# FACTORS ASSOCIATED WITH UTILIZATION OF COMMUNITY BASED VOLUNTARY COUNSELING AND TESTING FOR HIV AMONGST WOMEN IN KISARAWE DISTRICT, COAST REGION

By

Florence Peter Lema

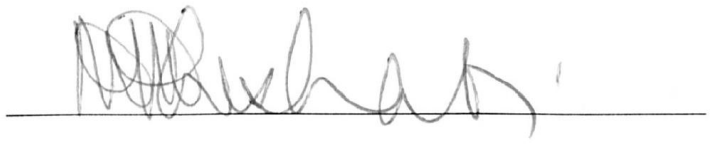
**A Dissertation Submitted in Partial Fulfilment of the Requirements for the Degree of Master of Public Health of the Muhimbili University of Health and Allied Sciences**

**Muhimbili University of Health and Allied Sciences**

**November, 2007**

## CERTIFICATION

The undersigned certifies that has read and hereby recommend for acceptance a dissertation entitled **Factors Associated with Utilization of Community Based Voluntary Counseling and Testing for HIV Amongst Women in Kisarawe District, Coast Region ,** in fulfilment of the requirements for the degree of Master of Public Health of the Muhimbili University of Health and Allied Sciences.



Prof. M.T Leshabari

(Supervisor)

Date: 3RD NOVEMBER, 2007

## DECLARATION AND COPYRIGHT

I, **Florence Peter Lema,** declare 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** 

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## DEDICATION

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# ABSTRACT

Voluntary Counseling and Testing (VCT) services have been found to be a cost-effective and powerful tool to induce behavior change and slow down rate of new HIV infections. The majority of potential clients of VCT services who are otherwise constrained due to cost of transport and service consider the mobile VCT as a great opportunity. Despite the known benefits of this service, records have shown that access to and utilization among women has been lower compared to men. The purpose of this study was to identify factors associated with utilization of Community Based Voluntary Counseling and Testing (CBVCT) for HIV testing amongst women in Kisarawe district, Coast region.

This was a cross sectional study involving 200 women. Structured and in-depth interviews were used for generating data. Results of the study revealed that over 70% of study participants believed to be at a low risk of HIV infection and that almost all (99%) were aware of the CBVCT services available in the area. However, only 24% had used the service. Factors motivating to use the CBVCT services included the need to know the HIV status, mobilization by CBVCT staff, provision of free service and living without fear. Barriers to use the services provided included women disempowerment, fear of a positive HIV result, confidence that they were not infected, poor mobilization by community leaders and fear of giving blood sample for HIV test.

Women recommended CBVCT Afiki staff and the community based outreach volunteers continue to mobilize people to go for HIV testing through door-to-door visits and special gatherings of women. They also suggested more provision of HIV/AIDS health promotion and PTSS centres be brought closer to where the majority of people live.

Based on the findings, better strategies for mobilizing women to use the CBVCT services are required. Also, since most women perceived themselves to be at a low risk of HIV infection, there is a need to develop strategies for changing such beliefs in order to improve suggested preventive measures against HIV infections.

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## LIST OF ACRONYMS

| | |
|---|---|
| AHEAD | Agriculture Health and Education Adventures |
| AIDS | Acquired Immuno Deficiency Syndrome |
| ANC | Antenatal Clinic |
| ARVs | Antiretrovirals |
| BAMITA | Baraza la Misikiti Tanzania |
| CBVCT | Community Based Voluntary Counseling and Testing |
| CCM | Chama Cha Mapinduzi |
| CDC | Centers for Disease Control |
| CUF | Civic United Front |
| DED | District Executive Director |
| DMO | District Medical Officer |
| FBOs | Faith Based Organizations |
| GDP | Gross Domestic Product |
| HIV | Human Immuno Deficiency Virus |
| ICASA | International Conference on HIV/AIDS And STIs in Africa |
| IEC | Information Education and Communication |
| IPPF | International Planned Parenthood Federation |
| KYODEN | Kisarawe Youth Development Network |
| MoH | Ministry of Health |
| MPEE | Ministry of Planning, Economic and Empowerment |
| MTCT | Mother To Child Transmission |

| | |
|---|---|
| MUHAS | Muhimbili University of Health and Allied Sciences |
| MVCT | Mobile Voluntary Counseling and HIV testing |
| NACP | National AIDS Control Program |
| NGOs | Non Government Organizations |
| NURRU | Network of Uganda Researchers and Research Users |
| PI | Principal Investigator |
| PMTCT | Prevention of Mother to Child Transmission |
| PTSS | Post Test Support Services |
| SPSS | Statistical Package for Social Sciences |
| STD | Sexually Transmitted Diseases |
| STI | Sexually Transmitted Infections |
| TACAIDS | Tanzania Commission for AIDS |
| TADENA | Tanzania Development Navigation Trust |
| TB | Tuberculosis |
| UKIMWI | Upungufu wa Kinga Mwilini |
| UNAIDS | United Nations Programme on HIV/AIDS |
| UNFPA | United Nations Population Fund |
| UPHOLD | The Uganda Programe for Human and Holistic Development |
| VCT | Voluntary Counseling and Testing |
| VVU | Virusi Vya Ukimwi |
| WASN | Women and AIDS Support Network |
| WHO | World Health Organization |

# CHAPTER ONE

# INTRODUCTION

## 1.1 Background Information

HIV/AIDS is a devastating pandemic threatening the world today, Sub - Saharan Africa being the most affected region. According to UNAIDS (2005), the region has just 10% of the world's total population, but has more than 60% of all people living with HIV. In 2005, an estimated 3.2 million people were newly infected and 2.4 million adults and children died of AIDS.

In Tanzania, during the last two decades the HIV/AIDS epidemic has spread relentlessly affecting people in all walks of life and decimating the most productive segments of the population, particularly women and men between the ages of 20 and 49 years (TACAIDS, 2004). The epidemic is a serious threat to the country's social and economic development and has serious and direct implications on the social services and welfare. Given the high HIV prevalence in the society, and the absence of cure, the devastating impact of the epidemic is incomprehensible (MoH, 2001).

Women in sub Saharan Africa are the most vulnerable group to HIV infection in the world. African women are 1.2 times more likely to be infected with HIV than African men (UNAIDS, 2003). Women are sexually, economically, and biologically more

vulnerable to HIV/AIDS. In terms of age, young women below 40 years especially adolescent girls are more susceptible to HIV than males of the same age group (Bwibo, 2004).

Barango and Happy (2004) reported that biologically, a woman is 4 times more likely to contract HIV infection during sexual intercourse with an infected man than vice versa. Women are at greater biological risk than men to HIV infection during sex because during this period the langerhans cells of the cervix predispose them to easier infection with sexually transmitted diseases including HIV/AIDS (CDC, 2007).

Economic hardship and the subordination of women make it difficult for women to protect themselves even if they know that they are at risk of being infected with HIV (Barongo and Happy, 2004).

Culturally, women are particularly vulnerable to sexual exploitation and coercion (Barongo and Happy, 2004). Most women are denied the freedom to manage their lives. The majority of women do not have access to a choice of safe and affordable contraceptive methods including condoms, which have been proven to be a reliable form of prevention of HIV infection (Montgomery, 2003 and Maman *et al.*, 2001). As a result of lack of control, women account for more than half of new HIV infections and the number of women becoming infected is increasing each year.

In 2006, it was estimated that 1,020,000 men and 900,000 women were living with HIV/AIDS in Tanzania (NACP, 2005). Between January and December 2004, a total of 16,430 cases were reported to the National Aids Control Program (NACP) from 21 regions of Tanzania mainland. Women were more affected by AIDS than males in the age group of 20-39. The preponderance of female cases was particularly striking for age groups 20-24 and 25-29 where female cases were almost twice as many as for males (NACP, 2005).

To date, several HIV/AIDS prevention strategies exist, these include abstinence, being faithful to one uninfected partner, condom use and Voluntary Counseling and Testing (VCT), which is an important component of HIV prevention and care strategy.

VCT provides opportunities for women to receive assistance in developing individualized risk reduction plans based on their serostatus and sexual relationship. Furthermore, VCT provides an opportunity to access accurate and comprehensive information on HIV/AIDS and a significant entry point to prevention, care, support and treatment programs (NACP, 2005).

Despite the known benefits of VCT, records have shown that access to VCT services and their utilization by women have been lower compared to men. For example, in 2005 a total of 112,360 people were tested in all Angaza VCT sites in Tanzania more than half (53.3%) were males (NACP, 2007).

Increasing utilization of VCT services by women require input from women themselves on the factors that affect their utilization. Previous studies did not reveal sufficient information in addressing the problem of underutilization of VCT services by women. None of the studies conducted in Tanzania tried to give a comprehensive overview about the factors affecting the accessibility of CBVCT services. This calls for more innovative strategies that could increase access and utilization of VCT services by women.

The research described below occurred in the context of a community-based intervention for HIV voluntary counseling and testing (CBVCT) being implemented in the rural district of Kisarawe, in Tanzania. This intervention, commonly known as Project Afiki, provides free mobile VCT services in five communities in Kisarawe district that extends beyond standard clinic based counseling and HIV testing to include Post Test Support Services (PTSS) and a community outreach component services. It has three major strategies: 1) To make VCT more available in community settings 2) To engage the community through outreach and 3) To provide post-test support. These three strategies are designed to change community norms and reduce risk of HIV infection among all community members, irrespective of whether they participate directly in the intervention. Although the CBVCT services are targeted to both women and men of eligible age (i.e. 16 years and above) and voluntarily wants to access the service, fewer women have been accessing the VCT services.

## 1.2 Problem Statement

Experiences observed from different developing countries reveal that women's access and utilization of health services appeared to be higher compared to men (GAD Consults, 2007). However, the opposite was observed in mobile community based VCT services in Kisarawe District. One year after commencement of the project, data showed that women's participation and utilization was generally lower compared to men. A total of 621 (5.6%) women out of 11,134 eligible women for HIV testing used the VCT services for HIV testing at the CBVCT sites compared to 1,336 (13.6%) men out of 9,836 eligible men for HIV testing since the launching of the intervention between March, 2006 and March, 2007 (Project Afiki, 2007).

VCT services have been found to be cost - effective and a powerful tool to induce behavior change and slow down the rate of HIV infections (NACP, 2003). It has been shown that the majority of potential clients of VCT services who were otherwise constrained by transport considered the mobile VCT as a very good alternative. It brought the service closer to the people and hence ensured increased access to the service (Narathius, 2004).

CBVCT is an approach to community change (Gladwell, 2002). The CBVCT services that were provided in Kisarawe district were mobile and they extended beyond the reach of clinic-based VCT provision to include PTSS and a community outreach component,

which targets both men and women. Although services provided were free of charge and highly confidential, utilization by women was very low compared to that of men.

The inability of women to utilize CBVCT services in Kisarawe could be due to several factors. As is usually the case with women in African cultural settings, most women cannot make decision even on issues that affect their health. Sometimes women need approval of their husbands or in-laws for health related visits. According to a study done by Kyampaire (2003), women who reported less education and economic dependency were less likely to make their own decisions on preventive health behaviours.

None of the studies conducted so far in the country have provided effective strategies on how participation of women in CBVCT services can be improved. It is for this reason that this study was conducted.

### 1.3 Study Objectives

The major objective of this study was to identify factors associated with utilization of CBVCT services for HIV/AIDS amongst women in Kisarawe district. Specifically, the study intended:

- To examine the awareness of women on available CBVCT services.
- To find out reasons motivating women to utilize the available CBVCT services.
- To identify women's barriers on the utilization of the available CBVCT services.

- To identify women's suggestions on what should be done for them to utilize the CBVCT services.

### 1.4 Rationale of the Study

Results of this study will contribute towards the type of information required for improving participation of women in CBVCT in Kisarawe district. Findings of the study will also contribute towards background information required for improving policies on providing counseling and testing for HIV to women in rural settings.

Furthermore, the findings are expected to add existing literature on factors that are associated with the utilization of CBVCT services for HIV prevention by women in rural areas in Africa South of Sahara.

# CHAPTER TWO

# LITERATURE REVIEW

## 2.1 Worldwide HIV/AIDS Situation

Acquired Immunodeficiency syndrome (AIDS) has killed more than 25 million people in the world since it was first recognized in 1981, making it one of the most destructive epidemics in recorded history (UNAIDS, 2005). At the end of 2006, an estimated 39.5 million people in the world were living with HIV and high numbers of new HIV infections continue to occur throughout the world (UNAIDS /WHO, 2006).

## 2. 2 Tanzanian HIV/AIDS Situation

Tanzania is experiencing a generalized HIV epidemic that is still growing (TACAIDS, 2004). Between January and December 2004, a total of 16,430 cases were reported to the National Aids Control Program (NACP) from 21 regions of Tanzania mainland. There were more female AIDS cases than males in the age group of 20-39 years. The preponderance of female cases was particularly striking for age groups 20-24 and 25-29 years where female cases were almost twice as many as males (NACP, 2005).

According to the TACAIDS report (2004), 7% of Tanzanian adults aged 15-49 were infected with HIV whereby prevalence among women was reported to be higher (8%)

than among men (6%). The HIV epidemic showed strong regional variation. The report indicated regions with highest HIV prevalence were Mbeya (14%), Iringa (13%) and Dar es Salaam (11%). The Coast region ranked the fifth with 7.3 % HIV prevalence.

### 2.3 Impact of HIV/AIDS in Tanzania

As for other sub Saharan African countries, HIV/AIDS is a major development crisis that affects all sectors in Tanzania. During the last two decades, the HIV/AIDS epidemic has spread relentlessly, affecting people in all walks of life and decimating the most productive segments of the population, particularly women and men between the ages of 20 and 49 (NACP, 2003). The epidemic is a serious threat to the country's social and economic development and has serious and direct implications on the social services and welfare. Given the high HIV prevalence in society, and in the absence of a cure, the devastating impact of the epidemic is incomprehensible (MoH, 2001).

The World Bank estimates that because of the AIDS epidemic, life expectancy in Tanzania by 2010 will revert to 47 years instead of the projected 56 years in the absence of AIDS (TACAIDS, 2005). The Bank further predicts that the mean age of the working population will decline from 31.5 to 29 years between 1992 and 2010. The overall younger work force will have less education, less training and less experience. The health sector workforce will also be affected because the disease is also affecting this group. In addition, they are also overworked in taking care/dealing with HIV/AIDS patients who increase in number everyday.

Furthermore, it was estimated that the number of children orphaned by AIDS increased from 260,000 to 360,000 in 1995 and 490,000 and 680,000 by the year 2000. As a result, families, communities and the government were required to generate resources to cater for the needs of these orphaned children.

The Bank further estimates that AIDS will reduce the average Gross Domestic Product (GDP) of Tanzania from a projected 3.9 % to 2.8 % - 3.3 % for the period of 1985 to 2010. AIDS will certainly have a negative impact on the overall economic performance of the country and its living standards (TACAIDS, 2005).

**2.4 Importance of VCT Services for HIV Prevention**

Researchers have identified measures that can be employed to control the HIV/AIDS epidemic such as sexual abstinence, marital fidelity, condom use, availability of Antiretroviral (ARVs) drugs and Voluntary Counseling and Testing (VCT) which is fast becoming an effective weapon to fight HIV/AIDS in Africa.

VCT is the process by which an individual undergoes confidential counseling to learn about his/her HIV status, exercise an informed choice in testing for HIV, and cope with the results. The client must make the decision to pursue counseling and testing at his/her own free will on the basis of the information provided during the counseling session i.e.

an informed decision. The client also has the option to terminate or postpone participation at any point in the process (NACP, 2005).

To date, VCT is one of the most important prevention interventions. Research has shown that it promotes important behavior change in both HIV negative and positive persons. People who test negative tend to adopt behavior that is likely to maintain their negative status and people who are positive are motivated to seek care earlier and support and plan for their own and their families' future. For those who test positive, counseling helps them to develop plans for coping with stress, possible stigma, and psycho-social effects. Counseling also provides referrals to appropriate facilities for care, support and treatment. Furthermore, VCT promotes more informed choices for future actions (NACP, 2005).

According to research done by De Zoysa *et al.*; (1995) and Coates *et al.*; (1998), HIV testing and counseling had an important social impact through people knowing their serostatus, sharing it with others and that it was a motivating factor for changing risk behaviors. Studies have also shown that an HIV positive result encouraged those infected to give personal testimonies in their communities, a consequence that could have a powerful effect on individual attitudes, behavior and social norms (Hughes and MacCauley, 1998).

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Furthermore, VCT services were found to be a cost - effective method and powerful tool to induce behavior change and slow down the spread of HIV (Sweat *et al.*; 2000).

### 2.5 Mobile VCT Services

Mobile VCT is a type of VCT service which has been found to be a very good alternative to community members who are otherwise constrained by cost of transport to access VCT services. It brings the service closer to the people and therefore increases access.

A study conducted in Zimbabwe revealed that mobile VCT encouraged acceptance by removing structural barriers. Also, it encouraged discussions with mobile VCT staff and outreach workers which helped them to overcome psychological barriers associated with testing (Khumalo-Sakutukwa, 2004).

Narathius (2004) identified four major strengths of mobile VCT service in a community:

- The mobile service brought equitable access to VCT service. Different socio-economic and demographic groups were provided with the opportunity for service. Those who were otherwise constrained by childcare, gardening, housekeeping and other household based chores, mainly women, could be served. The same was the case for the unemployed and the poor.
- The majority of potential clients of VCT services, who were otherwise constrained due to costs of transport, considered the mobile service a great opportunity.

- The fact that the mobile service attracted more clients was itself a strength. Given that in many situations VCT had been associated with behavior change, irrespective of the results of the test, more people turning up to test implied more likelihood of improvement in the country's response.
- Potential clients of VCT services who were constrained to seek service due to fear of anonymity and confidentiality were served. In some communities, people feared the disclosure of HIV status to wider community members by counselors known to them. The mobile VCT system handled that since the counselors were from different communities.

## 2.6 CBVCT Services

In order to stop or reduce the rapid increase of HIV in the rural districts of Tanzania, community based interventions were established (TACAIDS, 2005).Community based interventions have particular utility for HIV prevention in resource-poor settings where lower costs and intervention sustainability are given priorities. This kind of service improves access for hard-to-reach populations especially in rural areas.

CBVCT is an approach to community change (Gladwell, 2002). Community level approaches to HIV prevention are important because of their role in the epidemic impact. Community level approaches have the potential to alter the course of the HIV epidemic in developing countries (Valente, 1996).

The rationale for establishing the community based approach was to use the Diffusion of Innovation Theory which had been used to study social change in various countries (Rogers, 1995). Diffusion is the process by which an innovation is communicated over time among members of a social system. The theory has been used as a method for most community level interventions in the context of HIV prevention. It focuses on social networks, opinion leaders, and change agents.

### 2.7 VCT Services in Tanzania

The provision of HIV/AIDS-related counseling services in Tanzania started in 1988, five years after the first three AIDS cases were identified in Tanzania. In the beginning, these services were provided mainly by Faith Based Organizations (FBOs) and Non-Governmental Organizations (NGOs) to clients who sought such services (NACP, 2003).

In 1995, the NACP developed a VCT program to allow better integration and coordination of VCT services in the existing district health care system. In this regard, a national policy on HIV/AIDS in line with national guidelines for counseling and testing was designed and made available (MoH, 2001).

Recognizing the important role of VCT in HIV prevention, care and support, the Ministry of Health in 2001 started improving existing VCT services and established new

services in 29 districts without VCT. Training and retraining of counselors, procurement and distribution of test kits and other supplies, were done (NACP, 2005).

By March 2006, there were more than 806 sites and 2,110 trained counselors in Tanzania providing VCT services. The number of clients who accessed VCT services between July 2005 and March 2006 was 427, 272 (NACP, 2006).

### 2.8 Factors that Motivate Women to Utilize VCT Services

A study done by Khumalo-Sakutukwa (2004) reported that motivations to test for HIV included concern about physical symptoms of illness, the death or illness of a family member or friend, and perceived risk of HIV infection. Signs and symptoms, availability of support service after HIV test, and radio health messages were reported by Barongo and Happy (2004) to be the major motivating factors for women to seek HIV testing. Furthermore, Martin-Herz *et al* (2006) found that women's perception of risks associated with VCT, knowing their own serostatus, and confidentiality were important predictors of their willingness to be tested. Similar findings were reported by Bwibo (2004).

### 2.9 Factors that Prevent Women to Utilize VCT Services

#### 2.9.1 Stigma and Discrimination

Most women have been reluctant to seek HIV testing in places where VCT has been established in Tanzania (Maman *et al.*, 2001). This was probably due to fear, denial,

stigma and discrimination that HIV positive people face. These are supported by studies done by Ijeoma (2003) and Ching'ombe (2003) who indicated that stigma was the main inhibitor of VCT uptake while discrimination was identified as the main inhibitor by (Msobi, 2003) and (Zozie, 2003).

In places where VCT services have been established, women have been reluctant to seek HIV testing. This was because of fear, stigma, isolation and discrimination faced by those who tested positive (Montgomery, 2003).

IPPF (2004) quoted experiences from different women below:

> *My family would reject me if they found out that I was HIV positive.*
>
> *If I found out that I was HIV positive I would feel like I had been given the death sentence. At the moment I live my life unsure, but it is better than knowing I am definitely going to die.*

### 2.9.2 Gender Inequalities

Societies and cultures define female and male specific roles and entitlements. This makes women more vulnerable than men because the former dominate the reproductive role, which is not valued and in most cases not moneterized (Barongo and Happy, 2004). On the other hand, the latter dominate the productive role, which is public and valued in terms of money. This makes women dependent on men both financially and

emotionally. Women have few economic opportunities and pressure from men for commercial sex is sometimes difficult to resist (Ajambo, 2002).

The findings from UNAIDS (2000) outline that protection and support of vulnerable women who test seropositive must be considered when developing VCT services. In Zambia, women said that it was thought to be shameful to have HIV and if they were known to be seropositive, they worried that they would suffer discrimination (UNAIDS, 2000). A study done in Kenya had also shown that women were vulnerable and in some cases had lost their homes and children or had been beaten or abused by their husbands/partners if their status became known (Temerman, 1994).

### 2.9.3 Cultural Norms and Practices

It is vital to look at the cultural practices and beliefs that influence the utilization of VCT services by women. In most of the African countries, females represent a bigger percentage of new HIV infection than males and this is partly attributed to social and cultural vulnerability of females (Bwibo, 2004).

In some cultures, women can not discuss sexual matters with their partners. As a result of women's disempowerment, they live in denial of the effects of HIV/AIDS on their lives (Montgomery, 2003). In most Tanzanian families, women are not the decision- makers, even over issues that affect their health, including whether or not to visit a VCT center (Maman *et al.*, 2001).

Batambuze (2002) observed that practices among Muslim communities such as polygamy put themselves at high risk of HIV infection. However, the majority of people in Muslim communities do not consider themselves at risk.

Furthermore, Kirya (2002) reported that culture and gender related factors, such as the cultural belief that abstinence leads to gradual loss of sexual potency, society ostracism of those who delay sex and child bearing, promote unprotected sex. Such issues have put women in a disadvantaged position in the fight against HIV/AIDS and provision of VCT services.

### 2.9.4 Ignorance of Being at Risk

IPPF (2004) stated that many people, particularly in low prevalence areas where knowledge about HIV/AIDS was low, did not perceive that they were at risk. In high prevalence areas, people believed they were already infected. So, VCT services could help people understand their personal level of risk, encourage safer sex practices, and support people to access care early if they are infected.

Furthermore, Ajambo (2002) reported that there were great beliefs that married women were 'safe' from HIV infection therefore men went for sex with them. This implied that married women were considered to be at low risk, thus, exacerbating HIV prevalence and low support for VCT services for married women.

### 2.9.5 Poor Education and Source of Information

Bwibo (2004) reported that women could draw from a number of sources information about VCT services for HIV testing. These ranged from health care providers, peers, friends, relatives, workmates and mass media. There was low utilization of VCT services among women due to lack of information about the services and/or inadequate mobilization, sensitization and information in the community. However, not all who heard about VCT used the services, since some may not understand the personal benefits associated with VCT. Also information about VCT may not reach all women in a community. This may depend on the source of information, the type of information, and the timing of the information. These factors might not be appropriate for the targeted group of women. For information to be useful it should be appealing to the user and also meet their needs.

In a study done by Beverley in 2006 it was found that female illiteracy and limited educational attainment was the reason for neglecting HIV prevention. Lack of education and inability to freely discuss sexuality denied women access to health information and potentially exposed women to adverse consequences such as HIV infection.

### 2.9.6 Decision Making

Women have specific needs and issues when it comes to VCT. Women who lived with partners often had to ask for permission to leave the house, especially if they were to seek VCT services (Maman *et al.*, 2001). When partners were not involved, or did not

consent to the decision to test for HIV, women would rather not test on their own accord for fear of domestic violence (Maman *et al.*, 2003, Lie and Biswalo, 1996).

### 2.9.7 Benefits of VCT

Lack of understanding of the perceived benefits of testing for HIV among women could be a predictor of low access to VCT services (Ijeoma, 2003). In a study conducted in Malawi, 11% of the respondents felt that knowing about their status could result in an early death due to fear and anxiety, consequently, they opted not to know their HIV status (Zozie, 2003). That was an indication that the role of counseling was not known/or understood to them. Counseling was a professional, confidential relationship between a counselor and a client that enabled a client to accept, cope or solve her/his problems. This suggests that the role of VCT counseling played in HIV/AIDS needs to be emphasized (Bwibo, 2004).

### 2.9.8 Ability to Pay

Cost of a service may be an inhibiting factor, especially for women who are economically dependent on men. Moor (2003) mentioned that VCT services should be free or low cost, as cost was an issue of concern for women. Effective VCT services need to enable those women who want to test for HIV to access the service at a cost that they can afford.

### 2.9.9 Location of VCT site

Access to VCT center has a major impact on VCT uptake (Butterworth, 2003). Many women were generally poor and occupied with household chores and family responsibilities, leaving little time for themselves or anything else. If VCT services are located far away and require transport to reach, women will be less likely to use them. However, if the VCT services were brought closer to their homes there is a greater possibility that women may use them (Ching'ombe 2003).

Similar findings were reported from Kenya, where there was a positive response to VCT services that were located within the community (Achieng, 2003). Those findings indicated that accessible location was essential to increasing utilization of VCT services (Moor, 2003). However, those findings did not mention whether women preferred the location of VCT centers to be outside their local area or near their homes.

### 2.9.10 Privacy and Confidentiality

Moor (2003) advocated that privacy and confidentiality must be arranged for counseling sessions. Women must feel confident that their important and sensitive concerns are not told to other persons or overheard during counseling sessions. At some VCT facilities, the quality of counseling may be poor and the environment not conducive to women seeking VCT services, thus, failing to win the confidence of women clients. Often clients have reason to fear that their results will not be kept confidential. This created fear and mistrust among the potential users of VCT services. Women may therefore

want private, confidential services and good humane treatment ensured if they are to use VCT services. Concerns about confidentiality may also include fears that their partners might learn of their visit and react negatively towards them (Maman *et al.*, 2003).

### 2.9.11 Counselors Characteristics

Effective counseling requires well-trained and skilled counselors. Thus, counseling for HIV testing requires the acquisition of skills by the counselor. Trained counselors are needed to work competently and sensitively with women. Such a counselor requires interpersonal skills that can put women at ease and allow them to be comfortable to communicate their needs and concerns (Bwibo, 2004).

## 2.10 Strategies to Promote Women's Access and Utilization of VCT Service

Barongo and Happy (2004) identified strategies to promote access and utilization of VCT services by women. The strategies included mass sensitization about the utilization of VCT services among women and encouragement of community participation through plays, debates, discussion, seminars and reading materials. Other strategic approaches were to involve the religious leaders to sensitize the public about the importance of VCT services and using an integrated approach to providing VCT.

From the study done by Bwibo (2004), it was suggested that VCT program implementers improve communication campaigns so as to address awareness and knowledge of VCT for women by providing and increasing awareness of the benefits of

VCT. Also, to evaluate their messages and develop messages that pay particular attention to how women interpret the information they receive.

Generally, factors affecting VCT utilization by women require analysis to improve service and provide important information to create strategies aimed at increasing utilization. A detailed study was needed to come up with effective strategies on how women could be effectively reached with the mobile CBVCT services. The information had to be obtained from women themselves.

# CHAPTER THREE

# METHODOLOGY

## 3.1 Study Area

This study was carried out in CBVCT intervention communities in Kisarawe District. This district is located approximately 30 km, southwest of Dar - es - salaam region. It is one of the six districts of the Coast region. Other districts are Bagamoyo, Kibaha, Rufiji, Mkuranga and Mafia. The district is surrounded by Ilala and Kinondoni districts in the east, Mkuranga district in the southern east, Rufiji district in the south, Morogoro district in the west and Kibaha district in the north. There are 4 divisions, 14 wards and 77 registered villages within the district and 4-6 villages within each ward.

Kisarawe is a rural district with an estimated population of about 100,000 people, of which about 60% are women (DED,2007). The district covers an area of 3,535 square kilometers (DED, 2007). The district is largely agricultural with a good climatic condition, which favors growth of various types of cash and food crops like cashew nuts, coconuts, cassava, maize, rice, groundnuts and various fruits.

There are 15 public primary health care facilities in the district. They include three health centers, Maneromango, Masaki and Msanga, and twelve dispensaries, which include Chole, Gwata, Homboza, Kihare, Kurui, Mafizi, Marui, Marumbo, Msanga,

Kiluvya Sungwi and Masanganya. The estimated HIV prevalence for the district is 7.7% (DMO, 2007).

To date, several Non Governmental Organizations (NGOs) operates in this district performing different activities including health activities. These included: Vijana Vision which deals with youth and Orphans, Tanzania Development Navigation Trust (TADENA) dealt with cassava plantation project; Agriculture, Health and Education Adventures (AHEAD) – Vocational training and home based care; Baraza la Misikiti Tanzania (BAMITA) dealt with Health and VCT and Kisarawe Youth Development Network (KYODEN) which dealt with youth network for development.

### 3.2 Study Population

The study population consisted of women aged between 18 to 49 years. This age group was chosen because generally women in sub - Saharan Africa including Tanzania are the most vulnerable group to HIV infection in the world. They are sexually, economically and biologically more vulnerable to HIV/AIDS (Bwibo, 2004). Also, in terms of age, HIV infection rates within the mentioned age group were higher in women than in men (NACP 2005).

### 3.3 Study Design

A cross-sectional survey that includes both qualitative and quantitative methods was used to generate data for this study.

### 3.4 Sample Size

Sample size for the quantitative component of the study was calculated by using the following formula:

$$n = (Z^2)\ P\ (100\text{-}P)/\ \varepsilon^2$$

Where: n = minimum sample size.

Z= standard normal deviate value (set at 1.96 which corresponded to the 95% confidence interval level).

$\varepsilon$ = margin of error (taken to be 7% in this study).

P= the estimated proportional of women utilizing VCT services (47%, obtained from NACP surveillance report of 2007).

Substitution gave a minimum sample size of 195 women. This was rounded up to 200 so as to accommodate the unforeseen problems such as non-response to some or all questions and other errors.

### 3.5 Sampling Procedure

A multistage sampling procedure was used to select participants for the quantitative component of the study. Three communities were randomly selected from the five Project Afiki CBVCT communities. In each of the three communities, two villages were randomly selected. Thereafter, two sub-villages were randomly selected in each of the two villages. In order to identify the study participants, a sampling frame consisting of

all households with eligible women was made. Seventeen households in each sub-village were then randomly picked for the survey. In households where there was more than one eligible participant, a random selection was done to select one woman to be included in the study.

Participants for in-depth interviews (qualitative component of the study) were purposefully selected from the three randomly selected communities above. Six were participants who had utilized the CBVCT services for HIV/AIDS testing and six participants who had not yet utilized the services for HIV/AIDS testing. In order to cover the whole range of the study group and their status, the following categorization of participants to be interviewed was used: From each of the two groups, three young participants (18- 33 years) and three middle age participants (34-49years) were interviewed of which, two were married and one was unmarried participant.

### 3.6 Recruitment and Training of Research Assistants

Four research assistants were recruited and trained for three days before the work of data collection commenced. Selection was based on previous experience in research work in communities. All the four research assistants were males, form six leavers residing in Dar- es - Salaam but had experience in the study area.

The training focused on the general overview of the study, interviewing skills and procedures and finally, familiarization with the study instruments. The training also

emphasized how to obtain consent, maintain neutrality, privacy issues, personal relation and ethics.

### 3.7 Pretesting

Pretesting was done in order to test the clarity of questions and study logistics. It also helped the research assistants to exercise flexibility in the wording of questions and probing. This exercise was carried out in an area not selected for the study and was done before the actual study took place. Twenty structured interviews and two in-depth interviews were done. After this exercise, corrections were made. One question in the structured interview was modified; and also a few changes in the in-depth interview study guide were made.

### 3.8 Data Collection

The data collection took approximately one week using both the research assistants and the principal investigator (PI). The research assistants did the structured interviews while the in-depth interviews were conducted by the principal investigator.

#### 3.8.1 Qualitative method

In-depth interviews were used to explore in greater depth the factors associated with women's utilization of CBVCT services and the possible causes and solutions for the low utilization of the CBVCT services. The major themes which were covered by this method were: information on awareness of women's on CBVCT services, reasons which

motivated or hindered women's participation/utilization of CBVCT services and their suggestions on how to improve their utilization. A tool developed in English then translated in Swahili was used as an interview guide. The interviews were tape recorded and each session lasted for approximately 45 minutes.

### 3.8.2 Quantitative method

A structured interview with both open and close-ended questions developed in English and later translated in Kiswahili was used to gather basic demographic characteristics of the selected participants. Same major themes as for qualitative component of the study were covered by this method. These included, information on awareness of women's on CBVCT services, reasons that motivated or hindered women's participation/utilization of CBVCT services and their suggestions on how to improve their utilization. Each interview took approximately 30 minutes.

## 3.9 Data Management

At the end of each day of data collection, the PI assessed the completed interviews to look for omissions and inappropriate responses. This helped to improve the quality of data collection. There were also frequent debriefing meeting to discuss the progress of data collection.

All the completed interviews, tapes and the transcribed data were stored in a locked cabinet and were destroyed at the end of the study. Only the PI had the key to that cabinet.

### 3.10 Data Analysis

The in-depth interviews were transcribed and then translated into English. Themes were then obtained before coding. Thereafter, the texts were coded by using Atlas .ti program, and then organized around the themes based on the study objectives. The quantitative data analysis was performed using Statistical Package for Social Sciences program (SPSS).

### 3.11 Ethical Consideration

Ethical clearance was obtained from the Research and Publications Committee of Muhimbili University of Health and Allied Sciences (MUHAS), through the MPH Coordinator. Thereafter, permission to carry out this study was obtained from Kisarawe District Executive Director (D.E.D) and the respective local government leaders in the study area.

Each respondent in the study was briefed on what the study was all about and informed that participation was voluntary. Also, the respondents were assured of confidentiality and anonymity. No participants' names appeared in the interview sheet. Before the interview, participants were requested to give their consent for participation.

# CHAPTER FOUR

# RESULTS

## 4.0 Data Presentation, Interpretation and Analysis

### 4.1 Socio Demographic Characteristics

The study population consisted of 200 women whose age ranged from 18 to 49 years with a mean age of 31 years. The socio demographic characteristics of the study sample was as summarized in Table 1. The majority of the respondents (70%) were married, about one in five were single and the rest were either divorced, widowed, separated or in a cohabiting relationship. Muslim appeared to be the most predominant religion (90%) while the rest were Christians (Roman Catholics, Protestants and Born-again Christians). Literacy level was about 66% which is almost similar to the national female literacy rate (65%) (MPEE, 2006). The rest of the respondents were either illiterate. A large majority of the respondents (81%) were from Zaramo tribe. The rest (19%) were from other tribes including Makonde, Nyamwezi, Pogoro, Gogo, Kwere and Ndengereko. About two third of the respondents were peasants while about a quarter were petty traders and the rest were housewives.

Table 1: Socio - Demographic Characteristics of the Study Participants

| Characteristic | Frequency (n=200) | Percentage (%) |
|---|---|---|
| **Age (years)** | | |
| Less than 25 | 48 | 24.0 |
| 25-34 | 88 | 44.0 |
| 35-44 | 48 | 24.0 |
| 45 years and above | 16 | 8.0 |
| **Marital status** | | |
| Single | 36 | 18.0 |
| Married | 140 | 70.0 |
| Others | 24 | 12.0 |
| **Level of education** | | |
| Never attended school | 36 | 18.0 |
| Did not complete primary | 32 | 16.0 |
| Completed primary school | 121 | 60.5 |
| Others | 11 | 5.5 |
| **Occupation** | | |
| Peasants | 132 | 66.0 |
| Petty traders | 46 | 23.0 |
| Housewives | 22 | 11.0 |

### 4.2. Awareness of Available CBVCT Services

In order to assess HIV/AIDS awareness, respondents were first asked to mention major health problems in the study area. The purpose of this question was to find out whether HIV/AIDS was considered a serious problem. Malaria was reported by most respondents (83%) to be the major health problem, followed by HIV/AIDS which was mentioned by less than 50% of the study participants. Other major health problems reported were Tuberculosis (TB), Diarrhea, syphilis, fever, typhoid, coughs and gonorrhea.

For the respondents who did not mention HIV/AIDS as one of the major health problems, an attempt was made to find out whether they perceived HIV/AIDS to be a problem in their community. The majority of them (84%) perceived HIV/AIDS to be a major health problem after probing. The same trend was observed during the in-depth interview, whereby Malaria, HIV/AIDS and TB were reported to be the major health problems by almost all women interviewed in both categories i.e. those who utilized CBVCT services for HIV testing as well as those who did not utilize the service.

The main reason mentioned for HIV/AIDS been a major health problem was due to the fact that the disease killed a lot of people (52%). This reason was also mentioned by several women during the in-depth interviews. For example, a young married respondent aged 26 years who had utilized CBVCT services said that:

*The majority of people who lived here have died of HIV/AIDS. Those who are still alive are HIV positive and can be seen by signs and symptoms in their bodies.*

Other reasons given included many people been HIV infected (12%) and some mentioned existence of unprotected sex practice which led to HIV infection (9%).

Respondents were further asked about their perceived probability of getting infected with HIV. The response pattern obtained by marital status was as summarized in table 2.

**Table 2: Variation in Percent (%) of Perceived HIV Susceptibility by Marital Status**

| Marital status | Chances of HIV infection | | | | |
|---|---|---|---|---|---|
| | No chance | Little chance | Moderate chance | High chance | Total |
| **Single** | 36.1 | 27.8 | 19.4 | 16.7 | 100 (n=36) |
| **Married** | 29.3 | 43.5 | 18.6 | 8.6 | 100 (n=140) |
| **Others** | 20.8 | 41.7 | 25.0 | 12.5 | 100 (n=24) |
| **Total** | 29.5 | 40.5 | 19.5 | 10.5 | 100 **(n=200)** |

Generally, the majority (70%) of study participants perceived to have no or little chance of getting HIV infection. Married women had a higher proportion of those who believed to have lower chances of getting infected with HIV compared to the other marital

categories. Less than 11% of the respondents perceived themselves to be at a high risk of HIV infection. Single participants were more prominent among those who have this type of response than the rest. The reasons given by the majority of the respondents who perceived to have no or little chance of getting HIV infection were faithfulness to their partners and use of condoms. Those who believed to be at a high risk of HIV infection reported unfaithfulness of their partners as a major reason behind. This was also reported by a majority of interviewees during the in-depth interview sessions. One woman (43 years old) who was single and had utilized *CBVCT* services said:

> *Majority of men have extra marital relationship. If they practice unsafe sex outside their marriages, they can get HIV infection and hence it is easy to infect their wives. Therefore, women are at a risk of getting infected. So, there is a need for us to come out and check our health status.*

Study participants were also asked if there were any benefits to test for HIV. Most of them (96%) said that indeed there are advantages for doing such tests. They said knowing one's health status was considered to be a major advantage of HIV testing. Such awareness would help one to live without fear and take preventive measures against HIV infection. Access to ARVs and PMTCT for those found infected with HIV were also mentioned as benefits of testing for HIV. Similar views were also noted from the in depth interviews. For instance, a young unmarried woman aged 20 years old who had utilized the CBVCT service said that:

*It is very important for us to test, because once you test and realize that you don't have the virus you can live without fear, and if you are infected you get proper advice on how to cope with that situation.*

In another in-depth interview session, a married woman aged 40 years old who had utilized CBVCT services reported that:

*We are mothers; we might be pregnant and encounter problems. So, it is better to test so that we know our health status. For this case, it is easy to get pregnant and give birth knowing that we are not infected or infecting our babies.*

Fear of death and possibilities of getting positive results were mentioned by the few who believed that there was no benefit of HIV testing.

Many study participants (92%) were also aware that a pregnant HIV positive woman can transmit the virus to her baby. When asked specifically when the transmission occurs, 50.1% of the respondents said during pregnancy, 47.5% during delivery and 43.5% said during breast feeding.

Awareness about what can be done during pregnancy for an HIV positive pregnant woman to protect the unborn child from infection was rather low. Only 45% of the study

participants were aware of the protective measures of this type. For example in one in depth interview, a young married woman aged 33 years old who had not utilized CBVCT services reported that:

> *Honestly, I don't know the drugs; I have just heard about them from clinic when I was pregnant. I heard that if a pregnant woman is found to be infected with HIV, there are drugs which she would be given which will help to protect the baby from infection. But I don't know the kind of drugs.*

It was also revealed that the level of awareness of how to prevent unborn children of HIV positive women from getting infected increased with increasing level of education varying from 25% in those who never went to school to 36% in study participants with secondary school education.

In assessing the respondents' awareness of CBVCT services in their area, they were first asked if they had ever heard about VCT services. The majority of respondents (99%) reported to have heard about the service and they even knew where to access VCT. Among areas mentioned include: CBVCT services commonly known as "Afiki mobile VCT" which was mentioned by 77% of the respondents. Other VCT places mentioned were Kisarawe, Muhimbili and Amana hospitals as well as Health Centers and Dispensaries in Kisarawe District.

An attempt was also made to find out the source of information about CBVCT services and the response pattern obtained included mobile clinics around their villages. The same source of information was mentioned by all in-depth interview informants. A young single participant aged 19 years old who had not utilized the CBVCT services said that:

> *I first saw the tents in our sub villages, and later our village chairman came to tell us that the tents were mobile clinic for VCT services. We were told that if anybody wanted to check her health status voluntarily can visit the clinics and get the services free of charge, instant results and nobody else will know ones results.*

Other sources of information reported by the respondents were as follows:

- Community outreach volunteers (29.7%)
- Community leaders (29.7%)
- CBVCT staff (28.1%)
- Friends (15.1%)
- Community meeting (10.9%)
- Posters (9.4%)
- Family member (4.7%)
- Health workers (0.5%)

The level of awareness about sources of information about the availability of CBVCT services in their area increased with increasing age varying from 53.2% in those below 25 years to 73.3% for those aged 45 years and above. There was no difference in awareness of sources of information across different marital categories.

When asked about the specific functions of CBVCT mobile clinics, the majority (73%) of respondents said it provided VCT services, (21%) mentioned community mobilization for HIV testing and (1%) said Post Test Support Services (PTSS). About 2% of the study participants said that the clinics provided ARVs and financial assistance to HIV infected people.

When asked who were targeted for the services, the majority (95.3%) said that it was for everybody. This generally revealed that most women were aware of the target audience for the intervention. Awareness was also high among respondents of in-depth interview in which one single participant aged 38 years old who had utilized CBVCT service reported that:

*These services are for everybody. The service providers don't have any segregation. They provide the service for everybody.*

The result revealed that there was no difference in age, marital status and level of education in understanding that the service targeted everybody. A few (5%) study

participants reported young people and HIV/AIDS infected people as additional targeted clients for CBVCT services.

### 4.3 Motivating Factors To CBVCT Services Utilization

In order to find out factors which motivated women to utilize CBVCT services for HIV testing, respondents were first asked what motivated women to use VCT services in their community. The presence of persistent symptoms of illness was reported by more than half (57.5%) of the study participants as a major factor that could motivate women to seek VCT services for HIV testing. During one of the in-depth interviews, one married woman aged 36 years old who had utilized CBVCT services reported that:

> *When a woman is having persistent malaria or cough and especially when is having a partner who is unfaithful, she will start to be scared that she might be infected with HIV/AIDS. Then she will say, it is better if I go to check my status.*

Other reported motivating factors were as follows:

- Community mobilization for HIV test (36.5%)
- Discussion on HIV/AIDS in the local settings (20.5%)
- Partners influence (19.5%)
- When one gets new partner (15.5%)

An attempt was made here to find out the extent to which study participants used CBVCT services. Few (24%) of the respondents reported to have utilized them. The major motivating factor mentioned was the need to know ones health status. This response decreased with increasing age, varying from 18.8% in those aged less than 25 years to 12.5% in those aged 45 years and above. The response however increased with increasing in level of education varying from 13.9% in those who never attended school to16.5% in those completed primary and secondary.

Mobilization by CBVCT staff and provision of free services were also observed as motivating factors by a few (3%) respondents. A similar response was noted from an in-depth interview when one young single participant aged 20 years who had utilized CBVCT services said that:

> *Afiki mobile CBVCT services are provided in our villages and sub villages free of charge. The community leaders and the Afiki staff normally pass by our places to mobilize us to go to test for HIV.*

A few respondents (3%) said that living without fear and being pregnant were motivating factors towards CBVCT service utilization.

### 4.4 Factors Inhibiting Utilization of CBVCT Services

In order to find out reasons which prevented women in the study area from utilizing CBVCT services, respondents were first asked what usually prevented women from utilizing VCT services if available anywhere. The fear of positive results was reported by most (82%) study participants as major factor.

Stigma from community members was mentioned as a reason behind fear of an HIV positive result. This clearly came out during the in-depth interviews as reflected by a married woman aged 35 years who had not utilized CBVCT services:

> *People are afraid to go for HIV testing because they fear to be found HIV positive. If the results are positive, they will be known in the village and thus they won't be happy. The village members will be stigmatizing them. Even if you used to walk around, you will automatically reduce your movements and stay at home.*

Other mentioned barriers to utilization of VCT services by women were:

- Lack of perceived benefits of HIV testing (19.0%)
- Fear of partner's violence (15.5%)
- Fear of others knowing their HIV results (14.5%)
- Fear to be labeled promiscuous (14.5%)
- Stigma and discrimination (11%)

- Perception of people that a person who used VCT service is HIV positive (9%)
- Women disempowerment (3%)

During in-depth interviews one unmarried participant aged 44 years said that:

> *Many men suppress women. Some men tell their wives that they have heard of people who are testing for HIV/AIDS in the village. They warned them that, if they hear that they have gone to test they will be sent back to their parents' home. This scared women due to fear of potential divorce and consequently avoid going to test.*

Since the study area had a mobile VCT service and only 24% had utilized the service, those who had never utilized the services were asked for reasons. About a quarter of them said they had used other VCT services somewhere else before CBVCT services were introduced in their communities. In one in-depth interview an unmarried participant aged 41 years old who had not utilized CBVCT services reported that:

> *You know it's a long time since I last tested at Amana hospital in Dar- es salaam when I was pregnant. This time, I will go to Afiki mobile clinics (CBVCT) to check my status again.*

Other mentioned factors, which inhibited women to utilize CBVCT services, were:

- Women disempowerment (14%).
- Fear of a positive result (12%)
- Confidence that she was not infected (9%)
- The service did not give reliable results (7%),
- Poor mobilization by the community leaders (7%)
- Fear of giving a blood sample for the test (4%)

### 4.5 Suggestions on how to Improve Utilization of CBVCT services

Study participants were also requested for suggestions on how utilization of CBVCT services by women in their community could be improved. Many of them (62%) suggested that Afiki staff and the community based outreach volunteers should continue to mobilize people to go for HIV testing. The door-to-door visits and use of special gatherings of women were mentioned to be the best strategies for motivating women to use the services. Such suggestion was also mentioned during in-depth interview, as reflected in this response by a young married participant aged 29 years who had utilized CBVCT services:

> *In order to improve CBVCT services, strategies such as health promotion on HIV in women meetings, meetings for income generating activities, weddings and traditional dances (unyago) are necessary.*

Respondents further suggested that more frequent CBVCT services in their sub-villages (14%) could help a lot to improve utilization of these services. Currently, each sub-village is served after every ten weeks. HIV/AIDS education was also recommended by 12% of the study participants as another option for improving utilization of CBVCT services by women in community. For example, one married participant aged 37 years who had not utilized CBVCT services said that:

> *The CBVCT staff should continue to mobilize and educate women until we broaden up our mind to see the importance of testing and make a decision to go for testing. They should not get tired on this. I know it will take time but we can change*

A few (2%) suggested paying those who have tested as a way of attracting those who had not tested and free ARVs provision for those who test positive. A similar proportion of respondents (2%) suggested that testing community outreach volunteers should be compulsory so that they can serve as role models in the community.

The following were other suggestions made during the in-depth interviews:

- HIV testing should be compulsory as opposed to current voluntary option.
- CBVCT outreach volunteers should not belong to any political party. This was reported due to political differences in the area between the ruling political party Chama Cha Mapinduzi (CCM) and Civic United Front (CUF) which is one of the opposition parties in the area.

- PTSS services should be located closer to the local communities to avoid traveling long distances. It was proposed that PTSS centres be available at village levels instead of ward level where they are currently located.

The following response from one of the key informants emphasizes this point.

> *PTSS services should be brought closer to our villages, they are very far from the majority of women. I personally, have never been there due to distance.*

Findings of this study reveal that less than 25% of women have utilized the CBVCT even though project Afiki has provided mobile services in order to access a larger number of villagers. Although several reasons were given by the study participants for the observed low utilization rate, perceived susceptibility to HIV by most women was found to be low. This call for a need to raise women's perceived susceptibility to HIV in order for use of available counseling and testing services to be improved.

# CHAPTER FIVE

# DISCUSSION, CONCLUSION AND RECOMMENDATIONS

## 5.1 Discussion

The findings from this study have revealed that women perceived HIV/AIDS as a major health problem in Kisarawe district. However, the majority of them believed the chance of been infected with HIV was small or did not exist. This finding was rather surprising since HIV infection rates in Tanzania was reported to occur more in females than in males (NACP, 2005). According to this report, the infection rate was higher especially in age group of 20-39 years old where majority of the study participants falls.

Married women had a higher proportion of those who believed to have lower chances of getting infected with HIV compared to other marital categories mainly because they believed to be faithful to their spouses. However, it appears little attention was paid to potential promiscuous behavior of their husbands as is usually the case with men in our cultures. Since 90% of study participants were Muslims, it is more likely that the majority of them were in polygamous relationships, which suggests their husbands had at least one other sexual partner. This observation is supported by a study done by Batambuze (2002) who reported that the practice of polygamous among Muslims put them at a higher risk of HIV infection even though the majority of them do not consider themselves at risk.

The results also showed that 99% of the respondents were aware of available VCT services in their villages and they even knew where to get them. The Afiki VCT which was running in the study community as a project was mentioned by the majority (77 %) of study participants as an important service for everybody. This perceived benefit was attributed to the fact that presence of mobile VCT in the community is considered to be a good alternative to the majority of people who were otherwise constrained by transport to access other VCT centres. Narathius (2004) observed that mobile VCT brought the service closer to the people and hence ensured increased access to the service. Another study by Ching'ombe (2003) revealed that women were less likely to use VCT services which are located far away and require transport to reach.

The presence of persistent symptoms of illness was reported by many (57.5%) study participants as a major factor that could motivate women to use VCT services for HIV testing. A study done by Khumalo-Sakutukwa (2004) also reported that motivations to test for HIV included concern about physical symptoms of illness.

The few (24%) participants who had utilized CBVCT services reported the need to know one's health status was a major motivating factor. This factor was important to them because in knowing one's health status one can live without fear and take preventive measures against HIV. Furthermore, when one tests for HIV she can access ARVs and other referral services. Martin-Herz *et al.*,(2006) and Bwibo (2004) also reported that knowing ones serostatus was an important factor of women's willingness to test.

The availability of free mobile CBVCT services for HIV testing was also a motivating factor for those who utilized the service. Cost of VCT service may be an inhibiting factor especially for women who are economically dependent on men as is usually the case with many African rural communities. Experience has shown that, the majority of women in Kisarawe are also economically depending on their husbands even on issues that affect their health. That means provision of free VCT service would have contributed to accessing the service. Moor (2003) recommended that, VCT services should be free or of low cost as cost was an issue of concern for women.

Mobilization by Afiki staff, community leaders and community outreach volunteers played a significant role in rising awareness among community members on the utilization of the available CBVCT services in the area. Study findings reported by Bwibo (2004) identified lack of community mobilization among the factors contributed to the low utilization of VCT services (Bwibo, 2004).

Fear of positive results was reported by study participants as a factor that prevented women from using CBVCT services in the area. Stigma from community members, consequences of a positive HIV result such as suicide and blood pressure might be reasons behind fear of HIV positive result. In a study conducted in Malawi by Zozie (2003), respondents felt that knowing their status could result in an early death due to fear and anxiety. Consequently, they opted not to know their HIV status. This was also

reported by Montgomery (2003). Studies done by Ijeoma (2003) and Chingombe (2003) also indicated that stigma was a main inhibitor of VCT uptake.

Women were also inhibited to utilize CBVCT services due to disempowerment. In Kisarawe district, the majority of women reported being suppressed by their partners and that in decisions such as HIV testing, males partners should be involved to avoid chances of being divorced. Consequently, women get scared going to test. In a study done by Maman *et al.,* (2001) it was observed that in most Tanzanian families, women are not the decision- makers, even over issues that affect their health, including whether or not to visit a VCT center. This was also reported by Montgomery (2003).

Poor mobilization by the community leaders also contributed to low utilization of CBVCT services among women in the area. When people are not well informed of any new intervention they are less likely to accept it. Poor community mobilization was also reported in a study done by Bwibo (2004) as a barrier for utilizing VCT services by women.

Regarding improving utilization of CBVCT services by women in the area, several suggestions were put forward. Among them, 62% suggested that Afiki staff and the community based outreach volunteers should continue to mobilize people to go for HIV testing. The door to door visits and use of special gatherings of women were mentioned to be the best strategies for motivating women to use the services.

The provision of more frequent mobile CBVCT services in their sub-villages was also suggested by respondents for improving utilization. Currently, each sub-village is served after every ten weeks. Study participants also suggested the provision of HIV/AIDS education as another way of improving of utilization of CBVCT services among women and community at large.

Post - Test Support Services as part of CBVCT service were observed to not be conveniently located for access by the majority of people. Many of these services were reported to be far from where many people live. This is supported by a study conducted in Kenya which revealed that, there was a positive response to VCT services that were located within the community (Achieng, 2003). Those findings indicated that accessible location is essential for increasing utilization of VCT services.

The findings of this study have major strengths that they were based on the population based data and utilized both qualitative and quantitative methods of data collection.

**5.2 Conclusion**

From this study it can be concluded that women had high awareness of CBVCT services in the area. Utilization was observed to be low (24%) because of lack of women empowerment in decision making, fear of HIV positive results, confidence that they were not infected, poor mobilization by community leaders and fear of giving blood

sample for HIV test. Factors which motivated those who used the service included the need to know the HIV status, mobilization by CBVCT staff, provision of free service and living without fear.

In order to improve CBVCT utilization in the area, there is a need to strengthen community mobilization by Project Afiki staff and community based outreach volunteers for HIV testing. The door-to-door visits and use of special gatherings of women like initiation ceremonies (unyago), traditional dances and weddings were mentioned to be the best strategies for motivating women to use the services. It is further suggested that more frequent provision of CBVCT services in their sub-villages should be offered, the PTSS to be located in areas where majority of people lives, and the provision of HIV/AIDS health promotion could also improve utilization of CBVCT services.

### 5.3 Recommendations

It is recommended that more frequent provision of mobile CBVCT services in their sub-villages should be offered so as to improve utilization of these services. Currently, each sub-village is served after every ten weeks which was reported to be not enough by the majority of study participants.

Provision of HIV/AIDS health promotion is also recommended to improve utilization of CBVCT services among women and community at large. Health education on

HIV/AIDS will help to change people's perception and attitude towards HIV testing. Also, since most women perceived to be at a low risk of HIV infection, there is a need to develop strategies for changing such beliefs in order to improve suggested preventive measures against HIV infections.

CBVCT service implementers should come up with new and attractive mobilization strategies to women such as traditional dances and drama, and other women's gatherings to encourage more women to utilize the provided services.

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