PERCEPTIONS AND ATTITUDE OF THE COMMUNITY MEMBERS TOWARDS THE UPTAKE OF HOME BASED COUNSELLING AND TESTING IN ILALA DISTRICT

By

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A dissertation submitted in Partial Fulfillment of the requirements for the degree of Master of Public Health of the Muhimbili University of Health and Allied Sciences

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CERTIFICATION

The undersigned certifies that he has read and hereby recommends for acceptance a dissertation entitled ***Perceptions and attitude of the community members towards the uptake of home based counseling and testing in Ilala district*** submitted in Partial Fulfillment of the requirement for the degree of Master of Public Health of the Muhimbili University of Health and Allied Sciences.

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Dr. Tumaini M. Nyamhanga

(Supervisor)

Date: _____

DECLARATION

AND

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I, Sharon Fredrick Lwezaula, declare that this dissertation is my own original work and that it has not been presented, to any other university for similar or any other degree award.

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Signature…….…….. Date.……...

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DEDICATION

This dissertation is dedicated to my dear wife Mrs. Rose Bura who made me strong and gave me hope throughout the course. Secondly to my daughter Faith Lwezaula who always made me laugh whenever I had hardships during the period of my studies and Last but not least to my family, my father Mr. Frederick Lwezaula, my mother Mrs. Hilda Lwezaula, my sister and brothers who gave me a foundation of where I am today.

ABSTRACT

Background

Although home based counseling and testing has the potential of reaching many Tanzanians through bringing the services to their homes, little is known regarding the perception and attitude of the community members towards being counseled and tested in their home environment. Insufficient data exist to recommend large-scale implementation of home-based HIV testing in the country.

Objective

To determine the perception and attitude of the community members towards the uptake of home based counseling and testing services in Ilala municipal, Dar es Salaam.

Methodology

The study employed a cross-sectional Descriptive design using both quantitative and qualitative approaches. A multistage random sampling was used whereby 5 out of 22 wards were randomly selected. Then three streets in each of the five wards were randomly selected, from which a total sample of 384 respondents were recruited. Purposeful sampling technique was used to recruit Focus group discussion participants. Quantitative data were collected through a structured questionnaire and qualitative data were collected using focus group discussions.

Results

Among the respondents of the study, only 24.2% had ever heard of HBCT services and 21.6% were aware of the existing HIV and AIDS Act.

However, more than half of the respondents (58%) know their rights as long as counseling and testing is concerned. Regarding attitude of the respondents on the uptake of HBCT services, 200 (52.1%) indicated positive attitudes towards HBCT approach for provision of HTC services. Moreover, focus group discussion (FGD) participants of the respondents expressed perceived barriers in receiving counseling and testing services in their homes including fear of positive results, unavailable time to be counseled and tested at home and concerns about confidentiality.

Conclusion and recommendations

Generally, the results of this study have shown that community members of Ilala district have a positive attitude toward the uptake of home based counseling and testing. This is a good sign with respect to implementation of HBCT but perceived barriers should be addressed in the plan for roll out. Furthermore, community sensitization should be an integral component of HBCT rollout.

TABLE OF CONTENT

LIST OF TABLES

ABREVIATIONS AND ACRONYMS

HTC	HIV Testing and Counseling
PITC	Provider Initiated Testing and Counseling
VCT	Voluntary Counseling and Testing
HBCT	Home Based Counseling and Testing
HBC	Home Based Care
FGD	Focus Group Discussion

CHAPTER ONE: INTRODUCTION

This chapter presents an introduction to the study. It is organized under the following sub-headings: Background to the problem; problem to the statement; research question; objectives; rationale; conceptual framework; and definition of terms.

1.1 Background to the problem

The provision of HIV/AIDS-related counseling services in Tanzania started in 1988; 3 years after the first three AIDS cases were identified in Tanzania. At the beginning, these services were provided mainly by Faith Based Organizations (FBOs) and Non-Governmental Organizations (NGOs) to clients who sought such services. Efforts to establish VCT services in the public sector started in 1989 after the joint Tanzanian-Norwegian AIDS Project (MUTAN) started implementing its activities in Arusha and Kilimanjaro regions. Prior to 1989, people who were diagnosed with AIDS or those who tested HIV-positive were not informed of their test results. The main reasons for this were poor laboratory facilities in the country and the subsequent inability to produce reliable test results, as well as the absence of a counseling culture in the Tanzanian government health care system (MOHSW, 2005).

In 1996, an evaluation of VCT services in the country showed that these services were in high demand and recommended their expansion to all districts. In response to this, Counselors were trained countrywide from 1997 to 1998. Since then, VCT services have been expanded gradually. By 2005, there were over 1,200 trained Counselors nationally and more than 500 sites providing VCT services (MOHSW, 2005).

In October 2004, the Government of Tanzania commenced a programme of providing the life-saving antiretroviral drugs to HIV/AIDS patients.

The target was to provide treatment with antiretroviral drugs to 440,000 patients by the end of 2008. However, progress towards accomplishment of this target had been slow, partly due to inadequate and slow identification of those who are HIV infected and eligible for treatment.

Surveillance reports produced by the National AIDS control program estimated that only about 15% of Tanzanians know their HIV status. For many years, the client- initiated voluntary counseling and testing (VCT) has been the main approach through which individuals learn their HIV status. This approach has been quite useful in reinforcing HIV prevention especially in healthy people, but falls short of capturing important groups such as patients who present to health care facilities with HIV-related conditions (MOSHW, 2008).

As antiretroviral drugs (ARVs) were available and provided free, it became necessary to expand the models of HIV testing and counseling. In 2007, the Ministry of Health and Social Welfare adopted the provider-initiated HIV testing and counseling (PITC) in which health care practitioners would recommend HIV testing and counseling to persons attending health care facilities as part of standard of care. This kind of service gave Tanzanians the opportunity to access available prevention, treatment, care and support services MOHSW (2008).

In recent years, the Government of Tanzania made a decision to adopt a new approach of counselling and Testing known as Home Based Counselling and Testing (HBCT).After the decision to adhere to the new approach, the government of Tanzania initiated the development of HBCT guidelines but could not reach its end as there evolved a need to have one comprehensive guideline for HIV counselling and testing which will include all HIV counselling and testing approaches including HBCT. As of recent, the draft zero for comprehensive guidelines for HCT is in place and soon the document will be finalised.

The counseling and testing services administered in people's homes are conducted similarly to those in clinics. Community home based care providers are trained to provide only HIV counseling and must obtain consent from all individuals and there after the trained health care worker is called by the community home based care provider to do the testing. There are two ways that the services are being conducted. It can be either door-to-door whereby a community HBC provider goes in each household initiating HIV counseling to household members or it can be index patient method whereby the community HBC provider offers counseling to household members to a house that has an HIV positive patient.

Though this approach was piloted in 4 district of the country which included Ilala, Temeke, Mvomero and Arumeru by (HIV Counseling and Testing) HTC implementing partners i.e Pathfinder International and Family Health International, the results showed low uptake of services. Furthermore, no study has ever been conducted in Tanzania to know the attitude and perception of the household members towards the uptake of this new approach of counselling and testing in their homes to address the reasons as to why the uptake of HBCT is low. As the roll out of the HBCT services is still minimal, this study intended to find out the perceptions and attitude of household members towards the uptake of HBCT services as little is known about this.

1.2 Problem statement

Tanzania among other African countries has been struggling to combat the HIV and AIDS epidemic as it continues to pose challenge for being one of the top causes of morbidity and mortality in Tanzania. After the commencement of care and treatment program in 2004, the main goal was to test as many people as possible so as to enroll those who are HIV positive to the program.

In Tanzania, though efforts have been made to provide free counselling and testing services through voluntary counselling and Testing (VCT) and Provider initiated Counselling and Testing (PITC), still the number of people who are tested is 37% (NBS and ICF Macro, 2011).

With the above reason, the government adopted a new approach called home based counseling and testing (HBCT) whereby the counseling and testing services are being done at the households within the communities. HBCT has the potential of reaching many Tanzanians through bringing the services to their homes. This new approach complements the two other approaches (VCT and PITC) so as to meet the goal of testing as many Tanzanians as possible.

In recognition of its potential benefit, HBCT has been introduced in the form of pilot in some districts. The report from the pilot shows that the uptake of HBCT by the community members was little with a proportion of 32% uptake. Little is known regarding the perception and attitude of the community members towards being counseled and tested in their home environments which may contribute to the low uptake observed. Furthermore, insufficient data exist to recommend large-scale implementation of home-based HIV testing in the country. Further studies are needed to determine the feasibility of establishing home based counseling and testing services in Tanzania.

This study therefore intended to make a contribution in that direction by exploring the attitude and perception of the community members towards the uptake of home based counseling and testing in Ilala municipality, Dar es Salaam.

1.3 Research Questions

1. To what extent is the population aware of home based counselling and testing services?
2. What is the attitude of the community members about home based HIV counselling and testing services?
3. What are the community members' perceived benefits and risks associated with home based HIV counselling and testing services?

1.4 Objectives

1.4.1 Broad Objective

To examine perceptions and attitude of the community members towards the uptake of home based counseling and testing services in Ilala municipal, Dar es Salaam.

1.4.2 Specific objectives

1. To determine the awareness of the community members about home based HIV counselling and testing services in Ilala Municipal.
2. To determine the attitude of the community members about home based counselling and testing approach in Ilala Municipal.
3. To explore the community members' perceived benefits and barriers associated with home based HIV counselling and testing services in Ilala Municipal.

1.5 Rationale

This study generated information on the attitude and perception of the community members towards the uptake of home based counseling and testing. This information will help the Ministry of Health and Social Welfare (MOHSW) and its implementing partners to design appropriate interventions for promoting home based counseling and testing.

1.6 Conceptual framework

This study was conducted basing on a problem diagram shown in Figure 1 which depicts uptake of HIV counseling and testing services by the community as a main outcome variable. The figure also identifies socio economic and cultural factors, stigma and awareness or knowledge on HBCT factors as key predictor variables. The figure shows that, these factors influence the perception and eventually the attitude of the community members toward the uptake of HBCT. The influenced attitude from the above factors will affect the uptake of HIV counseling and testing services by the community (see figure 1 below).

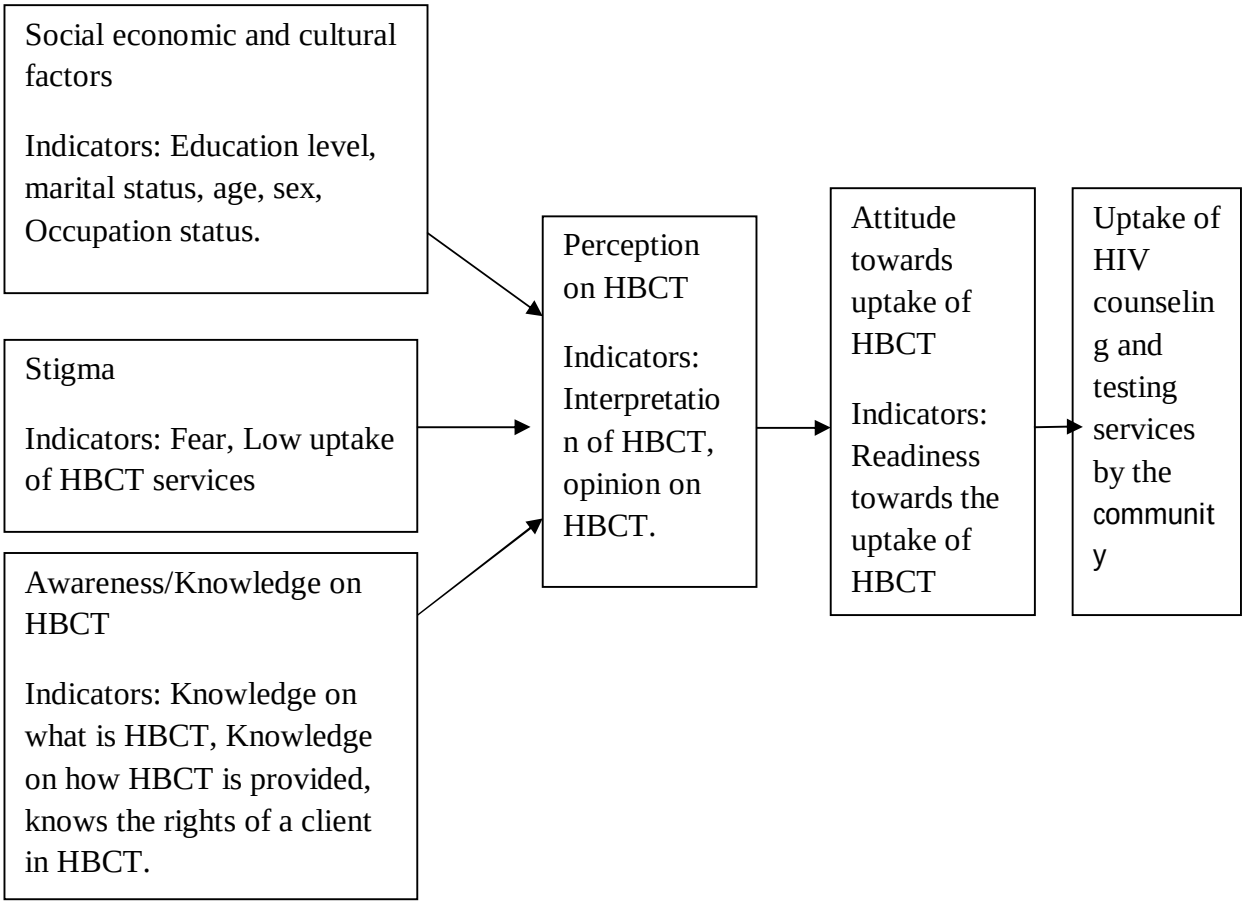

Figure 1: Conceptual Framework

DEFINITION OF TERMS

Attitude

Allport et al. (1935) defined an attitude as a mental or neural state of readiness, organized through experience, exerting a directive or dynamic influence on the individual's response to all objects and situations to which it is related. A simpler definition of attitude is a mindset or a tendency to act in a particular way due to both an individual's experience and temperament.

Perception:

Perception is closely related to attitudes. Perception is the process by which organisms interpret and organize sensation to produce a meaningful experience of the world (Lindsay & Norman, 1977). In other words, a person is confronted with a situation or stimuli. The person interprets the stimuli into something meaningful to him or her based on prior experiences. However, what an individual interprets or perceives may be substantially different from reality.

Home Based Counseling and testing:

Home based counseling and testing is an approach for HIV counseling and testing services whereby the services are being delivered/provided at home by a counselor. The approach has two methods of service delivery i.e Door to door and index patient.

Home

In this study, a home is considered to be a household which has members of a family living in it.

Counseling

Counselling is an interactive learning process contracted between counsellor(s) and client(s), be they individuals, families, groups or institutions, which approach in a holistic way, social, cultural, economic and/or emotional issues.

Counselling may be concerned with addressing and resolving specific problems, making decisions, coping with crisis, improving relationships, developmental issues, promoting and developing personal awareness, working with feelings, thoughts, perceptions and internal or external conflict. The overall aim is to provide clients with opportunities to work in self-defined ways, towards living in more satisfying and resourceful ways as individuals and as members of the broader society. *(EAC definition of counselling adopted AGM 1995)*

Community

Community is a social group of any size whose members reside in a specific locality, share government, and often have a common cultural and historical heritage.

HIV Testing

HIV test: A test for the human immunodeficiency virus, the cause of AIDS. HIV tests are designed to detect antibodies to the HIV virus or the HIV virus itself (MedicineNet, inc, 2012), HIV testing is a step by step procedure done by a counselor to conduct HIV test.

Uptake

Uptake is an absorption or incorporation of something into a body of an organism. In this study, the uptake of home based counseling and testing meant the usage of home based counseling and testing services.

Awareness

Awareness is a state of having knowledge or cognizance or ability to perceive, to feel, or to be conscious of events, objects, or sensory patterns. In this level of consciousness, sense data can be confirmed by an observer without necessarily implying understanding (Wikipedia, 2012).

CHAPTER TWO: LITERATURE REVIEW

This chapter presents literature review. It is organized under the following sub-headings: counseling and testing services globally; counseling and testing services in Africa; counseling and testing services in Tanzania; achievements from other countries; and conclusion.

2.1 Counseling and testing services globally

According to World Health organization (WHO, 2011), for over 20 years, client-initiated HIV testing and counseling, also known as voluntary counseling and testing (VCT), has helped millions of people learn their HIV status. Nevertheless, global coverage of HIV testing and counseling programmes remains low. Efforts are urgently needed to increase the provision of HIV testing through a wider range of effective and safe options.

In 2007, WHO and UNAIDS issued guidance on provider-initiated HIV testing and counseling (PITC) in health facilities to support increased uptake and improve access to HIV prevention, treatment and care. HIV counseling and testing (HTC) is a critical entry point to life-sustaining care for people with HIV, a key element of Treatment 2.0 and essential for prevention of vertical HIV transmission (WHO, 2011).

Currently the majority of people are still unaware of their HIV status and HIV Testing and Counseling (HTC) services need to be expanded in antenatal care, STI and TB clinics, and other clinical settings as well as through outreach for most at risk populations, home-based HTC, testing campaigns and client-initiated testing centers (WHO, 2011).

Furthermore, WHO recommends people who test HIV negative should also be supported and receive counseling on how to reduce exposure to HIV.

HTC for couples should also be promoted and expanded within a human rights framework because of the high frequency of sero discordancy and the important potential to reduce transmission in sero discordant couples. Sharing sero status allows couples to plan, make important life decisions, and to seek care and support together (WHO, 2011).

2.2 Counseling and testing services in Africa

In a study conducted by Van der Borght S et al, (2010), whereby the authors wanted to see the Long-term voluntary counseling and testing (VCT) uptake dynamics in a multicountry HIV workplace program in sub-Saharan Africa, the results showed that in this workplace program, HIV-1 infected individuals came earlier for an HIV test than uninfected people, and people with advanced infection came earlier than those with less advanced disease. It was also found that the employees' spouses are harder to reach than employees and extra efforts should be undertaken to reach them as well. They came into conclusion that Uptake of HIV testing can be actively influenced by educational or promotional activities.

In another study conducted in Zimbabwe the results showed that high-impact VCT strategies are urgently needed to maximize HIV prevention and access to care in Africa. VCT at the workplace offers the potential for high uptake when offered on-site and linked to basic HIV care. Convenience and accessibility appear to have critical roles in the acceptability of community-based VCT. (Elizabeth. et al, 2006)

Furthermore, a study conducted in Uganda showed that the HIV/AIDS epidemic remains a significant global health problem, especially in developing countries.

The rate of uptake of voluntary counseling and testing (VCT) is low, and only about one in 10 eligible people have access to VCT in developing countries. Challenges of HIV testing include the difficulty of getting to testing sites and the cost of being tested.

Researchers assumed that providing HIV testing or results or both in homes compared to in a healthcare facility would lead to higher uptake of HIV testing. This review attempted to evaluate this assumption. They found only one published study from developing countries and none from developed countries. The only study included in the review showed an increase in VCT uptake after home-based VCT intervention. Because of the limited evidence to date, however, further research is needed to evaluate if home-based VCT is better than facility-based VCT or other testing methods. (Bateganya et al, 2008)

2.3 Counseling and testing services in Tanzania

In the last 20 years, HIV/AIDS has spread rapidly across Tanzania, lowering life expectancy, harming the economy, and leaving one in ten Tanzanian children orphaned. While acknowledged as a national disaster, less than 10% of the country's late teen and adult population are aware of their HIV status, rendering it impossible to contain the disease and difficult to care for those who have been already infected.

For many Tanzanians, HIV/AIDS testing remains stigmatized. Until recently, testing was carried out with little regard to confidentiality and was followed up with ineffective and inappropriate counseling (AMREF USA, 2011).

A disproportionate number of HIV-positive women are failing to learn their status, which has implications for equitable access to onward referral for care and treatment services. Evidence that some high-risk behaviors may prompt VCT use is encouraging, although further interventions are required to improve knowledge about HIV risk and the benefits of VCT. Targeted interventions are also needed to promote VCT uptake among married women and rural residents (Wringe et al, 2008).

A pilot test conducted in Ilala municipal which focused on home based counseling and testing approach reveled low uptake and usage of the services by the community members (Pathfinder, 2008).

In a study conducted in Kilimanjaro, it showed that Mobile VCT in Kilimanjaro enhanced service uptake by high risk women and low-income persons; however, the service was also accessed by large numbers of men with relatively low risk. The study recommended that the future Counseling and Testing expansion should be further tailored to access the highest risk groups. Modeling uptake of mobile voluntary counseling and testing (MVCT) among at-risk populations in rural Tanzania (Reddy et al. 2011).

2.4 Achievements from other countries

In Uganda, a pilot project, funded by the US Centers for Disease Control and Prevention (CDC) was started by AIC in 2004 in the districts of Tororo and Busia in an attempt to reach as many people as possible in these districts and offer them home-based counseling and testing services. Trained outreach teams visited each home and offered all family members information so they could decide if they wished to participate. Adults in the household were given the choice to receive these services individually, or as couples.

Anyone who was found to be HIV infected during this process received referrals to treatment and care programs in their community (IAVI Report, 2010).

Many organizations have found that offering home-based VCT programs is an effective way to increase access to treatment and prevention services. The AIC program lasted for one year and during this time over 5000 individuals received VCT services in their homes, which was more than double the study's target. The outreach teams visited more than 2000 homes in these two districts of Uganda and in 65% of them at least one household member agreed to participate in VCT (IAVI Report, 2010).

The AIC concluded that stigma seemed to be much less of an influence on a person's decision to undergo HIV testing when VCT services are administered in the home, instead of in clinics. Home-based VCT services could also be a promising strategy for reaching disempowered individuals, especially women.

Another option is providing just the test results and post-test counseling at home. In settings where rapid tests are unavailable, people sometimes do not return to the clinic to find out the results of their HIV test. In a study conducted by the Medical Research Council in Entebbe, Uganda, researchers found that offering test results in a person's home was an effective way to ensure that people received them.

The most ambitious home-based VCT program took place in Lesotho, where on World AIDS Day 2003 the president announced plans to take VCT services door-to-door in an effort to reach every household in the country by 2007. To meet this challenge the government trained 6500 healthcare workers to provide VCT services. Prior to this universal HIV testing initiative, it was estimated that only 1% of the population had accessed VCT (IAVI report, 2010).

2.5 Conclusion

The above reviewed studies show that, with the availability of free Voluntary Counseling and testing services and Provider Initiated Counseling and testing services complementing it, still the number of people who are tested is low. Furthermore, the reviewed studies show that home based counseling and testing is needed to complement the two approaches as it has shown better results whereby more people are being counseled and tested using this approach. However, these studies do recommend that no large scale roll out of home based counseling and testing is needed as there is no enough evidence to scale up the implementation.

CHAPTER THREE: METHODOLOGY

This chapter presents the methodology used to conduct this study. It is organized under the following sub-headings: study design; study area; study population; inclusion and exclusion criteria; sampling; variable; data collection and ethical considerations.

3.1 Study Design

The study employed a cross-sectional descriptive design using both quantitative and qualitative approaches. Cross-sectional studies (also known as cross-sectional analyses), form a class of research methods that involve data collection at one specific point in time (William T et al, 2006). This type of study design allows for quick and easy data gathering even for a large target population. Assessment of outcomes and risk factors for the entire population is also done with little trouble, as the sample is a near-perfect snapshot of the whole. The snapshot nature of cross-sectional studies, while convenient, does have its weakness in that it doesn't provide a good basis for establishing causality. Ehow (2012).

3.2 Study Area

The study was conducted in Ilala municipality in Tanzania. Ilala Municipality is one of the 3 municipalities in Dar Es Salaam region, located in the Eastern part of Tanzania. Administratively there are 3 Divisions which are subdivided into 22 Wards 65 sub-wards, 9 villages, and 37 hamlets. The total population of Ilala Municipal Council is 634,924 with 50.5% being males (TBS, 2002). Ilala district was purposefully selected for this study as it was among the districts that HBCT was field tested whereby the uptake of the services was the lowest compared to other districts piloted.

3.3 Study Population

The study included community members aged –fifteen to forty nine years from Ilala municipality. This age group was chosen purposefully because it is the age group that has high prevalence compared to other age groups (TACAIDS, 2009)

3.4 Inclusion and exclusion criteria

Inclusion Criteria

- Age: 15-49 years
- Consent to participate in the study

Exclusion Criteria

- Unwilling to consent to the study

3.5 Sampling

3.5.1 Sample size estimation

The sample size was calculated from the following formula:

$$N = \frac{Z^2PQ}{d^2}$$

Where N = Minimum sample size

Z = Constant, Standard normal deviate (1.96 for 95% Confidence level)

P = Population proportion with characteristic of interest

Q = 1 – P

d = Acceptable Margin of error

Proportion of attitude among community members toward HIV testing at home at a rate of 50% will be used (worst case scenario).

Hence: $N = \frac{(1.96)^2 X 0.5\ (1-0.5)}{(0.05)^2}$

$= 384$

A minimum of **384** respondents were included in the study.

3.5.2 Sampling Technique

A multistage random sampling involving two stages was done. In the first stage, 5 out of 22 wards were randomly selected then about 76 individuals were selected from each ward. Three streets in each ward were randomly selected whereby the participants were drawn from each street.

Purposeful sampling technique was used to recruit participants to participate in the Focus group discussion.

3.6 Variables

3.6.1 Dependent variables

Attitude and Perceived benefits and risks of HBCT

3.6.2 Independent variables

Sex, Level of income, Education level, Age, Occupation, Marital status, Religion, Number of sexual partners' and family size.

3.7 Data collection

3.7.1 Data collection instruments and methods

Quantitative data were collected through a structured questionnaire. The questionnaire consisted of four sections whereby the first section included questions regarding socio demographic issues, the second section asked about awareness on HBCT, the third section asked about awareness on the legal rights and the last section had questions regarding attitude. The interviewers were research assistants that have been oriented/ trained on the developed questionnaire so as to increase validity. Data collected was assessed by the investigator only and the questionnaires did not include names of the participants for confidentiality purposes. Quality check of the collected data was on the same day of data collection.

Qualitative data were collected using focus group discussions whereby two facilitators were involved. One was a moderator and the other one was a note taker. A total of four focus group discussions were conducted engaging a group of 6 participants in each discussion. Among the four FGDs, two of them involved male participants and two involved female participants.

The moderator was responsible for leading the FGD, posing the critical questions that were specified in the discussion guide, keeping the discussion on track, and making sure that all participants contributed to the discussion. The Note taker was responsible for taking detailed notes of the discussion, even when a tape recorder was being used. He was responsible for operating the tape recorder during the focus group discussion, and labeling the cassette tapes.

3.7.2 Pre-testing

A one day field pilot survey was conducted with the following objectives; (a) to assess the applicability of the questionnaires to the local communities (b) to estimate time needed to administer each questionnaire (c) to assess the sequencing/flow of questions (e) to check the content validity of the questions after translation.

3.7.3 Data management and analysis

Questionnaires were routinely checked for completeness and clarity prior to double entry to MS Access database. Data files were cleaned and merged using MS Access.

Data was then entered into Statistical Package for Social Sciences Version 16 statistical software. Frequencies were generated for categorical variables. Differences between proportions were examined using Chi-square test. Continuous variables were summarized using means and SD. To control for potential confounders, multivariable logistic regression models were built where crude odds ratio (COR) and adjusted odds ratios (AOR) were calculated and presented. All the analyses were presented as two-tailed and significance level was set at 0.05.

Qualitative data were analyzed using content analysis approach. That is, data were analyzed by examination and categorization of respondents' opinions. Major categories were identified and data were unpacked accordingly. Finally, the information under major and sub-categories was presented through summaries and narrative text.

3.7.4 Reliability and validity

Reliability refers to the degree of similarity of the information obtained when the measurement is repeated every time on the same subject or the same group (Katzenellenbogen et al, 1997).

Though the validity of a measuring instrument refers to the extent to which the instrument measures what it is intended to measure (Riegelman at al, 2005), test score's validity is dependent on the score's reliability since if the reliability is inadequate, the validity will also be poor (Strunig & Stead, 2001) . To ensure reliability and validity of the study, questionnaire was developed with reference from previous questionnaires developed by Muhimbili University of Health and Allied Sciences.

Before the study, after development of the questionnaire, it was field tested by the principle investigator and trained experienced research assistants.

In all phases of this study, my supervisor took initiatives to review, input and comment every aspect throughout the study to make it better.

3.8 ETHICAL CONSIDERATIONS

3.8.1 Ethical clearance

Ethical clearance to conduct this study was sought from Ethical board of Muhimbili University of Health and Allied Sciences.

Permission to proceed with the study was sought from Ilala Municipal Council DMO and the Municipal Director.

3.8.2 Maintenance of confidentiality

The information that was collected was kept in a locked office and was destroyed at the end of the study. Every interviewee's information was kept separate from the answers they provided so that their names could not be linked to the data.

3.8.3 The right not to participate and withdraw

Before the interview, every participant was read his/her rights concerning participation and withdrawal through informed consent form. The informed consent form directed that taking part in the study was completely the interviewee's choice. If one chooses not to participate in the study or if one decides to stop participating in the study he/she will continue to receive all services that he/she would normally get. One could stop participating in this study at any time; even if he/she had already given his/her consent. Refusal to participate or withdrawal from the study would not involve penalty or loss of any benefits to which one was otherwise entitled.

3.8.4 Informed consent

Informed consent was sought from individual participants and for children below 18 years the signed consent was provided by the parents/guardians.

CHAPTER FOUR: RESULTS

This chapter presents study findings. It is organized under the following sub-headings: socio-demographic characteristics of the study population; awareness of the community members about home based HIV counseling and testing services; association between socio-demographic characteristics and attitude of community members on the HBCT approach; and perceived benefits and barriers of the community members in receiving HTC services in the home environment.

4.1 Socio-demographic characteristics of the study population

Three hundred and eighty four participants were recruited in this study. All surveyed participants responded giving a response rate of 100%. Table 3.1 below shows the distribution of socio-demographic characteristics of respondents. The mean (±SD) age of participants was 27 ± 10.8 years ranging between 18 to 67 years. There was preponderance of male participants (59.4%). More than a half of the study participants (89%) were below 39 years of age. Regarding the education level, about a third of participants (29.7%) had completed secondary school. Majority of the respondents 128 (33.3%) were self employed. Majority of the respondents, 202 (52.6%) were never married.

Table 1: Distribution of socio-demographic characteristics of respondents

Characteristic	Frequency (n)	Percent
Sex		
Male	228	59.4
Female	156	40.6
Total	384	100
Age (yrs)		
15-24	123	32.0
25-29	141	36.7
30-34	48	12.5
35-39	30	7.8
40-44	13	3.4
44-49	14	3.7
50+	15	3.9
Total	384	100
Education level		
No formal schooling	9	2.3
Less than primary school	30	7.8
Primary school completed	99	25.8
Secondary school completed	114	29.7
High school completed	54	14.1
College/University completed	75	19.5
Non response	3	0.8
Total	384	100
Occupation		
Government employee	22	5.7
Non-government employee	61	15.9
Self-employed	128	33.3
Student	115	29.9
Retired	6	1.6
Unemployed (able to work)	46	12
Unemployed (unable to work)	7	1.6

Total	384	100
Marital Status		
Single/never married	202	52.6
Divorced/separated	3	8
Widowed	7	1.8
Married/cohabitating-monogamous	163	42.4
Married/cohabitating-polygamous	7	1.8
Non response	2	0.5
Total	384	100

4.2 Awareness of the community members about Home Based HIV Counseling and Testing services

Awareness of the community members about the availability of HBCT services

A total of 93 (24.2%) interviewees reported that they had heard about Home based HIV Counseling and testing services. Only a few (22.9% and 19.3%) of the respondents said they knew where and how HBCT is provided, respectively (Table 2).

In a focus group discussion, it was revealed that majority of the members had not heard of Home based counseling and testing. Many reported knowing Home based care. A man in a Focus group discussion remarked*: "is there a difference between home based care services and home based counseling and testing services? The group responded "no", it is the same thing"* ***(FGD with men in Ilala 10th March, 2012)***. There were some confusion between home based care and home based testing and counseling interventions concluding that members were unaware of HBCT services. Also in the FGD, most members were confused on the modality of how these services are being provided. In a different focus group discussion, a man was quoted asking "*Can I have some guidance please…is it like the doctor leaves his work in the hospital and comes to your home with his coat to do the counseling and testing to you?*" ***(FGD with men in Ilala 10th March, 2012)***.

Table 2: Level of awareness of community members about the availability of HBCT services

Characteristic	Yes		No		Total
	n	%	n	%	n
Ever heard about HBCT	93	24.2	291	75.8	384
Know where HBCT is provided	88	22.9	296	77.1	384
Know how HBCT is provided	74	19.3	310	80.7	384

Awareness of community members about the legal rights in the context of HBCT services

Results show that, only about 21.6% of respondents said they were aware about the HIV and AIDS Act (2008). On the other hand, more than half the respondents (58.8%) reported that they know their rights concerning HTC services (Table 3).

In a focus group discussion, many respondents reported that they were not aware of the HIV act but contrary to that they all seemed to know their rights when it comes to HIV testing and counseling rights One woman said, I know my rights when it comes to testing, no one can cheat me, it's my right to agree to have testing or not" (a woman aged 27 years old) ***(FGD with women in Ilala 11th March, 2012)***.

Table 3: Level of awareness among of community members about the legal rights in the context of HTC services

Characteristic	Yes		No		Total
	n	%	n	%	
Aware of the 2008 HIV and AIDS act developed by the MOHSW	83	21.6	301	78.4	384
Know your rights concerning HIV counseling and testing	195	58.8	189	41.2	384

4.3 Attitude of the community members toward HBCT approach

To determine the attitude of community members toward the HBCT approach, respondents were asked to rate their responses to a series of 11 attitude items (Table 4). The items had a scale of Agree, Strongly agree, Undecided, Disagree and strongly disagree to elicit responses on their mental state of readiness towards receiving HTC services in the home.

Table 4 shows that 86.8% of the respondents agreed that provision of counseling and testing services at home reduces costs of going to the health facilities by the consumers of the services. Also, more than half the respondents agreed that HBCT provides confidentiality and reduces stigma compared to other HTC approaches. Regarding if counseling and testing of HIV when a partner is not around will not cause any problems, about half the respondents had a positive attitude. More than half (82.6%) the respondents agreed that if the household members knew that a person has been counseled and tested, they will be eager to know his/her results.

A larger number of respondents (41.5%) agreed that if a neighbor sees that a healthcare provider has come to his/her home, he/she will not gossip to other neighbors. More than half the respondents (52.4%) agreed that if their neighbors know that he/she have been counseled and tested, it will not affect their business in the neighborhood. Sixty three percent of the respondents agreed that a health care worker who will visit him/her at home will keep his/her results confidential. Concerning the readiness of the Ilala community members to be counseled and tested at their homes, 63.3% agreed to be provided these services as table 4 demonstrates.

Table 4: Attitude of the community members toward HBCT approach

SN	Item	Strongly agree n (%)	Agree n (%)	Undecided n (%)	Disagree n (%)	Strongly disagree n (%)
1.	Provision of counseling and testing services at home reduces costs of going to the health facilities by the consumers of the services.	226(66.7)	77(20.1)	24(6.3)	13(3.4)	14(3.6)
2.	Provision of counseling and testing services at home settings are favorable for confidentiality	159(41.4)	107(27.9)	50(13)	31(8.1)	37(9.7)
3.	Home visits by health providers reduces stigma in the community	132(34.4)	84(21.9)	67(17)	44(11.5)	57(14)
4.	As a wife/husband, discussion with a health care provider regarding	132(34.4)	76(19.8)	67(17)	58(15.1)	51(13)

	counseling and testing of HIV when my partner is not around will not cause any problems					
5.	As a wife/husband, discussion with a health care provider regarding counseling and testing of HIV without permission/consent from my partner, it will not cause any problems	115(30)	57(14.8)	63(16)	75(19.5)	74(19)
6.	If household members realize that I have been counseled and tested, they will be eager to know my results	223(58.1)	94(24.5)	32(8.3)	21(5.5)	14(3.6)
7.	If a neighbor sees that a health care provider has come to my home, he/she will not gossip to other neighbors	105(28)	52(13.5)	79(20)	69(18.0)	79(20)

8.	If my neighbors knows that I have been counseled and tested, it will not affect my business in the neighborhood	135(35.2)	66(17.2)	84(21)	50(13)	49(12)
9.	A health care worker who will visit me at home will keep my results confidential	150(39.1)	95(24.7)	89(23)	24(6.3)	26(6.8)
10.	I will be ready and prepared for counseling and testing when I hear a health care worker knocking at my door	147(38.3)	96(25)	53(13)	37(9.6)	51(13)
11.	I would rather go to the health facility for counseling and testing services at my own time instead of health care workers to come to my home	126(32.8)	63(16.4)	27(7)	33(8.6)	135(35)

During analysis, negative statements of the attitude items were reversed to make them positive. Scores on items in the range 18-22, corresponding to *Agree* and *Strongly agree,* were collapsed to Positive attitude while scores in the range 11-17, corresponding to *Undecided, Disagree* and *Strongly Disagree,* were collapsed to Negative attitude toward HBCT approach.

Results show that majority of respondents had a score of 17 (16.4%) while those with the score of 11 were the lowest (.5%) (Table 5). Results further show that, 200 of the 384 respondents (52.1%) reported accepting attitudes towards HBCT approach for provision of HTC services, which means that majority of community members in the surveyed population, express perceived socioeconomic, cultural and personal benefits to receiving HTC services in the home environment (Table 6).

Table 5: Respondents' scores on attitude items on the HBCT approach for HTC services

Score on perception items	**Frequency (n)**	**Percent (%)**	**Cumulative Percent (%)**
11	2	0.5	0.5
12	9	2.3	2.9
13	10	2.6	5.5
14	17	4.4	9.9
15	30	7.8	17.7
16	53	13.8	31.5
17	63	16.4	47.9
18	57	14.8	62.8
19	48	12.5	75.3
20	33	8.6	83.9
21	58	15.1	99
22	4	1	100
Total	384	100.0	100.0

Table 6: Collapsed scores of respondents on attitude items on the HBCT approach for HTC services

Attitude	Frequency (n)	Percent (%)
Positive (score 18-22)	200	52.1
Negative (score 11-17)	184	47.9
Total	384	100.0

4.4 Association between socio-demographic characteristics and attitude of community members on the HBCT approach

To determine the association between socioeconomic factors and attitude of respondents on HBCT approach to HTC services, cross tabulations between these factors and the collapsed scores on attitude items were generated. Significance in proportional differences of scores between categories was determined by running Pearson Chi-Square test at 5% significance level.

Results show that, female respondents expressed higher accepting attitudes to HBCT services (57.1%) than their male counterparts. This difference was not significant (p=0.107). Respondents who were 40-44 years reported the highest level (63.6%) of accepting HTC services in the home environment while it was lowest (50.4%) in the youngest age group of 15-14. Overall, positive attitude on HBCT approach increased with age across age groups to individuals aged 44 years, then declining in individuals aged 45-49 before raising again steeply in individuals 50 years or older. However, these proportional differences in acceptance levels to the HBCT approach in HTC services was not statistically significant (p=0.938) (Table 7).

When compared with education level, study participants who had completed primary school had the highest accepting attitudes (59.6%) towards HBCT approach while it was lowest (33.3%) among individuals with no formal schooling.

There was a general trend of positive attitude towards HBCT services to increase among individuals who had no formal schooling, had education level less than primary school and who had completed primary school. Positive attitude scores then decreased in respondents who had completed secondary and high school before increasing slightly in those who had attained college or university education (Table 7). Proportional differences between level of education of respondents and their attitude on HBCT was statistically significant (p=0.024), indicating that the highest level of education attained by respondents in this study was a significant predictor of attitude on HBCT services.

Furthermore, results show that scores on positive attitude was highest in respondents who were self employed (60.9%) while it was lowest in individuals who were unemployed who were unable to work (33.3%). The differences in percentage scores on positive attitude across different occupational categories was statistically not significant (p=0.184) (Table 7).

On the other hand, accepting attitudes on HBCT were highest (42.9%) in divorced or separated individuals and were lowest in widowed (14.3%). However, the difference in positive attitude levels across marital statuses of respondents was not significant (p= 0.097) (Table 7).

Table 7: Association between socio demographic characteristics and attitude of community members on HBCT approach

Background Characteristic	Category	n	Attitude		p-value †
			Positive (n, %)	Negative (n, %)	
Sex					
	Male	228	111(48.7)	117(51.3)	
	Female	156	89(57.1)	67(42.9)	.107
Age (yrs)					
	15-24	117	59(50.4)	58(49.6)	
	25-29	138	71(51.4)	67(48.6)	
	30-34	43	22(51.2)	21(48.8)	
	35-39	27	16(59.3)	11(40.7)	
	40-44	11	7(63.6)	4(36.4)	
	44-49	14	8(57.1)	6(42.9)	
	50+	15	9(60)	6(40)	.938
Education level					
	No formal schooling	9	3(33.3)	6(66.7)	
	Less than primary school	30	10(33.3)	20(66.7)	
	Primary school completed	99	59(59.6)	40(40.4)	
	Secondary school completed	117	63(53.8)	54(46.2)	
	High school completed	54	21(38.9)	33(61.1)	
	College/University completed	75	44(58.7)	31(41.3)	.024*
Occupation					
	Government employee	22	10(45.5)	12(54.5)	
	Non-government employee	61	26(42.6)	35(57.4)	
	Self-employed	128	59(46.1)	69(53.9)	
	Student	115	34(29.6)	81(70.4)	

	Retired	6	1(16.7)	5(83.3)	
	Unemployed (able to work)	46	11(23.9)	35(76.1)	
	Unemployed (unable to work)	6	2(33.3)	4(66.7)	.040*
Marital Status					
	Single/never married	202	103(51)	99(49)	
	Divorced/separated	3	2(66.7)	1(33.3)	
	Widowed	7	1(14.3)	6(85.7)	
	Married/cohabitating-monogamous	163	92(56.4)	71(43.6)	
	Married/cohabitating-polygamous	7	2(28.6)	5(71.4)	.097

†P-value from $\chi 2$ test for differences in proportions, * Indicates statistical significance at 5% level

4.5 Perceived benefits of the community members in receiving HTC services in the home environment

In the focus group discussion, a number of benefits of knowing status early through HBCT were mentioned by different groups: among of them being getting early treatment for illness, planning for the future, reducing costs of moving to the health facilities for acquisition of the services, preventing unplanned births which are seen to accelerate the course of disease, and allowing responsible individuals to take action to prevent spreading the virus to others.

A counseling and HIV testing intervention that is delivered in the home environment was seen to have considerable benefits. In addition to alleviating barriers of time and travel, participants felt that approaching clients in their homes would increase the perception of the importance for HIV testing. As one male participant stated from a FGD reported, ‘‘If a client is visited at home by a counselor, they will understand how serious and important HIV testing is’’ **(married man, 42 years old)**.

Respondents felt that getting tested in the home offered greater privacy and confidentiality than clinical settings because ‘‘most people would prefer not to be seen walking to a public HIV testing center’’ (**married woman, 26 years old).** This was particularly noted as a benefit for men, who were reluctant to be seen in the clinic for HIV testing.

Respondents also expressed trust about high levels of confidentiality with the health care providers. This was reported when participants were asked about their trust if a health care provider will test some one positive if they will keep results confidential. A woman said, “These health care providers are well trained on how to keep confidentiality, this is not a new thing to them, they keep many things they observe from clients even before coming of HIV” **(married woman, 54 years old)**

Women were eager to have an option for HIV testing that they felt their partner would participate in, as a way to share the burden and challenges of HIV testing. *Men will agree to test at home. We can talk to our husbands and they will agree to test for HIV at home. This is different from asking your husband to accompany you to go and test for HIV at the health facility.* **(married woman, 35 years old)**

4.6 Perceived barriers of the community members in receiving HTC services in the home environment

There were barriers to the uptake of HBCT that were expressed by the respondents. Among the barriers was the issue of time for the counselor to come and provide the services. This seemed to be an obstacle to most members as they claimed to be busy with their work. One woman said *“Can you please be clear to us.*

When is this counselor coming for counseling and testing? Because, With hardships of life that are facing us, I am forced to live my home from morning to evening doing my small scale business and when I get back at night I am always too tired to listen to anybody. With my tight schedule, I don't see where I will accommodate your counselor to talk with me". ***(FGD with women in Ilala 11th March, 2012)***.

Another common barrier was fear to learn one's own HIV status. This occurred mostly to those who had never received HIV counseling and testing. One woman said *"mh, I don't see myself getting tested for HIV sooner or later as my husband jumps to women a lot. My problem of getting home late from fish market, to him is an opportunity to enjoy with his women. Worse enough I can't leave him as I have a family with him"* **(married woman, 39 years)**.

Confidentiality was also a challenge and a barrier to some members. *If a counselor comes at home, always there will be somebody sneaking around* **(Man, 25 years).** Also another woman said "*Some of us being low class, the households that we are living in do not offer confidentiality at all. For example the house that I am living in does not have a roof such that my neighbor in the other room can hear whatever I say even if I whisper* (**Single woman, 29).**

CHAPTER FIVE: DISCUSSION

This chapter presents discussion of the results obtained from the quantitative and qualitative analysis conducted in this study.

The results in this study show that the level of awareness about HBCT among respondents is low (24.2%) and only a few (22.9% and 19.3%) of the respondents said they knew where and how HBCT is provided, respectively. This means that high proportion of the community members is unaware of HBCT services, something that may negatively influence their perception towards the uptake of HBCT. The low level of awareness about HBCT might be due to the fact that the services are still in the piloting stage in the country. According to Tabana H. et al (2012), knowledge of HIV status in the rural sub-district is low.

Regarding the attitude of the community towards the uptake of HBCT, generally, as seen from the results, a relatively higher proportion (52.1%) of respondents had a positive attitude towards the uptake of home based counseling and testing. This key finding is corroborated by a study done by Bateganya (2010) which found very high acceptability and uptake of VCT when testing and/or results were offered at home, compared to the standard (facility-based testing and results).

On the other hand, about half (47.9%) of the respondents had negative attitude regarding the uptake of HBCT. This might be attributed to the explored concerns (potential barriers) about HBCT, which included: inconvenient time of service provision, limited confidentiality, fear of one's own status due to stigma.

The negative attitude results of this study are supported by to those of the recent study done by Macpherson (2011) which revealed that anticipated stigma prior to Home based HIV Counseling and testing (HBCT) was common among both men and women.

Likewise, Flykesnes (2004) found that perceived risk of HIV infection had a major influence on VCT readiness among young people, whereas declining general health status, as indicated by self-rated health, was most evident among those of older age. A strong effect of placement on acceptability of VCT was demonstrated, indicating this barrier to be important in explaining low demands for VCT in the past. Differences in perceptions of how confidentiality is handled at the two locations might be an important underlying factor.

5.1 Study Limitations

The study had the following limitations:

Firstly, respondents might have agreed with statements as presented (acquiescence bias) by a researcher who was using a questionnaire. To avoid this, each question was asked with what Saris *et al* call "construct-specific response options" for instance, the researcher asked “How confidential do you think will the counseling and testing at home setting be? Not confidential at all, slightly confidential, Very confidential or extremely confidential? This method helped respondents to respond with less work mentally, but a more accurate answer.

Secondly, the respondents might have tried to portray themselves in a more favorable light (social desirability bias). That is, since the respondents learned that the government wants to introduce the home based counseling and testing approach in the community, some respondents might have answered the questions in favor of what the government wants. This bias was minimized by instilling a sense of detachment and reassurance to the potential respondents.

That is, before consenting to participate in the study each potential respondent was assured that no personal identification details would be required and that the responses to questions would be handled with confidentiality. The anonymous administration made respondents not to feel directly and personally involved in the answers they were giving.

CHAPTER SIX: CONCLUSION AND RECOMENDATIONS

This chapter presents conclusion and recommendations.

6.1. Conclusion

Generally, the results of this study have shown that community members of Ilala district have a positive attitude toward the uptake of home based counseling and testing. This is a good sign with respect to implementation of HBCT but perceived barriers should be addressed in the plan for roll out. However, focus group discussion respondents expressed perceived barriers in receiving counseling and testing services in their homes. With these results, it is recommended that more research to be conducted to verify the acceptance of the urban community members on the uptake of HBCT.

6.2 Recommendations

Basing on the findings of this study, it is recommended that:

1. Sensitization of the community about the new approach (HBCT) should be done by the Ministry of Health and Social Welfare (MOHSW) for the whole country through regional and district authorities so as to create awareness of HBCT services. Any inputs or suggestions from the community should be taken onboard so as to provide environment for ownership and sustainability.
2. Advocacy of the HIV and AIDS act should be done by the MOHSW to the communities to create awareness about the rights of clients who want to test for HIV and also for those who are found HIV positive so as to reduce the fear that the community has about HIV positive results.

3. The MOHSW through its district councils should come up with a strategy to conduct the HBCT at appropriate time that majority of the community will be at home. This can be easily done through involvement and participation of community leaders and local government authorities.
4. Home based care services should be expanded by the MOHSW at all levels as they are the main contributors in the provision of HBCT services.

5. Before scaling up the HBCT services, more studies are required to examine the acceptance of HBCT and related barriers among community members.

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ANNEXES

Consent form: English version

MUHIMBILI UNIVERSITY OF HEALTH AND ALLIED SCIENCES

DIRECTORATE OF RESEARCH AND PUBLICATIONS, MUHAS

INFORMED CONSENT FORM

ID-NO | | | | | | | | | | |

Consent to Participate in
……...

Greetings! My name is …….. I am from the Muhimbili University College of Health and Allied Sciences. We are conducting a research study about the attitude of household members towards the uptake of Home Based HIV Counseling and testing in Ilala Municipal. I want to invite you to take part in completing a survey for this study. First I will talk to you about the study and then answer any questions you may have.

Purpose of research project

The purpose of this study is to learn more about the perception and awareness of people in this new approach of HIV counseling and testing at home settings. We are talking to people in communities where these services are going to be provided so as to get information from the users of these services which are the community themselves. You were chosen to participate because you are part of the community. Overall study results will be shared with your supervisor and others, though not in a way that would allow them to identify you.

Procedures

If you agree to take part in the survey, I will ask you questions about your socio economic background, your awareness and perception on home based counseling and testing services. We will not put your name on the survey—it will be identified only with an identification number. Your responses will not be shared with anyone outside of the study team. The information that you provide will be kept in a locked office separate from the identifying information you provide. You do not have to take part in this study if you do not want to. If you decide to take part, you can decide not to answer any question you do not want to, or you can stop the survey at any time. You will not be penalized if you decide not to take part or to stop the survey.

Risks/discomforts

There are no physical risks from taking part in this survey. It is possible some questions I ask may make you feel uncomfortable or embarrassed, but I will make sure that we speak in a place where you feel comfortable to talk. There is a small risk that someone could learn about your responses. But I will do everything that I can to make sure that does not happen. The survey today will take about 60 minutes.

Rights to Withdraw and Alternatives

Taking part in this study is completely your choice. If you choose not to participate in the study or if you decide to stop participating in the study you will continue to receive all services that you would normally get. You can stop participating in this study at any time, even if you have already given your consent. Refusal to participate or withdrawal from the study will not involve penalty or loss of any benefits to which you are otherwise entitled.

Benefits

There is no direct benefit to you for answering the survey. However, the information you provide will help us know if the new approach of counseling and testing at home will be accepted by our communities or not. This is why your participation is so important.

Protecting data confidentiality

The information that we collect from you will be kept in a locked office and will be destroyed at the end of the study. We will also keep your identifying information separate from the answers you provide today so that your name cannot be linked to the data.

Who should you call with questions or problems?

If you have any questions about this study you may ask those now or later. In case you wish to find out more or ask any question later you may contact any of the following;

1. **Sharon Lwezaula,** Muhimbili University of Health and Allied Sciences (MUHAS), P.O. Box 65001, Dar es Salaam (Tel. no. **0787 435 937**).
2. **Dr Tumaini Nyamhanga,** who is the supervisor of this study (Tel. **0713 25 40 00**).

PERMISSION TO PROCEED

Certification of consent

I have been invited to take part in the study named attitude of the community towards the uptake of home based counseling and testing services in Ilala municipal, Dar es salaam. I have read the foregoing information or it has been read to me and have understood. My questions have been answered to my satisfaction. I agree to participate in this study.

Signature (or thumbprint) of participant _____

Signature of witness (if participant cannot read) _____

Signature of research assistant _____

Date consent signed _____

Consent Form: Kiswahili Version

CHUO KIKUU CHA AFYA NA SAYANSI YA TIBA CHA MUHIMBILI

KURUGENZI YAUTAFITI NA UCHAPISHAJI

Fomu ya ridhaa

Nambari ya Mshiriki ☐☐☐

Habari za leo! Jina langu ni …….. Natoka Chuo Kikuu cha Sayansi za Afya Muhimbili. Tunafanya utafiti kuhusu mtazamo wa jamii kuhusu unasihi na upimaji wa VVU nyumbani katika manispaa ya Ilala. Ninapenda kukukaribisha ushiriki katika zoezi hili. Kwanza nitazungumzia kuhusu utafiti huu halafu nitajibu swali lolote utakaloniuliza baada ya hapo.

Lengo la Utafiti

Lengo la Utafiti huu ni kujifunza zaidi kuhusu mtazamo wa jamii katika njia mpya hii ya upimaji na unasihi nyumbani. Tutaongea na watu katika jamii ampapo hizi huduma zitatolewa hivyo kupata taarifa kutoka kwa watumiaji wa huduma hizi ambao ndio jamii yenyewe. Wewe umechaguliwa kushiriki sababu wewe ni mmoja wapo katika jamii. Majibu ya utafiti huu yatakusanywa na kushughulikiwa na

mratibu mkuu wa utafiti akishirikiana na watafiti wengine lakini jina lako wala taarifa zozote kuhusu wewe binafsi hazitajulikana.

Mambo yatakayofanyika

Ili kupata majibu ya maswali haya, nakukaribisha kushiriki kwenye utafiti huu. Endapo utakubali kushiriki, utafanyiwa yafuatayo:

Utakaa na mhojaji aliyefuzu na utajibu maswali kuhusu taarifa zako bianafsi, uzoefu wako kuhusu upimaji wa VVU nyumbani. Hatutaweka jina lako katika utafiti huu bali utattambulika kwa namba ya mshiriki. Majibu yako hayatahusishwa kwa mtu yeyote nje ya timu ya utafiti. Ni hiari yako kukubali au kukataa kushiriki katika hili zoezi. Ukikubali kushiriki utaombwa kutoa maoni yako mbali mbali kuhusu huduma hii. Mhojaji atakuwa akinakili majibu yako ndani ya dodoso la utafiti. Utahojiwa mara moja tu kwa wastani wa dakika 30-45 ndani ya chumba chenye usiri.

Madhara na kujisikia vibaya

Utaulizwa maswali kuhusu mambo yanayohusiana na huduma za upimaji wa VVU. Baadhi ya maswali utakayoulizwa yanaweza kukugusa sana na yanaweza kukufanya ujisikie vibaya kiasi. Unaweza kukataa kujibu swali lolote na kukatisha mahojiano wakati wowote. Hata hivyo, mimi nitakayekuwa nakuhoji nitakuwepo kukusaidia kadri itakavyohitajika.

Haki ya kujitoa au vinginevyo.

Ushiriki katika utafiti huu ni wa hiari. Kutoshiriki au kujitoa kutoka kwenye utafiti hakutakuwa na adhabu yeyote na hutapoteza stahili zako, endapo utaona ni vyema kufanya hivyo.

Faida

Hakutakuwa na faida ya moja kwa moja kwako, hatahivyo, taarifa utakazotoa zitasaidia kuongeza uelewa wetu kuhusu njia mpya hii ya unasaha na upimaji wa VVu nyumbani kama itakubaliwa na jamii zetu ama la.

Usiri wa takwimu

Taarifa zitakazochukuliwa toka kwako zitahifadhiwa kwa usiri. Ni wafanyakazi wanaohusika kwenye utafiti tu ndio watakaoweza kufikia taarifa zako. Takwimu zitawekwa kwenye kabati ambalo litakua linafungwa mpaka zoezi letu liishe. Na baada ya hapo, takwimu hizi zitaangamizwa. Hatutaandika jina lako wala taarifa zako binafsi za kukutambulisha kwenye kumbukumbu za taarifa utakazotoa.

Kwa Mawasiliano zaidi

Kama utakuwa na maswali yoyote kuhusu utafiti huu unaweza kuuliza sasa au hata wakati mwingine. Ukitaka kuelewa zaidi au kuuliza maswali wakati mwingine, unaweza kuwauliza wafuatao:

1. **Sharon Lwezaula**, ambaye ni Mtafiti Mkuu wa utafiti huu, Chuo Kikuu cha Sayansi za Afya Muhimbili, S.L.P.65001, Dar es Salaam (Simu 0787 435 937).
2. **Dr Tumaini Nyamhanga**, ambaye ni Msimamizi wa utafiti huu, Chuo Kikuu cha Sayansi za Afya Muhimbili, S.L.P.65001, Dar es Salaam (Simu 0713 25 40 00).

RUHUSA YA KUENDELEA

Uthibitisho wa Ridhaa ya Kushiriki utafiti

Nimekaribishwa kushiriki kwenye utafiti unaohusu mtazamo wa jamii kuhusu unasihi na upimaji wa VVU nyumbani manispaa ya Ilala mkoani Dar es salaam. Nimesoma au nimesomewa mambo yote yaliyomo kwenye fomu hii na nimeelewa. Maswali yangu yamejibiwa na nimeridhika. Nakubali kushiriki kwenye utafiti huu.

Sahihi (au dole gumba) ya mshiriki

_____

Sahihi ya shahidi (kama mshiriki hawezi kuandika/kusoma)

_____

Sahihi ya Mtafiti Msaidizi

_____

Tarehe ya kusaini fomu ya Ridhaa ya Ushiriki

_____

Questionnaire: English version

ATTITUDE OF THE COMMUNITY TOWARDS THE UPTAKE OF HOME BASED COUNSELLING AND TESTING IN ILALA DISTRICT

Respondent Identification Number | | | |

Identification Information:

1	District:	
2	Ward:	
3	Street:	
4	Interviewer code			
5	Date of completion of the questionnaire				Day Month Year
	Consent	
6	Consent has been read out to respondent	Yes 1 ☐ No 2 ☐

		If NO, read consent
I7	Consent has been obtained (verbal or written)	**Yes** ☐ **No** ☐ **If NO, END**
8	Time of interview (24 hour clock)	☐☐☐☐

Step 1 Core Demographic Information`

			Coding Column
1	Sex (Record Male / Female as observed)	Male 1 Female 2	
2	How old are you?	Years	
3	What is the highest level of education you have completed?	No formal schooling 01 Less than primary school 02 Primary school completed 03 Secondary school completed 04 High school completed 05 College/University completed 06	

		Post graduate degree 07	
4	Which of the following best describes your main work status over the last 12 months?	Government employee 0 1 Non-government employee 0 2 Self-employed 0 3 Student 0 4 Homemaker 0 5 Retired 0 6 Unemployed (able to work) 0 7 Unemployed (unable to work) 0 8	
5	Taking **the past year**, can you tell me what the average earnings of the household have been?	per month Refused 8	
6	What is your marital status?	Single/never married Divorced/separated Widowed Married/cohabiting-monogamous Married/cohabiting-polygamous	
7	What ethnic group (religion) do you belong to?	Muslim Catholic Other Christian Other (Specify) None	**SINGLE RESPONSE**
8	**If polygamous:** How many wives/girlfriends do you have?		

Awareness questions

Now I am going to ask you some questions about your awareness. Let us start with awareness about home based counseling and testing services.			
		Response	**Coding Column**
1	Have you ever heard of home based counseling and testing?	Yes 1 No 2	
2	If Yes, Do you know where are these services provided?	Yes 1 No 2	
3	**If Yes,** Do you know how these services are being provided?	Yes 1 No 2	
Now let us go to awareness questions about the legal rights?			
1.	Are you aware of the 2008 HIV and AIDS act that has been developed by the Ministry of Health and Social Welfare?	Yes 1 No 2	
2.	Do you know your rights as long as HIV counseling and testing is concerned?	Yes 1 No 2	

Attitude Questions

Below is a list of forty statements. Some of these you might agree with and others you might even find offensive. These statements are designed to provoke a response. They do not necessarily reflect the opinions of the survey organizers. We would like you to tell us what your attitude is to each statement by **circling one of the numbers** from 1 - 5 …
1 = you **Strongly Agree** with the statement
2 = you **Agree** with the statement, but not very strongly
3 = you are **Undecided** and can't make up your mind
4 = you **Disagree** with the statement, but not very strongly
5 = you **Strongly Disagree** with the statement.
As we said on the first page, please try to answer all the questions and give your first thoughts on each statement. Don't spend a lot of time weighing-up your answers. There aren't any hidden catches. We just want to hear your opinions.

		Strongly agree	Agree	Undecided	Disagree	Strongly disagree
1	Provision of counseling and testing services at home reduces costs of going to the health facilities by the consumers of the services.	1	2	3	4	5
2	Provision of counseling and testing services at home settings are favorable for	1	2	3	4	5

	confidentiality					
3	Home visits by health providers reduces stigma in the community	1	2	3	4	5
4	As a wife/husband, discussion with a health care provider regarding counseling and testing of HIV when my partner is not around will not cause any problems	1	2	3	4	5
5	As a wife/husband, discussion with a health care provider regarding counseling and testing of HIV without permission/consent from my partner, it will not cause any problems					
6	If household members realize that I have been counseled and tested, they will be eager to know my results	1	2	3	4	5
7	If a neighbor sees that a health care provider has come to my home, he/she will not gossip to other neighbors	1	2	3	4	5
8	If my neighbors knows that I have been counseled and tested, it will not affect my business in the neighborhood	1	2	3	4	5
9	A health care worker who will visit me at home will keep my results confidential	1	2	3	4	5
10	I will be ready and prepared for counseling and testing when I hear a health care worker knocking at my door	1	2	3	4	5
11	I would rather go to the health facility for counseling and testing services at my own time instead of health care workers to come to my home	1	2	3	4	5

THANK YOU FOR YOUR PARTICIPATION!

Questionnaire: Kiswahili version

TABIA YA JAMII JUU YA HUDUMA ZA UNASIHI NA KUPIMA VVU NYUMBANI MANISPAA YA ILALA

Namba ya usajili ya mshiriki

Taarifa za mshiriki:

1	Wilaya:	
2	Kata:	
3	Wilaya:	
4	Namba ya mshiriki	
5	Tarehe ya ujazaji	Siku Mwezi Mwaka
	Utayari wa mshiriki (consent)	
6	Haki za mshiriki kukubali au kukataa kushiriki zoezi hili zimesomwa kwa mshiriki	Ndio 1 Hapana 2 **Kama HAPANA, soma**

		haki zake
I 7	Mshiriki kasomewa haki zake na mshiriki kakubali (Kwa mdomo au kimaandishi)	**Ndio** ☐ **Hapana** ☐ **Kama HAPANA, SIMAMISHA ZOEZI**
8	Muda wa mazungumzo (Katika masaa 24)	☐☐☐☐

Ngazi ya 1 Taarifa za mshiriki za kidemografia`

			Eneo la kujaza
1	Jinsi (Jaza Mwanaume au / Mwanamke kama unavyomuona)	Mwanamume 1 Mwanamke 2	
2	Una miaka mingapi?	Miaka	
3	Ni kiwango gani cha elimu ulichofikia?	Haukusoma kabisa 01 Kaukukamilisha elimu ya msingi 02 Umekamilisha elimu ya Msingi 03 Umekamilisha ya kidato cha nne 04 Umekamilisha kidato cha sita 05 Umekamilisha chuo kikuu 06	

4	Ni jibu lipi katio ya haya linaelezea kazi yako katika miezi 12 iliyopita?	Mwajiri wa serikali 0 1 Mwajiri wa shirika lisilo la serikali 0 2 Umejiajiri 0 3 Mwanafunzi 0 4 Umestaafu 0 5 Huna kazi (ana uwezo wa kufanya kazi) 0 6 Huna kazi (hana uwezo wa kufanya kazi) 0 7	
5	Katika mwaka mzima uliopita unaweza ukakisia ni kiasi gani ulichokua unapata kwa makadirio ya kila mwezi?	Kila mwezi	
6	Hali yako ya ndoa ni ipi kati ya hizi?	Hujawahi kuolewa/kuoa Mmetengana/mmetalakiana Mjane Umeoa /Umeolewa na mtu mmoja Umeoa /Umeolewa na watu wengi	
7	Dini yako ni ipi?	Mwisilamu Mkristo Nyingine (taja) Huna dini	**JIBU MOJ A TU**
8	**Kama una wake wengi/wame wengi:** Ni wake wangapi ulionao?		

Maswali kuhusu ufahamu

Sasa nitakuuliza maswali kuhusu ufahamu wako juu ya huduma hizi za unasihi na upimaji wa VVU nyumbani.			
		Response	**Coding Column**
1	Je, unazifahamu huduma za unasihi na upimaji wa VVU nyumbani?	Ndio 1 Hapana 2	
2	Kama jibu ni ndio, unajua ni wapi huduma hizi zinatolewa?	Ndio 1 Hapana 2	
3	Kama jibu ni ndio, unajua ni jinsi gani huduma hizi zinatolewa?	Ndio 1 Hapana 2	
Sasa ntakuuliza maswali ya ufahamu kuhusu haki zako za msingi			
1.	Je, unafahamu kwamba kuna sheria ya UKIMWI ya mwaka 2008 iliyotengenezwa na Wizara ya Afya na Ustawi wa Jamii?	Ndio 1 Hapana 2	
2.	Je, unafahamu haki zako za msingi kwenye suala zima la unasihi na upimaji wa VVU	Ndio 1 Hapana 2	

Maswali kuhusu mtazamo wako

Yafuatayo ni maswali ambayo yataashiria mtazamo wako kuhusu huduma za unasihi na upimaji wa VVU nyumbani. Baadhi ya maswali utakubaliana nayo na mengine utapingana nayo. Nitaomba utuambie mtazamo wako katika kila sentensi kwa kuzungushia jibu kwenye namba 1 hadi 5.

1 = **Unakubaliana hasa** na maelezo haya.
2 = **Unakubaliana** na maelezo haya ila **sio sana.**
3 = **Hauna uhakika** na maelezo haya.
4 = **Haukubaliani** na maelezo haya ila **sio sana**.
5 = **Haukubaliani kabisa** na maelezo haya.

Tafadhali jaribu kujibu maswali yote katika kila maelezo. Tunakuomba usichukue muda mwingi kufikiria. Nia ni kutaka kujua mtazamo wako tu.

	Maelezo	**Unakubaliana hasa**	**Unakubaliana sio sana**	**Hauna uhakika**	**Haukubaliani sio sana**	**Haukubaliani kabisa**	**Eneo la kuwekea jibu lako**
1.	Utoaji wa huduma hizi za unasihi na	1	2	3	4	5	

	upimaji wa VVU nyumbani unapunguza gharama za kwenda kituo vha kutolea huduma za afya kwa watumiaji wa huduma hizi						
2.	Utoaji wa huduma za unasihi na upimaji wa VVU katika mazingira ya nyumbani ni mzuri kwa utunzaji wa siri za mtumiaji huduma.	1	2	3	4	5	
3.	Kutembelewa nyumbani na mhudumu wa afya inapunguza unyanyapaa katika jamii.	1	2	3	4	5	
4	Kama mke/mume, kuongea na mhudumu wa afya kuhusu unasihi na upimaji wa VVU bila mwenzangu kuwepo hakutasababisha matatizo yoyote baadaye.	1	2	3	4	5	
5.	Kama mke/mume, kuongea na mhudumu wa afya kuhusu unasihi na upimaji wa VVU bila ridhaa ya mwenzangu hakutasababisha matatizo yoyote baadaye.	1	2	3	4	5	
6.	Kama wanafamilia ninaoishi nao watagundua kua nimepewa ushauri nahasa na pia nikapima VVU watakua na shauku ya kutaka kujua majibu yangu.	1	2	3	4	5	
7.	Endapo jirani wakimuona mhudumu wa afya amekuja nyumbani kwangu hawataniteta.	1	2	3	4	5	
8.	Kama majirani zangu watagundua kua nimepewa ushauri nasaha na kupimwa VVU, haitaathiri biashara zangu mtaani.	1	2	3	4	5	

9.	Mhudumu wa afya atakayenitembelea nyumbani atanitunzia siri ya majibu yangu.	1	2	3	4	5	
10.	Nikisikia mhudumu wa afya anagonga hodi, nitakua niko tayari kufanyiwa unasihi na upimaji wa VVU.	1	2	3	4	5	
11.	Ni bora niende mwenyewe kwenye kituo cha kutolea huduma za afya kufanyiwa unasihi na upimaji wa VVU kwa muda wangu kuliko kufuatwa nyumbani na mhudumu wa afya.	1	2	3	4	5	

ASANTE KWA USHIRIKIANO WAKO

Qualitative guide

Awareness section

1. a) Have you ever heard of home based counseling and testing? Where did you get this information?
   b) Je, unazifahamu au ulishawahi kuzisikia huduma za unasihi na upimaji wa VVU nyumbani? Ulipata wapi taarifa hizi?

2. A) Where are these services provided?
   b) Ni wapi huduma hizi zinatolewa?

3. A) How are these services provided?
   b) Ni jinsi gani huduma hizi zinatolewa?

Now let us go to awareness questions about the legal rights?

1. A) Are you aware of the 2008 HIV and AIDS act that has been developed by the Ministry of Health and Social Welfare? What does the act say?
   b) Je, unafahamu kwamba kuna sheria ya UKIMWI ya mwaka 2008 iliyotengenezwa na Wizara ya Afya na Ustawi wa Jamii? Sheria hii inasemaje?

2. A) Do you know your rights as long as HIV counseling and testing is concerned? What are they?
   b) Je, unafahamu haki zako za msingi kwenye suala zima la unasihi na upimaji wa VVU? Ni zipi?

Perception

A) What are the cost implications in the provision of home based counseling and testing services? b) Kuna gharama zozote ambazo mteja ataingia kutokana na

huduma za unasihi na upimaji wa VVU nyumbani? Ainisha gharama hizo. **Probe (If there are some cost implication or not)**

1. A) What is your perception about the provision of counseling and testing services at home settings and confidentiality?

   b) Una mtazamo gani kuhusu huduma za unasihi na upimaji wa VVU katika mazingira ya nyumbani na utunzaji wa siri?

2. A) How will the home visits by health providers affect stigma in the community?
   b) Je, ni jinsi gani kutembelewa nyumbani na mhudumu wa afya kutaathiri unyanyapaa katika jamii?

3. A) As a wife/husband, will the discussion with a health care provider regarding counseling and testing of HIV when your partner is not around cause any problems? Probe, How?
   b) Je, Kama mke/mume, kuongea na mhudumu wa afya kuhusu unasihi na upimaji wa VVU bila mwenzangu kuwepo kutasababisha matatizo yoyote baadaye? Dodosa.

4. A) As a wife/husband, will the discussion with a health care provider regarding counseling and testing of HIV without permission/consent from your partner cause any problems? Probe, How?
   b) Je, Kama mke/mume, kuongea na mhudumu wa afya kuhusu unasihi na upimaji wa VVU bila ridhaa ya mwenzangu kutasababisha matatizo yoyote baadaye? Dodosa.

5. A) If household members/neighbours realize that you have been counseled and tested, what do you think will their reaction?

   b) Kama wanafamilia/majirani unaoishi nao watagundua kua umepewa huduma ya ushauri nahasa na upiamji VVU, Unafikiri watafanya nini?Kwanini?.

6. A) What is perception when you see a health care worker coming to your home for counseling and testing?Probe, preference of provison of counseling and testing

   b) Utakua na mtazamo gani ukimwona mtoa huduma anakuja nyumbani kwako kwa ajili ya unasihi na upimaji VVU?Dodosa, ni wapi atapendelea huduma hizi wanapendelea kupewa.

ASANTE KWA USHIRIKIANO WAKO