

**FACTORS THAT INFLUENCE ATTITUDES TOWARDS VCT
UTILIZATION AMONG POLICE OFFICERS:
A CASE STUDY OF TEMEKE, KINONDONI AND ILALA
DISTRICTS OF DAR ES SALAAM REGION**

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A CASE STUDY OF TEMEKE, KINONDONI AND ILALA
DISTRICTS OF DAR ES SALAAM REGION**

**By
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A Research Dissertation Submitted in Partial Fulfillment of the Requirements for the Award of the Degree of Master of Public Administration (MPA) of Mzumbe University Dar es Salaam Campus College

2013

CERTIFICATION

We, the undersigned, certify that we have read and hereby recommend for acceptance by the Mzumbe University, a dissertation entitled: ***Factors That Influence Attitudes Towards VCT Utilization Among Police Officers: A Case study of Temeke, Kinondoni and Ilala Districts of Dar es salaam region***, for the partial fulfillment of requirements for award of the degree of Master of Public Administration of Mzumbe University.

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DEDICATION

This study is dedicated to my wife, Elizabeth Samwel, children and Police officers whom I want to encourage so that to adapt behaviors of VCT utilization.

LIST OF ABBREVIATIONS AND ACRONYMS

AIDS	-	Aquired Immuno Deficiency Syndrome
AMREF	-	African Medical Research Foundation
ARV	-	Antiretroviral
HCT	-	HIV Counselling and Testing
HIV	-	Human Immunodeficiency Virus
SARPCCO	-	Southern Africa Regional Police Chief Cooperation
SSA	-	Sub-Saharan Africa
STD	-	Sexually transmitted disease
UNAIDS	-	The Joint United Nations Programme on HIV/AIDS
VCT	-	Voluntary Counselling and Testing
WHO	-	World Health Organisation

ABSTRACT

The aim of this study was to assess the factors that influence VCT utilization among Police officers. The specific objectives of this study were to ascertain the uptake of VCT among Police officers, identify the barriers facing VCT utilization and to identify the strategies to increase VCT utilization among Police officers.

The types of data collected were quantitative which was collected using questionnaire and qualitative data collected using interview with focus group discussion.

The findings revealed that, VCT utilization among police officers is low. More than a half of the population under study did not know the importance of VCT utilization.

The findings as well revealed barriers of VCT utilization which are, fear of positive HIV results, lack of confidentiality by VCT staffs and lack of knowledge about VCT services.

Furthermore the findings revealed that most of respondents from focused group discussion suggested that VCT should not be isolated from the main health facilities, should rather be built in the way that people should not know one went for HIV test. Again health education about VCT utilization should be more emphasized among Police officers.

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CHAPTER ONE

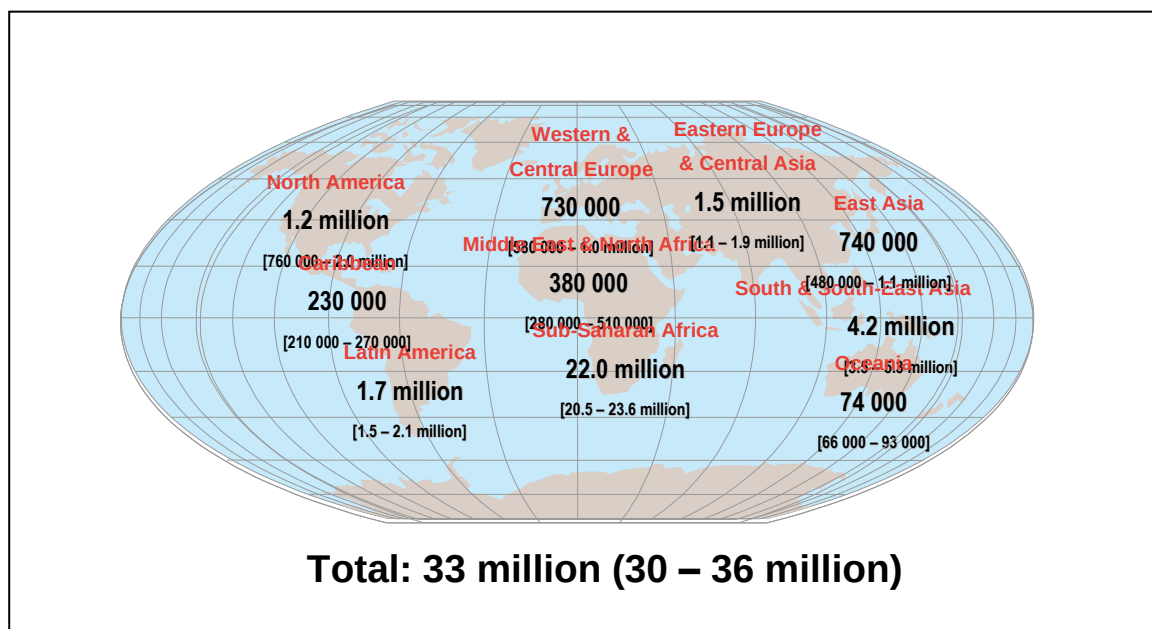
INTRODUCTION

The scope of the HIV pandemic and its effects cannot be over emphasized. The fast growth of the pandemic over the last two decades has put pressure on both individual families' resources and those of governments around the world. The effects of the epidemic are being felt not just by those living with the virus and their families, but by whole populations in high-prevalence countries. Increasing levels of illness and death are affecting the productivity and effectiveness of public and private institutions, for example. Levels of absenteeism are rising as people take time off from work because they are ill, must take care of relatives living with the virus, or must attend the funerals of those who have died. The cost of doing business is also increasing as more is spent on hiring and training new staff and caring for those who are ill. In the worst affected countries, this is increasingly impacting on not only national economies, but also the reach and responsiveness of the state, (Pharoah, 2012).

1.1 The Global spread of HIV

The Joint United Nations Programme on HIV/AIDS (UNAIDS) and the World Health Organization (WHO) estimates that at the end of 2007 there were 33 million men, women and children living with HIV globally. Approximately 30 million of these were adults and 2 million children. They estimate that between 2.7 million people contracted HIV in 2007, while 2 million died of AIDS (Gustav, 2008).

Figure 1.1: Estimated number of people living with HIV/AIDS globally in 2007



Source: UNAIDS/WHO 2007

Sub-Saharan Africa (SSA) is the region most heavily affected by HIV/AIDS. Despite being home to only 10% of the world's population, more than two out of every three of those with virus (67%) live in this region. UNAIDS estimates that as many as 75% of all AIDS-related deaths occurred in SSA in 2007. Several populous countries in other regions, such as Indonesia, the Russian Federation and various high-income countries, are showing worrying increases in prevalence levels, but nowhere else has yet to approach the levels of infection seen in SSA. (UNAIDS, 2008)

1.2 The southern African Epidemic

Southern Africa bears a disproportionate share of the global HIV/AIDS burden. In its 2008 report on the global epidemic, UNAIDS estimates that approximately 35% of all the new HIV infections in 2007, and 38% of AIDS-related deaths, occurred in southern Africa. According to this report, Swaziland had the most severe epidemic at the end of 2007, followed by Botswana (UNAIDS, 2008).

As shown above, it is estimated that one in six of Swaziland's population was living with HIV/AIDS at the end of 2007, with an only slightly smaller proportion of the population living with HIV/AIDS in Botswana. South Africa, however, was home to the largest absolute number of people living with HIV/AIDS, where it is estimated that 5.7 million people have the virus – the highest number globally. Mauritius had the lowest prevalence rates. Angola and the Democratic Republic of Congo (DRC) also had prevalence rates of less than 2 %,.(UNAIDS, 2008)

Table 1.1: Prevalence of HIV/AIDS in Southern African countries at the end of 2007

	Population	Prevalence	Total %
Swaziland	1 141 000	190 000	16.7
Botswana	1 882 000	300 000	15.9
Lesotho	2 008 000	270 000	13.4
South Africa	48 577 000	5 700 000	11.7
Zimbabwe	13 349 000	1 300 000	9.7
Namibia	2 074 000	200 000	9.6
Zambia	11 922 000	1 100 000	9.2
Mozambique	21 397 000	1 500 000	7.0
Malawi	13 925 000	930 000	6.7
Tanzania	46 454 000	1 400 000	3.0
Angola	17 024 000	190 000	1.1
DRC	62 636 000	320 000	0.5
Mauritius	1 262 000	1 300	0.1

Source: WHO/UNAIDS 2008

The epidemics in most southern African countries appear to have stabilized, but at very high levels. The reductions in HIV/AIDS prevalence are especially striking in Zimbabwe, where prevalence amongst pregnant women attending antenatal clinics fell from 26% in 2002 to 18% in 2006. In Botswana, a drop in HIV prevalence among pregnant 15–19-year-olds (from 25% in 2001 to 18% in 2006) suggests that

the rate of new infections could be slowing. The epidemics in Malawi and Zambia also appear to have stabilized, amid some evidence of favourable behaviour changes (UNAIDS, 2008)

1.3 HIV testing algorithm in Tanzania

An essential requirement of all HIV testing is accuracy of the test results. HIV test kits used in the country are those that are recommended by the World Health Organization (WHO) and have been evaluated in the country before local use. A testing algorithm refers to the combination of tests and the sequence of use in HIV testing to provide maximum sensitivity and specificity. The selection of the testing algorithm is based on scientific evidence after evaluation of various HIV test kits. An HIV testing algorithm uses at least two tests to confirm positive results, which can be done either serially or in parallel. HIV testing in Tanzania is done according the national testing algorithm and is based on the serial testing strategy recommended by WHO. This strategy is economical since a second test is required only when the initial test is positive. With ‘serial testing’ a blood samples taken and tested using the first test. If the result is negative the test result is given to the client as HIV negative. If the test result is positive the blood sample is tested using a second, different HIV test. If the second test is also positive, the result is given to the client as HIV positive. If the second test is negative, (first test is positive and second test is negative), a third test (also called a tie-breaker) is used. The final test result of the sample is determined by the result of the tie-breaker. In a situation where there is no tiebreaker for rapid testing, discordant samples should be referred to the laboratory for ELISA testing. Health care practitioners will be required to follow MOHSW guidelines on which test kits to use, (Tanzania National AIDS control Programme, 2007).

1.4 Research problem and justification

Despite of launching the Police Force work place HIV/AIDS Policy and the establishment of VCT centers in Police camps every region, the VCT uptake among Police officers is low.

Practical experience shows that attendance to voluntary counseling and HIV Testing among police officers is low, this has been evident through the following observations. A number of chronically ill Police officers who attend and some who got admitted in the major police Hospital do not know their HIV status and A number of pregnant mothers married to Police officers do report that, their husbands refuse to accompany them for VCT visit. (Police medical unit, 2011)

Researches on VCT uptake involving the whole population have been done in many countries and even in Tanzania, while forgetting to focus on special groups like members of forces like Tanzania Police Force, prisons and Tanzania Peoples Defense Force in which the nature of their work environment and residence setup contributes to inability of the members to access VCT services. Furthermore there has been no research on VCT utilization among Tanzanian Police Officers. Therefore this study was done to assess the factors which influence VCT utilization among Police Officers.

1.5 General objective of the study

The main objective of the study was to assess the factors that influence VCT utilization among police officers.

1.6 Specific Objectives

- (i). To ascertain the uptake of VCT utilization.
- (ii). To identify the factors that hinder VCT utilization among police officers.
- (iii). To identify the strategies to increase VCT utilization among police officers.

1.7 Research questions

- (i). How is the uptake of VCT utilization?
- (ii). What are the factors that hinder VCT utilization among police officers?
- (iii). What are the strategies to increase VCT utilization among police officers?

1.7 Limitations of the Study

The study was carried out in only three districts because of time and financial constraints. During data collection, the researcher faced a shortage of time because frequent movements were needed in order to pick the already filled questionnaire from the respondents. Therefore the research had to hire a motorcycle to make the task easier.

1.8 Delimitation of the Study

Bearing in mind that the researcher had no support for financial sponsorship, it was so mandatory to apply for a loan which in turn helped to cover the expenses during the study.

1.9 Organization of the study

The study has been organized into the following order:

Chapter one contains the global spread of HIV including the southern African region. Research problem and justification, research questions, general objectives, specific objectives, significance of the study and limitations of the study.

Chapter two contains the literature review which covers the introduction of VCT and HIV/AIDS. Elements of VCT and HIV counseling. Theories of counseling, high risk occupational groups for HIV, common attitudes towards VCT, perceived barriers to VCT , HIV testing process and HIV results.

Chapter three covers the research methodology. Ie. Theoretical frame work, study area, the target population, sample size, sampling techniques, Data collection method and data analysis.

Chapter four, presents the findings which includes, the characteristics of respondents,VCT utilization among police officers,VCT utilization according to gender, education and marital status of the respondents as well the barriers facing VCT utilization among Police officers and strategies to increase VCT utilization among Police officers.

Chapter five covers the discussion of the findings.

Chapter six gives the summary, conclusion and recommendations of the overall findings on the assessment of the factors that influence VCT utilization among Police officers in Temeke, Ilala and Kinondoni Districts of Dar es salaam region. As well the areas for further research.

1.10 Significance of the study

To generate information on the reasons that prevents police officers from accessing VCT services. And therefore to undergo reform of existing Tanzania Police Force HIV/AIDS Policy.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

Voluntary Counselling and Testing (VCT) is an important tool in preventing and managing HIV and AIDS. It provides the information necessary to make informed decisions about the future and to protect one's own health and that of loved ones. In a region where resources are often limited, VCT is one of the most effective and common interventions. VCT facilities are offered by a range of organizations in most countries.

HIV counselling is a confidential dialogue between a client and a counsellor aimed at enabling the client to cope with stress and take personal decisions related to HIV/AIDS. The counselling process includes evaluating the personal risk of HIV transmission and discussing how to prevent infection. HIV counselling concentrates specifically on emotional and social issues related to possible or actual infection with HIV and AIDS. With the consent of the client, counselling can be extended to spouses, sex partners and relatives (family-level counselling, based on the concept of shared confidentiality). HIV counselling has as its objectives both prevention and care. Counselling should be a process involving a series of sessions as well as follow-up. It can be done in any location that offers peace of mind and confidentiality for the client (Bukusi, 2007).

2.2 Understanding VCT and HCT

2.2.1 . History of VCT

Before the initiation of publicly funded HIV counseling and testing services in 1985 in the USA, little was known about the history and prevalence of HIV. HIV status was determined on donating blood. Introduction of counseling was to assist people understand their positive or negative results, address accuracy and consequences of

HIV tests, and also assist with the difficulties some face on learning about their HIV status.

By 1987, there was an increase in the knowledge of epidemic and predictive value of HIV test, resulting in the expansion of HIV counseling and testing for clients in need of care for family planning, childbirth, drug abuse, and sexually transmitted infections, with the aim of reducing the risk of HIV transmission. Later on in the USA, the introduction of anti-retroviral therapy to protect the unborn child from HIV infection had such a great effect that HIV testing was advocated as a routine test for pregnant women, (Fylkesnes, et al, 1999).

2.2.2 VCT in Africa

In Africa, by 1990, VCT was already a part of HIV management. It was also experiencing challenges in utilization. Concerns about confidentiality and length of time waiting for result were reported to have contributed to low-utilization rates. Studies from Kenya showed that women may get abused and beaten by their husbands for utilizing VCT and knowing their status, and may lose their home and children as a result of testing positive. Reports on the early history of VCT in South Africa indicate that in 1988, the mining health services sent nurses to the South African Institute for Medical Research to train as HIV counselors, and by 1992, nurses were made responsible for pre and post test counseling with VCT being made available on request at primary care centres. This was a period in South Africa when testing was offered to the sick as HIV infection was relatively rare. Voluntary request for testing was not common. However, in some African countries where the rate of infection and prevalence were relatively high, voluntary counseling and testing rates were increasing despite the low rates of sero-status disclosure to sexual partners. The Rakai project, a research organization which is a branch of the Uganda Virus Research Institute, had been providing home delivered VCT in Uganda since 1990. It reported an increase in the proportion of people receiving VCT and HIV test result from about 35% in 1994-1995 to 65% in 1995-2000, translating to about two fold increases in six years. It is worthy of note that Uganda, where the Rakai project was undertaken and which was one of the earliest countries in Africa affected by the

AIDS epidemic, demonstrated a decline of 22% in their HIV-1 prevalence in the early 1990s to a level of 8% HIV-1 prevalence among rural and urban dwellers, (Fylkesnes, et al, 1999).

2.2.3 Basic facts about VCT

Voluntary Counselling and Testing (VCT) is a process through which an individual receives counselling, makes an informed decision about being tested for HIV, assesses his or her personal risk for HIV and is motivated to reduce risky behaviour. Anyone who is sexually active should consider going for VCT, (King, 1999).

Although there is almost universal acceptance of the idea that counselling and testing should be an entirely voluntary process, the reality is that many people are still compelled in a range of ways to go for HIV testing. Many insurance companies, for example, require an HIV test before processing an application (and some refuse to insure people found to have HIV), (Robyn, 2004).

Some private and public institutions also screen new employees for HIV. Some also require existing staff to undergo HIV tests in order to apply for job promotions or training opportunities, or demand that staff working in particular jobs undergo regular testing. In some police services, for example, personnel must undergo testing before they can be deployed in peacekeeping missions. In other cases, individuals may be compelled to go for testing by their partner, relatives, or friends. One may also have to undergo testing before undergoing surgical procedures. Is it ever justified to compel people to undergo testing? This is a controversial issue. However, human rights organizations, bodies representing people living with HIV and AIDS, many legal organizations, as well as global institutions such as the United Nations generally agree that people should not be forced into testing. Such institutions feel that such testing infringes on people's rights and is discriminatory, (Robyn, 2004).

2.2.4 Elements of VCT HIV Counseling

HIV counseling has been defined as a confidential dialogue between a person and a care provider aimed at enabling the person to cope with stress and make personal decisions related to HIV/AIDS. The counseling process includes an evaluation of personal risk of HIV transmission and facilitation of preventive behavior. The objectives of HIV counseling are the prevention of HIV transmission and the emotional support of those who wish to consider HIV testing, both to help them make a decision about whether or not to be tested, and to provide support and facilitated decision-making following testing. With the consent of the client, counseling can be extended to spouses and/ or other sexual partners and other supportive family members or trusted friends where appropriate. (Rutenberg, 2003).

Counselors may come from a variety of backgrounds including health care workers, social workers, lay volunteers, and people living with HIV, members of the community such as teachers, village elders, or religious workers/leaders. HIV counseling can be carried out anywhere that provides an environment that ensures confidentiality and allows for private discussion of sexual matters and personal worries. Counseling must be flexible and focused on the individual client's specific needs and situation. In some settings HIV counseling is available without testing. This may help promote changes in sexual risk behavior. In one rural area, community-based counseling significantly increased rates of condom use among adults. (Rutenberg, 2003).

It is voluntary. No one can make you go for VCT – the decision to go for counselling and testing must be your own. You must only consent once you have received information on the test and testing. You are allowed to change your mind about undergoing testing and can terminate the processes at any stage (Dayalan , 2012).

It involves counselling. Counselling consists of a private, face-to-face conversation with a specially trained counsellor aimed at helping you make informed decisions. Counselling helps you to actively deal with your problems to lead more fulfilling lives, HIV and AIDS counselling strives to support those whose lives have been

affected by HIV and AIDS. It also aims to prevent HIV infection and transmission to other people. The counselling provided at VCT sites is usually free (Pharoah, 2012). It is confidential. Both the details of the counselling and the results of the test are kept confidential. This means that neither the counsellor nor the people doing the test or delivering the results can tell others about them without your permission (Pharoah, 2012). Many people are afraid to seek HIV services because they fear stigma and discrimination from their families and community. VCT services should therefore always preserve individuals' needs for confidentiality. Trust between the counselor and client enhances adherence to care, and discussion of HIV prevention. In circumstances where people who test seropositive may face discrimination, violence and abuse it is important that confidentiality be guaranteed. In some circumstances the person. (Rutenberg, 2000).

It is linked to support. All testing should be linked to appropriate and effective referral and support systems. These ensure that whether your results show that you are positive or negative, you receive the information and support necessary to continue a living healthy, productive life. It is important to emphasise that because VCT is a voluntary process, no one can force you to undergo any of these steps, and you can choose to leave the process at any point. You can also go through the process at your own pace and can choose whether you want to have a friend or relative accompany you. (Bukusi, 2007).

2.2.5 Importance of VCT service

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

VCT utilization is still important for a positive impact of VCT services includes facilitating decision-making, accepting and coping with HIV, improving family and community acceptance, increasing condom use, and reducing gonorrhea rates and HIV transmission.(Coovadia,2000).

Voluntary counseling and testing is also an effective strategy for facilitating behavior change for both clients, whose test result is either negative or positive. It has become evident that some of the positive effects of VCT includes decrease in unprotected sexual intercourse, a reduction in multiple partners, an increase in condom use, and more clients choosing abstinence,(Tsegay et al ,2011)

It has been estimated that most of the 37 million people worldwide living with HIV do not know that they are carrying the virus and the proportion is higher in countries worthily affected by the epidemic The first pillar of HIV prevention is voluntary counseling and testing (VCT). Despite the high number of people already living with HIV/AIDS, it is estimated that less than 10% are aware they are infected, mainly because of the limited availability, access, and use of VCT. This fact greatly hinders efforts to respond to the AIDS epidemic, as people have to know if they are infected in order to access services. Hence, the need for expanding VCT service and stimulating its utilization is outlined as a priority intervention area and as an entry point for HIV prevention, through creating more personal awareness, and care (Dejene, 2001).

VCT provides the opportunity for people to know their HIV status with quality counseling support to help them cope with a positive or a negative test result. The majority of adult populations are HIV negative, even in high HIV prevalence settings. Knowing one is HIV negative can serve as a strong motivating factor to remain negative, particularly for those who may otherwise assume it is too late to adopt safer sexual practices, (Dejene., 2001).

For people who test positive, while VCT services can link them to options for treatment if and where they exist, and to care and support, just as important, it allows for adoption of preventive measures. For some, self-protection is a stronger motivator for safer sex than the need to protect others for others, the responsibility to avoid spreading the virus is itself the critical motivator. Both contribute to HIV prevention.

By knowing one's positive status, HIV positive individuals may become more motivated to adopt a more healthy lifestyle that improves their health status and slows the progression from HIV infection to symptomatic HIV disease and full blown AIDS – for example, avoiding further risks of infection with other viral strains and STIs, seeking early treatment for opportunistic and HIV/AIDS related infections, eating healthy food, avoiding tobacco and reducing stress, (Rutenber, 2003).

Knowing one is HIV positive also provides an opportunity to protect sexual partners and to plan for the future from an informed position - deciding on marriage and on child bearing, and preparing children and family for the progression of disease and death. Today, there are many HIV positive people who are living healthy and positive lives, (Rutenber, 2003).

They serve as strong and effective HIV/AIDS advocates and also provide valuable support and motivation for others infected with HIV and affected by the epidemic. (Rutenber, 2003).

Going for VCT can be frightening and difficult, as can dealing with the implications of an HIV positive test result. The benefits of VCT, however, generally outweigh the costs. They include peace of mind and the reduction of unnecessary anxiety. Knowing your status can reduce unnecessary anxiety as you will know whether or not you have contracted the virus. Even bad news can sometimes provide relief. Planning for the future, your children and your dependents. With knowledge about your HIV status, you will be in a better position to make positive decisions about your life and the lives of those you care about, (Robyn, 2004).

Reduced risk of transmitting the disease to others, knowing your status allows you to take steps to prevent the transmission of the virus to others. If you are thinking about having a baby, for example, knowing your status can enable you put in place measures to prevent your baby contracting HIV. Similarly, knowing your status can help to avoid passing on the infection to your partner, (Pharoah. 2012).

Reduced risk. Even if your test shows that you are HIV negative, going through the VCT process can help to equip you with the information you need to protect yourself against infection. It can also provide the incentive needed to reduce your risk of infection by, for example, abstaining from sex or using condoms each and every time you have sex. This aspect is very important. Remember: you can not reverse an HIV positive result, but it is all too easy for a negative result to become a positive one(Bukusi,2007).

Accessing treatment and assistance. Health-care workers will be in a better position to provide appropriate treatment, advice and support if they know your status. Early warning will allow you to proactively protect your health. Monitoring, treatment and advice on how to achieve a healthy lifestyle can help you to live a long and productive life. Indeed, if diagnosed early, HIV and AIDS can turn from a lethal disease into a long-term, manageable illness,(Bukusi.,2007).

HIV and AIDS should not be seen as the end of the road but rather as a bend in the road. This is particularly true now that it is becoming easier to access ARV treatment through public and private health-care systems in southern African countries. Seeking VCT provides one with the support necessary to negotiate the bend, (Pharoah, 2012).

2.3 VCT utilization in Sub-Saharan Africa

Despite the priority assigned to VCT in prevention and treatment access plans, the actual uptake of VCT in most of sub-Saharan Africa remains quite low. In Zimbabwe, only approximately 11.8% of women and 9.2% of men report having been tested and being aware of their HIV status. The low overall uptake of VCT in

sub-Saharan Africa remains an important area for future research. In particular, it would be important to research whether having a critical proportion of community members aware of their HIV status has an effect on community norms and reduction of behavioral risk taking. Providing mobile testing along with community outreach and support may significantly increase the proportion of people who know their HIV status and, in turn, trigger greater HIV awareness in the community at large. Mobile VCT can also serve as an important link to care and treatment services as they become more widely available in limited recourse settings, (Simbayi, 2003).

2.4 Theories of counseling

A theory describes what factors or relationships influence behavior and/or environment and provide direction on how to impact them. Theories used in HIV prevention are drawn from several disciplines, including psychology, sociology and anthropology. A theory becomes formalized when it is carefully tested with the results repeatable in a number of different settings, and generalizable to various communities. Both formal and informal (or implicit) theories first begin with an individual's observation about a person or phenomenon. Informal theories, those conceived by service providers are not usually tested, yet these intuitive beliefs about why people do what they do are very useful and often similar to concepts found in formal theories conceived by academics (Witte, 1999).

Theories can help providers frame interventions and design evaluation. When designing or choosing an intervention, theory can show what factors should be targeted and where to focus interventions. Theories can help define the expected outcome of an intervention for evaluation purposes. Also, basing programs on a tested theory gives it scientific support, especially if the program hasn't been evaluated. HIV prevention providers are frequently required to use theory in the development of prevention interventions. It's common, though, for providers to pick a theory based on their intervention. Because many providers are not trained or supported in using theory, they can miss the opportunity to use it as a process for thinking critically about a community in the development of programs. (Witte, 1999).

2.4.1 The psychological theories that focus on individual

As HIV transmission is propelled by behavioral factors, theories about how individuals change their behaviour have provided the foundation for most HIV prevention efforts worldwide. These theories have been generally created using cognitive-attitudinal and affective-motivational constructs. Nearly all the psychosocial theories originated in the West but have been used for AIDS internationally with mixed results. Only one of the psychosocial models discussed below, the AIDS risk reduction model, was developed specifically for AIDS (Kalichman, 1997).

Psychosocial models of behavioural risk can be categorized into three major groups i.e. , those predicting risk behaviour, those predicting behavioural change and those predicting maintenance of safe behaviour. Models of individual behavioural change generally focus on stages that individuals pass through while trying to change behaviour.

These theories and models generally do not consider the interaction of social, cultural and environmental issues as independent of individual factors (Auerbach, 1994). Although each theory is built on different assumptions they all state that behavioural changes occur by altering potential risk-producing situations and social relationships, risk perceptions, attitudes, self efficacy beliefs, intentions and outcome expectations. Central to HIV prevention interventions based on psychological- behavioural theory is the practice of targeted risk-reduction skills. These skills are generally passed on to individuals in a process consisting of instruction, modeling, practice and feedback (Kalichman, 1997).

2.4.2 Health belief model

An individual's readiness to take action and engage in health-related behaviour relative to a particular health condition is a function of three factors. The first factor concerns with what a person perceives or believe the likely hood of susceptibility to and the severity of illness. The second factor is the perceived benefit of action in contrast to the barrier to acting. Thus, the person's evaluation of the health behaviour

both in terms of its gains or potential benefits in reducing possible susceptibility and severity of the illness, as well as perceived barriers to action, will determine whether or not a person will engage in health behaviour. The third factor relates to the means or anything that enable an individual to act in appropriate health behavior. (Tlou, 2009).

In this model, promoting action to change behaviour includes changing individual personal beliefs. Individuals weigh the benefits against the perceived costs and barriers to change. For change to occur, benefits must outweigh costs. With respect to HIV, interventions often target perception of risk, beliefs in severity of AIDS (there is no cure), beliefs in effectiveness of condom use and benefits of condom use or delaying onset of sexual relations.(King, 1999).

2.4.3 Social cognitive (or learning) theory

The premise of the social cognitive or social learning theory (SCT) states that new behaviours are learned either by modeling the behaviour of others or by direct experience. Social learning theory focuses on the important roles played by vicarious, symbolic, and self-regulatory processes in psychological functioning and looks at human behaviour as a continuous interaction between cognitive, behavioural and environmental determinants (Bandura, 1977).

Central tenets of the social cognitive theory are self-efficacy, the belief in the ability to implement the necessary behaviour (I know I can insist on condom use with my partner), outcome expectancies - beliefs about outcomes such as the belief that using condoms correctly will prevent HIV infection. .(King., 1999).

Programmes built on social cognitive theory integrate information and attitudinal change to enhance motivation and reinforcement of risk reduction skills and self-efficacy. Specifically, activities focus on the experience people have in talking to their partners about sex and condom use, the positive and negative beliefs about adopting condom use, and the types of environmental barriers to risk reduction. A metaanalysis of HIV risk-reduction interventions that used SCT in controlled

experimental trials found that 12 published interventions with mostly uninfected individuals all obtained positive changes in risk behaviour, with a medium effect size meeting or exceeding effects of other theory-based behavioural change interventions (Greenberg, 1996).

The Social Cognitive Theory is relevant to health communication. First, the theory deals with cognitive, emotional aspects and aspects of behavior for understanding behavioral change. Second, the concepts of the social cognitive theory provide ways for new behavioral research in health education. Finally, ideas for other theoretical areas such as psychology are welcome to provide new insights and understanding. The social cognitive theory explains how people acquire and maintain certain behavioral patterns, while also providing the basis for intervention strategies (Bandura, 1997). Evaluating behavioral change depends on the factors environment, people and behavior. Social cognitive theory provides a framework for designing, implementing and evaluating programs.

Environment refers to the factors that can affect a person's behavior. There are social and physical environments. Social environment include family members, friends and colleagues. Physical environment is the size of a room, the ambient temperature or the availability of certain foods. Environment and situation provide the framework for understanding behavior (Parraga, 1990). The situation refers to the cognitive or mental representations of the environment that may affect a person's behavior. The situation is a person's perception of the time, physical features and activity (Glanz et al, 2002).

The three factors environment, people and behavior are constantly influencing each other. Behavior is not simply the result of the environment and the person, just as the environment is not simply the result of the person and behavior (Glanz et al, 2002). The environment provides models for behavior. Observational learning occurs when a person watches the actions of another person and the reinforcements that the person receives. The concept of behavior can be viewed in many ways. Behavioral capability means that if a person is to perform a behavior he must know what the behavior is and have the skills to perform it, (Bandura, 1997).

2.4.4 Theory of reasoned action

The theory of reasoned action, advanced in the mid-1960s by Fishbein and Ajzen, is based on the assumptions that human beings are usually quite rational and make systematic use of the information available to them. People consider the implications of their actions in a given context at a given time before they decide to engage or not engage in a given behaviour, and that most actions of social relevance are under volitional control (Ajzen, 1980). The Theory of Reasoned Action is conceptually similar to the Health Belief Model but adds the construct of behavioral intention as a determinant of health behavior. Both theories focus on perceived susceptibility, perceived benefits, and constraints to changing behavior.

It explains the relationship between beliefs, attitudes, intentions and behaviour. According to the theory of reasoned action, the most accurate determinant of behaviour is behavioural intention. The direct determinants of people's behavioural intentions are their attitudes towards performing the behaviour and the subjective norms associated with the behaviour. Attitude is determined by a person's beliefs about the outcomes or attributes of performing a specific behaviour (that is, behavioural beliefs), weighted by evaluations of those outcomes or attributes. The subjective norm of a person is determined by whether important referents (that is, people who are important to the person) approve or disapprove of the performance of a behaviour (that is, normative beliefs), weighted by the person's motivation to comply with those referents. There are a number of social and contextual factors that influence HIV-related behaviors. Interpersonal and community-level factors shape an individual's perception of the world around them, as well as directly influence their behaviors. One important factor is societal norms about appropriate sexual behavior. Another is the confidence that a group feels toward enacting a certain behavior, such as preventing HIV in the community, called collective efficacy. Attention has also been directed at factors that address closeness or trust among people or groups, sometimes called social capital or connectedness or community identity; while each have somewhat different definitions, they address similar issues. Recently, HIV programs have attempted to address these community-level factors directly, and

evidence is emerging that addressing these issues will also affect HIV risk and prevention (Montano & Kasprzyk, 2002).

2.4.5 Integrative Model of Behavioral Prediction

Witte (1999) points out that most health communication theories are models of individuals' health-related and health information-seeking behaviours. As such, they identify important variables and specify how these variables work together to produce a desired outcome (e.g. report for early VCT). Through careful laboratory and field research, much knowledge has been accumulated on how to effectively motivate desired behaviours. Bartholomew et al. (2000) named the three models that are used most frequently to identify determinants of behavior, these are the health belief model, the social cognitive theory and the theory of planned behaviour.

Fishbein and Yzer (2003) mention that there are only a limited number of variables that need to be considered in predicting and understanding any given health related behaviour. These variables are contained in the three theories mentioned above. Fishbein and Yzer (2003) have integrated these theories into one model that provides powerful tools for identifying the specific beliefs that need to be addressed to change or maintain a given health behaviour.

Fishbein and Yzer (2003, p.166) state that "taken together, these three theories identify a limited number of variables that serve as determinants of any given behaviour. Furthermore, they indicate that most behavioral theories suggest three critical determinants of a person's intentions and behaviors, the determinants are the person's attitude toward performing the behavior, perceived norms, which include the perception that those with whom the individual interacts most closely support the person's adoption of the behavior and that others in the community are performing the behavior; and self efficacy, which involves the person's perception that she or he can perform the behavior under a variety of challenging circumstances.

Thus, Fishbein and Yzer (2003) have integrated the three considered theories into one model that they call an Integrative Model of Behavioral Prediction. Fishbein and Yzer (2003) state that “according to the model, any given behavior is most likely to occur if one has a strong intention to perform the behavior, if a person has the necessary skills and abilities required to perform the behavior, and if there are no environmental constraints preventing behavioral performance. When a person lacks skills to perform the behaviour or when environmental constraints are present, a successful intervention will be directed either at skills building or at removing (or helping people to overcome) environmental constraints”. Otherwise, if a person has not formed strong intentions to perform the behaviour in question, the model proposes that there are three primary determinants of intention which are the attitude toward performing the behaviour, perceived norms concerning performing the behaviour, and one’s self-efficacy with respect to performing the behaviour.

Then, it is important to realize that the relative importance of these variables as determinants of intention will depend upon both the behaviour and the population being considered (Fishbein and Yzer, 2003). For example, a behaviour that is primarily driven by attitude in one culture could be primarily driven by norms in another culture. Therefore, it is important to first determine the degree to which the intention is driven by attitude, norms, or self-efficacy in the targeted population before developing interventions.

2.4.6 Theory of Planned Behaviour

The Theory of Planned Behaviour (Ajzen, 1991), built upon the earlier Theory of Reasoned Action (Ajzen & Fishbein, 1970) focuses on the theoretical constructs that are concerned with individual motivational factors as determinants of the likelihood of performing a specific behaviour. The central factor of the theory is the individual’s intention to perform a given behaviour. Intentions captures the motivational factors that influence behaviour and are indications of how much of an effort people are willing to exert in order to perform a behaviour. As a general rule, the stronger the intention to engage in behaviour, the more likely should be its performance. The Theory of Planned Behaviour was designed to explain intention

only if the behaviour in question is under volitional control, if the person can decide at will to perform or not perform the behaviour. The theory predicts that the intention to perform a behaviour is a function of three salient beliefs, the person's attitude, subjective norms and perceived behavioural control.

Attitudes have been the most widely researched aspect of the TPB and continue to receive attention from social and cognitive psychologists (Ajzen, 2001; Bentler & Speckart, 1981). Attitudes toward performing behaviour reflect favourable or unfavourable evaluation of the particular behaviour. Attitude toward the behaviour in this case, uptake of VCT is determined by individuals beliefs about the outcome of performing the behaviour (behavioural belief, belief that VCT uptake is associated with certain attributes) weighed by the extent to which these outcomes are valued (belief outcomes, value attached to VCT uptake).

Subjective norms refer to the perceived social pressure to perform the behaviour. They are governed by perceptions of whether significant others think that one should perform the behaviour (normative beliefs, belief about whether each referent approves or disapproves of VCT) and one's motivation to comply with the wishes of significant others (motivation to comply, motivation to do what each referent thinks is right). With regard to norms, individuals differ in the weight they place on subjective norms as influencers, these also vary across behaviours (Ajzen, 2001).

In other words, some people may give importance to their attitude about the behaviour when deciding to engage in a behaviour, while others may give more importance to what they think others think they should do.

Perceived behavioural control reflects the perceived ease or difficulty associated with behaviour performance and with behavioural intention, and unlike attitudes or subjective norms, is posited to directly predict behavioural achievement. This construct of the theory is intended to account for situations where an individual has less than complete control over the behaviour and includes two components.

The first component is facilitating conditions, (Triandis, 1979) which reflect the availability of resources needed to engage in a behaviour. This might include access to the time, money and other resources required to engage in behaviour. The second

component is self-efficacy and refers to the individuals self confidence in his/her ability to perform a behaviour (Bandura, 1982).Ajzen argues that a person will expend more effort to perform a behaviour when his or her perception of behavioural control is high. Beliefs about the presence of factors that might hinder the behavioural achievement (control beliefs, perceived likelihood of occurrence of each facilitating/constraining condition) and perceived ability to control factors that might hinder the behavioural achievement (power of control, perceived effect of each condition in making VCT uptake difficult/easy) provide the basis for perceived behavioural control .According to the theory, an individual's intention to perform a specific behaviour is a direct determinant of whether he or she will act.

To accurately assess the behaviour, one must take into account the target, time, context and behaviour on which the intent is being judged (Ajzen& Fishbein, 2000, Ajzen&Fishbein, 1970). The theory therefore is applied through empirical support for the relationships among attitudes, subjective norms, perceived behavioural control and their relative path weights that lead to intention.

2.4.7 Theory of gender and power

Unlike the psychosocial theories which are essentially gender-blind, the theory of gender and power is a social structural theory addressing the wider social and environmental issues surrounding women, such as distribution of power and authority, affective influences, and gender-specific norms within heterosexual relationships (Connell, 1987).

Using this theory to guide intervention development with women in heterosexual relationships can help investigate how a woman's commitment to a relationship and lack of power can influence her risk reduction choices (Diclemente, 1995). Programmes using the theory of gender and power would assess the impact of structurally determined gender differences on interpersonal sexual relationships (perceptions of socially prescribed gender relations). (King, 1999).

2.5 High risk occupational groups

Some recent studies have tried to identify the high-risk occupational groups in spreading sexually transmitted disease (STD) as an important means of HIV

infection. These are truck driver itinerant market women, students and soldiers being identified as high-risk group to spread STDs, (Warner, 2010).

2.6 Who are vulnerable and most-at-risk populations

Vulnerable and most-at-risk populations are key populations that have vulnerability and high risk converge. These are populations that are at higher risk of being infected or affected by HIV, who play a key role in how HIV spreads, and whose involvement is vital for an effective and sustainable response to HIV. Key populations vary according to the local context and may include people living with HIV, their partners and families, people who sell or buy sex, men who have sex with men, people who use drugs, orphans and other vulnerable children, certain categories of migrants and displaced people, and prisoners , (Lindy,2008).

2.7 Vulnerability

In every society, there are individuals and population groups who are more vulnerable than others to come to harm. For instance, to become sick or to experience poverty and social rejection. Generally, the very young, the elderly and people who are sick or live with a disability are especially vulnerable in every society. In some societies, women, ethnic or religious minorities, migrants or other groups can also be especially vulnerable to abuse, discrimination and even hatred. Often, it is not so much the actual composition of a particular population that makes it more vulnerable, but rather how that population is regarded by others, for example by their local community, society, at political level or by the business sector. For that reason a population who is vulnerable in one country, could be well protected in another, (Perce, 2007).

Vulnerability to HIV is a result of a combination of factors, including more personal circumstances such as age, social mobility, education, gender identity, etc... but also, crucially, the environment in which an individual lives such as poverty, gender discrimination or lack or inadequacy of services. Vulnerable populations involve groups that enjoy lesser legal, social or policy protection, which limit their ability to access or use HIV prevention services (Kershaw, 2008).

In some cultures, girls and women face strong social pressures that can render them vulnerable to HIV. For example, harmful social and cultural norms often restrict girls' and women's access to information about sexual and reproductive health, or prescribe a more passive role for them in decisions about their sexual life. These norms can undermine girls' and women's autonomy and may prevent them from insisting on abstinence or condom use by male partners. Social and cultural norms related to masculinity can also mean that in some societies boys and men are expected by their peers to display dominant, sometimes violent behaviour to women and girls.⁴ Harmful concepts of masculinity can further discourage males from seeking health services and encourage them to engage in risky behaviour such as substance and drug use or multiple casual sexual relationships (Kershaw, 2008).

2.8 Police officers vulnerability to HIV

Uniformed Services including defense and civil defense forces, are a highly vulnerable group to sexually transmitted infections (STIs) mainly due to their work, environment mobility, age and other facilitating factors that expose them to higher risk of HIV infection. Among male population groups studied, military and police generally report higher levels of HIV/AIDS infection than the national average in many countries (Perce, 2007).

A key potential risk factor to police officers is increased exposure to high-risk individuals, particularly intravenous drug users and commercial sex workers, who through exposure to bodily fluids may provide a route of transmission to HIV/AIDS. The logic here is that as emergency first responders, police officers are more likely than the general public to come into contact with trauma victims- such as after a motor-vehicle accident- or violent individuals who may deliberately or indirectly put officers at risk through their violent contact and the potential for fluid transfer (Bruno, 2007).

Whether or not police officers are at greater risk of exposure to risky behaviours, we do know that police officers are at greater risk of exposure to at-risk populations. Chiefly, but not exclusively, these include intravenous-drug using populations and

commercial sex workers. Globally, the spread of HIV by drug-use is high among populations in the former Soviet Union, South-East Asia, and moderate in Latin America and the Caribbean. It is relatively low as a method of transfer in Africa, where drug-abuse is less endemic, and where the global burden of HIV/AIDS is highest. Commercial sex workers are high-risk populations across the world; and commercial sex work contributes greatly to the illegal trafficking of individuals. It goes without saying that this should not prejudice police officers' dealings with these groups, nor should it be taken as an argument for police officers to take a uniformly intolerant line with these groups. (Roderick, 2007).

The risks of a lack of knowledge of HIV/AIDS, and the social stigma and discrimination that accompany it, is as much of a threat to police in dealing with HIV/AIDS, as exposure to HIV/AIDS is itself. Training therefore should proceed on the assumption that until and only if research can conclusively prove that a police officer is at lower risk of HIV because they are a police officer then there is little harm in assuming that police need to take real precautions in avoiding and managing HIV/AIDS. (Kershaw, 2008).

Police forces globally face a serious risk of HIV/AIDS. The United Nation AIDS program states that the uniformed services including police forces are highly vulnerable to STIs including HIV and AIDS. This is in part due to long periods of deployment away from home during their sexually active age and other factors that expose them to higher risks of HIV infection. In the course of their work, police constantly interact with populations which help to drive the HIV epidemic such as commercial sex workers, jail and prison detainees, injecting drug users, illegal immigrants and homosexuals, (Roba, 2011).

The impact of HIV/AIDS on the police force and the role of the police force in fighting HIV/AIDS is a neglected area of research. This is partly due to a lack of testing and to poor systematic data collection among police services and governments around the world. This lack of information extends to the basic and

fundamental issues like levels of prevalence of HIV/AIDS and the vulnerability of police forces to HIV/AIDS (Roba, 2011).

Men make up the vast majority of personnel in most uniformed services around the world. Young men between the ages of 15 and 24, who are either not married or who are stationed far from their regular partners, are the largest and most vulnerable group. Like their civilian counterparts they are the most likely to become infected with HIV and to infect others. The fact that they are often away from home makes them more likely to use sex workers, become infected with STIs, contract HIV and, in turn, infect their wives and girlfriends or casual partners when demobilized or on leave. In countries with economies destabilized by conflict, the presence of large numbers of uniformed men is an important factor for the local sex industry. This may translate into trafficking of women for prostitution or women offering sex for survival, (Martin, 2003).

Largely because of unprotected sex with many different casual partners, uniformed services have, in general, much higher STI and HIV prevalence rates than the national average. According to UNAIDS, STI rates among armed forces are two to five times higher than among the civilian population, and even higher in times of conflict. Latest figures suggest that in certain parts of the world the difference may be even greater than this. A French study found its uniformed services that had tours of duty overseas were five times as likely to be infected by an STI, including HIV, than those who stayed within the country. In many non-industrialized countries, AIDS is the leading cause of death among uniformed services personnel (Adebajo, 2002).

It is widely argued that members of the uniformed services, including the police, are at particular risk of contracting HIV. A disproportionate number of personnel in these services are young men, who tend to be more sexually active; personnel often operate in a dangerous environment that encourages risk taking and machismo; staff are often posted away from home; and personnel enjoy status and relative wealth compared to the communities in which they live and work all of which increase opportunities for sex with multiple partners, (Martin, 2003).

Personnel frequently do work away from home particularly those in the Police Mobile Force, the Criminal Investigations Department (CID) and constables involved in patrol work and may be posted away from their families and communities for as long as three months at a time. Personnel do enjoy relative prosperity and status in relation to the communities they serve. It is also alleged that some senior personnel may use their power within the organization to obtain sexual favours from more junior members of staff. Many do not see themselves as at personal risk of contracting HIV, (Martin, 2003).

Police forces, particularly those stationed in rural areas, and military personnel usually have more income at their disposal than the local population around them. This gives them the financial means to purchase sex on an on-going basis, which is facilitated by the fact that the two groups, due to the nature of their work, frequently interact with large numbers of sex workers. It can also happen that military forces use rape as weapon of war as well. During times of conflict rape is abetted by high levels of alcohol and drug abuse by soldiers far removed both physically and psychologically from social norms which are commonly accepted, (Fleshman 2001). This phenomenon can fuel the spreading of the HIV/AIDS. Infection for sexually transmitted diseases (STD's) worldwide. HIV and other STD's impacts threaten the uniform populations' ability to perform important functions. There is a critical need to find effective ways to lower the risky behaviors. The technical nature of police work creates certain vulnerabilities.

A great deal of experience, skills and personal information could be lost because of staff with HIV/AIDS retiring from service or dying and these skills would take years to replace. The police depends on staff with specialist skills, such as detectives, personnel involved in judicial processes and liaison, handwriting experts, and other technical staff, who require specialized (often foreign) training and are hard to replace. (Barnett and Prins, 2005).

A number of organizational factors could similarly see the institution negatively impacted by the epidemic. These include a tendency towards hierarchy that prevents sharing of information and teamwork, the provision of generous funeral benefits, and

lenient sick and compassionate leave policies that are financially costly and make it difficult to replace staff (Martin, 2003).

In South Africa, one out of every seven police will have HIV/AIDS by 2015 in a country where more cops will be needed to deal with crime that could escalate because of the pandemic. Recent research by the Institute for Security Studies showed that 8% of functional police already had HIV in 2000. Estimates are that this figure would rise to 14% by 2015, (Fleshman 2001).

2.9 Common attitudes to VCT

VCT is promoted as a central component of HIV/AIDS prevention strategies, but it is still not as accepted as it should be. This is largely due to the attitudes and misconceptions that people have about VCT. In this section and the next, we explore the common concerns that people have about VCT and outline the costs and benefits of undergoing testing. Fear and denial lie at the heart of most people not wanting to go for VCT. People are afraid of how the test may change their lives, or simply refuse to accept that they are as vulnerable as anyone else to contracting HIV (Gustav, 2012).

2.9.1 Fear of having HIV/AIDS

Clients are anxious and under considerable stress when they suspect that they have HIV/AIDS or are referred for that reason. Before diagnosis it is the uncertainty of the disease, and after diagnosis it is the uncertainty of life that kills most patients.

The clients should be let explore their fear, openly and frankly. Active listening and empathizing often relieve the anxiety to a considerable extent (Erica, 2006)

2.9.2 Shock

Shock is the most common response to diagnosis of HIV/AIDS. Clients can express it through numbness, silence, disbelief or being stunned. Confusion, distractibility or uncertainty about present and future circumstances. Emotional instability (e.g. moving quickly and unpredictably from tears to laughter and vice versa). Withdrawal, distancing themselves from present issues and circumstances, reluctance of

becoming involved in conversation, counseling, or activities and plans for treatment or for the future. Shock is a normal response to hearing the news of a life threatening illness, (UNAIDS Pakistan, 2002).

2.9.3 Denial, anger, aggression and suicide attempts

Some people react to news about their HIV/AIDS status by denying it. For some of them, such refusal may present a constructive way to handle the shock of the diagnosis. However, if this condition persists, the denial can become unproductive, because these people refuse also the social responsibility associated with HIV positivity. This reaction is typical for children, in the case of the death on a parent. (Erica, 2006)

Anger and aggression are typical aspects which accompany people in situations of bereavement. Some individuals become angry and aggressive. They are often very upset about their fate. They continuously have the feeling, that they are not treated decently and tactfully enough. Anger can sometimes escalate into self-destruction: suicide. Aggression is one of the most frequently reported reactions in frustrating situations. In the frustrating situations, an individual may focus his anger, remorse, indignation, outrage, hostility on other people that are considered as suitable object. There is another possibility, presented by the concept of self-accusation, which the aggressive reaction are aimed at oneself, (Bukusi, 2007).

2.9.4 Guilt

In Pakistan, most of the PLWHAs pass through shock and denial into the stage of guilt. The feeling of guilt grows deeper if also loved ones are infected with the virus. A counselor must help the client fully explore the feelings of guilt. If these feelings are not examined in depth, there is a tendency for them to magnify as the illness progresses. One way of exploring guilt is to ask, “Many people feel guilty when they realize they are HIV-infected, is this something you are feeling?” In this way, the subject can be approached, but the client is given the opportunity to explore this feeling by himself. A supportive and sensitive counsellor can help the client make the choice towards responsible behaviour and a positive attitude towards life. During

this state, clients are more responsive to partner notification and couple counseling, (Erica, 2006)

2.9.5 Fear and loss

Fear of HIV/AIDS is closely associated with fear of our own death, which belongs to the most basic of fears. It is the fear which most of us are trying to fight with by constantly running away from the idea of self-termination or by inventing a series of comforting ideas. Escape and rationalization will help only to cultivate the fear of death. Above all, people have to be settled with self-extinction, with own death and thus perhaps would help those who just need help in the process of dying. In countries with high rate of infected people are found amongst doctors and other healthcare staff. PLWHVA are pushed to the margins of the society, and are isolated. They are forced to leave their job, they, lose their homes, often their family and friends. They are not given adequate health care and by the provided health care they are confronted with rejection. All of this happens because of an illness which cannot be transmitted by common contact. This attitude of professionals who are unable to overcome prejudices and refuse to provide health care is a deep misunderstanding of their mission. The reasons for this kind of handling is fear of being infected with HIV and, ultimately, fear from death itself, (Bukusi, 2007).

Another aspect associated with HIV/AIDS is a loss. People in the developed stage of AIDS are worried because of the loss of their life, their ambitions, physical performance and potency, sexual relations, loss of their position in the society, financial stability and independence. With the increasing essential need of systematic tendency they lose their sense of privacy and control over their lives. Perhaps the most problematic issue is the loss of confidence. It may affect the future, anxiety originating from a relationship with a loved one or caregiver and negative reactions from the society. For many people finding out about their HIV/AIDS status it is the first opportunity, to realize their mortality and psychological vulnerability. They face social isolation due to the inability to perform all daily activities which they used to do. Relationships within the family change more frequently, one loses their colleagues and the attitude of acquaintances and friends changes frequently as well. Many are afraid of the loss of memory, their concentration and ability to make

decisions. Death of a relative, who dies of a deadly disease, presents an extreme burden for each human being. He tends to surrender the pressure of the situation, which seems to be insolvable. Mental failure is accompanied by significant behaviour, changes in physiological and psychological processes in the body, which have sometimes permanent effects on health. This persistent extreme burden leads to disruption of relationships with the social environment, (Collins, (2009).

2.9.6 Depression

Although everyone, with or without HIV, experiences short periods of feeling sad or down, some people develop states of sadness and helplessness they cannot shake. These are often accompanied by low energy, problems in sleeping, eating or concentrating, and even feelings of wanting to commit suicide. These feelings are known as depression. Depression is very common, with more than 40 per cent of people with HIV experiencing episodes of depression at one time or another. Like other emotional problems, depression limits your quality of life and interferes with your immune system's ability to fight HIV. As well, depression can often undermine your ability to care for your health. It may lead to poor anti-HIV drug adherence, drug and alcohol abuse or unsafe sex. The causes of depression may include your genetics and family history, past experiences of loss, social isolation without support of friends and family, or the consequences of prolonged recreational drug use. Depression may also be brought on by some medications like the anti-HIV drug efavirenz or interferon treatment for hepatitis C. HIV disease itself can also be a factor in depression. Certain conditions related to advanced HIV disease such as anemia (low red blood cell count), severe fatigue and dementia can cause symptoms that feel very similar to depression. Low energy and feeling helpless are key symptoms of depression that make it hard for people to seek help. However, depression is very treatable and, with the right therapy, you can feel much better. Effective treatment for depression can include individual and group counseling, cognitive behavioural therapy, which alters depressive thinking, and antidepressant drugs, (Collins, (2009).

Depression can manifest itself in different ways. The person may become quiet or withdrawn, angry or irritable, lethargic, insomniac or constipated. The client may also verbalize his feelings of depression. If the counselor suspects that the client is depressed, it is important to share the suspicion with the client so that his feelings can be fully explored. As the feelings of depression are verbalized, they become more accessible to the client, helping him to cope and to manage his feelings (UNAIDS Pakistan, 2002).

2.10 The factors which hinder VCT utilization

2.10.1 Stigma and Discrimination

Underlying the fear of society knowing one's HIV positive status is the continued real existence of stigma and discrimination toward HIV-positive people. Particularly egregious was discrimination from hospital staff. Examples were given where HIV-positive people were allegedly unjustifiably denied basic surgeries with non-HIV related excuses. Respondents generally had great regard for the professionalism of medical staff, but these stories tended to reinforce the view that was summed up by one interviewee, who said "if even doctors and nurses would not respect HIV-positive people's rights, then what hope is there for wider society? (Casey, 2009).

2.10.2 Fear of a Lack of Confidentiality from Service Providers

Maintaining confidentiality of test results by service providers is an essential prerequisite for uptake of VCT. People who regularly visit VCT in different places can note a number of areas where confidentiality is, or is potentially, being compromised. The VCT arrangements sometimes do make feel there is low confidentiality, because are isolated from other hospital departments. Target groups felt that anybody seen entering those clinics would automatically be suspected of being HIV-positive and "It would be really hard to find excuses for visiting if you bump into somebody you know." On the other hand, "You could naturally go to a hospital without worrying about running into somebody you know because anyone can have problems and visit a hospital. (Casey, 2009).

One of the reasons as to why some people do not access VCT is fear about confidentiality. They fear that their test results would not be safe as persons other than the doctor could access the test result. Hence, some people prefer testing at anonymous test sites where nobody would recognize them. Confidentiality is very crucial in HIV and AIDS testing as for patients to trust health-care providers, they must be able to trust that the information they disclose would be kept secret. Some people therefore preferred to test where they were not known as there would be more confidentiality, (Chwaane, 2006).

2.10.3 Unfriendly and Unapproachable Counselors

Despite of VCT services being appreciated to offer good customer care, but some service provider have unfriendly attitude during counseling and HIV testing, and others may ignore confidentiality such as leaving the door open while attending a client. Some clients loose confidence to the VCT service provider and there for to decide not having HIV testing. But this is attributed to lack of training to VCT staffs. (Casey, 2009).

2.10.4 Location of the VCT centers

The location of VCT centres has an important impact on VCT utilization. Most clients are not pleased with the location of the available VCT centers which are mostly found within health facilities. Some argue that this is not a proper place because people will begin to think that you went there attending treatment related to AIDS. They talk about stigma, that people are still not well informed about this problem of HIV/AIDS. Furthermore, centers around health facilities are not suitable because you are likely to meet several people, (Mwakatobe, 2007).

2.10.5 No Perceived Benefits of Testing

Most at-risk groups tend to associate VCT with testing rather than counseling and support. Unfortunately, VCT is not seen as the first step toward a continuum of care and support that would be beneficial to them. As such, the benefits of testing are perceived to be far outweighed by its potential risks (Casey, 2009).

2.10.6 Awareness and knowledge of VCT

In many African countries, the uniformed services report an HIV prevalence rate higher than the national average. For example, in Uganda the 1996 HIV prevalence rate of 27% among the military was more than three times the 1999 national prevalence rate of 8.3%. South Africa reported a prevalence rate of 60%–70% in the armed forces, compared with 20.1% in the adult population. (Adebajo, S, 2007). Lack of knowledge about VCT services in uniformed services has also been observed to exist. Probably this contributes to HIV high prevalence as most of the times the military personnel are working in detach, (Azuogu, 2011).

2.11 HIV Testing

2.11.1 Facts about testing

There are two types of HIV test. The first, the Western Blot, tests for the virus itself. This test is expensive and is not the main test used to establish whether a person has the virus in their body. It is usually only used when other tests reveal an indeterminate result (a weak positive or a weak negative), (Ong’echi.J, 2007).

The most commonly used ones test for the antibodies produced by the body to fight the virus. They do not test for the presence of the virus itself. The most frequently used test is the Elisa HIV antibody test. This test requires the withdrawal of a small amount of blood from a vein in the arm (urine, stool and saliva can also be used to test for antibodies, but most testing uses blood). This blood is then sent to a laboratory for analysis, (Ong’echi, 2007).

If you are found to be HIV positive, you will need to go for additional, ongoing testing in order to monitor the concentration of the virus in your body (viral load), so that appropriate treatment can be prescribed and doctors can monitor the strength of your immune system. The doctor will explain the need to collect your blood and check your CD4 count. The test will determine whether or not to put you on ARV treatment. A CD4 count of less than 200 will require ARV treatment, (Gustav, 2012).

2.11.2 HIV negative and positive test results:

A negative test result means that HIV antibodies were not detected in the person's sample, either because the person is not infected or because the person is still in the window period. The client must understand that a negative result does not necessarily mean that he or she is uninfected or immune to HIV infection. An HIV-negative person who engages in risky behaviour is still vulnerable to HIV infection. A person who tests negative but has practiced unsafe behaviours during the window period may be infected with HIV and infectious to others, (Brennan, 1997)

A positive test result means that HIV antibodies were detected in the person's sample. The person is infected with HIV and can transmit the virus to others if he or she engages in risky or unsafe behaviours. It does not necessarily mean that the person has AIDS. Neither the presence nor the absence of HIV antibodies is confirmed by an indeterminate test result, for any one of three possible reasons, the person may be seroconverting (he or she has had an exposure risk within the window period). The person may have had an earlier inoculation that is cross-reacting with the HIV antibody test (cross-reactivity does not necessarily mean that HIV is present). The person may have a prior medical condition that is affecting the test (for example, arthritis or autoimmune problems, (Brennan, 1997)

2.11.3 False positive and negative results

False-positive results, the HIV antibody tests that are now available are extremely sensitive and false-positive rates are appreciable, particularly in low-prevalence populations. All clinical HIV testing strategies nevertheless require repeated HIV antibody assays. A false-positive on one assay is unlikely to also test positive on a second, different, type of assay. False-positive results may be due to technical error, repeated thawing and freezing of sample, and cross-reactivity. In ELISAs and rapid tests, human leukocyte antigens (HLAs) can cross-react, resulting in false-positives among persons with rheumatoid arthritis and multiple sclerosis, (Evans, 1997).

A false-negative result occurs in an infected person when the blood test gives a negative result for HIV antibodies even though it should have showed positive. The

likelihood of a false-negative test result must be discussed with clients if their history suggests they have engaged in behaviour likely to put them at risk of HIV infection. Repeated testing over time may be necessary before the client can be reassured that he or she is not infected with HIV. Most often a false-negative result arises among individuals who are newly infected and are not yet producing HIV antibodies. It is important to remember that someone who has rightly tested negative because he or she is not infected with HIV-can become infected at any time afterwards (Evans, 1997).

2.11.4 Couples Counseling and Testing

It can be helpful for couples to go through the VCT process together. If you are planning on getting married or having children you owe it to yourself, your partner and your children to know each other's HIV status. If you are already married, knowing your status can help you make informed decisions about your future. Even if you know your own HIV status, you cannot assume that your partner has the same status; discordant couples – couples where one partner has HIV and AIDS and the other does not - are very common. Undergoing CVCT can help to open lines of communication. It can allow you to support each other through the process. It also makes it easier to adopt measures to protect your health after the test, (Ong'ench, 2012).

2.12 Strategies and resources for VCT

2.12.1 Strategies for VCT

Some countries in Africa have successful VCT programmes, while others have no programmes or have achieved limited success with the programmes that they have put in place. International experience has shown that the success of a VCT programme depends upon the strength of the foundation on which it is built. In Botswana, for example, Tebelelo Voluntary Testing Centres have been successfully set up throughout the country. A media campaign to encourage people to learn their status formed an important component of the roll out, and the Centres continue to be widely publicised through various media. The success of this approach has encouraged the government to publicise other aspects of its response to the epidemic,

such as its PMTCT programme. In the same way, a successful VCT programme needs to form part of a comprehensive workplace programme dealing with HIV, (Pharoh, 2012).

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This chapter presents the methodology to be used in conducting the research. It starts with the theoretical frame work that will be used in the study after which research area, target population and data collection methods.

3.2 Theoretical frame work.

There have been more efforts of reducing HIV new infection in almost every country in the world. But still the ongoing programmes for HIV management in some segment of the population seem not to bring desired effects. Therefore the research takes an approach that there are many factors that affect utilization of VCT services among police officers. The factors being fear of being known HIV positive by other people fear of shock, guilt and depression contributes to inadequate use of VCT services. Due to lack of HIV counseling exposure denial of having HIV/AIDS is being used as a means of getting rid of psychological stress, (USAID 2009).Hence the research assumes to collect data about the understanding of HIV counseling, attitudes towards VCT services and the barriers of VCT utilization among police officers.

3.3 Research design

A descriptive cross-sectional design using qualitative and quantitative methods was used to collect data from Police Officers on voluntary counseling and HIV testing.

3.4 Study Area

The study was conducted in Dar es Salaam region. The region has a high population density, with a segment of 3816 police officers, making it the only region with a large number of police officers living in its three districts, namely Ilala, Temeke and Kinondoni.

3.5 Target Population.

The target population was police officers living in Dar es Salaam city. The Dar es salaam city was chosen because constitute a greater number of police officers working in easily accessible police stations when compared to other district polices stations, where accessibility is difficult especially in remote areas.

3.6 Sample size

A total number of 51 police officers was taken as sample size in which 17 police officers were drawn from each District police stations that is Temeke, Ilala, and Kinondoni police station.

A small number of the sample was drawn because the population understudy has similar characteristics.

3.7 Sampling technique.

In this study systematic random sampling was used. The method involves selecting the sample at a regular interval from the sampling frame, i.e. every n th term starting with a randomly selected number between 1 and n . It is employed when both the total population and sample size are known. The researcher chooses the sampling interval, which is the standard distance between elements selected in the sample. The sampling interval is calculated by dividing the population size by the sample size. (Patton, 1990)

In this study, the total number of police officers in each district and the sample size were known. The size of population understudy was as follows, Ilala $N=1370$, Kinondoni $N=1502$ and Temeke $N=944$. A total number of 51 (17 from each district) study subjects were selected using systematic random sampling. To get the n th term, the population size from each district was divided by the sample size ($n=17$).

Sampling frame was done by listing all police officers in each District police station. For easy accessibility of the members of population understudy, the sampling frame was done at District police station because the total number of police officers working in the district is maintained and available at the District police station.

Bearing in mind that the population under study was too large, for the matter of saving time, money and to make the exercise less tedious, systematic random sampling was chosen.

3.8 Data collection Methods

3.8.1 Questionnaire

Quantitative data were collected using semi structured questionnaire through open and close ended questions.

3.8.2 Focus group discussion

Three focus group discussions consisting of eight to ten participants were conducted by the investigator assisted by a note taker. We used a focus group discussion guide composed of predetermined topics including awareness of VCT services, importance of VCT, what are the reasons that lead to low VCT uptake among police officers, what are the process that take place during counseling for HIV test, the importance of pre-test, and post -test counseling, and what should be done to improve VCT uptake among police officers. This method was helpful in obtaining opinions and suggestions from respondents for VCT uptake improvement.

3.9 Data analysis

The data collected through questionnaire and focus group discussion was grouped in relation to the specific objectives. Then the quantitative data was processed using SPSS.

CHAPTER FOUR

PRESENTATION AND DISCUSSION OF THE FINDINGS

4.1 Introduction

This chapter is organized as follows: characteristics of respondents, findings from research question one: How is the uptake of VCT utilization. Findings from research question two: What are the factors that hinder VCT utilization among Police officers and findings from research question three: What are strategies to increase VCT utilization among Police officers.

Table 4.1: Demographic Data

Characteristic	Number	%
Sex		
Male	30	58.8
Female	21	41.2
Age		
19-25 Yrs	10	19.6
26-35 Yrs	18	35.3
36-45 Yrs	15	29.4
46-55 Yrs	7	13.7
56-60 Yrs	1	2
Education		
Primary	6	11.8
Form Four	29	56.9
Form Six	10	19.6
Diploma	3	5.9
Advanced Diploma	1	2
First Degree	2	3.9
Marital status		
Married	29	56.9
Single	21	41.2
Divorced	0	0
Widow	1	2

Source: Field data (2013)

4.2 Demographic data

Table 4.1 shows there were 51 respondents aged 19-56 years who participated in the study, of whom 58.8% (n=30) were male and 41.2% (n=21) were female. Majority of the respondents 56.9% (n=29) were married, 41.2% (n=21) were single and 2% (n=1) were widow.

The respondents education status ranged from standard seven to First degree. 11.8% (n=6) were standard seven, mostly 56.9% (n=29) were Form four, 19.6% (n=10) were Form six, 5.9% (n=3) were Diploma holders, 2% (n=1) were Advanced diploma and 3.9% (n=2) were first degree.

4.3 Findings from research question one

Research question one: How is the uptake of VCT utilization?

This question explores the general VCT uptake, VCT utilization based on gender, education status and the relationship of marital status.

Table 4.2: Utilization of VCT

	Disagree	Neutral	Agree	Total
Awareness of VCT	18 (35.3%)	1 (2.0%)	32 (62.7%)	51 (100%)
Visited VCT	30 (58.8%)	6 (11.8%)	15 (29.4%)	51 (100%)
Importance of visiting VCT	28 (54.9%)	2 (3.9%)	21 (41.2%)	51 (100%)

Source:Field data (2013)

4.5 Utilization of VCT

Table 4.2 shows that, when asked the respondents about awareness of VCT, 62.7% (n=32) replied that heard VCT, 35.3% (N=18) were not aware and 2% (n=1) were not sure of VCT awareness. When ascertaining the VCT utilization, a higher percentage of respondents 58.8% (n=30) responded that have never visited VCT, 29.4% (n=15) did ever visit and about 3.9% (n=2) remained neutral which signify

were not sure. Research results indicated that more than a half of respondents, 54.9% (n=28) did not know the importance of VCT, 41.2% (N=21) knew the importance of VCT and 3.9(n=2) could not reply whether they or do not know the importance of VCT.

Results indicated that more than half of respondents were aware of VCT services, Being aware of VCT services has shown not a factor to encourage people access VCT, in many other studies have shown most people are aware of VCT services but do not visit VCT because they have fear to some issues related to VCT use such as they don't want to be known by other people that they went for the service, as will be labeled probably have HIV/AIDS. And if they are found HIV positive, will be facing difficulties to accept HIV positive results because it is viewed as a death sentence. In this study a greater percent of respondents did not visit VCT as compared to the proportion of respondents who responded that were aware of VCT services. The study revealed that, awareness of VCT services was not associated with VCT uptake among Police officers. Voluntary Counselling and Testing (VCT) is proven to be one of the most powerful weapons in halting the spread of HIV/AIDS. It is known to be a very important component of HIV/AIDS prevention strategies.

Despite the fact that various studies have shown low utilization of VCT service particularly in developing countries. Investigations of VCT utilization have been done in a number of countries, e.g. Thailand, USA, Britain and Uganda. According to literatures, utilization rates vary enormously for different population groups ranging from 11 to 100%, (Irwin, et al, 1996). In this study, the VCT uptake by Police officers was low which is in conformity with the results of Aytenfisu, (1990) who found that among the armed forces of Ethiopia, VCT utilization was low. According to the results of this research a greater part of respondents had never utilized VCT services because of lack of knowledge about VCT services. This finding is also consistent to the integrative model of behavioural prediction; Fishbone and Yzer (2003) have integrated the three considered theories, namely the Health Belief Model, the social cognitive theory and the theory of planned behaviour into one model that they call an Integrative Model of Behavioral Prediction. Fishbein and Yzer (2003) state that "according to the model, any given behavior is most likely to

occur if one has a strong intention to perform the behavior, if a person has the necessary skills and abilities required to perform the behavior, and if there are no environmental constraints preventing behavioral performance. Since most respondents did not have knowledge about VCT services which according to this model the researcher regarded it as the skills that would lead them to access the VCT services. This finding is also supported by the Health belief model in the aspects of two variables namely, perceived benefits and the perceived barriers of VCT utilization. Based on these constructs, the perceived benefits of VCT services is the person's opinion of the value or usefulness of VCT services in decreasing HIV prevalence. The perceived barriers are an individual's own evaluation of the obstacles relating to VCT use. The finding of the present study shows that, a greater number of the population understudy did not know the importance of VCT utilization, therefore did not know the services provided by VCT which could serve as motivating variable for VCT utilization.

One of the factors hindering VCT utilization is the HIV/AIDS related stigma. According to the construct of perceived barriers of performing a certain behavior, a person needs to believe in the benefits of the behaviour so that to overcome the perceive barriers, (Glanz,Rimer and Lewis,1997). Results of this study show that stigma was not overcame by the importance of VCT utilization.

As well the finding is in consistent with the theory of reasoned action. Fishbein and Ajzen (1960) based on the assumption that human beings are usually quite rational and make systematic use of the available information and that people consider the implications of their actions in a given context at a given time before they decide to engage or not to engage in a given behavior. When focusing to the benefits and the consequences of the perceived barrier to VCT utilization, HIV/AIDS related stigma is a social cultural variable that influence poor VCT utilization. This finding suggests that, people are more sensitive to stigmatization than to the benefits of VCT services.

Table 4.3: VCT Utilization by Gender

VCT utilization by gender				
gender	Disagree	Neutral	Agree	Total
Male	18 (60%)	3 (10%)	9 (30%)	30 (100%)
Female	12 (57.1%)	3 (14.3%)	6 (28.6%)	21 (100%)

Source: Field data (2013)

4.6 VCT utilization by gender

Results of table 4.3 shows that only 30% of men who participated in the study did ever attend VCT, 60% of them never visited VCT. And 28.6% of women who did take part in the study reported to attend VCT while 57.1% of them never attended.

In this study when compared between male and female, more males attended VCT than female; however the difference is very small. A recent study of Uptake of HIV voluntary counseling and testing services in rural areas of Tanzania found that men accounted for 49 % while women was 41% about VCT use, (Wringe, et al, 2008).In this study, generally VCT utilization was low. When compared between men and women who did attend VCT, it can be seen that there is a slight gender disparity about VCT utilization. Studies on VCT uptake by gender provides mixed results with some research indicating a higher uptake by males than female, Reilley e tal,(200), Adamasu & Fitaw, (2006) and others Olewe et al., (2008) indicating a higher uptake by female than males.

The inconsistency in these studies might be due to differences in target populations, service delivery, geographical, and social-cultural context. .A possible explanation of this uptake imbalance in the current study could be in gender roles and relations which limit control by women in matters regarding sex. Uptake of VCT by female clients is influenced by the power women wield within a sexual relationship. In Tanzania, just like any other African countries, women are ranked lower in the gender hierarchy. Married women are still often subject to their husband's authority and may therefore have to get permission from their husband so that they can go for a test. This finding is consistent with the theory of gender and power (King, 1999).

This research finding is also similar to the findings of Reilley *et al.*, (2004), Adamasu & Fitaw (2006) about VCT attendance by gender showed that more male than female attended VCT.

Table 4.4: VCT Utilization in Relation to Education Status

VCT utilization				
Education	Disagree	Neutral	Agree	Total
Primary school	5 (83.3%)	0 (0%)	1 (16.6%)	6 (100%)
Secondary school	23 (58.9%)	5 (12.8%)	11 (28.2%)	39 (100%)
Tertiary Education	2 (33.3%)	1 (16.6%)	3 (50%)	6 (100%)

Source: Field data (2013)

4.7 VCT utilization in relation to Education status

Table 4.4 shows results of VCT utilization in relation to education status. The Education status of the respondents was grouped into main three groups namely the primary school, secondary school and tertiary education which composed of Diploma, Advanced diploma and first degree level. Among of the primary school level of education, only 16% of them did visit VCT, while a high percent of them 83.3% did not, 28.2% of secondary education level did attend VCT and again a larger proportion of this group 58.9% did not visit. Results showed that 50% of tertiary education did attend VCT and small a percent of them did not attend VCT.

Education had a significant influence on the uptake of VCT in this study. Those respondents with tertiary education, half of them did access VCT than those with less than tertiary education. The secondary school level of education even though their VCT utilization was still low, results showed their utilization was more than Primary school level respondents. This finding is consistent with those of Adeneye *et al.*, (2006) and Okpala *et al.*, (2006), which all reported that higher educational levels were positively associated with VCT uptake. The most probable explanation for these findings is that people with higher educational levels were more likely to have correct knowledge of HIV transmission and less of misconceptions; they were more likely to appreciate better the benefits of VCT and as they are also better exposed and therefore have better access to VCT services. Again this is still supported by the

integrated model of behavioral prediction, taking education as a variable that led them to have a correct knowledge about VCT services and therefore made them be able to utilize the service.

This finding is also in conformity to the Health belief model. Educational status is an individual characteristic which modify personal perceptions towards positive attitude to behavior performance if at all there is perceived benefits, (Glanz,Rimer and Lewis,1997).

Table 4.5: The Relationship Between Marital Status and VCT uptake

The relationship between marital status and VCT uptake				
Marital status	Disagree	Neutral	Agree	Total
Married	14 (47.2%)	4 (13.8%)	11 (37.9%)	29 (56.9%)
Single	15 (71.4%)	2 (9.5%)	4 (19.1%)	21 (41.2%)
Widow	1 (100)	0%	0%	1 (2%)
Total	30 (58.8%)	6 (11.8%)	15 (29.4)	51 (100%)

Source: Field data (2013)

4.8 The relationship between marital status and VCT uptake

Table 4.5 shows that among of 51 respondents, 56.9% (n=29) were married individual, 41.2% (n=21) were single and 2% (n=1) were widow. The comparison on VCT uptake according to marital status, of the 29 married respondents only 37.9% (n=11) did utilize VCT, a greater percent of them 47.2% (n=14) did not visit VCT and 9.5% (n=2) remained neutral.

Of 21 single respondents, only 19.1% (n=4) reported to utilize VCT, most of them 71.4% (n=15) did not utilize VCT and 9.5% (n=2) were neutral. Among the widow respondents no one utilized VCT. The comparison of VCT utilization according to marital status showed more married respondents utilized VCT than the single and widow respondents.

Findings in the literature on the relationship between marital status and VCT uptake are mixed. Iyaniwura and Oloyede, (2006) and Simbayi et al, (2003) argue that unmarried young people were more likely to desire an HIV test. Jereni and Muula

(2008), on the other hand, found no difference in VCT uptake between married and unmarried clients. This study indicated that married individuals were found to have more VCT users compared with never married included in the study. This implies that probably married individuals in the population understudy had an exposure to the programs of mother to child prevention of HIV transmission which is conducted during antenatal clinics. This program recommends couple counseling for HIV test in order to reduce HIV transmission in children below five years of age. This finding is consistent with that of Wondowssen,(2007) on assessment of VCT utilization for HIV/AIDS among government and non-government employee in Butajira of Ethiopia, results showed married individuals were more likely to use VCT services than unmarried ones.

4.9 Findings from Research Question Two

Research question two: What are the factors that hinder VCT utilization among police officers?

Table 4.6: Factors that hinder VCT utilization among Police officers

Barriers facing VCT utilization among Police officers				
Barriers	Disagree	Neutral	Agree	Total
willingness for HIV test	19 (37.3%)	3 (5.9%)	29 (56.8%)	51 (100%)
Fear of positive results	15 (29.4%)	5 (9.8%)	31 (60.8%)	51 (100%)
Lack of confidentiality by VCT staffs	12 (23.5%)	2 (3.9%)	37 (72.6%)	51 (100%)
Benefits of knowing HIV status	16 (31.4%)	3 (5.9%)	32 (62.7%)	51 (100%)
Lack of knowledge about VCT	12(23.5%)	3(5.9%)	36(70.6%)	51 (100%)
There is privacy during counseling	3 (5.9%)	4 (7.8%)	44 (86.3%)	51 (100%)
Attitudes of VCT staffs	Good	Satisfactory	Bad	Total
	18 (35.3%)	27 (52.9%)	6 (11.8%)	51 (100%)
Level of discrimination	High	Moderate	Low	Total
	5 (9.8%)	5 (9.8%)	41 (80.4%)	51 (100%)

Source: Field data (2013)

4.10 Factors that hinder VCT utilization among police officers

Table 4.6 shows that, fear of HIV positive results is a factor which hinder VCT utilization, where 60.8% (n=31) could not access VCT because of fear, 23.5% (n=12) could not fear positive results and 9.8% (n=5) remained neutral to the question. Lack of confidentiality by VCT staffs is the most hindering VCT utilization, in which 72.6% (n=37) agreed that VCT staffs lacks confidentiality, 23.5% (n=12) responded VCT staffs do not lack confidentiality about clients information. Lack of knowledge about VCT indicated to be another reason that contribute to failure of access to VCT services 70.6% (n=36) where 23.5% (n=12) responded lack of VCT knowledge is not a barrier. Results indicated privacy during counseling session was not a barrier to VCT utilization, 86.3% (n=44), only 7.8% (n=3) responded there is no privacy.

The attitudes of VCT staffs were determined using three categories, namely good, satisfactory and bad. 52.9% (n=27) responded that VCT staff attitudes is satisfactory, 35.3% (n=18) responded the attitude is good and 11.8% (n=6) responded the attitude is bad. The level of discrimination was rated using the words high, moderate and low. Of 151 respondents 80.4% (n=41) responded the level was low, 9.8% (n=5) responded high, and 9.8% (n=5) replied moderate.

The following were the factors that hinder VCT utilization among Police officers which includes, Fear for HIV positive results, Lack of confidentiality by VCT staffs and Lack of knowledge about VCT services.

Fear for HIV positive results was a factor that hinders VCT utilization among police officers. Results showed more than half of the respondents did not attend VCT because of fearing HIV results. This is true that when we are faced with a threatening message or image, people's emotion may become aroused and become fearful. For several decades health promotion interventions have sought to arouse a fear of potentially harmful consequences as a means of keeping people away from engaging in particular behaviours. The way HIV/AIDS in the 1980's was being put in mass media campaigns brought threatening ideas as consequences led to fear for having HIV positive results, Writte & Allen (2000). This signifies that it was assumed that if

people were made fearful of the consequences of HIV infection then would be motivated to use condoms to protect themselves. Within the general population in some African countries, a number of studies have been done in which fear of HIV positive results revealed a barrier to VCT uptake. The finding of this study conform to the observed low VCT uptake due to fear of HIV results particularly in sub-Saharan Africa, Kipp, (2001), Peltzer, (2002) and Gardner *et al.*, (2004).

This implies participants felt that, fear of HIV positive results is one of the factor hindering VCT uptake. This finding is also similar to the literature review of Day *et al.*, (2002). Many people feel that they are not strong enough to accept HIV positive result. This could mean lack of confidence in the quality of counseling offered. If VCT uptake is to increase, clients should be assured that the counseling offered is of good quality and that counselors are well equipped to do so.

Lack of confidentiality by VCT staffs. Results showed that 72.6% (n=37) lack of confidentiality by VCT staffs is a reason that discourage people to access VCT services, when client have trust in VCT staffs such a barrier cannot exist. A number of people afraid to access VCT services because they fear that results may not be treated with confidentiality, UNAIDS, (2000). This findings is in consistent with results of studies done in Vulindela, Soweto, Zimbabwe and Thailand which found that lack of confidentiality was limiting VCT uptake, Knyemba, (2000).

Visiting VCT centre in which VCT staffs are known and fear of being seen at the VCT centre are likely to reduce chances of VCT utilization. This was supported by studies which reported that those who feared being seen at the VCT centre were less likely to utilize VCT services than those did not fear. People usually feel save when they know somebody standing on their side, in a study of Boda boda VCT utilization it was seen that clients who had confidence that their HIV test results would be kept confidential were more likely to visit for VCT as compared to those think there would be no confidentiality of their information, Othiambo, (2012).

Lack of knowledge about VCT services. Results revealed that 70.6% (n=36) indicated lack of knowledge about VCT services contributes to failure of accessing VCT. In Tanzania VCT plays a key part in HIV related prevention and influencing change in sexual behaviour and practices. Where the goal of health policy in regarding HIV , VCT are to diagnose HIV infection for timely therapeutic or prophylactic intervention and secondary to identify unrecognized infections so that behaviour associated with viral transmission can be modified. Limited knowledge about the services offered by VCT has been cited as hampering VCT uptake Ginwalla et al,(2000).Still there is a concept that VCT services are for sick people, most people think all those who go for VCT are already sick form HIV/AIDS related diseases. This becomes a common feeling because most of people who did attend VCT are already have started showing symptoms and therefore feel there is no need of fearing and that VCT is the only place for improving their health Family health international,(2004). This finding is consistent with that of Azuogu et al,(2011) about HIV voluntary counseling and testing practices among military personnel and civilian residents in a military cantonment of southeastern Nigeria, found that more than half of the respondents lacked knowledge about VCT services.

Table 4.7: Comparison of the factors that hinder VCT Utilization among police officers in the three Districts

Ilala District				
Barriers	Disagree	Neutral	Agree	Total
Fear of positive results	4 (23.5%)	3 (17.6%)	10 (58.9%)	17 (100%)
Lack of confidentiality by VCT staffs	6 (35.3%)	1 (5.8%)	10 (58.9%)	17 (100%)
Lack of knowledge about VCT services	3 (17.6%)	0 (0%)	14 (82.4%)	17 (100%)
Kinondoni District				
Fear of positive results	6 (35.3%)	2 (11.8%)	9 (52.9%)	17 (100%)
Lack of confidentiality by VCT staffs	3 (17.6%)	1 (5.9%)	13 (76.4%)	17 (100%)
Lack of knowledge about VCT services	2 (11.8%)	2 (11.8%)	13 (76.4%)	17 (100%)
Temeke District				
Fear of positive results	5 (29.4%)	0 (0%)	12 (70.6%)	17 (100%)
Lack of confidentiality by VCT staffs	3 (17.6%)	0 (0%)	14 (82.4%)	17 (100%)
Lack of knowledge about VCT services	7 (41.2%)	1 (5.9%)	9 (52.9%)	17 (100%)

Source: Field data (2013)

4.11 Comparison of the factors that hinder VCT utilization among Police officers in the three Districts.

Table 4.8 shows that of the 17 respondents of Temeke Districts a larger percent of them 70.6% (n=12) had fear of HIV Positives results than Ilala 58.9% (n=10) and Kinondoni Districts 52.9% (n=9).

Among the three Districts, the comparison of respondents reply showed that Temeke constituted a greatest percent of individual who had fear of HIV positive results followed by Ilala and then Kinondoni in which more than half of their respondents did have fear.

As well the table shows that, Temeke Districts had the leading percentage of respondents who replied that lack of confidentiality by VCT staffs is a barrier to VCT utilization than Kinondoni 76.4% (n=13) and Ilala Districts 58.9% (n=10).

When comparison was made in the three Districts, results showed that more than three quarters of Temeke and Kinondoni responds felt there is lack of confidentiality by the VCT service providers however the difference was 6%, Temeke being the leading most. More than half of ilala respondents felt of the same problem

Finally the tables also shows that, Ilala District did have a greatest percent of respondents 82.4% (n=14) who replied that lack of knowledge about VCT services is a reason of low VCT utilization than Kinondoni 76.4% (n=13) and Temeke Districts 52.9% (n=9).

Research findings showed that, more than three quarter of respondents from Ilala, and Kinondoni as well more than half of respondents from Temeke lacked the knowledge about VCT services. From this findings, it can be seen that, among of the three Districts most respondents lacked knowledge about VCT services however Ilala is the most leading followed by Kinondoni and Temeke.

5.12 Findings from Research Question Three

Research question three: What are the strategies to increase VCT utilization among police officers?

For this question, the researcher wanted to get suggestions for strategies to increase VCT uptake among Police officers from the participants of the focus group discussion.

4.13 Strategies to increase the uptake of VCT services among Police officers

Most of people who participated in the focus group discussion were familiar with HIV/AIDS and VCT issues.

The participants on responding to the question that, what can be done in order to improve VCT uptake, mostly did mention three issues of concern to be addressed,

namely the issues of confidentiality, location of VCT and Health education programmes about VCT utilization for improving uptake.

About issues of confidentiality, most participants said counselors in many VCT centres do not keep secret of clients information about HIV status that is why people prefer to have HIV test in VCT where are not known by service providers. One participant said.

“I don’t trust some VCT staffs, I am afraid they may disclose my status to other people”

Mostly mentioned that most people are willing to visit VCT but they fear that their information will be known by other people. From all the focus groups participants said people know that VCT centres are there, it is not only police officers who do not utilize VCT. In many places it is commonly known that people do not want to associate themselves with VCT because of stigmatization. With this popular concept it is true that VCT centres are underutilized because clients fear lack of confidentiality and stigmatization. This finding is in conformity with the result of Chwaane, (2006) where results indicated that lack of confidentiality led to low VCT uptake.

As a result of fearing about confidentiality issues and stigmatization, people felt that living without knowing their status was better because they would not be worried about HIV/AIDS whenever were ill. Mostly did not use VCT centres because they were not sure of confidentiality about their status. They were worried that counselors may disclose status of people who went for testing. In respect to this concern, they gave a common opinion that VCT staffs should be trained on the issues of ethics and rights of client so that to operate the VCT centres in the context of assured confidentiality and to make them trusted by the community.

About the location of VCT, the most common response from the focus group discussion participants was, VCT centres are not in a conducive place for people’s attraction to the service, because are so open and built in isolation from main health

facilities, as it makes easier for people around to pay attention who is going to get in the building. This is one of the reasons that contribute to failure of VCT utilization despite of having a satisfactory number of people willing to pay a visit. In respect to this the participants gave a common opinion that VCT should be integrated in the same health facility so that many who are willing to utilize the service can do so confidently without being suspected that went for VCT. One participant said.

“People’s perception is that, those who visit VCT are not sure of their health status and may be already acquired HIV”.

This research finding is consistent with that of Mwakatobe, (2007), who came out with the conclusion that, people tend to fear accessing VCT services because may be seen by other people who know them.

This research finding as well is in conformity to the theory of planned behavior. The reason that people felt not comfortable to be seen by other people in respect to VCT use. This imply that, subjective norms had a strong influence to make people fear probably would be subjected to stigmatization simply on the basis of suspicion that one might be HIV positive. I.e. irrespective of one’s real HIV positive results. As such a situation may arise when ones is seen at a VCT site or being seen with health care providers working at such sites or who provide care and support to people living with HIV/AIDS, people actively avoid such association. According to Ajzen (2001), subjective norms refer to the perceived social pressure to perform the behaviour. They are governed by perceptions of whether significant others think that one should perform the behaviour (normative beliefs, belief about whether each referent approves or disproves of VCT)

In order to make people courageous in terms of VCT utilization , participants gave an opinion that more health education programmes about VCT utilization should be given to the population under study as this can bring about positive attitudes towards VCT’.

Moreover on the aspect of increasing the number of VCT uptake, participants mostly did have a view that, more health education about VCT service should be given to the community in order to make people feel there is a need of accessing VCT services and be assured of the confidentiality of their information. This finding is

also in conformity to Fishbein and Yzer (2003) who found the integrative model of behavioral prediction, stated that an individual may have a strong intention and ability of performing certain behaviour provided that there is no environmental constraints. According to the finding of this research, majority of the respondents reported that they were willing to pay a visit to VCT, but due to unfavourable environment surrounding the VCT, they feared some issues of confidentiality such as other people would see them while getting into the building. The finding is consistent with the social cognitive theory, Parraga (1990) behavior performance depends on social environment which includes family members, friends and colleagues. From the findings, it implies that the population under study has a cognitive culture of negative attitudes towards VCT utilization due to HIV/AIDS stigma.

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

This chapter gives the summary, conclusion and recommendations of the overall findings on the assessment of the factors that influence VCT utilization among Police officers in Temeke, Ilala and Kinondoni Districts of Dar es Salaam region. As well the areas for further research.

5.2 Summary

The purpose of this study was to assess the factors that influence VCT utilization among police officers. The study used both quantitative and qualitative methods of data collection. Quantitative data were collected using semi structured questionnaires containing open and close ended questions which were distributed to 51 police officers. The qualitative method was used to collect data concerning the strategies that should be done in order to improve VCT uptake among Police officers. There were three focus group discussions consisting of eight to ten participants conducted by the investigator assisted by a note taker. The participating police officers were from three districts of Dar es Salaam region, namely Ilala, Kinondoni and Temeke. About 29.4% (n=15) of respondents reported that they utilized VCT services. The comparison of gender VCT utilization showed a slight difference where more male than females visited VCT. Education status had a positive influence on VCT utilization; tertiary education respondents utilized the service more than secondary and primary schools.

Four barriers to VCT utilization were identified. Lack of confidentiality by VCT staffs was the most leading in percentage 72.6% (n=37), followed by lack of knowledge about VCT services 70, 6% (n=31) and the unfavourable location of most VCT centres was commonly said by the focus group discussions.

The strategies suggested in order to increase the VCT uptake among police officers were, the improvement of confidentiality of the VCT staffs, integration of VCT services into the main health facilities for assurance of confidentiality and emphasis should be made on continuous health education programs to address and reduce HIV/AIDS related stigma to enable individual feel more comfortable seeking VCT services.

5.3 Conclusion

This study concluded that Police officers in Dar es Salaam districts had a poor uptake of Voluntary Counseling and testing, only few of them did utilize VCT services. Education status had an influence on VCT utilization. Those with tertiary education were more likely to access VCT than those without it. Despite of the benefits that VCT centres confer, barriers to VCT utilization such as lack of confidentiality of VCT staffs, lack of knowledge about VCT services, and the location of VCT centres noted as unfavorable environment for utilization have shown negative influence towards VCT utilization. Majority of the people want to utilize the service but barriers preventing them. Hence the role of VCT staffs and the rights of HIV/AIDS clients should be clarified, and potentially expanded public education on why and how to access vulnerable groups like Police officer who have not been exposed to right health education programs about HIV/AIDS in order to build confidence towards VCT utilization.

5.4 Recommendations

- (i). Lack of knowledge to VCT services and the social stigma is as much of threats to police in dealing with HIV/AIDS. Training therefore should proceed until further research can conclusively prove that VCT uptake among polices officers is satisfactorily higher.
- (ii). Encouraging the new police recruits to have regular VCT utilization and addressing barriers to VCT uptake and their harmful consequences in order to build positive views on VCT services.
- (iii). Expansion of the established Anti-AIDS clubs and peer educator regarding HIV/AIDS to cover all police units and detach.

- (iv). In order to maintain VCT confidentiality, there is a need for exposing the police officers and VCT service providers to the ethical and legal issues in relation to HIV/AIDS programmes. The most basic human right principle requires that every person has the right to know his or her HIV status. In Tanzania, all health care practitioners are bound to ethical principles to do all that is necessary and available to provide the best possible care and follow up to any person. Therefore HIV test must be provided when consented to or indicated in accordance to “3Cs” principles of confidentiality, counseling and informed consent which includes voluntarism. Timely referral for follow up, medical care and psychological support must be ensured.

5.5 Areas for further research

- (i). The perception of lack of confidentiality appears to be the greatest barrier to VCT uptake. As such further research and analysis in this area should be prioritized.
- (ii). How is effective the HIV/AIDS work place police in tackling HIV/AIDS within the police force as compared to other governmental institutions.
- (iii). How can fear of positive HIV results and HIV/AIDS related stigmatization be dealt to improve the VCT uptake among police officers?

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APPENDICES

QUESTIONNAIRE

A. Socio-demographic factors		
NO.	QUESTIONS	ANSWERS
1.	Gender	1=Male 2.Female
2.	Age	Yrs.
3.	Religion	1=Christian 2=Muslim 3=Traditional Religion 5=None
4.	Education	
5.	Marital status	1=Married 2= Single 3=Divorced 4=Widow/widower
6.	Place of residence	
7.	Place of work	
B. Understanding of HIV infection, transmission and prevention		
8.	I have heard of a disease called AIDS	1=Strongly disagree 2=Disagree 3=Neutral 4=Agree 5=Strongly agree
9.	HIV/AIDS is a disease caused by virus	1=Strongly disagree 2=Disagree 3=Neutral 4=Agree 5=Strongly agree

10	HIV/AIDS is a disease caused by witch craft	1=Strongly disagree 2=Disagree 3=Neutral 4=Agree 5=Strongly agree
11	HIV/AIDS is a disease caused by curse	1=Strongly disagree 2=Disagree 3=Neutral 4=Agree 5=Strongly agree
14.	VCT is a place where voluntary counseling for HIV test is done	1=Strongly disagree 2=Disagree 3=Neutral 4=Agree 5=Strongly agree
15..	Sexual abstinence can prevent someone from contracting HIV	1=Strongly disagree 2=Disagree 3=Neutral 4=Agree 5=Strongly agree
16.	Use of condom can reduce ones chance of contracting HIV	1=Strongly disagree 2=Disagree 3=Neutral 4=Agree 5=Strongly agree
17.	Having only one sexual partner reduce ones chance of contracting HIV	1=Strongly disagree 2=Disagree 3=Neutral 4=Agree 5=Strongly agree
18.	Avoiding sex with a person who has many partners can reduce ones chance of contracting HIV	1=Strongly disagree 2=Disagree 3=Neutral

		4=Agree 5=Strongly agree
19.	Avoiding sex with homosexuals can reduce ones chance of contracting HIV	=Strongly disagree 2=Disagree 3=Neutral 4=Agree 5=Strongly agree
20.	A traditional healer able to protect one from contracting HIV	1=Strongly disagree 2=Disagree 3=Neutral 4=Agree 5=Strongly agree
21.	A traditional healer reduce ones chance of contracting HIV	1=Strongly disagree 2=Disagree 3=Neutral 4=Agree 5=Strongly agree
22.	A mosquito transmit HIV from an infected person to another	=Strongly disagree 2=Disagree 3=Neutral 4=Agree 5=Strongly agree
23.	I know the risk of contracting HIV infection	1=Strongly disagree 2=Disagree 3=Neutral 4=Agree 5=Strongly agree
C. Issues relating to VCT		
24.	I have heard of VCT	1=Strongly disagree 2=Disagree 3=Neutral 4=Agree 5=Strongly agree
25.	I have ever visited VCT	1=Strongly disagree

		2=Disagree 3=Neutral 4=Agree 5=Strongly agree
26.	One of the reasons why I do not access VCT is lack of knowledge about VCT services	1=Strongly disagree 2=Disagree 3=Neutral 4=Agree 5=Strongly agree
27.	The feeling that there is no need going for HIV test is another reason that makes people not to access VCT services.	1=Strongly disagree 2=Disagree 3=Neutral 4=Agree 5=Strongly agree
28.	According to my understanding , VCT is very important in making people prevent themselves from contracting HIV	1=Strongly disagree 2=Disagree 3=Neutral 4=Agree 5=Strongly agree
D. Issues relating to HIV test		
29.	I have been tested for HIV before	1=Strongly disagree 2=Disagree 3=Neutral 4=Agree 5=Strongly agree
30.	If I have HIV I would share results with anyone others	1=Strongly disagree 2=Disagree 3=Neutral 4=Agree 5=Strongly agree
31.	I am willing to test for HIV	1=Strongly disagree 2=Disagree 3=Neutral 4=Agree

		5=Strongly agree
32.	I would like to visit VCT for HIV test but I fear positive results because AIDS is a life threatening	=Strongly disagree 2=Disagree 3=Neutral 4=Agree 5=Strongly agree
33.	If I test and find HIV positive I will die early because of shock	=Strongly disagree 2=Disagree 3=Neutral 4=Agree 5=Strongly agree
34.	Denial of having HIV infection reduces discrimination	=Strongly disagree 2=Disagree 3=Neutral 4=Agree 5=Strongly agree
35.	if someone tests HIV positive feels guilt	=Strongly disagree 2=Disagree 3=Neutral 4=Agree 5=Strongly agree
36.	I would like to visit VCT for HIV test but I fear Lack of confidentiality by VCT staffs	=Strongly disagree 2=Disagree 3=Neutral 4=Agree 5=Strongly agree
37.	I can share my results with others	1=Strongly disagree 2=Disagree 3=Neutral 4=Agree 5=Strongly agree
38.	If one tests HIV positive is likely to be treated differently	1=Strongly disagree 2=Disagree

		3=Neutral 4=Agree 5=Strongly agree
39.	I can you rate the level of discrimination	1=Very high 2=High 3=Moderate 4=Low 5=Very low
40.	Iam willingly to take care of a family member who is suffering from AIDS	1=Strongly disagree 2=Disagree 3=Neutral 4=Agree 5=Strongly agree
41.	There benefit from knowing HIV status	1=Strongly disagree 2=Disagree 3=Neutral 4=Agree 5=Strongly agree
42.	Counselors can keep a secret of clients information about HIV status	1=Strongly disagree 2=Disagree 3=Neutral 4=Agree 5=Strongly agree
43.	There is privacy during counseling	1=Strongly disagree 2=Disagree 3=Neutral 4=Agree 5=Strongly agree
44.	The attitude of VCT staffs is	1=Good 2=Satisfactory 3=Bad