the table 4.7 below several suggestions were set for the youth to express their feeling on the matter of improving the uptake of Voluntary Counseling and Testing services.

Table 4.6 : Suggestions by youths on how to improve VCT uptake

No	Suggestions to improve uptake	Frequency	Percentage (%)
1.	Sensitization	16	16%
2.	No response	28	28%
3.	Bring services close to youth	21	21%
4.	Motivate the youth	30	30%
5.	Don't know	5	5%

(Source: Field Data 2015)

About a 30% of youth suggested that uptake of VCT would be improved by motivating youth through creating drama clubs, youth training others, setting -up youth testing sites, using youth counselors and using parents to convince them. However28/100 (28%) of youth did not give any suggestions. Other suggestions posed were 21/100 (21%) bringing services close to the youth which included taking services to schools and offering outreach services.

The government should pay all the youths who test some money as a form of incentive that would encourage more youth to go for VCT. (FGDs, male Student 2015)

Other suggestions that arose from the FGD participants that could improve uptake of VCT were sensitization through health education talks, putting bylaws and radio advertisements. All groups of the youth mentioned that they prefer listening to radio stations so adverts between music breaks on HIV would draw their attention and encourage them to go for VCT. However some groups said creating clubs, health education extended to schools and offering free of- charge and friendly services could improve uptake. If possible conducting workshops involving the young leaders, Outreach services, adolescent centers and counseling teams should be created in order to capture more youths with video shows and role plays.

CHAPTER FIVE

5.0 CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

This chapter describes the conclusion of the study as well as recommendations on the way forward. In order to be more precise summary of key issues of findings are summarized.

5.2 Conclusion

This study aimed at examining the factors affecting the uptake of Voluntary counseling and testing services among youth in Central District, Zanzibar. Study was conducted in Schools environments involving students who are 15-24 years old. Regardless to the VCT services being free of charge to young people from the age of 24 years and below, decisions to youth's attending the services or not is influenced by various factors around them. The findings show that most of the young people who attend VCT services are those who want to plan for their future life and avoid engaging in risk activities while others mentioned get treatment. Also few attend with reasons of knowing their health status and live positively. Also influence from friends who have been to VCT services identified as among the forces behind some young people in this study being attracted attending the VCT services. The study showed that a quarter of youth in the Central district have had voluntary counseling and testing services, being aware of place where services are offered enhances uptake of voluntary counseling and testing among youth.

Moreover, from the findings knowledge on HIV/AIDS including the VCT services was among of the factors that contribute to young people attending or not attending the services. Young people who had access to HIV/AIDS knowledge through HIV interventions efforts geared to youth's in schools environments tend to seek VCT services. The main sources of information about VCT were radio and followed by health workers and most youth knew where VCT services could be obtained where. Knowledge of youth on the routes of transmission and prevention of HIV was high this is similar to a study done by Matoro, 2002. However according to the AIDS epidemic update 2005, knowledge about HIV transmission route in sub Saharan countries was found to be low and generally women were less-well informed about HIV than men. A cross sectional population study carried out in Hong Kong by Lam et al, 2003 found that youth had good knowledge about correct modes of HIV transmission and prevention. These findings were similar to this study probably because of increasing awareness programs and campaigns on HIV/AIDS that are conducted in the country. From such results we can conclude that multi approaches are needed if we intend to make the VCT services being attractive and used by many young people.

Parents/Guardian's attitudes towards VCT uptake were not good. Majority of youth were willing to have an HIV test done and willingness to go for HIV test was statistically associated to uptake for VCT. Parents were said to have notion that their children are still young even if their age allow to decide independently without parental or guardian consent. From the findings parents and relatives associated VCT services with prostitution and it was found that due to such understanding prohibit them and other people around them accessing the service. On the other handPeers played a role

in encouraging the youth to go for testing and majority who have tested were encouraged by their peers and this was significant. Local leaders as well encouraged youth to go for testing. When youth were asked whether their parents would be willing to have them tested, majority said that their parents were not willing and emphasized that their parents would not facilitate them to have the test for example giving them money for transport**.**

Results show that barriers to access the VCT services by young people are related to individual, social, cultural and economic factors. Specifically, lack of resources to run the VCTs, difficult in accessing the services, restrictive policy on age limit for HIV test, lack of national monitoring system, lack of continuing support to HIV positive youth, also negative attitude to the VCT services by people surrounding youth's contribute to low uptake of the VCT services by young people. Youth's confidence that they are not at risk, an individual fear which is associated with stigma and segregation to people with HIV positive results, irresponsibility to an individual health, were among of the reasons associated with youth not attending the VCT services.

5.3 Recommendations

The following recommendations should be considered by various stakeholders in order to improve uptake of Voluntary Counseling and Testing among youth in Central District, Zanzibar.

a) The Ministry of Health and Social Welfare Zanzibar should expand the source of HIV/AIDS information. This can be achieved through supplying education and communication materials geared towards sensitizing the communities and youths in particular, the importance of testing and the role it plays in preventing

spread. To increase the coverage of HIV/AIDS information giving, there is a need to have special programs which will be operating in schools. In a school system the form of knowledge giving should be both formal and informal settings. Intention should be to cover as many school children as possible and this will serve the purpose of giving knowledge to children before they become sexually active.

b) The Ministry of health should continue to emphasize the use of local media to solicit involvement of youth as well as their parents in providing sex education. In areas with access to newspapers, TV, radio the health information can be channeled through such means of communication. This can be done by having special programs in radio and TV for young people and in the newspapers special articles should be put for information gain. In areas without access to such mass media education should be granted through popular theater, using professional actors to deliver the concrete messages to young people and in a simple language. Posters, brochures should be distributed in a big number in areas where access to TV, Radio and newspaper is limited

c) Provide positive attitudes towards HIV intervention efforts. Responsible people in HIV intervention to young people need to think of consulting policymakers on an established legal age for HIV test. I think it is important if such policies are working in response to young people level of HIV infection. As previously talked about young people being sexually active below the legal age of HIV test therefore, consideration on changes to this policy seems to be necessary. Also

perceived negative attitude to the VCT services by guardians/parents need to be tackled by the use of mass media and other community mobilization efforts. There is a need to have more supportive programs that will reduce stigma around VCT testing and those which will be dealing with promotion of widespread of HIV testing

d) Improve the quality of VCT services VCT services can be improved in various ways, by making the available VCT services more youth friendly services. Therefore, the training of the available counselors on the skills of how they can deal with young people is important if we want them to work with youth effectively. Also retraining programs to counselors are important because counseling is not static, it is dynamic there are some of the things are getting out others are coming in therefore according to this it becomes necessary for counselors to attend in refresher courses so that they are being retrained. It is possible on what they learned in past five years are already out of use but there are other things came in then retraining is important to cover this discrepancy.

5.4 Area for further Study

The current study is limited to the schools environments whereby major informants were students whom data have been gathered. On other hand in the process of conducting the study some areas necessary for more research emerged. Hence resulted to the following suggestions:-

a) Similar studies involving urban and rural setting should be conducted.
b) Studies should be conducted investigating the effectiveness's of the Government VCT policy.

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APPENDICES

QUESTIONNAIRE

Dear Respondent,

I am **Said KassimMoh'd**, a student of Open University of Tanzania. I'm undertaking a course leading to the award of Masters of Arts in Social work, as part of the academic requirements, am supposed to carry out research; I am carrying out a **study on The Factors affecting uptake of Voluntary HIV Counseling and Testing services among youths, a case of Central District in Zanzibar.**You have been specifically selected to participate in a study. Please feel free in answering these questions as all your responses shall be treated confidentially and used solely for the purpose of this research and under no circumstances shall they endanger your status in society.

Section I: General Background Information:

1. Sex *Please tick the appropriate*
   Male ( )
   Female ( )

2. Age of the respondent in years ……

3. What is the highest Level of education attained? Please Tick appropriate
   None ( )
   Primary ( )
   Secondary ( )
   Tertiary ( )

4. Religion
   Moslem ( )
   Christian ( )
   Hindu ( )
   Other (specify) ……

5. Are you ……? Tick appropriate

Single ( )

Married ( )

Separated/divorced ( )

Widow/widower ( )

6. What is your current employment status?

Unemployed ( )

Student ( )

Formal employment ( )

Self-employed ( )

Other (specify)…….

Section II. Knowledge on HIV VCT

5 What is the best known mode of HIV/AIDS transmission? *Tick only one mentioned*

By having sexual intercourse with a person who is infected with HIV. ( )

Mother passing it to the unborn baby. ( )

Sharing sharp objects. ( )

I don't know

Other (specify)……

6 Could you please tell me how you can find out if one has the germs (virus) that causes AIDS .*Tick only one*

Taking an HIV test ( ).

Doctor's Examination ( ).

Don't know ( ).

Other (specify)**……**

7 Have you ever heard of Voluntary Counseling Testing for HIV?

Yes ( )

No ( )……, If 'No' skip and go to 11.

8 Where did you get the information about HIV Counseling and Testing? Choose only one source

Radio ( )

Health worker ( )

Relative ( )

Straight talks ( )

Other (specify)…….

9 What do you know about HIV Voluntary Counseling and Testing?

Testing for HIV when someone forces you to do so but not your own decision ( )

Going for an HIV test after making a decision on your own without being forced by anyone ( )

10 Do you know of any place here in Central District where you can go and have an HIV test?

Yes ( ).

No ( )……If 'No' go to No. 14.

11 How did you know about the place?

Health worker ( ).

Friends ( ).

Radio ( )

Other (specify)…….

12 Do you know the benefits of having an HIV test?

Yes ( )

No ( )……skip 15 go to 16

13 What benefits does a person get in going for VCT? *Tick only one option*

People who test positive can get treatment ( )

Effective at preventing spread from those who are positive to the negative ( )

It also enables positive living through referral to social groups like (ZAPHA+) and peer support groups ( )

Increases community awareness about HIV ( )

Reducing stigma among HIV/AIDS people ( )

Helps plan for future ( )

14 Have you been previously tested?

Yes ( )

No ( )……..If 'No' go to 19

15 How long did you take while at the testing health facility?

1hour ( )

1- 2hours ( )

2hours ( )

16 Did you pay any money for the service offered?

Yes ( )

No ( )

17 What was the reason/s for the response in (16) above?

……

……

Section II: Attitudes on uptake to HIV VCT services

18 Would you be willing to have an HIV test carried out?

Yes ( )

No ( )

19 Do you think your parents / guardians would be willing to have you tested for HIV?

Yes ( )

No ( )

I don't know ( )

20 Would your parents give you money to go for an HIV test?

Yes ( )

No ( )

I don't know ( )

23 Have your peers (friends) ever encouraged you to go for HIV test?

Yes ( )

No ( )

21 Have the local leaders in your village ever encouraged youth to have an HIV test done?

Yes ( )

No ( )

Section II: Barriers on uptake of HIV VCT services

22 Do you think the services offered at the VCT sites encourage youth to get involved?

Yes ( ).

No ( )……If 'No'……..go to 26

23 What makes you think the services are youth friendly? *Tick all mentioned*

Privacy ( )

Counselors keep the result as a secret ( ).

Low cost ( )

free ( )

Counselors are approachable ( )

Others (specify)…….

24 If no, what is it that the VCT site does that doesn't encourage the youth to be tested? *Tick all mentioned*

Costs ( ).

Carried out on specific days of the week ( ).

Counselors attitudes ( ).

No privacy ( ).

Others (specify)……

25 In your view why do you think youth go for VCT services? (Tick all mentioned).

Know their status ( ).

Get married ( )

Asked by their parents ( ).

Start a relationship ( ).

Other (specify).....

26 What suggestions would you give to improve VCT uptake among Youth?

……

……

……

THANK YOU FOR PARTICIPATING!

FOCUS GROUP DISCUSSION GUIDE

Section I. Knowledge on HIV VCT

1. Can you tell us what you know about HIV/AIDS and its transmission?
2. Have you had about HIV Voluntary Counseling and Testing?
3. Where in this area can people go if they want VCT, Can you please mention any sites you know?
4. How did you come to know about this place?

Section II: Attitudes on uptake to HIV VCT services

5. Do you think VCT is important? Would you accept to go for VCT?
6. What do you think is the importance/ benefits of testing for HIV?
7. Do you think your parents/ guardian can accept you to go for an HIV test?
8. Are the VCT services offered at facilities encouraging/motivating youth to test? Yes / No, Give reasons for this.

Section II: Barriers on uptake to HIV VCT services

9. What problems do Youth face that stop them from having to test for HIV?
10. How does the community regard youth who undergo HIV testing?
11. Very few youths go for HIV VCT, what could be the possible reasons for this?
12. What do you think health workers should do to increase the number of youths going for VCT?