ASSESSMENT OF THE UTILIZATION OF VOLUNTARY COUNSELLING AND TESTING SERVICES AMONG YOUTHS: A CASE STUDY OF SINGIDA MUNICIPALITY

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

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CERTIFICATION

The undersigned certifies that, he has read and hereby recommends for acceptance by The Open University of Tanzania, a dissertation titled: ***Assessment of the Utilization of Voluntary Counselling and Testing Services among Youths: A Case Study of Singida Municipality*** in partial fulfilment of the requirements for the degree of Master of Social Work of the Open University of Tanzania.

Professor Sylvester Kajuna

(Supervisor)

Date

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DECLARATION

I**, Nyangi Margaret Paskal**, do herebydeclare that this dissertation is my own original work and that it has not been presented and will not be presented to any other University for a similar or any other degree award.

…….....

Signature

…….....

Date

DEDICATION

I dedicate this work to my lovely family for their tolerance in good heart while I was away during the course work.

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ABSTRACT

Guided by the Theory of Change and Health Belief Model, this study examined the awareness or responsiveness of the youth in Singida Municipality to the voluntary testing and counselling services offered by such institutions inthe Municipality. The study was guided by three objectives. These were;to determine the awareness of the youth about voluntary counselling and testing servicesin Singida Municipality, to determine the youth's attitudes on HIV/AIDS voluntary counselling on testing uptakes services to suggest ways that should be done in order to make the youth in Singida Municipality comfortably accessthe HIV /AIDS VCT services. The study used a sample size of 45 respondents who were purposively selected. The collected data were analysed by using Statistical Package for Social Sciences (SPSS) version 17 and are presented in figures, pie charts, tables and graphs where necessary they were expressed as content analysis. It was revealed that the youth in Singida Municipality had some awareness on the services provided by VCT centres in the municipality. More so, this awareness was largely propelled by pressing issues such as pregnancy, sickness, accidents and marriages which the youth encountered hence the need to seek such services. The study recommends for more measures to be taken by all stakeholders involved in the fight against HIV/AIDS to offer more better services to the youth so as to attract them to take interest in what the VCT centres have to offer hence achieving the mission in the fight against the prevalence of HIV/AIDS.

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AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Care Services
ARV	Antiretroviral
HIV	Human Immunodeficiency Virus
MCH	Maternal and Child Health
MSM	Men who have sex with men
NACP	National AIDS Control Programme
NGO	Nongovernmental organization
OI	Opportunistic Infection
PLWHA	People Living with HIV/AIDS
PMTCT	Prevention of Mother-to-child Transmission of HIV
PTC	Post-Test Club
STI	Sexually Transmitted Infection
TACAIDS	Tanzania Commission for AIDS
THMIS	Tanzania Health Management and Information System
UNAIDS	Joint United Nations Program me on HIV/AIDS
UNICEF	United Nations Children Fund
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation

CHAPTER ONE

INTRODUCTION

1.1 Background of the Problem

According to UNAIDS, (2012) Acquired Immunodeficiency Syndrome (AIDS) results from the destruction of CD4 cells, lymphocytes manifested as disease associated with opportunistic infections (OI). Viruses present in the body cause the condition but do not cause disease unless the immunity system is damaged.

The disease was first diagnozedin various parts of the world towards the year 1981. To date the disease has spread all over the world. Today approximately 38.6 million people are living with HIV and 4.1 million people became newly infected with HIV worldwide in 2005 (UNAIDS 2010).

However,of all the people living with HIV worldwide, two thirds 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. Although HIV/AIDS epidemic appears to be slowing down globally, however infections are continuing to increase in certain parts of Asia and sub Saharan Africa (Focus, 2008). However, according to the United Republic of Tanzania, (2010) adult HIV prevalence has been on the decline and in 2009, about 5.6% were living with HIV. The prevalence was 3.9% in young women (15-24) and 1.7% in young men.

1.1.1 HIV/AIDS Overview in Tanzania

In Tanzania, Kagera was the first region to report of the first HIV/AIDS cases in 1983. In response to this, a number of interventions were introduced including voluntary

counselling and testing services with the aim of overcoming the pandemic. By 1986 all regions had reported AIDS cases (URT 2010).The epidemic has evolved from being rare and new disease to a common household problem affecting most Tanzanian families. About 7% of the adults aged 15-24 years were infected with HIV and the prevalence of the disease among women was higher than that of men. It was 8% and 6% respectively according to the Tanzania HIV/AIDS indicator survey of 2003/4 (TACAIDS, 2010).

In cities and towns, HIV prevalence averaged 11%, twice the levels found in rural areas (TACAIDS, 2007). Development of HIV/AIDS epidemic has a major impact on all sectors of development. In 2003/4 TACAIDS conducted a community based HIV indicator survey with the full participation of the National Bureau of Statistics.

1.1.2 HIV/AIDS Epidemic among Youths

Youths face numerous health risks along the path to adulthood, many of which will affect the length and quality of their lives. If it remains uncontrolled, HIV/AIDS will lead many young people and their parents to early deaths. Available epidemiological data show that youths are at higher risk of HIV infection than older population groups. Sixty percent (60%) of all new HIV cases occur among young people between the infection in sub Saharan Africa, and it occurs among young people between ages of 10 to 24 (UNAIDS,1998).

According to Pathfinder International Report (2009) Half of HIV infections occur among youths aged 15-24 worldwide. However, in sub Saharan Africa, three young women are infected for every young man among 15-24 year-olds Rates of infection

are much higher among teenage girls and young women than they are among their male counterparts in the same age group (NACP Surveillance Report, 1994). There are several factors why youths are most vulnerable to HIV infection including among others early age at first sexual intercourse, a belief of being invulnerable and boys feeling pressure to prove their manhood. Other factors include low levels of condom use, tendency of sexually active youths to have multiple sexual partners, lack of skills in negotiating sexual decisions and using sex for exchange of basic needs such as food, clothes or shelter. Sometimes HIV infections are propelled by sheer idleness.

1.1.3 HIV Risk Youth Girls, Youths and Young Women

While the number of new HIV infections and AIDS related deaths worldwide is declining globally, (UNAIDS 1998) there is high prevalence of it among key populations. Among these, are 15-24 year old adolescent girls and young women in east and southern Africa where it is revealed these young girls are infected two to five times higher than the boys of their ages.

1.1.4 Voluntary Counselling and Testing (VCT)

Voluntary counselling and testing (VCT) is the process by which an individual undergoes counselling, enabling him or her to make an informed choice about being tested for HIV. In recent years, voluntary HIV testing, in combination with pre- and post-test counselling, has become increasingly important in national and international prevention and care efforts. Knowledge of sero-status through VCT can be a motivating force for HIV-positive and -negative people alike to adopt safer sexual behaviour, which enables sero-positive people to prevent their sexual partners from getting infected and those who test sero-negative to remain negative (UNAIDS, 2010).

This intervention also facilitates access to prevention services for sero-negative people and is a key entry point to care and give support services for those who are HIV-infected. This includes access to interventions to reduce mother-to-child transmission (MTCT) of HIV, interventions to prevent opportunistic infections (e.g. tuberculosis preventive therapy and prophylaxis for other infections) and other medical and supportive services that can help HIV-positive people live longer and healthier lives (UNAIDS, 2000).

VCT serves as an entry point to prevention, care, treatment and support, programmes and enables people to confidently understand their HIV status and learn about supportive behaviours for protecting and preventing further spread of HIV. Since the establishment of HIV testing and counselling services in Tanzania in 1989, the main model through which individuals learn about their HIV status has been client initiated Voluntary Counselling and Testing (VCT). Reports indicate that, VCT coverage has increased over the years to reach 37% of women and 27% of men aged 15-49 years (WHO, 2012).

HIV voluntary and testing (VCT) programmes have demonstrated their ability to increase safe sexual behaviours and use of care and support services among adults (Brown, 2001). By helping clients learn their HIV zero status and creating a personalized HIV risk reduction plan, VCT can provide information and support necessary to change risky behaviours that could lead to HIV infection or transmission (Mwakato, 2007).

Pre counselling and post counselling service, and a risk reduction plan are the key features that distinguish VCT from other HIV testing services.VCT is a vital point of

entry to other HIV/AIDS services, including prevention and clinical management of HIV-related illness, 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 behaviour-change intervention. VCT offers a holistic approach that can address HIV in the broader context of people's lives, including the context of poverty and its relationship to risk practice. It is out of the realisation of the alarming magnitudes that this study undertook an assessment on the utilization of VCT services among youths: a case study of Singida municipality.

1.2 Statement of the Problem

Although there have been massive prevention campaigns and efforts regarding HIV/AIDS, yet the infection rate among youth does not seem to be sized down. The youth are the most vulnerable group affected and the disease has been claiming many lives and national potential workforce WHO (2012). Despite the increasing number of VCT services in Singida Municipality, the number of youths attending the services provided in these facilities remains low and has signified a marginal pace and underutilization.

This situation is controversial and raises a concern as to why the youth are not attending VCT services given that these services are provided free of charge. Hence this study focused at exploring as to how this vulnerable age group does not utilize the available services.

1.4 Research Objective

1.4.1 General Objective of the Study

The purpose of this study was to assess the utilization of Voluntary Counselling and Testing services among youth in Singida Municipality.

1.4.2 Specific Objectives of the Study

The following were the specific objectives that accompanied the main objective:

(i) To determine the awareness of the youth on voluntarycounselling and testing services uptake among the youth in Singida Municipality

(ii) To determinethe y attitudes on HIV/AIDS voluntary counselling on testing uptake services.

(iii) To suggestways that should be done in order to make the youth in SingidaMunicipality comfortably access the HIV/AIDS VCT services.

1.5 Research Questions

Basing on the available information and national campaigns on HIV/AIDS in Tanzania.

(ii) What is the rate of utilization of voluntary counselling and testing services among the youth?

(iii) What is the perception and attitude of the youth in Singida Municipality with regard to HIV/AIDS Voluntary Counselling and Testing?

(iv) What should be done to make the Youth in Singida Municipality access HIV/AIDS voluntary counselling and testing services as protection means against HIV infections?

1.6 Significance of the Study

The study is expected to reveal the perceptions of youths towards HIV/AIDS VCT so that these perceptions find a remarkable consideration for which specific interventions could be crafted to address them. In turn, the study is expected to improve youths' attendance to the VCT centres after which sero status and vulnerability of youths is expected to be at manageable levels. The study also seeks to inform both policy and decision makers on how best could they intervene on HIV/AIDS among youths that is, informing them through different means; for example, changing their negative perceptions about VCT services by enlightening them how functional they are.

In addition, the study findings canbe used in planning and programming of youth friendly services that covers VCT. The study may also help young people who are most vulnerable to HIV infections acquire added knowledge on the purpose of VCT facilities and services in reducing their risks for new infections.Furthermore, the data from the study can be used by the government and the general public to save the youth workforce from perishing due to HIV/AIDS since the youth constitute the majority of the National labour power, workforce and economic engine.Academically, the study will add knowledge and evidence on the mismatching youths' perceptions; unfriendly operating programmed strategies and approaches now being used by VCT service deliveries. To that end, the study will attract new ways of intervention to suit the situation.

1.7 The Conceptual Framework

This study adopted the VCT Access and Utilization Model(Gall *et al*.2007) in describingaccessing VCT services. The VTC Access and Utilization Model details the

process of accessing VCT services from the point of knowledge on VTC services to the point of utilizing of the services. This model then, is in line with VCT services process as used in this study.

VCT 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 services, care and support of the HIV positive clients. It is thought that, if clients reach the positive valuation of the counselling and testing, they seek for service.

The process is followed by a pre-testing counselling and then a donation of blood from clients for testing. After testing, post test-counselling follows. The service goes further by a follow up counselling and client confirm whether negative or positive. The whole process is guided by a friendly relationship between service providers and clients. This conceptual framework isexemplified through Figure 1.1:

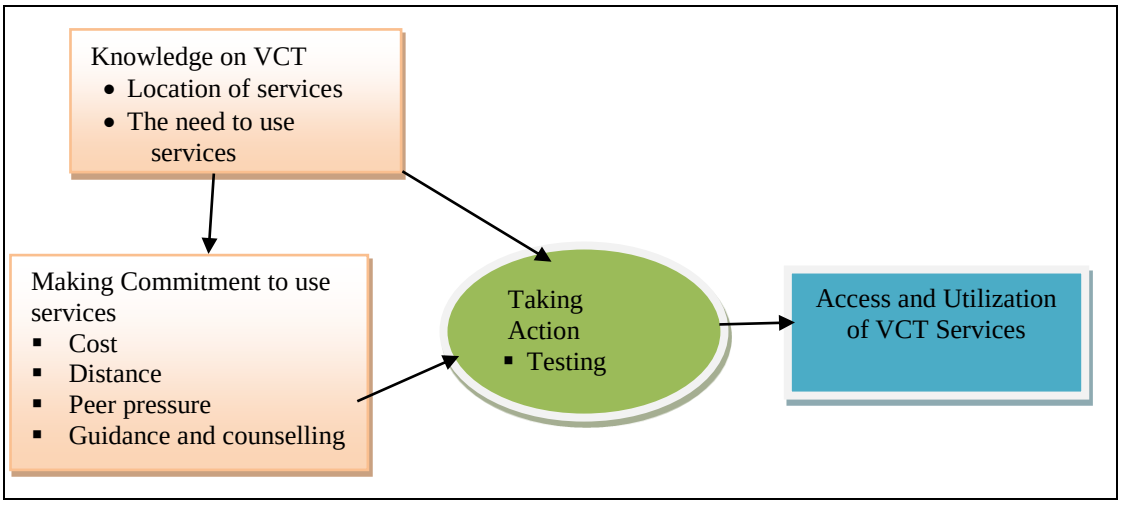

Figure 1.1 A Conceptual VCT Access and Utilization Model

Source: Adapted from Educational research and Review Vol. 4 (10), pp 490 – 497, October 2009)

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter gives the literature of different studies done related to HIV/AIDS infections, different beliefs surrounding testing for HIV/AIDS, cultural perception of community members with regard to the youth's sexual activities, the need and importance for youth to test for HIV/AIDS in VCT centres.

2.2 Sexuality among Youth

The emerging sexuality during teenage years together with lack of necessary information has made the youth today, vulnerable to many diseases such as AIDS. According to Brown, *et al*. (2001) sexuality is a super force without which sexual drive, explained as important for intimacy and pleasure would mean no life existence.However, human beings are not sex machines but they have many other aspirations in life. On the contrary, most adolescents and young people tend to place sexuality, tenderness, love and sexual feelings very central in their lives.

Yet still, others believe that bodily secretions such as saliva as well as skin contact, sharing food, cooking utensils, toothbrushes, clothes, underwear, toilets and handshaking with infected persons as well as mosquito bites could facilitate the transmission of HIV. Given this state of affairs, the youth continue to lack this important component of their progress towards adulthood. This is becausemost African cultural practice rshy away from exposing youth to sexual matters before marriage on the ground that it is immoralr ; as a result, sex is perceived as a top secret in most of the societies.

The fact that HIV has its major root of transmission through sex, apart from contact with the HIV infected body fluids etc; the traditional African sexual dormant perception has more risk and damages. This makes hard for young people to disclose their sexual life since that behaviour may be socially unacceptable. For example, a Ugandan mother was heard as arguing that,

> *"as a parent, especially for the boy, I would start imagining he has started moving around with women and Iwould get much worried* (WHO, 2010).

This exemplifies how sex matters of the youth within the context of many African societies remain a myth where adults remain spectators never wishing to be personally involved in matters that affect their young people. Due to such beliefs, youth fear to share their sexual experience with their parents or elders who could be of help in their sexual behaviours change. This would mean, it is even worse if the youth would attempt sharing with their parents about their ideas of going for the HIV tests. For example, male community members from Kenya argued that,

> "*within the age group underdiscussion, (11-24 years), there is fear, according to African culture, that a child in that group cannot tell his father that he wants to go for an HIV test. You know this will mean that he isindulging in immoral behaviours and this is not acceptable*" (WHO, 2010).

Given the explanations above, it can be argued that such argument may not be entirely relevant to this generation; these cultural practices and beliefs need to change. In order to facilitate and improve the sexual life of young people,parents, guardians and adults need to be fully involved. The idea that talking with youths will stimulate them into early sexual debut is not much valid to date because young people have sex in one way or another. Therefore, the right to information, counselling and testing are

necessary without which they continue to live unguardedly and often under influence of unreliable sexual information sources (WHO, 2010).

2.3 Definition of Terms

The following terms are defined according to the context of this study.

2.3.1 Human Immunodeficiency Virus

The term HIV is defined as human immunodeficiency virus that attacks human being's immune system. Once the virus gets inside the body, a human being may not feel or look sick for years but he/she can still infect others. However, overtime, the immune system may grow weak become causing the infected person to fall sickas he/she may be attacked by differentdiseases (Global Fact Sheet, 2014).

2.3.2 Acquired Immunodeficiency Syndrome

AIDS is an abbreviation, which stands for Acquired Immunodeficiency Syndrome (AIDS). Acquired means "transmitted from person to person" immune is the body's system of defence, deficiency means a "lack of" or not working to the appropriate degree; and a syndrome is a group of signs and symptoms. AIDS is the advanced stage of HIV infection (Global Fact Sheet, 2014).

2.3.3 HIV/AIDS Counselling

HIV/AIDS counselling has been defined as a dialogue between a client and a counsellor. The objective of this dialogue is to enable a person make informed and personal decisions about testing, and to learn how to cope with the stress brought about by the test results. Counselling has traditionally been offered on two occasions

during HIV testing; before the test (pre-test counselling) and after the test (post-test counselling). Pre-test counselling has been described as a prerequisite for obtaining consent, and according to UNAIDS (2013), it is necessary for preparing the client psychologically for the HIV test and its results.

At this stage, the counsellor discusses with the client ways to cope after knowing that one is HIV positive (UNAIDS, 2013).The Voluntary HIV Counselling and Testing Centre (VCT) is one of the HIV intervention measures with the purpose of giving education about living with HIV and avoiding infecting others, and to uninfected ones on how to maintain their sero negative status.

It assists in early detection of the of HIV infection. It also assists individuals in accessing intervention and support services including management of infectious diseases. Moreover, it assists infected individuals in assessing their personal risks and adopting risk reduction behaviours. It does not work at individual level only, but also provides strength to prevention efforts particularly at the community level **(**WHO, 2012).

2.3.4 HIV/AIDS Testing

HIV testing shows whether a person is infected with HIV or not. HIV is the virus that causes AIDS. AIDS is the most advanced stage of HIV infection. HIV testing can detect HIV infection but it can't tell how long a person has been HIV infected or if the person has AIDS. HIV testing helps protect one'shealth. Whether testing shows you are HIV negative or HIV positive, you can take steps to protect your health (Njeru, 2011).

2.3.5 HIV/AIDS Syndrome, HIV Counselling and Testing Centres (VCTs)

Syndrome is a group of signs and symptoms. AIDS is the advanced stage of HIV infection (Global Fact Sheet 2014). The Voluntary HIV Counselling and Testing Centre (VCT) is one of the HIV intervention measure with the purpose of giving education about living with HIV and avoiding infecting others, and to uninfected ones on how to maintain their sero negative status. It assists in early detection of the HIV infection. It also assists individuals in accessing intervention and support services including management of infectious diseases.

Moreover, it assists infected individuals in assessing their personal risks and adopting risk reduction behaviours. It does work at individual, and and community levels (Global Fact Sheet, 2014). VCT services facilitate decision-making, accepting and coping with HIV, improving family and community acceptance, increasing condom use, and reducing gonorrhoea rates and HIV transmission (Research to Prevention, 2012).

As a response to the above facts, Tanzania formed HIV/AIDS testing policy, which aims at promoting early diagnosis of HIV infection through voluntary testing with pre- and post test counselling. The main objective is to reassure and encourage 85-90% of the population who are HIV negative to take definitive steps not to be infected.Those who are infected are to cope with their status, prolong their lives and should not infect others. It is important therefore, for young people to use these services because they are among the risk group in this HIV/AIDS era.So far, they have all rights to information about their own HIV status and the right to use VCT services (URT, 2010).

The study conducted in three countries, Kenya, Tanzania, and Trinidad, provided a strong evidence to support the fact that VCT is effective and cost –effective as a strategy in facilitating behaviour change. VCT also is an important entry point for care and support (The Voluntary HIV-1 Counselling and Testing Efficacy Study Group 2000) (WHO, 2012).

A study done in Kenya and Zimbabwe by Erulkar*et al* (2005) reveals that young people were in favour of youth-friendly reproductive services. They mentioned some factors contributing to the existence of youth as,friendly giving of reproductive health services, positive staff attitudes, reasonable or affordable costs, short waiting time and the ability to obtain all services at once and convenient opening hours. The study recommended that these aspects should be improved because their presence guarantees good service delivery to the youth. Therefore, testing for HIV, as a part of reproductive health needs friendly and accommodatingenvironment.

Again the study by Mwakato (2007) done in Kinondoni in Dar-es-Salaam revealed that young people went for HIV testing in VCT centres for reasons such as individuals' perception that one is at risk, response to the sign of illness, future plans, learning the health status, and experience associated with partners or family members with AIDS. Other reasons weredonating or receiving blood, peer influence, access to HIV/AIDS information, and attraction to services provided in VCT centres other than testing, confidence, attending the VCT services as response to rumours, school programme, quality of the services, access to VCT clinic and antenatal programme.

According to Mwakato (2007) other reasons for the youth not seeking the VCT services were: lack of knowledge about VCT, reasons associated with fear, quality and

access to VCT services. Others included, lack of reasons, non-involvement in sexual activity, young age syndrome, lack of support and negative reaction, sexual reasons, number and availability of counsellors, as well as their age and sex, religious belief and economic reasons.

Some of the findings above could be true of the country the study is going to be conducted (Tanzania). However, it is very hard to give out a conclusion without any research findings. Some of the reasons the researcher finds to be not applicable to the study area. For example, on the issue of accessibility and cost of the services, these are among of the things, which are within youth reach in the area. There are VCTs in the district, which provide free services to the age group of this study (15-24 years).

Transport from or to VCTs is not a major problem because Singida Regional Referral hospital is found at thecentre of Singida town. Therefore, access to public transport is within affordable cost. Other reasons given out as barriers depend much on the VCTs set up, youth's HIV/AIDS knowledge, and service providers' competence in dealing with youth's needs. These may differ from one country to another. Therefore, instead of giving a generalization conclusion by using results from other studies, this work is going to give out the specific reasons as to why there is low rate of the youth attending VCT services in the area focused for the to Tanzania background.

Due to the fact that the youth are more vulnerable to HIV infection and other sexually transmitted infections, there is a need therefore, to explore the youth's feeling on the HIV problem and utilizing the VCTs as one of the HIV intervention measures. Their responsive attitude behaviour towards VCT services would promote a better utility of the offered services and give grounds of safer life, hence the need of this study.

2.3.6 Involving Youth in Health Education

Youth involvement in health education particularly in sexually related matters is very important. For example, in antenatal and maternal health care, in the belief involving youths as early as possible lays the foundation for better, more involved fatherhood. Integrating youths into maternity care can, however, have hitherto unexplored ethical complexities (UNAIDS, 2013).

2.4 Importance of HIV/AIDS Voluntary Counselling and Testing

HIV/AIDS counselling and testing is important because it helps to prevent contamination from HIV-infected people to their partners not yet tested or tested negative. Injecting drug use is one of the fastest growing routes of HIV infection in many parts of the world, primarily because needles, syringes and drug preparation equipment are frequently shared, enabling rapid spread of the virus (UNAIDS, 2000). HIV/AIDS counselling and testing prevents contamination from HIV-infected mothers to their children not yet tested or tested negative.

Sometimes mother is infected with her baby. This can occur during pregnancy, at birth and through breastfeeding. Therefore, counselling and testing is very important if we want to reduce infections from infected mothers to their children. Under HIV/AIDS counselling and testing, early treatment and use of adequate services such as family Planning, is very important because it includes counselling on choice assistance to individual, couple or family and it is better for future planning. People tested HIV Positive can access medical assistance, including ARV therapy and psychological support. Counselling is very important because it helps people to live in good conditions.

2.5 HIV/AIDS in Global Context

HIV/AIDS is a global challenge that poses a threat to the health of individuals, public health and development. Since the discovery of the virus, 60 million people have been infected of whom 25 million are reported dead. Currently 33.3 million people are living with the virus. In 2009, an estimated 1.8 million people worldwide died of AIDS, and 2.6 million new infections were reported globally (Njeru, 2011).

HIV/AIDS in North America: As of 2009, it was estimated that there were 1.5 million adults and children living with HIV/AIDS in North America, excluding Central America and the Caribbean. 70,000 adults and children are newly infected every year, and the overall adult prevalence is 0.5%. 26,000 people in North America (again, excluding Central America and the Caribbean) die from AIDS every year). HIV/AIDS prevalence rates in North America vary from 0.20% (UNAIDS 2013).

HIV/AIDS in South America: It was estimated that among 18 reporting countries in the Latin American region, there were approximately 1.4 million people living with HIV and AIDS at the end of 2011. An estimated 83, 000 were newly infected during 2011 and an estimated 60,000 people died. Adult HIV prevalence was 0.8% or less in all Latin American countries as of 2011.

In most countries, HIV is not generalized but is highly concentrated in populations at particular risk. Overall, the average adult HIV prevalence across central and South America is estimated at 0.4. Unsafe sex among men, who have sex with men, is common across the whole region. In 2011, the HIV prevalence range was between 7% (Nicaragua and Honduras) and 23% (Panama) among men who have sex.

There is little information about the use of VCT by youths in order to know what are the factors behind youths accepting or not accepting the VCT services, it is important to know what other countries have came out with in their findings on this issue.Allen (1992) on his study in Tanzania, Tanzania, Kenya and Trinidad assessed the impact of VCT on youth behaviours change. In the randomized study one group of youth received VCT and one received only standard health information. Participants were contacted six months and twelve later. A major finding of the study was that, the group, which received VCT, reduced their risk behaviour to a greater extent than the group, which received health information only. It was also discovered that the youth who were in couples were more likely to disclose their sero status to their partners if they received counselling. In addition, the study showed that the majority of those tested reported positive psychological benefits.

Further to that, the study showed that behaviour change has been most associated with counselling and testing couples together and among HIV positive clients. In Rwanda and Zambia for example, a VCT programme for couples was linked with increased use of condoms and reduced rates of and HIV. Among sero-discordant couples, the proportion using condoms after a one year follow up increased from 4% to 57% in Rwanda and 3% to > 80% in Zambia.

WHO (2010) reported that in addition to its role as an HIV prevention intervention, VCT is also an important gateway into care and support services to youth-especially for those who are HIV positive. Youth 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, diarrhoea, or tuberculosis. Pregnant

youth who are identified as HIV positive can seek short course anti-retroviral therapy (through PMTCT programmes) to reduce the risk of transmitting HIV to their unborn child.

HIV positive female youth can access family planning services to prevent unwanted pregnancies and prevent further MTCT of HIV to their children. Post-test clubs and supports groups for people living with HIV/AIDS can reduce stress and anxiety among people who suspect or know they are HIV positive as well 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 programmes and in disclosure to family and friends.

Finally, both HIV positive and HIV negative VCT clients can better plan the 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 HVI positive status.

Efforts Made by Tanzania in Promoting HIV/AIDS Counselling and Testing Government has the responsibility to provide management and financial leadership in the National response to the HIV/AIDS epidemic. The government had allocated US$ 8 million for HIV/AIDS activities for the fiscal year 2001/2002 and all sectors and councils are implementing HIV/AIDS interventions (Focus, 2008).

However, given the overwhelming high cost involved, it is beyond the capacity of the Government to provide adequate funds for the National response programme. Therefore, development partners and the private sector also share the responsibility and moral obligation to complement the Government efforts. Also, the government aim is to promote early diagnosis of HIV infection through voluntary testing with pre-and-post test counselling.

The main aim is to reassure and encourage the 85 - 90% of the population who are HIV negative to take definitive steps not to be infected, and those who are HIV positive to receive the necessary support in counselling and care to cope with their status, prolong their lives and not to infect others (URT, 2010). The ProtocalDeclaration on HIV and AIDS of June 2006 was adopted by Heads of States and representatives of Governments based on a comprehensive review of the progress achieved in realizing the targets set out in 2001. This declaration also established a number of goals to be achieved through implementation of country-driven specific, quantifiable and time bound targets towards universal access to comprehensive prevention, treatment, care and support programmes. The high level meeting during the 65th Session of the United Nations General Assembly resolution 19 held in June 2011 to review progress made in the HIV and AIDS response, Tanzania was represented and adopted the Resolution 65/277. During the period 2003/42 to 2011/123, the HIV prevalence in Tanzania has declined from 7.0% to 5.3% among youth aged 15-24.

Statistically significant decline was observed among men in the same age group from 6.3% to 3.9% but not among women. Data from four rounds of antenatal surveillance,

two national population surveys and projections indicate that HIV incidence in the age group 15-49 peaked at 1.48% in 1991, declined to 0.6% in 2004 and stabilized at 0.59% up to 2011. This decline in HIV incidence partly explains the observed decline in HIV prevalence; this is because of Government efforts (URT, 2014). The NMSF takes into consideration the number of National and International legal declaration documents.

National Policy on HIV and AIDS 2001 policy reiterates the Government of Tanzania's (GOT's) commitment to HIV and AIDS as a priority area and calls for strong political commitment and leadership from all levels of government and civil society to ensure sustained and effective interventions. The National Policy set the context for the 2003–2007 National Multi-sectoral Strategic Framework (NMSF) and the passing of legislation in 2001, the Tanzania Commission for AIDS (TACAIDS) were constituted in the Prime Minister's Office (PMO) to coordinate and operationalise the multi-sector response.

The new NMSF for 2008 – 2012 builds on that policy document and the last NMSF. Also, MKUKUTA recognized the effect and influence of HIV and AIDS on poverty; it did not incorporate the last NMSF into all its activities. Issues on impact assessment and the effects of HIV and AIDS on the macroeconomic situation as well as on households and families need to be factored into the next review of MKUKUTA. HIV can be both a consumption factor (consuming services) as well as an investment activity (greater donor support, enhancing human capacity, creating employment and delivering services).At a local level, HIV activities need to be mainstreamed into the economic and development projects at the district, village and community level with

transparency and involvement of CSOs. HIV programmes should also be linked to governance and accountability with enhanced and sustained commitment by political leaders and opinion makers.

The Poverty Monitoring 20 system of MKUKUTA should also develop linkages with the Tanzania Output Monitoring System for HIV and AIDS (TOMSHA) and enhance the overall monitoring and evaluation process in both frameworks. Overall 40% of the budget of the GOT is through donor assistance. Of particular significance is that 80% of the HIV budget is from donor sources with the majority of funds from three donors (the United States government (USG), the Global Fund to fight AIDS, TB and Malaria (GFATM) and the World Bank (WB). The HIV and AIDS response lends itself to being a thematic area. The formation of Development Partners Group on HIV and AIDS (DPGAIDS) give credence to such a theme.

The support to non-state actors also needs review to ensure their continued funding, support and sustainability. On the other hand, greater equity and coverage across Tanzania was enhanced as donor assistance was following a demand driven approach with local communities at the centre of the response. The JAST also makes provision for technical assistance and this should be utilized to the fullest by all structures in the HIV response to strengthen capacity and implementation and reduce bureaucratic obstacles (URT, 2007).

The Government of Tanzania is signatory to a range of international agreements, declarations, treaties and conventions which deal with HIV e.g., Beijing Platform of Action, United Nations General Assembly Special Session on HIV and AIDS

(UNGASS), New partnership for Africa's Development (NEPAD), Southern African Development Community (SADC), MDGs, Great Lake Initiative on HIV and AIDS (GLIA), East African Community (EAC) and Africa Region AIDS Care Capacity Network (ARCAN).

MDGs and UNGASS goals and indicators have been incorporated into the new NMSF. These commitments and ratification protocols need to be properly budgeted adequately resourced (human and technical) and managed by sector specific Ministries Departments and Agencies (MDAs) with support from TACAIDS where necessary (URT, 2007).

Despite the decline, the HIV epidemic in Tanzania remains heterogeneous with geographical and population variability. The HIV prevalence ranges from 1.5% in Manyara to a high of 14.8% in Njombe. While HIV prevalence is generally at 21 decreases, 8 regions namely Ruvuma, Kagera, Kigoma, Rukwa, Mtwara, Kilimanjaro, Singida and Arusha have recorded an increase (URT, 2014).

2.6 Factors Sffecting HIV/AIDS Voluntary Counselling and Testing

There are two types of factors which affectHIV/AIDS VCT.These aree facilitating and limiting factors.

2.7 Factors that Encourage People in HIV/AIDS Voluntary Counselling and Testing

People go for HIV/AIDS counselling and testing because they want to know their HIV/AIDS status. Eagerness to know whether they are positive or negative is one of

the factors that encourage people to go for test; people might want to know their status after having a relationship with an unfaithful partner. Health problem; this happens when people suffer from an unknown disease and decide to go for VCT to find out whether they are infected with HIV or not. When one experiences health problems in which he/she will go to find out about their status (Mwanga, 2012). Voluntary Counselling and Testing of the HIV/AIDS is also encouraged by religious leaders. Religious leaders encourage couples to go for HIV counselling and testing before they got married.

Thus marriage is one of the factors that influence people to go for VCT. Some people may decide to go for VCT before or shortly after their marriage, especially in the case of women (Kadowa and Nuwaha, 2009). Participating in HIV/AIDS counselling and testing is also motivated by married purposes. Going for HIV testing for marriage purposes and because of pregnancy is reiterated by all groups as advantageous because when people get tested, it is a sign of care for the future. These mitigate the rampant spreading of HIV and help youth plan for the future (Mwanga, 2012).

Peer education and support from NGOs and government institution; is reiterated by all groups and seems to be famous in Tanzania. Especially, of particular focus is the quotation from the President of the United Republic of Tanzania, Honourable, Dr.JakayaKikwete: (Tanzania without HIV/AIDS is possible), the president's words is a great factor which influences people towards attaining VCT, support from NGOs and government. Some government and non-government organizations, which give assistance to people suffering from HIV/AIDS, have also been taken as sources that influence other people to go for VCT. African Medical and Research Foundation

(AMREF), Tanzania Commission for AIDS (TACAIDS) and UNICEF are some of organizations, which give assistance to HIV positive people. The assistance could be in the form of food, medication or payment of school fees for dependent children (Meda, 2013).

2.8 Factors that Limit Youth in HIV/AIDS Voluntary Counselling and Testing

Fear of positive results is a chronic barrier to HIV counselling and testing. Also, Internet-based survey among at-risk Dutch indicated that fear of a positive test result is the most important obstacle to undertake an HIV test. Fear and not wanting to know or not feeling ready to cope with a positive result were also frequently mentioned reasons for not accepting an HIV test in the cross-sectional survey among people in Amsterdam, The most frequently mentioned reason for not having sought an HIV test was fear of the diagnosis, Worries about disclosure and breaches of confidentiality were also considered as an obstacle for seeking HIV counselling and testing (Deblonde et *al.*, 2010).

Although there are important benefits to knowing one's HIV status, HIV infection in many communities, is a stigmatizing condition.This can lead to negative outcomes for people following testing. Stigma may actively prevent people accessing care, gaining support, and preventing onward transmission. Many people are afraid ofseeking HIV service because they fear stigma and discrimination from their families and communities (UNAIDS, 2000). Few studies conducted in Africa showthat such factors like lack of awareness about the mode of transmission of the disease (HIV/AIDS), lack of perceived benefit for having the HIV test and limitation related with the

physical access to the service (distance to VCT centre) are some of the factors that can contribute for the low utilization of the already available services (Dejene, 2001).

Accessibility, affordability, reliability and dependability are factors, which influence or discourage people to go for VCT. Accessibility to VCT centres makes it easier for people to uptake the services at their convenience. If a VCT centre is located near the village; people would not want the person who knows them to see them visiting the facility. VCT centres therefore, must be scattered all over the country so that people wishing to go for testing could have a wider choice.

Generally, the greatest factors that make people not want to go for VCT are fear of positive results, lack of confidentiality, stigma, physical reason like distance where a person lives and VCT centres.The factors which encourage people to attend VCT, include need to know their HIV status, health problems, religious influence, marriage purposes, peer education and support from NGO‟s and the government institutions (Meda, 2013).

However Horizons (2001) conducted an exploratory study on HIV VCT which pointed out that VCT is a valuable way in identifying people who need HIV care. It has proved to lead as a safer sexual behaviour among some groups of youths (VCT efficacy Study Group, 2001). Sexual infections are transmitted during unprotected sexual intercourse (heterosexual and homosexual anal, vaginal or oral). Some of the infectious agents, such as HIV, hepatitis B and syphilis, can also be passed on from an infected mother to her unborn or newborn baby and can be transmitted via blood transfusions. Hepatitis B and HIV infections may also be transmitted through

contaminated blood products, syringes and needles used for injection. Counselling and testing help to prevent sexually transmitted diseases because a client may get advised on howto protect/ prevent himself/herself from STDs (UNAIDS 2000).

Good nutritional status is very important from the time a person is infected with HIV. Nutrition education at this early stage gives the person a chance to build up healthy eating habits and to take action to improve food security in the home, particularly as regards the cultivation, storage and cooking of food (WHO and FAO, 2002).

2.9 Theories on HIV/AIDS Voluntary Counselling and Testing

2.9.1 Theory of Change

Theory of change is the articulation of the underlying beliefs and assumptions that guide a service delivery strategy and are believed to be critical for producing change and improvement. The theory of change represents beliefs about what the target population needs and what strategies will enable them to meet those needs. They establish a context for considering the connection between a system's mission, strategies and actual outcomes, while creating links between who is being served, the strategies or activities that are being implemented, and the desired outcomes (Vogel *et al.*, 2012).

Although the origin of the theory of change is traced as far back as involving the works of the notable methodologists, such as Huey Chen, Peter Rossi, Michael Quinn Patton, and Carol Weiss, it was clearly articulated as a theory of change 1995 publication, New Approaches to Evaluating Comprehensive Community Initiatives by, Carol Weiss, who hypothesized that a key reason complex programs are so

difficult to evaluate is that the assumptions that inspire them are poorly articulated. She argued that stakeholders of complex community initiatives typically are unclear about how the change process will unfold and therefore place little attention to the early and mid-term changes that need to happen in order for a longer term goal to be reached.

Theory of change has two broad components. The first component of a theory of change involves conceptualizing and operationalising the three core frames of the theory. Populations you are serving; strategies you believe will accomplish desired outcomes; and outcomes you intend to accomplish. The second component of a theory of change involves building an understanding of the relationships among the three core elements and expressing those relationships clearly (INSP, 2005).

There are many change theories and some of the most widely recognized are briefly summarized in this study. The theories serve as a testimony to the fact that change is a real phenomenon. It can be observed and analyzed through various steps or phases. The theories have been conceptualized to answer the question, how does successful change happen (Kritsonis, 2004). In this study the teory of change was used so as to link the VCT's services and the youth as the move to bring about change in behaviouir on the part of the youth so as to control or avoid HIV/AIDS.

Change theory has the following stages: (1) Pre-contemplation, is a stage where by an individual is unaware of the problem; no intention to change behaviour is foreseeable. (2) Contemplation is the stage where by Individual is aware of the problem; Serious consideration of change in behaviour. (3) Preparation, in this stage, an Individual is

intending to take action (self-liberation) choosing and commitment to act or belief in ability to change (Morris *et al.,* 2012). Strengths and weaknesses of change theory: The strength of change model is that it is simple and easy to understand. This model concentrates on the fear of employees who oppose the change to happen. This is the main factor, which should be worked out by every organization to bring out (Robbins, 2003).

2.10.1 Health Belief Model

The Health belief model, developed in the 1950s by Hochbaum Rosenstock and Kegels, holds that health behaviour is a function of individual's socio-demographic characteristics, knowledge and attitudes. According to this model, a person must hold the following beliefs in order to be able to change behaviour:

(i) Perceived susceptibility to a particular health problem ("am I at risk for HIV?").

(ii) Perceived seriousness of the condition ("how serious is AIDS; how hard would my life be if I got it?").

(iii) Belief in effectiveness of the new behaviour ("condoms are effective against HIV Transmission").

(iv) Cues to action ("witnessing the death or illness of a close friend or relative due to AIDS").

(v) Perceived benefits of preventive action ("if I start using condoms, I can avoid HIV infection").

(vi) Barriers to taking action ("I don't like using condoms").

In this model, promoting action to change behaviour includes changing individual personal beliefs. Individuals weigh the benefits against the perceived costs and

barriers to change. For change to occur, benefits must outweigh costs. With respect to HIV, interventions often target perception of risk, beliefs in severity of AIDS ("there is no cure"), beliefs in effectiveness of condom use and benefits of condom use or delaying onset of sexual relations (UNAIDS, 1999).

2.11 Research Gap

The reviewed literature on VCT have revealed the positive use of VCT services, the way VCT services are offered, the obstacles to the provision of VCT services and the success of using VCT in combating HIV/AIDS in and outside the continent of Africa. However, the experience from the literature reviewed could not be extended to address the objectives sought to be met by this study due to contextual differences. For the better results which would be in line with the specific context of Singida region, this study was carried out to assess the ultilization of VCT services among youths in Singida Municipality.

CHAPTER THREE

RESEARCH METHODS

3.1 Introduction

This section details how the research was carried out in respect to the description of research design, study area, geographical location, sampling frame and sample size, data collection methods, data analysis approach, validity and reliability and ethical issues.

3.2 Research Design

The design employed for this study was descriptive cross section design. Robert (1994) defined a case study as "the empirical investigations in contemporally phenomena within its real life context. A cross sectional study is commonly used in medical and social science researches. A cross-sectional study or prevalence study is the type of observational study that involves the analysis of data collected from a population or representative subset at one specific point in time. The data were collected using questionnaires, which were given to respondents, and the analysis of the collected data portrayed the factors that challenge integration of the assessment of the utilization of VCT services by the youth in Singida Municipality. This will aid in developing strategies for effective integration and maximizing youth in the utilization of VCT service.

3.3 The Study Area

The research was conducted in Singida region, Singida district in Singida Municipality, specifically at Sokoine-VCT Centre where the data were collected

3.3.1 Geographical Location

Singida region is located in central Tanzania. It lies between longitudes 33 degree, 27", 5"and 35degree,26"east of Greenwich, and latitudes 3 degree52"and 7degree 34"south of the equator. Singida town is the regional headquarter and forms a vital en route transit town from Dar es salaam to lake Victoria zone in the North west, Lake Tanganyika in the west, and Arusha in the North.Singida town is 700 kilometres from the commercial port city of Dar es salaam, and 330 kilometres from the Capital town Dodoma (maplandia.com@www.maplandia.com/tanzania/singida/

The region is boundared by Arusha Region to the north, Dodoma Region to the east, Mbeya and Iringa Regions to the south, Tabora Region to the west, and Shinyanga region to the North-west respectively.Singida municipality was selected because they have a high prevalence of HIV/AIDS in Singida Municipality.

3.5 Sample, Sampling Procedure and Sample Size

3.5.1 Sampling Procedure

As defined by Rwegoshora, (2006) a sample is a portion of people drawn from a large population whereas sampling is an act of choosing a sample for the study. In this study the researcher used purposive sampling procedureto get all youths with HIV positive and negative status.

3.5.2 Sampling Frame and Sample Size

Nachimias (2003) defined sample as "the sub set of a population". The researcher used 45 respondents purposively selected for the study, from a sampling frame of 200 people.Interviewed youths were chosen from 3% of the sampling form, because of big

number of people limitation study. These were 20 youths with HIV/AIDS, 20 Youth without HIV/AIDS, 2 Staff (counsellor), and 3youth care takers to make the total of 45 participants.

The sample size was calculated by using the following formula; N=z2 $p(1-p)$

N=Z2P (1-P)/E

N=minimum sample size of the study

Z=the standard normal deviation, set at 1.96

E=standard error of the study set at 5% (0.05) and 95% confidence interval

P=proportion of the sampling frame set at 3%

Substituting;

$$N = \frac{1.96^2 \times 0.03 (1-0.03)}{0.05}$$

N = 45

In this research study the sample size was 45

3.6 Data Collection Methods

3.6.1 Questionnaires (Unstructured)

This is a method used to gather data in the field where the researcher wrote down some questions for the respondents to answer during data collection. The questions were given to the respondents and were collected later after they had been answered. This method ensured collection of enough information from the respondents since the

papers containing those questions were not written the names of the respondents. Therefore, the participants answered the questions extensively and with comfort ability. This method was useful especially to the literate respondents. Therefore, this technique was thought by the researcher to be the best method as respondents were able to write and read their opinions.

3.6.2 Focus Group Discussions

Kombo and Tromp (2006) explain that a focus group is a special type of group in terms of its purpose, size, composition and procedures. They add that a focus group is usually composed of 6 to 8 individuals who share certain characteristics, which are relevant for the study.This is another method that was used during research to collect the data. The researcher identified groups that were to discuss the topic questions together. The group members were from,youth with HIV/AIDS, youth who were not infected, counsellors and care takers.

3.6.3 Observation

As it is defined byWoods (2006) observation is a data collection method where information is sought by the way of the researcher's own direct observation without asking from the respondent. The main advantages of this method according to Woods (2006) are three. One, it eliminates bias if observation is done correctly. Two, the information obtained under this method relates to what is actually taking place at the time.

Third, it is independent or free from the respondents' willingness to respond and therefore, it is relatively less demanding of active cooperation on the part of the respondents, as it is usually the case with interviews and questionnaires.

However, the disadvantages of this method are as follows: first, it is an expensive method. Second, the information provided by this method is very limited. Third, sometimes, unexpected factors may interfere with the observational task. Despite the limitation, the researcher used the method and its weaknesses would be supplemented by other methods such asquestionnaires and focus group discussions as well as documentary reviews (Krishnaswanmi and Ranganatham (2010)

The researcher applied this method to observe, among other things, the level of the youth with HIV/AIDS' confidence, reduction of stigmatization and ability of the youth to socialize with other people, their return for appointment, physical appearance, CD4 checking and the like. This was done through the researcher's effective participation in testing and counselling session of the youth infected and not infected with HIV/AIDS.

3.6.4 Documentary Review

According to Willig (2008), documentary review refers to an act of scrutinising or perusing some documents for some information. This information is usually obtained from secondary sources of data whichare the sources which contain information which has been collected and compiled in the form of documents like compendia, reports, journals, dissertations, internets and others. This study also used such sources of information to enrich its findings.

3.7 Data Analysis ApproachÍ

Braun and Clarke (2006) state that "thematic analysis is a qualitative analytic method for identifying, analyzing and reporting patterns within data. Thematic analysis

minimally organizes and described data set in details. However, frequently it goes further than this and interprets various aspect of the research topic. In this study qualitative data obtained were analyzed manually by the use of data master sheet.

All data obtained from the respondents' filled questionnaires were entered on the data master sheet. Similar responses were grouped together and non-similar responses were entered separately. On the other hand, the quantitative data were analyzed by use of SPSS software version 17, hence data were presented in form of pie chart and bar charts.

3.8 Validity and Reliability

(Krishnaswanmi and Ranganatham (2010)elaborate that validity is a research tool which measures what was intended to be measured or how truthful the research results are. In another words, does the research instrument allow you to hit "the bulls' eyes" of your research object? Researchers generally determine validity by asking a series of questions and will often look for the answers in the research of others. Kirk et al (1986) defined reliability as "the extent to which results are consistent over time and an accurate representation of the total population under study". If the results of a study can be reproduced under a similar methodology, then the research instrument is considered to be reliable. The qualitative part of the research was to examine the youth utilization of VCT services.

To observe validity and reliability, the researcher paid attention in coding respondents' responses correctly so as to have results derived from the respondents. Data were collected instantly from the respondent after brief introduction of the

subject matter without letting them to have time for discussion, which could give unintended results.

3.9 Ethical Issues

A clearance letter was obtained from the Open University of Tanzania and submitted to the Medical Officer in charge of Singida Regional Hospital for granting permission to conduct the research study. An informed consent form was attached to each questionnaire and filled by the respondents for voluntary participation and to ensure confidentiality of the collected data. Respondents's names where not used. So far, respondents were assured of their confidentiality by explaining to them that the information they gave was not to be used otherwise except in this research and that their identity will not be revealed.

CHAPTER FOUR

DATA PRESENTATION, ANALYSIS AND DISCUSSION

4.1 Introduction

The objectives of this study were first, to determine the level of knowledge about VCT services among the youth in Singida Municipality as per available information and national campaigns on HIV/AIDS in Tanzania. Second, to examine the youths' attitudes on HIV/AIDS VCT uptake services; and three, to identify and suggest to the youth in Singida Municipality of the proper ways or means which they can use toutilize VCT services as a means of protecting themselves against HIV/AIDS. This chapter presents; analyses and discusses the findings of the study. The chapter starts by first presenting the demographic characteristics of the respondents.

4.2 Demographic Characteristics of the Respondents

The total number of the respondents involved in the study was 45, which was obtained through purposive sampling. The age range of these respondents was between 15-24 except for the 45 counsellors whose age range was between 35-45. Table 4.1 gives the categories of those respondents in terms of sex and age.

Table 4.1: Demographic Characteristics of the Respondents

Category of Respondents	**Age Range**	**Sex and Frequency**		**Total**
		Male	**Female**	
Youth	15-24	20	20	40
Counsellors	35-45	3	2	5
Total		**23**	**22**	**45**

Source: Research Data, (2016)

As it can be seen from Table 4.1, the age of the youth respondentsas it has been shown ranged between 20-24.This was important because, this is the age which as Ganle,et al; observe (2012) it is the age category within which many HIV/AIDS prevention and education messages are often constructed showing this group as one of the high risk groups. Therefore, the age category of these respondents reflected the topic under discussion.

With regard to the counsellors, although their age was not that advanced, the focus was not on their age except on their profession despite the fact that age would add something extra but very beneficial to the study in terms of experience related to the world of one's experience and personal life.

4.2.1 Marital Status of the Respondents

When it comes to awareness and fight aboutHIV/AIDS, one's marital status is important this is because, as Adair (2007) argues with a specific reference to adolescent women that married adolescent women in Sub-Saharan Africa are vulnerable to HIV infection than unmarried women because sexual initiation occurs earlier and there is greater frequency of sexual intercourse with their husband who in some cases, is more likely to be older and HIV positive than the partners of unmarried women. Also, it is argued that young married women may use condoms more rarely because of a lack of bargaining power in their marriage.

However,Shisanaet al. (2004) wrote about HIV within the context of South Africa observe that the risk of HIV infection is significantly higher among the unmarried compared with married people when only sex behaviour factors are considered. All

the same, this study considers marital status that is, being married or not to have some bearing in the exposure, prevalence or fight against HIV in some given circumstances. It was revealed that 8 of the female youth respondents equal to 29% of the youth respondents were married, and 5 of the male youth respondents equal to 18% were married. The total number of the married both female youth respondents was 46% against 54% of the unmarried youth respondents both male and female. As it can be seen, there were more unmarried youth respondents of both sexesthan those unmarried youth of both sexes. There were no cases of widowed, separated or divorce cases. Figure 4.1 highlights this aspect.

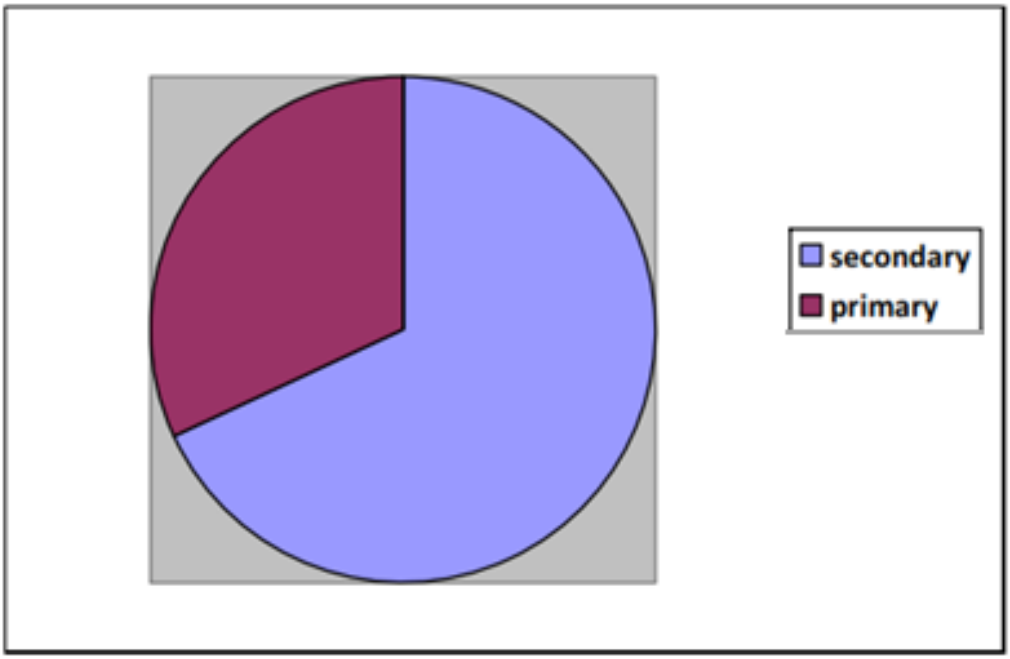

Figure 4.1: Marital Status of the Youth Respondents

Source: Research Data, (2016)

4.2.3 Educational Level of the Youth Respondents

It was revealed that 7 of the youth respondents had primary education level (25%), 15 had secondary education that is form four up to form six (53The remaining six (21%) had tertiary education that is, some training at the certificate, diploma and degree

level. From these figures (15% and 21%), it can be argued that the youth respondents involved in the study had the minimum level of education which would make them understand different issues that were presented to them with regard to HIV/AIDS in Singidamunicipality. Figure 4.2 highlights the educational level of the youth respondents.

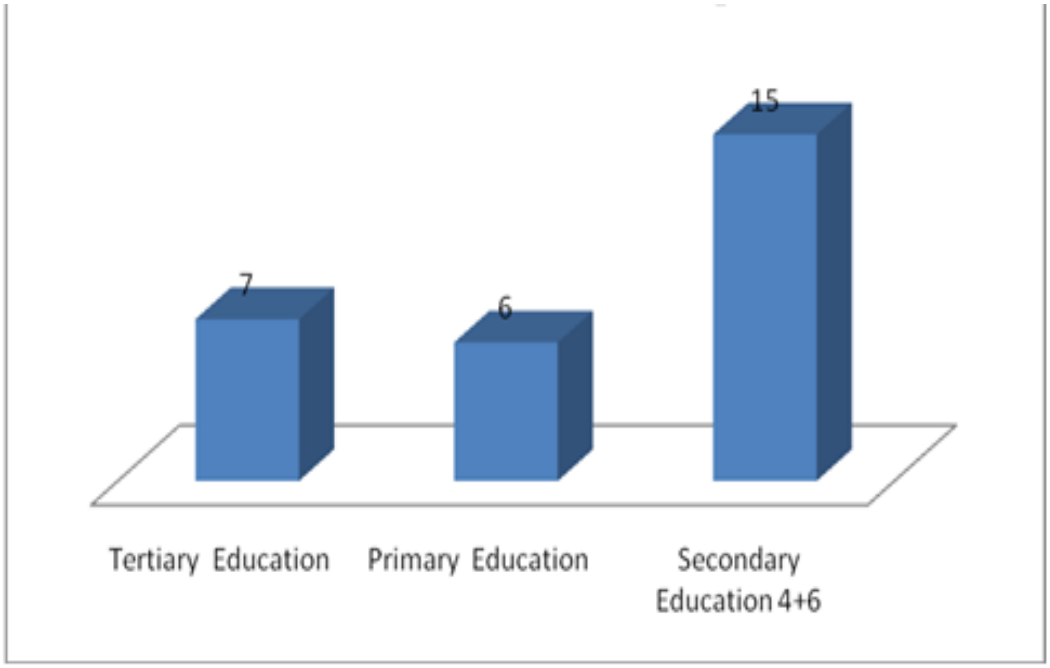

Figure 4.2: Educational Level of the Youth Respondents
Source: Research Data, (2016)

4.2.4 Educational Level/Professional Level of the Counsellor Respondents

It was revealed that those four counsellors involved in the study as respondents had the following relevant qualifications for their field. One had a certificate in Guidance and Counselling (25%). Two had a diploma in Counselling and Guidance (50%) and one had a bachelor degree in the field she was employed (25%). Therefore, it can be argued that these counsellors had the right qualifications, which would enable the discharge their responsibilities properly. Figure 4.3 shows this information.

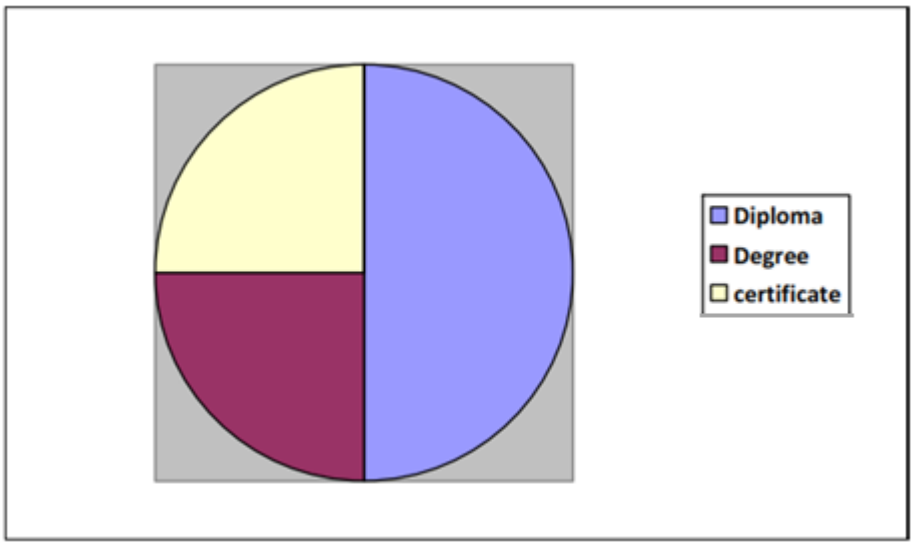

Figure 4.3: Educational Level/Professional Levels of the Counsellor Respondents

Source: Research Data, (2016)

4.2.5 Working Experience of the Counsellor Respondents

As it was revealed from the findings, one counsellor (25%) had a working experience of five years, two (50%) had a working experience of seven years each, and the remaining one (25%) had ten years in her profession. From these findings, it can be argued that the working experience of the counsellor respondents was enough to make them knowledgeable in what they were doing. Figure 4.4 highlights this fact.

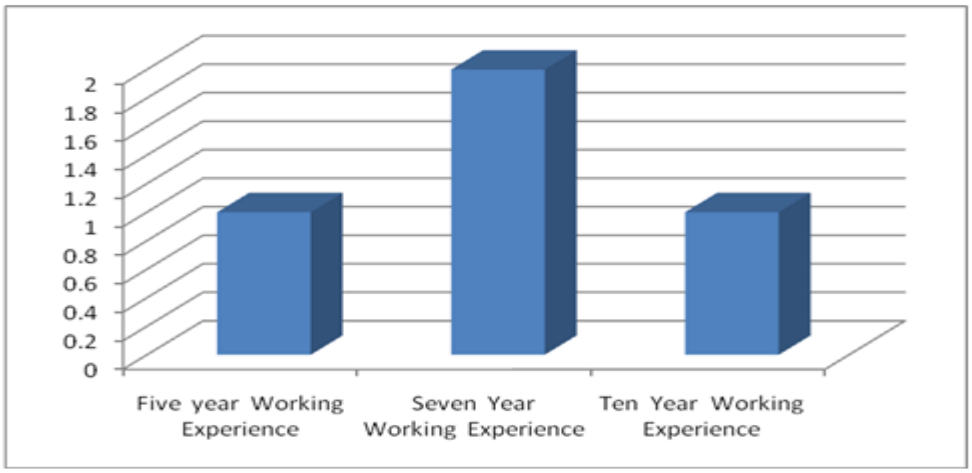

Figure 4.4: Working Experience of Counsellor Respondents

Source: Research Data, (2016)

4.3 Youth's Level of Knowledge about Voluntary Counselling and Testing

The first objective of this study was to determine the level of Voluntary Counselling and testing services uptake among the youth in Singida Municipality as per available information and national campaigns on HIV/AIDS in Tanzania. But before going into the details of the findings, the following two Tables below give the general picture of the HIV testing for the youth in Singida Municipality.

Table 4.2: The Number of Young People who went for Screening in 2015 (January to December)

Age Category	Males	Positive	Females	Positive	Total of Those who screened	Total No of Positive Cases F+ M	Percent of Positive cases
14+	408	24	368	20	776	44	5.6
15-25	2760	77	3692	142	6,452	219	3.3
TOTAL	**3168**	**101**	**4060**	**162**	**7,228**	**263**	**3.6**

Source: Current Literature, (2016)

Table 4.3: The Number of Young People who went for Screening in 2016 (January to September)

Age Category	Males	Positive	Females	Positive	Total No of Those who Screened	Total No of Positive Cases F+ M	Percent of Positive cases
14+	445	28	400	29	845	57	6.7
15-25	1949	20	3134	85	5,083	105	2.0
Total	**2,394**	**48**	**3534**	**114**	**5,928**	**162**	**2.7**

Source: Current Literature, (2016)

As it is revealed in two Tables (2 and 3) above, the number of the youth going for testing in the two years (for those who ranged between 15-25) were 2760 (males) in 2015 and 3692 (females) out of which 77 (males) were found to be HIV positive and 142 (females) were found to be HIV positive. Again, in the year 2016 from January to

September a total of 1949 males aged between 15-25 went for testing out of which 20were found to be HIV positive. Again, 3134 female youth went for testing out of which 85 were found to be HIV positive. Basing on this information, the researcher was interested to know if this number of the youth turning for testing was self initiated or there was a mechanism behind it.

Through the questionnaires administered to counsellor respondents, it was found that awareness of the youth/young people who were turning up for counselling was not that impressive, rather the number of the youth who were tested in those years was it because of other reasons such as pregnancy and when one wanted to donate blood. It waslearnt that pregnant women were required to be HIV tested when they attended the maternal clinic. It was learnt that when these pregnant young women went for clinic they were required also to bring their mates/husbands so as to have the test together. On this aspect of the youth, one counsellor respondent remarked:

It is true that unlike in the past, nowadays the youth turn up for testing, however, this utilization is not that big. Those who go to hospital and get HIV tested are those who are pregnant. Since, in most cases they are required to bring their mates/husbands, the number appears to be that big. Fine, it is a kind of utilization especially when husbands or matesof pregnant women turn up for testing.

With regard to the level of knowledgeor awareness about voluntary counselling, through questionnaires administered to the youth not infected with HIV, the following findings were generated.

4.3.1 Knowledge about the Existence of VCT Centres

On this particular aspect, it was revealed that 5 respondents (63%) among the8 youth uninfected with HIVthe remaining 3 (37%) said they were not aware if there existed any VCT centre in Singida Municipality. When asked asto how they came to know that they were HIV negative, those who said that theydid not know about the existence of any VCT centre in Singida claimed that they felt motivated to go for screening due to some pressing matters such as when they were pregnant and found themselves compelled to screen. Others said that they were required by their partners to go for screening before they were married. They claimed that they knewthat they were goingto hospital for screening but theydid not know that they were going to the voluntary counselling and testing centres. These findings to a certain extent reflect what (Meda, 2013) found that, the greatest factors that make people to attend VCT, include need to know their HIV status, health problems, religious influence, marriage purposes, peer education and support from NGO"s and the government institutions (Meda, 2013). The following Figure summarizes these findings.

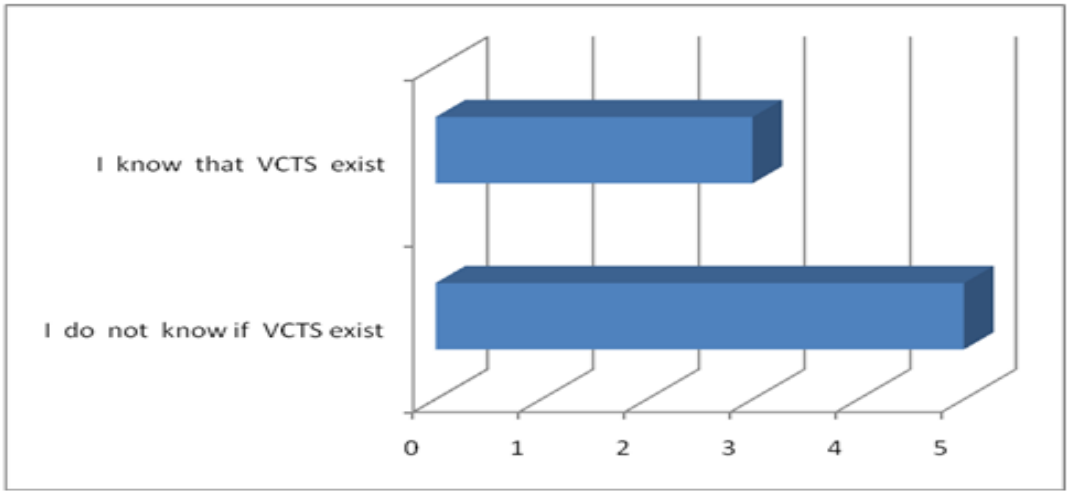

Figure 4.5: HIV Negative Youth's Knowledge about Testing and CounsellorCentres

Source: Research Data, (2016)

The study was also interested to know about the utilize on those youth infected with HIV had on the existence of VCT Centres in Singidamunicipality. It was revealed that all the eight (100%) HIV positive youth had knowledge about the existenceof VCT centres in Singida municipality. However, this awarenesscame after they hadbeen tested for HIV and were found positive. One of them remarked this:

> *I went to hospital to receive treatment after Ihad experienced chest pains for some months and I was losing weight andappetite. One of the specimens taken was blood. When the findings were given I was told that I was HIV positive. I was then taken to a room where I was met with a cheerfulmiddle-aged woman. She asked me a lot offriendly questions which I enjoyed answering. She told me that being HIVdid not meanend of life. I would go onfunctioning as normalas before if I only adhered to what I wastold includingattending counselling sessions. It is only then that for the first time, I knew what VCT means.*

Another HIV positive youth remarked:

> *I did not intend to go for screening inthe first place. It only happened after I had been involved in an accident where as a result I was admitted at the Singida referral hospital .I badly needed blood and therefore people had to donate me some blood. However, in the process, my blood had to be taken to establish its group. It was only then that I was HIV positive. It completely took away my peace.You knowwhat thestigma associated with beingidentified with HIV/AIDS in the community. Although I was asked to be regularly attending counselling clinic, I have never been able tofollow that to the letter. Why, I feel shy and isolated. I have never beenable to overcomethis kind of self-stigma.*

Yet another HIV positive youth explained how she came to know about VCT centres:

> *I was about to be marriedto the man I loved. However, before he led me to the altar, his parents andthe clergy insisted that we go for HIV test first. I then did not know that there existed any VCT centre. Well, I was tested HIV and the marriage plans then collapsed. It is then I knew that there were these VCT centres.*

Generally, the above findings show that unlike the youth who were identified as HIV negative after screening, some of whom never knew what the VCT centres were, those

who were identified HIV positive some of them were like them that is, they lacked knowledge on whatwere the VCTs. However, they came to know them after they were HIV tested positive that is when they knewthese centres, definitely through having to attend the counselling andtesting sessions. Figure 4.6 explains the way this kind of awareness about VCTs was created among the HIV positive.

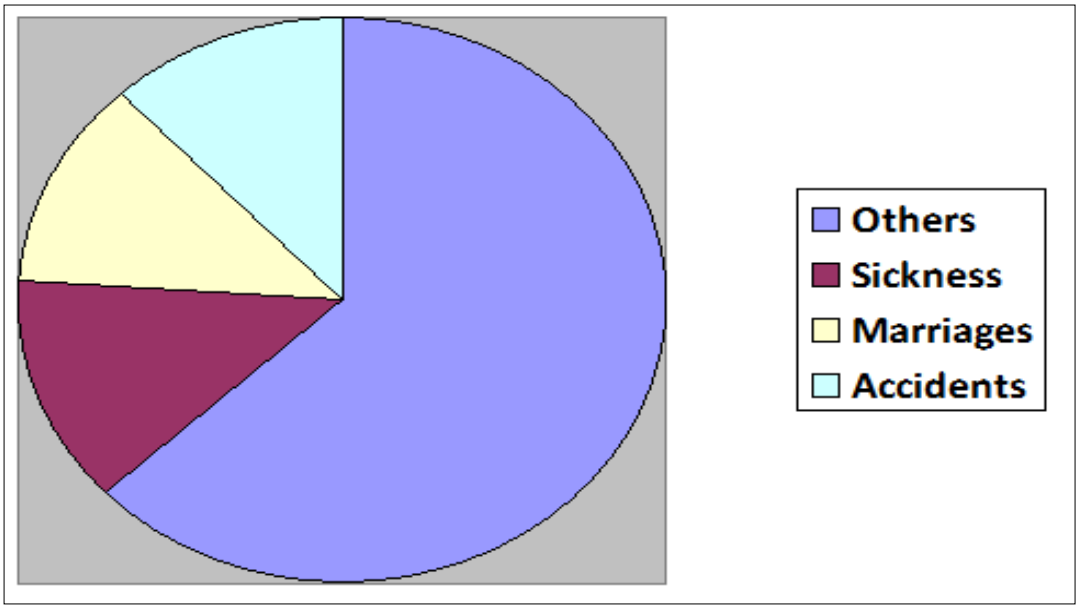

Figure 4.6: HIV Positive Respondents' Utilizationof VCT ServicesYouth's Knowledge about Testing and Counsellor Centres

Source: Research Data, (2016)

The second objective of this study was geared towards examining the youth's attitudes on HIV/AIDS voluntary counselling and testing services in Singida municipality. Through the findings, it was revealed that more than 24 (86%) had negative attitudetowards the counselling and testing services in Singida municipality. It was revealed that it was only 4 (14%) youth respondents who had a positive attitude towards these services. Those who had a negative attitudetowards these services had the following reasons:

4.3.2 Fear of being Identified as HIV Positive

It was revealed through the findings that youth people in Singida municipality had fear of going to VCT centres in order to test for HIV for fear that they would be declared HIV positive. These were especially concerned what would bethe outcomes ifthey were identified HIV positive. Many feared the stigma that would be associated with them ifthey were identified asHIV positive. It was learnt that those who had their worries on this aspectwere recalling their present and past sexual activities and they were scared that they might be affected. One respondent on this particular aspect had this to say:

> *For my side, it was not easy to make the decision to come here for testing and counselling. It was becausewhenever I reflected back on my past sexual life styleI was scared to death. Frankly speaking, I had had a very promiscuous life. Some of my past known sexual partners have been reported to be infected with HIV and some of them have already died. When I could not holdit any longer, I decidedto come here for testing. Come what may be, I said. But I am happy that what I was fearing most did not come true. I mean I tested negative. I know alot of young peopleout there who have a story like mine. They cannot venture to come here for testing. They are afraid ofwhat might come as a result of testing. Some of them even wish that these VCT Centres were not there in the first place.*

4.3.3 Not Trusting the Counsellors

Some youth respondents revealed that some of them did not like to go to VCT centres for HIV testing and counselling because they did not trust the counsellors. They were ofthe ideathat whatever transpired after the testing, would be spilled by the counsellors. This made them never wish to go to VCTcentres for testing and possibly counselling.

4.3.4 Meeting Someone you know at the VCT Centre

It was revealedthat some youth had a negative attitude towards the VCTs because they were afraid that if they went there they would meet someone they knew thus they

would be embarrassed because what they wanted to do would be known. It was revealed that some youth had a perception that going toVCT centre for testing it must be that you were promiscuous and therefore you were HIV positive. These findings closely relate with those by the World Health Organization (WHO,2012), which among other things found that health services were delivered in a way that adolescents did not want to obtain them even if they could. According to WHO (ibid) one common reason for this that was the dislike the youth had to go to, and wait in, a place where they could be seen by people they knew. Other reasons were the fear that healthworkers would scold them, ask them difficult questions, and put them through unpleasant procedures orthat health workers would not maintain confidentiality.

4.3.5 Feeling that you are Healthy without any Sickness Sign

As it was revealed above, some ofthe youth who went for testing did not actually go there simply because they felt like going there but they were prompted by some compelling reasons such as feeling sick and others. In contrast, as it was revealed, some youth who felt that they were healthy, they did not feel like going to VCT centresfor counselling. Some had evena spurious notion that ifyou did not drop your weight,then youwere not HIV positive. With this false notion in mind, they would weigh themselves on some weighing scales which were usually a business of some young vendors in Singida municipality. That means, if a person appeared to lose weight, then one would start suspecting that he or she might be HIV positive.

On the contrary, if the personweighed oneself onthe scale and found that he or she was not losing weight, or perhaps there was some improvementor gain, then one would

conclude that he or she did not have any HIV infection. Some even did a funny thing; they made their wives or lovers as yardsticks to measure also their status. If they became sick and or perhaps went for testing for HIV at VCT centres, when they were tested positive they would buy that information wholesale without minding to go for testing themselves.

4.3.6 Shortageof Awareness or General Knowledge on HIV Infections

Through focus groups, it was revealed that some youth hada negative attitude on voluntary HIV screening because they lacked awareness or knowledge on HIV infections. It was reported that some people did not believe that HIV/AIDS was real. Since they did not believe in such reality, they were seeing the VCT Centres as places of imposition which some people haddecided to create for their own ends. It was reported that even when they became sick with all signs of full blown AIDS, some people did not believe that they were suffering from AIDS. They believed to have been bewitched by some people who did not like them.

Therefore, instead of going to hospital or to VCT centres to knowtheir status, they flockto the traditional healersbut who could not diagnose their sickness with success. These findings correlate with those by Ganl,*et al*(2012) in Ghanawhich revealed that some respondents could not distinguish between HIVand AIDS and therefore they incorrectly linked AIDS to physical appearance that is, it waspossible to tell whether a person had been infected with AIDS through the physical appearance of such a person such as being physically thin or weak. Again, some participants believed that AIDS could be caused by witchcraft.

4.3.7 Shortageof Facilities at the VCT Centres

It was reported by some youth respondents that they were averse to go to the VCT centres for services because these centres lacked enough facilities such as chairs, benches and toilets. They complained that they would go there andfind themselves lackingsitting facilities such as chairs and benches. They said that this made them very tired and uncomfortable having to stand up for so long while waiting for the service. One youth respondent remarked:

> *We would like to go to the VCTcentres for HIV testing and counselling. Many of us in fact. However, the problem that makes many young people dislike going there is the lack of facilities suchas chairsand benches. I for one went to one of these centres and found such a situation. I tell you, after waiting for a long time for service without having anywhere to sit, I decided to go away. I have never gone back there again.*

The findings above closely align with The Focus on Young Adults study (1999), which informs that there is a growing recognition among reproductive health providers throughout the world that "youth-friendly" services are needed if young people are to be adequatelyprovided with reproductive health care. Thereport makesit clear that if such services are available and properlygiven,they will be able as a result, to effectively attract young people, meet their needs comfortably and respectively.

Likewise, the study findings by Erulkaret et al. (2005) showed that young people were in favour of youth-friendly reproductive services. They mentioned some factors contributing to theexistence of youth -friendly giving of reproductive health services to be: positive staff attitudes, reasonable or affordable costs, short waiting time and the ability to obtainall services at once and convenient opening hours. The study recommended that these aspects should be improved because their presence guarantees good service delivery to the youth.

Again, these findings closely align with the Theory of Change, which argues that individuals changebehaviour after they havebecome aware ofthe problem. Likewise, these findings reflect the HealthBelief Model, which holdsthat people changetheir behaviour because theyhold some belief about their condition or a phenomenon. In the context ofthe study, young people in Singida Municipality were going to the VCTcentres because some had some awareness about HIV therefore they wanted to verify if they were infected or not and what they should do if they were confirmed positive or negative.

4.3.8 Shortage of Enough Trained Counsellors

It was revealed that shortage of enough trained counsellors or other staff in many VCTcentres in Singida municipality made many youth cherish a negative attitude towards them. Through focus group discussion, one counsellor stated that they werehaving a problem of shortage of staff intheir VCT Centres. Thus, sometimes they were to deal with a big number of youth wishing to test beyond the number of the serving staff. However, because they were few in number, it was not possibleto give them theservice they neededno matter how much they wished:

We would like to give the best service to our clients. However, due to the shortage of staff to accommodate the growing demand ofthe youth who would needour services, we find ourselves stranded. This may translate into negligence or sheer lack of careto our customers. Because they do not get the service they would wish, they go back disappointed and hencethey develop a negative attitude towards us. Through observation, the researcher also noted that the counsellors and other members in these VCTcentres were weighed down with so many duties such that they failed to deliver

goodservices to the youth, as result they made them develop a negative attitude towardsthese centres.The following Figure sums these responses in terms of percentages of the respondents' reactions.

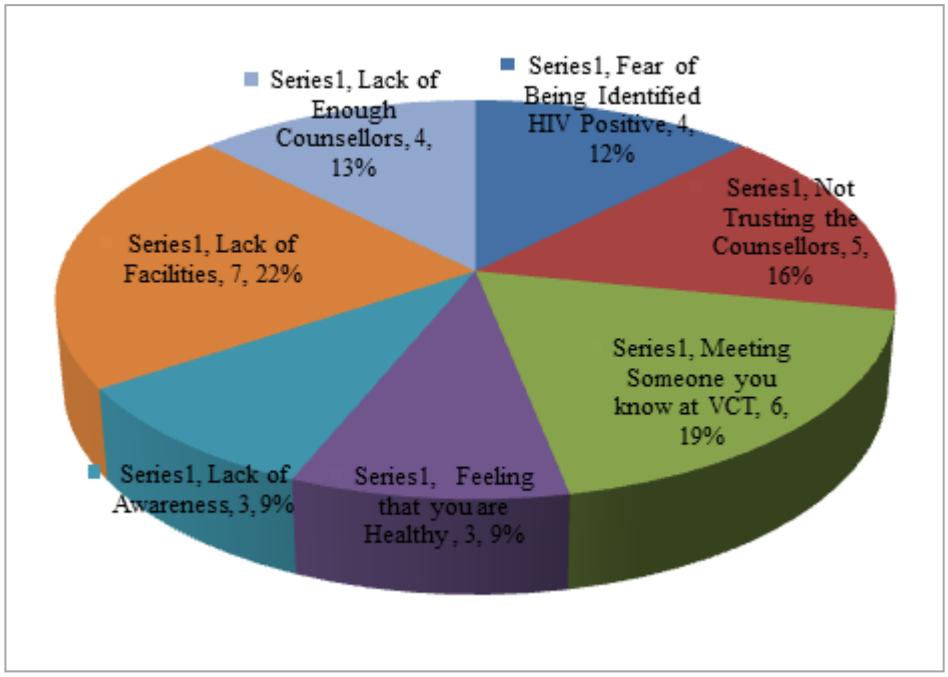

Figure 4.7: Reactions of Respondents as Revelations of Attitudes Towards VCT Services

Source: Research Data, (2016)

4.4 Identification and Suggestionson the Best Ways or Means to Utilize VCT Services for the Youth

The specific objective number three sought to identify and suggest to the youth in SingidaMunicipality of the proper ways or means which theycan use to utilize VCT services as a means of protecting themselves against HIV/AIDS.Through the findings, it was revealed that there were different ways, which the youth would use to utilize the counselling and testing services so as to successfully deal with the cases of HIV/AIDS or simply for them to have optimal sexual health. The following are those means or suggestions:

4.4.1 Creating more Utilization of VCT Services

As it was stated in the findings onobjective number one, many youth were not utilizing the services provided by VCT centres. Those who happened to beutilize those services only became so through being pressed by some circumstances such as feeling sick or infected with HIV or when one was pregnant or was involved in an accident or when they want to marry each other is where testing for HIV became a necessary options.

Through the focus group discussions and questionnaires administered to respondents, they suggested that more awareness should be created onthe VCT servicesin order to get the youth go for those services on the voluntary basis instead of waiting for some emergency or pressing problem to force the person. This suggestion was supported by 10 respondents (31%) involved in the study.

4.4.2 More VCT Centres should be Opened

Through observation, questionnaires and focus group discussions it was learnt there is a need to open more VCT centres soas toaccommodate the risingdemands for testingand counselling whethervoluntary one orthat is imposed by some demands. This suggestion was given by 9 respondents (28%) out of the 32 respondents involved in the study.

4.4.3 Training or Employing More Counsellors

Through the findings, it was learnt that there was a shortage of qualified counsellors in the VCTs in Singida municipality who would handle different matters related to voluntary testing and counselling. Out of the 32 respondents, 5 respondents (16%) raised this matter and recommended forsuch employment and training need.

4.4.4 Improving the Delivery of Counselling and Testing Services

It was found that in order to attractthe youth and get them use the testing and counselling servicesoffered bythe VCTs, there was a need for improving the services. This would be achieved, by for example, having afriendly and accommodating workingenvironment, providing services such chairs or benchesto allow the respondentsto sit comfortably whenwaiting forthe services would be a very good thing that will encourage the youth to attend VCTs. This improvement was givenby 8 respondents (25%) out of the 32 respondents involved in the study. As a summary of what have been discussed on this objective, the following Figure gives the percentage of the respondents on each suggestion given.

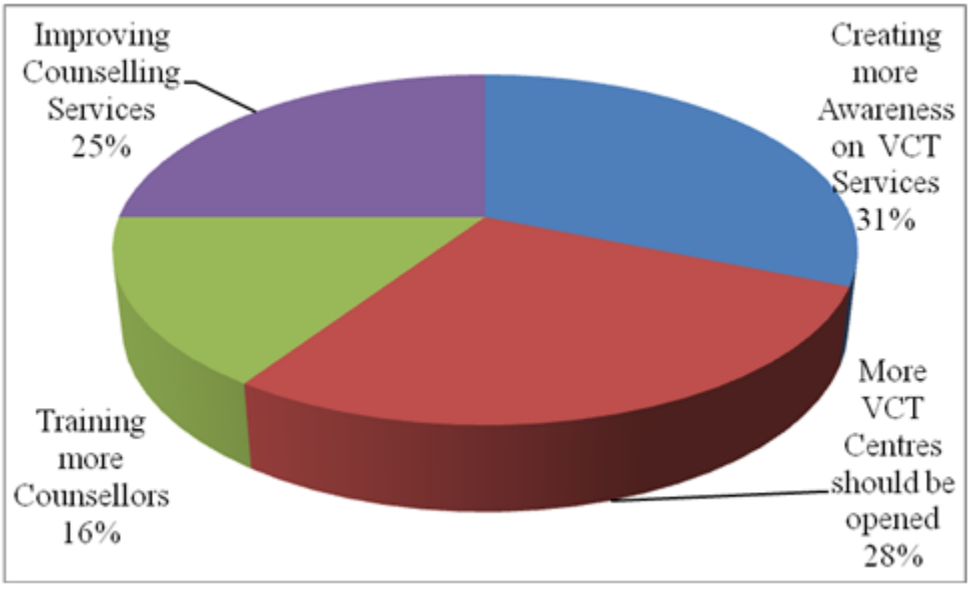

Figure 4.8: Respondents Suggestions on how to Improve VCT's Counsellilng and Testing Services

Source: Research Data, (2016)

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

This chapter presents a summary of the major findings of the study followed by conclusion and recommendations. The aim of this study was to assess the utilization of theVCT services by the youth inSingida Municipality. It was enshrouded into three specific objectives, whichwere first, to determine the level of knowledge about VCT services among the youth in Singida Municipality relying onthe available information and national campaigns on HIV/AIDS in Tanzania. Second, to examine the youths' attitudes on HIV/AIDS VCT uptake services; and three, to identify and suggest to the youth in SingidaMunicipality of the proper ways or means which they could use to access VCT services as a means of protecting themselves against HIV/AIDS.

5.2 Summary

The findings of the study showthat the youth in Singida Municipality had some awareness on the services provided by VCT centres in the municipality. However, this awarenesswas largely induced by pressing issues such as pregnancy, sickness, accidents and marriages, which compelled the youth to seek such services. For example, it was revealed that pregnant young mothers were required to be tested for HIVwhen they started attending clinic. As aresult ofthis they came to know and utilise the VCT services for example counsellingthrough attending different counselling sessions. Again, in some respects, they were required to bring their partners when they had any. Likewise, those who were involved in accidents and those who weresuffering from related HIV/AIDS pandemic such as tuberculosis on attending hospital, they

would be tested of HIV.Also, those who were involved inaccidents and those who wanted to get married.In some respects, they were requiredto screenfor HIV. In this way, they came to develop awareness of the VCT services. Despite this kind of awareness, there were those youth who ontheir own, were motivated to knowtheir HIV status andtherefore decided to go to VCT centres for the same purpose.

It was learnt that the attitude of the youth towards the VCT centres was largely negative. This was especially caused by the services given by the centreswhere in most cases there was a delayin the delivery ofthe services caused by the shortage of counsellors and also some youth did not like to go to these centres for fear of meeting someone they knew. For these, the act of screening was to be done in strictest confidentiality.

5.3 Conclusion

conclusion this study has demonstrated that there is no adequate knowledge on the availability of VCT services in youth of singida municipality, the community though still have traditional methods of Disseminating and providing information to the youths are still being used.

An interaction of individual, community and institutional factors were found still to be limiting the youths'' access and utilization of the VCT services and hence have an influence on the commitment to take action to test or no, another factor is that most of the young people who attend VCT services are those who feel that they are at risk, especially after involving into unprotected sex according to counselors experiences.

These factors have the possibility of adding on the overall costs of providing the services to the youths, which in most cases reduces the utilization levels. Mobile clinics and outreaches seem to be more acceptable to the young in case VCT service is to be provided to them rather than the structural arrangements in health facilities and project site. The policy on VCT is still silent on providing youth friendly VCT services; thus provides a stabling block to the service providers and hence limiting access to VCT services among the youths.

However, there are limited opportunities for retraining counselors. Other obstacles being lack of resources to run the VCTs, difficult in accessing the services, restrictive policy on age limit for HIV test, lack of national monitoring system, lack of continuing support to HIV positive youth, also negative attitude to the VCT services by people surrounding youth's contribute to low uptake of the VCT services by young people. Youth's confidence that they are not at risk, an individual fear which is associated with stigma and segregation to people with HIV positive results, irresponsibility to an individual health, were among of the reasons associated with youth not attending the VCT services.

Moreover, from the findings knowledge on HIV/AIDS including the VCT services was among of the factors that contribute to young people attending or not attending the services. Young people who had access to HIV/AIDS knowledge through HIV interventions efforts geared to youth's in schools and out of schools environments tend to seek VCT services. While in areas without such intervention programs the return rate of young people to the VCT services mentioned to be low.

Given the findings, the study concludes here that there was some awareness on the use of VCT services by the youth in Singida municipality although this awareness was largely propelled by some pressing matters that made the youth seek for those services thus automatically finding themselves connected to use such services. National Policy on HIV and AIDS 2001 policy reiterates the Government of Tanzania's (GOT's) commitment to HIV and AIDS as a priority area and calls for strong political commitment and leadership from all levels of government and civil society to ensure sustained and effective interventions. From such results we can conclude that multi approaches are needed if we intend to make the VCT services being attractive and used by many young people.

5.4 Recommendations

In the light of the study findings, the following recommendations are here being made.

5.4.1 Recommendations for Action

First, there should be more sensitization of the youth on the services offered by the VCT centres in Tanzania and Singida in particular. The youth should be sensitized to such a point that they will see that going to VCT for HIV screening is a normal thing regardless of the consequences.

Second, the working environment of the VCT centres should be improved in terms of service delivery such as having enough rooms and counsellors who can offer maximum testing and counselling services in an environment that is friendly, comfortable and with maximum confidentiality. To affect this, more training for the

counsellors and improvement of the physical environment of the centres will be needed.

5.4.2 Recommendations for Further Study

Despite the fact that studies on HIV in relation to the youth and VCT centres abound, specific environments with regard to the youth and HIV in relation to utilization of voluntary counselling and testing would warrant some studies in order to explore the specific attributes surrounding some people and their environment. With this in mind, this study recommends that there should be done some other studies in some other places in Tanzania and other countries in order to explore the specific environment surrounding the awareness of the youth with regard to VCT services.

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APPENDICES

Appendix I: Research Tools

1. QUESTIONNAIRE GUIDE FOR THE YOUTH RESPONDENTS (THOSE NOT INFECTED WITH HIV/AIDS)

PRELIMINARY INFORMATION

(a) Sex of the Respondent: MALE...../FEMALE.....(Write M or F where appropriate)

(b) Age of the Respondent.....Years

(c) Married/( )Single ( ) Separated ( ) Divorced ( ) Widowed ( ) Put a tick where appropriate

(d) Educational Level

(i) Standard Seven ( ) Form Four ( ) Form Six ( ) Tertiary Education (Certificate, Diploma, Degree)

(i) Do you know why the VCT centres are there?

(ii) Why did you go for screening/why have you decided to come for screening?

(iii) What the importance is of HIV/what are the reasons whichmake young people go for screening?

(iv) What are the reasons which makeyoung people go to VCTfor HIV screening?

(v) Are you satisfied with the services given by the VCT centres?

(vi) Apart from being scared of going for voluntary testing, what are the other reasons, which prevent the youth in SingidaMunicipality from going for such services?

(vii) What do you advise the following stakeholders in the fight against HIV/AIDS

-Counsellors/NGOs?

-The Government?

-The youth?

THANK YOU VERY MUCH!

Appendix II: Questionnaire Guide for the Youth Respondents (Those Infected with HIV/AIDS

PRELIMINARY INFORMATION

(a) Sex of the Respondent: MALE...../FEMALE..... (Write Mor Fwhere appropriate)

(b) Age of the Respondent.....Years

(c) Married () Single ( ) Separated ( ) Divorced ( ) Widowed ( ) Put a tick where appropriate

(i) How did you know that you were HIV positive?

(ii) Upon knowing that you were HIV positive, did you receive any kind of counselling?

(iii) For how long have you been HIV positive?

(iv) Do you regularly go for testing after you wereidentified as HIV positive?

(v) Some people especially the youth are scared ofgoing for HIV testing. Why do you think this is the case?

(vi) Are you taking any ARVs? Where do you get them?

(vii) Those who are already HIV positive have a duty to tell those not infected totake some precautions not to be infected with HIV. Do you do anything about this? How?

(viii) Apart from being scared of going for voluntary testing, what are the other reasons which prevent the youth in Singida Municipality from going for such services?

Appendix III: Questionnaire for the Staff Counsellors/Youth Care Takers/Tunajali NGO

PRELIMINARY INFORMATION

(a) Sex of the Respondent: MALE...../FEMALE..... (Write Mor Fwhere appropriate)

b) Age of the Respondent.....Years

(c) Married () Single ( ) Separated ( ) Divorced ( ) Widowed ( ) Put a tick where Appropriate

(d) Educational/Professional Level ……

(e) Working Experience……..Years

(i) What is the response for the young people for HIV screening?

(ii) What do you think are the reasons, which make young people, go to VCT centres/hospitals for HIV screening?

(iii) What are the reasons, which make the youth, not go for screening?

(iv) What are the challenges, which you encounter, in your counselling career/ helping young people already infected/Not infected?

(v) How many young people on average, turn up for help/counselling/screening in a week/month?

(vi) What should be done to make the youth like voluntary HIV screening?

THANK YOU VERY MUCH!

Appendix IV: Focus Group Discussion for Young People not Infected and those Infected with HIV/AIDS, Counsellors, NGO Staff and Youth Care Takers

(i) you been doing to young people to make them understand and volunteer for counselling and encourage those who are already infected?

(ii) What are the advantages of voluntary HIV screening?

(iii) When someone is identified as HIV positive, what should he/she do to help others test for their status?

(iv) One of the challenges young people face when they have been tested HIV positive is how they will lead their life especially their sexual and family life. Should they marry? Who should they marry that is, a person infected with HIV like themselves or what?

(v) What are the challenges do you face as HIV infected persons?

(vi) What are the challenges do you face in dealing with HIV positive individuals?

(vii) Some people never believe that they are HIV positive. They attribute this to witchcraft. How do you deal with this problem?

(viii) Are you stigmatised in your day to day life?

(ix) Are you still going on with your schooling after being tested HIV positive?

(x) What do you think should be done to bring more awareness to the whole community and specifically for the youth such that they go for voluntary testing ?

(xi) Do you think the Government has been doing enough in helping the nation fight against HIV/AIDS? Do you think more is needed?

Appendix V: Observation Checklist

Physical Appearance	**Encouraging**	**Not Encouraging**
Confidence/comfort ability with oneself		
Positive Response to stigmatisation		
Ability to socialise with others		
COUNSELLING PROCEDURES		
Return for appointment		
Response to Counselling in general		
TESTING IN GENERAL		
Willingness to screen		
CD4 count		
Willingness to receive the test results		
Openness to share one's test results with close relatives and friends		
Advocacy about HIV/AIDS basing on one's negative or positive HIV/AIDS status		

Appendix VI: Informed Consent Form

My name is **Margaret p nyangi.** I am a student at Open University of Tanzania. Am conducting research for the requirements of Master's Degree in Social Work.

The title of my study is the assessing the of utilization of VCT service among youth in singida municipality. The purpose of the study is to gain better understanding of the above mentioned issues.

The methods that will be used to meet this purpose are: Questionaire

This study will be conducted to acquire masters of social work from Open University of Tanzania. The participation in this study will be on voluntary base.

The collection of data will limited for this use or other research related usage with the recognition of the university.

The interview will be recorded for accurate capturing of the insights. The name and identifying information will not be associated with any part of the written report and also all information and interview response will be kept confidential. Pseudonyms will be used instead of real names.

There is a full right to withdraw from the participation in any time and information would be cancelled upon request. A summary of the result will be given to participant upon request.

By signing this consent form I certify that I ----------

Agree to terms of this agreement.

Name----------

Date----------

Appendix VII: Research Clearance Letter

THE OPEN UNIVERSITY OF TANZANIA

DIRECTORATE OF RESEARCH, PUBLICATIONS, AND POSTGRADUATE STUDIES

P.O. Box 23409 Fax: 255-22-2668759Dar es Salaam, Tanzania,
http://www.out.ac.tz

Tel: 255-22-2666752/2668445 ext.2101
Fax: 255-22-2668759,
E-mail: drpc@out.ac.tz

05/10/2016,

To The Regional Medical Officer

Singida Region.

RE: RESEARCH CLEARANCE

The Open University of Tanzania was established by an act of Parliament no. 17 of 1992. The act became operational on the 1st March 1993 by public notes No. 55 in the official Gazette. Act number 7 of 1992 has now been replaced by the Open University of Tanzania charter which is in line the university act of 2005. The charter became operational on 1st January 2007. One of the mission objectives of the university is to generate and apply knowledge through research. For this reason staff and students undertake research activities from time to time.

To facilitate the research function, the vice chancellor of the Open University of Tanzania was empowered to issue a research clearance to both staff and students of the university on behalf of the government of Tanzania and the Tanzania Commission of Science and Technology.

The purpose of this letter is to introduce to you **Ms. Margaret P Nyangi;** a Master student at the Open University of Tanzania. By this letter, **Ms. Margaret P Nyangi** has been granted clearance to conduct research in the country. The title of her research is **"Assessment on th utilization of VCT Service among Youth: A Case Study of Singida Municipal .** The research will be conducted in Singida Municipal. The period which this permission has been granted is from 05/10/ 2016 to 06/12/2016.

In case you need any further information, please contact:
The Deputy Vice Chancellor (Academic); The Open University of Tanzania; P.O. Box 23409; Dar es Salaam. Tel: 022-2-2668820

We thank you in advance for your cooperation and facilitation of this research activity.
Yours sincerely,

Prof Hossea Rwegoshora

For: VICE CHANCELLOR

OPEN UNIVERSITY OF TANZANIA