

**PERCEPTIONS AND PRACTICES OF YOUTHS TOWARDS VOLUNTARY
COUNSELLING AND TESTING (VCT) UPTAKE SERVICES: THE CASE OF
KINONDONI MUNICIPALITY**

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**A DISSERTATION SUBMITTED IN PARTIAL FULFILLMENT OF THE
REQUIREMENTS FOR THE DEGREE OF MASTER OF SOCIAL WORK OF
OPEN UNIVERSITY OF TANZANIA**

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CERTIFICATON

The undersigned certifies that she has read and hereby recommends for the acceptance by the Open University of Tanzania a dissertation titled: **“Perceptions And Practices of Youths Towards Voluntary Counselling and Testing (VCT) Uptake Services: The Case of Kinondoni Municipality”** in partial fulfillment of the requirements for the degree of Master of Social Work of the Open University of Tanzania.

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DECLARATION

I, **Meinrad Haule Lembuka**, do hereby declare that this dissertation is my own original work and that it has not been submitted and will not be presented for the similar degree in any other University.

.....

Signature

.....

Date

DEDICATION

This work is dedicated to my mother Balbina H. Lembuka for offering her support during my study and in the preparation of this dissertation. She has shown vital and highly source of encouragement throughout my life and my study.

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Despite my personal endeavour, the successful completion of this study is the product of collective efforts from different people, who contributed positively throughout its preparation. Because it's not possible to acknowledge each individual who offered material and moral support, I would like to recognize profoundly the following individuals.

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Notwithstanding the contribution above, I take full responsibility for any views or shortcomings in this dissertation.

ABSTRACT

This study examined the perceptions and practices of Youths towards VCT uptake services that aim to determine the level of practices on youths on VCT uptake and to explore youth's perceptions on VCT uptake services in Kinondoni Municipal. The data were collected through interviews, focus group discussion, questionnaires, secondary data reviews, and observation. The study revealed that, youths aged 15-24 generally get tested because they would like to know their HIV status. One of the contributing factors maybe, exposure to sexual encounters predisposing them to HIV risk. This applies to all young people, regardless of sex, marital status, age or residential status. Most young people do not go for tests because they fears to be diagnosed with HIV+ve and a feeling that, they might be infected with the virus. Young people get motivated to go for VCT in places where their peers are provide services and where health providers have a welcoming attitude and where privacy is ensured. Young people would therefore like to uptake VCT services at facilities where special interventions to attract them are put in place including friendly environment. Also the study has presented and discussed the findings of the study with the rationale of examining the Perceptions and Practices of the youths towards the VCT services. It has been found in the study that majority of the youths have positive perceptions and value services offered by VCT sites, unfortunately they don't go for these services because of the fact that they are afraid and hesitant of the positive results. Again, others are uncertain of the stigmatization by other fellow members. The study has recommended that there are still areas that require further studies for other groups including young Women who are majority of VCT visitants. Also there is an urgent need for the government and decision makers to intervene on the efforts to encourage more youths to attend VCT while addressing stigma and increasing HIV/AIDS awareness among the youth populations.

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LIST OF ABBREVIATIONS

AIDS	Acquire Immune Defiance Diseases
ART	Antiretroviral
DSM	Dar es Salaam
FCS	The Foundation for Civil Societies
GoT	Government of Tanzania
HIV	Human Immune Virus
HCWs	Health Care Workers
HIV	Human Immunodeficiency Virus
HTC	HIV Testing and Counseling
KMC	Kinondoni Municipal Council
KPs	Key Populations
ILO	International Labour Organization
MoHSW	Ministry of Health and Social Welfare
NACP	National Aids Control Program
NBS	National Bureau of Statistics
NHP	National Health Policy
PITC	Professional Initiative Testing and Counseling
PMTCT	Prevention of Mother to Child Transmission
SBCC	Social Behavioral and Change Communication
TACAIDS	Tanzania Commission for AIDS
OUT	Open University of Tanzania
UDEC	University of Dar es Salaam Entrepreneurship Center
UNAIDS	United Nations AIDS

UNICEF	United Children Educational Fund
VETA	Vocational Education and Training Authority
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

CHAPTER ONE

INTRODUCTION

1.1 Background to the Study

1.1.1 Global Overview of HIV/AIDS

Acquired Immunodeficiency Syndrome (AIDS) was a result of destruction of T4 lymphocytes manifested as diseases associated with opportunistic infections (OI) caused by organisms bacterial or viruses normally present but do not cause disease unless the immune system is damaged. The disease was first described in various parts of the world since 1981. To date the disease has spread all over the world. Approximately 38.6 million people were living with HIV and 4.1 million people become newly infected with HIV worldwide in 2005 (UNAIDS, 2006). Two third are in Sub Saharan Africa where 24.5 million people were already infected in 2005. HIV transmission continues to increase among both adults and children. HIV/AIDS epidemic appears to be slowing down globally, however new infections are continuing to increase in certain parts of Asia and sub-Saharan Africa (UNAIDS 2006). It is reported that, approximately 2.8 million people died of AIDS-related illnesses in 2005 (ibid).

1.1.2 An Overview of the HIV/AIDS Epidemic in Africa

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 2015).

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).

1.1.3 An Overview of the HIV/AIDS Epidemic in Tanzania Mainland

Since the first three AIDS cases were reported in Tanzania in 1983, infections have spread rapidly, leading to a generalized epidemic, with pockets of a concentrated epidemic, and a devastating impact on social and economic development. The predominant mode of HIV transmission is heterosexual contact between HIV-infected and uninfected individuals, with sexual transmission accounting for approximately 80% of infections. Vertical infections from mothers to newborns account for about 18% of infections and medical transmission through unsafe blood for approximately 1.8%. By the end of 2012, Tanzania had an estimated 1.5 million people living with HIV and approximately 86,000 new HIV infections (Spectrum, 2013). This can be attributed in part to widespread risky behaviors, inconsistent and incorrect condom use, inadequate numbers of eligible individuals on antiretroviral therapy, increased gender-based vulnerability, and some risky, traditional cultural practices (Spectrum, 2013).

In Tanzania, Kagera was the first region to report on the first HIV/AIDS cases in 1983, in response to that, a number of interventions were introduced including voluntary counseling and testing services with the aim of overcoming the pandemic. By 1986 all the regions in Tanzania had reported AIDS cases (THIS, 2015). The epidemic has evolved from being rare and new disease to a common household

problem, affecting most Tanzanian families. About 7% of adults aged 15-49 years are infected with HIV.

The prevalence among women is higher than that of men 8% and 6%, respectively according to the Tanzania HIV/AIDS indicator survey of 2003/4(TACAIDS, 2005). In cities and towns, HIV prevalence averaged 11%, twice the levels found in rural areas (TACAIDS, 2007). The development of HIV/AIDS epidemic has a major impact on all sectors of development.

1.1.4 HIV Prevalence on the General Population in Tanzania

Although HIV prevalence in Mainland Tanzania has declined from 7.0% to 5.3% during the period from 2003/04 to 2011/12 (2011-12) among all adults aged 15-49, and from 6.3% to 3.9% among men in the same age group, there has not been a statistically significant decrease among women. Regional variation throughout Mainland Tanzania ranges from 1.5% in Manyara to 14.8% in Njombe (Global Fund, 2013).

1.1.5 Early Sexual Debut

Early sexual debut and adolescent sexual networking without protection exposes young people, especially girls, to HIV and STI infection. In Mainland Tanzania, 9.7% of young women and 10.2% of young men aged 15-24 had sexual intercourse before age 15, while 51.6% of young women and 43.9% of young men aged 18-24 had sexual intercourse before 18 (THMIS, 2011-2012). Out of those who were unmarried (15-24), only 57.9% of women and 59% of men used condom during their last sexual intercourse (ibid).

1.1.6 Gaps and Challenges on HIV National Response vs Youth Population

The challenges in the implementation of HTC services include low utilization of the VCT services especially in rural areas due to long distances; inadequate human resources; stigma and discrimination, gender inequalities and gender based violence; limited couple testing; and low disclosure of HIV test results to partners preventing efforts to make informed health decisions such as use of condoms (NMSF, 2013).

Programmatic gaps arising as a result of the above challenges include: 47% of men and 62% of women aged 15-49 were tested and received results leading to a gap of 53% for men and 38% for women that needs HTC services. PITC services had not been rolled out in 50% of health centers and in all dispensaries considering that health centers and dispensaries serve over 80% of the country's population. There is a huge difference between awareness of the epidemic and specific knowledge of how to prevent transmission and acquisition. There are notable differences among different age groups in comprehensive knowledge of HIV prevention. Although there is no clear relationship between older age and better knowledge, youths aged 15-19 appear to have lower knowledge than those in older age groups. Knowledge of HIV prevention methods is lowest among those who have never had sex. Levels of knowledge of preventive methods are higher in urban than in rural areas (NMSF, 2013).

1.1.7 Extend of the Problem in Kinondoni Municipality

Despite the above mentioned measures, the HIV/AIDs prevalence in Dar e salaam specifically Kinondoni Municipal 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.

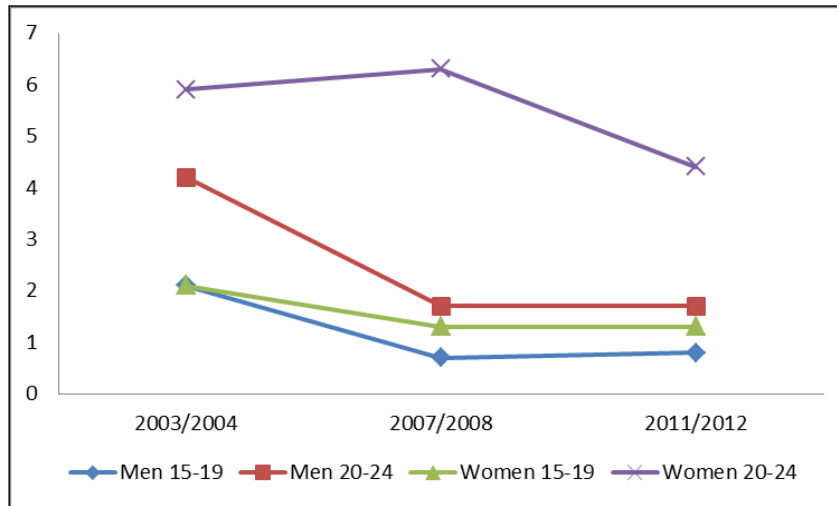


Figure 1.1: HIV Prevalence among Young People Aged 15-24 from 2004/2012

Source: THMIS, (2012)

1.1.8 Policy Issue

Since the beginning of the HIV epidemic in Tanzania, various national and sectoral policies have been developed in response to HIV and AIDS within specific sectors. These have also been complemented by strategies and work plans which emphasize the importance of prevention in the response to HIV epidemic.

Recently, the Third National HIV and AIDS Strategic Framework (2013/14 – 2017/18) was developed in order to guide the national HIV and AIDS response. The NMSF III was developed after a comprehensive review of National HIV and AIDS Policy of 2012, stakeholder's consultation and evaluation of the achievement made

since the previous framework. The rationale of the NMSF III was to provide an agenda for all HIV and AIDS interventions in Tanzania.

The policy and legal frame work in Tanzania characterizes the National HIV response. Tanzania developed its first National Policy for HIV and AIDS in 2001, subsequently implemented by two strategic frameworks, which were completed in 2012. In 2008, Tanzania enacted a HIV Prevention and Control Act (HAPCA). In 2010, regulations for HIV Counseling and Testing, use of ARVs, and disclosure were developed and gazette. The regulations provide for protection against forced testing and mandatory disclosure. The National HIV and AIDS Policy (2012) further emphasize the importance of respect for the human rights of PLHIV. Specifically the policy commits to enhancing measures to ensure men, women, boys and girls living with HIV and AIDS are entitled to all civil, legal, and human rights without discrimination based on gender differences or serostatus in accordance with the URT Constitution and other International Conventions (NACOPHA, 2013).

1.2 Statement of the Problem

Although there are massive prevention campaigns and efforts over the country, HIV/AIDS is still a threat and a major crisis affecting the most productive members in Dar es Salaam Region. Youths are most vulnerable groups affected by HIV/AIDS and their loss due to HIV/AIDS and related illnesses compromise the economic sector of Tanzania. HIV/AIDS is claiming the lives of many young people at an alarming rate, which leaves many orphans in the care of the grandparents or care for themselves (UNAIDS/WHO, 2006).

Despite the increasing number of VCT centers and service providers in Kinondoni Municipality, the number of youths attending the services is low and has signified a marginal pace and their underutilization of the VCT services is the concern of many people in the fight against HIV/AIDS. This situation is unacceptable and raises a concern why are youths not attending VCT services given the fact that services are freely provided (NACP, 2014). Again, though people know the benefits offered by HIV counseling and testing, the uptake is still low particularly a slight increase from 7% to 16% especially for the adults, it is yet to be confirmed amongst the youth, although there is evidence that after the national campaign on testing there was the utilization rate of the service is as high as anticipated for the youth (NACP, 2014). Therefore there is a need to examine the youth's perceptions and practices on the 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.

1.3 Objectives of the Study

This study had the following research objectives.

1.3.1 General Objective

To examine the perceptions and practices of youths towards VCT uptake services in Kinondoni Municipality.

1.3.2 Specific Objectives

- (i) To explore level of awareness on VCT Services among youths aged 15 to 24 in Kimara Ward.

- (ii) To determine the level of practices on uptake VCT services among youths aged 15-24 in Kimara Ward.
- (iii) To explore the perceptions of youths aged 15-24 on VCT uptake services in Kimara Ward.

1.4 Research Questions

- (i) What is the level of awareness on VCT up take among youths aged 15-24 in Kimara ward?
- (ii) What is the level of practices on uptake VCT services among youth aged 15-24 in Kimara Ward?
- (iii) How youths aged 15-24 perceive VCT uptake services?

1.5 Significance of the Study

Firstly, this study examined the perceptions of youths with regards to the VCT uptake, so that their perceptions could find a remarkable position on best interventions dealing with HIV/AIDS pandemic. This in the long run will improve the youth's attendance on VCT centers. Therefore, the study informs both the policy and decision makers on best ways to intervene and encourage the youth's attendance to VCT centers.

Secondly, the research presents the findings on the attendance and perceptions of youth in VCT uptake service in Kinondoni municipality as a case study in Kimara ward. The study suggests possible solutions that will be adopted to free the youth from various risk of HIV/ AIDS and other STDs in Dar es Salaam and elsewhere in Tanzania.

Thirdly, this research will benefit the Government of Tanzania (The Ministry of Health, Community Development, Gender, Elderly and Children) and the general public which losses much of its income due to HIV/AIDS infections to young women and men in Tanzania who provide more than 50 % of Tanzanian labour force thus affecting negatively the economy.

Fourthly, academically, the study has added knowledge on the perceptions of youths on VCT uptake so that future studies on the same filed can find a base.

1.6 Limitations of the Study

Reluctance of the respondents was one among the challenges the study encountered. Due to the sensitivity of the topic, some of the respondents were not willing to participate in the study. Financial Constraint was one of the challenges that the study encountered. The study encountered a problem of meeting its sample due to the fact that youths do not attend VCT services.

1.7 Delimitation of the Study

Reluctance of the respondents was addressed with the assistance of the service providers, the ward and hamlet leaders who assisted the researcher to attain consent of the respondents. Financial constraint was addressed by asking for assistance from parents and other relatives who contributed some money. Moreover, this challenge was addressed by focusing on specific study location that enabled the researcher to meet the objectives of the study.

The scope of the study in terms of the area covered was reduced when collecting data. The sample of the research respondents was reduced from the whole of Tanzania towards Kinondoni Municipal Council in Dar es Salaam, where also some sample used to reduce cost and manage time given for the study.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter presents literatures relevant to the study on the perceptions of the youths on the VCT uptake in Kimara Ward, Kinondoni District. The chapter presented and discussed the theoretical and empirical literatures related to this study. A discussion of the key concepts for the study and the theoretical review of the literatures enabled the study to identify a literature gap. This chapter presents the conceptual framework that guided the study. Moreover, this chapter also presents the policy review, which has been important in guiding the interventions on the problem.

2.2 Definitions of the Key Concepts and Terms

2.2.1 Youth

According to Pocket Oxford Dictionary (1994) youth being young; period between childhood and adult age, young man and young people collectively (the youth of the country) and sometimes meaning the age group between 18-34, male or female. The UN defines Youth as an individual female or male between 15 and 24 years. Individuals below 15 years are defined as children while those above 24 are defined as

adults. Mwenyango (2009) basing on the ministry of Health of Uganda guideline defines youth as any persons aged between 15 and 24 years. Therefore, in this study the researcher adopted operational definition of Youth from UN that the youth is an individual between 15 and 24 years.

2.2.2 Perception

An act or faculty of perceiving (often followed by of) intuitive recognition of a truth, aesthetic quality, way of seeing and understanding (POD, 1994). Webster (2016) online dictionary defines perception the way someone thinks about or understand or notice something. The ability to understand or notice something easily. The way that you notice or understand something using one of your senses. For the sake of the study then term perception stands for internal understanding that seeks to explore the Youth feelings and views toward HIV/AIDS VCT uptake services.

2.2.3 Voluntary Counseling and Testing (VCT)

Voluntary Testing and Counseling is a gateway to prevention and treatment, an essential tool in the control of HIV/AIDS epidemic. HIV testing and counseling is a direct, personalized and person-centred intervention, tailored to prevent transmission and obtain referral to additional medical care, preventive, psychosocial and other needed services in order to remain healthy. Counseling was designed to help persons interpret the meaning of negative or positive antibody results, to initiate and sustain behavioural changes that reduce risk of becoming infected and to assist HIV positive individuals to avoid infection (Horizon, 2014). According to Kwazulu Natal Health

Department (2001) VCT stands for Voluntary Counseling and Testing that applies when a person chooses to undergo HIV/AIDS counseling so that they can make an informed decision about whether to be tested for HIV. The Government is encouraging all people to come forward to be tested for HIV (Horizon, 2014).

VCT as a 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.

2.2.4 Practices

Practice is the act of rehearsing a behavior over and over, or engaging in an activity again and again, for the purpose of improving or mastering it,

2.3 Review of Empirical Literature

HIV voluntary counseling and testing (VCT) is a valuable way to identify people who need HIV care and has been shown to lead to the adoption of safer sexual behaviors among some groups of adults (Voluntary HIV Counseling and Testing Efficacy Study Group, 2000). Little is known, however, about the use of VCT by youth, a group that comprises more than half of those newly infected with HIV. An exploratory study conducted in Nairobi, Kenya, and Kampala and Masaka in Uganda revealed that, youth want information, confidentiality, low-cost HIV testing, and friendly, professional counseling (Horizons, 2001). Two facilities in Kampala, Uganda, the AIDS Information Center (AIC) and Naguru Teenage Information and Health Center (NTIHC), Voluntary counseling and testing for HIV (VCT) has been shown in many different contexts worldwide and with many different populations to be an important

and effective component of a comprehensive HIV prevention strategy. VCT provides an extremely powerful motivation for behavior change. Those who undergo VCT and test negative change their behaviors to maintain their negative status; while those who undergo VCT and test positive change their behaviors to protect themselves as well as their spouses, partners, and future offspring. (Horizon, 2011)

For example, a 1992-93 study conducted by AIDS Information Centre found that, at three and six month follow-up with VCT clients, reported consistent condom had increased significantly, especially among those who tested positive at their VCT visit, from 10% at baseline to 90% six months later. (Horizon, 2011)

A study in Tanzania, Kenya, and Trinidad assessed the impact of VCT on behaviour change. In the randomised study one group received VCT and one received only standard health information. Participants were contacted six months and twelve later. A major finding of the study was the group who received VCT reduced their risk behaviour to a greater extent than the group who received health information only. It also discovered that, couples were more likely to disclose their zerostatus to their partner if they received counselling. In addition, the study showed that, the majority of those tested reported positive psychological benefits (Horizon, 2004).

A similar study conducted in Uganda by Mwenyengo (2010) 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 is explained by the fact that these youth had some form of employment and have the finances and probably the knowledge and are aware of the benefits of knowing

their HIV status as compared to the lower age group. 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 et al., 2006). The findings were similar to another longitudinal study carried out in a rural area in Uganda (Matovu et al., 2005) with a high HIV prevalence which found that those with higher than primary education accepted to test while UNAIDS (2001) report reveals 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 sero-status.

Evidence on behaviour change has been most associated with counselling and testing couples together and among HIV positive clients. For example, in Rwanda and Zambia, a VCT program for couples was linked with increased use of condoms and reduced rates of gonorrhoea and HIV. Among zero discordant couples the proportion using condoms after a one-year follow-up increased from 04% to 57% in Rwanda and 3% to >80% in Zambia (Allen et al., 1992). In Mozambique a study showed that, those who had used VCT services increased their condom use over time, especially with friends and prostitutes (Mola et al., 2006).

In addition to its role as an HIV prevention intervention, VCT is also an important gateway into care and support services- especially for those who are HIV positive (WHO, 2003). Those who know their positive status can initiate preventative actions and seek medical attention for early symptoms of often easily treatable opportunistic

infections, such as malaria, diarrhea, or tuberculosis. Pregnant women who are identified as HIV positive can seek short course anti-retroviral therapy through Prevention of mother-to-child transmission of HIV (PMTCT) programs to reduce the risk of transmitting HIV to their unborn child. HIV positive women can access family planning services to prevent unwanted pregnancies and prevent further MTCT of HIV to their children. Post-test clubs and support groups for people living with HIV/AIDS can reduce stress and anxiety among people who suspect or know they are HIV positive as well as provide access to information on health issues and good nutrition that can prolong and improve the quality of their lives. Post-test services can also help in ARV adherence programs and in disclosure to family and friends. (WHO, 2003)

Finally, both HIV positive and HIV negative VCT clients can better plan for their future with accurate knowledge of their HIV status. This may include making decisions about whether or not to have children or get married, arranging care for children or other dependents, and will planning. Some evidence from countries like Uganda suggests that VCT may also help at a societal level by decreasing HIV/AIDS related stigma and discrimination and increasing personal risk perception for HIV- as more people become aware of their HIV positive status (Mwenyengo, 2010)

2.4 Theoretical Framework

“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).

The person-in-environment (or person-in-situation, biopsychosocial, psychosocial) perspective has historically been the central organizing focus of the social work profession's approach to the helping process. This perspective underscores "the interdependence of individuals within their families, other social networks, communities and larger environments" (Northern & Kurland, 2001, p. 49). Social Work From its inception, the profession has drawn from a variety of disciplines (for example, psychology, sociology, biology, anthropology, economics, and political science) to inform its theoretical base for practice.

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 (Kassim, 2015).

2.5 Trends of HIV Prevalence by Regions in Tanzania

While there was an overall decline in HIV prevalence in Tanzania in the period 2008 and 2012, the change was not statistically significant. There are 8 regions that witnessed an increase in prevalence levels; these include Ruvuma, Rukwa, Kagera, Mtwara, Kilimanjaro, Kigoma, Singida and Arusha (THMIS, 2013). The increase in HIV prevalence in these regions could be a factor of successful care and treatment

program or an actual rise in HIV infection within the regions or both. Other possible factors, such as HIV test refusal rates, should also be explored to explain the change in prevalence over this short time period (THMIS, 2013).

Six regions in the Southern Highland Zone (Njombe, Iringa, Mbeya, Ruvuma, Rukwa and Katavi), two regions in the Coastal (Pwani and Dar es Salaam) zone and one in the Lake zone (Shinyanga) had HIV prevalence rates above the national average (THIMS, 2013) These variations call for a strategic focus in NMSF III to control and scale down new HIV infections in regions with high prevalence and understand and address the factors behind rising trends in prevalence in the regions (THMIS, 2013).

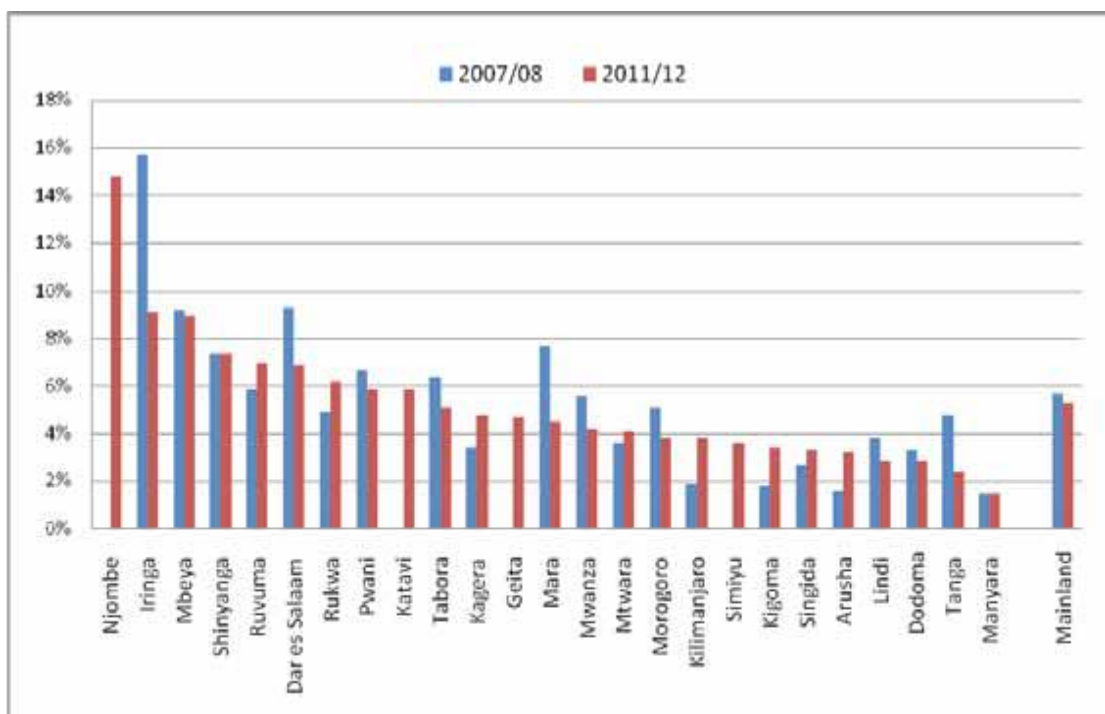


Figure 2.1: HIV Prevalence by Region in 2007/2008 and 2011/2012

Source: THMIS (2007/08) and THMIS (2011/ 2012)

2.5.1 HIV Prevalence by Age and Sex

There exist age and sex differentials in HIV prevalence in Tanzania as indicated in Figure 2.2. Among both men and women, HIV prevalence increases with age generally and women invariably have higher prevalence rates in all age groups compared to men. However, prevalence among young women aged 25 – 29 is 3 times higher compared to young men in the same age group (THMIS, 2013).

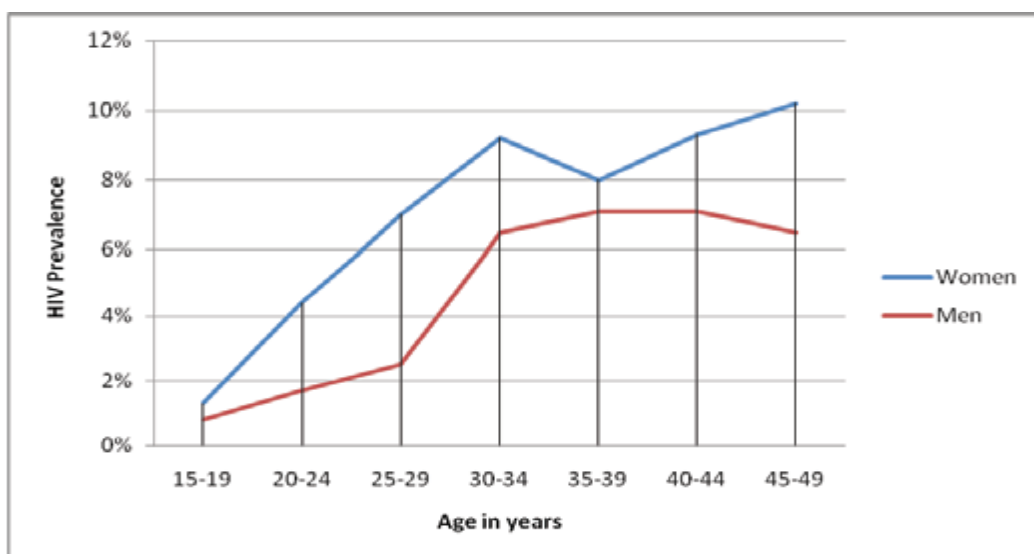


Figure 2.2: HIV Prevalence by Age and Sex

Source: THMIS (2011/12)

2.5.2 Trends in HIV Incidence and Prevalence

Data from four rounds of *antenatal* clinic attendees and two national population surveys and projections indicate that, HIV incidence and prevalence have declined and stabilized.

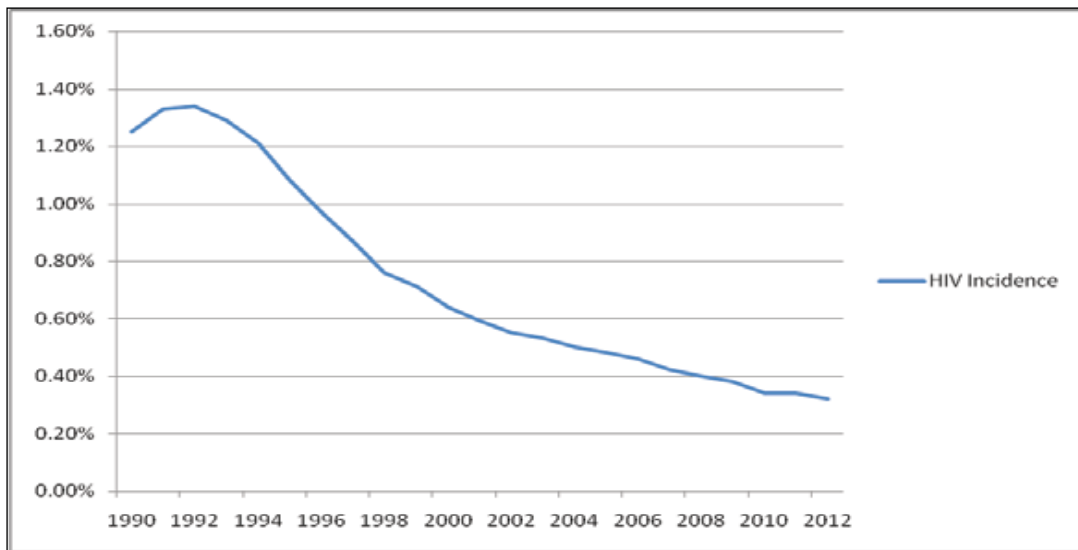


Figure 2.3: HIV incidence in Tanzania (Age 15-49)

Source: Spectrum estimates (UNAIDS, 2013)

The incidence of HIV infection in the age group 15-49 years peaked at 1.34% in 1992, declined rapidly down to 0.64% in 2000, and steadily declined further to 0.32% in 2012. Similarly, HIV prevalence increased to a peak of 8.4% in 1996, declined to 5.7% in 2008, and declined further to 5.3% by 2012. However, a wide variation exists between regions and within regions across social and age groups (THIS 2004, THMIS 2008 & 2012).

2.5.3 The HIV/AIDS Epidemic Among the Youths in Tanzania

The youths come face-to-face with numerous health risks along the path to adulthood, many of which will affect the length and quality of their lives. Left uncontrolled HIV/AIDS will lead many young people and/or their parents to an early death. Available epidemiological data show that youth are at a higher risk of HIV infection than older population groups (UNAIDS, 1998).

According to THMIS 2011/2012, 9.4% of women and 9.9% of men aged 15-24 reported to have started sexual intercourse before the age of 15. Reporting of sexual experience before the age of 15 remained unchanged between 2003/2004 and 2007/2008 for both sexes but recorded a decline among female (11% to 9%) and remained stable among males (10%) throughout 2012. This stabilization or decline could be attributed to various ongoing interventions focusing youths. Practice of multiple sexual partnership was reported by 45% of women and 14% of men aged 15-24 years in 2012. Condom use during last sex increased from 46.3% and 49% in 2008 to 58% and 59% in 2012 among women and men, respectively. This is an indication of positive results of intensified condom programming among young people in Tanzania

2.5.3.1 The Key Factors For HIV Transmission For Youths Population

A number of key factors in HIV transmission have been identified, including individual behavioral, socio-cultural and biomedical factors. The HIV infection among teenagers starts from as early as 12 years of age and increase very fast in the age group 15 to 24 years. Half of HIV infections occur among youth aged 15-24 worldwide. And that in sub Saharan Africa three young women are infected for every young man among 15-24 year-old (Pathfinder International report, 2009).

2.5.3.2 Inter or Cross-Generational Sexual Relations

Inter- or cross-generational sex, involving high-risk intercourse, between young women and older men was estimated at 7.6% among women aged 15-19 in mainland Tanzania in 2010. There was a notable difference between urban and rural populations, with 10.4% of Mainland urban young women at risk and 6.7% of

Mainland rural young women. Urban Dar es Salaam, however, performed better than the national trend with only 4.8% of young women reporting such high-risk behavior (TDHS, 2011). *Anecdotal* evidence indicates that, male youth also practice sex with older women, motivated by money, gifts or a social standing aspiration (ibid).

2.5.3.3 Voluntary Counseling and Testing (VCT)

HIV voluntary counseling and testing (VCT) programs have demonstrated their ability to increase safe sexual behavior and use of care and support services among adults (Coates et al., 1998). By helping clients learn their HIV zero status and creating a personalized HIV risk reduction plan, VCT can provide the information and support necessary to change risky behaviors that could lead to HIV infection or transmission (CDC, 1994). Counseling, Pre and post counseling service, and a risk reduction plan are the key features that distinguish VCT from other HIV testing services (ibid). VCT for HIV infection is a process of providing individuals, groups of people or couples with HIV pre- test and post-test counseling.

The process of pre-test counseling is concerned about whether to take an HIV test and what one's personal risks are for HIV infection. It is followed by testing if and only whether the client decides to do so based on pre test counseling. In post test counseling session, the client is counseled among other things, on how to receive the test results. Client work with the counselor during the post-test counseling session to develop life plans for change of behavior to protect themselves and others from HIV infection (Kalinga, 2007).The world Health organization (WHO) have drawn urgent

attention to the need of rapidly increase access to knowing one's HIV status through VCT (Kalinga, 2007).

VCT is a vital point of entry to other HIV/AIDS services, including prevention and clinical management of HIV-related illnesses, TB control, psychosocial and legal support, and prevention of mother to child transmission of HIV. High-quality VCT enables and encourages people with HIV to access appropriate care and is an effective HIV-prevention strategy. VCT can also be an effective behavior-change intervention. VCT 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 (FHI, 2012).

Now that treatment has become more widely available, health planners perceive VCT as a way of identifying those who require care and support services. Emphasis is changing from prevention to care thus less attention is being placed on high quality counseling that can motivate people particularly youth to adopt safe behaviors and the usefulness of VCT as a preventive measure is being undermined. VCT programs have demonstrated their ability to increase safe sexual behavior and utilization of care and support services among adults (Sangiwa et al., 1998 and Coates et al., 2001).

VCT has numerous advantages both at individual and community perspectives. VCT offers benefits to those who test positive or negative. VCT alleviates anxiety, increases clients' perception of their vulnerability to HIV, promotes behavior change, facilitates early referral for care and support including access to ARV therapy, nutritional services, legal aid, spiritual support, home based care, treating and preventing

tuberculosis, sexually transmitted infections and opportunistic infections (THMIS, 2007-2008). Also VCT assists in reducing self-stigma and facilitates understanding and coping. Similar observations were made by (Annemarie et al., 2008) in the study to examine how fear of stigmatization can be barrier to HIV/AIDS counseling and testing. In this study the researcher, acknowledged that if stigma is dealt according could improve access to HIV counseling and testing (THMIS, 2007-2008).

At community level VCT is vital as it creates peer educators, mobilizes support for appropriate responses and it can reduce denial, stigma and normalizes HIV/AIDS (FHI, 2006). In that case Tanzania, like many other countries, needs a prompt and adequate action to control of the new HIV/AIDS infections. This will be achieved if voluntary HIV/AIDS testing knowledge is adopted by the whole community. VCT is a vital point of entry to other HIV/AIDS services, including prevention and clinical management of HIV-related illnesses, TB control, psychosocial and legal support, and prevention of mother to child transmission of HIV. High-quality VCT enables and encourages people with HIV to access appropriate care and is an effective HIV-prevention strategy (FHI, 2006).

2.5.4 An Overview of Tanzania National HIV/AIDS Policy and VCT Services

HIV testing is one of the specific objectives in the Tanzania National HIV/AIDS Policy, aiming at promoting early diagnosis of HIV infection through voluntary testing with pre and post-test counseling. The main aim being reassure and encourage the 85-90% of the population who are HIV negative to take definite steps not to be infected and for those who are HIV positive to receive the necessary support in

counseling and care to cope with their status, prolong their lives and not to infect others (URT, 2001).

VCT services in Tanzania were introduced since 1988 and by March 2006 there were more than 806 VCT sites and 2110 trained counselors providing VCT services (NACP, 2006). However, most people in the country have not been tested and consequently do not know their status, as only 37% of women and 27% of men have ever been tested and received results (THMIS, 2008).

In Dar es Salaam, the percentage of women who had ever tested and received their results is 33.0% and those who had never tested were 58.4%. The percentage of men who had ever tested and received their results was 16.8% and those who had never tested was 79.1%. These results point to the need for studying the reasons and perception of individuals regarding HIV VCT uptake and to keep sensitizing the general population to know their health status through the available VCT sites in the country (THIMS, 2007-08).

2.5.4.1 VCT: A Prevention Intervention/ Care and Support Intervention

To date, most VCT interventions have been mostly an HIV prevention intervention aimed at reaching people who have no signs and symptoms of HIV or AIDS (most people with HIV infection, remember, do not have any symptoms and are not noticeably ill). VCT with high quality counseling has been shown to change the behavior of people with HIV, as well as those who are HIV negative. This is the case as long as there is high quality risk reduction counseling as part of the intervention. Numerous studies have shown, however, that there is little or no change in behavior with just testing for HIV alone (UNAIDS, 2001).

Most of the VCT clients at stand-alone centers have said that they came to learn their status because “they just want to know,” because they want “peace of mind” or reassurance that they are not infected. Some come because they have had a scare such as an STI or a broken condom/no condom episode, or because they fear that they might have been exposed to HIV from a partner who had other partners (wife discovers her husband has been having an affair). Oftentimes visiting a VCT center is related to major life changing events such as going away to school, getting married, or having a new baby (THMIS, 2012).

Besides changing behavior, high quality VCT services link asymptomatic HIV positive people (who often are early in their stage of infection) into psycho-social support services for coping with an HIV positive diagnosis. Sometimes this is through individual counseling (and most VCT centers recommend that all HIV positive people return for at least one or more follow up counseling sessions) but also through referral to support groups for people living with HIV/AIDS (PLHA) or “post-test” clubs. Post-test clubs generally accept anyone who has been tested for HIV positive or negative, but tend to attract mostly people who are infected with the HIV virus and need support in coping with the diagnosis (THIMS, 2008)

For those people who are sick or ill because of HIV, however, good VCT services may also serve as a much needed link into medical or other needed care. This is why a strong referral network is crucial to a good VCT program no matter what model of VCT service delivery your program is using. Although they are not the majority of clients, people who are ill with HIV related illnesses will come to stand alone VCT

centers or to VCT sites for counseling and testing, especially as access to treatment programs are expanded. In Namibia, for example, after the government announced the introduction of free ARVs at government health centers, many people who were ill with HIV related illnesses and AIDS started appearing at PSI's traditional stand-alone VCT centers for an HIV test, for counseling, and also for referral into a treatment program (THMIS, 2008).

2.5.4.2 VCT Approaches

According to Caroline (2008) there are different ways through which voluntary counseling and testing can be offered and these vary between nations, these include.

2.5.4.3 Free-Standing Services

Although free-standing services offer VCT away from health facilities, they may have links with other care and support services. Many free-standing services are run by local or international NGOs, and rely upon a high level of public awareness of the benefits of VCT. Publicity, understanding of VCT in the community, and concerted efforts to reduce the stigma associated with HIV, are therefore all important factors contributing to success. VCT sites that have been successful in attracting people have been supported by information, education and communication (IEC) campaigns, community mobilization and advertisements. The ANGAZA sites are VCT free-standing sites exemplified in Tanzania. Individuals can undergo an anonymous HIV test, receive HIV testing and counseling and attend a peer support group (THMIS, 2012).

The essential advantages of the approach include; dedicated counseling staff as the purpose of free-standing services is primarily to provide VCT, full-time counseling staff with no other duties are employed and flexible opening times as free standing services are not within other services (such as health services which have fixed hours). Also employed staff they can arrange or extend their opening times to be more convenient for clients, for example by offering services at the weekends and evenings. Anonymous testing, most free-standing services offer VCT that is either confidential or even anonymous (where people can attend without giving their name). Separate from medical services this encourages people who are asymptomatic to attend VCT, which they might not otherwise do (THIMS, 2007-08). Men in particular rarely attend health facilities unless they have symptoms of illness, so free-standing sites are more likely to extend the reach of VCT to a wider population community links, free-standing sites are often situated within communities and have a less rigid management structure. This may facilitate community linkages and partnerships in the design of services and provision of follow-up care Post-test support groups, many free-standing VCT sites have incorporated post-test support groups into their services. Free-standing sites may have more autonomy and provide a less medical approach to post-test care and support community mobilization (Caroline, 2008).

However, this kind of VCT approach has numerous disadvantages, these include; funding because the majority of such services are provided by NGOs and rely on donor support, ensuring adequate funding for their continuation has often proved difficult. Potentially stigmatizing, this is attributed with the fact that free-standing sites are known to have a single service relating to HIV/AIDS, they may be

stigmatizing. People may be reluctant to attend, as they fear they will be identified as having HIV. This can be a real obstacle, especially in small communities and in lower prevalence countries where HIV is particularly stigmatized. In these smaller communities, a multipurpose or integrated VCT service that uses a coding system may afford greater privacy and increase the uptake of services. Staff burnout at dedicated centres staff may suffer burnout and depression, as they have no relief from HIV/AIDS counseling, which can be emotionally exhausting and stressful (Caroline, 2008).

2.5.4.4 Integrated into Existing Health-Care Services

VCT services can be integrated into the established health-care setting across a range of services. In this approach, people attending primary health care services (including family planning and well-baby clinics), or those seeking more specific medical attention (for example by presenting at TB or STI clinics), can also receive VCT. Counseling is usually carried out by clinic staff or by HIV/AIDS counselors. Established links with other medical services in the clinic may also facilitate cross-referral. A successful and properly integrated VCT service may require counseling staff, dedicated counseling time or time for staff to attend regular meetings, held between clinics, to ensure good liaison and cross-referral between services. This should be supported by a commitment to (and understanding of) VCT services by clinic management, and by the planning and development of VCT services (THIMS, 2007-08).

This approach has the following advantages; low cost, VCT services that are integrated into existing health facilities will require little extra funding for accommodation and utilities. Furthermore, in some integrated settings existing staff are trained to provide counseling services so that no further staffs are required ease of replication/scaling up in many countries a nation-wide network of primary health care clinics has already been established. If VCT can be successfully integrated into a pilot clinic this model can be more easily replicated as the basic infrastructure is already in place less stigma as primary health care sites offer a wide range of services, people can attend for VCT discreetly linkage to medical interventions. The diagnosis of HIV associated infections, access and monitoring of treatment and preventive interventions can be facilitated through linkages at the clinic. Accesses for women integrated VCT sites have proved popular with women who may be more reluctant to visit free-standing sites (THIMS, 2007-08).

Many women attend primary health care settings routinely for family planning, *antenatal* and child-health services, and can be offered VCT on these occasions. Access for young people VCT can be incorporated into youth-friendly services, which are beginning to be provided in primary health care settings and which already offer family planning, STI services, general health education, drug, alcohol and sex education, peer education and outreach (Caroline, 2008).

It is worth to declare that this approach is not free from challenges, the approach encompass a vast of disadvantages, these include; increased workload where no additional staff are employed for counseling duties those carrying out counseling may

be unable to provide adequate time for in-depth counseling and, in busy clinics, they may be under so much pressure that they avoid promoting VCT. Also space requirements VCT requires adequate space for privacy, and small primary health care clinics may be unable to offer suitable accommodation for VCT, with limited opportunity for expansion. Limited access for men and couples, men do not routinely attend primary health care clinics, and people infrequently attend as couples (NACP, 2008).

However, even if HIV testing is available in primary health care settings (and even if health workers receive good counseling training), in the absence of adequate time and privacy, service delivery may be poor and uptake low. Insufficient training and counseling. Counselors have often been trained primarily in VCT but are then expected to provide ongoing counseling and management of complex issues (NACP, 2008).

2.5.4.5 Integrated into Family Planning Services

Family-planning (FP) services are well developed in many countries and provide routine contact with sexually active women. However, VCT (or even HIV/AIDS counseling), has not been generally incorporated into these services and this represents a major missed opportunity. The government of Sri Lanka has developed a strategy that aims to “incrementally build a comprehensive reproductive health approach on the existing maternal and child health and family planning delivery systems, including reduction of anemia, prevention and early detection of reproductive tract infections, including STDs and HIV/AIDS and reproductive organ malignancies at the primary health care (PHC) level. This is to be achieved through

the establishment of 300 well-women clinics and control of reproductive tract infections among other activities” NACP, 2008).

(a) The Advantages of Integrated VCT into Family Planning Services

Systems are already in place, as with STI and TB care services, infrastructure and staff are already in place. Counseling skills, many health workers providing family planning services will have already had some counseling training and already have experience in dealing with sensitive issues relating to sexuality. These staff may only require short additional HIV counseling training. Cross-referral knowing their HIV status benefits people by helping them to decide about contraceptive use and their future reproductive intentions, including the avoidance of unwanted pregnancies (NACP, 2008).

(b) The Disadvantages of Integrated VCT into Family Planning Services

Integrated into family planning services this approach has the following disadvantages; Limited accesses for men, men rarely attend family planning services. Limited access for young people, in many countries family planning services are not sufficiently “youth-friendly” to attract young people who would benefit from family planning and VCT. Additional workload for health workers, family planning providers have sometimes expressed reluctance to take on additional tasks which they do not perceive of as being of direct relevance (NACP, 2008).

2.5.4.6 Integration into Antenatal Care Services

Currently, the greatest increase in VCT provision within *antenatal* care settings is taking place in relation to program for the PMTCT of HIV infection Offered VCT at

subsequent VCT visits, VCT offered to partner infant feeding counseling, safer sex counseling. VCT within *antenatal* care has many of the same advantages and disadvantages as VCT integrated into other primary health care settings. However, specific considerations include the need to offer VCT to all pregnant women attending antenatal care services and the need to encourage the participation of their partner(s) where women are in agreement. Midwives and nurses also need to be given additional training in VCT and PMTCT. In addition, follow-up care needs to be provided for mother and infant post-delivery and all women who test HIV-positive must be offered PMTCT interventions (NACP, 2008).

(a) The Advantages of the Approach Integration into Antenatal Care Services

Integration into Antenatal Care services possesses the following advantages, opportunity for the prevention of mother to child transmission of HIV. The aim of VCT in *antenatal* clinics is to identify HIV positive pregnant women so that they can be provided with interventions for PMTCT. In many countries in Europe, Asia and the USA, the majority of pregnant women are tested and given antiretroviral therapy for PMTCT, resulting in very low levels of pediatric HIV infection comprehensive care. Care and support across a broad continuum can be offered to the woman, her partner and child.

(b) The Disadvantages of the Integration into Antenatal Care Services Approach

Caroline(2008) states the disadvantages including: women blamed for HIV infection – Focusing VCT on women may result in women being blamed for HIV infection Women's lack of autonomy. For cultural and economic reasons, women are often unable to make decisions following VCT. They may have to consult with, and obtain

the consent of, their husbands or families in relation to prevention interventions. Limited access for men. There has been a poor uptake of VCT services in antenatal settings by husbands/partners, even when PMTCT programs have made efforts to encourage their participation.

2.5.5.7 Integration into STI Services

The prevalence of HIV is often significantly higher among people attending STI clinics than in the general population. In many developed countries VCT is routinely available for all STI attendees. In such settings, treatment, care and advice can all be provided for those testing HIV positive. In developing countries, although some STI services can offer HIV-testing, there are few examples of a high quality VCT service (Calorine, 2008).

(a) The Advantages of the Integration into STI Services Approach

The advantages of this approach include: high detection rate, Offering VCT in STI services will identify large numbers of people with HIV and facilitate their access to appropriate healthcare Systems in place for partner notification/disclosure. In some STI services there are well-developed systems for partner counseling and notification. Except in carefully defined circumstances, where disclosure of an individual's HIV status to another person is required by law or by ethical considerations. The person with HIV has the right to privacy and to exercise informed consent in all decisions about disclosure of his/her status (Caroline, 2008).

(b) The Disadvantages of the Integration into STI Services Approach

Integration into STI services is prone to disadvantages: Stigma, Sometimes people are reluctant to attend STI services because of worries about being identified or fearing

lack of confidentiality. Limited access to asymptomatic people, VCT within services will only reach those who have symptoms of illness and have presented for treatment. STIs are often asymptomatic, additionally many people who have symptoms of STIs may choose to self medicate, and therefore VCT may not reach a significant proportion of those requiring attention (Calorine, 2008).

2.5.5.8 Integration into TB Services

Almost 30% of people with HIV are also infected with TB. TB is the most common opportunistic infection among people with HIV and is a leading cause of death among people who are HIV positive. In more and more countries the epidemic of TB and HIV are fuelling each other. HIV infection and TB have usually been managed separately. TB programs have often paid little attention to interventions other than case finding and treatment of TB, and likewise HIV programs have generally paid little attention to TB. There is a need for greater collaboration between VCT services and TB services (Calorine, 2008).

(a) The Advantages of the Integration into TB Services Approach

The advantages of Integration into TB Services include: high detection rates offering VCT in TB services will therefore identify people with HIV who can then be offered appropriate medical interventions including referral. Currently established infrastructures in many countries for TB services are well organized, have national coverage and employ trained personnel to diagnose TB and provide supervised TB treatment. The delivery of VCT in these established services is feasible. It has been proposed that, TB services could also provide the necessary infrastructure to deliver

ART to people who test HIV positive. VCT is entry point for HIV/TB prevention, care & ART, Cross referral between VCT and TB (NACP, 2008).

(b) The Disadvantages of the Integration into TB Services Approach

The disadvantages of Integration into TB Services approach are limited access to asymptomatic people as with STI integration, VCT within TB services will only reach those who have symptoms of illness and have presented for treatment.

2.5.5.10 VCT in Private Setting

HIV testing in such settings is often carried out without adequate pre-test counseling or informed consent, and insufficient quality control of HIV-testing procedures. VCT (or more often HIV testing alone) is usually carried out as part of clinical care, often to confirm the clinical suspicion of HIV infection. Although in many countries where ART is available, patients may be able to access appropriate medical care, HIV prevention is often largely ignored. There is therefore great potential for improving VCT in the private setting (NACP, 2008).

(a) The Advantages of the VCT in Private Setting Approach

In general, the advantages of VCT in this setting include: Funding, because these services are paid for either by the clients or by the business sector, they do not rely on external funding and are therefore more sustainable. Medical care, Private practitioners will often be able to provide ongoing medical care for people living with HIV/AIDS (PLWHA). Convenient for some client groups, people who have already established a good relationship with their private practitioner may feel comfortable attending for VCT (NACP, 2008).

(c) The Disadvantages of the VCT in Private Setting Approach

The disadvantages of the VCT in Private Setting approach are; the cost of VCT in the private sector will exclude large numbers of people, particularly in developing countries. Quality of counseling and quality control of testing, many private practitioners operate independently with limited training or supervision in VCT activities. This can result in poor quality counseling and inadequate quality control of testing procedures. As services are provided often on a “timed fee for service” basis, many clients are unwilling or unable to pay for the extended consultation that may be required. Confidentiality, systems may not be in place to ensure the confidentiality of test results. This may be of particular concern for people attending workplace clinics, and who fear that their test results could be divulged to their employers (NACP, 2008).

Coercion, in situations where employers provide health services, they may impose HIV testing on employees prior to promotion or provision of further education opportunities. Lack of HIV prevention, people without symptoms may have few contacts with their private doctor, decreasing the potential for providing VCT to encourage HIV prevention. Doctors may limit prevention work with clients to the provision of information. Few doctors have been trained to explore the constraints a client may encounter in reducing risk behavior, or have the training to be able to offer the client strategies to overcome these constraints (NACP, 2008).

However, despite these reservations, the private sector in many countries has the potential to provide a significant proportion of VCT services. Ensuring that, the service is ethical and of high quality remains an important challenge for the offering

of VCT services. Towards this end, strategies need to be developed to increase the capacity of private practitioners to provide ethical and confidential, high-quality VCT services. Private practitioners could be offered incentives to undertake training, for example, by gaining continuing medical-education credits for accreditation and registration. Training could also be offered through distance learning or part-time courses, and partnerships between government and private services could facilitate the sharing of personnel and expertise (NACP, 2008).

2.5.5.11 Home Testing

Several different self-test kits are now available, allowing people to test themselves for HIV infection at home. Although the major regulatory authorities do not yet approve self-test kits (which provide an instant result and can be used without assistance), they are widely available and can be bought directly from pharmacies in some countries or ordered on the Internet. Home collection kits are also available in some countries and have been approved for use in the USA. These allow users to collect their own blood sample at home and send it to a testing facility. After about one week, clients telephone the centre for the test result, which if negative is communicated by a recorded message. If the result is positive the client is “counseled” over the telephone and referred for further follow-up if required (NACP, 2008).

Experience from the USA has shown that, 97% of people phoned for their results and 65% of those testing HIV positive accepted referral for counseling. The use of home testing and home collection kits has, however, now been prohibited in the USA because of fears of misuse and inaccuracies of the test kits used in some situations. Self/home testing and home collection cannot properly be described as an approach to

delivery of VCT as it does not usually include any pre-test counseling, while post-test counseling may or may not be available (NACP, 2008)

Studies suggest that, there is a risk of suicide associated with HIV testing and proper pre- and post-test counseling would normally involve an assessment of an individual's ability to cope with a positive test result. Without such counseling assessment of suicide risk is difficult, as is the development of appropriate management strategies where such a risk is acknowledged or suspected (NACP, 2008).

(a) The Advantages of the Home Testing Approach

Despite such concerns, the potential advantages of testing in this setting include: Privacy, they offer complete privacy, provide a service for people who do not seek testing at VCT sites, and could increase the number of people who know their HIV status. Access for “special groups”, there are special groups who could benefit from home testing. These include health-care workers who may be reluctant to be screened for HIV after an occupational exposure because they fear they may already be infected, and people who may wish to self-test prior to mandatory testing for travel abroad or for a work permit Cheap for the health system. As the user has to pay for the test and no counseling is available they are a cheap way of providing HIV testing. There is, however, very little information on outcomes following self-testing (NACP, 2008).

(b) The Disadvantages of the Home Testing Approach

No pre-test counseling, people using self-test or self-collection kits receive no pre-test counseling Limited post-test counseling or follow-up care or support although it is

claimed that with self collection referral to post-test counseling was accepted by the majority of people who tested HIV positive, there is no information on how many people actually took up this offer. Additionally, there is no information about the quality of the counseling and the behavioral and psychosocial outcomes following testing (NACP, 2008).

There is increased risk of suicide associated with testing without adequate emotional support. There is a potential for home testing to be misused. People can “persuade” sexual partners to test poor quality control, many of the self-test kits that are available over the Internet have not been evaluated sufficiently or have high levels of false-positive test results single test. Users must understand the need for a confirmatory test and be informed about the window period. Difficult to perform, although self-testing kits are marketed as being “easy-to-use” some are relatively complicated, especially for people who have no technical background or who cannot read English (instructions may not be in locally used languages) (NACP, 2008).

2.5.5.12 Provision of VCT through Mobile/Community Outreach

In order to make VCT more widely available to groups who do not routinely attend health facilities, mobile VCT clinics have been developed in some settings. The “mobile unit” can be a van/ caravan which offers VCT in site and has a schedule of places which it visits at pre-advertised times. This approach has been used to access “hard-to-reach” populations who do not visit formal health settings, such as homeless people, sex workers or injecting drug users (IDUs). It may also be appropriate for increasing access to remote or rural areas. One variation of this model is to have a

mobile “VCT team” which provides services at fixed times at a variety of sites such as community centres, religious centres or schools (NACP, 2008).

Pre-advertising (via fliers and public announcements), can provide potential clients with information, maps and schedules for the mobile service. Using rapid tests makes it possible for results to be given to clients on the same day. However, in some settings it has been more feasible to ask clients to return the following day for their result. One study from Australia has demonstrated that, marginalized populations who received services from a mobile HIV/STI bus eventually used the associated permanent site. A key feature of the service that promoted this transfer of clients was that the outreach service employed the same staff at both the mobile site and the associated permanent site.

As trust grew between clients and staff of the mobile service, clients started to use the permanent site. There is, however, little published information on mobile VCT services beyond the description of small pilot projects information, condom social marketing and VCT services (NACP, 2008).

(a) The Advantages of the Provision of VCT through Mobile/Community Outreach Approach

The advantages of such an approach include: Anonymity, as mobile units can be independent of health or other institutions; they can easily offer anonymity to clients. Improved access, mobile units can offer greatly increased access over a wide area, and vulnerable and marginalized groups can be reached through mobile and community outreach. Links to permanent services, once good relationships have been established,

the regular attendees of mobile sites can be better integrated into larger and more comprehensive, permanent services (NACP, 2008).

(b) The Disadvantages of the Provision of VCT through Mobile/Community Outreach Approach

Follow-up and post-test support, as a mobile service will usually only offer VCT on a limited number of days at each site it may be difficult to provide follow up support for clients who require ongoing counseling care. Maintenance, if the mobile unit consists of a van or caravan, maintenance can be difficult in some developing countries, particularly in remote areas or where roads are poor. Confidentiality, People attending a single-purpose VCT mobile service may be readily identified in small communities. Limited numbers of people receive VCT. If the service is conducted in a mobile van then usually only one person may be seen at a time if confidentiality is to be maintained.

2.5.6 Youth and Voluntary Counseling and Testing

In general, fewer young people use health services than do adults. As part of the study, the research team interviewed staff at seven of the inventoried sites that provide youth services as well as at six additional HIV testing facilities in Kibera, they found out that, the facilities provide general health services to fewer than ten young clients per month. Only four organizations serve more than 20 young people on average per month, although two services see an average of 500 female and 800 male clients of all ages per month for their general health care services (The Population Council Inc, 2001).

The benefit of VCT services cannot be taken for granted anywhere they operate. Sometimes under certain circumstances, the phenomena can hinder the uptake of VCT services. For instance the evaluation study on scaling up HIV VCT in Africa concluded that, “although there is a wide spread belief that scaling up of HIV VCT programs in Africa will have large prevention benefits through reductions in risk behaviors, these claims are difficult to establish from existing evaluations of the services”. And that, the potential uptake of those at risk is uncertain (Glick, 2005).

2.5.7 Untested Youth’s Awareness of the Existing VCT Services

A majority of untested youth, more than eight out of ten in all study samples had correctly named at least one facility that provides HIV testing services. The parents and community leaders interviewed in Kenya concurred that testing is only for those who are ill. One respondent in a focus group discussion noted that, “residents of community do not go for HIV tests. They only go for treatment of opportunistic diseases.” It is through the process of diagnosing an illness that young people are tested for HIV, according to community members in the study. Having an HIV test to know one’s status generally or to prevent the spread of HIV was mentioned only rarely (The Population Council Inc, 2001).

2.5.8 The Demand for VCT Service

More and more people have turned up for voluntary counseling and testing during the reporting period. For instance, the NACP (2003) reports that, in 2002 there were a total of 57,223 clients who made use of VCT services that year, 83% (n=47,956) of whom consented to taking the HIV test. In 2003 and 2004 the number of persons who were counseled and tested was 139,972 and 227,973 respectively. 25,754 people in

2003 and 22,121 people tested HIV+ ve in 2004, making prevalence rates of 18.4% in 2003 and 9.7% in 2004 respectively. There has also been an increase in the number of people donating blood between 2002 and 2004 (NACP, 2006).

However, the turn up is still low compared to the total population as to 2002 census. Integration of VCT services within health care delivery system has been found as an important factor for the increase uptake of VCT services in Rungwe district, where unlike non integrated VCT, the uptake of VCT was higher (78.6%) in health facility based (Kalinga, 2007). Also the study found that, increased uptake was attributed by the short waiting time of result with rapid test assays being employed. However, the report recommends that, the community mobilizations such as seminar and health education are crucial in order to increase the uptake of VCT services and then there is a need to evaluate the quality of service offered (ibid).

2.5.9 VCT's Relevance to Young People

The more general needs of young people, children, families and couples must also be addressed as part of providing comprehensive services including VCT. Young people actively seek and receive VCT even where VCT services have not been designed specifically for them. The AIDS Information Center (AIC) in Uganda has reported an increase in the number of youth seeking VCT, especially for pre-marital testing. About 15 percent of AIC clients are between 15- and 19-years-old. By the end of 1995, 39,000 adolescents had visited the center. Of these adolescents, 78 percent were females and 40 percent came to the center with their sexual partners. Few countries have VCT services specifically developed or adapted for young people. This is

important as the reasons for seeking VCT services, outcomes and needs following VCT can be different for young people (Family Health International, 2002).

VCT has become a widely advocated HIV/AIDS prevention strategy among adults. Most clients of VCT services are in their mid- to late twenties (Ladner et al., 1996; Coates et al., 1998). Because few young people use any health services, using VCT as a strategy to reduce risk behaviors among young people appears to be more challenging than it would be among adults. It has been particularly important to study the coverage of voluntary HIV testing among youths, not only because of their vulnerability but also because they may experience obstacles in accessing the service (THMIS, 2007-08). The survey did not answer the question as to what were perceived as obstacles that has lead to low uptake of the service. Voluntary counseling and testing (VCT) programs have increased the adoption of safe sexual behavior and the use of care and support services among adults (Coates et al., 1998).

2.5.10 A Research Study of Youth VCT in Dar es Salaam

Youth need HIV counseling when seeking reproductive health services, a research study in Tanzania found large differences between actual and perceived risk for HIV infection among young reproductive health clients. More information is needed to address questions that affect the design of HIV voluntary counseling and testing (VCT) services for youth. With the School of Nursing at the Muhimbili University College of Health Sciences, YouthNet conducted a descriptive study of youth attending VCT and other reproductive health (RH) services in Dar es Salaam, Tanzania. (RH services include sexually transmitted infections, family planning, and other services.) The study produced information on alternative VCT service delivery

models, their related quality of care, and the focus of this brief was on the proportion of youth who practice risky sex compared with the youth's own perceptions of risk (FHI, 2006).

Exit interviews were conducted with 719 youth (310 males and 409 females) ages 15 to 24 as they were leaving four clinics in Dar es Salaam. The clinics represent four types of sites where youth might seek VCT for HIV, with approximately the same number of youth interviewed from each type of site: 1) a youth-only, combined VCT/RH site, where different providers address VCT and RH needs) a youth-only, combined VCT/RH site, where the same provider offers all services) a general VCT-only site for all ages) a general VCT/RH site for all ages with special hours for youth, where the same provider offers all services.

The study defined a person as having risky sex if, in the last three months, he or she was sexually active and either had sex without condoms or had more than one sexual partner; or in the last 12 months, had been diagnosed with a sexually transmitted infection (STI). Youth were interviewed only if they had received either VCT or RH services, not if they received both. (In two sites that offered RH services, there were very few male clients who received only RH services) (FHI, 2006).

It was found that, the average age of the youth surveyed was 21, and the average age at first intercourse was 17. About a third of the females (34 percent) but only 6 percent of males were married or cohabiting. More than half of the RH clients were married or cohabiting (56 percent), compared with only 11 percent of the female VCT clients.

The majority of the male RH clients came for STI services, while the female RH clients came primarily for family planning services.

The study calculated what percentage of youth had had risky sex. The proportion was higher for RH clients, where 80 percent of females and 61 percent of the male clients were classified as having had risky sex in the previous three months. In contrast, about half of the female VCT clients (49 percent) engaged in risky sex, as did a smaller but similar percent of male VCT clients (42 percent). To assess youth's perceived risk of HIV infection, the study asked participants if they thought they were at great, moderate, low, or no risk of getting the virus that causes AIDS. Among those classified as practicing risky sex, about half of the male VCT clients (56 percent) and RH clients (52 percent) felt that they were at moderate or great (FHI, 2006).

2.5.11 Perception of High School Students towards VCT

Similar studies were done using a cross sectional descriptive study in January 2006, in Ethiopia among the Butajira senior secondary school students where a multi stage sampling method was used. It was revealed that, majority of students had heard about VCT and revealed willingness to undergo VCT. The study showed that High perception of susceptibility and barriers were associated with low willingness to undergo VCT.

On the other hand, students with high perceived benefits showed better willingness to undergo VCT. It is recommended that, messages on VCT give emphasis on personal susceptibility to HIV/AIDS and benefits of VCT (Abebe, 2010). The second round Methods Behavioral Surveillance Survey in Ethiopia indicated that Study: A

descriptive cross sectional study was conducted only less than half (41%) of the in-school-youth were in January 2006 in order to assess knowledge, and level of aware of the existence of confidential HIV testing in their perception towards VCT among high school students. Vicinity and the proportion of youth that had VCT was below 10%.

In the same report nearly half of the youth Study area: The study was conducted in Butajira town, perceived themselves at low or no risk in spite of which is found in Southern Nations and Nationalities and engagement in multiple sexual partnerships. This Peoples Region, Gurage Zone which is located 130 km study was conducted to assess the perception and attitude away from Addis Ababa, Ethiopia. Butajira was selected of students towards VCT services using the Health Belief because of its logistical advantages and the existing Model (HBM). The HBM was originally developed in Butajira Rural Health Program that funded the study and USA by social psychologists in the 1950s (Abebe, 2010).

2.5.12 Number of Clients Requesting VCT Service

HIV/AIDS epidemic has been declared as a National disaster by the former president Benjamin .W. Mkapa in 2001 in Tanzania. Major of cause of the epidemic transmission is heterosexual intercourse, unsafe blood exchange, sharing sharp objects, transmission of virus from the mother to the infant during breast feeding and others. Due to problems it is causing, various efforts have been developed to reduce/curb the situation; VCT provision is among the strategies, which is believed to enhance early accesses to HIV/AIDS prevention as well as care and support services.

It also marks the commencement of a well synchronized behavioral change communication campaigns (KIWAKKUKI, 2004).

Recent studies indicate that, many young people in countries where HIV prevalence is high want to know their HIV status. Voluntary counseling and testing (VCT) services may be an appropriate entry point to address young people's HIV prevention and care needs. However, such services are limited and more research is needed to determine their impact. As countries try to implement or expand VCT services for young people, program planners face complex issues. They need to establish policies and bolster support services, develop adequate training for counselors who work with young people, make existing services youth-friendly, and address potential problems of stigma. Care and support services are needed for those young people who test positive, as well as those who test negative (Pathfinder, 2015).

Limited research is currently available on how VCT services affect young people, including the support they receive and how their behavior changes. However, research findings do address important related issues. These include the level of young people's demand for VCT services, the impact of VCT on their behavior, and programmatic challenges such as legal and ethical concerns, adequate counseling, and ongoing support (Pathfinder, 2015).

Tanzania is currently implementing a national HIV testing campaign that was inaugurated by His Excellency, President Jakaya Mrisho Kikwete on 14th July 2007. The President, other top government leaders, members of the community as well as people from the community of development partners took the test on the launching

day of the campaign. The inauguration was followed by campaigns all over the country to open new testing sites and to encourage people to go for VCT using the media and posters. By the end of December 2007, a total number of 3.2 million people had already undergone the testing. This is 78% of the targeted number of 4.2 Million people by the end of the year.

The number of VCT sites increased from 1,027 in 2006 to 1,981 by end November 2007. Voluntary Counseling and Testing (VCT) is the predominant approach in HIV testing in Tanzania Mainland. “Provider Initiated HIV Testing and Counseling” (PITC) is provided in the public health care facilities using the WHO developed package of interventions to reduce the burden of HIV among TB patients (TACAIDS, 2008).

2.6 Policy, Guidelines and Strategic Review

2.6.1 Health strategic Number Nine

HIV/AIDS as part of its strategy development process, the Ministry of Health Community Development Gender and Elderly and Children (MoHCDGEC) has developed a health sector HIV/AIDS strategy. Key achievements, constraints and future priorities identified in the strategy are summarized in the HIV/AIDS situational analysis under ten broad themes: epidemiological surveillance and social research; behavior change communications (Adolescents and other vulnerable populations); stigma and discrimination; STI prevention and control; blood safety; voluntary counseling and testing; PMTCT and other prevention programs; care and support for PLWA; home-based care and psychosocial support; and formulation of a Health Sector Strategy for HIV/AIDS/STI research coordination (TACAIDS, 2016).

2.6.1.1 Achievements

Tanzania has made some progress in the ten thematic areas discussed above. In summary: a solid surveillance system is now in place in NACP, guidelines for second-generation surveillance and protocols for ANC surveillance. ANC and behavioral surveillance (including youth) are underway in 6 regions. Overall awareness of HIV/AIDS in Tanzania is over 96%. Activities successfully focused on target populations including special programs for Adolescent Reproductive and Sexual Health (ARSH) through traditional, mass and innovative media in its BCC campaigns and in partnership with the private sector.

NACP has achieved good regional STI control coverage through a complex program that has included training service providers, procuring and distributing drugs, and IEC/BCC interventions for different target groups. For blood safety, achievements include an HIV/AIDS/STD laboratory at NACP, training of staff in all blood transfusing sites, provision of testing materials to hospitals, development of guidelines on appropriate use of blood and screening of blood in all hospitals. VCT centres were established in 170 facilities; over 200 counselors were trained; and NACP established strong partnerships with voluntary agencies involved in quality VCT service provision (TACAIDS, 2016).

PMTCT is in a pilot phase in five public facilities in Tanzania, and benefiting from intense research, resources and planning. Required guidelines, IEC materials, and training materials are being developed and pre-tested in preparation for dissemination nationwide. Two activities built a foundation for a future drug access initiative for PLWA: a situation analysis to examine capacity of the health system to take this on;

and development of guidelines for clinical management of HIV/AIDS. NACP established an organized home-based care model in the public sector and developed a training approach for district, health facility and community levels. Twenty-eight districts have HBC services; over 100 providers and trainers were trained as TOTs; and close to 200 voluntary agencies, NGOs and CBO's are providing HBC services (TACAIDS, 2016).

2.6.1.2 Constraints

Constraints in the ten thematic areas relate to human and financial resources, development of relevant policies; prioritizing HIV/AIDS activities in the area of accessible ARV's; and extending services deep into communities where they are needed through improved integration of HIV/AIDS/STI services. The absence of a robust drug and commodity procurement, storage and distribution system is an additional issue that cuts across thematic areas. Finally, government's activities to distribute widely and promote condoms, through public and private sector channels, periodically meet with some opposition. Specific constraints affecting individual thematic areas include the following. Cultural and societal pressures severely impact on the success of communication activities (that is gender, religion among others) (TACAIDS, 2016).

The legal environment makes it difficult to reach high-risk target populations with appropriate BCC messages (in particular sex workers). For STI control, problems include coverage; quality of STD care and management, reporting, issues with syphilis screening and availability of drugs. Human resources (increasing numbers of trained personnel including supervisors); supplies; strengthening of the national

quality assurance system; and accelerating the establishment of a National Blood Transfusion Service are key issues in blood safety. For VCT, additional issues related to poor quality of services, which results in poor client uptake. Stigma and poor male participation represent significant constraints to successful PMTCT programs, as does poor compliance by pregnant women (TACAIDS, 2016).

An overarching issue for PMTCT in Tanzania is the relatively low rate of hospital births. The constraints to establishment of a drug access program are significant: financial resources; human capacity; institutional capacity in facilities at national, regional and district levels; poor procurement, storage and distribution capacity for ARV's. For home-based care, there is insufficient support to HBC providers from hospitals and district health teams and inadequate community participation in HBC services (TACAIDS, 2016).

2.6.1.3 Way forward

Across the board, priorities for improved HIV/AIDS/STI services focus on human capacity development; improving drug and commodity logistics; integration into existing services; and formulation of required policies to allow Tanzania to unroll its PMTCT and treatment initiatives. The situation analysis strongly suggests the need to address stigma and discrimination as an integral element of any HIV/AIDS intervention. Specific priorities for different thematic areas follow. For surveillance, priorities are to expand ANC and behavioural surveillance to 12 regions in three years; integrate HIV/AIDS/STI surveillance in to existing system; and strengthen STD and AIDS surveillance through a sentinel surveillance system. For BCC, partnership between relevant government and private agencies will be needed to develop and

implement a comprehensive ARSH activity. Advocacy activities to reduce stigma and encourage providers to work with high-risk populations are also BCC priorities. For VCT, NACP's strategy is to gradually increase the number of sites providing quality VCT services while concurrently creating demand for VCT through communication programs (TACAIDS, 2016).

The priorities for the PMTCT program are to put in place all required systems for scale up (personnel; network of institutional and community counselors; systems for psychosocial support; client follow up; procurement, storage and distribution system; and PMTCT guidelines). Priorities for a drug access program are complex. They range from improving human capacity, improving diagnostic and monitoring capacity in medical facilities; improvement of the system for procuring, storing and distributing ARV's; to formulating a policy on ARV's. It is essential for the NACP to develop comprehensive worksite interventions for health sector staff. There is a need to address the Health sector infrastructure and the support services to cushion the big burden of HIV/AIDS on the hospital services. It is clear that the issues of employment of more human resources, their deployment, retention and incentives need to be urgently addressed if the services are to continue (NACP, 2016).

2.6.2 NACP: National Guideline for HIV Counseling and Testing for Clinical Setting, 2007

HIV testing in Tanzania is guided by a number of approaches as stipulated in the guideline for the operation of the VCT in Tanzania. The guideline presents a variety of approaches for the VCT operation in Tanzania, these include:

2.6.2.1 Client-Initiated Voluntary Counseling and Testing (VCT)

In this approach the client voluntarily makes the decision to learn his or her HIV status and seeks for counseling and testing services out of his or her own will for the purpose of prevention of HIV infection and personal life decision making. The National guidelines for VCT produced in 2005 by the MOHSW provide guidance specific for the delivery of VCT services in Tanzania.

2.6.2.2 Provider-Initiated HIV Testing and Counseling (PITC)

PITC refers to HIV testing and counseling which is recommended by health care providers to persons attending health care facilities as a standard component of medical care. The major purpose of such testing and counseling is to enable specific clinical decisions to be made and/or specific medical services to be offered that will not be possible without knowledge of the person's HIV status. In the case of persons presenting to health facilities with symptoms or signs of illness that could be attributable to HIV it is a basic responsibility of health care providers to recommend HIV testing and counseling as part of a patient's routine clinical management.

PITC also aims to identify unrecognized or unsuspected HIV infection in persons attending health facilities. Health care providers may therefore recommend HIV testing and counseling to patients in some settings even if they do not have obvious HIV-related symptoms or signs. Such patients may nevertheless have HIV and may benefit from knowing their HIV-positive status in order to receive specific preventive and/or therapeutic services. In such circumstances HIV testing and counseling is recommended by the health care provider as part of a package of services provided to all patients during all clinical interactions in a health facility (TACAIDS, 2016).

It is emphasized that, as in the case of client-initiated testing and counseling, PITC is voluntary and the three C's informed consent, counseling, and confidentiality must be observed. In PITC, persons retain the right to decline the HIV test without being denied any services to which they are entitled to at the health facility. HIV testing without consent may only be justified in the rare circumstances whereby a patient is unconscious and where knowledge of HIV status is necessary for purposes of optimal treatment. Resources and capacity constraints may require a phased implementation of PITC. The following should be considered priorities for the implementation of PITC in Tanzania.

- (i) Children and adults seeking In-patient and Out-patient services
- (ii) TB and STI patients
- (iii) Reproductive and child health services, including family planning
- (iv) Services for adolescents (TACAIDS, 2016).

2.6.2.3 HIV Testing for Medical Research and Surveillance

In Tanzania this is performed according to specific guidelines and regulations approved by the appropriate scientific and ethical review boards (TACAIDS, 2016).

2.6.2.4 Mandatory HIV Screening

This refers to routine screening for HIV and other blood borne viruses of all blood that is destined for transfusion or for manufacture of blood products. Routine screening of donors is required prior to any procedure involving transfer of bodily fluids or parts, such as artificial insemination, corneal grafts and organ transplant. In addition, mandatory testing does also refer to HIV testing for immigration purposes on a mandatory basis or for pre-recruitment and periodic medical assessment of military

personnel for the purposes of establishing fitness. Mandatory testing can also be ordered by court order.

Discussion of VCT, HIV testing for medical research and surveillance, HIV screening of blood, organ and semen donors, and mandatory HIV screening are outside the scope of the current guidelines for HIV testing and counseling in Tanzania (TACAIDS, 2016).

2.6.3 HIV Testing Technologies in Tanzania

Persons who become infected with HIV produce antibodies against the virus. Likewise, HIV antigens can be found in the blood of people infected with HIV. The following tests are available for detection of these antibodies and antigens:

2.6.3.1 HIV Rapid Tests

Rapid tests are recommended for PITC services because they are simple to perform, even in clinics without laboratories or specialized laboratory equipment and they provide results within 30 minutes. The results are as accurate as ELISA tests when Standard Operation Procedures (SOPs) are followed. Most rapid tests utilize whole blood, plasma or serum in running the test. Thus, venous blood or finger prick blood samples may be used. Although rapid tests are simple to perform and can be performed outside laboratory settings, staff training is required for proper performance of the test and interpretation of the test results. Efforts should be made to encourage use of capillary blood as it is simple to obtain, minimally invasive, and less frightening (TACAIDS, 2016).

2.6.3.2 Enzyme-Linked Immune Sorbent Assay (ELISA)

ELISA was the first test to be developed to detect HIV infection. The test requires qualified staff and specialized laboratory equipment and is suitable for batch testing in laboratories where large numbers of samples are tested. The testing takes 2 to 4 hours and results are usually not available on the same day of specimen collection since batches of samples need to be collected before running the test (TACAIDS, 2016).

2.6.3.3 HIV Antigen Tests

These tests include deoxyribonucleic acid (DNA) or ribonucleic acid (RNA) polymerase chain reaction (PCR) and p24 antigen tests. These assays are useful in the diagnosis of HIV infection in children less than 18 months of age. The tests require highly sophisticated laboratory equipment, qualified staff and dedicated space, which are currently not widely available and therefore making infant diagnosis a major challenge. Currently, infant diagnosis capacity exists at the consultants (Zonal) hospitals. Specimens for PCR will therefore be collected and transported to the nearest point where the testing capacity exists (TACAIDS, 2016).

The utility of antibody detection tests in the diagnosis of infection in children less than 18 months is limited by the fact that antibodies to HIV are passed over from infected mothers to their babies during pregnancy, delivery and breast-feeding and may persist in the baby's blood for up to 18 months after birth. Although the presence of antibodies in children less than 18 months does not confirm HIV infection, their presence indicate that the child has been exposed to HIV and may benefit from HIV prevention, care and support services until diagnosis is confirmed. Rapid tests or

ELISA can be used to detect the antibodies in these children to determine exposure to HIV (TACAIDS, 2016).

2.6.4 Window Period in HIV Testing

The ‘window period’ is the period from being infected with HIV to the time when the body has produced enough antibodies detectable by an HIV antibody test. This period varies but is usually between 6 weeks and 3 months. This means that a client who has just been infected may test negative because their body has not produced enough antibodies to be detected by the tests. Such a client can still transmit HIV to others. It is important to note that during this period an infected client is highly infectious hence it is crucial to emphasize preventive measures. For patients who test HIV negative and are strongly linked to risk behavior, but may be in the window period, the health care practitioner should recommend and encourage them to undertake a repeat test after 3 months (TACAIDS, 2016).

2.6.5 HIV Testing Algorithm in Tanzania

An essential requirement of all HIV testing is accuracy of the test results. HIV test kits used in the country are those that are recommended by the World Health Organization (WHO) and have been evaluated in the country before local use. A testing algorithm refers to the combination of tests and the sequence of use in HIV testing to provide maximum sensitivity and specificity. The selection of the testing algorithm is based on scientific evidence after evaluation of various HIV test kits. An HIV testing algorithm uses at least two tests to confirm positive results, which can be done either serially or in parallel (TACAIDS, 2016).

HIV testing in Tanzania is done according the national testing algorithm and is based on the serial testing strategy recommended by WHO. This strategy is economical since a second test is required only when the initial test is positive. With ‘serial testing’ a blood sample is taken and tested using the “first” test. If the result is negative the test result is given to the client as HIV negative. If the test result is positive the blood sample is tested using a “second”, different HIV test. If the second test is also positive, the result is given to the client as HIV positive. If the second test is negative, (first test is positive and second test is negative), a “third” test (also called a tie-breaker) is used. The final test result of the sample is determined by the result of the tie-breaker. In a situation where there is no tiebreaker for rapid testing, discordant samples should be referred to the laboratory for ELISA testing. Health care practitioners will be required to follow MOHSW guidelines on which test kits to use. These guidelines will be updated periodically, and will be disseminated to all facilities providing HIV testing services including PITC clinical settings (TACAIDS, 2016).

2.6.6 Ethical and Legal Considerations

2.6.6.1 Human Rights

The most basic human right principle requires that every person has a right to know his or her HIV status. In Tanzania PITC services are provided in an environment where human rights are observed and respected. The human rights principles most relevant to PITC, and which every service provider and patient should ensure that they are observed include:

- (i) The right to informed consent before a medical procedure is carried out
- (ii) The right to information for making choices about one’s health and well being.

- (iii) The right to education
- (iv) The right to privacy
- (v) The right to non-discrimination, equal protection and equality before the law
- (vi) The right to marry and found a family
- (vii) The right to the highest attainable standard of physical and mental health

In Tanzania, all health care practitioners are bound by ethical principles to do all that is necessary and available to provide the best possible care and follow-up to any person. Therefore an HIV test must be provided when consented to, or indicated in accordance with the “3Cs” principles of confidentiality, counseling and informed consent which includes voluntarism. Timely referral for follow up, medical care and psychological support must be ensured (TACAIDS, 2016).

2.6.6.2 Stigma and Discrimination

In the context of HIV and AIDS, stigma and discrimination refer to actions taken against individuals solely on the basis of their HIV status. PITC is an approach aimed at scaling up HIV testing and counseling services in clinical settings so that more people will know their HIV status. It has been shown that programs that allow more people to know their HIV status may reduce stigma and discrimination and foster normalization of HIV testing (TACAIDS, 2016).

2.6.6.3 Informed Consent

The term “informed consent” refers to a person being given an opportunity to consider the benefits and potential implications associated with having access to information regarding their HIV sero-status, an understanding of the testing procedure, and then making the decision to be tested for HIV. A person should be able to consider the

implications of a negative or positive HIV test result on their personal and professional lives (TACAIDS, 2016).

The actual process of obtaining informed consent can be adapted to suit the different settings under which PITC services will be implemented. Although the process of obtaining informed consent will vary according to different settings, all patients should receive sufficient information and should be helped to reach an adequate understanding of what is involved. The three crucial elements in obtaining truly informed consent of HIV testing are providing pre-test information on the purpose of testing; treatment and support available; and ensuring the person's understanding of these messages and respecting the person's autonomy. Only when these elements are in place will patients be able to make a fully informed decision on whether or not to be tested. Documentation of informed consent must be consistent with that of other non-invasive medical investigations. Therefore, verbal consent for PITC is adequate, and therefore written consent will not be required in clinical settings (TACAIDS, 2016).

2.6.7 Legal Issues Relating to Informed Consent

2.6.7.1 Minimum Age for HIV Testing

PITC of children and adolescents below 16 years of age shall be carried out with the consent of parents or legal guardians, and when the health care practitioner has determined and is satisfied that testing is in the best interest of the child. Adolescents aged 16 years and above may consent for PITC themselves. Also adolescents who are married, have children, or are sexually active shall be categorised as “mature minors”

and permitted unrestricted access to PITC services irrespective of their age (TACAIDS, 2016).

2.6.7.2 PITC for Children

The welfare of the child must be the primary concern when considering testing a child for HIV. Counseling should be provided to both the child and the parent or guardian and consent for testing must be obtained from the parent or guardian. In the event where the parents or legal guardians refuse to consent and there is obvious clinical evidence suggestive of HIV infection in the child, the health care practitioner should proceed to test the child, give the results to parents or legal guardians, and seek the support of the department of social welfare (TACAIDS, 2016).

2.6.7.3 National PITC Guidelines 19

In PMTCT programs, HIV testing for babies who have been exposed to HIV must be routinely recommended through the parents or legal guardians according to the National Guidelines on PMTCT Services.

2.6.7.4 Testing of Mentally Challenged Persons

The welfare of persons who are mentally challenged should be the primary concern of health care practitioners when PITC services are to be provided. The service can be provided after obtaining consent from the parent or legal guardian in deserving cases, and only if it is in the best interest of the patient. PITC services must not be provided to clients who cannot give true informed consent for HIV testing because they are under the influence of alcohol or illicit drugs. The service should be withheld until they have recovered (TACAIDS, 2016).

2.6.7.5 Confidentiality

Confidentiality is one of the guiding principles for provision of HIV testing and counseling services and must be protected. HIV test results shall be confidential, provided only to the person who has been tested. Any health care practitioner who breaches confidentiality acts contrary to the professional code of conduct and may be subjected to legal action.

2.6.7.6 Confidential Record Keeping

All medical records, including those with HIV-related information, must be managed in accordance with the stipulated standards of confidentiality in the health care facility. Only persons with a direct role in the management of the patient should have access to these records.

2.6.7.7 Shared Confidentiality

Shared confidentiality is when a person utilizing a PITC service wishes to involve significant others in the HIV testing and counseling process, including receiving the HIV test result. In clinical settings, shared confidentiality shall involve also the patient and relevant health care practitioners directly involved in providing care. Shared confidentiality can also apply to the disclosure of information from an individual to family member and friends. Health care practitioners should educate persons on the importance of disclosure of their HIV status and encourage them to do so.

2.6.7.8 National PITC Guidelines 20

(a) Written Results

Health facilities providing PITC services should record HIV test results in all medical records. HIV testing result certificates should not be provided to any person because

this may compromise confidentiality, and may lead to misuse of the results. When an HIV positive patient is being referred, the referral documents must state all essential information, including the HIV test result. The procedure of referral and continuity of care must be clearly laid down for those who are HIV positive. The health care practitioner must ensure that the person understands the referral process and the importance of keeping personal medical records and presenting these at the referral site (TACAIDS, 2016).

(b) Partner Notification

All persons, both HIV positive and HIV negative, should be encouraged to inform their partner(s) about their HIV test results. HIV positive persons that are reluctant or fearful to disclose their results must be referred for additional, ongoing more in-depth counseling to help them inform their partner(s). In the interest of public health, a health care practitioner may inform the partner(s) of the HIV test results in the presence of the person tested. Inability to disclose positive test results to a partner can result in the onward transmission of HIV. Therefore, in the few cases in which a properly counseled HIV-positive person refuses to disclose to a partner, the health care provider should be able to counsel and inform the respective partner, without the consent of the source person, provided there has been an ethical weighing of the potential harm involved, and appropriate steps have been taken (TACAIDS, 2016).

(c) Occupational Exposure

Health care practitioners who become accidentally exposed to HIV in the course of providing care should follow appropriate steps as described in the MOH infection prevention guidelines and should have access to PEP and be appropriately supported

by the employer. It is the responsibility of each employer to ensure that PEP services are available and appropriately used at the workplace (TACAIDS, 2016).

(d) Stigma and Discrimination Reduction

(i) Magnitude of Stigma and Discrimination in Tanzania

Many studies and surveys in Tanzania indicate that quite a few Tanzanians increasingly desire to be tested for HIV. Many of them however remain hesitant to fulfill their desires due to various reasons including lack of testing facilities, fears and uncertainty on what to do with the results, as so far there is no cure for HIV/AIDS. But the most significant obstacle is stigma. In a study conducted in Dar es Salaam by NACP in 2000 (Fimbo et al, 2000), for the needs assessment on voluntary counseling and testing (VCT) services, 570 respondents were interviewed and 396 (69.5%) of them were willing to utilize the VCT services.

However, 17.4% of those willing to use these services expected to be stigmatized against if their sero-status was disclosed. For those who were not willing to use these services, 77.6% of them indicated that stigma was the major obstacle of using these services. 76% of the respondents indicated or believed that they will be discriminated by very close family members and colleagues. Only 20% of them believed there would be no discrimination at all, the success of many of the HIV/AIDS interventions for prevention or care and support will largely depend on whether stigma has been addressed (Fimbo, 2000).

Ignoring stigma will be suicidal to any undertaking in HIV/AIDS. The services being established are under-utilized because of stigma. HIV prevalence and incidences are still high because stigma is wide spread. Any intervention cannot work as many

people still fear of discrimination and outright rejection from services and certain rights. Therefore, it is the aim of the guideline to define stigma and discrimination, describe the sources of stigma and discrimination and discuss stigma and discrimination at different levels.

2.7 Conceptual Framework

The conceptual Framework for this study describes VCT services as a process that starts with a decision for testing and counselling. This decision is influenced by a number of factors like knowledge about significances for testing and counselling, availability of the VCT sites, the post testing situation of the client and care and support of the positive clients. If clients reach a positive valuation of the counselling and testing they seek for the service.

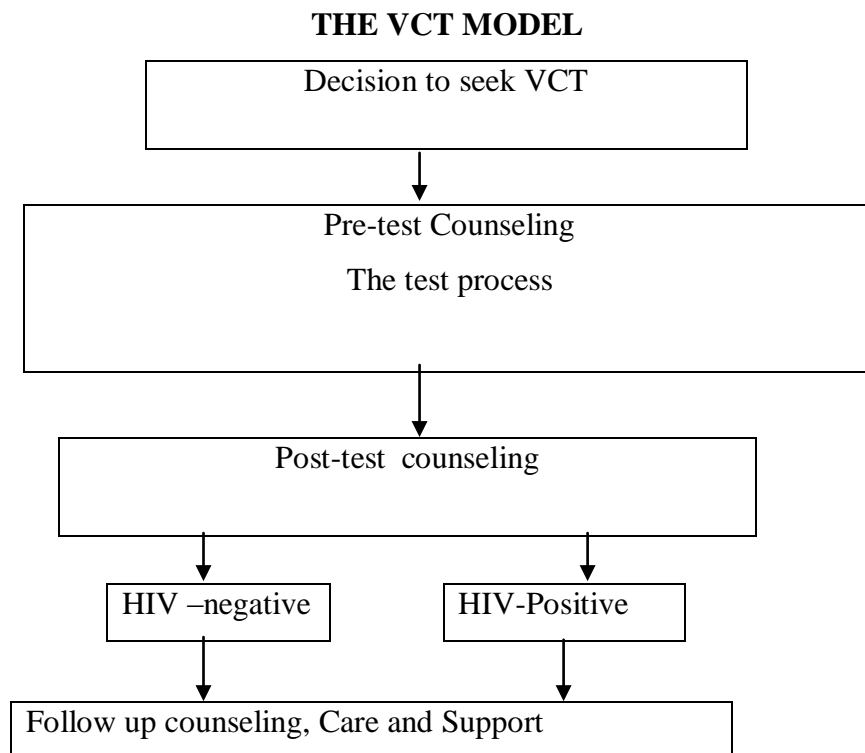


Figure 2.4: Conceptual Framework

Source: A conceptual Framework adopted and modified from (Horizons, 2002)

The process is followed by a Pre-testing counselling and then a withdrawal of blood by clients follows for testing. After testing, a post testing counselling is offered to both positive and the negative clients. The process ends with a follow up counselling and support for both positive and negative clients. The process is guided by a friendly relationship between service providers and the clients.

2.7.1 Dependant Variable

Voluntary Counseling and testing uptake

2.7.2 Independent Variable

- (i) Individual factors like age, religion, sex, education level, occupation, level of awareness, peer pressure.
- (ii) Community factors as perceived by the youth like cultural beliefs, Stigma and fear of taking an HIV test.
- (iii) 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 and specific working days.

2.8 Research Gap

Though studies on VCT especially as strategy for behavioural change and a mechanism for care and support of positive clients are active and diverse, there limited efforts to examine perceptions of youths towards VCT services. Again, from the literatures surveyed, the researcher found that studies to examine the opportunities and challenges for offering VCT services for youths have a limited attention and as

result youth's perceptions and attitudes of the VCT services have not been explored and therefore to increase their uptake to VCT sites have found been signifying to challenging.

For example, (Horizon, 2002) conducted a research study wanted to find out if the VCT programs are appropriate for young people, who account for the majority of all new HIV infections in East and Southern Africa. Thus, they conducted exploratory research to identify opportunities for and barriers to providing VCT for youth. They found out that, youth would like access to HIV testing and counseling services if the services are confidential and inexpensive and if the results are reported honestly (Horizon, 2001) However, the study did not disclose the perception of youths regarding the service. This study therefore examined the perceptions and practices of youths towards VCT uptake services in Kinondoni Municipality to fill this gap.

CHAPTER THREE

RESEARCH METHODS AND PROCEDURES

3.1 Introduction

This chapter explains the overall methods and techniques used in conducting the research. According to Kothari (2004:34), research methodology is a way to systematically solve the research problem. It may be understood as the science of studying how research is done scientifically. This chapter presents the research design, study area, sampling techniques, research instruments, and data collection procedure and data analysis.

3.2 Description of the Study Area

This study was conducted at Kimara ward, in Kinondoni Municipality, Dar es Salaam. The Kinondoni Municipality was thought to meet the objectives of the study due to the fact that the area was ranked the first affected area with HIV/AIDS in Dar es Salaam region (NACP, 2003).

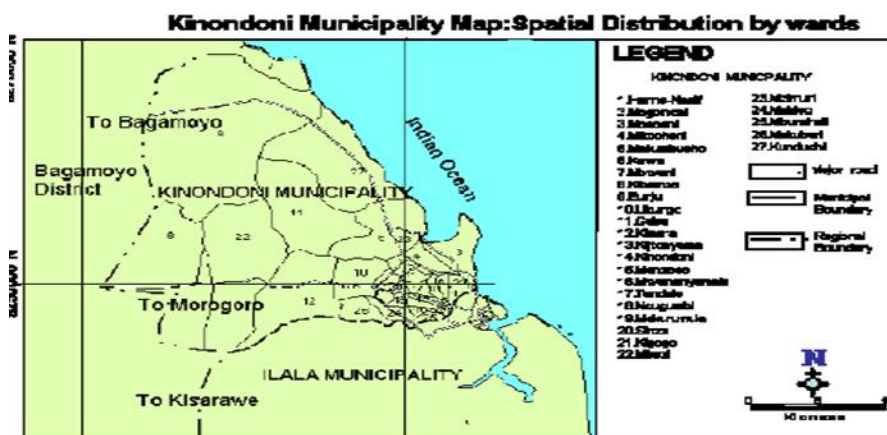


Figure 3.1: A map of Kinondoni Municipality

Source: Dar es Salaam Profile (2009)

Again, in Dar es Salaam the prevalence of HIV/AIDS was 11% and ranked the third after Mbeya and Iringa, therefore the region was sufficient to meet the objectives of the study. With this state, there are a number of VCT sites and Peer Educators, which were thought relevant to reveal the information on the objectives of the study (ibid).

3.2.2 Population Density

According to the 2002 population census, the Kinondoni Municipality has a population of 1,088,867 people, which includes 549,929 males; and 538,938 females with a growth rate of 4.1% per annum.

Table 3.1: Population of Kinondoni Municipality by ward

o		Population (Number)				Household	
		Type	Male	Female	Total	Number	Average/Size
	District Total		549,929	538,938	1,088,867	260,269	4.2
1.	Magomeni	Urban	11,448	11,128	22,616	5,609	4.0
2.	Makurumla	Urban	27,493	26,301	53,794	13,623	3.9
3.	Ndugumbi	Urban	18,679	18,750	37,429	9,351	4.0
4.	Tandale	Urban	23,588	12,470	45,058	11,875	3.8
5.	Mwananyamala	Urban	21,946	22,585	44,531	10,643	4.2
6.	Msasani	Urban	21,792	21,573	43,457	10,134	4.3
7.	Kinondoni	Urban	10,628	10,861	21,489	5,132	4.2
8.	Mzimuni	Urban	12,710	12,573	25,283	6,024	4.2
9.	Kigogo	Urban	19,282	18,682	37,964	9,064	4.2
10.	Mabibo	Urban	37,477	36,501	73,978	18,137	4.1
11.	Manzese	Urban	34,389	32,477	66,866	17,685	3.8
12.	Ubungu	Urban	22,014	22,325	44,339	10,070	4.4
13.	Kibamba	Mixed	9,164	8,834	17,998	4,219	4.3
14.	Goba	Rural	4,473	4,044	8,517	2,198	3.9
15.	Kawe	Urban	48,058	46,477	94,535	21,487	4.4
16.	Kunduchi	Mixed	38,251	34,676	72,927	16,885	4.3
17.	Mbweni	Rural	1,865	1,610	3,475	671	4.0
18.	Bunju	Mixed	10,668	10,200	20,858	5,344	3.9
19.	Makuburi	Urban	17,341	17,292	34,633	7,871	4.4
20.	Mburahati	Urban	10,882	10,726	21,608	5,242	4.1
21.	Makumbusho	Urban	28,296	27,043	55,702	14,261	3.9
22.	Sinza	Urban	17,031	19,438	36,469	7,841	4.7
23.	Kijitonyama	Urban	23,053	24,043	47,096	10,624	3.9
24.	Kimara	Urban	33,053	33,235	66,288	14,328	4.6
25.	Mikocheni	Urban	13,711	13,572	27,283	6,200	4.4
26.	Mbezi	Mixed	16,584	16,057	32,641	7,290	4.5
27.	Hananasif	Urban	16,040	15,983	32,023	8,231	3.9

Source: Kinondoni MC Profile (2014)

Therefore, it is estimated that, Kinondoni Municipal Council has a total population of 1,306,115, in the year 2007 with 624,872 female populations while 636,802 are males. The average household size is 4.1. The population density is 2,825 persons per square km influenced by natural causes and migration (birth rate and net migration rates respectively) (Kinondoni Municipal Strategic plan, 2007/2010). The migrants are usually upcountry migrants seeking for employment opportunities in the city. Kimara ward had a population of 66,288 (Table 3.1)

3.2.3 Economic Activities

Employment and economic activities. It is estimated that 360,000 residents of Kinondoni Municipality are employed in both private and public sectors. Out of these, 95% are employed in the private sector while the 5% are employed in the public sector. A working force of 200,000 people is self-employed. The majority of the resident's working force is engaged in subsistence agriculture in the peri-urban areas. There are no big farms but only small plots ranging from 2.5 acre to 6 acres (Kinondoni Municipal Strategic Plan, 2007/2010).

3.3 Types of Data

The study employed both the primary and secondary data.

3.3.1 Secondary Data

The secondary data for this data were gathered by the researcher from a number of written materials such books, journals, pamphlets and ward and hamlet reports from a number of libraries and institutions both governments owned and from the non government institutions. The Open University of Tanzania, The Institute of Social

Work, University of Dar es Salaam, Tanganyika libraries and the ministry of Social affairs were visited by the researcher.

3.3.2 Primary Data

These were data that were collected by the researcher himself in the field. Data were collected at Kimara ward. The collected data were about the levels of knowledge on VCT among youth aged 15 to 24 years old at Kimara ward-Kinondoni Municipality, the level of uptake of VCT services among youth service as a means of protecting themselves against HIV/AIDS and the youths perceptions on VCT uptake services at Kimara Ward targeting young men and women aged 15-24 years.

3.4 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.

The study employed both the quantitative and qualitative study design. The use of both quantitative and qualitative design was important for the study because of the need for the two techniques to compliment and supplement each other. This study adopted a descriptive research design. 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.

In quantitative approach, a convenience sample of young people aged 15–24 were selected whereby structured interview were administered to both those who had taken an HIV test and untested youth. To complement the quantitative data, a qualitative approach was used whereby focus group discussions and in-depth interviews were employed to youth.

3.5 Research Methodology

This chapter explains the overall methods and techniques used in conducting the research. According to Kothari (2004:34), research methodology is a way to systematically solve the research problem. It may be understood as the science of studying how research is done scientifically. It presents the research design, study area, sampling techniques, research instruments, and data collection procedure and data analysis.

3.5.1 Data Collection Techniques

A number of techniques were employed in the study for the collection of data.

3.5.2 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).

Structured interviews were held with the youth at VCT sites, youth centres and streets. This technique was employed to capture information to determine the level of knowledge and understanding of the youths aged between 15 and 24 years at Kimara Ward and the uptake of VCT in the study area which were objectives number one and two for the study. A structured interview has an advantage that questions are asked by the researcher to respondents are the same at different times and these questions are in a written form and systematically ordered (Kothari, 2004). This technique was guided by the interview guide questions which were prepared and pre-tested in advance.

2.5.3 Unstructured Interview

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).

Unstructured interviews were held with different youths who attended the VCT centres on their perceptions and practices towards the VCT up take services which were objective number three for the study.

The researcher himself sat together and conducted exit interviews with youths who came from the service promptly. Also, youths were found in different youth camps and stations. With this technique, questions were asked to respondents by the researcher himself and youths provided responses. This technique was thought advantageous for the study because it offered a room to respond to situations and questions arising in due course of the interview and interviews are dynamic (Kothari, 2004).

3.5.4 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). These were respondent administered questionnaires where respondents filled in their responses in the questionnaire and the researcher collected them. This technique was employed to capture information on the uptake of VCT and determine the perceptions of youths towards the services. Questionnaires are employed because of an advantage that they save time and resources giving a room of collecting a lot of information at a time (Kothari, 2004).

Questionnaires are the written questions, which carry the objectives of the study. The questions formed in the questionnaires helped the researcher to get other information

that a respondents may not feel comfortable answering the through interview method. Also, Kombo and Tromp (2006) contend that, in questionnaire respondents answer questions in written way and researcher collects data from the completed forms. For ethical considerations, questionnaires were pre-tested in the pilot areas before actual field collection to ensure their validity and reliability for the study and respondents.

3.5.5 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).

FGDs were also employed in the study to obtain information on the perceptions of youths towards the VCT uptake and their level of awareness and understanding of the VCT uptake at Kimara Ward. Two Groups with 6 Youth members aged between 15-24 were formed on the basis of their sex. One group was formed at Kimara Peer Educator for the youths who came for VCT services and another group was formed at Friends of Don Bosco Centre whereby a researcher sat together with the respondents and facilitated the discussions together with the recording of the responses from the youths. FGDs have an advantage that they enable a collection of a lot of information at a time (Kothari, 2004).

3.5.6 Observation

An overview of the VCT site visit it was observed on the study that Youths visited VCT centers that are located on the other street rather than VCT on their own street, also with more friendly information (i.e. Leaflets, outdoor banners/posters etc.) that address STIs and general peer reproductive health.

3.6 Reliability and Validity of the Instruments

3.6.1 Reliability

Reliability of an instrument is the consistency with which an instrument measures an attribute is supposed to measure and whether the same techniques if applied at different times to different people will yield similar results (Babbie, 2001: 140). An instrument is said to be reliable if its measures accurately reflects the true score of the attribute under investigation or Reliability is the measure of an instrument consistency (Polit and Hungler, 1999: 653) and the reliability of an instrument can be assessed through measuring the stability, internal consistency and the equivalent of the instruments. To attain the pre-retest reliability of an instrument, instruments were pre-tested in the pilot areas. Interview schedules were also pre-tested to determine the relevance of the questionnaires in terms of language and time.

3.6.2 Validity

It is the degree to which an instrument measures what is supposed to be measuring. It is the extent to which an empirical measure adequately reflects the real meaning of the concept under investigation (Babbie, 2001: 142). The methods for validating the research instruments include; criterion related validity, construct validity and content validity. In this study, the method employed to attain the validity was the examination

of different variables to different respondents with different age, sex and education levels.

3.7 Ethical Considerations

The research ethics as stipulated by Struwing and Stead (2001) were adhered by this study. These ethics included consent, confidentiality, anonymity, privacy, dissemination of information, withdrawal from the study, trustworthiness, reliability and validity. In this case, both interviews and discussions, respondents were asked of their consent and willingness to participate in the study, information was only used for the objectives of the study and was confidential.

3.8 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.

3.8.1 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. Churchill 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

purposive was employed to select respondents to be involved in the study. The selection of the respondents with technique was attributed with the low number of youths who attend the VCT services. Therefore, for the study to find a sufficient number of respondents to meet the objectives of the study, purposive sampling was thought important.

3.8.2 Simple 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. Simple random technique was employed to select a ward of study of different wards found in Kinondoni municipality. All the wards in Kinondoni Municipality were given a number and table of random number was employed to select a single ward for the study. The selected ward of study picked randomly was Kimara ward.

3.8.3 Selection of the Study Area

The study had two study units that were involved in data collection. The first study unit was youths who went for the VCT services were interviewed by the researcher. Another study unit for this study was the found on Youth centers and streets with this youths found at these areas were interviewed.

3.8.3.1 Sample Size

Sample size is the number of observations in a sample (Evans *et al.* 2000). It is commonly denoted. According to Cohen et al (2000), the knowledge gained from the sample is representative of the population under study. A total number of a hundred

(100) respondents were involved in the study, comprised of forty (40) youth found at VCT sites, thirty (30) from youth's centers/educational Institutions and Thirty (30) responds from streets with regarding of gender sensitivity. The cluster sampling technique was employed to divide the population in two categories. 40% of the respondents were males and 60% of the respondents were females (Table 3.2).

Table 3.2: Sample size

Responds	VCT Sites	Youths Centres/Gathering	Streets	Male %	Female %
No	40	30	30	40	60

Source: Research Findings, 2016

3.8.4 Desk Research

Desk research method of collecting data is the process that confers to the reviewing and assessing already gathered data and procedures that concern the subject at study (Kothari, 2004). It was carried throughout the study, but mostly during the first stages of proposal writing. Various important documents from the library (general) and VCT centres exit clients reports were reviewed to analyse their activities. The importance of desk research is that, it helped the researcher to prepare research conceptual and empirically analysis before going to the field to gather fresh data valuable to the study. Elsewhere, desk research helped to assess data obtained from the field.

3.9 Data Processing and Analysis

3.9.1 Data Analysis

Both the qualitative (Content analysis) and the quantitative measures for data analysis were employed for the manipulation of the raw data from the field to obtain meaningful information. Analysis of the both data was done through computer

software known as the Statistical Package for Social Sciences (SPSS) Version 16. Initially, data were coded, refined and later analyzed. Analysis was done delivering the simple distribution of the responses and the multiple responses for the study. Analysis of the data also ensured that data were cross tabulated for easy comparison of the responses.

For qualitative data, the use of tape recordings and field notes which were transcribed in verbatim and analyzed using descriptive approach according to themes was employed. All the information obtained through the questionnaire were analyzed and crosschecked for errors, and then they were coded manually. Then the information was interpreted with the support of psychological concepts.

3.9.2 Data presentation

Data were presented by using tables, charts, models and pictures. Data presentation include findings, in quantitative in percentages and qualitative forms. Using statistical tools and conceptual underpins of the problems.

CHAPTER FOUR

RESEARCH FINDINGS AND PRESENTATION

4.1 Introduction

This chapter is concerned with presentation and interpretation as well as discussion and analysis of data as they were collected from the respondent, through self-administering questionnaire that were prepared, distributed to them. The presentation is based on the research finding and how the responses per respondents were so as to come up with what was intended, it involved processing of data, and where by editing coding and classification of the data was the basic concern of the researcher. The presentation was focused on giving out social demographic characteristics of the respondents, their responses to the questionnaire which are presented in the frequencies and percentages in tables, graphs, and charts that are complemented by qualitative information.

The findings were obtained through different data collection techniques including interviews to youths individually and administered questionnaires to some to the VCT Centres, youth gatherings and youth camps members. Part of these findings were obtained qualitatively but presented quantitatively; others remain in their form (qualitatively or quantitatively during presentation). Data presented in this chapter were obtained from various areas so as to avoid bias; documentary reviews were also used to assist interview sessions.

4.2 Social Demographic Characteristics of the Respondents

4.2.1 Educational Level of Respondents

Educational level for the respondents was seen to be important for the study because of the influence it plays upon the decision for youths to visit VCT sites and it

determines the extent to which these youths would protect themselves from HIV/AIDS pandemic. For this study 40% of the respondents were Higher learning level, 40% of the respondents were high school students, 10% were primary school holders and the other 10% were Secondary school holders (Table 4.1). It can therefore be observed from the data that, percentages of the respondents were deliberately made in order to make judgment of who are majority visitants of the VCT sites as per educational level.

Table 4.1: Distribution of Total Respondents per sex and Education Level

Categories		Total Respondents
Higher Learning	40	40%
High School	40	40%
Secondary School	10	10%
Primary School	10	10%
Total		100%

Source: Research Findings (2016)

4.2.2 Age and Sex of Respondents

The study revealed that, 60% of the respondents were females and 40% of the respondents were males (Table 4.2). This was attributed with the fact that majority of the visitants of the VCT sites are females as compared to males. Young women have habits to visit health centers for frequent cross checking of their health status. In terms of age, majority of respondents had age ranged from 16 to 19 years old (Table 4.2). This is due to the fact that the study focused on the youths aged between 15 and 24 years old.

Table 4.2: Distribution of Respondents by Age and Sex

Age Group	Male	Female
14	1(1%)	2(2%)
15	4(4%)	5(5%)
16	3(3%)	8(8%)
17	4(4%)	6(6%)
18	6(6%)	3(3%)
19	7(7%)	10(10%)
20	2(2%)	7(7%)
21	5(5%)	9(9%)
22	5(5%)	4(4%)
23	1(1%)	4(4%)
24	24(24%)	2(2%)
TOTAL	40	60

Source: Research Findings (2016)

4.2.3 Primary Health and Social Welfare Services Engaged in the Study

A content analysis for this study revealed that, majority of NGOs/FBOs and health facilities perform VCT services, peer education, advocacy, guidance and counseling, legal assistance, information and referral system. These were Kimara Peer Educator (KPE), Bochi Hospital, Kimara Dispensary-VCT, Friends of Don Bosco. Others such as St. Groly and KAM Health College provide educational and training services.

**Figure 4.1: KAM College of Health at Kimara Baruti**

Source: Research Findings (2016)



Figure 4.2: Friends of Don Bosco at Kimara Suka

Source: Research Findings (2016)



Figure 4.3: Kimara Peer Educators (KPE) at Kimara Kilungule

Source: Research Findings (2016)

4.3 Awareness of VCT Services of the Respondents

The study revealed that, 67% of the respondents were aware of the HIV/AIDS campaigns and only 33% were not aware of the campaigns (Table 4.3). Respondents were aware of the campaigns because of the number of initiatives that are taken by the government to deal with the pandemic because of the awareness youths have, there still efforts needed to encourage them to test and counsel. The study found that, though youths were aware of the campaign for HIV testing and available VCT, majority don't go for it.

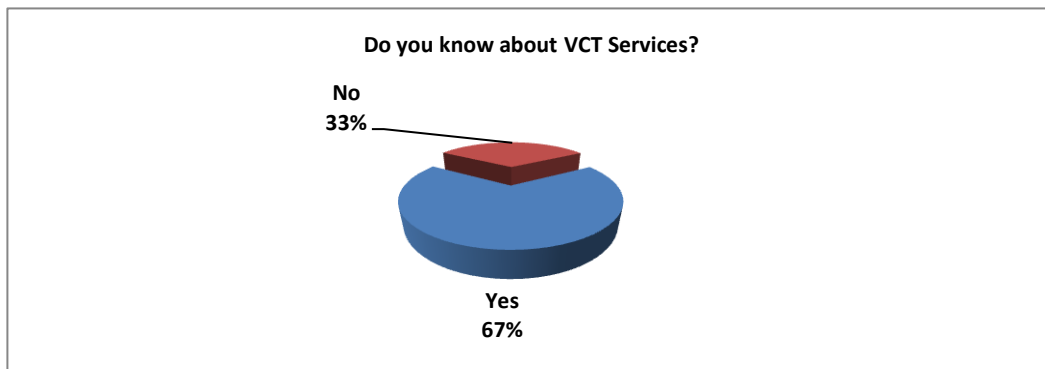


Figure 4.4: Awareness of VCT of the Respondents

Source: Research Findings (2016)

4.4 Respondents' Source of Information about HIV/AIDS

The study revealed that, 80% of the respondents had their source of knowledge about HIV/AIDS through Television, and only 10% of the respondents knew through radio and 10% from Newspaper (Figure 4.4). This study is similar to other studies in the academic arena (Horizon, 2002), have observed that people's awareness of the efforts to deal with HIV/AIDS pandemic is increasing. A study conducted in Zanzibar Isles shows a major sources of information for Youths about VCT services was relying on radio 37/100 (37%)

“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” (Kasim, 2015).

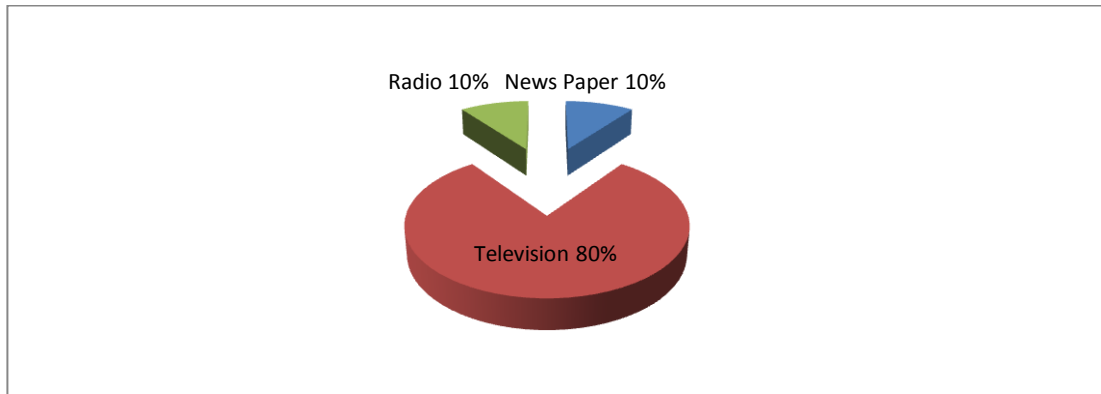


Figure 4.5: Source of Information of Respondents about HIV/AIDS

Source: Research Findings (2016)

4.5 Respondents’ Opinions towards VCT Sites

It was imperative for the study to examine whether respondents had sufficient information about VCT services. The researcher intended to seek out about their opinions if they think they have got enough. The study found that, sixty two percent of the respondents; (62%) said that they had sufficient information about the VCT services and (32%) of the respondents said that they had no enough information. Only six (6%) percent of the respondents said they don’t know (Figure 4.5). It can therefore be spotted from the data that majority of the respondents have information of the VCT services and this is attributed with the fact that these services are integrated in the daily health services. Therefore, their low attendance for the service can to a small level be explained of lack of information though greatly is not a case.

Again this study does not diverge from many other studies in Africa and Tanzania in particular, (NACP, 2006). 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).

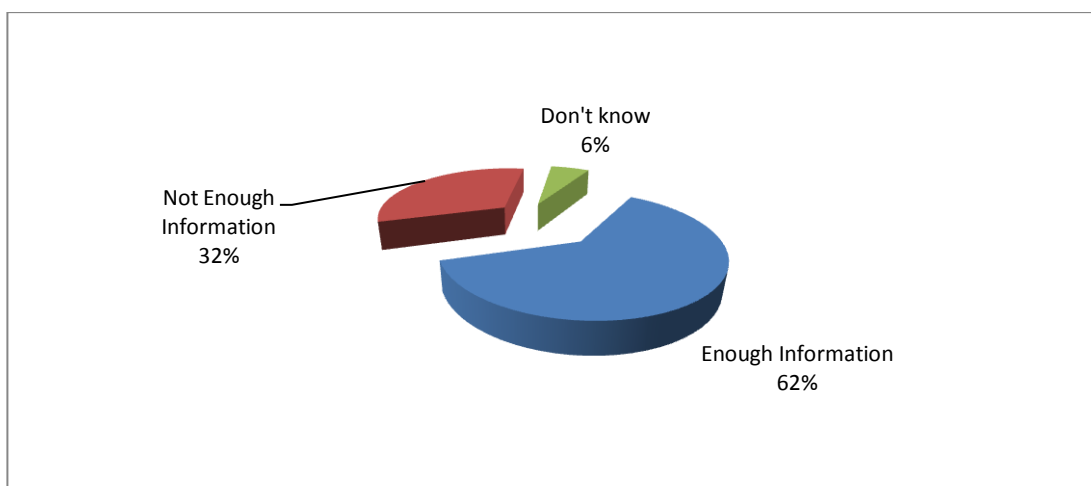


Figure 4.6: Respondents' Opinions in towards VCT

Source: Research Findings (2016)

4.6 Respondents' who Ever Tested Since the Campaign of HIV Voluntary Testing Started

The researcher wanted to find out from the youth's opinions if they ever volunteered to be tested for the HIV status since the inception of campaign for VCT in Tanzania. This is important because it determines the kind of perception and practices towards VCT services. It was revealed by the study that, only 33% of the respondents that

tested for HIV since the HIV campaign started and 50 % of the respondents revealed that, they did not test for HIV/AIDS since the campaign started while 17% did not reveal their status.

Similar study showed that 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, 2011).

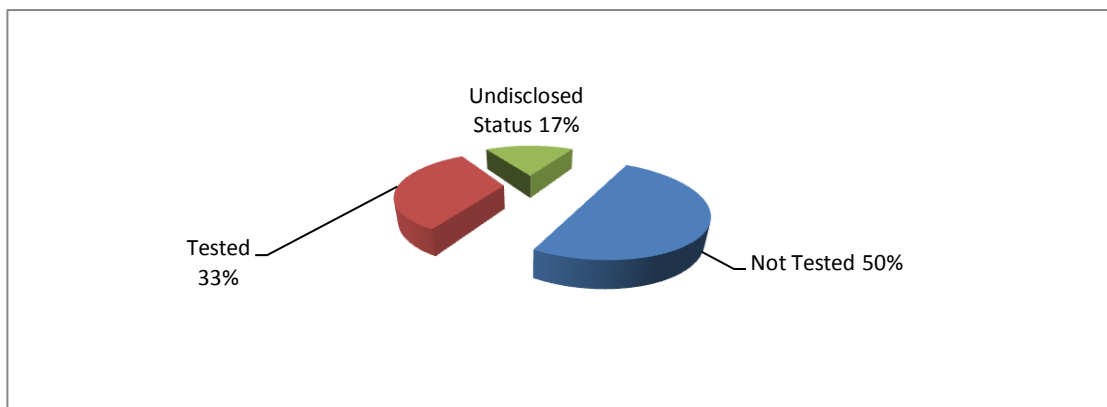


Figure 4.7: Respondents' Findings (2016)

Source: Research Findings (2016)

4.7 Reasons for Respondents' Not Attending VCT Service

The rate of increase among people testing is very gradual. It can therefore be observed from the data that majority of the youths though they have sufficient information of where to test and counsel, they don't go for it. It was found by the study that majority of the youths are hesitant of the results and they are afraid of the stigma after positive results. 66% said they are afraid or fear of the results, 26% said time is not yet, only 4% did not know what to do (Table 4.8).

To support the findings of this study, Swai (2005) declares that, though a number of people who go for VCT services is increasing, there are still challenges with the pace. This therefore calls for deliberate measures to be taken to address stigmatization for positive clients and also encourage youths to test and counsel.

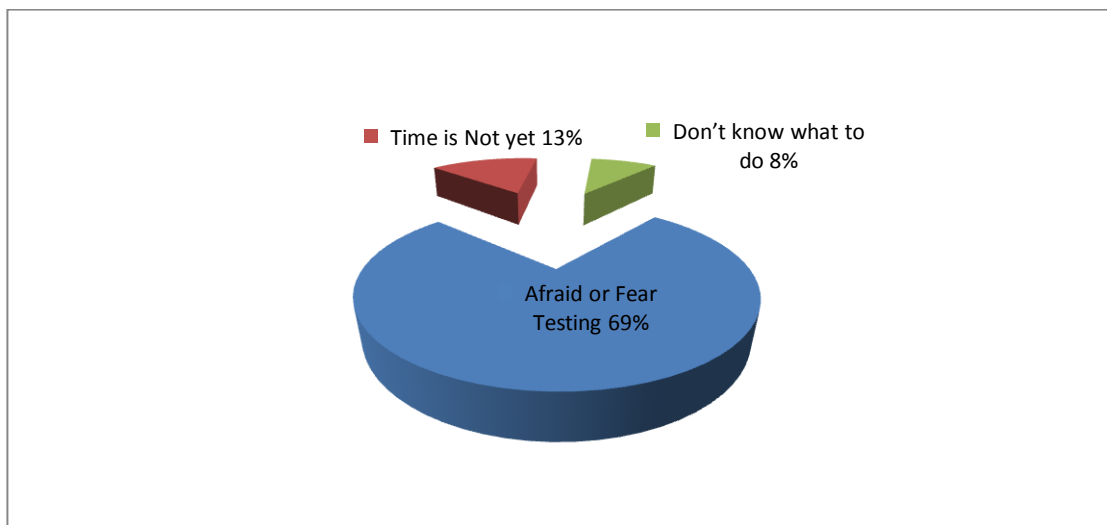


Figure 4.8: Reasons for Respondents' not Attending VCT

Source: Research Findings (2016)

4.8 Respondents Ever Advised Other Youths to go for VCT

An effort to examine the youths' perceptions and practices towards VCT services obliged the researcher to explore whether respondents had ever advised other people to go for VCT. This was seen imperative for the study because of the fact that if youths had positive value and perceptions towards VCT, they would have taken initiatives to encourage others to go for it with fact that youths are likely to have more good trust to their respective peer youth mates than non-youths.

It was found by the study that, only 20% of the respondents ever advised other fellow youths to go for VCT services regardless of whether they had tested or not tested, the

rest that is 80% of respondents said they had never volunteered to advice others. It can therefore be observed from the data that, majority had not taken efforts to encourage others to go for VCT services (Figure 4.8). This again is another, which calls for deliberate interventions to build a mindset of youths being ambassadors for others if efforts to deal with HIV/AIDS have to be sustained.

Other studies have shown that 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 newsexual relationships (Kassim, 2015). 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)” (Kassim, 2015).

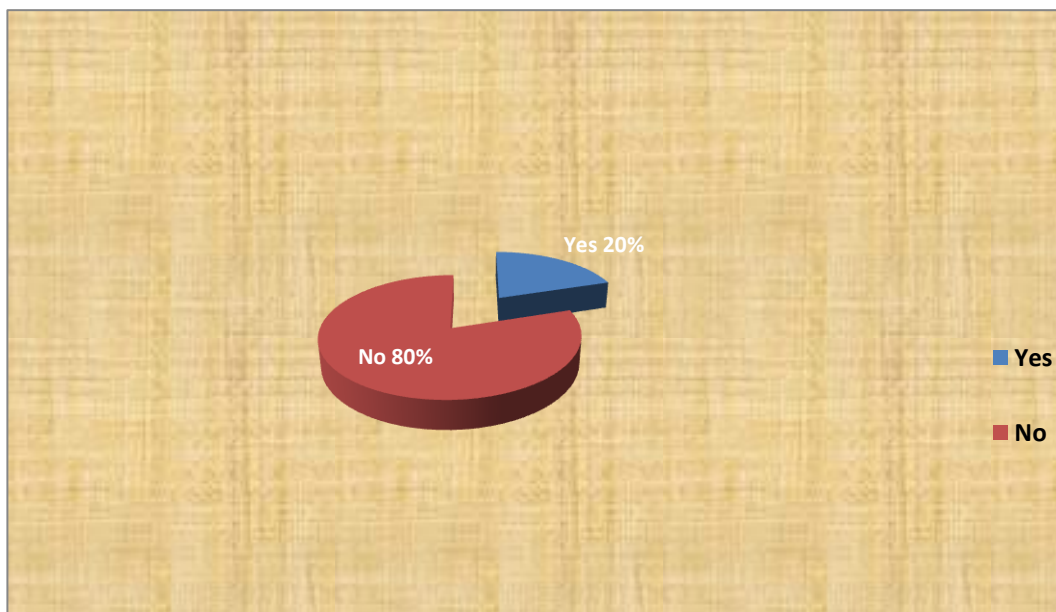


Figure 4.9: Respondents' Ever Advised Others

Source: Research Findings (2016)

4.9 Respondents' Perceptions Towards VCT Services

It was also the rationale for the researcher to examine whether respondents had positive or negative perceptions on the VCT services. A positive perception for this study was the value inclined in the services important for youth and a negative to it rested upon the absence of the significances for attending the services. This was seen to be potential for the study because of the fact that their perceptions towards VCT services influenced their decision to visit these services. The study revealed that, 36 (72%) of the respondents had a positive perceptions towards VCT services. That is, respondents disclosed of the significances and importance for VCT services and 14(28%) had a negative attitude with the effectiveness of the VCT services (Table 4.8). Their negativity resided upon the notion of the absence of the treatment for the disease.

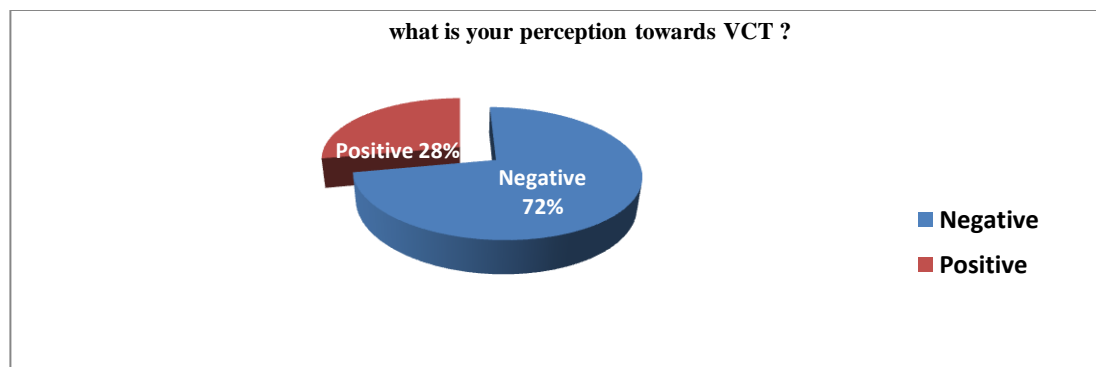


Figure 4.10: Respondents' Perceptions Towards VCT Services

Source: Research Findings (2016)

Other study have shown that Youth's perception on seeking VCT services, the majority of youth (75%) indicated that they were not ready to seek VCT services. They indicated that their worst nightmare was fear of testing positive and what others would think about them if they realized they had sought the services. A few, (25%) of

youth indicated that they were ready to seek VCT services. They indicated that their perception was informed by the desire to know their status so as to live responsibly based on the test results (Asuke et al, 2014).

4.10 Respondents Perceptions whether VCT Services are Necessary for Youths

It was important for the study to examine how youths' perceive VCT services to be necessary for youths or not. According to NACP (2003) there is up scaling for the VCT uptake because of the increasing information for services and therefore youths see VCT the increasing importance of the VCT services and prevention for risk behaviors, this study therefore reflects what others have found.

It was found that 65% of the respondents said that VCT services are necessary and important for youths, 23% of the youths said that they don't see the importance for counseling and testing due to the fact that even if they are found to be positive, there no treatment for the disease (Figure 4.7). From the data, the study calls for committed interventions to change the perceptions of youths who see the absence of the significances for HIV counseling and testing.

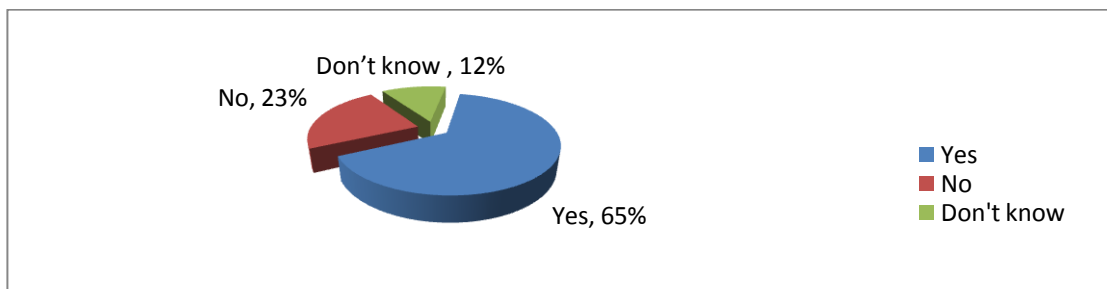


Figure 4.11: Perceptions Whether VCT Services are Necessary for Youths

Source: Research Findings (2016)

4.11 Respondents' Perceptions on HIV Testing For Health Looking People

The researcher also wanted to know, how many respondents perceive HIV testing is necessary for and health looking people, 45% percent of the respondents answered Yes, only 5% percent said no. This reveals that, young men and women are blinded by health looking people that are HIV negative therefore VCT is not necessary for them which bring them into temptation to risk sexy behavior. Similar study conducted in Kinondoni Municipal council have shown that young people were aware that AIDS has no cure and therefore the treatment provided in the VCT centers and in hospitals had to do with STIs treatment and opportunistic diseases.

Young people prefer being attended in one site rather than being referred to hospitals for treatment or other services because their doubts were on the attitudes of the hospital workers to them as youth, if they attend with medical problems like STIs. To their experience, reported that staffs from hospitals and similar other centers are having negative attitude to young people who have STIs, blaming them involving in sexual intercourse at early ages. In this case young people suggested to find all the important services (Mwakatobe, 2007).

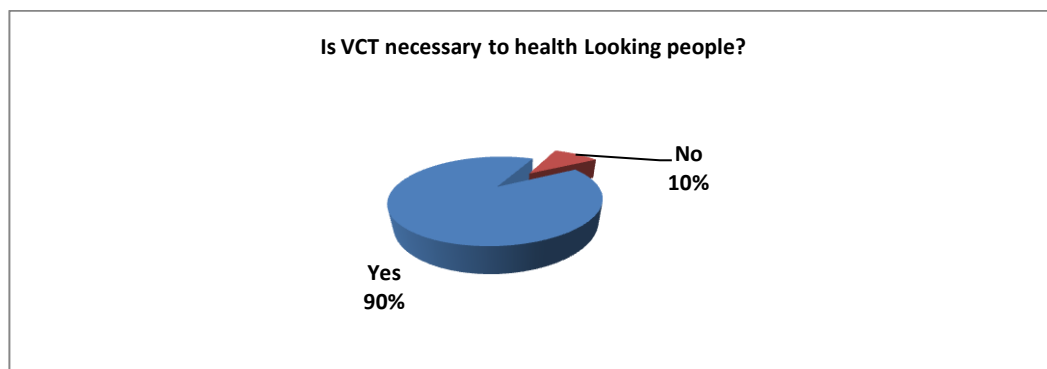


Figure 4.12: Respondent's Perceptions of HIV Testing for Health Looking People

Source: Research Findings (2016)

4.12 A Right Time for HIV/AIDS Testing

It was also seen important for the study to explore if it's the right time for youths to go for HIV counseling and testing comparing to adults. This was imperative because of the connectivity that others had low morale to attend these services. The study revealed 10% percent said they would like to take HIV test before marriage, 40% percent said after marriage and 50 % percent said that they do not know. The varied responses among the respondents were attributed with the forces for testing. While others undergo VCT because of they want to know their status, marriage has been an obligatory carrier for testing.

Other study have shown similar results Youth who are pregnant they seek VCT services as part of the antenatal services. Counselors admitted to have an increased number of girls who attend VCT services due to such program within antenatal clinics. Also the estimations in percentage on young people who attend VCT services. All agreed on less than 50% of young people seek the VCT services. Various reasons were brought forward about them not using the services (Mwakatobe, 2007).

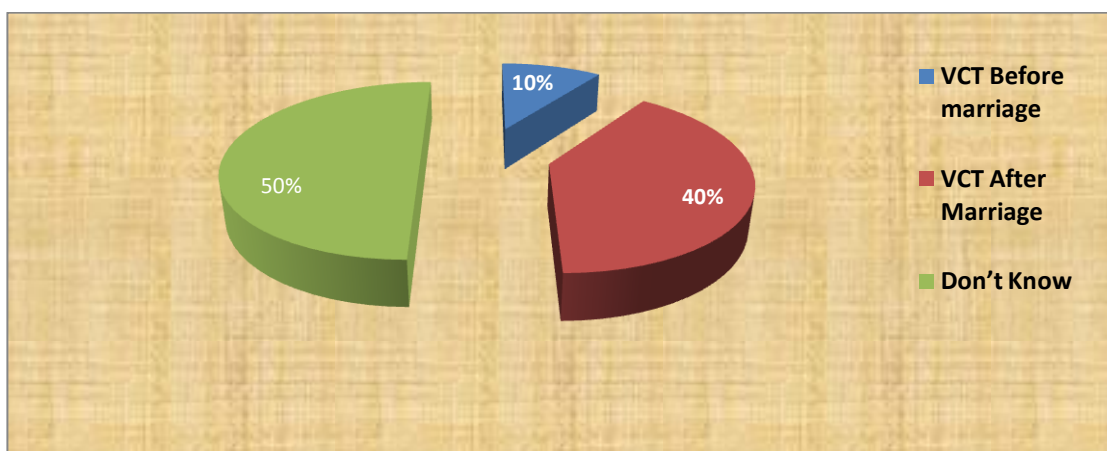


Figure 4.13: A Right Time for Voluntary Counselling and Testing

Source: Research Findings (2016)

4.13 Perceptions of Youths on VCT Comfortably

The study assessed comfort ability on the perceptions of Youths were evaluated to determine those who have never tested HIV before the study and those have tested before the study. Below is the figure that shows the results of the perceptions levels that assessed based on the type of services and experiences perceived before VCT uptake and after the service. Majority of the respondents were not sure with VCT service providers followed by location of the VCT sites that do not provide comfort zone to Young men and Women.

Other study have explored the Youths comfort ability how is measured Most young people are concerned with the confidentiality of the VCT services. Some of the young respondents aired their worries that counselors cannot keep the clients secrets because they are also human beings, prone to making mistakes. Moreover, some gave clarification on the whole issue of confidentiality arguing that it is hard to judge if counselors keep secrets or not.

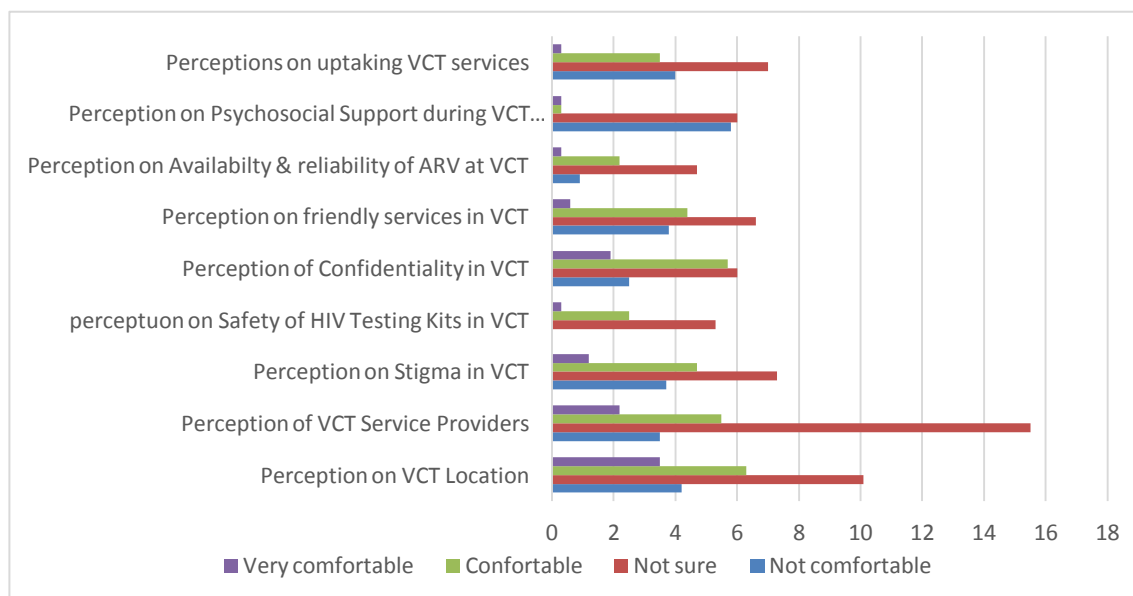


Figure 4.14: Perceptions of Respondents who have Never Attended VCT
Source: Research Findings (2016)

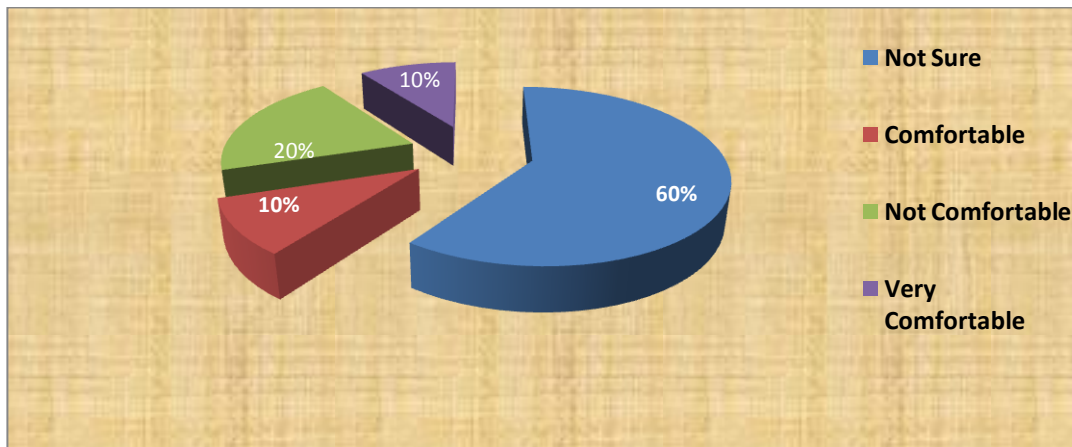


Figure 4.15: Perceptions of Respondents who have Never Attended VCT

Source: Research Findings (2016)

However, to most youth's who had been to VCT services mentioned about counselors keeping clients secrets while those who have not been to VCT services appeared with such worries that may be they do not (Mwakatobe, 2007).

Based on the results of the findings (figure 4.1) illustrates result from the assessed youths who have never attended VCT services that reveals 60% of all participants were not sure with VCT services while the small number of 10% was comfortable with VCT services. The most cases Youths had fear of stigma and discrimination factors associated with STD, psychosocial care and support, communication and attitude from the VCT service providers as well as community members especially youths who will notice him or her when exit from the VCT centers.

The study shows that, youths who have undergone VCT services were very comfortable with VCT services provision with reference to figure 4.2 which illustrates result from the assessed youth who have attended VCT services that reveals 90% of all participants were very comfortable with VCT services. This was experienced

during the VCT services that within the process all fear that were created pre VCT was not observed in VCT center. VCT services providers were very friendly and provided psychosocial care during HIV Testing as well as attitudes were also appealing.

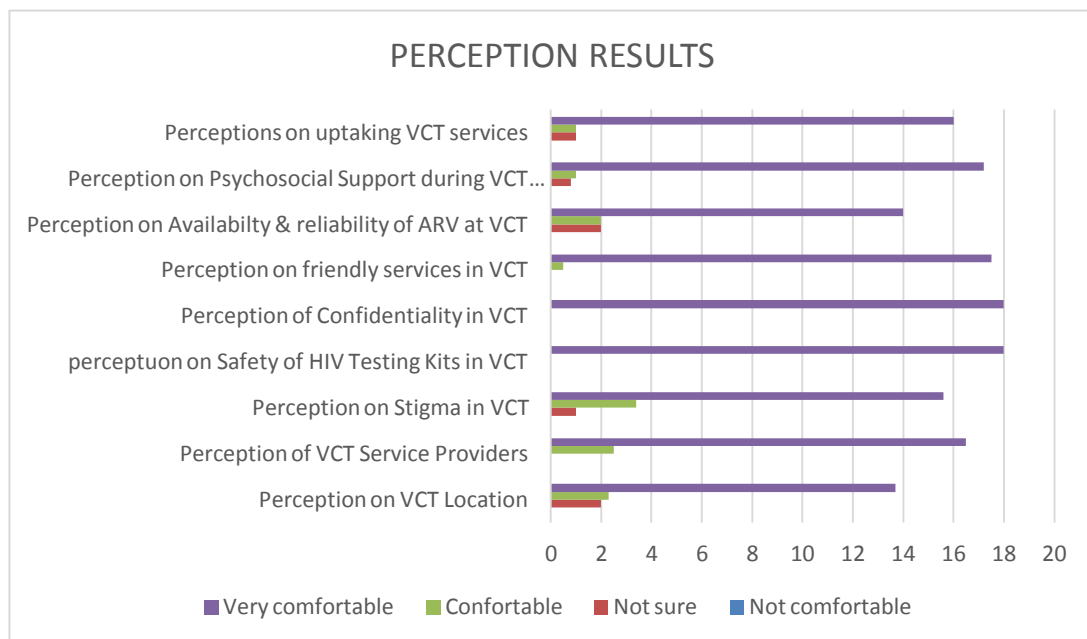


Figure 4.16: Perceptions of Youth who have Attended VCT Services

Source: Research Findings (2016)

Other study have proven similar results 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 (Mwakatobe, 2007).

4.14 Factors that Influence Respondents to Attend VCT Uptake Services

The study examined young men and women on the factors that influence them from attending VCT service where by negative perception was a leading factor that covered most of the responses. Youths are active in sex than adults thus the emerging sexuality during teenage years together with lack of necessary information has made the young people today to be more prone to Sexual transmitted diseases (STIs) as well as HIV/AIDS.

Similar study by Zenebu (2005) conducted a study on Youth on Utilization of VCT services in Ethiopia taking Jijiga Town as a case study and he identified that most commonly factor given by respondents to attend VCT was to know their HIV Status (61.65) and for not undertaking VCT was fear to get the HIV Test Results. Also the study developed two category of the youth that aged between 14 -19 and 20-24 where by those above 20 are more willing for VCT uptake services compared to the opponent group of 14-19 due to confidence and level of understanding of HIV and VCT in general as a result age become a determinant factor in VCT uptake service among youth Populations. Mwenyango (2010) conducted a similar study in Uganda and his study he find out that youth in the age group (20-24) were more likely to go for HIV test than those 15-19 years.

Distance from the community residential area where youths resides to VCT centres as not all the streets have VCT centres thus most of the respondents on the study mentioned distance as an influential factor towards VCT uptake services. This finding was backed up by Nuwaha et al.,(2002) findings through a study conducted in Bushenyi District through whereby people staying close to the health centres are able

to walk easily to access for primary health care services including VCT. When there's a long distance between VCT centers and Youths residence it's less likely for Youths VCT uptake service and also those who are living close to VCT centres are likely to access VCT information and attend benefits of VCT uptake services.

VCT service providers also are coming from almost the same community of the youths and sometimes it hinders Youths from the nearby community to attend VCT services especially for the Youths who are not married and this may results into judgmental attitude. This was founded out by similar study by Mwenyango (2010) that unmarried but sexual active partner Youths in Bangladesh are not comfortable seeking family planning and VCT from nearby health related services due to perceptions that service providers are judgmental and unfriendly.

From the study the youths are aware that VCT is campaigned as free of services but they perceive that there must be a hidden cost that is associated with VCT uptake service. Other studies have noted the issue of cost as well with regards to association of VCT uptake and cost. Mwenyango (2010) notes most of the youths are aware of VCT free service and those who had tested have not paid a single coin with fact that majority of VCT centres are owned by the Government and others are donor related VCT Free of service. This was reported the same in Uganda Youth Friendly Services Report (2005) that majority of Youth Populations reported that VCT services were free and only few reported that the services were affordable.

CHAPTER FIVE

CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

This chapter presents the conclusion and the recommendations for the study. This chapter provides conclusion on the study to examine the uptake of VCT among the youths aged 15 and 24 years old. This chapter also provides recommendations to policy and decision makers on how youth's perceptions on VCT can find remarkable considerations on efforts to deal with HIV/AIDS pandemic.

5.2 Summary of the Findings

The study revealed that Young people generally get tested because they would like to know their HIV status. One of the contributing factors maybe exposure to sexual encounters predisposing them to HIV risk. This applies to all young people regardless of sex, marital status, age or residential status.

Most young people are not going for testing because of fears of being diagnosed HIV+ve and a feeling that they might already have the virus. Young people get motivated to go for VCT in places where their peers provide services and where health providers have a welcoming attitude and where privacy is ensured. Young people would therefore like to get VCT services in places where special interventions to attract them to the facility are put in place. These include providing VCT services in youth centres with friendly health Service providers, having special room for young people in the health facilities and having youth friendly health providers with clean environment.

5.3 Conclusion

This study has presented and discussed the findings of the study with the rationale of examining the perceptions and practices of the youths towards the VCT services. It has been found by the study that majority of the youths have a positive perceptions and value services offered by VCT sites, unfortunately they don't go for these services because of the fact that they are afraid and hesitant of the positive results. Again, others are afraid of the stigmatization by other fellow members.

5.4 Recommendations for Further Studies

Though the study has examined the youth's perceptions towards the VCT uptake, it is honest to divulge that this study has not explored everything as far the area HIV/AIDS is concerned. There are still areas that require further studies.

Firstly, the need for further studies to be undertaken, to examine why majority of the visitants to VCT sites are young women.

Secondly, there are still needs for studies on perceptions of VCT to other age grouping.

Thirdly, there still gaps to be filled by academicians on the opportunities and the challenges facing the offering of the VCT uptake among youths.

5.5 Recommendations to Policy and Decisionmakers

- (i) Firstly, there is a need for the government and decision makers to intervene on efforts to encourage more youths to attend counselling and testing if after all efforts to deal with HIV/AIDS has to enriched.

- (ii) Secondly, the study calls for dedicated efforts to deal with the stigmatization of the positive clients
- (iii) Thirdly, there is also still a need for awareness to be enriched on the changing the attitudes of youths who think there is no need for them to go for VCT because of the absence of the treatment.

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APPENDICES

DATA COLLECTION INSTRUMENTS

Appendix I: Questionnaire designed for research on “Perceptions and Practices of Youth Towards VCT Uptake Services”

The information provided will be used for academic purpose only and not otherwise

(Please provide true and correct information)

Questionnaire No
 District.....
 Street.....
 Date.....

Section A; Background information Let us now discuss about your background information.

1. What is your age in years?
2. Sex of respondent

1= Male	[]
2= Female	[]
3. Have you been to school?

1=Yes	[]
2=No	[]
4. What is the highest level of education attained?

1= Adult education	[]	2=Primary education	[]
3=Post primary	[]	4= Secondary	[]
5= Higher education	[]	6=others (specify).....	
4. What is your marital status?

1=Single	[]	2= Widow/widower	[]
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- 3=Married ☐ 4=Divorced ☐
☐
 5=Separated ☐ 6=Living together ☐
☐
 5. What is your occupation?
 1=Employment ☐ 2=Agriculture ☐
☐
 3=Livestock ☐ 4=Commerce ☐
☐
 5=Manufacturing ☐ 6= Others ☐
☐
 7=Does not work ☐

Section B: Knowledge towards a voluntary HIV test

Now let us discuss about knowledge towards a voluntary HIV test, and how Youth can protect themselves from the risk of HIV infection

1. Have you ever heard about voluntary HIV/AIDS testing?
 1=Yes ☐ 2=No ☐
2. When last did you heard about HIV/AIDS testing?
 1=Last week ☐ 2=More than one month ago ☐
 3= More than one year ago ☐
3. From which media you heard about voluntary HIV/AIDS test in the past -months?
 1= Radio ☐ 2= TV ☐
 3= Magazines/News papers ☐ 4= Journals ☐
 5= Meetings ☐ 6= others specify ☐
4. Would you say that you have enough information about voluntary HIV/AIDS testing?
 1=Yes ☐ 2=No ☐
 3=don't know ☐

5. Is there anything a person can do to avoid getting HIV/AIDS?

- 1=Yes ☐ 2=No ☐
 3=don't know ☐

6. Do you think that a person infected with HIV/AIDS always shows symptoms?

- 1=Yes ☐ 2=No ☐
 3=don't know ☐

8. State one major preventive method that a person can do to avoid getting HIV/AIDS

- 1=Abstain from sex ☐ 2=Use condoms ☐
 3=Limit sex to one ☐ 4=Avoid using razors/ blades ☐
 5=Avoid blood transfusions ☐
 6=Avoid sharing food with people who have AIDS ☐

9. Would you like to be tested for HIV/AIDS?

- 1=Yes ☐ 2=No ☐
 3=Don't know ☐

10. I don't want to know the results, but have you ever been tested to see if you have AIDS virus?

- 1=Yes ☐ 2=No ☐
☐

11. Do you know the place where HIV/AIDS testing is carried?

- 1=Yes ☐ 2=No ☐
☐
 3=Don't know at all ☐

12. When was the last time you were tested?

- months ago ☐
year ago ☐

13. What are the chances that you might catch HIV/AIDS?

- 1=No chance ☐ 2=Moderate ☐
- 3=Good chance ☐
- 1= Does not want to know/afraid ☐ 2=Is sure she/he does not have HIV ☐
- 3=Is sure she/he is HIV positive ☐ 4=Cost too much ☐
- 5= No time to go ☐ 6=Un decided ☐
- 6=Other ☐

Section C: The influence of campaign on voluntary HIV testing among Youth.
Let us discuss the influence of campaign on voluntary HIV testing among the people.

- Have you heard about the campaign on voluntary HIV testing?
 1=Yes ☐ 2=No ☐
- When last did you heard about it?
 1=Last week ☐ 2=More than one month ago ☐
 3= More than one year ago ☐
- From which media you heard about the campaign on voluntary HIV test in the past - months?
 1= Radio ☐ 2= TV ☐
 3= Magazines/News papers ☐ 4= Journals ☐
 5= Meetings ☐ 6= others specify ☐
- Would you say that campaign on VCT to the public ha been given enough?
 1=Yes ☐ 2=No ☐
 3=Don't know ☐
- Do you know the place where HIV is tested?
 1=Yes ☐ 2=No ☐

6. Have you seen/heard people going to test for HIV?

1=Yes [] 2=No

[]

7. Since the campaign on voluntary HIV testing started have you already tested?

1=Yes [] 2=No

[]

3=Don't know []

8. If not why?.....

9. Did you advise other youth or friend to test for HIV/AIDS voluntarily?

1= Yes [] 2=No []

10. What is your perception towards voluntary HIV/AIDS testing?

1=positive []

0=negative []

Section D: The influence of distance on voluntary HIV testing among Youth, Let us discuss about the influence of distance on voluntary HIV testing.

1. Do you know the place where HIV/AIDS testing is carried?

1=Yes [] 2=No []

3=Don't know at all []

2. Mention one place where you can go and test for HIV (Name).....

3. What is the distance from the voluntary counseling testing centers to your place of residence?

1= 500 meters [] 2=One kilometer []

3=More than two kilometers []

4. How one can reach the voluntary HIV centers you know?

1= walking by foot [] 2=riding a bicycle []

3=by car/bus []

5. Can you say that distance location of the voluntary HIV testing centers have an impact for you to go for HIV test?

1=Yes [] 2=No []

3=Don't know at all []

Section D: Perceptions of the Youth Towards voluntary HIV/AIDS testing. Please pick a number from a scale to show how you Agree or Disagree with the following statements: 1=strongly agree; 2=Agree; 3=Undecided/Neutral; 4=Disagree; 5=strongly disagree

	Attitudinal statements	Strongly disagree (1)	Disagree (2)	Undecided/ neutral(3)	Agree(4)	Strong agree(5)
1	Voluntary HIV testing should not be done before marriage					
2	Voluntary HIV testing is purposely for polygamist					
3	Voluntary HIV testing is necessary to the whole society					
4	People perceive negatively to voluntary HIV testing					
5	HIV testing is not necessary for health looking person					
6	Voluntary HIV testing should be done before even after marriage					
7	Voluntary HIV testing is not Purposely for polygamist					
8	Voluntary HIV testing is important Even for health looking people					
9	Voluntary HIV testing is more important for youth than adult					
10	People perceive positively to voluntary HIV testing					

Section E: Youths Perception Towards VCT Services, Please pick a number from a scale to show how do you feel Comfort, Not comfort or More Comfortable with the following statements: 1=Comfort; 2=Not Comfort; 3=Not Sure; 4=Very Comfort;

(I) Questions for those who have not attended VCT services Before this study

	Tick (✓) One			
	1	2	3	4
Perception on VCT Location				
Perception of VCT Service Providers				
Perception on Stigma in VCT				
perception on Safety of HIV Testing Kits in VCT				
Perception of Confidentiality in VCT				
Perception on friendly services in VCT				
Perception on Availability & reliability of ARV at VCT				
Perception on Psychosocial Support during VCT				
Perceptions on up taking VCT services				

(II) Questions for those who have Attended VCT Services

	Tick (✓) One			
	1	2	3	4
Perception on VCT Location				
Perception of VCT Service Providers				
Perception on Stigma in VCT				
perception on Safety of HIV Testing Kits in VCT				
Perception of Confidentiality in VCT				
Perception on friendly services in VCT				
Perception on Availability & reliability of ARV at VCT				
Perception on Psychosocial Support during VCT services				
Perceptions on up taking VCT services				

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THANK YOU FOR YOUR PARTICIPATION

Appendix II: Guideline for Focus Group Discussion (FGD)

Appendix 1: Guidelines for Focus Group Discussion designed for research on “Perceptions and Practices of Youth Towards VCT Uptake Services”

The information provided will be used for academic purpose only and not otherwise

1. What do you know about VCT uptake services?
2. What is your perception towards voluntary HIV test in general?
3. Did ever uptake VCT service?
 - (a) If yes, give reasons
 - (b) If no, gives reasons.....