

UNIVERSITY OF GHANA
SCHOOL OF NURSING
COLLEGE OF HEALTH SCIENCES, LEGON

**EXPLORING THE ATTITUDE, KNOWLEDGE AND EXPERIENCES OF THE YOUTH
TOWARDS HIV COUNSELING AND TESTING**

BY



**THIS THESIS IS SUBMITTED TO THE UNIVERSITY OF GHANA, LEGON
IN PARTIAL FULFILLMENT OF THE REQUIREMENT FOR THE
AWARD OF MPhil NURSING DEGREE.**

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DECLARATION

I declare that except the information derived from published work of others that have been duly acknowledged in the text and list of references, this thesis is my own work that has not been submitted in any form for any degree or diploma at any University or other institution of tertiary education.

Signature.....

Date.....

APPROVAL

The undersigned certify that the supervisors have read this research work and recommended to the School of Nursing for acceptance.



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DEDICATION

I dedicate this work to the almighty God who selflessly gave me the strength and wisdom to carry out this thesis right from the beginning to the end. I also dedicate this work to my late parents Mr. Joseph Tanye and Mrs. Rosina Nandong Tanye for nurturing me and making me what I am today and my wife Akosua Nyuor, my children, Nicholas Tanye and Nestor Tanye who inspired me to complete this work.



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ABSTRACT

The study explored the attitudes, knowledge and experiences of the youth regarding HIV counseling and testing in the Jirapa district of the Upper West Region of Ghana. The study aimed at finding out the knowledge of the youth about HIV infection, transmission, the beliefs and attitudes toward undergoing HIV test and their experiences at the HIV counseling and testing centres. An exploratory qualitative design was used to explore the youth experiences. The sampling method employed was purposive and was based on data saturation- when no new information was forthcoming. Saturation occurred at the 12th participant but four more interviews were conducted to cross check new emerging themes. The findings of the study showed that the youth had adequate knowledge of HIV counseling and testing but the participants indicated that there was lack of confidentiality at HIV counseling and testing centres, as counsellors easily spread the news to people about others who tested positive to HIV and the likely occurrences of stigma among the youth when HIV has been diagnosed. Findings from the study also indicated that there are some cultural and traditional practices as well as some parental influences on the utilization of HIV counseling and testing centres by the youth in the Jirapa district of Ghana. The study recommended that the health authorities in the district should re-strategize their HCT education programmes to include the youth in their own settings through the use of youth friendly services and the community Based Health Planning and Services (CHPS) in the district.

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LIST OF ABBREVIATIONS

AIDS - Acquired Immune-Deficiency Syndrome

ANC - Ante-Natal Clinic

ARV - Antiretroviral

CHPS - Community-Based Health Planning and Services

DHS - Demographic and Health Survey

FGD - Focus Group Discussions

FGM - Female Genital Mutilation

FHI - Family Health International

FSW - Female Sex Workers

GHS - Ghana Health Service

HCT - HIV Counseling and Testing

HIV - Human Immune-Deficiency Virus

JDHS - Jirapa District Health Service

KCMC - Kilimanjaro Christian Medical College

MOH - Ministry of Health

MTCT - Mother-To-Child Transmission

OPD - Out Patient Department

PLWHA - People Living With HIV/AIDS

PMTCT - Prevention of Mother to Child Transmission

TB -Tuberculosis

UNAIDS - United Nations AIDS

UNFPA - United Nations Population Fund

VCT- Voluntary Counseling and Testing

WHO - World Health Organization

CHAPTER 1

BACKGROUND OF THE STUDY

1.0 Introduction

This chapter provides the background to the study, the problem statement, purpose and objectives of the study as well as the significance and the definition of terms of the study.

1.1 The Inception of HIV/AIDS

Human Immune-Deficiency Virus (HIV) and Acquired Immune-Deficiency Syndrome (AIDS) have become a global public health as well as a social problem. Three decades from when the first case of (AIDS) was first reported in 1981, the human race continues to suffer huge human, economic and social losses as a consequence of not finding a cure for the disease. Lamptey, Johnson and Khan, (2006) have referred to HIV/AIDS as the greatest catastrophic and most devastating health challenge in human history. The immensity of the consequences of HIV and AIDS is reflected in the death toll statistics as well as those living with the virus around the globe. Statistics indicate that about 39.5 million people were infected globally by the end of 2008 (UNAIDS, 2008).

This figure includes the estimated 4.3 million adults and children who were newly infected with HIV in 2008, which were about 400,000 more than in 2004. Sub-Saharan Africa continues to bear the brunt of the global epidemic. Two thirds (63%) of all adults and children with HIV globally live in sub-Saharan Africa, with its epicentre in southern Africa (UNAIDS, 2008). One third (32%) of all people with HIV globally live in southern Africa and 34% of all deaths due to AIDS in 2008 occurring there (UNAIDS, 2008). More than 50% of all HIV infections world wide are among young people aged 15-24 years (Family Health International [FHI], 2006;

WHO, 2007). Again, more than 6000 youth are newly infected with HIV each day throughout the world.

This rate of infection is due to the fact that the youth are more likely to engage in highly risky behaviours such as unprotected sexual intercourse that will lead them to contract HIV infection. Over half of the youth would have had sex at age 17 (Summerfield, 2008). Adolescents and the youth have much more power of sexual desire and are also more likely to engage in unprotected sexual intercourse, (GHS/UNFPA/MOH, 2005). Therefore, young people remain at the centre of the epidemic in terms of transmission, vulnerability, impact and also potential for behaviour change. This implies that young people will determine the course of the epidemic and therefore they are a critical focus for HIV prevention and behaviour change programmes (Mwandira, 2008). HIV counseling and testing provides an environment for teaching and learning about the virus and its transmission and the youth stand to benefit by their participation.

According to Boswell and Baggaley (2002) Voluntary Counseling and Testing (VCT) for HIV which is now simply known as HIV counseling and testing (HCT) is the process whereby an individual or couple undergo counseling to enable him/her/them make an informed choice about being tested for HIV. This decision must be entirely the choice of the individual where trustworthiness and confidentiality at the HCT centre need to be ensured.

HCT is much more than drawing and testing blood and offering counseling sessions. It is a vital point of entry to other HIV/AIDS services, including prevention and clinical management of HIV-related illnesses, tuberculosis (TB) identification for treatment and control, psychosocial and legal support, and prevention of mother-to-child transmission of HIV (MTCT). HCT offers benefits to those who test positive *or* negative. HCT alleviates anxiety, increases clients' perception of their vulnerability to HIV, promotes behaviour change, facilitates early referral for

care and support including access to antiretroviral (ARV) therapy and more importantly, provides assistance for reducing stigma in the communities, (Mwinituo & Wright, 2010; Jeremi and Muula, 2008). Studies (Mwinituo & Wright, 2010) show that stigma is an issue in the study setting (Jirapa) and the Upper West Region as a whole. Persons infected or affected by HIV are often given names such as “muora” woman or “lean legs” or “lean buttocks” woman (Mwinituo & Wright, 2010).

Jeremi and Muula (2008) also indicated that HIV voluntary counseling and testing has been described as an important intervention for HIV prevention as it may serve as an early entry point for prevention and cure and support for those found infected. HIV counseling and testing (HCT) therefore remains the most widely accepted approach for promoting knowledge of serostatus especially for young people who constitute the future work force for any nation (Baiden, Akanlu, Hodgson, Alweongo, Debpuur & Binka, 2007). This is because it forms the gateway to HIV and AIDS prevention, care, treatment, and support interventions. High quality HCT enables and encourages people to patronise HCT services and these services are undoubtedly some of the most effective HIV prevention strategies. Hence, as a healthcare professional and a nurse educator in the Jirapa district, it is important to explore the perception of the youth regarding HCT and their views about its conduct.

In Ghana, according to Abokyi (2008), HCT is also believed to offer strong motivation for those who test negative to remain so. HCT provides an opportunity for people to know their HIV status and consists of a package of services including pre-test counseling, the actual test for HIV and post-test counseling services. Irrespective of the results or outcome of a test, the client obtains information that could translate into behaviour change if the test result is negative so as to endeavour to always remain negative. On the other hand if test results turn out to be positive,

it offers the opportunity for early treatment and avenues to also live healthily for a longer time. With the advent of antiretroviral therapy, people living with HIV/AIDS (PLWHA) are able to live much more productive and healthy lives. HCT promotes a wider social acceptance of the HIV/AIDS epidemic. In fact a negative test result is believed to motivate behaviour change (Abokyi, 2008). This therefore underpins the importance for young people to take advantage of HCT services, as it will encourage them to develop acceptable behaviour practices for prevention of HIV infection. Unfortunately just 5% of people living with HIV and AIDS are estimated to be aware of their HIV status (WHO, 2004). It has also shown that, in Ghana, the patronage of HCT by the youth is low though they are aware of the existence of HCT services according to Abokyi (2008).

Information from the Jirapa District Health Service annual reports indicate that between the years 2003 and 2007, the youth of the district constitute 24% of the general population of the district and only 13% of this group utilized the available HCT services in the district even though their behaviour and conduct make them the most vulnerable group to HIV infection. An anecdotal observation by the researcher show that some cultural/traditional practices such as festivals, funerals and intestate marriage (widow inheritance) in the district do involve the youth and increase their exposure to higher risk of HIV infection. It is therefore important to investigate the youths' utilization of HCT services in the district by exploring their knowledge, attitudes and experiences of HCT.

1.2 Statement of the Problem

Baiden et al (2007) in a research in HCT on Northern Ghana stated that access to HCT remains limited in most parts of Ghana with the rural population being the least served. This is

an indication that HCT patronage will equally be at a lower level because of the limited access. However, according to the health demographics in Ghana, there is an indication that almost every district in the country has at least one HCT centre. The Jirapa district in the Upper West Region of Ghana for instance, has two HCT centres one of which is located in the rural health centre in the Han community (Jirapa District Health Service [JDHS], 2007). It is expected that with the gradual availability of HCT service centres in the district, patronage of HCT by the youth will increase especially with the introduction of adolescent reproductive health services and youth friendly clinics by the Ghana Health Service in 2005. The adolescent reproductive health services do incorporate HCT services in Ghana. Abokyi (2008) confirmed an increase in the willingness for HCT by stating that, a survey conducted in Kintampo, Ghana, indicated that among 11604 respondents, 93% expressed willingness for HCT.

An observation made by the researcher who is also a native of Jirapa shows that the majority of the youth in the Jirapa District are those that are usually involved in certain cultural practices such as engagement in liberal sexual practices at cultural festival grounds and funerals. More often than not the youth are those that are engaged in re-marriages of their late brother's wives or a late husband's brother without knowing the cause of death. This cultural and traditional practice of widow inheritance has been documented in the Upper West Region of Ghana by Mwinituo and Wright's (2010) study among women diagnosed with HIV infection. In the midst of such unhealthy cultural practices that engage the youth to continue the lineage of families or clans, it is expedient to investigate youth participation in HCT to avert future explosion of HIV infection in the Jirapa district and also to educate the indigenes on the need for modification of their cultural and traditional practices.

The Jirapa District Health Service (JDHS, 2008) annual report indicate that for the period 2003-2007 a total of 1,754 people utilized the HCT services in the Jirapa district. Out of this number only 13% (235/1754) aged 15-24 years did utilize HCT out of a total youth population of 24%. This indicates a very low patronage of HCT by the youth in the district. A study conducted by Baiden et al. (2007) who used lay counselors to promote community-based voluntary counseling and HIV testing in rural northern Ghana reported a low patronage of HCT.

If HCT is one of the powerful strategies that could be used to reduce the spread of HIV, and the youth in northern Ghana are aware of HCT services, why then are the youth not accessing the HCT services? The research questions that need answers include:

- What is the knowledge and awareness of the youth on HCT?
- What do the youth in Jirapa district know about the process of HCT?
- How is privacy and confidentiality ensured at HCT centres?
- What are the attitudes of the youth towards HCT?
- What encourages or discourages youth participation in HCT?
- What are the beliefs of the youth regarding HCT?
- What are the experiences of youth who have utilized HCT services?
- How do young people feel about undergoing HCT before and after?
- What inform their decision to undergo HCT?
- What are the reasons associated with the utilization and non utilization of HCT services by the youth in the Jirapa District?

1.3 Purpose of the Study

The purpose of this study was to explore the attitudes, knowledge and experiences of the youth towards HIV counseling and testing and their reasons for utilization and non-utilization of HCT services in the Jirapa District.

1.4 Objectives of the Study

The objectives of the study were to:

- Determine the knowledge and awareness of the youth of HCT in the Jirapa District.
- Investigate the reasons for the utilization and non-utilization of HCT services by youth in the Jirapa District.
- Investigate the willingness of the youth to undergo HCT in the Jirapa District
- Ascertain the experiences of the youth who have utilized HCT services in the District.

1.5 Significance of the Study

The findings of this study will benefit the indigenes of Jirapa and the Upper West region as a whole. Health authorities will have an insight into some of the attitudes and experiences of the youth regarding HCT. It is envisaged that the current study will identify the gaps in HCT knowledge and barriers to utilization by the youth in Jirapa. Strategic plans for HCT utilization among the youth in the district could be made through documenting the factors that motivate others to utilize the available HCT services. Findings could also be used to guide, develop and implement appropriate youth educational programmes on HIV/AIDS. The study can also serve

as a knowledge base for future research into HIV/AIDS among the youth in the Jirapa district by non-governmental organizations and other researchers.

1.6 Definition of Terms

Youth:- Any young adult aged 18 – 25 years and above regardless of marital or economic status and whether one has a child or not.

Young people:- Any person age 18-24 years regardless of marital or economic status and whether one has a child or not

Voluntary Counseling and Testing (VCT) for HIV:- A process whereby people willingly undergo an HIV counseling process and have an HIV test.

HCT:- HIV counseling and testing, whether it is voluntary or provider initiated.

Attitude: - Personal view, opinion or general feeling about something.

Knowledge:-Awareness and availability of HCT.

Uptake/utilization:- It means having gone through HIV counseling and testing and having had all the experiences.

Culture:- the customs and traditional practices of the “Dagaaba” of the Upper West region such as their festivals, funeral rites and marriage systems, dance and way of life.

CHAPTER 2

LITERATURE REVIEW

2.0 Introduction

In conducting the literature review, the various search engines including Pub Med, Jstor, EBSCOHOST, Sage Journals Online, Science Direct, Wiley Blackwell, Hinari, and google scholar were consulted. Search terms included HCT, HIV/AIDS in Africa, voluntary counselling and testing, youth behavior towards HIV/AIDS and so on. Literature was also obtained from annual reports of various organizations as well as books on HIV/AIDS, HCT and the youth. In compiling the literature, the under listed themes were employed:

- Knowledge of the youth about HCT;
- Attitudes towards HCT ;
- Socio-cultural and sexual practices of the youth that influence their attitudes;
- Barriers to HCT;
- Utilization of HCT and
- Experiences of youth on HCT.

Finally the chapter ends with a summary of the review.

2.1 Knowledge of the Youth about HCT

A qualitative study conducted by Sebudde and Nangendo (2009) in Rakai district of Uganda on the topic; HCT Services: Breaking resistance to access and utilization among the Youth, found that, there was adequate knowledge and awareness of HCT services available to youth in the district through various publicities. The main channel of publicity was the print media and radio communication as well as direct health education campaigns employed by HIV/AIDS counselors which were the main sources of information to most of the youth. Furthermore, the study identified certain limiting factors of individual, community and health care institutional structures that repel the youth from participating in HCT. Sebodde and Nangendo's (2009) study concluded that mobile clinics and outreach programmes on HCT was more suitable to attracting youth participation than structural arrangements in health facilities.

The current study set out to explore the attitudes, knowledge and experiences in a district dominated by illiteracy and lack of development in a deprived region (Upper West) of Ghana. There is only one radio station (Upper West Radio) and print media are available only once a week. Other channels of communication such as television constitute a luxurious choice for the few elite group stationed in the bigger towns. Thus, researching into the attitudes, knowledge and experiences of the youth in Jirapa district towards HCT is relevant. The reviewed study was also deemed relevant to the current study as it focused on the knowledge of the youth towards HCT. It discussed the need to increase the youths' utilization of HCT. The study employed qualitative methodology to ascertain in-depth knowledge of the participants similar to the current study and the findings contribute to knowledge on youth and HIV.

In another study, Bayray (2010) researched into University students' knowledge, attitude, and practice of voluntary counseling and testing (VCT) for HIV and increased uptake at Mekelle and Tigray in Northern Ethiopia, using a cross-sectional design and questionnaire.

The study found that female respondents were more knowledgeable about HCT than male respondents. Furthermore Lemessa (2005) reported that females were more knowledgeable than males. Conversely, in a study conducted in North and South Gondar, Ethiopia, Mengesha (2006) found that with regards to issues of HCT, males and females did not differ in their knowledge and awareness about HCT. The current study employed a qualitative methodology which aimed at getting varied and rich information from youth participants through semi structured interviews.

2.2 Attitude towards HIV Counseling and Testing (HCT)

In a qualitative study, Dennis (2010) examined the ways in which out-of school youth responded to a context of HIV/AIDS and how they themselves can be active participants in HIV/AIDS prevention. The title of the study was: "They should know where they stand": attitudes to HIV Voluntary Counseling and Testing amongst a group of out-of-school youth. Four out-of-school youths, trained as fieldworkers, interviewed 32 other out-of-school youths in the Shongweni area of KwaZulu-Natal about their attitudes towards HCT. Interviews conducted in Zulu were translated into English by the four trained out-of-school youth researchers. Analysis of the data made use of both qualitative and quantitative methods to respond to the specific needs and observations that arose from the data collected.

The study found a high general level of awareness of HIV/AIDS, certainly to the point that out-of-school youth could repeat many of the standard messages used in campaigns against HIV/AIDS. The study also reported that the out-of-school youth displayed positive attitude

towards HCT with 91% stating their intentions of getting tested and on the contrary, only nine (28%) actually testing due to high levels of fear of stigma surrounding HCT. Forty-three (43%) percent of the participants in the area indicated their preference for a HCT site or hospital to be far from home, or, if they could afford it, a private doctor, to minimize the likelihood of being seen by someone they knew. This factor made it more difficult and cost more for out-of-school youth to access HCT. For some, the fear of HIV infection has caught up with their existing social exclusion. In contrast, one reason for wanting to test amongst girls was their concern for the health of their future children. While out-of-school youth understood the role of HCT in maintaining a healthy lifestyle, the obstacles to acting on those intentions included the context of poverty, gender inequalities, stigma and the fear of gossip. Campaigns succeeded in raising awareness, but translating awareness into action remained a central problem.

The study is significant to the present study as it employed a qualitative method. However the researcher did train people to do the interviews and not the researcher himself. The trained personnel may follow exactly the guiding questions and may not make further probing to obtain in-depth information that could enhance the findings of the study.

In a similar study, Tenibiaje (2010) investigated the attitude of youths toward voluntary counseling and testing for HIV/AIDS in Nigeria with the aim to change the attitudes of youths in prevention of HIV infection. Using a descriptive quantitative survey through random sampling, 357 youths were selected from three states (Ondo, Kogi and Ekiti) in Nigeria. Data was gathered using an 18 item questionnaire. The data was analysed using percentages and multiple regression. The findings showed that the youth were aware of transmission and prevention of HIV/AIDS and knew the centre and importance of HCT HIV/AIDS.

The findings also showed that most of the youths (males and females) were sexually active, and that males had more sexual urge and more sexually curious. It was also found that male youth attached a sense of conquest to sexual activities than their female counterparts and also that, the youth were engaged in high risk sexual behaviour with about 65% of the youth experiencing sexual intercourse several times. Furthermore, (58%) of the youth had multiple partners.

Despite the fact that the youths were aware of transmission and prevention of HIV, about 70.0% of the youth engaged severally in sexual activities without using condoms. The results again revealed that age, gender and religion have a significant partial correlation coefficient in the predictions of attitude of youths towards HCT.

This study is relevant to the present study since it did investigate the attitude of youth towards HCT which the present study wished to emulate. However the findings could differ because the study employed a quantitative method whilst the current study used a qualitative approach.

A study conducted by Abebe and Motikie (2009) entitled “Perception of High School Students towards Voluntary HIV Counseling and Testing, using a Health Belief Model (HBM) in Butajira”, sought to assess the perception and attitude of students towards HCT services. A cross sectional descriptive study was conducted in January 2006, among Butajira senior secondary school students where a multi stage sampling method was used. A probability sampling method was used to select 608 senior secondary school students and self administered questionnaires were used to gather data for the study.

The study found that almost all the respondents indicated that they have heard of HIV/AIDS and HCT and that they heard it through the radio, television, friends and at school. About half of

the respondents also indicated that HCT was important. Fifty-two percent of the respondents stated that they preferred to be counseled by trained counselors, followed by physicians, HIV patients and religious leaders respectively. The majority 382 (60%) of the respondents showed preference to confidential testing, followed by anonymous way of testing 156 (24.4%). As a way of receiving HIV test result, the majority 365 (57.2%) preferred face-to-face while by 197 (30.9%) preferred it to be done secretly in an envelope. Regarding their attitude towards HCT and its practice, 118 (18.5%) had used HCT service. When students' willingness to undergo HCT was assessed, five hundred and twenty six (82.5%) of the respondents explained they were willing to undergo HCT. Those who were not willing to undergo HCT and gave the reason as fear of anxiety following possible positive result was 50 (45.5%) and those due to fear of stigma and discrimination by the society was 22 (19.6%).

The results also indicated that less than half of them had low perception of acquiring the infection. The most frequently cited reasons by those with low perception were having had no sexual contact (41.6%), being faithful to their partners (37.3%) and using condom consistently (18.7%). Half of the respondents had high perception towards severity of HIV/AIDS. Also majority of the students had high level of perception on barrier for HCT. Furthermore the majority of the respondents had high confidence in using HCT.

The study concluded that the majority of students have heard about HCT and revealed willingness to undergo HCT. Willingness for HCT was affected by age, education and previous sexual experience. High perceived susceptibility and high perceived barriers were associated with low willingness to undergo HCT. On the other hand, students with high perceived benefits revealed better willingness to undergo HCT.

This study is relevant to the present study as the author evaluated the knowledge level of HIV counseling and testing as well as the students' willingness to test for HIV. Respondents of the questionnaire were students who were within youthful ages similar to the participants that were sampled for the present study. The only difference was that the researcher employed a quantitative methodology as against a qualitative methodology that was employed in the present study.

A qualitative study conducted by Adekeye (2011) on the attitude of HIV/AIDS counselors towards undergoing HIV voluntary counseling and testing themselves in Ado-Odo/Ota, Nigeria revealed that participants had high knowledge of HIV/AIDS but they refused to go for the test themselves due to the fear they harbour that they may be positive and that their acquaintances may blame them for the positive results. Other reasons for the refusal to test were the belief that if they tested positive, they would have problems disclosing their HIV status. They also had fears about the lack of confidentiality in testing centres. Other reasons included fear of death.

This study is relevant to the present study since it employed a qualitative methodology with the intention of getting in-depth knowledge and attitudes of participants for HIV testing. Findings of the study could be similar to the present study since the present study also employed a qualitative approach for data collection. However the study cannot be generalized to cover all counselors for HIV counseling and testing because the researcher who was using HIV counselors as participants could not actually tell whether all the participants had not actually been tested for HIV.

Mphaya (2006) used an exploratory descriptive design in a study to explore factors that motivate young people to access HCT services in Malawi. Both male and female youth who were sexually active felt that they had been exposed to HIV and hence the need to seek HCT

services. The study indicated that females in urban and semi-urban areas were more likely to access HCT services than their counterparts in rural areas. Friends, radio and school health education were found to be the main sources of information about HCT. Mphaya (2006) again found that other young people reported that they were not willing to have HCT because of fear of testing positive. They preferred seeking HCT services at government health facilities, to ensure confidentiality and conducive conditions for testing. Conducive conditions included having a youth friendly health facility and young people providing the services in a clean environment with privacy. This is comparable to the findings of Mwandira (2008) that “youth to youth” counseling sessions were the best motivation factors for young people seeking HCT services.

2.3 Socio-cultural and Sexual Practices that influence attitude of the youth toward HCT

A non-governmental organisation, Action Aid Ghana (2007) conducted a survey entitled “violence against women and HIV in northern Ghana” with a sample of 222 participants recruited for interviews and focus group discussions. It was found that women in their fertile age comprising of mostly young women and widows according to culture, were forced into marriage with their late husbands’ brothers. When such widows are inherited without knowing the cause of the husband’s death and in cases where the husband died of AIDS, and she being positive herself, she will end up infecting the new man who will also infect his other wives. Such widows may be confused as to whether to go in for HIV test or not.

The study further found that women as widows were not allowed to remarry outside the clan but to continue staying in their deceased husband’s homes, remaining single or having several secret lovers. The study reported that such women were willing to do the HIV test because they were free from extended family intrusion and could decide for themselves.

These studies are relevant to the current study and informed the researcher to explore the issues of cultural practices relative to youth experiences of HCT in the Jirapa district. The difference from the present study was that the survey concentrated on violence as a cause of HIV/AIDS transmission and not HCT to diagnose HIV infection.

A study in Ghana by Mwini-Nyaledzigbor and Wright (2011) also found that in sub-Saharan Africa and Ghana in particular, women reported having no right to either refuse sex with their husbands or boyfriends or suggest the use of condoms. The risk of women becoming infected with HIV is disproportionately high to the men being infected. The study also reported that in Ghana young women between the ages of 15 and 19 years were three times more likely to be infected than their male counterparts, whilst women aged 20-24 years old were 10 times more likely to be living with HIV than men in their age cohort (Mwini-Nyaledzigbor & Wright, 2011). Additionally it has been reported that women who were divorced, separated or widowed tend to have significantly higher HIV prevalence than those who were single, married or cohabitating. Often, divorce or widowhood of women stems from the woman's HIV status since many women diagnosed with HIV are usually divorced or driven out of their marital homes or lose their spouses to AIDS related illnesses (UNAIDS, 2009).

In a related study, on the misconception about HIV infection faced by diagnosed Ghanaian women (Mwini-Nyaledzigbor & Wright, 2011) found that widow inheritance was a sociocultural practice among the people in Northern, Upper East and Upper West regions of Ghana where young ladies were often obliged to their late husband's senior or junior brothers from the same clan to enable the family to continue with the lineage as a way of pacifying the ancestors and also ensuring peace for the souls of the late or departed husbands. In that study most of the women who were diagnosed with HIV had lost their husbands to AIDS in mining

and urban centres and towns of Ghana, but could not break the news for fear of being ostracized from society. Such women may not want to know their status if not already known for fear of being positive to HIV and facing the consequences of ostracism.

Socio-culturally, a woman diagnosed with HIV in the northern part of Ghana has brought 'muora' (a contagious disease associated with HIV/AIDS) to her husband who will suffer bloating of his abdomen and swelling of his feet before dying. (Mwini-Nyaledzigbor & Wright, 2011). The word 'muora' was used on the diagnosed woman to mean spoiled woman who slept with other men apart from her husband. The socio-cultural beliefs and practices in some societies in sub-Saharan Africa and Ghana contribute to the sustained presence of the virus in Africa and the sub region. This can be explained by the fact that there have been dearth of literature on the socio-cultural beliefs and practices to bring a change in people's behaviour regarding the prevention of HIV transmission and other practices. These therefore have an influence on the people's attitude towards HCT (Mwini-Nyaledzigbor & Wright, 2011).

Other modes of transmission of HIV such as scarification, tribal marking and female circumcision favour the spread of HIV. Awusabo-Asare, Biddlecom, Kumi-Kyereme and Patterson (2006) in their survey observed that some initiation rites like female genital mutilation (FGM) that ushered young people into adulthood as well as tribal marking for social identification is commonly practised among tribes in the Northern parts of Ghana. The indigenous 'surgeons' of FGM mostly do not know much about the germ theory and could easily transmit HIV through their practices among young people. Once young persons who have undergone FGM and have also become aware of the mode of HIV transmission, they may not utilise HCT for fear of positive results and stigmatization.

Several authors (Mavhu, Langhaug, Manyonga, Power and Cowan, 2008; Debrah, 2007) did suggest that culture and societal norms and economic factors have a strong influence on adolescent sexuality. Mavhu et al (2008) for instance reported that culture and societal norms have a major role to play in obtaining sexual information from the youth. Mavhu et al (2008) also argued that socio-cultural and economic factors have an influence on adolescent sexual activities. In the Jirapa district, it is a common practice for parents to give out their youth daughters (e.g. drop outs from school and those that have never been in formal education) to other families as betrothal for marriage and elopement. Younger male siblings get married to the wives of their late elder male siblings without knowing the cause of death. This is an issue of great concern (IPPF, 2008). Debrah (2007) suggested that sex and sexuality are some of the major elements of contemporary Ghanaian youth culture. The researcher did observe that the youth in the Jirapa district are more aware of their sexuality than previously; they express their sexuality more than before and sex is gradually becoming a normal component in the lives of most Ghanaian youth (Debrah, 2007). Hence, sex education has of late become a component part of the educational curricula in Ghana.

According to Debrah (2007), the youth have different beliefs concerning sexuality. For some young people, sexuality is a question of morality based on religion and faith. But for the majority of the youth, it is simply a choice to satisfy an innate human desire. Furthermore, Debrah (2007) showed that young people of all ages are sexually active and increasingly parents are losing their ability to control the sexuality of their children resulting in most parents blaming the problem on peer pressure and the social implications of their fast growing communities. Parents often complained about the influence of the media and western cultures for instance (indecent dressing that exposes the private parts of females) to their young peer counterparts.

According to the author, there exists a gap of mistrust between parents and youth on issues of sexuality due to a generation gap between them. This perception of the Ghanaian parent could stem from their belief that sex matters should not be discussed among children/youth as a way of preventing children from becoming sexually active. Also, Awusabo-Asare et al. (2007), observed that the spread of HIV/AIDS and other sexually transmitted infections (STIs) are still highly topical issues in Ghana and the youth form the biggest risk group for the spread of HIV/AIDS. Studies by (Awusabo-Asare, 2007; Anochie & Ikpeme, 2001) have shown that youth in Ghana engage in premarital sex and that the majority of those who do so start at an early age. In a Ghana Demographic Health Survey (DHS) report (2006) more than 90% of Ghanaian youth are aware of HIV/AIDS and yet the majority do not use condoms when engaging in sex.

These studies conducted by Awusabo-Asare (2006) and others are relevant to the present day attitude of youth in the Jirapa district of the Upper West Region. The traditional area have certain cultural traditional festivals observed at the beginning of the new crop harvest and end of year celebrations for good rain and bumper harvest each year known as the 'Bogri' and 'Bongo'. Such festivals require the participation of all and sundry most especially the youth. On such occasions, vulgar music/dance carry the day where youth display their skills in many ways including sexual rendez vous amidst much displays.

The question the researcher puzzles on is what is the knowledge, attitude and practices/experiences regarding HCT? Do the youth ever feel such exposures could render them liable to become victims of the virus that causes AIDS? Whose responsibility is it to draw the attention of the traditional people of Jirapa about the vulnerability of the youth to HIV infection? The purpose of the current study was to explore the knowledge, attitude and experiences of the

Jirapa youth towards HIV counseling and testing (HCT) with considerations of their socio-cultural practices which can serve as deterrant to participation in HCT.

2.4 Barriers to HCT and Youth

Meiberg, Bos, Onya and Schaalma (2008), conducted a qualitative study on “Fear of Stigmatization as Barrier to Voluntary HIV Counseling and Testing in South Africa”. Their aim was to identify psychosocial correlates of HIV counseling and testing (HCT), with an emphasis on the association between fear of AIDS-related stigma and willingness to have an HIV test. The study was conducted among students of the University of Limpopo (UL), Polokwane, South Africa. The group was a sexually active target population and was relatively easy to reach. Ten focus group discussions were held among students to explore correlates of HCT and fear of stigma and discrimination. A total of 72 black students comprising 35 men and 37 women of the UL participated. They were undergraduate (62) and postgraduate (10) students, varying in different grades. All students, except one who was married, were single and they were between 18-36 years of age, and belonged to different ethnic groups, but most of whom were “Sotho” or “Tsonga”. The students were asked about their HIV/ AIDS knowledge and the underlying factors (transmission, ways of protection, and consequences of being HIV positive / negative). Also, their HCT knowledge was asked including benefits and barriers associated with going for testing. To stimulate group discussion, the facilitators told ‘stories’ to which students could react. The stories were used so that the students could replace themselves in the person in the story, to give an accurate opinion. In the stories the themes of stigmatization and HCT were cited. Participants were recruited by means of posters, announcements on the University radio station by research assistants and peer educators.

Results from the study indicated that there was still a strong HIV/AIDS-related stigma in South Africa. Most participants agreed that people living with AIDS (PLWA) were neglected, ignored and isolated. For instance, participants frequently mentioned that it would be very difficult to get a job when you are HIV positive, that many men leave their women when they are HIV positive, that even family members frequently blame their relatives for contracting HIV/AIDS, and that many PLWA are rejected by friends because people do not want to be associated with someone with HIV/AIDS. The FGD also revealed that the participants were struggling with HIV/AIDS-related stigma themselves. Many acknowledged that PLWA should not be stigmatized and discriminated against; they recognized that they themselves were also not free of stigmatizing reactions.

The results of the study by Meiberg et al (2008) also revealed that although HCT becomes increasingly available nowadays in South Africa, at the time of the study, antiretroviral drugs were still unavailable in Limpopo province and participants in all FGD still strongly associated HIV/AIDS with 'dying' and 'death'. During the discussions HIV/AIDS was frequently described as 'the disease that cannot be cured' or 'another international death sentence'. Many participants expected that HIV infection would end all their future plans, and some thought that they might commit suicide when tested HIV positive. Only a few participants believed that HIV is not immediately causing death and that it can be possible for PLWA to live a rather normal life. The FGD further revealed that participants were seriously concerned about contracting HIV/AIDS. Although they recognized that their beliefs about HIV prevalence at the University campus were based upon rumours, they assumed that about half of the students might be HIV positive.

According to Mwinituo and Wright (2010) at the beginning of the AIDS epidemic in the early 1980s when there were no known drugs and prophylaxis; fears gripped many people to undertake HCT. The general attitude was not to be told about one's infection but to remain unaware until the AIDS set in. Many claimed such attitude gave them false hope and boosted their psychological morale. Once diagnosed, worries and sleeplessness set in that deteriorate the individual psychologically. The psychological and emotional distress stemmed from the way society views the diagnosed individual (Mwinituo & Wright, 2010).

In a psycho-education intervention study to teach HIV infected women on positive living and avoidance of self-stigmatization, in a non-governmental organization setting, (Mwinituo & Wright, 2010) reported that the stigma and discrimination attitudes of people including friends, family members and significant others resulted in the development of various negative impression and feelings leading to suicidal ideation, social isolation, low self esteem and sleeplessness among the sample studied.

The participants were sad, shy and embarrassed because they had contracted a disease that society label as "bad" (Mwinituo & Wright, 2010). The worries experienced by most participants in the Mwinituo and Wright (2010) study stemmed from the women always thinking about the disease, its outcome, and the shuttered future plans and hopes for their children. Hence availing oneself to HCT when one was not sure of negative test results was sufficient to sign for a death warrant.

Sukari (2008) also conducted a study on Barriers and attitudes towards HIV voluntary counseling and testing (HCT) among secondary school pupils of Sengerema in Mwanza. A cross-sectional design was used for the study. A total of 400 secondary school students from two schools in Sengerema district, Mwanza were included in the study. By using simple random

sampling technique, the two secondary schools (Sima and Tuitange) were selected and enrolled in the study. After a verbal consent from each interviewee as well as observing confidentiality, data were collected using a pre tested Swahili questionnaire. Data analysis was done using Epi Info 2002.

The findings of the study were that only a small number (4.2%) of the students thought that HCT was not necessary with 47.8% saying it was against their religious teachings. While a large proportion (65.8%) of the students knew HCT sites in Sengerema district, only a few (24.3%) of them ever used the available HCT services. Of those who ever used HCT services, 32.7% were just interested in knowing their HIV status and to get HIV education while only a small number (6.2%) of students used HCT services because they were pressurized by their spouses. For those who never used HCT services, (41.8%) said they feared being labeled as HIV positive and 34.9% said these services were not meant for students. It was also observed in this study that HCT services were more accepted among female students than male students.

From the findings it was concluded that a large number of students knew that HCT use was necessary and the acceptance of HCT among the students was influenced by age where younger students were more willing to use HCT services than older students.

Similarly, Yahaya, Jimoh and Balogun (2010) conducted a study that aimed to examine the factors hindering the acceptance of HCT by the youth in Kwara state of Nigeria. A descriptive quantitative methodology was employed using 600 youths as respondents to a questionnaire. Findings from the study indicated that the main factors hindering acceptance of HIV/AIDS testing was ignorance, fear of being positive, high cost of HCT, inadequate HCT centres, stigmatization, discrimination, religious beliefs, cultural beliefs, parental pressure and inadequate motivation. Though HCT is a health promotion strategy that monitors individuals and their

health, most people especially the youth may view it as doing the health care provider some good. Whereas HCT is known for just diagnosing HIV infection, the process of HCT accrues several benefits to clients other than just testing for HIV. The HCT affords individuals with knowledge about the virus, detection of other diseases such as STIs for early treatment and above all, early detection of HIV infection for management and prevention of AIDS. It is therefore important for population groups such as the youth to undertake HCT.

2.5 Utilization of HCT

Many studies conducted on HCT utilization report that the utilization of HCT was related to a number of factors. In one of these studies in Eastern Cape, South Africa conducted among 3,374 adults aged 15 years and older, Hutchinson and Mahlalela (2006) reported that HCT utilization generally was low and identified less educated men and women who were more likely to utilize HCT than highly educated individuals. Women in particular were less likely than men to utilize HCT due to stigma. The study also found that availability of HCT services were more likely to have a greater impact on HCT utilization by men.

In a related study on “Factors Associated with Utilization of a Free HIV HCT Clinic by Female Sex Workers in Jinan City, Northern China,” Wang, Li, Pan, Sengupta, Emrick, Cohen and Henderson (2011) employed a quantitative methodology with 1059 female sex workers (FSW). The FSW were sampled for the interviews at entertainment centres in Jinan Township. The study revealed that the majority of the subjects had the willingness to be tested for HIV, though only few (11%) got tested.

The results from the study also indicated that the low level of the actual testing was due to the fear of stigma and identification as sex workers by their acquaintances at the testing clinic.

Tefera (2006) conducted a study to determine the demographic characteristics and factors that affect HCT acceptance as well as HIV prevalence among youth in Addis Ababa. Both quantitative and qualitative data collection methods were employed. A total of 3220 youth aged 15-24 accessed HCT and were used for the interviews. The findings from the study revealed that there were high utilization rates of HCT among youth, and particularly females in Addis Ababa, Ethiopia and the reason for this high uptake was that, they wanted to know their status and they also suspected they were infected and wanted to go abroad.

Hutchinson and Mahlalela (2006), who conducted a study with 3,374 adults aged 15 years and over in South Africa sought to examine attitudes towards voluntary counseling and testing (HCT) services, patterns of utilization of HCT services and the relationships between HIV/AIDS-related stigma, HCT service availability and quality and the use of HCT. A quantitative methodology was employed. The study revealed that HCT utilization was poor.

A similar study by Fabiani, Cathrone, Nattabi, Ayella, Ogwang and Declichs (2007) investigated the factors associated with HCT uptake among women attending the ante-natal clinic (ANC) of the St. Mary's Hospital Lacor in Uganda and found that uptake of HCT among ANC women was generally low. Utilization rates were associated with age, marital status, level of education, recent change of residence and having a partner with a government occupation. The study did not take into account certain variables such as: the accessibility of the clinic; the woman's relationship with the staff; the confidentiality of HIV testing; and the women's willingness to be informed of positive HIV test results. The study also did not consider several factors that may have been barriers to HCT: the stigma attached to being HIV positive, self perceived HIV risk, the woman's fear of her partner, and the knowledge of and attitude towards

testing. These factors contributed to the generally low utilization of the HCT services by the women.

Also a study in Northern Ghana by Baiden et al. (2005) found that the participants' spousal involvement in HCT had a strong positive influence on the utilization of HCT. Van Dyke and Van Dyke (2003) also agreed with the other authors on barriers to HCT that people may refuse to utilize HCT because of fear of rejection if found to be positive, fear of a breach of confidentiality, fear of people knowing them and shunning them if found to be positive after testing, and lack of trust of the HCT personnel and services.

Again Mwandira (2008) evaluated the effectiveness of youth HCT counselors in promoting HCT uptake among fellow youth, using client satisfaction data from exit surveys. The findings indicated that older adolescents were more likely than younger adolescents to access HCT services from youth friendly sites or centres. Marital status was found to significantly affect the choices of an HCT site by youth; single sexually active young people were more responsive to HCT motivation messages and perceived HCT services as being very vital for decision making in their lives especially before marriage. Despite this finding, there was generally low demand for services by the youth. The author reported that a high proportion of youth in youth centres and health facilities preferred peer counselors to adult counselors.

Furthermore, Regassa and Kedir (2011) aimed at assessing students' attitude and practice on preventive measures against HIV/AIDS. Six hundred and six (606) participants were drawn from Addis Ababa University through multistage sampling. Data were collected using quantitative survey (questionnaire) and qualitative methods (FGDs) and subsequent analysis was made through the use of descriptive statistics. The results of the study revealed that half of the respondents adopted abstinence as a top preventive measure. The results also showed that almost

all the participants were willing to take HIV test and half of the participants had already taken the test.

Similarly Mgosha et al. (2009) conducted a study on the evaluation of uptake and attitude of HCT among health care professional students in Kilimanjaro Region, Tanzania whereby the main objective was to assess the acceptability of HCT and its actual uptake among health professional students at Kilimanjaro Christian Medical College (KCMC). The study was a cross sectional survey that employed structured questionnaires delivered to health care professional students aged between 18-25 years enrolled for degree, diploma and certificate programmes at KCMC. A total of 309 students were recruited through a convenience sampling method. That is, only students who were available during the class sessions were selected and the questionnaires administered to them.

The results indicated that female students were more likely to be at high risk of contracting HIV/AIDS than males. Knowledge about the availability of HCT services and programmes was also high. However, the uptake of HCT among the students was very low. The majority of the students had a positive attitude towards HCT and was willing to do the test. Almost all the students agreed that HCT should be free of charge and preferred being tested at the school. This was as a result of the majority of the students perceiving themselves to have low risk of HIV contraction. The mass media played a role in the education of the students on HCT. But students had a lower level of knowledge on the benefits of HCT. Hence the study concluded that efforts be put in place to educate the students more on the benefits of HCT.

In another study, Ma, Wu, Qin, Detel, Shen, Li, Lui and Chen (2008) compared the knowledge, attitudes and uptake of HCT in one county in China that had an HIV/AIDS testing and care, China CARES (CC) programme with a county that did not have the programme. A

cross sectional study with two-stage cluster sampling was employed and the data analyzed quantitatively after administration of questionnaire to respondents.

Results from the study revealed that, participants in the CC County had better knowledge and uptake of HCT but a more negative attitude towards persons living with HIV. For any HCT centre to provide the needed services on HIV care, counseling and care is paramount as it affords the health care provider to have closer relationships with the clients and their needs.

Hutchinson and Mahlalela (2006) sought to examine attitudes towards voluntary counseling and testing (HCT) services, patterns of utilization of HCT services and the relationships between HIV/AIDS-related stigma, HCT service availability and quality and the use of HCT. They used household survey data linked with clinic-level data to assess the impact of expanded HCT services and access to rapid testing on the likelihood of being tested in rural areas and on /AIDS stigma. Analysis of the study findings revealed that HCT utilization generally was low.

However, less educated men and women were more likely to utilize HCT than highly educated ones. Men were more likely to utilize HCT than women because of stigma. Non- availability of HCT services was more likely to have an impact on HCT utilization by men.

In a related study, Madebwe et al. (2012) conducted a study entitled “Taking the test: voluntary counseling and testing among midlands state University students.” Probability in the study, sampling was used to select the 173 students that took part in the questionnaire survey. The students were selected from each department in the faculties of Arts. The majority of students (81.1%) were aged below 25 years and predominantly single. The study showed that most of the students had heard about HCT but only 28% and 27% of male and female students respectively had taken the HIV/AIDS test before the survey. Among those who had not undergone HCT, 87% of male and 91% of female students expressed a willingness to be tested

for HIV/AIDS. More male (54%) than female students (43%) would choose to take the test on campus. Fifty-seven percent of male students and 68% of female students who had sex in the 6 months preceding the survey did not use a condom at last sex suggesting a low HIV/AIDS risk perception among the students.

2.6 Experiences of the youth with HCT

Yoder and Matinga (2004) conducted a study on VCT for HIV in Malawi on Public Perspective and recent VCT Experiences”. The aim of the study was to document experiences of HCT clients at the testing facilities which included the way clients were welcomed, how they gave blood for the test, and how they were counseled and advised. A qualitative approach was used whereby 12 people were trained to collect data through in-depth interviews on participants’ interactions with counselors at the testing facilities. The interviews were tape recorded, translated and transcribed by the trained personnel. A total of 245 participants were interviewed in four districts most of whom were youth or young people.

The participants’ experiences at the testing facilities showed that clients were warmly received at the testing centres. Results from the studies also indicated that clients who came to the testing facilities were counseled and told everything about HCT. Almost all participants indicated that the counselors asked about their feeling before and after the test. It was also revealed that participants came in for the test for several reasons which included:

- Wanting to know their status of HIV.
- Response to signs of illness.
- When individuals feel at risk or vulnerable to HIV infection.

- When they are planning an event in their lives, such as having a child, getting married, or getting a new job.
- Fear of having been exposed to HIV by one's own actions and
- Fear of having been exposed to HIV by the actions of one's spouse or partner(s).

Denison et al. (2008) also explored the HIV testing experiences of Zambian adolescents and the involvement of families, friends and sexual partners in decisions about HCT and the disclosure of HIV status. The study was based on 40 qualitative in-depth interviews with 16 to 19 year olds who knew their HIV status in Ndola, Zambia. The findings from the study demonstrated that: (a) almost half of the youth turned to family members for advice or approval prior to seeking HCT; (b) a disapproving reaction from family members or friends often discouraged youth from having HCT (c) participants often attended HCT alone or with a friend, but rarely with a family member; and (d) disclosure was common to family and friends, but infrequent to sex partners. Disclosure was not linked to accessing care and support services. It was concluded that family members need access to information on VCT so they can support young peoples' decisions to test for HIV and to disclose their HIV status. These results reinforced the need to provide confidential VCT services for adolescents and the need to develop and test innovative strategies to reach adolescents, their families and sex partners with VCT information and services.

2.7 Summary

Thus far, there seemed to be a dearth of literature from the study setting, Jirapa and in Ghana as a whole concerning the attitudes, knowledge and experiences of the youth towards HIV counseling and testing. There is therefore the need to bridge the gap regarding HCT among the youth. Literature from six thematic areas were reviewed. These were knowledge of the youth

about HCT, attitudes towards HCT, socio-cultural and sexual practices that influence attitudes toward HCT, barriers to HCT, utilization of HCT, and experiences of youth with HCT. When examined, the literature supports a number of important issues such as the youth's knowledge of HCT, the attitudes, socio-cultural and sexual practices that influence attitude which may enhance or prevent HCT utilization. Barriers to and experiences of the youth with HCT were also reviewed to support the study. This information as documented in the literature provided the basis upon which the research on exploring the attitudes, knowledge and experiences of the youth was undertaken in the Jirapa district.

CHAPTER 3

METHODS AND DESIGN

3.0 Introduction

This section describes the research methods and design employed in the study, the study setting/context, the population for the study, the sampling techniques and procedures for data gathering, data management and data analysis. It also includes the pretesting of the interview guide and tape recording instrument and finally, the rigour regarding to the qualitative study as well as the ethical consideration for the study.

3.1 The Study Design

An exploratory descriptive qualitative design was employed for the study. A qualitative study is an inquiry of understanding a social or human phenomenon based on building a complex, holistic picture, formed with words, reporting detailed views of informants, and conducted in a natural setting (Creswell, 2009). Qualitative research is therefore the method of inquiry in which phenomena are explored in their natural environment (Mayan, 2009). A qualitative methodology brings out the hope to the discovery of extremely covert, subtle and subjective realities and truths about the meaning and expressions of participants (Mayan, 2009). A descriptive qualitative research primarily seeks to explore and understand phenomenon of interest under study (Creswell, 2009). For example, the attitude of the youth towards HIV counseling and testing is such a phenomenon that needs to be explored using a qualitative design. Hence, the reasons for such an attitude and behaviour by the youth were described in the context of the culture of the youth (Morse & Field, 1999). The approach focused on finding answers to questions and explanations centred on the attitudes of youth toward HIV Counseling and Testing

(HCT). The approach also gave the researcher the opportunity to develop in-depth understanding of the attitude and experiences of the youth rather than the researcher's own perspectives.

Knowing the reality of the youth having built an attitude toward HCT was an important assumption. A descriptive qualitative method was therefore the best approach to answer a research question that had implications for human subjectivity and interpretation (Streubert & Carpenter, 2001). The researcher's commitment to the views of the participants is also an important aspect of qualitative research because it draws the attention of the "emic view" (Streubert & Carpenter, 2001), that is the inner perspective of the participant. A descriptive qualitative method was preferred because it is also unique to nursing as it involves description and interpretation of a shared health or illness phenomenon from the perspectives of those who live it (Thorne, Kirkham & MacDonald-Emes, 1997). Some research problems that are best explored using qualitative method include: behaviours, feelings, thoughts, actions and experiences (Mayan, 2001; Burns & Groove, 1993; Polit & Hungler, 1993). Qualitative research reflects for knowledge about aggregates in a manner that does not render the individual case invisible and recognizes that there are multiple realities, which are subjective and mentally constructed by individuals (Polit & Hungler, 1995). Until the feelings and experiences of the youth concerning HCT is investigated, there exists no other way of knowing about youth attitude toward HCT. Hence this method will facilitate the development or enhancement of HCT services in the district.

A qualitative methodology was used by the researcher because individual attitudes and experiences differ and one needs to explore and understand in detail the participants' thinking and feelings about HCT unlike quantitative method that will direct these thoughts and feeling on specified issues on HCT. A qualitative method will unearth the attitudes and experiences as lived

by the youth in terms of HCT so that the true picture of the phenomenon being studied will be understood. Literature reviewed indicated that research work on youth and HCT have been extensively done worldwide especially in sub-Saharan Africa mostly using the quantitative approach and a few qualitative studies. In Ghana a few, studies have been done on youth and HCT. The quantitative approach was employed. There was no evidence of use of qualitative methods, especially in the Jirapa district. This therefore provided the basis for which this research study was embarked upon.

Even though the researcher is a Registered Nurse Educationist and an HIV/AIDS counselor, he did not go into the research with any biases and prejudices which was necessary to ensure that the realities on the ground were described as true reportage from the participants. Also setting aside any biases and prejudices during the research data collection, analysis and writing of the report did allow for identification of the attitudes and experiences of the youth toward HIV counseling and testing.

3.2 Research Setting

The research was conducted in Jirapa, the capital of the Jirapa district in the Upper West region of Northern Ghana. The district has a total population of 110,894 with 24% of this population comprising of the youth (Ghana Statistical Service, 2010). The Jirapa town itself has a population of 8000 people and 1,900 of them are youth. Eighty-five per cent of these youthful population are students in the senior high schools and training colleges located in the Jirapa district. The district has one referral hospital which is located in the town, six clinics in sub-districts and four Community-Based Health Planning Services (CHPS) zones in surrounding villages. The district also has established HIV Counseling and Testing centres (HCT) located in each health service institution within the district and in the main hospital within Jirapa township.

There are other ones in Han Health Centre; a rural community located 35 kilometres east of the Jirapa Town.

The district shares boundaries with the Lawra district to the north, Sissala West district to the east, Nadowli district to the south and the Black Volta River to the west. Geographically, the district is a savanna land and has two main seasons, the rainy and dry seasons. The study was conducted at two HCT service centres within the district, namely Han and the Jirapa Town HCT. The HCT centre at Jirapa is managed by two trained counselors one of whom is a public health nurse and the other counselor a nurse midwife all trained in HIV pretest and post-test counseling and testing. The Jirapa centre is located at the western end of the Jirapa hospital administrative block. It has three rooms, the first to reach is a room where the counselors of the centre usually sit and receive visitors to the centre. The second or middle room is an inner room of the first one and it is reached through a door from the first room. This is where the counseling and testing usually take place. Privacy and confidentiality are ensured in this room through the provision of partitions. Only the counselor and the client stay in this room during the counseling. Third persons are kept away until counseling and testing are over. There is a door that leads to the outside of the building. The last room is a big room with adequate furniture, in-door games with assorted books, journals and posters for visitors to the centre. People living with HIV/AIDS (PLWHA) usually receive their counseling, anti-retro viral treatment and support in this room since the centre is one of the treatment centres for PLWHA in the Upper West Region of Ghana.

The centre at Han is also managed by a resident midwife and a resident community health nurse who are both trained in HIV testing, pre and posttest counseling (JDHS Annual Reports, 2008). The centre at Han has only two rooms, one for the counselor to receive visitors and the other for counseling and testing. For the purpose of confidentiality, the HCT room has

two doors to its entry, one door is connected to it through the visitors' room whilst the other door is at the back of the room. People living with HIV/AIDS in this area are usually referred to the Jirapa centre for treatment and support. The Jirapa district also has three senior high schools and three nurses' training schools.

The people of the district are mainly subsistence farmers who rear small herds of animals for sale and domestic use. Most of the youth with no formal education and those that are out of school migrate to the Brong Ahafo Region especially Techiman and its environs in search of jobs to earn a living. These migrants occasionally return home to participate in traditional festivals and funeral rites. While away from the influence of parents and elders in the strange lands, the youth are liable to social influence regarding friendship and dating. This attitude is exhibited as the researcher observed that the youth often date and engage in sexual relationships during festival celebrations constituting a culture of vulnerability amongst youngsters in the region. The common language spoken in the region is Dagaare. The researcher is an indigene of this region and understands the culture and traditional practices of the Dagaaba people as a whole which may be divergent from the perceptions of the contemporary youth of today's Ghana.

3.3 The Target Population and Sample

The target population for the study is the youth aged 18-24 years both literate and non-literate, in school and out of school in the Jirapa district, and youth who have utilized or not utilized HCT services.

3.3.1 Sampling Technique

Nothing highlights the difference between quantitative and qualitative methods explicitly than the logic that underlie sampling. The aim of quantitative sampling is about generalization to

the larger population based on random sampling and statistical probability theory (Mayan, 2009) for control of sampling bias. Where as in this qualitative exploratory study, the researcher aims at understanding the phenomenon of interest in-depth and in its totality i.e. understanding the knowledge, attitude and experiences of the youth in the Jirapa district concerning HCT through the use of purposive selection of the participants as a way of increasing the sampling strength to reduce threats to rigour. The researcher selected individuals and contexts based on their characteristics and ability to give the most and best information about the topic in a most conducive context.

The HCT centre in the Jirapa Township and the one at the Han community were the selected sites respectively. These two HCT centres were well known for their provision of privacy and confidentiality among people who visited the facilities. There also existed a good interpersonal relationship between the health care professionals and their clients. Consequently, the researcher planned to interview participants each by purposively selecting from these two HCT centres in the district. The final sampling frame (16) was however based on data saturation, when no new data emerged, when all leads were followed and negative cases were checked and the story came to a close (Mayan, 2009).

3.3.2 The Eligibility Criteria of the sample

Eligibility criteria for the sample included:

- Youth within the ages of 18-24 years.
- Youth residing in Jirapa district for more than one year
- Youth who could express themselves in English or “Dagaare”.

- Youth who have ever migrated to other regions outside Upper West Region
- The youth who were either literate or non-literate
- Youth in school and out of school
- Youth who had utilized or not utilized HIV Counseling and Testing services, and most importantly,
- Youth who indicated their willingness to participate in the study

3.4 Data Gathering Procedure

The Nurses in-charge of the clinics at both Jirapa and Han were briefed about the study and on how to recruit participants to the study. A participant information leaflet (see Appendix I) containing the study objectives, purpose and recruitment formalities was used and explained to the HCT counselors at the Health centres. The counselors further explained the aims and objectives of the study to any youth that visited their clinic for services and obtained their mobile phone numbers for the researcher to contact. Notices about the study objectives, the inclusion criteria were put up in the clinic premises, schools and college campuses and also in the Jirapa Township with the researcher's contact number for prospective participants to contact the researcher if they wished to participate in the study.

Before the commencement of data collection, ethical clearance was sought from the Noguchi Memorial Institute for Medical Research (Appendix II: Ref. No: DF 22). Permission for site approval from the School of Nursing was written to the Director of Health Services in the region and to the District Health Directorate and the Health facilities involved (see Appendix III). The purpose of the research was outlined in an information leaflet for the participants and

Head Nurses (Appendix III). Informed consent was also sought from every participant verbally and written form by thumb printing or signature (Appendix I). An office space was allocated to the researcher for conduction of interviews in each of the HCT centres. The researcher assigned days when he was always present at each of the centres to conduct the interviews.

The data were gathered over a period of nine months commencing from September, 2009 to May, 2010 after the guiding questions and the audio recording equipment were pretested on two youth 18 years old in a senior high school in the district. Each participant was identified by the HCT counselors and asked for his or her participation in the research and any of them who agreed was then referred to the researcher. The researcher further explained the objectives and purpose of the study to prospective participants using the information leaflet. Any participant that indicated willingness was then made to sign a consent form. The interview guide (Appendix IV) had two sections. The first, section A was made up of questions on personal information while the second section, B was made up of guiding questions on knowledge, attitudes and experiences. The guiding questions were supplemented with probing questions. Once a participant was recruited, interviews were carried out. The researcher anticipated to interview each participant between forty-five minutes to one hour. However some of the interviews went beyond this period as the researcher being a nurse and an HIV counselor in the district had to spend time creating rapport with each of the participants. Usually after the interview, the researcher obtained the mobile phone numbers of each participant and physical address locations for the purpose of follow-up interviews. After each interview the participant was informed that he/she could be contacted for another interview after transcribing and reading the first interview.

In all, four participants needed to be traced for a follow-up interview to clarify some themes that emerged from the initial interview. The follow-up interviews were conducted under

sheds and shady trees away from public scene. The participant was usually contacted on phone and informed about the need for a second interview. Participants' views were sought concerning the venue of the interview.

During the interview process, the researcher maintained a cordial and friendly environment to relax the participants to enable the participants to talk. Permission was obtained from each participant to tape record the conversation. Some of the participants exhibited non-verbal cues in their responses which were recorded in the field notes. A Journal of all activities that took place was also kept including the objective of each interview, the venue, the environment. The incidents that were heard, seen, expressed and thought about during the process of data collection were recorded by writing in order to comprehend and interpret the content of the interviews better.

3.5 Data Management

Data that were gathered from each interview were immediately transcribed and typed out on Microsoft word and stored in identifiable files in a personal computer by the researcher and a password given to the transcribed data. Print out transcriptions and the tape recorder used for the study were kept in a cupboard under lock. The transcripts will be kept for a period of five years after which (in the absence of any untoward occurrences from the study) these recordings and transcribed data would be destroyed according to the University of Ghana and School of Nursing policy. Only the researcher and his supervisors had access to the transcribed data for purposes of audit trail.

3.6 Data Analysis

The techniques described by Mayan (2009) were used to analyze the data collected. Content analysis was employed whereby specific words expressed by the participants were reported

verbatim. The analysis and data collection were done concurrently which provided the opportunity for the researcher to identify what probing questions to ask in subsequent interviews. The cross checking of information from each interview with other participants assisted the researcher in recognising the level at which no new information emerged from the interview leading to saturation of the data. Finally, the themes that emerged were read over again making sure that they were those that were expressed by the participants regarding the phenomenon under investigation. Data from the field notes were also analyzed to enhance understanding of the various categories and themes that emerged. Themes verification was done by involving some of the participants in a second interview who consented to this second meeting.

According to qualitative research paradigm, data analysis usually commences immediately with the first interview. Data that were gathered yielded interesting and complex wholes. After each interview the audiotape was played several times to listen. Then those interviews conducted in the Dagaare language were translated into English after which the data were then transcribed verbatim. This transcription was first written down by hand and later typed and printed out with margins by the sides. The transcribed data were first read through several times to get the meaning and understanding. Similar words, phrases, sentences, ideas and concepts were identified by using different colour pencils to code by underlining them. Similar colours form an idea and this was noted by the side margins. Similar ideas by the side margins were also grouped to form categories, sub-themes and themes.

3.7 Methodological Rigour of the Study

Rigour in qualitative research is demonstrated through a researcher's attempt to confirm information discovered and to ensure that the information accurately represented the attitude and

experiences of the study participants (Streubert & Carpenter, 1999). When the rigour of a study was being addressed, trustworthiness was often the core concern. For maintenance of trustworthiness in qualitative research, four techniques involved are; member checks, thick descriptions, audit trail and dependability.

To ensure that the study was rigorous a member check was done, that is by making follow up interviews with some of the participants whereby participants were asked to validate the accuracy of the transcribed interview and the themes that emerged. The thick description include the thorough descriptions of the research setting, the context where interviews were conducted and the processes throughout the investigation period as recommended by (Polit & Hungler, 1999). This was achieved through the vivid descriptions of the research setting and the recording of things that happened during the interview processes in the field notes. All transcribed interviews together with the field notes and themes that emerged were made available to the research supervisors for the purposes of audit trail.

According to Mayan (2009), an audit trail is a documentation of the researcher's decisions, choices and insights. The audit trail enables the researcher to document why, when and how decisions were made throughout the research process. Similarly, an audit trail is usually done to enable another researcher follow the decisions made during the research processes. In this study, before data collection started the proposal was examined and accepted by the supervisors and the Noguchi Memorial Institute Ethics Review Committee. All important notifications and observations were documented in the field notes so that the researcher's decisions, choices and insights could be monitored by the supervisors.

Dependability refers to the findings of the study yielding similar results with other groups in a similar context (Polit & Hungler, 1999). Participants had varied views because of their cultural

background. The interview guide was also pre-tested with two youth, from one of the two HCT service centres in the district (Han centre) but they were not included in the main study sample. This clarified and made the set of questions more comprehensible. Pre-testing the interview guide also enhanced the credibility and dependability of the guide since amendments were made to portions of the guide to enable the questions to generate data that meet the desired expectations of the study. The pretesting also enhanced the researcher's ability to handle the tape recorder in the main interview.

3.7 Ethical Considerations

Research that involves human beings as participants in particular should be conducted in an ethical manner to protect the rights of people. The three ethical principles of beneficence, respect for human dignity and justice (Polit & Beck, 2004) were followed. Ethical clearance was sought from the Noguchi Memorial Institute for Medical Research (see Appendix II). Permission and support were sought from the managers of the two HCT service centres in the Jirapa district. Informed consent was also sought from all participants. Potential participants were informed of the research through the officers in-charge of the HCT service centre that were involved in this study, as well as through notices posted at the HCT centres, schools, public notice boards. The purpose and the significance as well as the benefits and risks of the research were explained through an information leaflet before the participant's consent was sought. The participants were also informed of their freedom to leave or withdraw from the study any moment and their refusal to continue in the study would not compromise their medical care.

Confidentiality of the participants was maintained by not using participants' real names and other characteristics that would disclose their identities. The data that were collected were treated confidentially and kept under lock and key and the analysis of the data gathered were done by

the investigator and supervisors in order to prevent a third party having access to it. Participants were given the address of the chairman of the Ethics Committee and they were told that they had the liberty to contact the Ethics Committee for any information. The HCT services centres were available to provide counselling to participants who would experience distress emotions in the process of interviewing.

3.9 Summary

Chapter three presented the research methods, the application of rigour in the qualitative study, how ethical considerations were made and how data was analysed by content analysis. Chapter four presented the findings of the study.

CHAPTER 4

FINDINGS OF THE STUDY

4.0 Introduction

Qualitative inquiry is primarily an inductive activity. Morse and Richards (2002) described the cognitive process of an inductive thinking as moving from comprehending to synthesizing, theorizing and to re-contextualizing. The comprehending began as the researcher started thinking about the research topic and the setting as well as learning from the literature. The comprehending continued through the data collection and the initial stages of data analysis which was attained as saturation was reached enabling the researcher to write a dense description of the phenomenon. The synthesizing enabled the researcher to merge the stories and experiences of the study respondents to describe their patterns of behaviours and how they act, react or connect. The synthesis enabled the researcher to describe the typical phenomenon by providing stories as examples of this generalization.

The narratives were identified and made personalized by the participants using pseudonyms according to the participants' pattern of entry into the study in order to ensure confidentiality and anonymity. For instance, participant 1 (P.1) was identified by the name as Han dokpong1b, P2 as Handobile1a, P3 as Hanpoglee1a, etc. These pseudonyms were also formulated taking into account the age of the participant and the centre where the participant was recruited for the data collection.

4.1 Demographic Characteristics of the Participants

The ages of the study participants were between 18 and 24 years. Eight participants from both centres and settings were between ages 18 and 20 whilst the other eight were between ages 21 and 24 years respectively. Half of the participants did not know their right ages and aligned their ages to historical incidents in the district.

All the participants except one could understand both English and Dagaare because the Jirapa district is composed of only one ethnic (Dagaaba) group. Eight participants preferred speaking Dagaare during the interview and the other eight spoke English. The eight participants at the Jirapa centre were nursing students and hence were in their tertiary level of education. Only one participant at the Jirapa centre was a Junior High School graduate. At the Han centre, only one participant did not have any education. Three of them were Junior High School (JHS) graduates and four were Senior High School (SHS) graduates. Only two of the participants were married. The rest of the fourteen were unmarried. The general characteristic of the participants is presented in (Appendix V).

4.2 Themes and categories

The content analysis used in chapter three yielded seven major themes and various categories which are described in the chapter. The broad themes generated from the data included the following:

- Knowledge about HCT
- Reasons for utilization of HCT by individual youth

- Reasons for non-utilization of HCT by some youth
- Sharing of information about HCT among the youth fellows
- Cultural practices and their influence on HCT
- Parental factors that hinder or enhance youth participation in HCT
- Youth satisfaction with HCT services

The themes and their categories are presented in Table 4.2:

TABLE 4.2: Themes and categories

Themes	Categories
Knowledge of HCT	<ul style="list-style-type: none"> • Meaning of HCT • Availability of HCT • Sources of information on HCT
Reasons for utilization of HCT by individual youths	<ul style="list-style-type: none"> • Knowing HIV status • Accessing HIV Counseling • Prevention of spread of HIV • Perceived benefits and good services • Perception of negative results • Perception of adopting an appropriate lifestyle • Influence by peer group
Reasons for non-utilization of HCT centres by some youth	<ul style="list-style-type: none"> • . Indulgence in casual sex • Lack of time • Fear of positive test • Fear of stigmatization • Fear of spread of HIV positive test news • Lack of confidence in health care workers • Fear of being called names (mockery) • Positive diagnosis is death warrant • HCT meant for married women

Sharing information about HCT among the youth	<ul style="list-style-type: none"> • Educating colleagues on HCT • Recommending/enticing HCT to colleagues • Indifference towards sharing information
Cultural practices and their influence on HCT	<ul style="list-style-type: none"> • Cultural practices facilitating the youths' access for HCT • Widow inheritance • Practices that influence the youth negatively for HCT
Parental factors that enhance or hinders youth participation in HCT	<ul style="list-style-type: none"> • Positive influence by parents for HCT • Negative influence by parents for HCT • Parents unwillingness for their youth to test for HIV • Parents misconstrue HCT for pregnancy and abortion • Youth under strict parental vigilance and teacher monitoring for youth in school
Satisfaction with HCT services	<ul style="list-style-type: none"> • Feeling of Happiness and easiness • Provision of good services • Maintenance of confidentiality and privacy

4.2.1 Knowledge of HIV Counseling and Testing

Generally knowledge of HCT was high with most of the participants expressing high knowledge of HCT. The knowledge about HCT that was identified among the participants included the meaning of HCT, the availability of HCT to the youth, and the sources of information on HCT in the Jirapa district. These categories about HCT are described and supported by verbatim quotes from the participants.

a) Meaning of HIV Counseling and Testing

A lot of participants were actually able to state in-depth description of what is meant by HCT. The participants were able to describe what procedure was involved in HCT.

Hanpogkpong 2b who was a primary school dropout and not yet married had this to say about HCT:

What I know about the testing is that the health personnel will test you to know whether you have it or not after which they will inform you about the test results whether you are negative or positive. When they want to test you they usually prick your thumb finger to take some blood and put it on a certain testing kit so that after some few minutes they can read it and tell you the results.

Jirepoglee 1a who was very fluent in her speech and also a junior high school graduate awaiting to attend senior high school indicated that:

HIV Counseling and Testing is a test you do to know your status. People who wish to go for it usually get to the centre and they are taken through some procedure before the test and after the test the nurse in charge will tell you the results and also advice you on what type of food you are to take if positive in order to live long and if negative she will advise you on the non use of infected skin piercing instruments and protected sex or abstinence before marriage.

In the course of explaining what is meant by HCT, Jirepogkpong 2b who was advanced in knowledge about HCT because she knew that testing was not by coercion remarked:

What I usually hear on radio is that HCT is somebody who voluntarily goes in to do counseling and test for HIV after giving his/her consent. Testing for HIV is not by coercion So one cannot test for HIV without consenting to it.

In a related story about what is meant by HCT, Jiredokpong 2b, a student at the nurses training college in Jirapa also verbalized this way:

At the HCT centre, the health personnel will test you and tell

you your status. When you are negative or positive they will advice you about the next step you will take. They tell you how to interact with your friends and colleagues and if positive they will give you some drugs that you will be taking to let you live long. They will also tell you how to help your family and how to educate them so that they will protect themselves from getting HIV.

Jirepoglee 2a a student at the Jirapa midwives' training college who said she knew what is meant by HCT stated her version this way:

What I also know about HIV test is that the person doing the test usually take your blood and test to know whether you have the HIV virus in your blood or not. I also know that those who have the HIV usually go to the testing centre for drugs that can keep them for long life. Since AIDS is a killer disease if you don't test to know your status you may become sick one day and die without knowing what killed you.

From the statements the participants gave, it is quite clear that the participants knew what HCT meant. However they concentrated on the HIV test itself and said little about the counseling.

b) Availability of HCT services centre

The availability here implied the accessibility and nearness of HCT centres in the district, the quick services provided at the centre and the ease and comfort with which one can easily test for HIV. Some of the participants talked about the available HCT service centre near the community. In such an instance Handobile 1a, a junior high school graduate narrated his story this way:

It was at the antenatal clinic that the nurses told us that there is a clinic here that the HIV test can be done for anybody to know your status whether you are positive or negative to HIV.

Jirepoglee 1a was another participant who knew that HCT centre was available She had this to say:

People who wish to go for it usually get to the centre which is located in the hospital premises and there they are taken through some procedure before the test and after the test the nurse in charge will tell you the results and also advice you on what type of food you are to eat if positive in order to live long and if negative she will advice you on the non use of infected skin piercing instruments and protected sex or abstinence before marriage.

Han dobile 2a also had this to say about availability of HCT services centre:

HCT for HIV was first introduced to Han Clinic when a durbar was first held to inaugurate the centre by the Health Director and the Regional Minister. Youth especially were advised to go and do the test to know their status. But I did not go to do the test until recently when the health staff of the clinic came around for a know your status campaign and I actually called some of my friends for us to come over and do the test.

Jiredobile 1a who knew exactly where the HCT centre was located in the community stated his version this way:

The HCT centre is located in the hospital premise and as one walks along the street you can read the inscriptions on the wall. Actually the centre is not a hidden place.

As far as the location of the HCT service centre was concerned, the participants knew that the HCT centre is located within the premises of the hospital or the clinic and can easily be located if one wants to go in for the services that are provided there.

c) Sources of information on HCT

The participants expressed knowledge of various sources of information about HCT. The most common information sources identified by participants were radio, health personnel, television, churches, mosques, sign post and at schools. The participants had information on HCT from diverse sources. Hanpoglee 1a who was a Junior High School graduate who got the information on HCT through the community health nurses that go to their school for school health and health education programmes reported the sources of information on HCT as:

I have been hearing much at school and over the radio. I however once heard of HIV test on the radio which stated that people should go in for the test for them to know their status.

Another participant had rich sources of information, through announcements from information vans, churches and education by health workers. She expressed how she got to hear about HCT as follows:

Usually announcements are made with the information service van and in the churches. Sometimes the health workers themselves will tell you that there is a centre in the hospital where you can go and test to know your status free of charge. (Jirepogkpong 1b)

Jirepoglee 1a said that she got the information about HCT at school and also at home. She narrated her version this way:

I heard of HCT when I was at the high school. I also saw it on the wall of the building in the hospital when I was walking on the street with my mother so I asked her and she told me it is all about HCT. I also used to hear about HCT in the church as well.

Similarly, Jiredobile 2a also had this to say about how he got the information about HCT:

Health personnel use to come to our school i.e. high school level to talk to us about HIV/AIDS and HCT for HIV. They actually used to advice us to go in for the test in order to know our status. Also in Jirapa here I usually hear about HCT in church announcement and that people should go and be tested.

Handokpong 2b indicated that he got to know about HCT from health workers who usually got closer to the people at their communities to deliver health services as well as giving information about health promotion. He had this to say this:

I got to know about HIV testing when I was passing one day and people gathered listening to health workers educating people of the village about HCT and asking that anybody who wishes to test should come to the clinic for the test and that the test is free. It was there that I got to know of it and gained

Interest to do the test.

The manner in which participants expressed themselves indicated that information about HCT was widespread. However some of the important areas like festival grounds were not mentioned.

4.2.2 Reasons for utilization of HCT by the youth

Most of the participants expressed willingness to go for HCT. The participants had already used HCT centres before they were interviewed. The others too did not have HCT because they visited the hospital/clinic to seek health services other than HCT. Some of these participants expressed knowledge as well as willingness to go in for the HCT. Others who did not do the HCT expressed unwillingness to do the HIV test. Those youth who expressed acceptance to undergo the test was because they wanted to know their status, accessing HIV counseling and prevention of HIV transmission.

a) Knowing one's HIV status.

Through HCT one will know his or her HIV status and one will take precautions to remain negative if he/she tested negative and to prevent transmission to others, live cautious life to avoid development into AIDS and to access anti-retroviral drugs for long life if tested positive.

One of the participants stated the reason why he wanted to know his HIV status as follows:

I purposely went in for the test to know my status; whether I'm positive or negative so that I will know how to take care of myself. If I test negative I will adopt the prevention methods and if positive I will go by the advice that the nurses will tell me. (Handobile 1a)

In a similar way Jiredobile 1a stated that he wanted to know his status in order to plan his future life towards health. He also said:

what actually prompted me into the test was about knowing my status as to whether I'm positive or negative, and God being so good I was negative after she pronounced it. She later encouraged me to remain negative by living a good and moral life and also by abiding by the other preventive methods.

Another participant who had inadequate knowledge of HIV/AIDS wanted to know his status in order to learn more about the disease AIDS. He indicated that he was equally attracted by the health personnel for the test and when he went for the test he tested negative. He verbalized his message this way:

I was happy and keen to know my status because I don't know much about the disease and for that matter I was eager to know whether I have it or not. And fortunately enough I was negative and these my two friends were also negative. Again the motivation and the importance of knowing your status by the health personnel also attracted me to come in for the test. (Handobile 2a)

Knowing one's status so that they will know how to live their life was the reason for most of the participants' attraction to do the test. In similar narrations, Jirepogkpong 2b said this:

Though I am a health worker I could have decided not to go for the test if I wanted but I decided to come to the HCT centre for the test in order to know my status so that I will know how to live my life. Also it is important to test because if you test and even get a positive result, the health workers will know how to care for you so that your life will be prolonged and if you test negative you will also know how to live your life in order not to get infected. As a health worker too I should know my HIV status in order to know how to deal with my clients .

Jirepogbile 2a thought of living a morally sound and positive life. She put it this way:

I just wanted to know my status For instance if test positive the nurse or the person doing the test will advise me to go in for the drugs and how I can prevent the transmission to other people. If I test negative she will advise me to live a life that will prevent me from contracting the HIV.

From the fore-going, it was quite clear that participant's main reason for going in for HCT was to live a healthy life after the test. One of the participants indicated that one can still live long if one tests positive by taking antiretroviral drugs.

b) Accessing HIV Counseling

Accessing counseling is one of the benefits that attracted most youth who went in for the HIV test. According to them they will be counseled during the process. Jirepogkpong 2b who was a student midwife at Jirapa testified this in this statement:

Also it is important to test because if you test and even get a positive result, the health workers will know how to care for you so that your life will be prolonged and if you test negative you will also know how to live your life in order not to get infected. As a health worker too I should know my HIV status in order to know how to deal with my clients .

In a similar narration Jirepogbile 2a also stated this way:

For instance if one tests positive the nurse or the person doing the test will advice me to go in for the drugs that I can be taking in order to live for long with the disease.
If I test negative like in my case too she will equally advise me to live a life that will prevent me from contracting the HIV.

c) Prevention of spread of HIV

A particular participant, Jiredokpong1b was the only one who stated prevention of transmission of HIV as what attracted him to go for HCT. He said this in a very short sentence:

If I test negative like in my case too the nurse will equally advise me to live a life that will prevent me from contracting the HIV. If I happen to test positive too, the nurse will advise me to be taking the drugs for the infection and also use condom anytime I am having sex so that I will prevent the spread of the infection to other people

d) Perceived benefits and good services

Some of the participants believed that the benefits the youth will derive from the test is what usually encourage them to go in for the test and this was clearly represented in Hanpoglee1a who was a single junior high school graduate. He made this statement:

If you know your status you will be able to handle your lifestyle well.
If you are negative after the test you know how to protect yourself
so that you don't get infected with the HIV virus.

Another participant, Handobile1a an eighteen year old senior high school graduate had this to say on perceived benefits of HCT:

I believe that some of the youth who went in for the test wanted to know their status so that they will either guard themselves against HIV infection or to prolong their lives.

e) Perception of negative results and adopting appropriate lifestyle

One of the participants believed strongly that one of the things that will encourage the youth to go in for HCT is when they trust themselves that they have not engaged themselves in any behaviour that will expose them to contracting HIV and hence will believe that when they go for the test, they will be negative. Jiredokpong1b a twenty-four year old nursing student at Jirapa had this to say:

Those who went in for the HIV test trusted themselves that they will test negative because they believed that they lived an upright life without blemish i.e. those lifestyles that will prevent them from HIV infection since everybody knows the causes of HIV transmission.

Some of the participants also believed that HCT can change the lifestyle of the youth and this will be a way that will encourage some youth to go in for HCT. One participant had this to say about the adoption of appropriate lifestyle which will serve as an encouraging factor for going in

for HCT. Jirepogkpong 2b, a twenty-three year old female nursing student at Jirapa narrated her story this way:

Most youth are aware that if you go for the test and you test negative, you will live a life that will protect you from getting infected and if you test positive too you will live a life that will prolong your life and for that matter they will want to know their stand so that they can adopt the appropriate lifestyle.

Another participant Jirepogkpong1a, a female student midwife also had this to say;

If you know your status you will be able to handle your lifestyle well. If you are negative after the test you know how to protect yourself so that you don't get infected with the HIV virus.

f) Influence by peer group

One participant stated that some of the youth are encouraged by their colleagues to go for the test after they themselves have gone in for the test. She had this to say;

Some of the youth went in for HCT because their colleagues informed them that the services that are rendered there were good and less time wasting.

Knowing one's HIV status, accessing HIV counseling, prevention of spread of HIV, perception of benefits and provision of good services, perception of negative results, perception of adopting appropriate lifestyle, and influence by colleagues were the factors that participants cited as what encouraged the youth to utilized HCT.

4.2.3 Reasons for non-utilization of HCT centres by some youth

Some of the participants indicated that they were not willing to accept HCT for various reasons such as: indulgence in casual sex, lack of time, fear of positive test results, fear of stigma, fear of being mocked by fellow youth and the rationalization that HIV test is meant for

married women. These subcategories under the reasons for non-utilization of HCT will be described.

a) Indulgence in casual sex

Hanpoglee 2a, an eighteen year old junior high school graduate at the Han HCT centre accepted the fact that she had indulged in casual sex without protection and for that matter feared that she might test positive since she did not know the HIV status of her sexual partner. She had this to say:

Actually I will not deny I had sex with some of my school mates and they did not use condoms and I usually think that if I go in for the test I may be positive and it will not be easy for me.

Another participant Hanpogkpong2a, a twenty four year old female primary school dropout who said she had a boyfriend and knew very well that she was not the only girlfriend of the boyfriend but yet they usually had sex without the use of condoms. She narrated her story this way:

I usually have sex with my boyfriend without the use of condoms because he will not agree to use condoms but I know very well that he has other girl friends apart from me. So I'm afraid to test for HIV.

b) Lack of time

Other participants had not gone in for HCT and associated it to lack of time to attend to the HCT clinic. The lack of time as an answer for the reason for not going in for HCT might be something that participants remained adamant to say. Jirepoglee 1a, a student nurse was one such participant who responded as follows:

It is usually because I don't have the time to go there and be there for about two hours when I'm not actually sick.

I know I'm not sexually promiscuous so I'm aware I'm negative. you can imagine when you come to the OPD of the hospital the number of hours you wait there to be seen and through till you take your drugs at the pharmacy. Time wasting is what prevented me from going in for the test.

Hanpoglee 1a, a nineteen year old female participant who also stated lack of time as reasons indicated:

It is because I do not control my own time but my parents always make sure that they engage me in household chores anytime I return from school till I retire to bed in the evening. It is usually on Sundays after church that I become free and on this day the clinic personnel will not work.

c) Fear of positive results

Some youth participants had fear of the results as a factor that discouraged them from HCT. These fears were expressed with the statements that follow:

Handokpong1b, a twenty-two senior high school graduate at Han centre gave his version on the fear of results which may lead to committing of suicide. He reported it this way:

They think that if they go for the test and happen to test positive, they may commit suicide. Some of the youth also go about saying that they will not go in for the test because whether you get AIDS or not you will definitely die.

Hanpogkpong1b smiled when she was asked about the reasons for non-utilization of HCT centres. She stated:

Actually, some people especially some of my colleagues refuse to go for the test because they usually say that when they go for the test and happen to be positive, they will be filled with thoughts since they know that the final result will be death.

d) Fear of spread of HIV positive test news/death warrant

Another deterrent for the non-utilization of HCT was the fear of spread of positive test results. Some participants indicated that the youth may be discouraged to go in for HCT because they fear that the results of their test may be spread to people in the community especially their colleagues who will be pointing hands at them or making mockery of them if the test results happen to be positive. According to the participants if such situations happen then those affected people may commit suicide to avoid social ridicule. The participants narrated their fear in these excerpts:

Most of them will not want to go in because they have been hearing from people who tell them that if you test positive, the hospital personnel will go about in town telling people that they are positive. Because of that some of my colleagues who wish to do the test travel to HCT centres far away from the district where people don't know them to do the test there. Such people will avoid public ridicule (Jirepogkpong 1b).

Another participant did not hesitate to say this:

This is very simple, I feel they think that if they go in for the test and the results happen to be positive, the news will spread far and people will be making mockery of them and they will feel shy to go about their normal life because sex is sacred among the “Dagaaba” and HIV transmission is associated with sex.

A third participant was confident to express views on fear of exposure as a deterrent to HCT by the youth. She narrated it this way:

Majority of the youth actually do not want to go for the test because they think that the person that will take the test may reveal his/her client's status to other people that is if the client is positive and the message will be spread all over the community and people will be pointing fingers at you. Most people cannot withstand this societal pressure on them and hence may commit suicide. (Jirepoglee 2b)

People, especially the youth hate to be exposed or mocked at and if they think that when they go in for HCT and the information happen to spread in the community where they live, they

will be embarrassed and for that matter commit suicide to avoid social ridicule. For these reasons why the youth may refuse to go for HCT in the district need further investigations, regarding ensuring the confidentiality of HIV test results by HIV counselors.

e) Fear of stigmatization/being called names

If someone is stigmatized, people try avoiding such a person socially. Regarding fear of stigmatization, one participant who gave stigmatization as a discouraging factor for HCT expressed herself courageously in this way:

Most of the youth refuse because they think that if they are tested positive, they will begin to spread the information in the village that they have AIDS. People will begin pointing fingers at you anywhere you pass. Again when people get to know about it they will shun your company and put you into worries because nobody will get closer to you again to avoid contracting the disease. Even your closest friends will stigmatize you and call you an AIDS patient (Jirepogkpong 1a)

Another participant also cited stigmatization as a discouraging factor to HCT in this narration;

That is not all. Some people feel that when they go in for the test and happened to be positive, people will be spreading the message about that they have AIDS and that the affected person feel ashamed because she will think that people have been made aware that she has AIDS; a disgraceful disease that people acquire through sexual promiscuity (Hanpoglee1b)

A participant at the Han centre also narrated her story on stigmatization and denial as factors that discourage the youth from going in for HCT as follows:

They also think that when they test and they happen to be positive the information will spread and their own colleagues will discriminate against them forcing them to isolate themselves from people. This will actually put them into thinking and have suicidal tendencies. People usually think that once you are positive you have AIDS and that nobody will have sex with you again and nobody will like to use something that you have used earlier on. Even nobody will like to eat with you. Your brothers and sisters will not want you to use anything of theirs.

The findings in these verbatim narrations provide clear evidence that stigmatization constituted one of the factors that discourage the youth towards HCT.

f) HCT is for only married people

Most of the participants were not married and participants perceived HCT to be patronized by only people who were married. The participants indicated that since family planning is meant for people who are married then also should HCT be meant for them.

Hanpoglee1b, in her narration about HCT being meant for married people had this to tell:

I did not go for the test because I thought the HCT is meant for married people. It was just recently that I heard that people as young as fifteen years can equally go for the HCT. The place which was used for family planning is now being used for the HCT

The second participant that thought that HCT was meant for married people knew that HCT was carried out at the antenatal clinics because that was where he ever saw it being done to pregnant women. He narrated his story this way:

I initially believed that HCT was meant for married people who wanted to have a child and for that matter they will test the pregnant woman to see if she has AIDS. I got to know of this when I ever accompanied my brother's wife to the antenatal clinic where she told me she has been tested for HIV.

4.2.4 Sharing information about HCT among youth fellows

The next theme was how participants communicate with each other on HCT. Participants who had HCT done for them and those who accepted HCT and had not yet decided to test expressed the need to share ideas of HCT with their youth colleagues. Though a few participants were indifferent personally, they did not decline to share ideas of HCT with colleagues.

The subcategories here include educating fellow youth colleagues on HCT, recommending HCT to colleagues and being indifferent.

a) Educating colleagues on HCT

On educating colleagues on HCT, the participants were ready to educate colleagues on HCT so they could also have the benefits of the test. This is what a participant at Han centre had to say on education of colleagues:

What I was already telling them even before I came for the test was that, going in for the test does not mean that you have HIV. If even after the test and you become positive to the test, the nurses will teach you and aid you with some drugs that will help you to live for long without getting the AIDS itself (Handokpong1b).

Similarly, another participant had this to say about educating colleagues on HCT;

I will inform them that HIV testing is good. This is because it will help you change your living style and behaviour. I will inform them that you rather live in fear by not testing than to test. (Handobile1a)

Jiredokpong1b also had this to say about what he had to share with his colleagues about HCT and its benefits:

I was very proud to tell them that I have gone for the test and I'm negative and since we are all colleagues that move together they can also go in for the test. And that, it is good to know their status so that they can live decent life and also plan their lifetime better against such infectious and deadly, terminal diseases.

Another participant, Handobile2a had bright ideas to share with his colleagues on HCT. She narrated it this way:

I will share with them the importance of the testing and how the testing is usually conducted in the sense that if you don't know your status how will you either prevent yourself from contracting the disease without transmitting it to other people innocently. I now know that government and other bodies are helping those who have the HIV to live long in order to increase productivity of the nation. These are all ideas that I will explain to them to entice them to go for the test.

Jirepoglee2a stated that she will stress on the importance of HCT when sharing HCT ideas with colleagues. She had this to say:

My advice to my colleagues after this test will be that HCT is free, the nurses in-charge are friendly and will assure of confidentiality and that the nurse will not expose your result to anybody else. I will also tell them the importance of HCT for HIV i.e. it will help you know your HIV status in order for you to choose the life you will want to live. I mean i.e. if positive, you will be advised on good diet, retroviral drugs and transmission prevention. If negative then you protect yourself from being infected.

b) Recommending HCT to colleagues

Generally, many of the participants demonstrated the need for others to go in for the test and tried to entice them to do so. One such participant at the Han centre had this to say about an enticing message to the colleagues to go for HCT for HIV:

I will inform them that you rather live in fear for not testing than to test. My main challenge after the test was how to advise my colleagues also go in for the test as I have done.(Handobile1a)

Hanpoglee2a, a twenty year old junior high school graduate at Han had this to say:

My colleagues may not know whether I have gone in for the test or not. I'm sure that some of them might have seen me in the clinic set up so they may think I have come in for the test. But what I will share with them is that they should do well to voluntarily go in for the test and know the HIV status. Probably, if I'm able to convince them to go in for the test and they come out negative that might also

encourage me to go in for the test because I'm aware that we are all in the same shoes. We all engaged in unprotected casual sex.

Jiredobile1a also recounted in this way:

I already tried to entice them to have them tested when I was going in for it but unfortunately they didn't come along with me. Now that I've gone through it and have a good experience I will encourage them to go in for the test.

Jiredokpong1b used himself as an example to relay the information about the HCT test to his colleagues. He stated in this way:

I was very proud to tell them that I have gone for the test and I'm negative and since we are all colleagues that move together they can also go in for the test. And that, it is good to know their status.

Handobile 2a also had this to say:

I will share with them the importance of the testing and how the Testing is usually conducted in the sense that if you don't know your status how will you either prevent yourself from contracting the disease.

c) Indifference toward sharing HCT information

A participant was indifferent regarding sharing knowledge of HCT with colleagues. He will neither encourage nor discourage anybody from going in for HCT. This was what he had to say:

What I will tell them is that if they are brave to withstand the test results whether positive or negative then they can go for the test. I will usually tell them what I feel and if they share the same sentiments like me then they tow my line. If they can manage it fine, else they don't go for it. (Jiredobile2a)

From the stated narratives by the participants on the sharing of information on HCT to friends and colleagues, it may be that their information somehow influenced their colleagues' attitude either positively or negatively towards HCT because youth most often listen to information coming from their peers.

Varied factors contributed to the youths' willingness to go in for HCT. These factors ranged from perceived benefits, good services offered at the HCT centres and the fact that HCT services are free. On some occasions participants identified benefits which contributed to encouragement of the youth for HCT. Other factors that encouraged the youth to go in for HCT included: perception of negative results, perception of adopting appropriate lifestyle and influence by colleagues. The theme on cultural practices was the next to be analysed

4.2.5 Cultural practices and their influence on HCT

The cultural and traditional practices in the Jirapa district contributed to the use or non-use of HCT centres. The influence of cultural practices on HCT was indirect. Cultural practices such as funerals, festivals and other communal gatherings are common grounds for the youth to interact and build relationships and friendships with each other. This however promoted casual unprotected sexual activities as most of the participants indicated that sexual behaviour among the youth during these occasions were common and usually these behaviours make the youth to feel that they might have contracted HIV because of multiple unprotected sexual activities during festivals and cultural activities.

Therefore they were afraid to go in for HCT to avoid becoming aware of their status. Marrying of widows of their late brothers is also a cultural practice among the "Dagaabas". This may be dangerous because most often the actual cause of the death of the late husbands of widows was

not always known hence such widows may not want to go for the HIV test for fear of being positive. Most young boys who were involved in widow inheritance declined to test for HIV.

A few participants however insisted that despite the increased rate of unprotected sex during festivals, funerals and communal gatherings, some people maintain decency and were scared of HIV test. The tradition and beliefs of the community generally forbid sex before marriage, sex outside marriage and multiple sexual partners. These practices are punishable by ridicules and fines by the chiefs, infliction of strange diseases by the gods and banishment. These deter the youth from promiscuity and pre-marital sex making them willing to go for HCT because they are not afraid of getting positive results.

a) Cultural practices facilitating access to HCT

Some of the participants at Han and Jirapa centres where the interviews were conducted had a lot to say about some positive cultural practices which the youth usually want to be associated with and for that matter when those particular youth realize that they were actively performing those practices, they are motivated to go in for HCT.

One participant, Hanpoglee1a had this to say about the positive cultural practices of the youth:

It is actually true that when some youth in this area realize that they have not lived a life that the indigenous people approve of they have no confidence to go for the HIV test because they will be aware that once they have not lived those lifestyles that the community does approve of then they most likely will test positive and they will feel very miserable.

Again another participant at the Han centre also narrated her version in this way:

In our cultural system since the females are those that are usually accused of infidelity and adultery, most of the newly married young ladies who know the customs of this ethnic group very well and are aware that they have not indulged themselves in any of these acts will test for HIV to clear themselves of any false accusation of adultery or otherwise.

Jiredokpong1b at Jirapa centre indicated that those youth who went by cultural practices of the community that prevented people from having indiscriminate sex knew that they were free of any such acts and for that matter were motivated to go in for HCT. He had this to say about it:

It is a taboo for a young girl to have sex before marriage in this particular community for the sake of maintaining her virginity before marriage. Those married young ladies who knew they had gone by this traditional practice will definitely feel motivated to go in for the HIV test because they will want their mother-in-laws to be proud of them that they were actually virgin before they married their sons.

Jirepogkpong1b stated that some youth who do attend these traditional festivals are disciplined and for that matter will not participate in some of these immoral activities that are commonly practised on such festival grounds and for this reason will be willing to do the HIV test once they are sure that the result from the test will be negative. She narrated her story as:

Despite the involvement of some youth in the cultural festivals such as the ‘bogri’, ‘konuo’ and ‘kobine’ where indiscriminate sex is commonly practiced due to freedom from the watch of parents/guardians. They will not engage themselves in such acts. Such youth may only be interested in the dancing, drinking and making fun. Once they did not engage themselves in such immoral acts, they will be willing and actually go in for the HIV test since they know the highest mode of transmission is sexual intercourse without the use of condoms and such a behaviour has been out of their way.

b) Cultural practices inhibiting access to HCT

Most participants indicated that it is the involvement of the youth in traditional festivals that are celebrated every year among the “Dagaabas” that most of the youth engage themselves in indiscriminate unprotected sex that make them harbour the fear of being positive to the HIV. This accounted for their unwillingness to undertake HIV test. These participants reported about cultural practices that inhibit access to HCT.

Hanpoglee1a, a female participant at Han centre had this to say:

Again on the grounds of such traditional festivals, men are free to go in for other women even when they are married but women by our culture and tradition are not allowed to do that or else you face the wrath of the gods of the land. So, men mostly may not want to test because of their extra marital activities outside the family.

She continued and indicated again:

Also of late some young people may marry the widows of their late brothers as tradition demands without knowing the kind of disease that killed the late brother. When such men suspect that their late brother might have died from the "slimming disease" then they will never go in for HCT for fear of being positive to the test.

Hanpogkpong1b, another female participant at Han centre reported:

Our tradition have it that if a married woman engages in adultery even though nobody might know, the gods of the land will punish her and she will become pale, lose weight and finally die if she does not voice out for traditional purification. The young women who may engage in adultery without voicing out will definitely refuse to test for HIV because of fear of being positive and also exposing their infidelity activities.

As regards the culture and tradition, a nineteen year old Handobile2a stated this:

It is actually true that these youth will be reluctant to go for the test because of their behaviour in such cultural activities like "konuo", "bogri" etc. These are festivals that everybody will want to attend to enjoy life and have fun. Some of the girls for instance come from poor families but because they want to enjoy life at such grounds they will be enticed by the males who will give them money or buy them meat and drink for sex. When such things occur to them they feel guilty to go for the test.

Cues from the participants' verbatim narrations indicate that the youths' involvement in the cultural practices mentioned actually have a big influence on their attitude towards HCT participation in the Jirapa district as a whole.

4.2.6 Parental influence on the youth for HCT

Most of the youth expressed their experiences about parental influence and its effects on their participation in HCT. They expressed how parents need to give the go ahead for their wards to undergo HCT. The tradition of the “Dagaaba” people impose strict control of the child even though the young person may be above the age of eighteen years or more once he/she still lives under the roof of the parents, young men and women are often under control by parents especially on any decision that is to be taken by the youth regarding issues of HIV/AIDS and marriage.

a) Positive influence by parents for HCT

Some of the participants indicated that their parents and elders were literates or had adequate knowledge of HIV transmission, spread, prevention and management. Such parents usually encouraged the youth to go in for the test in order to receive the appropriate education on prevention if they test negative or how to learn about the management if they test positive.

Participants who had parents that encouraged their wards to test made several statements as follows:

Jiredobile2a, an eighteen year old male nursing student had this to say:

Yes parents have a big influence. I think that every parent will want their wards to go in for the test so that they will know their status and advice them as to what to do next.

Another participant at the Han centre indicated that:

Most parents will want their children to go in for the test so that if they know their children’s status they will know how to take care of them and even control their behaviour such that they will promote their health as regards HIV/AIDS. This is because they fear losing their children at that tender age in case they are positive and it is not detected early enough. (Handokpong2b)

A participant at the Jirapa centre also had this to say:

I think that majority of parents know the behaviour of young people these days and for that matter they will want the youth to go in for the test so that they will know their status. So that they will know what they will do to influence their ward's behaviour in case of a positive or a negative test.

b) Negative influence by parents for HCT

The participants who indicated that their parents had negative influence on them regarding HCT explained that such parents were either illiterate, ignorant or they did not want to be embarrassed by their children who might test positive.

A participant at the Han centre explained her point this way:

Parents are usually particular about their grown girls and boys visiting the clinic always and many try to prevent them because they think they can go there for pregnancy test and may try to cause abortion in case they are pregnant or they can go there to receive family planning medicines that encourage them to indulge in sexual activities(Hanpogkpong2b).

She continued and indicated:

The boys who also visit the clinics will also continue to impregnate girls and have ways of testing for pregnancy and causing abortion for them. (Hanpogkpong2b).

The strictness nature of parents prevent some youth from participating in HCT.

4.2.7 Youth satisfaction with HCT services

Participants who received the HCT services were generally satisfied. They expressed their satisfaction in different ways ranging from; happiness during HCT sessions, good services being provided at the HCT centres, healthy relationship with the service providers, and maintenance of confidentiality, privacy, and individuality by the service providers.

a) Feeling of happiness and easiness

The youth participants who patronized the HCT and were satisfied with the services at the centre provided their opinions about the HCT centres in the following statements:

A twenty year old male graduate of senior high school at Han centre expressed his views as:

The nurse was very lively and cheerful since she knew me personally and during a health education at the village, I was present so I was warmly received. And since the nurses were there for our own good, the session was smooth without any problems can affirm that the session was smooth and both of us were happy, especially when the test came out to be negative.

Another participant who was so delighted expressed his feelings about the session this way:

The session was not bad at all because the nurse related with me cordially and wished me well and that I should try and live a good lifestyle while waiting for the three months period to come so that I can come for the confirmatory test. (Handokpong1b)

He indicated his satisfaction as regards how easy he felt and had this to say:

It was quite okay. I actually felt very easy because the nurse assured me that everything that is said and done in the room is between she and myself alone and that nobody will have access to it, so I got relaxed and listened to her attentively.

A female participant also had this to say on the part of the HCT session conduction:

I felt very easy because I was already used to the nurse who did me the test and she was very hospitable. I was particularly very happy when she told me that the result of my test was negative (Hanpoglee1a)

b) Provision of Good Services

Good services that are delivered at the HCT centres has enhanced the utilization of these centres by young persons who seek for HIV testing at these centres because quality assurance is insured.

Hanpoglee1b expressed her feelings this way:

The sessions are usually lovely and with cheerful staff. They will welcome you in a nice way and they will also make sure you are seated and relaxed in a room. The counselor will talk a lot to you and you are also free to ask questions before and even after the test. She will not force anything on you but through your own volition.

Another participant who was a male student of Jirapa nursing training college and had undergone HCT expressed himself this way:

When you approach the centre the nurse in charge will welcome you and give you a seat before she will ask you of your mission there. If she is engaged, she will excuse the other client and get you a comfortable room where you can find a lot of posters and reading materials to read. She will then attend to you later after she has finished with the first client you met there.

c) Maintenance of confidentiality, privacy and individuality

A person who has been identified as being HIV positive is very likely to be discriminated against or stigmatized and for that matter almost all youth who desire to go in for the HIV test will definitely wish that confidentiality and privacy be maintained wherever the test is done.

Jirepogkpong2b narrated what happened during the HCT session in a friendly mood:

The nurse usually counsel you into detail before you are tested i.e. after you have consented to the test. The nurse usually makes sure that you have your privacy and she usually tells you that it is highly confidential i.e. the nurse does not counsel you in public.

In a similar narration where confidentiality was mentioned, Jirepoglee2a also stated this:

They welcomed me and gave me a nice seat whereby they assured me of confidentiality and that whatever you do here is just between her and you alone and that one should rule out that such information will get to someone else.

There was only one participant who expressed that she was not satisfied with the way the sessions were conducted because the nurse who conducted the HCT session did not inform her about certain aspects of HCT for HIV to her. She however attributed this misfortune to the fact that the service provider was somebody familiar. She had this to say;

She did not tell me anything about the test, but I thought because they have been educating us always on the test and because a number of us from our village came to the clinic to do the test, it was likely that the nurse was in a hurry to finish with the three of us. Hence the inability on her part to take good care of me.
(Hanpoglee1a)

Generally, participants who had experience of HCT had a positive impression of the whole process because they said they were received very well at the HCT centres by the HCT providers at both Jirapa and Han centres. According to the participants, they were equally satisfied with the services and more especially confidentiality, privacy and individuality were maintained and these were some of the facts that they could use to convince their colleagues to go for the HCT.

4.2.8 Summary

The findings of the study realised seven major themes that emerged from the data. These have been described and supported with verbatim reports from the participants. The field notes that were written on every interview were also analysed which added the context of the study.

CHAPTER 5

DISCUSSION

5.0 Introduction

To achieve the purpose of this study which was to explore the attitude, knowledge and experiences of the youth towards HIV counseling and testing, in-depth interviews were conducted with sixteen youth within the ages of 18 and 24 living in the Jirapa District of the Upper West Region to determine their level of uptake of HCT. The youth constitute the most vulnerable population group in the Jirapa District regarding the spread of HIV / AIDS and its prevention programmes. The importance of HCT as a cost-effective HIV prevention intervention strategy and its role in improving access to care and support means that HCT services should be more widely promoted and developed and incorporated into the primary health care package for a developing district such as the Jirapa District in the Upper West Region of Ghana.

In this chapter, the findings in chapter four will be discussed. The UNAIDS and other agencies have emphasized the importance of HIV counseling and testing (HCT) as a critical strategy for HIV/AIDS prevention but there have been considerable reluctance the youth to be tested, a reluctance that has been attributed to fear of receiving positive test results with its implications for more stigma and death (Angotti et al, 2008). In the Northern part of Ghana, especially in the Jirapa district, it is believed that certain cultural practice among the youth can have an influence on their attitudes towards HCT (Action Aids Ghana 2009; Mwini-Nyaledzigbor, 2010).

There are barriers to HCT in the Jirapa District emanating from parental factors and the cultural and traditional practices among the Dagaaba people. The parental factors that hinder the youth from participating in HCT included unwillingness of parents to allow their youth boys and girls to utilize HCT centres as HCT has been misconstrued for pregnancy test and opportunities for indulgence in abortion practices. Thus, the youth were mostly hiding to undergo HCT hoping never to be seen by a parent or familiar relations. This is an exceptional finding that is peculiar to the Jirapa District. The youth were most often under strict vigilance and monitoring by both parents and teachers for those youth in school. This parental vigilance stems from the cultural practices and traditions among the Dagaaba people where a youth or a grown-up man is never considered to be independent from parental control even if he turns 40 years and above, let alone being 18 years; so far as he is still under the watch of his parents for continued educational and economic support or cultivating family lands. Hence the youth both literate and non-literate had problems negotiating ways and means to participate in HCT freely. The findings of the study on the barriers to youth participation in HCT though related to those of McCauley, 2004a, Mwinituo and Wright, 2010, Mwangi Ngure and Thiga, 2008, is an exclusive finding due to its cultural and traditional connotations. What compounded these barriers was the fact that the youth themselves had their own reasons for non-participation in HCT such as early indulgence in casual sexual practices, resulting in increasing fear for positive HIV test results, fear of spread of the news about the HIV positive test, and consequently the fear of stigmatization from fellow youth and society. These negative perception among the youth was the driving force for some of the youth who feared to utilize the HCT centres although the study found that those youth who defied these unfounded fears and undertook the test received negative test results. This results were

confirmed by studies regarding youth and HIV testing, (Meiburg et al, 2008, Yahaya et al, 2010, & Sukari, 2008).

The findings of the current study are indications for major work that health workers/ HIV counsellors in the Jirapa district need to do in order to increase youth participation in HCT. There is also the need for further research on assessment of stigma of HIV/AIDS among the people of Jirapa, especially among the youth. HIV counsellors have the task of educating the youth about the use of condoms during casual sex and health programmes should be initiated to involve parents, teachers and the youth in HIV programmes regarding its prevention and treatment.

5.1 Knowledge of HCT

Knowledge of HCT was adequate with participants giving relevant information about the benefits of HCT such as: it being a means of obtaining information about prevention when tested negative whilst those who tested positive have opportunity to access antiretroviral therapy to minimize the development of AIDS. The depth of knowledge of HCT among participants is an indication that the HIV/ AIDS menace has gained the needed attention from both health workers and ordinary people in the district. In the literature, similar findings about knowledge of HCT have been observed by Ma et al (2008) who compared the knowledge, attitudes and uptake of HCT in one county in China (CC) that had an HIV/AIDS testing and care programme with a county that did not have the programme. Results from the study revealed that, participants in the CC County had better knowledge and uptake of HCT but a more negative attitude towards persons living with HIV.

Similarly, the current study findings confirm the findings of Sebudde and Nangendo (2009) who researched on the topic “breaking resistance to access and utilization of HCT among the Youth in Rakai District of Uganda” which found that, there was adequate knowledge of HCT and its availability. This is an indication of the amount of publicity on HCT among the youth in most Low and Middle income countries including Ghana. The participants’ knowledge about HIV and HCT in the current study also confirms Dennis’ (2010) results which revealed a high general level of awareness of HIV/AIDS, to the point that out-of-school youth could repeat many of the standard messages used in campaigns against the disease. However, it was observed that while there were generally positive comments about the knowledge and awareness of HCT, there was also considerable vagueness as to what exactly it entails. However, the adequate knowledge of HCT shown by these findings imply that the youth were aware of transmission and prevention of HIV/AIDS and knew the centres and importance of HCT.

5.2 Reasons for utilization of HCT by the youth

A second major theme that was identified was the reasons for utilization of HCT by the youth either as an individual or the youth in general. These reasons did not come from only those participants who utilized HCT but also those who did not utilize HCT. Even though those youth did not utilize HCT, they were aware of the reasons why some youth did not have the courage to go for HCT. Generally as a result of wide spread campaigns and education of the youth in the district on HIV/AIDS and HCT, participants were able to come out with a lot of different views about the reasons why some youth went in for the HIV test. The reasons identified were developed as sub themes. Some participants as individuals indicated that knowing one’s HIV status was an important issue they considered for going in for the HIV test so that when they know their status they would then decide on how to live. Some participants also gave the reason

that they wanted to access the counseling that is usually given by the counselor at the HCT centre. Others also accepted the fact that they could prevent the spread of HIV if they went in for the test. Also according to some of the participants, the most relevant reason to go for HCT was serious health complaints. Girls did mention pregnancy as a strong motivation for HCT. For example, one female participant said: “For me now I think it is not so important, but if I get pregnant I would go in for the test with the aim of protecting my baby”. Other reasons for the willingness of the youth in Jirapa to patronize HCT were also directly linked with the perceived benefits of having HCT done and services provided at the HCT centre. Participants were of the view that HCT was beneficial irrespective of the outcome of the test. Thus both positive and negative tests were perceived to yield benefits to the one doing the test. They observed that a negative test result would relieve the individual from worry, and at the same time the person would benefit from health education on measures recommended to maintain a negative status such as safe sex practices. On the other hand, people who tested positive would have an opportunity to receive treatment in the form of antiretroviral therapy as well as information on lifestyle and nutritional practices necessary to reduce opportunistic infections, wasting and rapid advancement to AIDS. Other reasons for uptake of HCT included accessibility, availability and confidentiality.

Nevertheless, some participants most of whom had already taken the HIV test gave their reason for going in for the test as a perception of getting a negative test result because they knew that they had not indulged in any activity that will let them contract the HIV virus that causes AIDS. The predominant transmission method of HIV from an infected person to those who are not infected is through casual sex. This was the slogan for all HIV transmission campaigns and

health educational programmes not only in the Jirapa district, but in Ghana, sub-Saharan Africa and the world as a whole.

These findings agreed with studies conducted in sub-Saharan Africa. Some of the studies also contrasted with the findings of this major theme. Tefera (2006) who conducted a study to find out the factors that affect the acceptance of HCT among the youth in Addis Ababa stated that one of the youths' reason for HCT uptake was to know their status. However Tefera's findings differed from the findings of this study because he found that some of the reasons for the HCT uptake were that the youth suspected they were infected and also because they wanted to go abroad that was why they went in for the HIV test. The findings of Mgosha et al. (2009) in a study conducted on health professional students confirm the findings of the present study. Health professional students were willing to do the HIV test because they knew they had low risk of contracting the HIV virus. On the other hand Wang et al. (2011) who conducted a research in northern China found out that the researchers' interest was on the willingness of female sex workers who did not use condoms during their sexual activities for HCT. Though the majority of the female sex workers were not willing to be tested, the few that were willing knew they were at a higher risk of contracting HIV. This differs from the present study's findings where only youth who thought they had lower risk of contracting HIV were willing to be tested.

5.3 Reasons for non-utilization of HCT by the Youth

Youth engagement in certain traditional practices such as the "bagri" and "konuo" festivals among the Dagaaba in the Jirapa district of Ghana were fertile grounds where liberal casual sex without intimidation took place though sex is supposed to be practised out by only adults who are married. Those youth who engage themselves in sexual activities on such grounds know that they put themselves at a higher risk of contracting HIV. For this reason the non-

acceptance of HCT uptake by individual participants was varied. Some gave the reason for not going for the test as being afraid of receiving positive test result since they have had casual sex without protecting themselves. Other participants did not give any reason for not accepting to go in for the test. Another reason by participants was lack of time to go in for the test because at that age they were usually engaged in household chores and other activities assigned to them by the parents. Some participants had other reasons for non-utilization as fear of spread of HIV positive news.

Again, some of the participants expressed the fear that news of HIV positive results of those youth that have gone in for HCT may spread in the community and those affected may be embarrassed leading to tendencies to commit suicide because of disgrace. That apart, it was realized by the researcher that stigmatization of those who were infected with HIV was common in the community. It was therefore not surprising that some of the participants expressed stigmatization as one of the reasons for non-utilization of HCT by the youth in the district. Since that most of the participants were not married, it was not surprising when some of the participants expressed that HCT should be for married women. This was an act of denial to cover up their own deeds so far as indiscriminate sexual activities were concerned. A number of studies agree with the present study's findings.

One of these findings, that is indulgence in casual unprotected sex was a reason for not accepting HCT and agrees with the findings of Tenibiaje (2010) who conducted a research on the attitude of youth toward HCT. The findings of Tenibiaje (2010) revealed that there was a negative attitude for HCT if the youth were aware they had engaged in unprotected sex. Such youth needed persuasion and motivation to undergo HCT. Meiberg et al. (2008) also in their study agreed to the fact that the youth may not utilize HCT because of fear of stigmatization and the

fear of positive results which may lead them to commit suicide to avoid disgrace to themselves as well as their families. Van Dyk and Van Dyk (2003) also agreed with other authors on barriers to HCT that people may refuse to utilize HCT because of fear of rejection if found to be positive, fear of a breach of confidentiality, fear of people knowing them and shunning them if found to be positive after testing, and lack of trust in the HCT personnel and services. Meiberg et al (2008) also agreed with the findings of the present study through a qualitative study they conducted and found out that there was still a strong HIV/AIDS-related stigma in South Africa. Participants agreed that PLWA are neglected, ignored and isolated. For instance, participants frequently mentioned that it would be very difficult to get a job when you are HIV positive, many men leave their women when they are HIV positive, even family members frequently blame their relatives for contracting HIV/AIDS. Many people living with AIDS (PLWA) were rejected by friends because people do not want to be associated with someone with HIV/AIDS. The focus group discussions (FGD) also revealed that participants were struggling with HIV/AIDS-related stigma themselves which prevented them from going for HCT. It was important to educate people about AIDS related stigma and to design theory- and evidence based interventions to reduce AIDS-related stigmatization. Such interventions should move beyond the individual level to be effective, and should also target the reduction of stigma at the organizational and community level.

The fear attached to HIV/AIDS is of great magnitude that explanations and information provision will always be paramount to attract people to participate in its related activities such as HCT. Community mobilization for community action as a strategy can enhance the people's readiness to participate in HCT.

5.4 Sharing information about HCT among the youth

Participants who accepted HCT and those who did not express willingness to go for HCT were ready to share knowledge of HCT with friends and colleagues. They were motivated to do so because when knowledge of HCT is widespread prevention of HIV would also improve thereby reducing everybody's risk of infection of the HIV virus. They were of the view that on sharing information of HCT to colleagues and making them understand the benefits of the test, the ultimate thing to do next would be to recommend to them to have HCT done. This indicates that bonding among the youth in the Jirapa district is strong. The peer group influence is so glaring because the youth usually meet themselves during the traditional festivals where they find girlfriends and boyfriends purposely for engagement in sexual activities and marriage thereafter. Nonetheless, peer groups are also formed in the educational institutions all over the district and beyond and these are avenues that the youth could use to give information about HCT to their colleagues. Several studies agree with the findings of the present study while others contrast with the findings of the present study.

Botma, Motiki and Viljoen (2007) in their study to find out the perceptions and knowledge of people for HCT in the Free State in South Africa confirmed that participants indicated that they were prepared to share their status of HIV with their colleagues who were their sexual partners as well as parents. This is an indication that sharing their experience of HIV test with partners or colleagues can either influence them to either equally go in for the HIV test or not.

MacPhail et al (2008) in their qualitative research on the attitude of the youth on HCT in South Africa agreed with the youth sharing their HIV testing experiences with friends but indicated that these youth stated that they will share their experiences with very good friends who will not

reveal their secrets. This is a good idea since friends are able to motivate those who have not tested for HIV to do so.

5.5 Cultural practices' influence on HCT

The influence of cultural practices on HCT was indirect. Cultural practices such as funerals, festivals and other communal gatherings are common grounds for the youth to interact and make friends with one another. This however promoted casual unprotected sexual activities as most of the participants said that sexual behaviour among the youth during these occasions were common and usually these behaviours make the youth to feel that they might have contracted HIV because of multiple unprotected sexual activities during these cultural activities. However, participants indicated that during cultural activities such as funerals and festival messages about HCT could be transmitted to many people through health education. Botma, Motiki and Viljeon (2007) in a study which sought to investigate perceptions of the youth regarding HCT and other sexual aspects confirmed the fact that certain cultural practices in Africa had the potential of increasing the spread of HIV/AIDS. For that matter, if the youth in particular who were involved in focus group discussions in the study indicated that such a practice exposes people to contracting HIV, then it is likely that those youth who knew they had engaged in indiscriminate sex will definitely refuse to go for the HIV test for fear of being positive because the African culture abhors making public sexual activities. The authors of the study categorically indicated that “African culture prohibits parents from talking to their children about sex because sexual activities are sacred and not supposed to be made public”. This is also the case in the present research where some youth participants indicated that some youth will not want to go in for the HIV test because they had exposed themselves in risky behaviours at some cultural festival grounds where sex is allowed freely in secrecy.

Action AID Ghana (2007), supported the findings of this study through a survey conducted on violence and HIV in northern Ghana. Their study found out that women in their fertile age mostly young women who became widows as culture demands are forced to marry the brother of the late husband. When such widows are inherited without going into the cause of the husband's death, and if the husband died as a result of HIV and she is positive herself, she will end up infecting the new man who will also infect his other wives. Such widows may be confused as to whether to go in for HIV test or not.

Results from the survey also revealed that since women were not allowed to remarry and continue staying in their deceased husband's home, they remain in the homes, stay single and have several lovers. This may also lead to the spread of AIDS. These groups of women were willing to do the HIV test because they were free from bondage and could decide for themselves. It was quite clear that some of these cultural practices may encourage or discourage widowed women from going in to test for HIV. It is advisable that such cultural practices are discouraged through education.

5.6 Parental factors that hinder or enhance youth participation in HCT

Parental influences on the youth towards their participation in HCT were one of the major emerging themes from the transcribed data collected. Generally, participants expressed divided opinions about the influence parents have on the youth to go in for HCT. Whilst some believed that parents were positive conduits in encouraging their children to go in for HCT, others felt that the reverse was the case. Some of the participants indicated that their parents and elders were literates or had adequate knowledge of HIV transmission; spread, prevention and management. They usually encouraged the youth to go in for the test in order to receive the appropriate education on prevention if they were negative as well as drugs and nutritional management if

they were positive. Participants who indicated that parents had negative influence on the youth regarding HCT explained that such parents were either illiterate, ignorant or they did not want to be embarrassed by their children who might test positive. On the other hand, those parents who were literate and understood the benefits of HCT were willing that their children go in for HCT. “Dagaaba” children, by tradition, are under strict control of their parents and should have their consent before making any attempt to go in for HCT. The parent can decide to refuse the request of the ward to go in for the HIV test.

Findings from the present study agree with the findings of McPhail, Pettfor and Coartes (2006) who conducted a study among South African youth and parents. According to them, parents were willing to allow their wards to go in for contraceptives that can be used to prevent pregnancy and sexually transmitted infections but had a different view for that of HCT. The parents indicated that the providers of the HCT needed their consent as to whether they will allow the ward to go in for the HCT or not. The findings of this study were similar to the South African such that both had parental influence on their children who wished to go in for HCT. Again Botma, Motiki and Viljeon (2007) in a qualitative study that sought to investigate perception of the youth towards HCT and other sexual aspects also confirmed that parents have a major influential role to play in their children’s sexual activities. The study cited the lack of parental guidance as one of the major obstacles to informing the youth about safer sex practices. African culture prohibits parents from talking to their children about sex. Parents should be educated on how to communicate with their children about sex and other activities related to sex e.g. HIV testing.

5.7 Youth satisfaction with HCT Services

Regarding the experiences of participants during HCT, almost all the participants at both centres who either did the HCT by themselves or got the experiences from other colleagues who went in for the HCT indicated that the attitude of the nurses who provided the HCT was cordial. Some participants indicated that the pre and post counseling sessions were adequate and informative as they enabled them to understand the importance of HCT. Participants who received the HCT services were generally satisfied. They expressed their satisfaction in different ways ranging from happiness during HCT sessions, good services being provided at the HCT centres, healthy relationship with the service providers, and maintenance of confidentiality, privacy, and individuality by the service providers. It can be concluded that if the barriers to HCT uptake could be broken through persistent education as well as friendly attitude of health workers during counseling, the uptake of HCT could greatly improve. The positive correlation between quality of HCT services and uptake therefore cannot be overemphasized. Mwandira (2008) in evaluating the effectiveness of youth HCT counselors in promoting HCT uptake among fellow youth, using client satisfaction data from exit surveys noted that older adolescents were more likely than younger adolescents to access HCT services from youth friendly sites or centres; HCT motivation messages and perceived HCT services were also found to be very vital for decision making in their lives especially before marriage.

Mphaya (2006) stated in her study on factors that motivate young people to go for HCT for HIV in Malawi that, young people are likely to go in for HCT if they realize that the service centre provides satisfactory services such as; healthy relationship with the service providers, and maintenance of confidentiality, privacy, and individuality by the service providers.

5.8 Summary

Thus far, the chapter has provided a discussion of the themes that emerged from chapter four (4). The themes discussed were compared with findings from the literature. The themes covered (1) knowledge of HCT, (2) knowledge of availability of HCT, (3) reasons for utilization of HCT by the youth, (4) reasons for non-utilization of HCT centre by the youth, (5) sharing of information about HCT among youth fellows, (6) cultural practices and their influence on HCT, (7) parental factors that hinder or enhance youth participation in HCT and (8) youth satisfaction with HCT services.

CHAPTER 6

SUMMARY, CONCLUSION, IMPLICATIONS AND RECOMMENDATIONS

6.0 Introduction

In this chapter, a summary and conclusion of the study was described outlining the various chapters and themes including their implications to nursing practice and recommendations for future research.

6.1 Summary and Conclusion

For the past three decades Human Immune-deficiency Virus (HIV) and Acquired Immune-Deficiency Syndrome (AIDS) have remained a global public health as well as a social problem. Since then, there have been attempts by various governments and the World Health Organization to curb the pandemic especially in Sub-Saharan Africa where it is estimated that 1.3 million people die annually from AIDS related diseases. Out of these AIDS related deaths about 50% of them are the youth. According to Boswell and Baggaley (2002), the youth aged 15-24 account for more than 50 percent of all HIV infections worldwide (excluding perinatal cases). More than 7,000 youth are newly infected with HIV each day throughout the world. In Africa alone, an estimated 1.7 million youth are infected annually.

The prevention of HIV infection include; using a condom (either a male or female condom) during sexual intercourse, having a monogamous relationship with an HIV-negative partner who has no other sexual partners, or having non-penetrative sex, delaying sexual activity of young people (until they become sexually active) and abstaining from sex. Apart from the aforementioned HIV transmission prevention methods, HIV counseling and testing (HCT) was

also identified as one of the most effective methods of preventing the infection from spreading. It is an important entry point to other HIV/AIDS services, including prevention of mother to child transmission (PMTCT), prevention and management of HIV related illnesses, and social support (FHI, 2006).

In Ghana according to Abokyi (2008), HIV Counseling and Testing (HCT) is also believed to offer strong motivation for those who test negative to remain so. This therefore underpins the importance for more people to take advantage of HCT services more especially the youth in the Jirapa district of Ghana where the uptake of HCT service has recorded low figures among the youth between 2004 and 2007 (JDHS, Annual Report, 2008).

In line with the purpose of the study, data on the attitude, knowledge and experiences of the youth towards HCT uptake was collected using in-depth interviews. Content analysis of the data generated the following themes: Knowledge of HCT, reasons for HCT uptake, experiences associated with HCT, sharing of information on HCT with colleagues, views of the youth regarding HCT and socio-cultural practices influencing attitude for HCT uptake. The findings of the study were presented in chapter four. In chapter five, the results were discussed in relation to findings of others in the literature review to determine similarities and disparities in the findings. In this chapter, the implications of the findings of this study were discussed. It also included summary and conclusion of the entire work based on which recommendations were made to policy makers, stake holders and researchers in health. Directions for future researchers interested in HIV / AIDS and HCT uptake was particularly highlighted.

The youth in the Jirapa District who participated in the study expressed their desire to go in for HCT; this was motivated by the perceived benefits of uptake of HCT. The youth were of the view that when HCT test results are either positive or negative, it is still beneficial to the

individual; individuals who tested positive would have the opportunity to receive treatment and advice on nutrition and safe sexual behaviours to reduce opportunistic infections and delay the development of advanced stage of HIV. A negative result on the other hand, would relieve worry about a positive test as well as obtaining information on life style modification in order to prevent HIV infection. Attitude of the youth was not entirely positive as some participants in the other extreme were either indifferent or had negative attitude towards HCT uptake. Indifference and negative attitude towards HCT in a way had a negative influence on the uptake of HCT, as participants who expressed these feelings towards HCT did not patronize HCT services. Generally the youth expressed the desire to go in for HCT but acceptance of HCT uptake did not reflect this desire as youth who had not gone in for HCT remained adamant during the follow up interviews.

Low uptake of HCT in the district was found to be the result of barriers such as fear of a positive result, fear of disclosure of results and fear of being stigmatized. These findings could be attributed to knowledge gaps in relation to HIV/AIDS and HCT. Again low uptake of HCT in the district by the youth was also found to be the result of the feelings of the youth that they might have involved themselves directly in unprotected sexual activities. In almost all cultural activities (festivals and funerals) and night market grounds, sexual promiscuity occurs which predispose people to HIV infection

6.2 Field Experiences

There were a number of experiences and challenges the researcher faced during the study. Some caused set backs in the study whilst others enhanced the work of the researcher. During the collection of the data, it was obvious that it was going to take a very long period for the

collection of the data since health demography in the district reveal a low HCT attendance by the youth. This reflected during the collection of data from the two HCT centres at Han and Jirapa. The researcher had to get to the centre earlier in the morning and waited for clients and potential participants for the whole day and closed in the evening with the health care providers at the centre. Sometimes the researcher interviewed only one participant within three weeks and it took the researcher several months to get to data saturation level. Even though the researcher took the home addresses of participants especially at the Han centre, going after participants for follow up was difficult. Moreover some were not present during follow up. This compelled the researcher to wait for the whole day for that particular participant or scheduled another day for the follow up interview since the follow ups were scheduled to take place in clients' homes or places of their choice. Seven out of the eight participants interviewed at the Han centre spoke "Dagaare" (a local Ghanaian dialect of some people in Upper West Region) even though only one participant at the Han centre spoke English during the interview and the researcher was impressed at the high level of fluency in English. At the Jirapa centre only one participant spoke Dagaare, the rest spoke English because they were all students of secondary and tertiary institutions in the Jirapa Township. Tracing such students for follow up interviews was not a big problem to the researcher because they were readily available. Some participants did not talk much requiring probing, paraphrasing and clarifying questions to meet their level of reasoning. During the follow up interviews, participants who had not done the HIV test but were enrolled as participants of the study and equally accepted that they will go in for the HIV test did not actually do the test. However the researcher did not probe into the reasons why they did not go in for HIV test in order to preserve their dignity and confidence.

6.3 Implications to nursing education

Since the days of Florence Nightingale when scientific or modern nursing emerged, the need for knowledge base to back practice has been emphasized. As teachers of patients on diseases and health the nurse must be knowledgeable enough to give informed reliable information to the client. The barriers to uptake of HCT in Jirapa points to a knowledge gap leading to these perceived barriers. The threat to mankind posed by the HIV/AIDS pandemic cannot also be overemphasized. In view of these HIV/ AIDS should be integral in nursing curricula at all levels. Information on HIV already existent in curricula should be reviewed periodically as new issues about HIV emerge so that the nurse will always will be informed to clarify knowledge gaps and misconceptions about the disease as well as HCT uptake and mother to child transmission of HIV. For instance, WHO (2007) came out that HIV counseling and testing should not only be client initiated HCT but should also be provider initiated. This was accepted globally.

6.4 Implications to clinical Nursing

Nurse clinicians should consider the sensitive nature of HIV /AIDS and HCT and treat clients visiting the health centre with confidentiality. They should be nonjudgmental during pre and post counseling and encourage people especially the youth to open up and freely express their concerns and reservations for appropriate responses to be given. Nurses themselves must be agents of change and must show leadership by patronizing HCT services so that the youth can be motivated to do so as well. It is important for nurses to intensify education of the youth on HIV / AIDS and HCT whenever a client visits the health unit even if not for purposes of receiving HCT services

6.5 Implications to nursing administration

Nurse administrators especially those at the HCT units should endeavour to supervise junior nurses and encourage them to be polite, friendly and most importantly be trustworthy to gain the confidence of the youth since one major barrier to HCT uptake was lack of trust in nurses regarding confidentiality and the likelihood of disclosure of test results to other people. Nurse administrators must encourage and facilitate participation in refresher courses on HIV and HCT among staff in those units. They must demonstrate adequate knowledge of HCT and HIV / AIDS so that junior nurses can tap from this knowledge to give education to the youth.

6.6 Implications to nursing research

A major research gap identified in this current study is reasons for the barriers to HCT uptake and why the youth express willingness to seek HCT services but fail to actually go in for the service. Further research should explore the influence of demographic disparities such as age, level of education, marital status and cultural disparities on HCT uptake.

6.7 Recommendations

Following the findings, discussion and conclusion derived from the study of the attitude knowledge and experiences of the youth toward HCT in Jirapa District, it was realized that there was an education policy and administrative gap to improve on the youth's interest and willingness for HCT uptake. The following recommendations were then made:

1. The Jirapa District Health Service in collaboration with the Wa Diocesan Health Service should repackage their educational programme towards educating the youth in particular on the need for HCT and its benefits to the youth.

2. Youth friendly centres should be established throughout the district to provide youth reproductive health services with HCT inclusive with well trained staff manning these centres.
3. The Ministry of Health of Ghana with its implementing agencies should consider including HCT in Community Based Health Planning and Services (CHPS) targeting the youth of the CHPS communities in the country and the Jirapa District in particular
4. The Jirapa District Health Service and the Wa Diocesan Health Service should target educating the youth on HCT at cultural festival grounds, funeral grounds and at their traditional homes and night markets
5. Further research on factors contributing to low uptake of HCT services by the youth in the Jirapa district should be explored by the district health service and nongovernmental organizations in the district.
6. The NGOs in the Jirapa District and the district health service should collaborate with the district education service to establish HCT education clubs in the second cycle and tertiary educational institutions in the district since the majority of the youth in the district are students in these schools.

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APPENDIX I**INFORMED CONSENT FORM****EXPLORING THE ATTITUDE KNOWLEDGE, AND EXPERIENCES OF THE YOUTH TOWARDS HIV COUNSELING AND TESTING (HCT)****VINCNT KOJO TANYE****SCHOOL OF NURSING
COLLEGE OF HEALTH SCIENCES
UNIVERSITY OF GHANA
LEGON – ACCRA
CONTACT NUMBER: 0242301291**

The study you are requested to participate is an academic exercise that is required for the attainment of Master of Philosophy in Nursing certificate at the University of Ghana. The utilization of HIV counseling and testing among the youth in the Jirapa district has been low over the period 2003-2007. Hence the need to conduct this study because HCT is one of the strategies used to control the spread of the HIV pandemic. For this reason, I will like to invite you to take part in a study which will involve having an interview with you for about one hour. The purpose of the study is to find out the attitude that the youth of this district have towards going in for voluntary counseling and testing (HCT) and also the experiences for those who have already gone in for HCT. You are free to express yourself to any level during the interview interaction. The interview will be tape recorded for easy interpretation later.

It is possible that if your other colleagues happen to see you with me having the interview they may think otherwise or may shun your company. However if you agree to it despite this knowledge then you can still participate.

The findings from the study will be used to plan some strategies to improve on the utilization of HCT by the youth in the district.

All information that will be gathered during the interview will be kept confidential and private unless those that are directly linked with the study such as my supervisors. The recorded information will be played back by me alone privately except when you equally want to listen. You will not be named in any part of the study if it is published later.

You will not be paid for this interview, however an amount of five Ghana cedis will be given to you for transport home and back in case of the need for another interview session.

Participation is highly voluntary and you can decide to leave the study at anytime if you so wish, without suffering any losses.

If you have any questions of doubt about your rights as a participant in the study please discuss with me at anytime of participation. Or you may contact the chairman of the research studies review committee at Noguchi Memorial Institute for Medical Research, Rev. Dr. Ayete-Nyampong, NMIMR-IRB, mobile 0208152360.

VOLUNTARY AGREEMENT.

I agree to the document that described the benefits, risks and procedure, for the study; “Exploring the attitudes of the youth in Jirapa district towards HCT for HIV” that have been read and explained to me. And I agree to participate as a volunteer.

Date

Signature or thumbprint

If volunteer cannot read and witness is involved:

I was present while the benefits, risk and procedures were read and explained to the volunteer and he/she has agreed to participate in the study.

Date

Signature or thumbprint of witness

I certify that the nature and purpose, the potential benefits and possible risks associated with participating in this research have been explained to the above individual.

Date

Signature of Person Who Obtained Consent

PARENTAL CONSENT

I agree to the document that described the benefits, risks and procedure, for the study; “Exploring the attitudes of the youth in Jirapa district towards HCT for HIV” that have been read and explained to me. And I agree that my ward should be a volunteer.

Date

Signature or thumbprint

If volunteer's parent/guardian cannot read and witness is involved:

I was present while the benefits, risk and procedures were read and explained to the volunteer's parent/guardian and he/she has agreed to participate in the study.

Date

Signature or thumbprint of witness

APPENDIX II: ETHICAL CLEARANCE CERTIFICATE**NOGUCHI MEMORIAL INSTITUTE FOR MEDICAL RESEARCH
INSTITUTIONAL REVIEW BOARD**

(UNIVERSITY OF GHANA)

Phone: +(233) 21 500374 /501178
Fax: +(233) 21 502182
Email: Director@noguchi.mimcom.org
Telex No: 2556 UGL GH



P.O. Box LG581
Legon
Ghana

My Ref. No: DF.22

2nd September, 2009

Your Ref. No:

ETHICAL CLEARANCE**FEDERALWIDE ASSURANCE FWA 00001824****IRB 0001276****NMIMR-IRB CPN 012/09-10****IORG 0000908**

On 2nd September, 2009, the Noguchi Memorial Institute for Medical Research (NMIMR) Institutional Review Board (IRB), at a full board meeting reviewed and approved your protocol titled:

TITLE OF PROTOCOL : **Exploring the Attitude of the Youth in Jirapa District Towards Voluntary Counselling and Testing (VCT) for HIV**

PRINCIPAL INVESTIGATOR : **Vincent Kojo Tanyi (Student)**

Please note that a final review report must be submitted to the Board at the completion of the study. Your research records may be audited at any time during or after the implementation.

Any modification of this research project must be submitted to the IRB for review and approval prior to implementation.

Please report all serious adverse events related to this study to NMIMR-IRB within seven days verbally and fourteen days in writing.

This certificate is valid till 1st September, 2010. You are to submit annual reports for continuing review.

Signature of Chairman:

Samuel Ayete-Nyampong
Rev. Dr. Samuel Ayete-Nyampong
(NMIMR – IRB, Chairman)

cc: Professor Alexander K. Nyarko
Director, Noguchi Memorial Institute
for Medical Research, University of Ghana, Legon

APPENDIX III: INTRODUCTORY LETTER FOR SITE APPROVAL

SON/F.11

September 15, 2009

The District Director of Health Service
Districts Health Service
Jirapa

Dear Sir/Madam,

LETTER OF INTRODUCTION
MR VINCENT KOJO TANYE

I write to introduce to you the above-named M.Phil student of the School of Nursing, University of Ghana, Legon. He is seeking your permission to collect data for his research on the topic "Exploring the Attitude of the Youth in Jirapa District Towards Voluntary Counseling and Testing (VCT) for HIV".

It would be appreciated if you could give him the necessary assistance.

Thank you.

Yours faithfully,

Dr. Francis Anto
LECTURER

Cc: The Medical Director
Jirapa Hospital
Jirapa

The In-charge
Han Health Center
Han U.W.R

APPENDIX IV: INTERVIEW GUIDE**Part One**

Interview Guide for Youth who have utilized HCT

Section A

Personal Information

Name address.....

Age.....

Educational Background.....

Occupation.....

Languages spoken.....

Preferred language for interview.....

Residence in district.....

Marital status.....

Ethnic background.....

Religion.....

Section B

- Tell me everything you know about HCT
- How did you get to know about the test?
- Tell me all about your experience right from the time you decided to go in for HCT and during the HCT session
- What were your main reasons for going in for HCT?
- How were you treated by the nurse when when you went in for the test?
- What do you think are the factors that encourage your colleagues to go in for the test

- What do you think are the reasons why some of your colleagues refuse to go in for the test?
- What were the socio-cultural ideas and practices that influenced your decision to go in for HCT?
- What do you think are some of the socio-cultural practices that will also influence your colleagues not to go in for the test?
- What will be your attitude and expectations after HCT?
- What will you share with your colleagues after HCT?
- What do you think are some of the cultural practices that can influence the youth to go in for HCT?
- Tell me how do parents influence their older children to do the test or not

Part Two

Interview Guide for Youth who have not utilized HCT

Section A

Personal Information

Name address.....

.....

Age.....

Educational Background.....

Occupation.....

Languages spoken.....

Preferred language for interview.....

Residence in district.....

Marital status.....

Ethnic background.....

Religion.....

Section B

- Tell me everything you know about HCT
- What were actually the main reasons behind you not going in for HCT?
- Tell me what was your main reason why you did not go in for the test
- Tell me about socio-cultural ideas and practices that might have influenced you not to go in for HCT?
- Now that you have not gone in for HCT, what will be your attitude towards HCT?
- What will you tell your colleagues about HCT now that you have not gone for it?
- What do you think are the reasons why many young people are not going in for the HIV test?

- Tell me about some socio-cultural practices that might have influenced some of your colleague to either go in for the test or not to go in for the test
- Tell me how some parents can have influence on their wards going in for the test or not going in for the test

APPENDIX V: PARTICIPANTS PROFILE

Table 4.1: General characteristics of the participants

Participant Entry Number	Marital Status	Age	Sex	Level of Education (No Education, JHS, SHS, Tertiary)	Languages Spoken English/Dagaare	Place of Interview	Pseudonym
11	Single	22	Male	SHS	English/Dagaare	Han	Handokpong 1b
2	Single	20	Male	SHS	English/Dagaare	Han	Handobile 2a
3	Single	20	Female	JHS	English/Dagaare	Han	Hanpoglee2a
4	Married	24	Female	No Education	Dagaare	Han	Hanpogkpong 2a
5	Single	18	Female	JHS	English/Dagaare	Han	Hanpoglee 1a
6	Single	24	Female	SHS	English/Dagaare	Han	Hanpogkpong 2b
7	Single	19	Male	Tertiary	English/Dagaare	Jirapa	Jiredobile 1a
8	Married	24	Male	Tertiary	English/Dagaare	Jirapa	Jirepokpong 1a
9	Single	22	Female	Tertiary	English/Dagaare	Jirapa	Jirepogkpong 2b
10	Single	19	Female	Tertiary	English/Dagaare	Jirapa	Jirepoglee 2a
11	Single	18	Male	Tertiary	English/Dagaare	Jirapa	Jiredobile 1b

12	Single	18	Male	SHS	English/Dagaare	Han	Handobile 1a
13	Single	23	Male	SHS	English/Dagaare	Han	Handokpong 1a
14	Single	23	Female	Tertiary	English/Dagaare	Jirapa	Jirepogkpong 2b
15	Single	24	Male	Tertiary	English/Dagaare	Jirapa	Jiredokpong 1b
16	Single	19	Female	JHS	English/Dagaare	Jirapa	Jirepoglee 1a
Total=16	Total Married =2 Total Single=14	Total Age 18-20=8 Total Age 21-24=8	Total Male=8 Total Female =8	Total JHS=3 Total SHS=5 Total Tertiary=7 Total No Education=1	Total Dagaare=1 Total English/Dagaare =15		