DETERMINANTS OF MEN's INVOLVEMENT IN HIV/AIDS VOLUNTARY COUNSELING AND TESTING IN RUANGWA DISTRICT COUNCIL IN LINDI REGION, TANZANIA

DETERMINANTS OF MEN's INVOLVEMENT IN HIV/AIDS VOLUNTARY COUNSELING AND TESTING IN RUANGWA DISTRICT COUNCIL IN LINDI REGION, TANZANIA

By

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A Dissertation Submitted to Institute of Development Studies in Partial Fulfillment of the Requirements for Award of the Degree of Master of Science in Development Policy (MSc.DP) of Mzumbe University

2015

CERTIFICATION

We, the undersigned, certify that we have read and hereby recommend for acceptance by the Mzumbe University, a dissertation entitled, **Determinants of Men's Involvement in HIV/AIDS Voluntary Counseling and Testing in Ruangwa District Council in Lindi Region, Tanzania** in partial fulfillment of the requirement for award of the degree of Master of Science in Development Policy of Mzumbe University.

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DIRECTOR, INSTITUTE OF DEVELOPMENT STUDIES

DECLARATION AND COPYRYGHT

I, Hosea Asangalwisye Shibanda, declare that this dissertation is my own original work and that it has not been presented and will not be presented to any other university for a similar or any other degree award.

Signature_____

Date_____

ACKNOWLEDGMENT

This dissertation is the result of the cooperation exercised by a number of people whom I owe a great debt of gratitude for their remarkable input. I am grateful to all individuals who in various ways helped me to accomplish this study. The production of this dissertation would not have been possible without the help and abundant counsel given to me by my major Supervisor Mr. Moses J. Ndunguru of the Institute of Development Studies (IDS), Mzumbe University.

I would also, like to express my sincere thanks to course lecturers and staff members of IDS, Department of Development Policy and MSc. DP classmates of the year 2013/2014 for their constant friendly cooperation and encouragement that they had provided to me during my study period.

It should be appreciated that, this dissertation is a product of discussions and consultations between the author, supervisor and many experts in the field of Health system especially those at Ruangwa District Council, Department of Health. Without them this study would not have been possible and successful. Furthermore, I would like to thank the following officers who supported this study in one way mostly, their information was very crucial towards accomplishment of the research findings. These include Mrs Grace Mwambe (CDO and Council HIV/AIDS Coordinator), Dr. Rashid Liputa (District AIDS Coordinator (DACC).

Special thanks go to my employer, District Executive Director, Mr. Reuben Mfune for giving me permission to undertake master's programme. Also, I will always acknowledge the assistance of Mrs. Reuben Mfune (District Social Welfare Officer), Ruangwa District Council staffs, and my fellow colleagues F. Kandete, G. Gulamiwa J. Mbiha, C. Kighahe and N. Maokola.

DEDICATION

This work is dedicated to my lovely girlfriend, Faraja Enock Kandete who had great support and inspiration on my academic accomplishments and to my parents, especially my father A. Shibanda and my lovely mother Tupege Ijengo for their love and tolerance they showed me when I was away and busy with studies, they really pray for me. Also, the dedication goes to my lovely Sisters Upendo Shibanda and Eva Shibanda who have been inspiring me on my academic career. Furthermore, special dedication of this work goes to my best friend, Richard James Kifutumo who had courageous encouragement on academic career to me and my siblings.

To all people who helped men materially or/ and spiritually.
May the Almighty God Bless you all!

ABBREVIATIONS AND ACRONYMS

ADA	American Dietetic association
AIDS	Acquired Immunodeficiency Syndrome
ARV	Antiretroviral
CBO	Community Based Organisation
CDC	Centre for Disease Control
CI	Confidence Interval
CMAC	Council Multi- Sectoral AIDS Committee
CRHCS	Commonwealth Regional Health Community Secretariat
DC	District Council
ESRF	Economic and Social Research Foundation
FAO	Food and Organization of the United Nations
FGDS	Focus Group Discussion
GOT	Government of Tanzania
HCT	HIV Counseling and Testing
HIV	Human Immunodeficiency Virus
IDI	In-depth Interview
INSP	International Network on Strategic Philanthropy
MCH	Maternal Child Health
MDG	Millennium Development Goal
MTCT	Mother to Child Transmission
NACP	National AIDS Control Programme
NICE	National Institute for Health and Care Excellence
NMSF	National Multi- Sectoral Strategic Framework
NGO	Non-governmental Organisations
PFIP	Partnership Framework Implementation Plan
PITC	Provider Initiated Testing and Counseling
PLHA	People Living with HIV/AIDS
PMTCT	Prevention of Mother to Child Transmission
REPOA	Research on Poverty Alleviation

THMIS	Tanzania HIV/AIDS and Malaria Survey
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations Children's Fund
URT	United Republic of Tanzania
USA	United States of America
VMAC	Village Multi- Sectoral AIDS Committee
VCT	Voluntary Counseling and Testing
VEO	Village Executive Officer
WHO	World Health Organisation
WEO	Ward Executive Officer
WMAC	Ward Multi- Sectoral AIDS Committee
WSDH	Washington State Department of Health

ABSTRACT

The main aim of the study was to assess the determinants of men involvement in HIV/AIDS Voluntary Counseling and Testing (VCT) in Ruangwa District council. The specific objectives were: to document the status of men involvement in the HIV/AIDS VCT, investigate efforts made by the Ruangwa District Council to encourage men involvement in HIV/AIDS VCT, to find out influencing factors and limiting factors and explore ways of promoting participation of men in the VCT. The study used a cross-sectional research design and involved 78 respondents who were sampled purposively and randomly. Data were collected using questionnaires, interview, and documentary review and were analyzed by using Statistical Package for Social Sciences (SPSS) and MS Excel.

Findings on the status of the HIV/AIDS VCT show that many people had heard about it, many respondents agreed that the rate of performance of VCT was very important to them, number of VCT centres was not enough and number of men participating in the HIV/AIDS VCT was smaller than that of women. The efforts made by Ruangwa District Council to encourage men involvement in the HIV/AIDS VCT were, establishment of Council Multi-Sectoral AIDS committee (CMAC), establishment of HIV/AIDS radio programmes, establishment of secondary schools and youth HIV/AIDS clubs, encourage preventive mother to child transmission (PMTCT), factors hindering men from participating in HIV/AIDS VCT were, absence of confidentiality, fear of positive results, stigma, location of VCT room and distance to VCT centers, while facilitating factors were the health problems, religious influence and marriage purposes.

The study came up with the following policy implications so as to encourage men in HIV/AIDS voluntary counseling and testing: To meet minimum requirement for VCT, to improve the quality of VCT centres, site security and confidentiality and human resources issues prioritised for sustainability.

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CHAPTER ONE

INTRODUCTION OF THE STUDY

1.1 Introduction

This chapter presents background information, problem statement, research objectives, research questions, significance of the study and scope, research limitations and organisation of the study.

1.2 Background Information

HIV continues to spread around the world. Based on the latest UNAIDS report on the global AIDS epidemic (UNAIDS, 2012), an estimated 34 million people worldwide are living with HIV more than ever before. Sub-Saharan Africa remains the region most heavily affected by HIV. In 2011 there were an estimated 1.8 million new HIV infections in Africa; 69 percent of all people are found in Sub-Saharan **(**UNAIDS, 2012). Overall, the survey found that 5.1 percent of those tested were HIV positive. The 6.2 percent of women were HIV positive, which was significantly higher than the 3.8 percentage rate for men (URT, 2013).

In 2000, the global community took an historic step in the United Nations Millennium Declaration by acknowledging the importance of an effective response to HIV/AIDS and by placing it in the context of the broader development agenda. Among the many health targets that were then established in the Millennium Development Goals (MDGs), MDG 6 calls for unprecedented action to halt and begin to reverse the AIDS epidemic. As the United Nations Member States implicitly recognised when they endorsed the Millennium Declaration, the persistent burden associated with communicable diseases undermines efforts to reduce poverty, prevent hunger and preserve human potential in the world's most resource-limited settings. We are now less than two years from the deadline for the MDGs. Over the years, the gloom and disappointments chronicled in the early editions of the UNAIDS Global report on the AIDS epidemic have given way to more promising

tidings, including historic declines in AIDS-related deaths and new HIV infections and the mobilisation of unprecedented financing for HIV-related activities in low- and middle-income countries. Yet, AIDS remains an unfinished MDG, underscoring the need for continued and strengthened international solidarity and determination to address this most serious of contemporary health challenges (UNAIDS, 2013) Generally, the most hit population in the world is that of age ranging from 15 to 49 years. The urban areas appear to be most affected than the rural areas. Among the more risky groups are women and divorced men (Ndile and Bashemera, 2007).

Tanzania HIV/AIDS policy of 2001 has been declared HIV/AIDS as a National crisis and is now one of the top priority development agenda in the Government, The policy aim is to reassure and encourage the 85 - 90% of the population who are HIV negative to take definitive steps not to be infected. Those who are HIV positive to receive the necessary support in counseling and care to cope with their status (URT, 2001), but generally the policy just mention a little beet about HIV Testing and counseling without going deeper on it (URT, 2001).

In Mainland Tanzania, HIV prevalence is markedly higher than in Zanzibar (5 percent versus 1 percent). Differentials by region are large. Among regions on the Mainland, Njombe has the highest prevalence estimate (15 percent), followed by Iringa and Mbeya (9 percent each). Manyara and Tanga have the lowest prevalence (2 percent). HIV prevalence is higher among women than men in nearly all regions of Tanzania. Despite the ability to recite the HIV testing messages broadcasted in their communities, the rate of men in Testing HIV/AIDS is very low compare to women (Kelley *et al.*, 2011).

The latest Tanzania HIV and Malaria indicator Survey (THMIS) 2011 to 2012 interviewed 10,967 female and 8,352 male age group between 15-49 shows that there are 1.4 million to 1.6 million people living with HIV in the country. Overall, the survey found that 5.1% of those tested were HIV positive. The 6.2% of women were HIV positive, which was significantly higher than the 3.8 percentage rate for men (URT, 2013).

AIDS has resulted in an estimated 1.3 million orphaned children. During the last two decades the HIV/AIDS epidemic has spread relentlessly affecting people in all walks of life and decimating the most productive segments of the population particularly Women and Men between the ages 20-49 years (URT, 2001).

HIV/AIDS in Ruangwa continues to be a problem like other district councils, in the process of fighting against HIV/AIDS Women in Ruangwa are still in front line compare to men. Most of the men in Ruangwa DC delay in HIV/AIDS Voluntary counseling and testing. Likewise, Statistics in Ruangwa district HIV/AIDS Report shows that in the year 2014 number of women tested for HIV/AIDS were 6544 while men were 6252 (Ruangwa HIV/AIDS Report, 2013), Why? It is from this point the researcher was interested to assess the determinants of men involvement in HIV/AIDS counseling and testing in Tanzania. The research come out with reasons and other relevant information on why men are not involved much in HIV/AIDS counseling and testing compared to women. The findings were useful to relevant authorities and practitioners in taking the right measures to get me involved in HIV testing and counseling.

1.3 Problem Statement

Tanzania HIV/AIDS and malaria indicator survey of 2007/08 show that 62 per cent of women in Tanzania Mainland and Zanzibar have undergone voluntary blood testing compared to 47 per cent of men. The survey tested 9,756 women and 7,989 men in the 15 to 49 age group, the survey still state that women are the ones who volunteering in Blood testing compare to men (URT, 2009). HIV and Malaria indicator Survey (THMIS) 2011 to 2012 interviewed 10,967 female and 8,352 male age group between 15- 49 shows that there are 1.4 million to 1.6 million people living with HIV in the country. Overall, the survey found that 5.1% of those tested were HIV positive. The 6.2% of women were HIV positive, which was significantly higher than the 3.8 percentage rate for men (URT, 2013). The problem of low involvement of men in HIV/AIDS Voluntary Counseling and Testing is seen in Ruangwa District Council. Statistics show that while 6544 of women have undergone HIV/AIDS counseling and testing only 6252 of men tested (URT, 2014).

This study intends to investigate the determinants of men involvement in HIV/AIDS voluntary Counseling and Testing in Ruangwa District council, Tanzania.

1.4 Objectives of the Study

1.4.1 Main Objective

The main objective of this study was to investigate determinants of men involvement in HIV/AIDS Counseling and Testing in Ruangwa District Council, in Tanzania.

1.4.2 Specific Objectives

This study was guided by the following specific objectives:-

i. To document the status of men involvement in HIV/AIDS Voluntary Counseling and Testing in Ruangwa District Council
ii. To investigate efforts made by the district council to encourage men involvement in HIV/AIDS counseling and testing
iii. To find out factors affecting HIV/AIDS Counseling and Testing among men in Ruangwa District Council
iv. To explore ways of promoting HIV/AIDS Counseling and testing among men in Ruangwa District council

1.5 Research Questions

1.5.1 Main Research Question

The main research question of this study was "What are the determinants of men's involvement in HIV/AIDS Voluntary Counseling and Testing?"

1.5.2 Specific Research Questions

This study was guided by the following specific research questions:-

(i) What is the current status of men's involvement in HIV/AIDS counseling and testing in Ruangwa District council?

(ii) What are the efforts made by District Council to encourage men's involvement in HIV/AIDS counseling and testing?

(iii) What are the factors affecting HIV/AIDS counseling and testing among men in Ruangwa District Council?

(iv) What are the ways of promoting men's involvement in counseling and Testing in Ruangwa District Council?

1.6. Significance of the Study

Utilization of the VCTs services by men has been reported to be low in Tanzania as elsewhere in African societies. Since behavioural change is one way of combating HIV/AIDS, then men need to be motivated to participate in the process by having reliable source of knowledge about HIV/AIDS. Due to the fact that efforts to influence them to regularly attend VCTs services have not been productive, the findings from this study give an opportunity to learn more on what are the barriers from men using the services. The gain insights from the findings that may help in identify the necessary changes in making VCTs attractive, more appropriate and acceptable for men. The changes to be made should be geared to explore various ways that would promote the increase use of VCTs among men. Aiming at raising their awareness on the susceptibility of being HIV infected severity of AIDS, efficacy of counseling centers, self- efficacy, and protective motivation as means towards protective sexual behavior. As an end result young people who are vulnerable to HIV/AIDS, their life quality will be improved or prolonged.

1.7 The Scope of the Study

This study was conducted in Ruangwa District of Lindi Region particularly at Ruangwa and Mandawa wards. The study was focused on researching the determinants of Men involvement in HIV/AIDS counseling and testing in Ruangwa District council with specific focus in two villages where by the researcher document the status of HIV/AIDS testing and counseling. The study was conducted in Ruangwa DC since it was not possible to conduct the study in the whole country due to time factor. In villages where a research was done each respondent was given

questionnaires written in English was translated in Kiswahili to enable respondents to answer the questions in a language they use for daily communication also interview was used to get In-depth explanations.

1.8 Study Limitations

In the long process of accomplishing this study some limitations have aroused. First, some of the interviewees were reluctant to express themselves whether have been tested or not. Time frame and financial difficulties also affected a researcher during data collection. This was due to the fact that the researcher is sponsoring himself, thus was depending on his own source of income; hence it was difficult to meet all expenses while conducting the research. To solve this problem first, the researcher tried as much as possible to lobby the respondents to be confident with him to provide information. Second, the researcher tried to conduct the study as cheap as possible to curb financial constrain.

1.9 Organisation of the Study

This work is organised into five chapters. Chapter one provides the introduction of the study, it provides background of information and explains the research problem. The objectives of the study and the guiding questions that were designed on the basis of the questionnaires and interviews are also illustrated. The chapter familiarises the topic of determinants of men involvement in HIV/AIDS voluntary counseling and testing in Ruangwa DC.

Chapter two presents literatures review related to the study. The chapter discusses the definitions of the key terms, importance of studying HIV/AIDS counseling and testing, HIV/AIDS in the global context, symptoms of HIV/AIDS, HIV/AIDS policy and prevalence and the current situation of HIV/AIDS voluntary counseling and testing in Tanzania, efforts made by the government; factors affecting men in HIV/AIDS counseling and testing, influencing and limiting factors in HIV/AIDS voluntary counseling and testing and the different views by some researchers about HIV/AIDS voluntary counseling and testing whether there is any progress in HIV/AIDS campaign.

Chapter three presents methodology of the study. It includes research design, the study area, target population, sampling frame, sampling unit, sample size, sampling procedures and technique, data sources, data analysis and ethical issues.

Chapter four presents findings and discussion. It specifically presents demographic characteristics of the respondents, status of HIV/AIDS Voluntary Counselling and Testing, efforts made by District council to encourage men in HIV/AIDS Counseling and Testing, factors affecting men involvement in HIV/AIDS Counseling and Testing, hence ways of promoting men's involvement in HIV/AIDS Counseling and Testing.

Chapter five presents a summary, conclusions and policy implications of the study. The conclusions summarize major features that were established during the research in relation to the objectives and research questions of the study. The recommendations are constructed from the findings and provide potential policy implications for the stakeholders aimed at encouraging men's involvement in HIV/AIDS Counseling and Testing.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter presents a relevant literature review. It includes definition of the key terms, importance of studying HIV/AIDS counseling and testing, HIV/AIDS in the globally context, Symptoms of HIV/AIDS, HIV/AIDS Policy in Tanzania, Prevalence of HIV/AIDS in Tanzania, the current situation on HIV/AIDS counseling and testing in Tanzania, efforts made by Tanzania in HIV/AIDS counseling and testing, factors affecting HIV/AIDS Counseling and Testing, HIV prevalence in Ruangwa District council, theories on HIV/AIDS voluntary Counseling and Testing, empirical review of other studies and conceptual framework.

2.2 Definition of Key Terms

Key terms used in this study and that need elaboration include, determinant, HIV, AIDS, HIV/AIDS counseling, HIV/AIDS testing, involvement, and men.

(i) Determinants

This is defined as an element that identifies or determines the nature of something or that conditions an outcome or defined as a factor which decisively affects the nature or outcome of something (www.merriam-webster.com/dictionary/determinant)

(ii) HIV

Defined as virus that attacks human immune system, once the virus gets inside the body, human being may not feel or look sick for years but he/she can still infect others, overtime immune system may grow weak and you can become sick with different illnesses (Canadian Strategy on HIV/AIDS, 2001).

(iii)AIDS

Defined as Acquired Immunodeficiency Syndrome (AIDS) Acquired means “transmitted from person to person” immune is the body’s system of defense, deficiency means a ”lack of” or not working to the appropriate degree; and a

syndrome is a group of signs and symptoms. AIDS is the advanced stage of HIV infection (UNAIDS, 2000).

(iv) HIV/AIDS Counseling

HIV/AIDS counseling has been defined as a dialogue between a client and a counselor. The objective of this dialogue is to enable a person to make informed and personal decisions about testing, and to learn how to cope with the stress brought about by the test results. Counseling has traditionally been offered on two occasions during HIV testing; before the test (pre-test counseling) and after the test (post-test counseling). Pre-test counseling has been described as a prerequisite for obtaining consent, and according to UNAIDS, it is necessary for preparing the client psychologically for the HIV test and its results. At this stage, the counselor discusses with the client ways to cope with knowing ones HIV status (UNAIDS, 2013).

(v) HIV/AIDS Testing

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

(vi) Involvement

This is a process of encouraged people to be involved in a certain activity for example in antenatal and maternal health care, in the belief that involving men as early as possible lays the foundation for better, more involved fatherhood. Integrating men into maternity care can, however, have hitherto unexplored ethical complexities (UNAIDS, 2013).

(vii) Men

This is an adult male person, as distinguished from a boy or a woman, in HIV/AIDS Testing and counseling, the percentage of men participating in HIV prevention, care and support efforts has typically been lower than that of women. For example, men

test for HIV and access ARV treatment in significantly smaller numbers than do women (UNAIDS, 2012).

2.3 Importance of HIV/AIDS Voluntary Counseling and Testing

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

HIV/AIDS counseling and testing prevents contamination from HIV-infected mothers to their children not yet tested or tested negative. From a mother who is infected to her baby; this can occur during pregnancy, at birth and through breastfeeding. Counseling and testing is very important if we want to reduce infections from infected mother to their children.

Under HIV/AIDS counseling and testing early treatment and use of adequate services such as family Planning is very important because it include counseling on choice assistance to individual, couple or family and better for future planning. People tested HIV Positive can access medical assistance, including ARV therapy and psychological support. Counseling is very important because it help people to live in good conditions (nutrition). Good nutritional status is very important from the time a person is infected with HIV. Nutrition education at this early stage gives the person a chance to build up healthy eating habits and to take action to improve food security in the home, particularly as regards the cultivation, storage and cooking of food (WHO and FAO, 2002).

Sexual infections are transmitted during unprotected sexual intercourse (heterosexual and homosexual anal, vaginal or oral). Some of the infectious agents, such as HIV, hepatitis B and syphilis, can also be passed on from an infected mother to her unborn or newborn baby and can be transmitted via blood transfusions. Hepatitis B and HIV infections may also be transmitted through contaminated blood products, syringes

and needles used for injection. Counseling and testing help to prevent sexually transmitted diseases because a client may get an advice the way to protect/ prevent himself/herself from STD's (UNAIDS, 2000).

2.4 HIV/AIDS in Global Context

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

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

HIV/AIDS in South America: It was estimated that among 18 reporting countries in the Latin American region, there were approximately 1.4 million people living with HIV and AIDS at the end of 2011. An estimated 83, 000 were newly infected during 2011 and an estimated 60,000 people died. Adult HIV prevalence was 0.8% or less in all Latin American countries as of 2011. In most countries HIV is not generalised but is highly concentrated in populations at particular risk. Overall, the average adult HIV prevalence across central and South America is estimated at 0.4. Unsafe sex among men, who have sex with men, is common across the whole region. In 2011, the HIV prevalence range was between 7% (Nicaragua and Honduras) and 23% (Panama) among men who have sex with men in central and South American countries. It is estimated that in 2011, across low and middle income countries in Latin America, an average of 68% of people requiring antiretroviral treatment are receiving (UNAIDS, 2013).

HIV/AIDS in Asia: Today, almost 5 million people are living with HIV in South, East and South-East Asia. Although national HIV prevalence in most Asian countries is relatively low, the population of some countries is so vast that these low percentages actually represent very large numbers of people living with HIV. In India for example, the most recent statistics show that an estimated 0.1 percent of adults aged 15-49 are living with HIV, which seems low when compared to HIV prevalence in some parts of sub-Saharan Africa. However, with a population of around 1 billion, this actually equates to 2.3 million adults living with HIV in India. Nonetheless, the situation is improving; the number of new infections in Asia went down from 450,000 in 2001 to 369,000 in 2011. Although it is useful to understand the overall impact that AIDS is having on the Asian region as a whole, there is no single 'Asian epidemic'; each country in the region faces a different situation. Progress has been made in countries such as Cambodia, Myanmar and Thailand, where there has been a 25 percent decline in HIV prevalence between 2001 and 2011. On the other hand, in Bangladesh, Indonesia, and the Philippines the number of people living with HIV has increased by more than 25 percent between 2001 and 2011. There are also huge variations within countries. In China, for example, the six provinces with the highest HIV prevalence account for 75.5 percent of the people living with HIV (UNAIDS, 2012).

Sub-Saharan Africa: Sub-Saharan Africa remains the most affected region by this pandemic and it harbours over two-thirds of those living with the virus (22.5 million). This region recorded 1.3 million deaths in 2009, accounting for almost three-quarters of all HIV related deaths globally. In the same year, 1.9 million new infections occurred in the region, a figure that is more than half the number of new infections worldwide. However, HIV incidence has been reported to be declining or stabilizing in 22 countries in sub-Saharan Africa. This decline has particularly been associated with reductions in risk behavior (Njeru, 2011).

2.5 Symptoms of HIV/AIDS

The majority of people infected by HIV develop a flu-like illness within a month or two after the virus enters the body. This illness, known as primary or acute HIV

infection, may last for a few weeks. Possible signs and symptoms include: Fever, headache, muscle aches, rash, chills, sore, throat, mouth or genital ulcers, and swollen lymph glands, mainly on the neck, joint pain, night sweats, and diarrhea. Following initial infection, you may have no symptoms. The progression of disease varies widely among individuals. This state may last from a few months to more than 10 years. During this period, the virus continues to multiply actively and infects and kills the cells of the immune system. The immune system allows us to fight against the bacteria, viruses, and other infectious causes. The virus destroys the cells that are the primary infection fighters. Once the immune system weakens, a person infected with HIV can develop the following symptoms: Lack of energy, weight loss, frequent fevers and sweats, persistent or frequent yeast infections, persistent skin rashes or flaky skin, Short-term memory loss, genital, or anal sores from herpes infections (UNAIDS, 2000).

2.6 HIV/AIDS Policy in Tanzania

Tanzania HIV/AIDS policy states that HIV/AIDS is a major development crisis that affects all sectors. During the last two decades the HIV/AIDS epidemic has spread relentlessly affecting people in all walks of life particularly women and men between the ages of 20 and 49 years. The increasing number of AIDS related absenteeism from workplaces and deaths reflects the early manifestation of the epidemic leaving behind suffering and grief. Others include lowering of life expectancy, increasing the dependency ratio, reducing growth in GDP, reduction in productivity, increasing poverty, raising infant and child mortality as well as the growing numbers of orphans (URT, 2001).

It has been well established that poverty influences the spread and impact of HIV/AIDS. In many ways it creates vulnerability to HIV infection, causes rapid progression of the infection in the individual due to malnutrition and limits access to social and health care services. The human capital loss has serious social and economic development in all sectors and at all levels. Ultimately the high cost of care and burials leave heavy burden on the already overburdened households, orphans and dependants, People Living with HIV/AIDS (PLHAs) and vulnerability to HIV

infection. Therefore the ‘poverty factor’ at the household level has to be addressed simultaneously with the National efforts to combat the HIV/AIDS epidemic (URT, 2001).

The Government has the responsibility to provide management and financial leadership in the National response to the HIV/AIDS epidemic. Experience has shown that Strong political and government are necessary in spearheading the fight against the epidemic. It is expected the prevailing strong political and government commitment shall be sustained at all levels. It is important that political and Government accountability in the fight against the epidemic is strengthened at all levels. Also, the policy aim on promoting early diagnosis of HIV infection through voluntary testing with pre-and-post test counseling. The main aim is to reassure and encourage the 85 - 90% of the population who are HIV negative to take definitive steps not to be infected, and those who are HIV positive to receive the necessary support in counseling and care to cope with their status, prolong their lives and not to infect others (URT, 2001). One of the principles which guide National policy on HIV/AIDS state that Pre-and-post test counseling for HIV testing shall observe professional ethics, with emphasis on confidentiality and informed consent.

The overall goal of the National Policy on HIV/AIDS is to provide for a framework for leadership and coordination of the National multi sectoral response to the HIV/AIDS epidemic. This includes formulation, by all sectors, of appropriate interventions which will be effective in preventing transmission of HIV/AIDS and other sexually transmitted infections, protecting and supporting vulnerable groups, mitigating the social and economic impact of HIV/AIDS (URT, 2001).

Many studies about HIV/AIDS have been done (URT, 2010; UNAIDS, 2012; URT, 2013). Also, others study about prevention and treatment of HIV/AIDS in Tanzania, (Garbus, 2004; URT, 2008). Others have tried to research about the impact of HIV/AIDS in Tanzania (REPOA, 2010; Garbus, 2004; Timbagebage *et al.*, 2004; Bollinger *et al.*, 1999).

2.7 Prevalence of HIV/AIDS in Tanzania

The first AIDS cases in Tanzania were reported in 1983. By 1987, all regions of the country had reported AIDS cases. HIV/AIDS is a major Development crisis that affects all sectors in Tanzania. During the last two decades the HIV/AIDS epidemic has spread relentlessly affecting people in all walks of life and decimating the most productive segments of the population particularly Women and Men between the ages 20-49 years (URT, 2001). One reason for high prevalence rates is that most people are unaware of their HIV status, which poses a major challenge in preventing HIV transmission and providing effective care to infected persons. The Tanzania HIV/AIDS Indicator Survey (2003-04) estimated that 7% of adults aged 15-49 years are infected with HIV. In the year 2002, the National AIDS Control Programme (NACP) estimated that 2.2 million people were living with HIV/AIDS, Heterosexual sex accounts for the majority of infections (80 percent) on Tanzania mainland. On the semi autonomous island of Zanzibar the HIV prevalence is far lower among the general population (0.6 percent) and the epidemic is more concentrated, primarily affecting female sex workers, men who have sex with men and injecting drug users, although this number has recently fallen slightly, the epidemic's severity differs widely from region to region (URT, 2007).

Women in Tanzania are particularly affected by HIV and AIDS. In 2011, women comprised nearly 60 percent of people living with HIV. Among the 15-24 age groups, prevalence is 2 percent among young women and 4 percent among young men. Women tend to become infected earlier, which is partly due to the tendency of women to have older partners or get married earlier. Another reason for the higher prevalence is the difficulty women experience negotiating safer sex because of gender inequality. One example of women's dependency is the widespread culture of 'sugar daddies': women were often accept the sexual advances of older men, or 'sugar daddies' for a variety of reasons including money, affection and social advancement. There are 230,000 children living with HIV and 1.3 million children orphaned by AIDS in Tanzania. Grandmothers and other relatives often provide invaluable support to orphans, but they are still more vulnerable to poverty, sexual abuse and poor nutrition than children who live with both their parents. They also

receive little support from the Tanzanian government: less than 1 in ten receive some type of support (usually school related assistance) while less than 5 percent receive medical or social support (Averting HIV and AIDS, 2012).

Tanzania's Five-Year National Care and Treatment Plan for 2003-2008 was developed and approved in October 2003. The plan advocates for care, treatment and support services to improve the quality of life for people living with HIV and AIDS (PLHA), in order to achieve this goal, access to HIV counseling and testing services must be expanded as a clinical and core intervention in the comprehensive national response to the epidemic. This includes scaling up both client-initiated voluntary counseling and testing (VCT), Mother-to-Child Transmission (MTCT) and provider-initiated HIV testing and counseling (PITC) services especially to Men youth who don't want to volunteer in HIV testing (URT, 2007). In Tanzania HIV prevalence has dropped slightly in the country from 5.7 per cent in 2008/2009 to 5.1 per cent in 2011/12, a new report shows (URT, 2013).

In spite of HIV prevalence has fallen in Tanzania over the past decade, tens of thousands of people become infected with HIV every year. Human resource shortage is among of the obstacle to ensuring a sustained reduction of new HIV infections and to providing care and treatment to those already infected. Although Tanzania has long been a popular country with foreign donors, in a strained financial climate, the current levels of funding are by no means guaranteed. Signs have already appeared that the capping of PEPFAR funds is affecting the provision of drugs for HIV positive people in Tanzania. Increased funding for HIV and AIDS from the Tanzanian government and commitment to prevention efforts will be necessary if Tanzania is to overcome the debilitating effects the HIV and AIDS epidemic continues to have on its economy and society (Averting HIV and AIDS, 2012).

2.8 The Current Situation of HIVAIDS Voluntary Counseling and Testing in Tanzania

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 (Mwakatobe, 2007).

Barriers to voluntary counseling and testing in adults appear to be largely similar across Tanzania. Despite evidence that VCT is efficacious in promoting behaviour change, particularly in high HIV prevalence settings, fewer than one in ten people in Tanzania know their HIV status. Regardless of country however, willingness to seek VCT allows early commencement of treatment and the protection of transmitting the virus to others which are essential to the fight against HIV (Matovu *et al.*, 2007).

Further, 62 per cent of women in Tanzania Mainland and Zanzibar have undergone voluntary blood testing compared to 47 per cent of men. Despite the ability of women youth to get tested but Men volunteering to be tested is problematic, The third Tanzania HIV and Malaria Indicator Survey 2011 – 2012 (THMIS III) HIV prevalence data were obtained from blood samples voluntarily provided by a total of 20,811 women and men interviewed. Of the eligible women and men age 15-49, 90% of women and 79% of men provided specimens for HIV testing (THMIS, 2011-2012). In HIV Testing always women are many than men in HIV Testing behavior, so due to this situation it is very difficult to achieve the Goal in time (Kelley *et al.*, 2011).

VCT serves as an entry point to prevention, care, treatment and support, programmes and enables people to confidently understand their HIV status and learn about supportive behaviours for protecting and preventing further spread of HIV. The main model through which individuals learn about their HIV status has been client initiated Voluntary Counseling and Testing (VCT). HIV testing and counseling has increased tremendously; currently, 62% of women and 47% of men age 15-49 have ever been tested for HIV and received their results, compared with just 37% of

women and 27% of men in 2007-08. (THMIS 2007-2008). Male participation is a crucial component in the optimization of Maternal and Child Health (MCH) services. This is especially so where prevention strategies to decrease Mother-to-Child Transmission (MTCT) of HIV are sought. This study aims to identify determinants of male partners involvement in HIV counseling and testing, focusing specifically on HIV prevention of maternal to child transmission (PMTCT), and Voluntary Counseling and Testing (VCT) in Ruangwa DC so as to achieve the National HIV Prevention Strategy's vision, consistent with that of the NMSF: a Tanzania with no new HIV infections (URT, 2008).

2.9 Efforts Made by Tanzania in Promoting HIV/AIDS Counseling and Testing

The Government has the responsibility to provide management and financial leadership in the National response to the HIV/AIDS epidemic. The government has allocated US$ 8 million for HIV/AIDS activities for the fiscal year 2001/2002 and all sectors and councils are implementing HIV/AIDS interventions. However, given the overwhelming high cost involved, it is beyond the capacity of the Government to provide adequate funds for the National response programme. Therefore, development partners and the private sector also share the responsibility and moral obligation to complement the Government efforts. Also, the government aim is to promote early diagnosis of HIV infection through voluntary testing with pre-and-post test counseling. The main aim is to reassure and encourage the 85 - 90% of the population who are HIV negative to take definitive steps not to be infected, and those who are HIV positive to receive the necessary support in counseling and care to cope with their status, prolong their lives and not to infect others (URT, 2001).

The Political Declaration on HIV and AIDS of June 2006 was adopted by Heads of States and representatives of Governments based on a comprehensive review of the progress achieved in realizing the targets set out in 2001. This declaration also established a number of goals to be achieved through implementation of country-driven specific, quantifiable and time bound targets towards universal access to comprehensive prevention, treatment, care and support programmes. The high level meeting during the 65th Session of the United nations General Assembly resolution

held in June 2011 to review progress made in the HIV and AIDS response, Tanzania was represented and adopted the Resolution 65/277. During the period 2003/42 to 2011/123, the HIV prevalence in Tanzania has declined from 7.0% to 5.3% among adults aged 15-49. Statistically significant decline was observed among men in the same age group from 6.3% to 3.9% but not among women. Data from four rounds of antenatal surveillance, two national population surveys and projections indicate that HIV incidence in the age group 15-49 peaked at 1.48% in 1991, declined to 0.6% in 2004 and stabilised at 0.59% up to 2011. This decline in HIV incidence partly explains the observed decline in HIV prevalence; this is because of Government efforts (URT, 2014).

The NMSF takes in consideration the number of National and International legal declaration documents. National Policy on HIV and AIDS 2001, the policy reiterated the Government of Tanzania's (GOT's) commitment to HIV and AIDS as a priority area and called for strong political commitment and leadership from all levels of government and civil society to ensure sustained and effective interventions. The National Policy set the context for the 2003–2007 National Multi-sectoral Strategic Framework (NMSF) and the passing of legislation in 2001, the Tanzania Commission for AIDS (TACAIDS) were constituted in the Prime Minister's Office (PMO) to coordinate and operationalise the multi-sector response. The new NMSF for 2008 – 2012 builds on that policy document and the last NMSF.

Also, MKUKUTA recognised the effect and influence of HIV and AIDS on poverty; it did not incorporate the last NMSF into all its activities5. Issues on impact assessment and the effects of HIV and AIDS on the macroeconomic situation as well as on households and families need to be factored into the next review of MKUKUTA. HIV can be both a consumption factor (consuming services) as well as an investment activity (greater donor support, enhancing human capacity, creating employment and delivering services). At a local level, HIV activities need to be mainstreamed into the economic and development projects at the district, village and community level with transparency and involvement of CSOs. HIV programmes should also be linked to governance and accountability with enhanced and sustained commitment by political leaders and opinion makers. The Poverty Monitoring

system of MKUKUTA should also develop linkages with the Tanzania Output Monitoring System for HIV and AIDS (TOMSHA) and enhance the overall monitoring and evaluation process in both frameworks.

Overall 40% of the budget of the GOT is through donor assistance. Of particular significance, is that 80% of the HIV budget is from donor sources with the majority of funds from three donors (the United States government (USG), the Global Fund to fight AIDS, TB and Malaria (GFATM) and the World Bank (WB). The HIV and AIDS response lends itself to being a thematic area. The formation of Development Partners Group on HIV and AIDS (DPGAIDS) give credence to such a theme. The support to non-state actors were also needs review to ensure their continued funding, support and sustainability. On the other hand, greater equity and coverage across Tanzania was enhanced as donor assistance was following a demand driven approach with local communities at the centre of the response. The JAST also makes provision for technical assistance and this should be utilised to the fullest by all structures in the HIV response to strengthen capacity and implementation and reduce bureaucratic obstacles (URT, 2007).

Government of Tanzania is signatory to a range of international agreements, declarations, treaties and conventions which deal with HIV e.g., Beijing Platform of Action, United Nations General Assembly Special Session on HIV and AIDS (UNGASS), New partnership for Africa's Development (NEPAD), Southern African Development Community (SADC), MDGs, Great Lake Initiative on HIV and AIDS (GLIA), East African Community (EAC) and Africa Region AIDS Care Capacity Network (ARCAN). MDGs and UNGASS goals and indicators have been incorporated into the new NMSF. These commitments and ratification protocols need to be costed, adequately resourced (human and technical) and managed by sector specific Ministries Departments and Agencies (MDAs) with support from TACAIDS where necessary (URT, 2007).

Despite the decline, the HIV epidemic in Tanzania remain heterogeneous with geographical and population variability. The HIV prevalence ranges from 1.5% in Manyara to a high of 14.8% in Njombe. While HIV prevalence is generally at

decrease, 8 regions namely Ruvuma, Kagera, Kigoma, Rukwa, Mtwara, Kilimanjaro, Singida and Arusha have recorded an increase (URT, 2014).

2.10 Factors Affecting HIV/AIDS Voluntary Counseling and Testing

There are two types of factors affecting HIV/AIDS Voluntary Counseling and Testing which include facilitating factors and limiting factors.

2.10.1 Factors that Encourage People in HIV/AIDS Voluntary Counseling and Testing

People go for HIV/AIDS Counseling and Testing because they want to know their HIV/AIDS status. Eager to know whether they are positive or negative is among factors that encourage people to go for test; people might want to know their status after having a relationship with an unfaithful partner. Health problem; suffer from unknown disease and decide to go for VCT to find out whether they are infected with HIV or not. When one experiences health problems in which he/she will go to find out about their status (Mwanga, 2012).

Voluntary Counseling and Testing of the HIV/AIDS is also encouraged by religious leaders. Religious leaders encourage couples to go for HIV counseling and testing before they got married. Thus, 'marriage' is one of the factors that influenced people to go for VCT. Some people may decide to go for VCT before or shortly after their marriage, especially in the case of women (Kadowa and Nuwaha, 2009).

Participating in HIV/AIDS Counseling and Testing is also motivated by married purposes. Going for HIV testing for marriage purposes and because of pregnancy was reiterated by all groups as advantageous because when people got tested, it was a sign of care for the future. These mitigate the rampant spreading of HIV and help people plan for the future (Mwanga, 2012).

Peer education and support from NGO's and government institution; was reiterated by all groups and seems to be famous in Tanzania is the quotation from the President of the United Republic of Tanzania, Honorable, Dr. Jakaya Kikwete: (Tanzania without HIV/AIDS is possible), the president's words is a great factor which

influences people towards attaining VCT, support from NGO's and government; Some government and non-government organisations which give assistance to people suffering from HIV/AIDS have also been taken as sources that influence other people to go for VCT. African Medical and Research Foundation (AMREF), Tanzania Commission for AIDS (TACAIDS) and UNICEF are some of organisations which give assistance to HIV positive people. The assistance could be in the form of food, medication or payment of school fees for dependent children (Meda, 2013).

2.10.2 Factors that Limit People in HIV/AIDS Voluntary Counseling and Testing

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

Although there are important benefits to knowing one's HIV status, HIV infection in many communities, is a stigmatising condition and this can lead to negative outcomes for people following testing. Stigma may actively prevent people accessing care, gaining support, and preventing onward transmission. Many people are afraid to seek HIV service because they fear stigma and discrimination from their families and communities (UNAIDS, 2000)**.**

Few studies conducted in Africa revealed that other factors like lack of awareness about the mode of transmission of the disease (HIV/AIDS), lack of perceived benefit for having the HIV test, limitation related with the physical access to the service

(Distance to VCT centre) etc. are some of the factors that can contribute for the low utilisation of the already available services (Dejene, 2001).

Accessibility, affordability, reliability and dependability are factors which were influencing or discourage people to go for VCT. Accessibility of VCT centers. Nearness of VCT centers makes it easier for people to uptake the services at their convenience. If a VCT centre is located near the village; people they would not want people who know them to see them visiting the facility. VCT centers must be scattered all over the country so that they could have a wider choice.

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

2.11 HIV Prevalence in Ruangwa District Council

HIV prevalence in Ruangwa DC from different data sources; in 2013, Ruangwa DC estimated that prevalence of HIV among adults was 14.4 percent, with a range from 12 to 17 percent. This range of HIV infection has remained constant for the last three years. Estimates for the rural population and urban areas were 12.4 and 23.0 percent, respectively (URT, 2013).

HIV infection is not spread uniformly across the District; there are clear wards differences in HIV prevalence. The District is divided into three Divisions: Mnacho, Ruangwa, and Mandawa.. Until 2013 Mnacho Division had always shown lower prevalence rates than the other Divisions. Rural rates have always been lower than urban rates. In Ruangwa HIV prevalence is markedly higher than the Region average (2.9 percent). The HIV prevalence in Ruangwa is about 3.2, almost twice. Generally, Mandawa and Ruangwa wards had more HIV Prevalence (3.3 percent).The prevalence is high because of migration of people from different regions who engage in Mining activities around the wards and presence of sex workers around mining

areas. Likewise, statistics in Ruangwa district shows that number of women tested for HIV in 2013 were 6544 while men were 6252 (URT, 2013).

Ruangwa district is not spared. Statistics for Ruangwa District indicate that there has been a rapid increase in HIV/AIDS prevalence among blood donors from 0 in 1992 to 1418 in 2013. The age groups 25-34 and 35+ have shown consistently high prevalence rate compared to age group 15-24. Overall, 2.0% of young women and men age 15-24 are HIV-positive. HIV prevalence among young women in Ruangwa is higher than among young men, particularly for youth age 23-24 where women are more than twice as likely to be infected as men (6.6% versus 2.8%) (URT, 2013).

There are many efforts being made to reduce the HIV prevalence rate through education and through offering free counselling and testing for HIV at healthcare providing institutes (Provider Initiated Testing and Counselling - PITC) or at (Voluntary Testing and Counselling - VCT). The success of these initiatives is shown by the increase in the number of women and men who have ever been tested for HIV and received their results. In 2012-2013, 62% of women and 47% of men said they had been tested and received their results compared with just 37% of women and 27% of men in 2008-2009 (URT, 2013).

Whilst improvements have been made to the number of people tested, there are still a large percentage of people who have not been tested. Also, it is important that people are tested repeatedly, as a negative result from a single HIV test does not guarantee the client is free of the virus (due to the sensitivity of the test method) thus clients must repeat testing after 3 months.

2.12 Theories on HIV/AIDS Voluntary Counseling and Testing

2.12.1 Theory of Change

Theory of change is the articulation of the underlying beliefs and assumptions that guide a service delivery strategy and are believed to be critical for producing change and improvement. Theories of change represent beliefs about what is needed by the target population and what strategies will enable them to meet those needs. They

establish a context for considering the connection between a system's mission, strategies and actual outcomes, while creating links between who is being served, the strategies or activities that are being implemented, and the desired outcomes (Vogel *et al.*, 2012).

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

There are many change theories and some of the most widely recognized are briefly summarized in this study. The theories serve as a testimony to the fact that change is a real phenomenon. It can be observed and analysed through various steps or phases. The theories have been conceptualised to answer the question, How does successful change happen? (Kritsonis, 2004).

Change theory has the following stages: (1) Pre-contemplation, is a stage where by an individual is unaware of problem; no intention to change behaviour in foreseeable. (2) Contemplation is the stage where by Individual is aware of problem; Serious consideration of change in behaviour. (3) Preparation, in this stage an Individual is intending to take action (self-liberation) choosing and commitment to act or belief in ability to change (Morris *et al.*, 2012).

Strengths and Weaknesses of change theory: The strength of change model is that it is simple and easy to understand. This model concentrates on the fear of employees who oppose the change to happen. This is the main factor, which should be worked out by every organisation to bring out (Robbins, 2003).

2.12.2 Behavioural Theories

(i) Behavioural Change Theory

Behavior change is often a goal for staff working directly with constituents, organisations, governments, or communities. Models of individual behavioural

change generally focus on stages that individuals pass through while trying to change behaviour. (Glanz *et al.*, 1990). These theories and models generally do not consider the interaction of social, cultural and environmental issues as independent of individual factors. 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 (Kalichman *et al.*, 1997).

As HIV transmission is propelled by behavioural factors, theories about how individuals change their behavior have provided the foundation for most HIV prevention efforts worldwide. These skills are generally passed on to individuals in a process consisting of instruction, modeling, practice and feedback (Kalichman *et al.*, 1997).

(ii) Cognitive Theory

Cognitive theory is part of behavior change theory, Individuals can learn by direct experiences, human dialogue and interaction, and observation. Social learning theory, later renamed social cognitive theory, proposes that behavior change is affected by environmental influences, personal factors, and attributes of the behaviour itself. In other words, behavior is a result of consequences. Individuals react to how they perceive consequences of their behavior. Self efficacy is believed to be the most important characteristic that determines a person's behavioral change because these expected outcomes are filtered through a person's expectations or perceptions of being able to perform the behavior in the first place. Self efficacy can be increased in several ways. Three methods to increase self-efficacy include: provide clear instructions, provide the opportunity for skill development or training, and model the desired behavior (Robbins, 2003).

Strengths of Cognitive Theory: Research has provided a lot of knowledge about how people think and perceive and has consequently provided a lot of support for cognitive theory. Second, perhaps because of these positive findings, cognitive theory has gained in popularity both in the professional and pop psychology arenas**.**

Weaknesses of Cognitive Theory: Like all theories, the cognitive perspective is not free from criticism. First, behaviorists see this theory as weak due to the abstract nature of thoughts and the difficulty in defining them. Second, there is no agreed upon definition or application of the theory. It is seen as fairly new and while it receives a great deal of research, the underlying theory of personality development is weak at best. So, while it may have very positive outcomes in treatment, it does not provide a solid understanding of development. For the neo-Freudian, this might mean that cognitive therapy is only a temporary approach and does not address the real reason behind a personality issue**.**

2.13 Health Belief Model

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

1) Perceived susceptibility to a particular health problem ("am I at risk for HIV?"
2) Perceived seriousness of the condition ("how serious is AIDS; how hard would my life be if I got it?")
3) Belief in effectiveness of the new behavior ("condoms are effective against HIV Transmission")
4) Cues to action ("witnessing the death or illness of a close friend or relative due to AIDS")
5) Perceived benefits of preventive action ("if I start using condoms, I can avoid HIV infection")
6) Barriers to taking action ("I don't like using condoms").

In this model, promoting action to change behaviour includes changing individual personal beliefs. Individuals weigh the benefits against the perceived costs and barriers to change. For change to occur, benefits must outweigh costs. With respect to HIV, interventions often target perception of risk, beliefs in severity of AIDS

("there is no cure"), beliefs in effectiveness of condom use and benefits of condom use or delaying onset of sexual relations (UNAIDS, 1999).

Table 2.1: Summary of Key Issues of Each Theory/Model

SN	Theory/Model	Key Points/Issues
1	Change theory	✓ Banks on connection between a system's mission, strategies and actual outcomes ✓ View behavior as a dynamic balance of forces working in opposing directions ✓ People oppose the change to happen. ✓ The model is cyclical not linear
2	Behavioral Change Theory	✓ Focus on stages that individuals pass through ✓ Do not consider the interaction of social, cultural and environment issues as independent of individual factors.
3	Cognitive theory	✓ Individual can learn by direct experiences, human dialogue, interaction and observation ✓ Behavior is a result of consequences ✓ Self efficacy is believed to be the most important characteristics that determines a person behavour change
4	Health Belief Model	✓ Health behavior is a function of individual's socio-demographic characteristics, knowledge and attitudes ✓ Perceived susceptibility to a particular health problem ✓ Belief in effectiveness of the new behavour ✓ Cues to action
		✓ Perceived benefits of preventive action

Source: Research Findings, 2015

Selected theory for this study

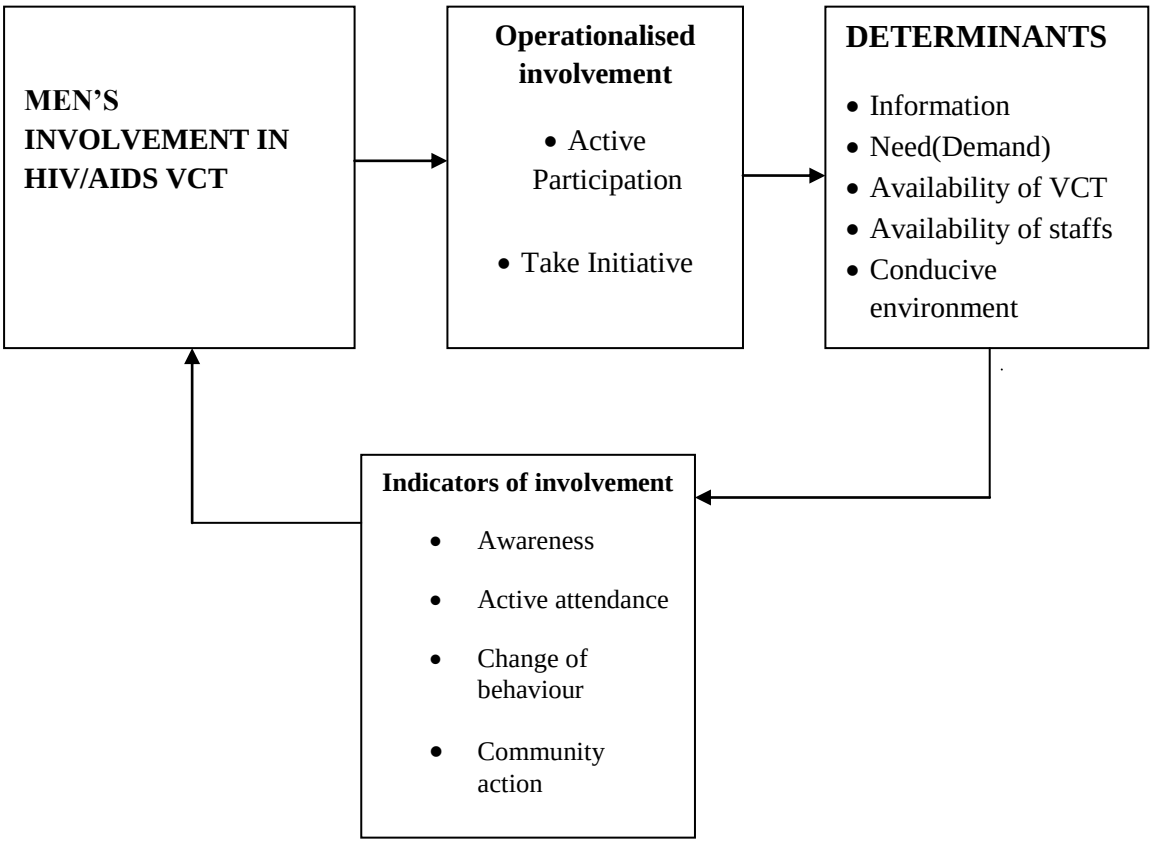
In this work I preferred to use behavioral change theory because is an essential component for an individual to change his/her behaviour concerning HIV/AIDS voluntary counseling and testing. Based on the theory of behaviour (Montano and Kasprzyk, 2008), it shows an important contribution to disclosure research by explaining the underlying the determinants of men's involvement in HIV/AIDS

VCT. The theory states that attitude toward behaviour, subjective norms, and perceived behavioural control, together shape an individual's behavioural intentions and behaviours. This theory proposes that people's behaviour is determined by a set of control beliefs about the presence of contextual factors such as culture, stigma and knowledge to influence positive or negative attitudes towards HIV/AIDS voluntary counseling and testing. These factors interact with individuals socio-demographic characteristics. It thus implies that, the contextual factors and individual factors need to be taken into account in promoting it (WSDH, 2013).

2.14 Conceptual Framework

Behavioral change will be used as the conceptual framework for the study. The behavioral change theory provides a conceptual framework for understanding and explaining the determinants of men's involvement in HIV/AIDS Counseling and testing. In this study, the conceptual framework outlines variables that shape the decision to go for HIV/AIDS test or not summarised in the Figure 2.1. The conceptual framework starts with an idea that men's involvement in HIV/AIDS VCT which means participation, activeness and take initiatives can lead to determinants of Men's Involvement in HIV/AIDS VCT. The Participation, activeness and initiatives depend on information available, need or demand of the people, availability of VCT centres and availability of staffs. The determinants of men's involvements can be measured by the following indicators: awareness, active attendance in VCT centres, conducive environment and community action. Determinants of men's in HIV/AIDS VCT can be achieved when supported by favorable operation environment which act as a catalyst in men's involvement in HIV/AIDS VCT.

Figure 2.1: Conceptual Framework for the Study Investigating Determinants of Men Involvement in HIV/AIDS Voluntary Counseling and Testing



Source: Researcher's Own Construct, 2015

2.15 Definition of Variables

(i) Men's involvement

Men's involvement means active participation; take initiatives and empowering men through provision of information and services targeting boys, youth, and adults within home, community, and work settings (Maja, 2006).

(ii) Active Participation

Participation means individual choices and actions that people make as a part of their daily life encompassing the involvement of rural people in decision making sharing benefits and implementation (Fekade, 1994). It also means process through which

stakeholder's influence and share control over priority setting, policy-making (Glass, 1979). Active participation means involvement of the local population in the decision making that enables individuals to be included in their care and have a greater say in how they live their life in ways that matter to them (Brieger,2006). Berry (2008) postulates that four key elements characterize the word active are: (1) critical thinking, (2) individual responsibility, (3) involvement in open-ended activities, and (4) organization of learning activities.

(iii)Information

Information means facts provided or learned about something or it is that which reduces uncertainty. It is data that which assists in decision making (Faibisoff *et al* ,1975). Also, information means statements or facts that are received by a human and that have some form of worth to the recipient "describe information as news or facts about something" (Losee, 1998; Callaos and Callaos, 2002).

(iv)Need

Need defined as require (something) because it is essential or very important rather than just desirable or a thing that is wanted or required. It is a condition or situation in which something must be supplied in order for a certain condition to be maintained or a desired state to be achieved (Leagans, 1964).

(v) Availability VCT centres

Availability of VCT centre means is the best ways and means of extends VCT services to reach more people in an area (Houten, 2002). It also means presence of enough VCT service centres or means of extends VCT services so as to change people's risk behaviour (USAID, 2008).

(vi)Awareness

Awareness is defined as the state or condition of being aware, having knowledge; consciousness or means having knowledge or discernment of something. Awareness implies knowledge gained through one's own perceptions or by means of outside information or is an ability to make forced-choice decisions above a chance level of

performance. Awareness, therefore, can be defined as what is manifest in all forms of perception, in all forms of knowing (Marikle, 1984).

(vii) Behaviour Change

This refers to actions to bring about behaviour change may be delivered at individual, household, community or population levels using a variety of means or techniques. The outcomes do not necessarily occur at the same level as the intervention itself. For example, population-level interventions may affect individuals, and community- and family-level interventions may affect whole populations (NICE, 2007).

(viii) Community action

Community action means community diagnosis to determine the root causes of a community issue and come up with necessary ways to overcome it. It is also means changes people's lives, embodies the spirit of hope, and improves communities (Mooney, 2011).

2.16 Empirical Review of Other Studies

Various other studies related to HIV/AIDS testing and counseling in Tanzania have been conducted by various researchers as follows**:**

USAID (2013) found that in Tanzania, levels of VCT are generally low. In the most recent national survey, only 62% of women and 47% of men in Tanzania have been tested and received their results at some point in their lifetime (TACAIDS, 2014). In the year preceding the survey, 30% of women and 26.5% of men in the overall adult population had been tested for HIV and received results. In Iringa, lifetime prevalence of ever testing and receiving results for HIV was 68.6% among women (26% in the past year) and 52.7% among men (28.2% in the past year). Despite these low rates of HTC in the region, 98.5% of women and 92.6% of men said they knew where they could get an HIV test performed. These results suggest that research is needed to better understand the barriers preventing widespread utilization of HTC services in Tanzania (TACAIDS, 2014).

Mwakatobe (2007) found that youth misinformation from mostly unreliable sources of sexual matters in African societies; peers and media programmes remain the big problem. This problem is contributed by, elders quietness on over their sole responsibility of informing young people about the important changes in their physiological, biological psychological beings that would render them vulnerable for incurable HIV/AIDS. Young people would continue to lack this important component of their progress towards adulthood because of the most African cultural practice whereby youth's of the societies. The fact that HIV has its major root of transmission through sex, apart from contact with the HIV infected body fluids etc; the traditional African sexual dormant perception has more risk and damages. This makes hard for young people to disclose their sexual life since that behavior may be socially unacceptable, exposure to sexual matters is considered immoral before marriage, as a result sex is perceived as a top secret in most African societies.

Due to such beliefs, young people have fear to share their sexual experience with their parents or elders who could be of help in their sexual behaviors change. This would mean, it is even worse if the young people would attempt sharing with their parents about their ideas of going for the HIV tests (Mwakatobe, 2007).

USAID (2012) the available evidence suggests that VCT can have an effect on reducing unprotected sex and the number of sex partners. The results indicate that participants receiving VCT were more likely to report reducing their number of sexual partners than those who did not receive VCT. All individual studies showed a positive trend toward reducing their number of sexual partners when comparing those who received VCT to those who did not. Although VCT did not have a significant overall effect on condom use, people living with HIV who received VCT reported an increase in condom use compared to people living with HIV who did not receive VCT.

Lastly, Commonwealth and USAID (2002) also conducted another study on HIV/AIDS Voluntary counseling and testing, the study states that; The burden of handling HIV infections has increased to levels beyond the current capacity of health systems to cope with it. Thus, advocacy efforts have intensified to mobilize resources

and to extend use of interventions that evidence has shown to be effective, with the result that NGOs and partners have expanded VCT services. Increasing donor support for VCT, more favorable government policies, and the potential for expanded access to antiretroviral (ARV) drug therapy because of significant price reductions and free donations to prevention of mother-to child transmission (PMTCT) programmes have all served to integrate VCT into public health services. VCT is increasingly recognized as importantly central to effective HIV/AIDS prevention and care efforts to combat the epidemic.

The empirical literature review, therefore, shows that more funds and efforts invested on HIV/AIDS counseling and testing but still the number of people especially men who participate on the phenomena are very few. This had negative implications on the war against HIV/AIDS in Tanzania.

Research gap, empirical studies have revealed the importance of HIV/AIDS voluntary counseling and testing. VCT services recognized as importantly central to effective HIV/AIDS prevention and care efforts to combat the epidemic. Empirical review shows that efforts invested on HIV counseling and testing were not enough, more efforts needed. A number of these empirical studies have analysed VCT services and it's roles play in prevention and care to combat HIV/AIDS. More studies on HIV/AIDS voluntary counseling and testing and its effectiveness are needed.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This chapter explains the methodology to be used in the collection of data and information on the determinants of men's involvement in HIV/AIDS Voluntary counseling and testing. The chapter is organised as follows; research design, study area, sample size, sampling procedure and methods which were used in data collection, data processing, data analysis and data presentation.

3.2 Research Design

A research design is the arrangement of conditions for collection and analysis data in a manner that aims to combine relevance to the research purpose with economy procedure (Kothari, 2004). A research design in many instances dictates the approach that will be used to gather information and then ultimately analyse the data, interpret the findings to provide a vehicle to satisfy the various objectives (Babbie *et al.*, 2001).

This study employed a cross- sectional research design where exposures and outcomes are observed or measured simultaneously in a population (ADA, 2011). A cross- sectional research design was employed in this study. This type of research can be used to describe characteristics that exist in a community. The design provides useful information for simple statistical information and interpretation, the study employed cross-sectional research design because is inexpensive and allow researchers to collect a great deal of information quite quickly, researchers are often able to amass large amounts of information from a large pool of participants. Another benefit is that researchers can collect data on some different variables to see how differences in sex, age, educational status, and income might correlate with the critical variable of interest (Babbie, 1995). Cross- sectional research design was employed to investigate the determinants of men involvement in HIV/AIDS

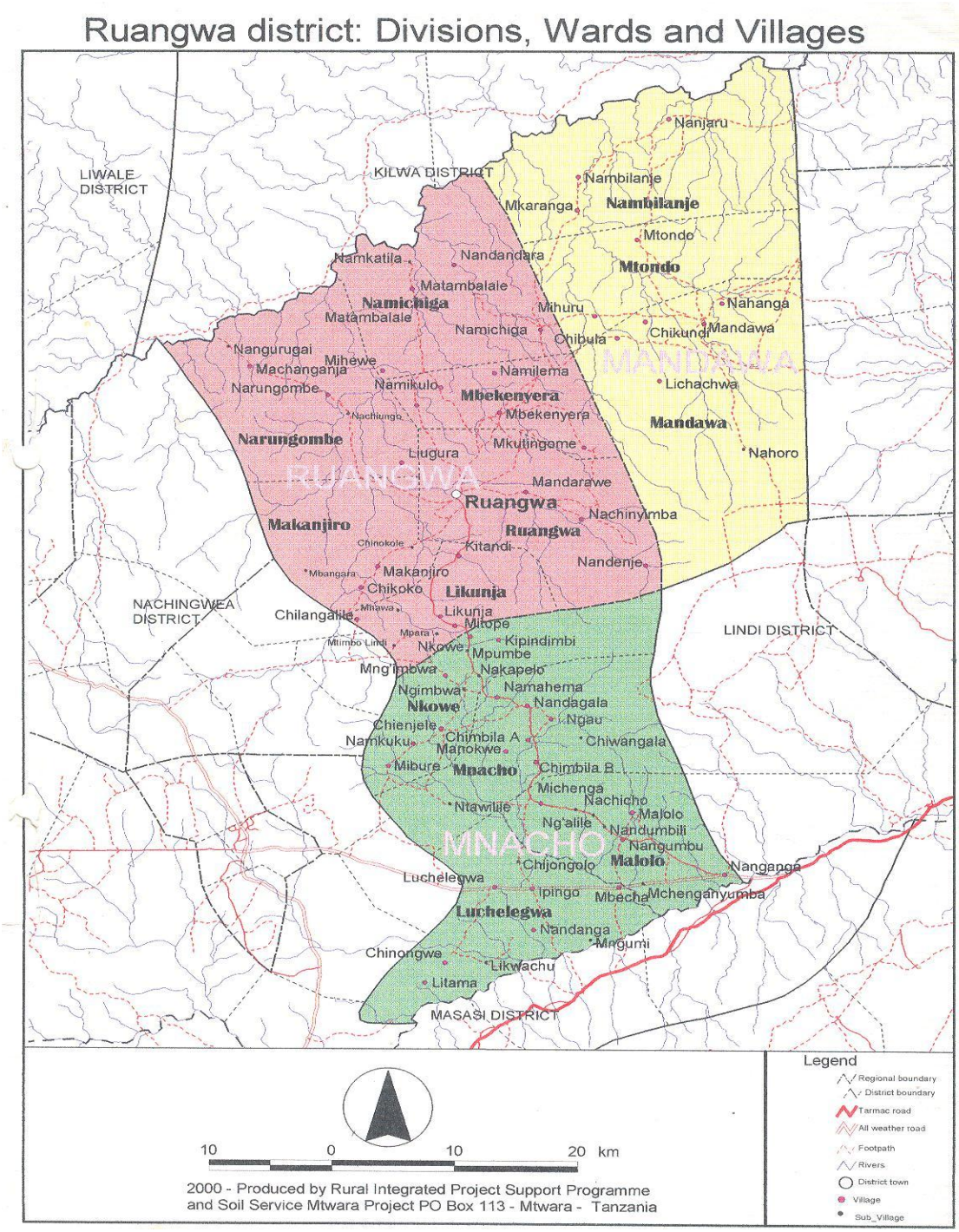
counseling and testing. In this study data were collected through; interviews, observation and questionnaires.

3.3 The Study Area

3.3.1. Location

The study was conducted in Ruangwa District council in Lindi Region specifically in two wards as follows; Mandawa and Ruangwa were chosen for the study because HIV prevalence is very high and the percentage of men involvement in HIV testing and counselling is very low compared to other wards. Ruangwa District is one of the five administrative districts that make Lindi Region. It lies between latitude 9.5^0 S and 10^0 S and longitude 38.5^0 E and 39.5^0 E. The District lies between 213 meters and 549 meters above sea level. There are permanent rivers which are Mbwemkuru and Lukuledi Rivers and seasonal ones are Chingunduli, Mandawa, Mmawa, Luwega and Ruangwa. These seasonal rivers originate from Rondo Hills. The District headquarter is known as Ruangwa Town and is about 152 kilometres from the Region headquarter Lindi Town. Arable land covers about 204,826 hectors, natural and planted forests 40,614 hectors and 10,562 hectors is used for human settlements and other uses. Ruangwa stands on a broad upland of plateau with an attitude ranging between 200 – 1000 and annual rainfall ranging between 800 – 1200 millimeters (RDC, 2011).The district shares borders with Kilwa in the north, Liwale in the Northwest, Nachingwea and Masasi in the South and Lindi in the East.Figure 3.1 illustrates the map of Ruangwa District Council.

Figure 3.1: Map of Ruangwa District



Source: Ruangwa District Profile, 2013

3.3.2 Population and Climate

According to Tanzania Population and Housing census 2012, Ruangwa District has the total population of 131,080 people. Out of these, 63,265 are male and 67,815 are female. It was not difficult to establish population growth trends due to the fact that the district has effectively participated in Population and Housing Census in the year 2012 (URT, 2013). Table 3.1 shows total district population including female and male with house hold size.

Table 3.1 Population Distribution and Household's Size in Ruangwa District

SN	WARD	MALE	FEMALE	TOTAL	HOUSEHOLD SIZE
1	Ruangwa	2,546	2,889	5,435	3.7
2	Mbekenyera	5,398	5,859	11,257	3.6
3	Nkowe	2,610	2,654	5,264	3.3
4	Malolo	3,572	3,833	7,405	3.3
5	Luchelegwa	2,210	2,318	4,528	3.4
6	Chienjele	4,216	4,475	8,691	3.3
7	Namichiga	2,542	2,623	5,165	3.6
8	Narungombe	4,086	4,321	8,407	3.4
9	Makanjiro	1,632	1,691	3,323	3.3
10	Likunja	4,123	4,302	8,425	3.4
11	Mnacho	3,195	3,412	6,607	3.4
12	Mandawa	3,140	3,522	6,662	3.6
13	Nambilaje	3,044	3,138	6,182	3.7
14	Chunyu	2,801	3,009	5,810	3.5
15	Mandarawe	1,807	1,989	3,796	3.4
16	Nachingwea	3,769	4,373	8,142	3.4
17	Matambarale	2,492	2,579	5,071	3.6
18	Chibula	1,476	1,461	2,937	3.4
19	Nandagala	2,529	2,785	5,314	3.7
20	Nanganga	2,425	2,534	4,959	3.5
21	Chinongwe	3,652	4,048	7,700	3.5
	Total	**63265**	**67815**	**131,080**	**3.5**

Source: 2012 Tanzania Population and Housing Census

3.3.3 Climate

The climate in the district is of two seasons which are more or less uniform. The temperature ranges between 24^0C and 34^0C with an average temperature of 26^0C per annum. The District enjoys a monsoon wind that is northeast winds from June and October and south east winds from November to May each year. It rains from mid-

November to May annually. Most parts receive rainfall between 800mm and 1,200mm per year. The slopes of Rondo Mountains get more rainfall over 1,000mm per year and generally rainfall decreases from East to West (URT, 2013).

3.3.4 Economic Activities

Ruangwa district economy primarily depends on agriculture with more than 90% of the population engaging in production of food, cash crops and livestock keeping. Food crops include maize, sorghum, paddy, cassava, pigeon peas, cow peas and groundnuts. Cash crop includes cashew nuts, sesame, onions, tomatoes, sunflower and groundnuts.

(i) Agriculture

Agriculture production is basically for local consumption in the district domestic market. In this context of agricultural production as far as Ruangwa district is concerned, climate is the major constraint for agricultural production of both food and cash crops and livestock keeping. Besides cash and food crop production, there is livestock keeping. Ruangwa district has an area of 767.99 square kilometres (29.99%) suitable for cultivation, where 1,279.99 sq. km (49.99%) not suitable for cultivation. The remaining 506.1 sq. km were not cultivated by the year 2012. Total tons of food crops produced in the year 2011/2012 is 55,466 tonnes (URT, 2013).

(ii) Forest Reserve

Ruangwa District has three forest reserves which cover total area of 170,666.7ha Namely National forest reserve found in Nandimba (Lichwachwa) it covers 740ha owned by the government. Another forest reserves are community based forest reserves funded by FINIDA covering 24,356.52ha and TASAF which covers 10,755.47ha. Forest reserves funded by FINIDA which makes a compilation of Kipindimbi forest which has 920ha, Nandenje has 366.4 ha,Nahanga 3,752.8 ha, Likwachwa 3,187 ha, Ng'au 3,752 ha, Mtondo 2,141.1 ha, Kitandi 2,149.69ha, Chingumbwa 1513ha and Michenga 3,276.93ha. Forest reserves funded by TASAF are Malolo 512.01 ha, Nangumbu 919.77 ha, Michenga 2,162ha, Chimbila A 1,312ha, Mpumbe 2,010ha, N'gimbwa 1,200ha, Ngau 2,500ha, and lastly Kitandi

2,149.69ha. Also, there is a general forest land that covers 134,754.71ha owned by government (URT, 2013).

(iii)Industrial and Mining Sector

In Ruangwa District the industrial Sector is subdivided into different parts that are local or individuals factories that deals at local levels this is like, Oil processing and mining industry at Namungo, Nandagala, Chunyu, Nangurugai and in some rural areas which are not very specific at the moment. This is one of the major sources of income at individual level that enable to sustain their lives, but in the case of industry at large, there is no any processing, finishing and/or raw material industry that at national level that Ruangwa District residents may depend on it. Basing on quantitative data the state of industrial sector in Ruangwa district is still very poor. Number of households engaged in industrial sector is very low and it is operated at a local level, despite the fact that there are industrial opportunities prevailing in the District. Most small scale industries in the district collapse due to lack of capital and knowledge as well as technology (URT, 2013).

3.4 Target Population

Population can be defined as all items in any field of inquiry (Kothari, 2004). In this study, the target population was the community. In this study Households and service providers in Ruangwa District council were the target population. The WEO's, VEO's, Council leaders and health centre managers with a specific focus in 2 wards as follows; Ruangwa and Mandawa. I was decided to deal with this two wards because are division's headquarters in Ruangwa, also in this two areas the involvement of men in HIV/AIDS Voluntary counseling and Testing was very low.

3.5 Sampling Frame

A sampling frame was drawn from a list of 2 wards and 2 villages, 2 health facilities in Ruangwa District Council. The working population was interviewed from household and Service providers and gender sensitivity was put forward to reduce prejudice in order to achieve the intended objectives.

3.6 Sampling Unit

Every household from the sample size in relation to the selected number of households was involved in the study. The unit to deal with was health facilities involved in providing Services so as to determine the involvement of men in HIV/AIDS Testing and counselling.

3.7 Sample Size

The sample size for the study was 78 respondents (55 households, 15 service providers and 8 key informants (officials). This is because the sample size chosen was quite manageable in relation of time and cost. The sample size was chosen so as to simplify data analysis through SPSS software and other data analysis and other methods for producing a good and quality report. Number of household in each village was equally considered so as to minimize errors and sample biasness. The household's questionnaires were prepared in accordance to the sample size selected.

Table 3.2 Number of Sampled Respondents in Ruangwa District by Ward and Sex

Ward	**Households**		**Service Providers**		**Official**		**Total of Respondents**	
Mandawa	Male	Female	Male	Female	Male	Female	**N**	**%**
	16(20.51)	11(14.10)	4(5.13)	3(3.85)	2(2.56)	2(2.56)	38	**48.72**
Ruangwa	15(19.23)	13(16.67)	4(5.13)	4(5.13)	3(3.85)	1(1.28)	40	**51.28**
Total	**31(39.74)**	**24(30.77)**	**8(10.26)**	**7(8.97)**	**5(6.41)**	**3(3.85)**	**78**	**100.00**

Source: Researcher's construction 2014

3.8 Sampling Procedures and Technique

This study applied two sampling techniques: purposive and simple random sampling. Purposive sampling refers to a deliberately non-random method of sampling, which aims to sample a group of people or settings, with a particular characteristic, usually in qualitative research designs (Bowling, 2002). This is also sometimes called judgment sampling where respondents are selected because they have knowledge

that is valuable to the research process. Purposive sampling was used to pick DMO, WEO's, VEO's, Health Centre's Managers and Councilors.

Also, this technique was used to pick wards and Villages which have low rate of men involvement in HIV/AIDS Counseling and testing.

Simple random sampling was employed to households of HIV/AIDS Testing and Service Providers whereby each individual was chosen randomly and entirely by chance, such that each individual had the same probability of being chosen as any other subset of households or Service Providers (Yates *et al.*, 2008). Hence, simple random sampling unbiased survey technique and should not be confused with systematic random sampling. Table 3.3 provides the summary of sampling techniques and terms sampled.

Table 3.3 Sampling Techniques of the Study

S/N	Technique	Items	Respondents	Percentage
1	Purposive Sampling	DMO	1	1.28
		WEO's	2	2.56
		VEO's	2	2.56
		Health Centres Managers	2	2.56
		Councillor	1	1.28
	Sub Total		**8**	**10.26**
2	Simple random sampling	Households	55	70.51
		Service Providers.	15	19.23
	Sub-Total		**70**	**89.74**
	TOTAL		**78**	**100.00**

Source: Researcher's construction, 2014

3.9 Data Sources

In this study, the researcher used semi structured questionnaires, interviews, observation and documentary reviews. Both primary and secondary data was used to collect information. The main instrument of collect primary data was questionnaires

because more information can be collected from a large number of people in a short period of time and in a relatively cost effective.

3.9.1 Secondary Sources

Secondary data constituted the readily available information and already compiled statistical statements and reports whose data has been used by the researcher in the study. In this study, Ruangwa district council was a major source of secondary data specifically District Medical Officer Office, Mandawa and Ruangwa health facilities, Ward Health workers concerning low rate of Men involvement in HIV counselling and testing and different government reports on HIV/AIDS. The researcher was applying Secondary data as a source because it can be easy to secure quickly and cheaply (Babbie, 1990). In order to get current information a researcher was take specific period of (3-5 years) from 2010-2013 in health facilities and DMO's documents.

3.9.2. Primary Sources

Primary data were collected from the field by the help of questionnaire to household members, village executive officers were selected sample unit was provided with questionnaires and the checklist was used to the selected unit. The tool to be used was structured and semi-structured questionnaires.

3.10 Data Collection Methods

Five methods were used in collecting of data. They include questionnaire, interviews, documentary review, focus group discussion, and observation.

3.10.1 Questionnaires

Questionnaire is a form containing a series of questions with spaces to be replied or felt by the respondent. This was the main tool of data collection that facilitated the collection of quantitative data from and both direct and Indirect Beneficiaries to investigate low rate of men in HIV/AIDS Testing and Counselling. Questionnaire is

list of questions to a number of persons for them to answer Questionnaires contain both open ended and closed questions. Open ended question will be used in order to get experiences and feelings from villagers about involvement of men in HIV/AIDS testing and counselling. Closed ended questions were for gathering information that the researcher intend to get (Rwegoshora, 2006).

However, the technique enables the respondents to have more time to digest the questions for them to provide accurate answer. This was used to respondents who know how to read and write. The method was useful to collect information from some key informants such as WEO'S, VEO'S, DMO and other influential people who could hardly get enough time to be interviewed. The method is generally proffered as it is economical and covers a large geographical area within a short time. In case of illiterate respondents who neither know how to read nor write an interview method was applied.

3.10.2 Interviews

Semi-structured interview schedules was used for data collection where DMO, 2 Health centre managers, 1 District Health Board Chairperson, 2 WEO's, 2 VEO'S and 2 councilors because always are very busy, they have general information, experiences and knowledge about HIV/AIDS counselling and testing. I preferred to use Interview method due to flexibility in data collection since a researcher was able to modify difficulty questions for more clarity and even ask more questions depending on context.

3.10.3 Documentary Reviews

Various documents were reviewed in District Hospital, Health centres, dispensary, and DMO's office: records on the trend of attending in blood testing (VCT) in Ruangwa DC. These documents were obtained from DED's office, DMO's office and selected Health centres. Documentary review was a very useful method because help the researcher to document the status of HIV/AIDS in Ruangwa District Council. The document reviewed include the patient register, VCT book Register and annual HIV/AIDS report.

3.10.4 Focus Group Discussion (FGD)

Focus group discussion is small number of people, usually between 4 and 15, but typically 8, brought together with a moderator to focus on a specific topic (Kothari, 2004).

Provides information directly from individuals who are invested in the issue or hold expert knowledge about a topic of which little is known among researchers, provides a relatively low cost and efficient way to generate a great deal of information. Provides information from people who can provide insights about actual conditions and situations.This method was used in soliciting information from local people (Household) four (4) from each ward (Mandawa and Ruangwa) selected to be asked various questions ranging for their knowledge about the war against HIV/AIDS, objectives, its benefits and associated problem. After discussion all members in a group were asked individually to write shortly on their views about low rate of men involvement in HIV Testing, particularly with the intention of expressing what they cannot say in groups due to fear.

3.10.5 Observation

Non-Participant observation has a long history in the social and behavioral sciences. It is distinguished from participant observation by the observer's level and kind of involvement in the research setting, the nonparticipant observer adopting a more distant and separate role. At its most extreme, the nonparticipant observer has no contact whatsoever with the researched, but watches and records events through one way mirrors or with camera. When observation is covered either by hidden cameras or by an observer pretending not to be studying the setting participants are unaware that they are being studied. Nonparticipant observation has several strengths. First, it provides unique, contextualised insights into events and activities and the meanings that they hold for members of the setting. Second, enable the researcher to capture the dynamics of participants' interactions with each another and with their work environment, and to do so over time, observing processes as they unfold. Third, it provides a different kind and quality of data than those gathered through self-report methods, such as surveys or interviews. Indeed, it may offer the only viable way to

collect data on especially sensitive topics. The study used this method because it wanted to observe HIV/AIDS Counseling and Testing through VCT programme in Health centres and to see the trend between men and women (Liu and Maitlis, 2013).

Table 3.4: Summary of Methods of Data Collection and Redistribution

S/N	Types of Respondent	Number of Respondent	Method of` data collection
1	DMO	1	Interview
2	WEO's	2	Interview
4	VEO's	2	Interview/Questionnaire
5	Health Centre's Managers	2	Interview/Questionnaire
6	Councilors	1	Questionnaires
8	Household	55	Questionnaire/Observation
9	Service Providers (Health workers, dispensary health committees, Home based care	15	Questionnaire/Observation

Source: Researcher's construction 2014

3.11 Data Analysis

Performing calculations almost at the speed of light, the computer has become one of the most useful research tools in modern times. Editing and coding of the questionnaires was done and data was entered following the developed codes. After completing data entering, cleaning and verification of the entered data was done so as to remove committed errors like illogical and errors. Descriptive statistical procedures including cross-tabulations and frequency distributions were used to provide comparisons and contrast between different background respondent's characteristics. Data analysis was done by using SPSS version 20 in concomitant with Microsoft Excel of windows 7 professional 2010. By SPSS Analysis was done in descriptive statistics were by frequencies and multiple responses were acquired. Presentation of findings in various levels of analysis presented was done using percentage, tables, figure and charts after being processed in Microsoft excel.

3.12 Ethical Issues

Before starting the research the participants were informed about the purpose of the study as earlier stages. Every effort was made to protect participant's privacy.

Information on purpose and procedure for conducting the study (including the right to refuse or withdraw at any time) was explained to all interviewees. In this proposed study, I visited the headquarters of Ruangwa District Council and 2 respective villages so as to put everything clear before starting the study.

I further stressed the fact that participating in the study was not expose participants to any risks. The participants were also treated equally and confidentially (UNCEF, WHO and UNAIDS, 2010).

CHAPTER FOUR

FINDINGS AND DISCUSSIONS

4.1 Introduction

This chapter presents the findings and discussions established through the data collected from the respondents. The presentation and discussion are organised according to the specific objectives and research questions. The presentation starts with main demographic characteristics of the respondents mostly sex, age, marital status, education, household size, occupation and income. Then, status of HIV/AIDS VCT, efforts made by Ruangwa District Council to encourage men involvement in HIV/AIDS VCT, factors affecting men involvement in HIV/AIDS and ways of promoting men involvement in HIV/AIDS

4.2 Demographic Characteristics of the Respondents

It was important to find out from the respondents their sex, age, education levels, marital status, household size, occupation and income they have. These particular characteristics would affect their involvement in HIV/AIDS counseling and testing.

4.2.1 Distribution of Respondents by Sex

The study involved a total of 78 (100%) respondents. They included 44 (56.41%) males and 34 (43.59%) females. The study involved both males and females because both of them participated in HIV/AIDS voluntary counseling and testing. The respondents were categorised into three groups' households, service providers and key informants (from the District to ward level). Among household' respondents, 31 (39.74%) were males and 24 (30.77%) females, service providers respondents, 8 (10.26%) were males and 7 (8.97%) females whereby key informants, 5 (6.41%) were males and 3 (3.85%) females. Table 4.1 summarises the number of respondents by sex.

Table 4.1: Sex of the Respondents

S/N	Category of respondents	Sex of respondents				Total	
		Male		Female			
		NO	%	NO	%	NO	%
1	Households	31	39.74	24	30.77	**55**	**70.51**
2	Service Providers	8	10.26	7	8.97	**15**	**19.23**
3	Key Informants	5	6.41	3	3.85	**8**	**10.26**
Total		**44**	**56.41**	**34**	**43.59**	**78**	**100.00**

Source: Research Finding, 2015

4.2.2 Distribution of the Respondents by Age Group

The study sought information of age of respondents. Age of respondent is important in research because it helps to analyse the relationship with the group members. To achieve the objective, the respondents were asked to select the age category among the list provided. The findings showed that 8 (10.26%) respondents were aged between 15 - 24 years old, 29 (37.18%) were aged between 25 - 34 years old, 20 (25.63%) were aged between 35 – 44 years. Other 13 (16.67%) respondents were aged between 45 - 54 and 8 (10.26%) respondents were aged between 55 years old and above. The majority of the participants ranged between the ages of 25 - 54 years (79.49%) while the minorities were the age between 15-24 years and 55 years above (20.51%). Table 4.2 presents summary of the age of respondents.

Table 4.2: Respondents by Age Group

S/N	Age Group	Category of respondents							
		Households		Service Providers members		Key Informants		Total	
		NO	%	NO	%	NO	%	NO	%
1	15 - 24	8	10.26	-	-	-	-	**8**	**10.26**
2	25 - 34	15	19.23	8	10.26	6	7.69	**29**	**37.18**
3	35 - 44	12	15.38	6	7.69	2	2.56	**20**	**25.63**
4	45 - 54	12	15.38	1	1.28	-	-	**13**	**16.67**
5	55 +	8	10.26	-	-	-	-	**8**	**10.26**
Total		**55**	**70.51**	**15**	**19.23**	**8**	**10.26**	**78**	**100.00**

Source: Research Finding, 2015

4.2.3 Education Levels of the Respondents

The aspect of education was considered important since lack of knowledge about HIV/AIDS counseling and testing. The study wanted to explore education levels of respondents. The researcher asked respondents about the level of their education because the level of education tends to determine level of awareness, ability to grasp training and handle responsibility where one will perform. To achieve the objective, the respondents were asked to mention the education level among the list provided. The findings showed that 46 (58.97%) respondents had primary education, 18 (23.08%) respondents had secondary education and 4 (5.13%) respondents had tertiary education. Also, 10 (12.82%) respondents had University education. This can be best illustrated more in Table 4.3.

Table 4.3: Education Levels of Respondents

S/N	Education Levels	Category of Respondents							
		Households		Service Providers		Key Informants		Total	
		NO	%	NO	%	NO	%	NO	%
1	Primary education	40	51.28	2	2.56	4	5.13	**46**	**58.97**
2	Secondary education	7	8.97	9	11.54	2	2.56	**18**	**23.08**
3	Tertiary education	-	-	3	3.85	1	1.28	**4**	**5.13**
4	University Education	8	10.26	1	1.28	1	1.28	**10**	**12.82**
Total		**55**	**70.51**	**15**	**19.23**	**8**	**10.26**	**78**	**100.00**

Source: Research Finding, 2015

4.2.4 Marital Status of the Respondents

The study sought to find out the marital status of respondents. Marriage is an important factor for exposure of male and female to sexual intercourse which is the leading mechanism to HIV infection TDHS, (2005). Respondents in this study were asked if they are single, married, divorced, separated or widowed. This was important to the study sought to determine the proportion of different categories of marital status and how they involve in HIV/AIDS Counseling and Testing; also marital status is associated with the responsibilities in the society. The study

discovered that the majority of respondents 46 (58.97%) were married followed by 16 (20.51%) respondents who were single, 7 (8.97%) respondents was divorced, 8(10.26%) respondents were widowed and 1 (1.28%) respondent was separated. The results about marital status are summarised in Table 4.4.

Table 4.4: Marital Status of Respondents

S/N	Marital status	Respondents						Total of Respondents	
		Households		Service providers		Key informants			
		NO	%	NO	%	NO	%	NO	%
1	Single	11	14.10	4	5.13	1	1.28	**16**	**20.51**
2	Married	34	43.59	7	8.97	5	6.41	**46**	**58.97**
3	Divorced	5	6.41	1	1.28	1	1.28	**7**	**8.97**
4	Widow	4	5.13	3	3.85	1	1.28	**8**	**10.26**
5	Separated	1	1.28	-	-	-	-	**1**	**1.28**
	Total	**55**	**70.51**	**15**	**19.23**	**8**	**10.26**	**78**	**99.99≈100.00**

Source: Research Finding, 2015

4.2.5 Household Size of the Respondents

The study wanted to reveal the size of household of the respondents. This was relevant because the size of the family can influence an individual to make a decision. To achieve this objective the respondents were told to mention the number of the family members. The request was directed to 55 households and 15 service providers' and 8 key informants. The finding showed that 14(17.95%) own the family which range between 1 – 3 members, 45(57.69%) as a majority of respondents own the family which range between 4 – 6 members and 19(24.36%) respondents own the family which range between 7 – 9 members. The household size is summarised in the Table 4.5.

Table 4.5: Household Size of the Respondents

S/N	Household Size	Respondents						Total of respondents	
		Households		Service Providers		Key Informants			
		NO	%	NO	%	NO	%	NO	%
1	1-3	8	10.26	5	6.41	1	1.28	**14**	**17.95**
2	4-6	36	46.15	6	7.69	3	3.84	**45**	**57.69**
3	7-9	11	14.10	4	5.13	4	5.13	**19**	**24.36**
	Total	**55**	**70.51**	**15**	**19.23**	**8**	**10.26**	**78**	**100.00**

Source: Research Finding, 2015

4.2.6 Occupation of the Respondents

The study sought information of main occupation of the respondents. This was relevant in order to ascertain their economic activities that influence their income. The findings show the majority 38 (48.72%) respondents were farmers, 18 (23.08%) respondents were employed such as the teachers, health workers and other sectors in the District 6 (7.69%) respondents were involved in Petty business, and 16 (20.51%) respondents who were involved in Mining sector. The occupation of the respondents is summarised in the Table 4.6.

Table 4.6: Occupation of the Respondents

S/N	Main Occupation	Respondents						Total of Respondents	
		Households		Service Providers		Key Informants			
		NO	%	NO	%	NO	%	NO	%
1	Farming	28	35.90	6	7.69	4	5.13	**38**	**48.72**
2	Employed	6	7.69	8	10.26	4	5.13	**18**	**23.08**
3	Mining	6	7.69	-	-	-	-	**6**	**7.69**
4	Petty trading	15	19.23	1	1.28	-	-	**16**	**20.51**

Source: Research Finding, 2015

4.2.7 Income Earned by the Respondents

The study sought information of income earned by the respondents per year. The income of the respondents in research was important because it give us opportunities to know the annual income of our people. To achieve the objective the respondents were asked to select their income category. The finding showed that the majority of respondents live less than one dollar per day. About 41(52.56%) respondents earned between Tsh 200,000 – 500,000, 15(19.23%) respondents earned between Tsh 500,001 – 800,000, 9(11.54%) respondents earned between Tshs 800,001 – 1,100,000, 1(1.28%) respondent earned between Tshs 1,100,001 – 1,400,000 and 12(15.38) respondents earned between Tshs 1,400,001 and above. The findings about income earned are summarised in Table 4.7.

Table 4.7: Income Earned per Year of the Respondents

S/N	Income earned per year (TShs)	Respondents						Total of Respondents	
		Household		Service Providers		Key Informants			
		NO	%	NO	%	NO	%	NO	%
1	200,000 - 500,000	38	48.72	3	3.84	-	-	**41**	**52.56**
2	500,001 - 800,000	11	14.10	-	-	4	5.13	**15**	**19.23**
3	800,001 - 1,100,000	5	6.41	-	-	4	5.13	**9**	**11.54**
4	1,100,001 – 1,400,000	1	1.28	-	-	-	-	**1**	**1.28**
5	1400,001 +	-	-	12	15.38	-		**12**	**15.38**
	Total	**55**	**70.51**	**15**	**19.23**	**8**	**10.26**	**78**	**99.99≈100.00**

Source: Research Finding, 2015

4.3 Status of HIV/AIDS Voluntary Counseling and Testing in Ruangwa District Council

In this section the following were investigated; knowledge of HIV/AIDS Voluntary Counseling and Testing, perceptions of HIV/AIDS VCT among both men and women, number of VCT centres available, and number of people visiting the VCT centres.

To understand the knowledge of the respondents regarding HIV/AIDS Voluntary Counseling and Testing, the respondents were asked whether they had ever heard of

HIV/AIDS VCT. The findings show that majority 69(88.46%) heard about it while 9(11.54%) did not heard about it. The findings about the knowledge of respondents in HIV/AIDS VCT are summarised in the Table 4.8.

Table 4.8: Heard About VCT Services

S/N	Heard About VCT or Not	NUMBER	PERCENTAGES
1	Heard about VCT	69	88.46
2	Not heard about VCT	9	11.54
	Total	**78**	**100.00**

Source: Research Finding, 2015

For those who said that they heard about it they were asked to mention the sources of information. The findings showed that 35(50.72%) respondents heard VCT service from village dispensary, 12(17.39%) heard VCT from District hospital, 21(30.43%) of respondents heard VCT service from mass media and 1(1.44%) respondent heard VCT service from HIV/AIDS World day which held in every 1st December. The findings are summarised in Table 4.9.

Table 4.9: Source of Information

S/N	Heard About VCT or Not	NUMBER	PERCENTAGES
1	Village dispensary	35	50.72
2	District hospital	12	17.39
3	Mass media	21	30.43
4	World HIV/AIDS day	1	1.45

Source: Research Finding, 2015

In order to get more information regarding HIV/AIDS Voluntary Counseling and Testing, the respondents were asked whether they had participate in the HIV/AIDS VCT or not. The findings show that 65(83.33%) participated while 13(16.67%) did not participate. The findings about whether they participated in HIV/AIDS VCT or not summarised in Table 4.10

Table 4.10: Participated in HIV/AIDS VCT

S/N	Participated in HIV/AIDS VCT	NUMBER	PERCENTAGES
1	Participated	65	83.33
2	Not Participated	13	16.67
	Total	**78**	**100.00**

Source: Research Finding, 2015

Perception of the importance of HIV/AIDS VCT; In order to get more information about HIV/AIDS in the society, researcher was interested to know their perception of the importance of HIV/AIDS VCT. The findings show that 28(35.90%) respondents argued that HIV/AIDS VCT is very important, 22(28.21%) perceived that VCT is important, 19(24.36) of respondents perceived that VCT is satisfactory and 9(11.54) respondents argued that HIV/AIDS VCT not important. The findings about perception of the importance of HIV/AIDS VCT are summarised in Table 4.11.

Table 4.11: Perception of the Importance of HIV/AIDS VCT

S/N	Perception of HIV/AIDS VCT	NUMBER	PERCENTAGES
1	Very important	28	35.90
2	Important	22	28.21
3	Satisfactory	19	24.36
4	Not important	9	11.54
	Total	**78**	**100.01≈100**

Source: Research Finding, 2015

For those who perceive that HIV/AIDS VCT is very important, important and satisfied about the importance of VCT, researcher asked the respondents to mention the importance of HIV/AIDS Voluntary Counseling and Testing. Findings showed that 44 (63.77) % respondents rated it as important because clients can be able to plan for their health in future so to minimize acquiring new infections, 17(24.64%) rated it as important because it helps the clients to cope with test results due to pre-test counseling, 8 (11.59%) it is important because people can be able to avoid new infections so as they can protect themselves. The findings about the importance of HIV/AIDS VCT summarised in Table 4.12

Table 4.12: Importance of HIV/AIDS Voluntary Counseling and Testing

S/N	Importance	NUMBER	PERCENTAGES
1	Plan for their health in future	44	63.77
2	Cope with test results	17	24.64
3	Avoid new infections	8	11.59

Source: Research Finding, 2015

Other questions asked in this part were; what is the number of VCT centres in Ruangwa District Council (question were asked to some key informants through interview) and number of people visiting VCT centres.

Regarding the number of VCT Centres, research finding from District documents especially DMO office shows that Ruangwa District Council had 1 District Hospital, 3 health centres, and 28 dispensaries but they have only 22 VCT centres out of 32 health facilities. Only 22 health facilities provided VCT services and10 of health facilities were not provide VCT services (URT, 2014). One of the service providers said: -

> *"We have 32 health facilities but only 22 health facilities provide VCT services, many people have no access to VCT services because most of our new health facilities lack equipment especially fridge, gases and other important equipments so as VCT to be established"*

The researcher wanted to understand people's feelings whether the number of VCT satisfactory or enough to them or not. Findings showed that 60(76.92%) were not satisfied with the number of VCT available while 18(23.08%) respondents were satisfied. Number of VCT satisfactory or not summarised in Table 4.13.

Table 4.13: Number of VCT Satisfactory or Not

S/N	Satisfactory or Not	NUMBER	PERCENTAGES
1	Not Satisfactory	60	76.92
2	Satisfactory	18	23.08
	Total	**78**	**100.00**

Source: Research Findings 2015

Regarding the number of people visiting VCT Centres,the research findings from District documents especially DMO office show that number of people who attend the HIV/AIDS VCT decrease year after year, In 2014 Mandawa ward out of 6662 only 280 (4.2%) males and 340(5.1%) female got tested while in Ruangwa ward out of 5435 only 250 (4.6%) males and 272(5%) females got tested. In 2013 out of 6662 only 275 (4.1%) males and 355(5.3%) females got tested in Mandawa ward while in Ruangwa ward out of 5435 only 245 (4.5%) males and 298(5.4%) females were tested. In 2012 out of 6662 only 320 (4.8%) males and 353(5.3%) female got tested in Mandawa ward while in Ruangwa ward out of 5435 only 250 (4.6%) males and 301(5.5%) females got tested (URT, 2014). In spite of presence of VCT which encourage people to test HIV/AIDS number of people who got tested decreased last three years. The findings about the number of people visiting VCT are summarised in Table 4.14.

Table 4.14: Ruangwa District HIV/AIDS Voluntary Counseling and Testing 2012, 2013 and 2014

YEAR	WARD	Ward Population	Number of People Tested by Sex/ Gender				Total number of people Tested	
			Male		Female			
			NO	%	NO	%	NO	%
2014	**Mandawa**	6662	280	4.2	340	5.1	**620**	**9.3**
	Ruangwa	5435	250	4.6	272	5.0	**552**	**9.6**
2013	**Mandawa**	6662	275	4.1	355	5.3	**630**	**9.4**
	Ruangwa	5435	245	4.5	298	5.4	**543**	**9.9**
2012	**Mandawa**	6662	320	4.8	353	5.3	**673**	**10.1**
	Ruangwa	5435	250	4.6	301	5.5	**551**	**10.1**

Source: District Medical Office, 2015

4.4 Efforts Made by Ruangwa District Council to Encourage Men in HIV/AIDS Counseling and Testing

In this part the researcher reviewed different literatures so as to get more information about efforts made by District council to encourage men involvement in HIV/AIDS counseling and testing, among of the reviewed documents were HIV/AIDS annual reports in 2012-2013 and 2013-2014. The findings showed that, the District council had managed to put more efforts to encourage people in HIV/AIDS voluntary council and testing through.

(i) Establishment of Council Multi-Sectoral AIDS Committee (CMAC)

The committee guided by the National Policy on HIV and AIDS and the NMSF [2003 – 2007 & 2008 – 2012], TACAIDS and key stakeholders coordinated implementation nation-wide. The committee had the following members: Council vice chairperson, council HIV/AIDS coordinator (CHAC) as secretary of the committee, District AIDS Control Coordinator (DACC), 2 religious leaders, 2 youth from both sex, 2 PLHA, and 2 invited guests, The CMACs have clear roles: promote VCT and provide and ensure access to VCT services for all members of the community, especially for youth and key populations vulnerable to HIV, to make sure that resources in the war against HIV/AIDS are available, plan HIV/AIDS activities on behalf of the council, educate or to spread knowledge about HIV/AIDS VCT to Ward Multi- sectoral AIDS Committee and Village Multi-sectoral AIDS committees, according to HIV/AIDS annual report 2014 showed that in Ruangwa DC more than 14 wards out of 21 and 45 villages out of 81 were reached. Challenges face CMAC in Ruangwa DC; lack of transport: bicycles, motorbikes, (hard to reach) due to long distances travelled to reach the clients, Lack of sense of urgency: political will at the district level, inadequate budgets for HIV and AIDS (TACAIDS, 2008).

(ii) Establishment of HIV/AIDS Radio programmes

Ruangwa radio programme involves dialogues about HIV/Aids among adolescents and young people, through entertainment and education approach to address risky sexual behaviours in efforts to reduce new HIV infections among them, those programmes based on educating people about HIV/AIDS prevention, Voluntary Counseling and Testing and Preventing Mother to Child Transmission, Those programmes are conducted every Friday 19:00 - 21:00 P.M by inviting different district experts like (CHAC, DAC, PLHA,) in Ruangwa FM radio. HIV/AIDS radio programme is used to encourage people to participate in HIV/AIDS VCT. The radio programme is used to spread the information about what is going on in Council about HIV/AIDS VCT and rate of HIV/AIDS infections (URT, 2014).

(iii)Establishment of Secondary Schools and Youth HIV/AIDS Clubs

This idea was introduced by Former district commissioner (Honorable, Hawa Mchopa) with the aim of the establishment of secondary schools and youth clubs was to spread knowledge to students and youth about HIV/AIDS VCT so as to reduce the infections of HIV/AIDS in future generation. Youth HIV/AIDS clubs programme's interest is not only in HIV/AIDS prevention, but also in the directly related topics of relationships, sexuality, and healthy life skills. The programme also prepares and equips students to share what they learn with other students as peer educators. In this programme 15 secondary schools HIV/AIDS clubs were established out of 19 secondary schools in 2010 –2014. In 2012-2014 more than 12 youth clubs were established in 14 wards out of 21 wards. Each year in June, council conducts two-week long day camps in Ruangwa secondary school, involving 100 - 150 students and teacher participants, volunteers, and teachers plan and lead the daily activities of camp. The main function of the youth clubs is to exchange experiences and ideas among the youths about HIV/AIDS VCT. Those clubs are very important because students/youth that have the same age can be free to express themselves about HIV/AIDS VCT. At the conclusion of camp, family, friends, and community members are invited to a graduation ceremony during which students showcase what they have learned through song, drama, and art. The ceremony conveys to its audience the importance of community support in the fight against HIV/AIDS. After student leaders complete peer-educator training, they return to their schools and form HIV/AIDS clubs. The goal of these clubs is to provide an open forum for students to educate their fellow students in HIV/AIDS VCT, life skills and health issues relating to youth (URT, 2013).

(iv)Encourage Preventive Mother to Child Transmission (PMTCT)

The council makes a lot of effort to encourage people to participate in HIV/AIDS Counseling and Testing; to reduce maternal and child morbidity and mortality (sickness and death) due to HIV/AIDS and improve the care of the HIV positive mother and/or child by preventing HIV infections among women of childbearing age, preventing transmission of HIV from mother to child, improving maternal health related to HIV and AIDS, improving child health related to HIV/AIDS. The

programme was established national wide so as to prevent children from HIV/AIDS infections. Through PMTCT couples are encourage to go and test for HIV/AIDS, pregnancy women together with their partners are targeted group in this programme so as to prevent mother to child transmission. In order to encourage more men to participate in this programme the council gives men an offer to go and test HIV/AIDS without wasting time in lines; Through PMTCT service men are given consideration more than women. The barriers identified included the belief that pregnancy is a "woman's affair"; the belief that a man's role is primarily to provide financial support for the woman's care; the man's perception that he will be viewed as jealous by the community if he comes to clinic with his pregnant wife (URT, 2014).

Furthermore, majority of respondents agreed that Ruangwa District Council made great efforts to encourage not only men but also women. To get more information researcher continued asking respondents, is there any effort made by district council to encourage men in HIV/AIDS VCT. The finding shows that, 69 (88.4%) agreed that there were efforts made by Ruangwa DC to encourage men in HIV/AIDS VCT while 9 (11.5) did not agree by saying there were no enough efforts to encourage men in HIV/AIDS VCT.

Also, the researcher decided to ask the respondents to mention the efforts made by District Council to encourage men in HIV/AIDS VCT. The findings showed that 24(34.78%) respondents mentioned establishment of new VCT centres as an effort made, 13(18.84%) respondents mentioned the provision of education in public radio as an effort made, 32(46.38%) respondents mentioned that men were encouraged through PMTCT. The findings about efforts made by Ruangwa District Council to encourage men’s involvement in the HIV/AIDS VCT summarized in Table 4.15.

Table 4.15: Efforts made by Ruangwa DC to Encourage Men in HIV/AIDS counseling and Testing

S/N	Efforts Made	NUMBER	PERCENTAGES
(i)	Establishment of new VCT centres	24	34.78
(ii)	Provision of education in Public Radio	13	18.84
(iii)	Encourage men through PMTCT	32	46.38

Source: Research Finding, 2015

4.5 Factors Affecting Men Involvement in HIV/AIDS Counseling and Testing in Ruangwa District Council

The researcher sought to find out factors affecting men in HIV/AIDS counseling and Testing. In order to go deep the researcher asked the respondents to mention factors hindered men involvement in HIV/AIDS VCT and factors encouraging men involvement in HIV/AIDS VCT.

4.5.1 Factors Hindered Men Involvement in HIV/AIDs Counseling and Testing In this part

In this part the researcher sought to find out factors hindered men involvement in HIV/AIDS VCT, the following are the factors hindering men's involvement in HIV/AIDS VCT, fear of positive results, confidentiality, stigma, location of VCT room, distance to VCT centre. The findings about factors hindering men's involvement in the HIV/AIDS VCT are summarised in Table 4.15.

(i) Fear of Positive Results

Explanation for why people do not take HIV tests or return for results is fear. People may fear the life-threatening nature of HIV infection, as well as the negative social consequences that may accompany a diagnosis, such as rejection by loved ones, loss of a job or housing, discrimination and even physical violence. The findings show 33(42.31%) mentioned fear of positive results hindered people in HIV/AIDS counseling and testing. This factor is evidenced by the following quotation;

"I am working as hotel waiter, I know if I get tested for HIV/AIDS, I am going to suffer because I am going to lose my job, and people will always look me different, thus why I don't want to test HIV/AIDS"

(ii) Confidentiality

Confidentiality is another important ethical dimension of counseling and testing that has implications both for patients' rights and for the public health objective of increasing utilisation of testing, since perceptions of how confidentiality is handled may influence clients' willingness to be tested. The finding of this study show that 9(11.54%) respondents agree that confidentiality is one of the factors hindered men in HIV/AIDS counseling and testing. This study is supported by WHO (2009), which maintains that laws, governmental policies, institutional policies, available resources and prevailing attitudes are all factors that influence the extent to which health workers protect the confidentiality of medical information in health care settings. Evidence suggests that lack of confidentiality can be a serious problem in many settings. In a comparative study in India, Indonesia, the Philippines and Thailand, 34% of HIV-positive respondents reported that health care workers had revealed their HIV status to someone else without their consent. In some settings, health workers do not have a positive view of patient confidentiality and may even see confidentiality as a way to protect irresponsible individuals.

(iii) Stigmatisation

Fear of stigma and discrimination is mentioned to be a major barrier in HIV/AIDS testing in Ruangwa DC, fear of stigma, discrimination and violence also affects the decision to disclose HIV status. Some observers have noted that health workers may discourage testing if they stigmatise against HIV-positive patients by treating them differently, using excessive precautions. The findings show that 15(19.23%) respondents mentioned stigma as a factor hindering men in the HIV/AIDS VCT. This factor is evidenced by the following quotation:

"A number of people don't want to get tested because if you become positive the society will isolate you"

(iv) Location of VCT Room

It was found that location of the VCT room was another factor hindering men's involvement in HIV/AIDS VCT, respondents argue that VCT room was very close with other rooms that the results given to clients may be easier to be seen through client's body language, The findings showed that some households 7 (8.97%) said that VCT room are located very close with other rooms, so there were no privacy at all. The study supported by picked respondents who said:-

> "*The problem here is that our dispensary is too small, so there is no privacy. For example, if you go for an HIV test and your results come back positive, everybody is able to guess the outcome of the test from your body language as you have to pass the very same queue you were in.*

> *"My problem is that there is absolutely no privacy as the VCT room is right in the middle of the clinic. It is very uncomfortable, as people in the clinic can all see the people who go into the VCT room, after which they will gossip and say, "Did you see Mr X coming from the VCT room?"*

(v) Distance to VCT Centre

Distance to VCT centre seen as a hindering factor for men to participate in the HIV/AIDS VCT. The findings showed that 14 (17.95%) said that VCT centres are located very far away from their settlements, for example from Mandawa chini harmlet to Mandawa health centre in the same ward the distance is about 45 kilometers. The findings about factors hindering men in the HIV/AIDS VCT summarised in Table 4.16.

Table 4.16 Factors Hindering Men in the HIV/AIDS VCT

S/N	Factors hindering	NUMBER	PERCENTAGES
(i)	Fear of positive results	33	42.31
(ii)	Confidentiality	9	11.54
(iii	Stigma	15	19.23
(iv	Location of VCT room	7	8.97
(v)	Distance to VCT centre	14	17.95

Source: Research findings, 2015

Fear is a chronic barrier to HIV counseling and testing. Fear of a positive test result was mentioned as important obstacle to undertake an HIV test. Worries about disclosure and breaches of confidentiality were also considered as an obstacle for seeking HIV counseling and testing. Fear of stigmatisation was said to be among of the factors affecting men in accessing the HIV testing services. ECDC (2010) came up with justification. The fear is still attached to HIV is a barrier to testing, especially among communities that are themselves stigmatised and among healthcare workers.

4.5.2 Factors facilitating Men in HIV/AIDS Voluntary Counseling and Testing

In this part researcher tried to find out factors facilitating men participation in the HIV/AIDS VCT in Ruangwa District Council. The following are factors facilitating men in the HIV/AIDS VCT: health problem, marriage purpose, religious leaders influence, to know HIV/AIDS status, peer education and support from NGO and government institution:-

(i) Health Problems

Health problem was among of facilitating factors that facilitate men in the HIV/AIDS VCT. The findings show that 32(41.03%) encouraged to go to find out their health status because of their health problems. The findings supported by the study by Yorder (2004) show that most of people who experienced sickness for a period of three to six (3-6) months were reported to have taken a decision of going for HIV/AIDS testing, this is because those who experienced continuously sickness for that period becomes in doubt with their health. Hence, their intention was to know their health status. Another study conducted by Urassa, (2004) in Moshi indicated and cited some of the reasons that made people volunteer for HIV/AIDS testing, indicated that people being into illness for a long period influenced to go for HIV/AIDS VCT. This evidence supported by the picked respondents who said:-

> "*Most of the men attending for HIV/AIDS counseling and testing because of health problems, those who suffer from unknown disease are the one who decide to for VCT to find out whether they are affected with HIV or not"*

(ii) Marriage Purposes

Another facilitating factor was marriage purposes, going for HIV testing for marriage purposes was reiterated by some of respondents as advantageous because when people got tested were free for them to start a new life in marriage. The findings revealed that15 (19.23%) respondents supported that marriage purposes were one of the factors which encourage a number of people especially men to go and test for HIV/AIDS VCT.

(iii) Religious Leaders Influence

Religious leaders' influence was among the facilitating factors that encourage many people to go for HIV/AIDS VCT. The finding shows that 4(5.13%) respondents mentioned religious leaders' influence was one of the factors facilitating men to go for HIV/AIDS VCT. Religious leaders encouraged their people to participate in HIV/AIDS VCT, before many people died due to HIV/AIDS, so from there most of religious leaders in Ruangwa DC started to be open to their people to tell them the truth about HIV/AIDS, because without telling them the truth the situation may be worse in the future.

(iv) To Know HIV/AIDS Status

Another facilitating factor was clients want to know their HIV/AIDS Status, some of people decided to find out their health status because they wanted to know their HIV/AIDS status. The finding revealed that 17(21.79%) respondents agreed that some of men go and test for HIV/AIDS because they just want to know their HIV/AIDS status, after knowing their HIV/AIDS status they can be in a position to copy with the test results, they can be in a position to avoid new infections. Knowing their HIV/AIDS status early helps people especially men to live better, longer and more comfortable lives.

(v) Peer Education and Support from NGO'S and Government Institutions

Peer education was mentioned as an important factor which encourages a number of men to go for HIV/AIDS counseling and testing. Also, support from NGO's and the government institutions contribute to encouraging a number of men to go for HIV/AIDS counseling and testing. Respondents think that taking anti-retroviral

(ARVs) is the best option to become better if tested positive. The finding revealed that 10(12.82%) respondents supported that peer education and support from NGO'S and government institutions encourage men to go for HIV/AIDS VCT. Support of good nutrition was a fundamental part of caring for people living with HIV/AIDS. Good nutrition translated into a balanced diet was a positive way to respond to this illness, and it helps people live better, longer and more comfortable lives. The findings about factors facilitating men to go for HIV/AIDS VCT are summarised in Table 4.17

Table 4.17: Factors Facilitating Men to go for HIV/AIDS Voluntary Counseling and Testing

S/N	Factors facilitating	NUMBER	PERCENTAGES
(i)	Health problems	32	41.03
(ii)	Marriage purposes	15	19.23
(iii)	Religious leaders influence	4	5.13
(iv)	To know their HIV/AIDS status	17	21.79
(v)	Peer education and support from NGO's and government	10	12.82

Source: Research Findings, 2015

Health problems is the main factor that encourage men to go for HIV/AIDS counseling and testing, others were, need to know their HIV/AIDS status, marriage purposes, religious influence, peer education and support from NGO's and government institutions. The findings supported by Meda (2013) which asserted that the need to know whether they are positive or negative is among factors that encourage people to go for test; people might want to know their status after having a relationship with an unfaithful partner. Religious leaders encouraged couples to go for HIV counseling and testing before they got married. Thus, 'marriage' is one of the factors that influenced people to go for VCT. Some people may decide to go for VCT before or shortly after their marriage, especially in the case of women.

4.6 Ways of Promoting Men Involvement in HIV/AIDS Counseling and Testing

In order to encourage men to involve in HIV/AIDS counseling and testing researcher asked respondents about the measures that can promote men participating in HIV/AIDS counseling and testing. The findings were as follows:-

(i) HIV/AIDS Voluntary Counseling and Testing Need Collaboration Efforts

In order to encourage more men in HIV/AIDS testing collaboration between all stakeholders is very important. Finding shows that 4(5.13%) respondents argued that collaboration between NGO's and GOT encourage more men in HIV/AIDS counseling and testing. ECDC (2010) report come up with justification that developing the strategy requires the participation of all major stakeholders in order to build a coalition around shared objectives. These include people living with HIV, representatives of communities most affected, civil society and prevention agencies, professionals with expertise in HIV testing and others with a role in implementing the strategy. One of the service providers said:-

> *"Government itself will never win this war; we need more efforts from different stakeholders like civil society, Non- governmental organisation, prevention agencies and the community themselves"*

(ii) **Community Action to Reduce Stigma**

The findings show that 7 (8.97%) respondents argued that another way of encouraging men to go for HIV/AIDS testing is through Community action so as to reduce stigma. WHO (2012) report came up with justifications that more work needs to be done to reduce stigma and discrimination in communities, and to promote positive preventive behaviours. Some of respondents said:-

> *"It was difficult to remain engaged in HIV/AIDS testing due to the social stigma from friends and family if feeding practices deviated from local norms*"

(iii)Confidentiality

The results show that 12(15.38%) respondents argued that the best way to encourage men to go for HIV/AIDS testing is through service providers and other stakeholders keeping confidentiality. This can encourage men to go for HIV testing. ECDC (2010) report indicates that confidentiality is a fundamental principle of all healthcare centres but because of the stigma attached to HIV and the behaviours through which it may be transmitted, it is critically important for HIV testing. Lack of confidence in confidentiality among people at risk may act as a barrier to accessing HIV testing services.

(iv) Provision of Motivation to Men in HIV/AIDS Counseling and Testing

The results show that 6(7.67%) respondents argued that one of the best way to encourage men in HIV/AIDS testing is through motivation of men in different ways. WHO (2012) reports indicate that those who had never tested were least motivated, empowered, resourced, socially confident and knowledgeable about HIV. This suggests interventions intended to increase motivation, knowledge, access to resources and social confidence should disproportionately benefit those who have never tested.

(v) Media and Radio talks should be Aired to Educate the Society

The research shows that 13(16.67%) respondents argued that the best way to encourage men in HIV/AIDS testing is through raising awareness in media and public in general, this situation is supported by report by Akarro, Deonisia and Sichona (2011) emphasised seeking and accepting HIV testing, the public, and especially groups at higher risk of HIV; and the need to understand its benefits. A strategic approach to communication is needed, using a range of different channels. Visible and high-level support from opinion formers, including politicians, community leaders and celebrities, and supportive and accurate coverage in the media, can all be used to raise awareness.

(vi) Awareness should be Created among Men

The research shows that 36 (46.15%) respondents argued that the best way to encourage men in HIV/AIDS testing is through creating more awareness among men. This result supported WHO's report (2012) which argued that awareness campaigns that educate men and couples about HIV serodiscordancy are urgently needed so that more men will be motivated to seek HIV testing for themselves instead of using their partner's status as a proxy measure of their own status, men were well aware of media efforts to promote their involvement in testing, but they said:

> *"Media campaigns did a less effective job of explaining why men should be tested and what benefits they would derive from testing".*

The results showed that the awareness should continue to be created among men so as to encourage men's involvement in HIV/AIDS testing. The findings about ways of promoting men's invovement in HIV/AIDS VCTare summarised in Table 4.18.

Table 4.18: Ways to Promoting Men in the HIV/AIDS Voluntary Counseling and Testing

S/N	Ways of Promoting Men	NUMBER	PERCENTAGES
(i)	Collaboration between Government and NGO'S	4	5.13
(ii)	Community action	7	8.97
(iii)	Confidentiality	12	15.38
(iv)	Provision motivation to men	6	7.69
(v)	Media aired to educate the society	13	16.67
(vi)	Awareness created to men	36	46.15

Source: Research findings, 2015

4.7 Discussion of Results

This part presents discussion of the results obtained from the study. This study was intended to assess the determinants of men involvement in HIV/AIDS Counseling and Testing in Tanzania experience of Ruangwa District. The objective was specifically attained through four specific objectives which were to investigate the status of HIV/AIDS VCT, efforts made by District council to encourage men's involvement in HIV/AIDS VCT, factors affecting men's involvement in HIV/AIDS counselling and testing, and ways of promoting men's involvement in HIV AIDS counselling and testing.

Objective number one intend to find out the Status of HIV/AIDS Voluntary Counseling and Testing in Ruangwa District Council. The findings showed that many respondents had knowledge about HIV/AIDS VCT; many respondents had heard about HIV/AIDS VCT, they heard about it from village dispensary, mass media, and others heard it from world HIV/AIDS day. The findings showed that majority participated in HIV/AIDS VCT; many respondents perceived HIV/AIDS

VCT as very important; the findings showed that a number of VCT centres are not spread in all health facilities, people are not satisfied with the number of VCT available in Ruangwa DC. Many respondents tried to mention the importance of HIV/AIDS VCT, not only that but also the findings showed that number of women got tested for HIV/AIDS is greater than number of men. The findings showed that the rate of people who got tested for HIV/AIDS was very low. Generally, the findings showed that the majority had knowledge about HIV/AIDS VCT but the number of people who attend VCT was still low. These findings are consistent with other literature showing that majority had heard knowledge about HIV/AIDS VCT but the number of people who attend VCT was very small. In some countries where VCT services have been established there has also been a reluctance of people to attend. This may be because of denial and of the stigma and discrimination that people who test seropositive may face (UNAIDS, 2000).

Objective number two was intended to find out efforts made by Ruangwa DC to encourage men in HIV/AIDS voluntary counselling and testing. The findings showed that many of respondents mentioned the efforts made by Ruangwa district council to encourage men's involvement in HIV/AIDS voluntary counseling and testing, some efforts made by District council to encourage men's involvement in HIV/AIDS counseling and testing were, establishment of Council Multi-Sectoral AIDS Committee, establishment of secondary school and youth AIDS clubs, establishment of HIV/AIDS radio programme under Ruangwa FM. Also, through Prevention of Mother to Child Transmission (PMTCT), men were encouraged to go with their partners to clinics for more checkups including HIV/AIDS testing; the aim is to protect children from HIV/AIDS infections. These means that Ruangwa District council should continue putting more efforts to make sure that people change their mindset about HIV/AIDS. The council must come up with special efforts to encourage men's involvement in HIV/AIDS VCT. These findings consistent with other literatures showing the effort made by different countries to encourage people in HIV/AIDS Voluntary Counseling and testing. Recent advances in HIV testing technology have resulted in a variety of rapid assays, many of which are relatively easy to administer and do not require refrigeration. In Malawi, the introduction of

rapid tests and same day results caused a significant increase in demand for VCT, with a six fold increase in the number of persons informed of their sero-status (CRHCS, 2002).

Objective number three was intended to find out factors affecting HIV/AIDS voluntary counselling and testing. The study revealed that some of the factors that facilitate and limit men to go for HIV/AIDS counselling and testing.

The following were factors facilitating HIV/AIDS voluntary counselling and testing; marriage purposes, Religious leaders' influence and health problems. This means that religious leaders should be given more techniques and knowledge about HIV/AIDS VCT by experts so as to influence their followers to understand the strengths of HIV/AIDS VCT, because religious leaders lead a number of people in their houses (mosques and churches).

Also, the study revealed that some of the factors that limit men in HIV/AIDS voluntary counselling and testing were; confidentiality, stigma, fear of positive results, distance to VCT centres and location of VCT room. The findings showed that majority are discouraged to participate in HIV/AIDS voluntary counselling and testing because of fear of positive results, this means more knowledge is needed among the people so as to change their mindset, counselling before and after testing is very important but service providers fail to practice effectively because are very few, it is very difficult for them to use a lot of time in counselling because most of them have other duties in the facility. Also, efforts should be put forward to increase the number of VCT centres in all health facilities and number of staff in Ruangwa DC. These findings are consistent with literature from Africa showing that fear of being positive limit a number of people to go and test (Maman *et al*, 2001), confidentiality (Kipp *et al.*, 2002), Lie *et al.*, 1994), unfaithfulness (Antelman *et al.*, 2001; Kilewo *et al.*, 2001; and Stigma (Cartoux *et al.*, 1998) were important factors hindering the acceptance of HIV/AIDS testing. However, it has also been reported that several socio-demographic factors were associated with acceptance of HIV/AIDS testing (Bakari *et al.*, 2000).

Objective number four was intended to find out ways of promoting HIV/AIDS voluntary counseling and testing among men in Ruangwa DC. The findings from this objective demonstrated ways of promoting men involvement in HIV/AIDS counseling and testing as follows; media should be aired to educate the society, provision of motivation to men, community action to reduce stigma, needed of strong collaboration between government and NGO'S, as well as confidentiality and creating awareness among men. These findings are consistent with literature showing that in areas without access to such mass media education should be granted through popular theater, using professional actors to deliver the concrete messages to men and in a simple language (Mwakatobe, 2007). Posters and brochures should be distributed in a big number in areas where access to TV, radio and newspaper is limited. In Uganda media promotion of VCT services by Straight talk and radios lead to influx of young people seeking VCT services.

Determinants of HIV/AIDS Voluntary Counseling and Testing in Ruangwa District Council, the determinants of HIV/AIDS VCT classified into 5 categories: - Socio-economic factors like marriage purpose, religious leaders' influences, peer education and government support and gender. In gender, female were more likely to get tested than male and peer education and government support; many people were encouraged to test for HIV/AIDS because they expected to get support from the Government and NGO's (economically and socially).

HIV/AIDS related stigma: - is the second category of the determinants whereby people were not willing to know their HIV/AIDS status because they were afraid of being discriminated by their partners or neighbours.

HIV/AIDS VCT knowledge is the third category of the determinants of HIV/AIDS VCT: results indicate that for those who had heard about HIV/AIDS VCT were willing to get tested for HIV/AIDS but for those who had not heard about HIV/AIDS VCT did not attend to get tested.

Health problem is the fourth category of the determinants of HIV/AIDS VCT: the results indicated that most of the people who experienced sickness are more likely to use VCT services.

Health facility infrastructures is the fifth category of the determinants of HIV/AIDS VCT, health facilities infrastructures may encourage or limit people to get tested for HIV/AIDS. The results found that some of people were discouraged because of location of the health facilities, the distance from people's settlements to the health facilities were very long that is why many people failed to attend VCT. Also, the results found that some people were no happy with the location of VCT room, they argued that VCT room was very close to other rooms, there was no confidentiality at all.

Furthermore, there were some propositions that could encourage men's involvement in HIV/AIDS Voluntary Counseling and Testing.

The most important is confidentiality; best way of encourage men in HIV/AIDS Voluntary Counseling and Testing is through service providers and other stakeholders ensuring confidentiality in the whole process of HIV/AIDS Voluntary Counseling and Testing. Community should understand that stigma is very dangerous, community action should be in practice so as to reduce stigma, more work needs to be done to reduce stigma and discrimination in communities. Other literatures from different countries showing some strategies to increase number of men to attend VCT services, some of their strategies were community mobilization for VCT, mass media campaigns, social marketing and the testing a catchy brand name, special promotions for instance sponsoring big outdoor events, increased number of VCT sites, increased use of mobile and outreach services (CRHCS, 2002).

CHAPTER FIVE

SUMMARY, CONCLUSION AND POLICY IMPLICATIONS

5.1 Introduction

This chapter summarises the information obtained from the study. Conclusions are drawn and finally policy implications are made concerning determinants of men's involvement in HIV/AIDS Voluntary counseling and testing.

5.2 Summary

The study made an assessment of the determinants of men's involvement in HIV/AIDS counseling and testing Ruangwa District council. The study area was Ruangwa District Council. This analysis looked on the following: respondent's characteristics (age, gender, marital status, education level of respondents and family size), Status of HIV/AIDS Voluntary Counseling and Testing, efforts made by Ruangwa District council to encourage men's involvement in HIV/AIDS Voluntary Counseling and Testing, factors affecting HIV/AIDS Voluntary Counseling and Testing in Ruangwa District council, and ways of promoting HIV/AIDS Voluntary Counseling and Testing among men in Ruangwa District council.

Data were collected through questionnaires, interviews, focus group discussion, observation and documentary review. The study comprised 78 respondents who were selected randomly as well as purposively sampled. The data were analysed by using SPSS and Microsoft excel programme in descriptive statistics whereby frequencies and multiple responses were acquired, and presented in tables and pie charts.

The findings showed that majority had knowledge about HIV/AIDS VCT, most of them had heard about HIV/AIDS VCT. Also, most of them perceived HIV/AIDS VCT as very important and were satisfied with the importance of VCT. A number of women who participated in the HIV/AIDS VCT was greater than the number of men. Not only that but also the number of VCT centres were not enough to cover the whole population, more new VCT centres were needed. Moreover, the results

showed that majority of surveyed household participated in HIV/AIDS counseling and testing in order to plan for their future while others participated so as to avoid HIV/AIDS infections.

Also, the findings from the study find out that there were efforts made by district council to encourage men to participate in HIV/AIDS VCT, the District council manage to establish radio programmes so as to educate the society, also they managed to establish secondary school and youth HIV/AIDS clubs, people were encouraged to participate in PMTCT,

Also, the findings come up with factors facilitating men's involvement in the HIV/AIDS VCT which were health problem, religious leaders' influence; they want to know their HIV status and marriage purposes. Also, few of surveyed households did not participate in HIV/AIDS counseling and testing due to fear of positive results, lack of confidentiality among service providers and stigmatisation in the community. Concerning factors that hindered and facilitated men's involvement in HIV counseling and testing, the study found that the factors that hindered men's involvement in HIV/AIDS VCT included confidentiality, location of VCT room, distance from settlements to VCT centers, fear of being positive and stigmatization. This implies that in order to overcome all factors that hindered men's involvement in HIV/AIDS VCT the following must be done: more awareness to be created among men (more media and radio talks should be aired to educate the society), enhancing confidentiality among service providers and community action so as to reduce stigma and discrimination, provision motivation to men who decide to test HIV, more collaboration between NGO's and government institutions

Nevertheless, a lot needs to be done since some households did not test. The findings show that very few people participated in HIV/AIDS voluntary counseling and testing.

5.3 Conclusions

Based on the objectives of the study, the general objective of the study was to investigate determinants of men's involvement in the HIV/AIDS VCT. Man is a key

contributor to community acceptance and support of HIV/AIDS voluntary counseling and testing programmes, male involvement needs to be comprehensive in terms of establishing friendly health facilities. The contradiction between men towards their involvement and low participation rates suggests that external barriers play a large role in this decision making process. The present study has demonstrated that knowledge and awareness of men on HIV/AIDS counseling and testing among respondents is almost good but still the number of people participating in the HIV/AIDS VCT still very low.

Precisely, the study examined the status of the community about VCT and how knowledge can help men to get involved in HIV/AIDS counseling and testing that increases the rate of performance. The assessment noted that majority of people are knowledgeable but still the trend of HIV/AIDS counseling and testing still low. Therefore, the trend of HIV/AIDS VCT is not enough, the study has conclusively confirmed the secret that poor trend of HIV/AIDS voluntary counseling and testing due to fear of positive results, this means that people are not well informed about HIV/AIDS.

In case of the District efforts, it was observed that District council makes a lot of efforts to encourage men in HIV/AIDS counseling and testing through PMTCT, public education in radio programmes and establishment of more VCT centres, but the trend for HIV/AIDS counseling and testing still a problem, very few people attend for HIV/AIDS counseling and testing.

Involvement of men in HIV/AIDS counseling and testing is very important factor but is discouraged with some external factors such as; lack of confidentiality among service providers, stigma in the society, distance to VCT centres and fear of positive results. Involvement of men will be more advanced if the religious leaders' encourage their followers to test for HIV/AIDS before marriage.

In case of ways of promoting of men involvement in HIV/AIDS counseling and testing, majority managed to mention some ways in promoting men involvement in

HIV/AIDS counseling and testing; men should be motivated enough in order to change their mindset, because men are the decision makers in their families.

5.4 Policy Implications

In view of the major findings and the above conclusions, the following policy implications are made in order to improve men involvement in HIV/AIDS counseling and testing so as to reduce HIV/AIDS infections in Ruangwa District especially in wards of Mandawa and Ruangwa.

i. Meet Minimum Requirement for VCT

District authority should meet minimum requirements for VCT; a discreet and easily accessible site, clear and non-stigmatising signs for VCT service, a private room for counseling, a comfortable and discreet waiting room, a trained counselor on site, printed health education material and condom stocks. VCT sites should be organised in a manner that is convenient to clients. All measures should be taken to assure client comfortability from the point of entry to the point of exit

ii. Service Providers Responsibilities

Service providers are supposed to provide information at the same time they should maintain confidentiality, they should not be judgmental and they are expected to be good models in the society. In order for service providers to be competent in their work training is important for them. They include retraining, because the field they are involved in things are not static, many new things are coming up which need their attention in their work. Among mentioned interests of men is to meet qualified service providers, if service providers were responsible they will maintain clients confidential and stigma.

iii. Improve the Quality of HIV/AIDS Voluntary Counseling and Testing Services

The District authority should make sure that VCT services can be improved in various ways, by making the available VCT services more men friendly services. Therefore, the training of the available counselors on the skills of how they can deal with men is important if we want them to work with men effectively. Also, retraining

programmes to counselors are important because counseling is not static, it is dynamic there are some of the things are getting out others are coming in therefore according to this it becomes necessary for counselors to attend in refresher courses so that they can be retrained.

It is possible that what they learned in past five years are already out of use but there are other things that have come up, then retraining is important to cover this discrepancy. Counselors lacking such opportunities of attending retraining courses work with difficulties due to lack of new skills. Provision of ongoing counseling services to men is important to meet men's needs. Also, if all of the available VCT sites will have the STIs treatment component it might attract many young people to use the services and will reduce the stigma to those who attend such treatment in other health facilities. Moreover, by introducing men' friendly services within the available VCT services might improve the uptake of the VCT services among men. Introduction of men' friendly services should go hand in hand with increasing skills to counselors on men' friendly services.

iv. Site Security and Confidentiality Requirements

The District authority should make sure that site security and confidentiality requirements are available; all clients' records will be maintained in locked cabinet, access to client records should be restricted to counselors, the coordinators and the site manager. This may reduce stigma in the society.

v. Human Resources Issues Prioritized for Sustainability

Government should improve the recruitment on Human resources. Without adequate staffing for clinical and community-based services and programmes, delivery systems and channels, and research and management functions. The government should produce qualified health and social welfare workers; supporting local government to improve recruitment, retention, and productivity of human resources for health and emphasising scale up of pre-service training.

In general, for enhancement of men's involvement in HIV/AIDS counseling and testing, all policies that favour health sector (such as VCT), Voluntary counseling and testing, PITC (Provider initiated for testing and counseling) and PMTCT

(Preventive mother to Child Transmission) should be created effectively especially to youth.

5.5 Areas for Further Studies

The findings of this study have raised theoretical and methodological questions that need further investigation. On the other hand, in the process of conducting the study some areas for more research emerged. To this end, the following areas for further research are recommended:

1) Studies should be conducted investigating the effectiveness's of the Government VCT policy
2) A comparative study be done on the level of men's involvement between those who are partners of HIV/AIDS positive women and who are partners of HIV/AIDS negative women

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APPENDICES

APPENDIX: I

QUESTIONAIRE FOR HOUSEHOLDS

Introduction

My name is Hosea Shibanda. I am a Master's student at Mzumbe University pursuing Master of Science in Development Policy. I am conducting a study titled "HIV/AIDS testing and counseling in Tanzania and low rate of men's involvement in Ruangwa district council. I am asking for your valuable time to set aside some few minutes to participate in research in the form of a questionnaire. I assure you that the information given from you will be used for academic purposes only.

Village_____ Ward_____

A. Personal Information

Tick (√) where appropriate

(1) Sex of respondent

a. Male _____ { }

b. Female _____

(2) Age of respondents

a. Between 15 and 24years _____

b. Between 25 and 34 years _____

c. Between 35 and 44 years _____ { }

d. Between 45 and 54 years _____

e. Between 55 and above _____

(3) Education level

a. None _____

b. Primary education _____

c. Secondary education _____ { }

d. Tertiary education _____

e. University _____

(4) Marital status

a. Single _____

b. Married _____

c. Divorced _____ { }

d. Widow _____

e. Divorced/separation _____

(5) The size Household _____

a. 1 - 3

b. 4 – 6 { }

c. 7 - 9

(6) Occupation _____

a. Farming

b. Employed { }

c. Mining

d. Petty business

(7) Income earned per Year_____

a. 200,000 – 500,000

b. 500,001 - 800,000

c. 800,001 – 1,100,000 { }

d. 1,100,001 -1,400,000

e. 1400,0001 +

B. Status of HIV/AIDS Voluntary Counseling and Testing in Ruangwa District Council

(8) Have you heard of HIV/AIDS Voluntary Counselling and Testing?

a. Yes _____

b. No _____ { }

(9) If yes (in question 8) where did you get the information? mention

a. Village Dispensary

b. District Hospital { }

c. Mass media

d. HIV/AIDS World day

(10) Have you ever participated in the VCT of the HIV/AIDS?

a. Yes { }

b. No

(11) What is your perception in the rate of importance of HIV/AIDS Voluntary counseling and Testing?

a. Very important

b. Important { }

c. Satisfactory

d. No important

(12) Mention the importance of HIV/AIDS Voluntary Counseling and Testing?

i. …….

ii. …….

iii. …….

iv. …….

(13) What is your view regarding the number of VCT centres for HIV/AIDS?

a. Satisfied

b. Undefined { }

c. Not satisfied

C. Factors hindered men in HIV/AIDS testing and counseling

(14) What are factors facilitating men in HIV/AIDS counseling and Testing?

a. ……

b. ……

c. ……**.....**

d. ……

(15) What factors hindered men in HIV/AIDS counseling and testing

a. ……

b. ……

c. ……...

d. ……...

D. Efforts done to encourage men involvement in HIV/AIDS testing and counseling

(16) Is there any effort by district council to encourage men in HIV testing in your village?

A) Yes { }

b) No

(17) If yes, mention any efforts you know

a. ……..

b. ……..

c. ……..

d. ……..

e. ……..

(18) If no in question 16, from your understanding what can be the reasons

a. …….

b. …….

c. …….

d. …….

e. ……

E. Ways of Promoting Men involvement in HIV/AIDS Counseling and Testing in Ruangwa DC

(19) What are the ways of promoting men involvement in HIV/AIDS voluntary Counseling and Testing in Ruangwa.

a. …….

b. …….

c. …….

d. …….

e. …….

Thank you for your good cooperation.

APPENDIX: II

Interview Guide for DMO

1) What is your title?
2) When did you start working with Ruangwa DC?
3) What is your role in Ruangwa DC?
4) How many Health facilities are there within your area?
5) Is there any private health facility in your area?
6) What is the status of HIV/AIDS in your District council
7) How do you rate the performance of HIV/AIDS Voluntary counselling and testing in terms of percentage?
8) What are your experiences with HIV prevention programmes eg. VCT
9) What do you think hinders/facilitating men in this community from being tested for HIV/AIDS?
10) How could VCT services be modified to make them more acceptable to men?
11) Is there any effort made by district council to encourage men in HIV counseling and testing in your District?
12) What are the ways of promoting men involvement in HVI/AIDS counseling and testing in Ruangwa DC?
13) What could be done to encourage men to participate in HIV/AIDS testing and counseling?

APPENDIX: III

Interview guide for WEO's AND VEO's

1) What is your title?
2) When did you start working with Ruangwa DC?
3) What is your role in your governing area?
4) How many Health facilities are there within your area?
5) Is there any private health facility in your area?
6) What is the status of HIV/AIDS VCT in your area
7) What is the performance of HIV/AIDS testing and counselling in your area?
8) What do you think hinders/Facilitating men involvement in HIV/AIDS counseling and testing in your area
9) What are the main challenges that your staff face in providing services related to HIV/AIDS testing/ Counseling?
10) Is there any effort made by district council to encourage men in HIV counseling and testing in your area?
11) What are the ways of promoting men involvement in counseling and testing in your area

APPENDIX: IV

Table 1: Time Schedule

Activity	Period										
	2014						2015				
	July.	Aug.	Sept.	Oct.	Nov.	Dec.	Jan.	Feb.	March	June	
Preparing research Instruments											
Orientation and review of different Documents											
Design Questionnaires And prepare for interview											
Distributing Questionnaires and Conducting Interview											
Collection of Questionnaires(data collection)											
Data editing coding Analysis and Interpretation											
Report writing											
Submission of the First report draft to MU											
Final report writing											
Submission of the Final draft											
Defending of the Dissertation											

APPENDIX: V

TABLE II: ACTIVITY BUDGET

ACTIVITY BUDGET		
CORE ACTIVITY	**ITERM/PARTICIPANTS**	**COST INCURED (Tshs)**
Consolidation of literature Designing and developing research instruments	Library search travelling expenses for 20 days. Typing and photo copying of research instruments	80,000
Pilot survey Finalizing of research instruments typing and photocopy	Transport for a researcher to and from Questionnaires	200,000
Main field data collection 1 month	Travel accommodation, subsistence .1researcher …	700,000
Data processing analysis and reporting	1 researcher	540,000
Miscellaneous cost		500,000
Total		**2,020,000/=**