

FACTORS MOTIVATING YOUNG PEOPLE IN MALAWI TO GO FOR VOLUNTARY COUNSELLING AND TESTING FOR HIV

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ABSTRACT

Background: Knowledge about how HIV is transmitted and one's own HIV status is a way to empower oneself. Young people (14–25 years) are more vulnerable to this infection. Knowledgeable young people can solve the problem regarding HIV/AIDS.

Purpose and objectives: The purpose was to enable more young people in Malawi to utilise voluntary counselling and testing (VCT) services. The objectives of the study were to identify factors motivating young people to use VCT services Malawi, identify barriers preventing them from doing so and to formulate strategies for helping them to utilise VCT services. Only young people who had used VCT services participated in this study.

Method: A quantitative, descriptive and exploratory research design was followed. Structured interviews were conducted with 145 respondents at three VCT service sites.

Results: Young people go for VCT mainly to know their HIV status because they are sexually active and feel at risk. Exposure to education, proximity of VCT services, provision of VCT services by peers, and clean VCT sites motivate young people to access VCT services. Fear of being HIV positive, poor attitudes of health service providers towards young people, and long queues at VCT sites were seen as barriers to the utilisation of these services. Provision of more VCT information, involving young people as VCT counsellors and providers and the availability of youth-friendly health services will promote young people's utilisation of VCT services in Malawi.

Keywords: Health Belief Model (HBM), HIV positive, Malawi, voluntary counselling and testing (VCT), young people, youth-friendly services.

Abbreviations used in the article

AIDS	–	acquired immunodeficiency syndrome
HIV	–	human immunodeficiency virus

MACRO	–	Malawi counselling and resource organisation
NAC	–	National AIDS commission
NSO	–	National statistical office (Malawi)
SSA	–	sub-Saharan African
SPSS	–	Statistical Package for Social Sciences
VCT	–	voluntary counselling and testing
WHO	–	World Health Organization

INTRODUCTION AND BACKGROUND INFORMATION

In 2001, 15–24 year olds accounted for 50% of new cases worldwide, indicating that young people are particularly vulnerable to HIV/AIDS (Boswell & Baggaley 2002:1). The Joint United Nations Programmes on HIV/AIDS (UNAIDS 2004a:1) reported that a global estimate of 39.4 million people were living with HIV/AIDS in 2004. This report further estimated that 4.9 million people became newly infected during 2004 while 3.1 million people died of AIDS during the same year. Sub Sahara Africa (SSA) is the worst hit region in the world with 60% of all people living with HIV/AIDS, while this region only has 10% of the world's population. HIV (human immunodeficiency virus) prevention, treatment and care require that people know their HIV status. Voluntary Counselling and Testing (VCT) is an important tool for preventing infection and it allows young people to evaluate their behaviours and the consequences thereof. A negative test offers a key opportunity to reinforce the importance of safety and risk reduction behaviours. Knowledge of HIV status is the gateway to behavioural change, treatment, care and support. However, VCT services are not utilised by the majority of young people globally because of fears of stigma and discrimination (UNAIDS 2004b:85).

The importance of VCT for HIV has brought about the wider promotion and development of VCT services. The majority of communities where HIV has a major impact on the health of the population, are poor. Lack of resources implies that VCT might not be widely available. According to McCauley (2004:8) young people actively seek and receive VCT in several sub-Saharan African (SSA) countries even though the available VCT services were not designed specifically for young people.

Counselling and testing have been integrated as one of the priority components in Malawi's national HIV/AIDS Policy (NAC 2003b:12). Many organisations, both public and private, have been seeking ways to support the implementation of this HIV policy (Yoder & Matinga 2004:3).

THE PREVALENCE OF HIV/AIDS IN MALAWI

AIDS was first diagnosed in Malawi in 1985 and in that year 17 cases were reported (Yoder & Matinga 2004:3). Malawi now ranks among the countries with the highest incidence of HIV/AIDS in the world, with a prevalence rate of 14% (NAC 2005:18).

The prevalence rate is not evenly distributed among adults by age and gender. In the age group 15–19 years, the HIV infection rate of females is four times higher than those of males, while in the age group 20–29 years, this decreases to three times higher than the male infection rate (NAC 2003a:10). This means that HIV continues to be higher among adolescent girls who become sexually active at an earlier age than their male counterparts. A reason for this difference can be that intergenerational sex between young girls/women and older (and often HIV positive) male partners is common (Fischer, Reynolds, Jacobson, Barnett & Schueller 2005:17). The World Health Organization (WHO 2005:1) also reported that in Malawi, males (41.0%) seem to be more knowledgeable about HIV prevention than females (34.0%) in the age group 14–24 years. Knowledge about HIV/AIDS and of one's HIV status are key factors in the prevention of HIV/AIDS.

Voluntary counselling and young people

This decision to use VCT services should be the person's own and the process should be kept confidential (Boswell & Baggaley 2002:1). These authors are of the opinion that people's knowledge of their HIV status is the gateway to behavioural change, treatment, care, and support. VCT is based on the fact that tested clients who are HIV negative should receive counselling to identify and reduce risky behaviours. Those who test HIV positive should be helped to get proper clinical care as well as support services and counselling to reduce the chances of transmitting HIV (and to access treatment and care, should this be necessary). Misiri and Muula (2004:84) regard VCT as a cost-effective measure to control HIV.

“Young people aged 15–24 years account for over 50% of all HIV infections occurring worldwide (excluding perinatal cases)” (Boswell & Baggaley 2002:2). A reason for this devastating spread of HIV among people aged 15–24 years might be that their risk perceptions are lower and they have less information about the disease than adults (AIDSMARK 2002:8). Few countries have VCT services that provide youth-friendly services helping with the prevention HIV.

PROBLEM STATEMENT

Malawi's National Statistical Office (NSO 2005:26) reported that only 4.0% of the girls and 7.0% of the boys, aged 15–24 years had gone for HIV testing during 2004. According to Maluwa and Kawala (2003:7), 87.0% of young people (aged 14–25) knew where they could go for VCT and 76.0% indicated that they would like to be tested. As VCT services are available free of charge in Malawi, and as the majority of young people knew where they could get tested, and wanted to be tested, barriers to getting tested needed to be identified. Stated simply, the research problem was to find out what motivated the young people in Malawi who had used the VCT services, what barriers existed to utilise these services and how the utilisation could be improved.

Information on factors that hinder young people's access to VCT is mostly based on studies conducted among young people who had not yet utilised VCT services. Behavioural change programmes have been developed based on this information and yet there is still no great improvement in the number of young people who access these services. There is little information available about factors that motivated young people who had actually utilised VCT services. Young people who went for VCT can provide information to health service providers to make the VCT service more youth-friendly, based on their experiences.

A study was therefore undertaken to identify factors that motivated young people aged 14–25 years to have utilised VCT services in Malawi. This age group can contribute to the reduction of HIV, as many of them might not yet be infected.

PURPOSE AND OBJECTIVES OF THE STUDY

The purpose of the study was to enable more young people to use VCT services in Malawi. The objectives were to

- identify factors that motivated young people aged 14–25 years to utilise VCT services in Malawi
- identify possible barriers experienced by young people in accessing VCT services in Malawi
- identify strategies that could enhance VCT access for young people in Malawi.

THEORETICAL FRAMEWORK

The Health Belief Model (HBM) is one of the most widely used conceptual frameworks for understanding, explaining and predicting health behaviour (Campus 2005:1). According to ReCAPP (2005:2), the constructs of the HBM include:

- perceived susceptibility explaining one's chances to acquire the condition;
- perceived severity in one's opinion about the seriousness of the condition;
- perceived benefits, including one's beliefs in the efficacy of the advised action to reduce the risk or seriousness of impact;
- perceived barriers, which are one's beliefs about the tangible and psychological costs of the advised behaviour;
- cues to action, which are strategies to activate readiness when one feels the desire to take action; and
- Self-efficacy, which refers to the strengths of people's beliefs in their ability to respond to novel or difficult situations.

Definitions and key concepts

The following key concepts were relevant to the study.

Voluntary counselling and testing (VCT). This is a process whereby persons undergo counselling to enable them to make an informed choice about being tested for HIV. The decisions should be entirely their own choice and they should be assured that the process will be confidential (Boswell & Baggaley 2002:1).

Young people: In this report, young people are regarded as persons aged 14–25. This is in congruence with practices of organisations like the World Health Organization.

RESEARCH METHODOLOGY

The research methodology presents an outline of the methods and instruments used in this study.

Research design

A quantitative, descriptive and exploratory design was used for this study. A structured interview schedule, based on literature reviewed regarding tenets of the Health Belief Model (HBM) was designed and used to collect data about the reasons for the youth to go for VCT, barriers experienced in accessing VCT services, and to suggest strategies for enhancing young people's utilisation of VCT services in Malawi.

According to Burns and Grove (2007:549), a population comprises all elements, for instance persons, objects, events or substances that meet the inclusion criteria for the study. The population in this study were therefore young people aged 14–25 years, both males and females, who had gone for HIV testing and were residing in the selected rural, urban area and peri-urban areas in Malawi. These sites were selected as the clinic facilities as well as the infrastructure (including roads, public transport, communication systems) are best in the urban areas and poorest in the rural areas, with semi-urban areas in between these extremes. As the health care facilities' positions and accessibility could affect young people's utilisation of VCT services, one site representing each of the three major types of areas in Malawi were selected. This was done in an effort to obtain information about young people's utilisation of VCT services in all three types of areas.

No census (or sampling frame) existed of young people who had used VCT services, residing in specific areas of Malawi, making probability or random sampling impossible. Non-probability or convenience sampling was used. In each of the three targeted communities, young people aged 14-25 of both sexes who had used VCT services, and who belonged to post (VCT) test clubs, were requested to participate in this study. Every respondent was requested to refer his/her peers who had utilised VCT services.

In this way snowball sampling was used and all respondents remained anonymous. No questions were asked about the respondents' HIV status, as this was not relevant to the purpose of the study, and as each person's right to confidentiality was respected.

A structured interview schedule was used to collect data. This method was chosen because according to Polit and Hungler (1999:298) it is the most powerful method to obtain information as the interviewer will meet each respondent face to face. An interview schedule, based on literature reviewed and on the tenets of the HBM was designed and used to collect data. The interview schedule was divided into different sections, namely biographic data (5 items); sexual behaviours (7 items); VCT knowledge, access and utilisation (13 items); factors promoting young people's access to VCT (4 items); challenges young people face when accessing VCT (4 items) and suggestions for improving access to VCT services by young people (4 items). Only closed-ended questions were asked. Respondents were, however, asked for any comments. These comments were recorded verbatim, grouped and analysed quantitatively.

Data analysis is the systematic organisation and synthesis of research data (Polit & Hungler 1999:643). The data in this research were entered using the EPI Info version 6 computer program and analysed using Chi-square statistics by applying the Statistical Package for Social Sciences (SPSS) version 11. Chi-square statistics are used to determine significant differences between observed frequencies within data and frequencies that were expected (Burns & Grove 2007:532).

The draft interview schedule was discussed with a statistician who was knowledgeable about the construction of structured interview schedules. The final draft was then pre-tested among young people meeting the inclusion criteria at VCT sites, which were excluded from the main study. Consequently all persons who participated in the pre-test did not participate in the actual study.

Validity refers to the degree to which an instrument measures what it is supposed to measure (Babbie 2001:142). To establish internal consistency, the interview schedule was pre-tested. Content validity of the interview schedule was established by submitting it to a panel of experts in research and VCT. Their feedback was used to make alterations to the interview schedule. External validity was ensured by having young people (males and females) from different (urban, semi-urban and rural) regions of Malawi included in the study.

Reliability is the degree of consistency with which an instrument measures the attribute it is supposed to be measuring, and whether repeated measures of the same object yield comparable results (Babbie 2001:140). The major attributes of reliability are stability, equivalence, internal consistency and test-retest consistency (Polit & Hungler 1999:371). In this study the structured interview schedule produced stable results, because the results obtained from the three study sites during the pre-test and during the actual data collection processes were similar. The information obtained through the structured interviews was accepted as being equivalent because the information obtained from the

three separate sites yielded similar data. Internal consistency, usually tested through the split-half method, was not applied to this study as the interview schedule did not contain two similar halves. Test-retest stability was observed as the data gathered during the pre-test and the actual data collection phases were similar.

ETHICAL CONSIDERATIONS

Protection of the rights of human subjects should be exercised when humans are used as study respondents (Polit & Beck 2004:141). Permission to conduct this research was requested from and granted by the Malawian Ministry of Health Research and Ethics Committee. Informed, voluntary permission was obtained from each respondent. The respondents were ensured of the confidentiality of information obtained from them. No identifying information collected would be made public and their right to privacy was also respected by conducting the structured interviews in private rooms. Approval was also obtained from the Research and Ethics Committee of the Department of Health Studies, Unisa.

RESEARCH RESULTS

The research results will be discussed in terms of the sections of the structured interview schedule.

Demographic data

There were 145 respondents aged 14–25 years who participated in the study, of whom 55.2% (n=80) were male and 44.8% (n=65) were female. This result mirrors a previous finding indicating that more males (7.0%) had undergone HIV testing than females (4.0%) in Malawi (NSO 2005:26). However, as convenience sampling had been used, the gender difference in this study might have been incidental. All the respondents had attended school and the majority of the respondents (84.1%; n =122) were single. Of those 122 respondents who were single, 60.7% (n=74) reported that they engaged in sexual intercourse.

Of the 145 respondents, 44 (30.3%) came from rural, 45 (31.0%) from semi-urban and 56 (38.6%) from urban areas. Only in cases where differences between respondents from the three areas were observed, will these differences be highlighted. Otherwise results will be provided for the total sample of 145 respondents from all three areas combined.

VCT knowledge and decision-making

Respondents mentioned friends (29.7%; n=43), the radio (27.6%; n=40) and school lessons (27.6%; n=40) as their primary sources of VCT information. These results show that peers play a major role in providing information leading to the decision to build their capacity of VCT knowledge (see Figure 1 for details). Hospitals, radios, videos, films, newspapers and school teachers were also mentioned by Munthali, Chimbiri and Zulu (2004:27) as sources of information about HIV/AIDS and VCT.

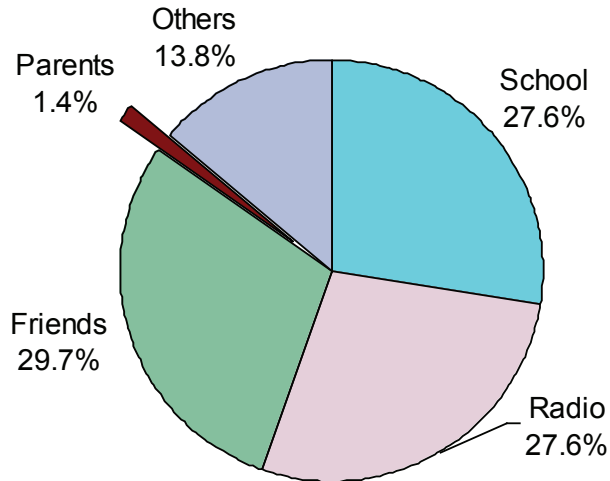


Figure 1: Primary sources of VCT information for young people (N=145)

Parents were not mentioned as one of the primary sources of information for VCT and yet 62.0% (n=90) of the respondents stayed with their parents. Munthali et al (2004:23) also reported that only 5.0% of the young people in their study mentioned parents as their primary source of sexual information. This poses a question as to why parents were not taking a leading role and how they could be helped to provide information to their children. Grobler, Botma, Jacobs and Nel (2007:36, referring to Ampinm 2003: Online) maintain that in many black African cultures, children were historically forbidden to discuss sexual activities with their parents. The majority (77.9%; n=113) of the respondents made independent decisions to go for VCT, although more of those younger than 18 were influenced by others to go for testing. Grobler et al. (2007:33) remark that peer pressure has a strong influence on adolescents' sexual behaviours.

Reasons why young people decide on VCT or fail to use VCT services

The main reason for being tested, provided by 93.1% (n=135) of the young people who went for VCT, was curiosity to know their HIV status. This is in line with findings by

Yoder and Matinga (2004:26). Only 3.4% (n=5) indicated that peer pressure was the reason for them to be tested. Two (1.4%) respondents said illness was their reason, while three (2.1%) planned to get married and wanted to start families.

Factors hindering access to and utilisation of VCT services by young people were fear of getting HIV positive results (88.9%; n=129) and a feeling that they might already be HIV positive (76.6%; n=111), as can be seen in Table 1. This supports the findings by Munthali et al. (2004:27) that young people in Malawi refrain from VCT because they fear receiving HIV positive results. Two other factors that also figured in this table were young peoples' lack of knowledge about VCT (70.3%; n=102) and fear of stigma (66.9%; n=97). Only 37.9% (n=55) of the respondents indicated that their fear of their parents' reactions prevented them from using VCT services.

Table 1: Reasons why young people do not access VCT services in Malawi (N=145)

Reason for not going for testing	Definitely yes		Yes		No		Not at all	
	n	%	n	%	n	%	n	%
Fear of HIV results	113	77.9	16	11.0	12	8.3	4	2.8
Lack of knowledge about VCT	66	45.5	36	24.8	37	25.5	6	4.1
Uncomfortable with VCT sites	45	31.0	39	26.9	45	31.0	16	11.0
Peer pressure	29	20.0	33	22.8	56	38.6	27	18.6
Feel no need for testing	29	20.0	37	25.5	55	37.9	24	16.6
Fear of parents' reactions	18	12.4	37	25.5	82	56.6	8	5.5
Uncomfortable with providers	41	28.3	42	29.0	50	34.5	12	8.3
Unsure about confidentiality issues	58	40.0	31	21.4	37	25.5	19	13.1
Fear of stigma	46	31.7	51	35.2	34	23.4	14	9.7
Feel they are already HIV positive	68	46.9	43	29.7	21	14.5	13	9.0
Other reasons	0	0	2	1.2	117	88.0	14	10.5

VCT testing centres and factors hampering young people’s access to these centres

Places where the young people were tested varied. Reported testing centres included youth centres (44.1%; n=64), government facilities (44.1%; n=64) and the Malawi Counselling and Resource Organisation (MACRO) where 44.1% (n=64) of the respondents had reportedly used VCT services.

Opinions regarding the attributes that a VCT site should have if young people were to be attracted to these services are displayed in Table 2. These attributes included privacy when tested and counselled (82.7%; n=120), having young providers with whom the clients could identify (88.9%; n=129), cleanliness of the service provision site (81.4%; n=118) and short waiting times to get tested and counselled (72.4%; n=105). Boswell and Baggaley (2002:4) reported that young people disliked long waiting queues, but preferred VCT sites where there was privacy and the cost was low. Youth centres ensure privacy because young people visit these centres for various reasons, including playing soccer, listening to music and dancing. There is thus less potential stigma attached to these services.

Table 2: Requirements of a VCT site (N=145)

Characteristic	Definitely yes		Yes		No		Not at all	
	n	%	n	%	n	%	n	%
Privacy	113	77.9	7	4.8	23	15.9	2	1.4
Adult providers	54	37.2	37	25.5	45	31.0	9	6.2
Young providers	104	71.7	25	17.2	11	7.6	5	3.4
Short waiting time	68	46.9	37	25.5	28	19.3	12	8.3
Cleanliness of the site	77	53.1	41	28.3	15	10.3	12	8.3
No linkage to a health facility	31	21.4	44	30.3	52	35.9	18	12.4
People should not know that one went for VCT	45	31.0	46	31.7	40	27.6	14	9.7
Other	3	2.3	4	2.8	117	88.0	9	6.8

Negative factors that hampered VCT services included that the VCT site was too close to their homes (65.5%; n=95); and that the waiting time at the VCT site was too long (77.2%; n=112). The respondents did not mention possible reactions of their peers or communities in this regard. However, if the VCT sites were close to their homes, they might have feared being seen at these sites and being stigmatised thereby.

Qualities of the counsellors

The respondents would like VCT services to be provided by counsellors with welcoming (100.0%; n=145), non-judgemental (83.4%; n=121) attitudes. Of the respondents, 95.2% (n=138) were of the opinion that the VCT services provided adequate HIV information to young people. McCauley (2004:1) agrees that the young people want knowledgeable and youth-friendly counsellors.

Preferences of a VCT site

Respondents mentioned the government health facility (90.4%; n=131), MACRO (86.2%; n=125) and youth centres (85.5%; n=124) as the most preferred places to obtain VCT services (see Table 3 for details). Despite the fact that 44.1% (n=64) of the respondents had been tested at youth centres, many had been tested at government health facilities.

Table 3: Preference for VCT site (N=145)

Testing site	Definitely yes		Yes		No		Not at all	
	n	%	n	%	n	%	n	%
Government health facility	110	75.9	21	14.5	10	6.9	4	2.8
Youth centre	95	65.5	29	20.0	17	11.7	4	2.8
School	51	35.2	27	18.6	55	37.9	12	8.3
Mobile VCT sites	49	33.8	41	28.3	39	26.9	16	11.0
MACRO	97	66.9	28	19.3	13	9.0	7	4.8
Private clinic	47	32.4	33	22.8	49	33.8	16	11.0
Other	0	0.0	4	3.0	115	87.1	13	9.8

Pearson’s Chi-square tests showed that there was a significant association between the youth centre and residential area (Pearson’s Chi-square: α 0.01; 6 df). Young people residing in the semi-urban areas (77.8%; n=35) and rural areas (72.7%; n=32) preferred to get tested at youth centres. In addition, more respondents from the semi-urban areas (68.9%; n=31) and rural areas (61.4%; n=27) preferred mobile VCT services, whereas more respondents from urban areas (42.8%; n=24) preferred mobile VCT services (p-value < 0.001). This might be the case since VCT sites are widely available in urban areas compared to rural areas – hence the preference for a mobile clinic and youth centre in the rural and semi-urban areas.

Moreover, the services rendered by a mobile clinic might have been perceived to be more anonymous and confidential, as the staff members would probably not be members of the rural communities served by the mobile clinics.

Interventions to promote young people’s access to VCT services

The research results indicated that more information on VCT should be given to young people (99.3%; n=144), more young VCT providers (84.1%; n=112) should be used, and peers should talk to them (84.1%; n=122) as portrayed in Table 4. While peer education has a documented role, it is usually not appropriate for youth peer educators to provide counselling (Boswell & Baggaley 2002:22). These authors recommend that youths should be actively involved as members and leaders in post-test clubs, but not as counsellors as the role of counsellor and educator differs.

Table 4: Interventions that will make young people go for VCT (N=145)

Intervention	Definitely yes		Yes		No		Not at all	
	n	%	n	%	n	%	n	%
Providing more VCT information	142	97.9	2	1.4	1	0.7	0	0.0
Bring testing to schools	47	32.4	47	32.4	38	26.2	13	9.0
Use more young VCT providers	96	66.2	26	17.9	14	9.7	9	6.2
Sensitise parents on testing needs	67	46.2	28	19.3	36	24.8	14	9.7
Have young people talk to peers	94	64.8	28	19.3	8	5.5	15	10.3
Have special room for young people	71	49.0	33	22.8	31	21.4	10	6.9

Have special day for young people at site	42	29.0	34	23.4	57	39.3	12	8.3
Deploy youth-friendly providers	66	45.5	36	24.8	13	9.0	30	20.7
Conduct mobile VCT provision	53	36.6	40	27.6	27	18.6	25	17.2
Other	1	0.8	4	2.9	116	89.2	9	6.9

Of the respondents, 94 (66.8%) agreed that providing VCT at schools would enhance young people's usage of VCT services. Pearson's Chi-square tests indicated that bringing testing to a school had a significant difference with regard to residential area (Pearson's Chi-square test: $\alpha < 0.001$; 6 df). More rural young people would demand testing done at schools while urban and semi-urban young people would prefer to be tested at VCT sites outside the school environment.

The majority (84.1%; n=122) of the respondents wanted to talk to peers at VCT sites. Having young people talk to their peers also differed significantly in relation to residential area (Pearson's Chi-square test: $\alpha < 0.05$; 6). More young people living in urban and semi-urban areas would prefer that their peers talked to them at VCT centres while more rural young people did not welcome this idea.

CONCLUSIONS

Conclusions will be presented in two ways, according to the three major objectives and according the HBM's major tenets.

Conclusions in terms of the stated objectives

The major objectives were to identify factors motivating your people to use VCT services, barriers in accessing VCT services and strategies that could promote VCT utilisation by young people in Malawi.

The major motivating factor to use VCT services was the individuals' desires to know their HIV status (93.1%; n=135). As many as 80.0% (n=116) were secondary school learners, thus education seemed to influence persons' decisions to get tested for HIV. Contributing factors that motivated young people to take the actual step to use VCT services included information from their peers that a specific VCT site was youth friendly and maintained strict confidentiality and privacy (82.7%; n=120), was clean (81.4%; n=118) and had short waiting periods (72.4%; n=105). These factors might explain why 44.1% (n=64) of the respondents were tested at youth centres.

Barriers to utilising VCT services included fears of testing HIV+ve (88.9%; n=129); VCT sites did not provide privacy (65.6%; n=95), expected people to wait for long periods (77.2%; n=112), and were not perceived as guaranteeing confidentiality of HIV test results (61.4%; n=89); and the fact that young people required more information about VCT (70.3%; n=102) and that the VCT site was too close to their homes (65.5%; n=95).

Strategies that could promote young people's access to VCT services included that more VCT information should be available (99.3%; n=144); young people should be health educators and service providers (84.1%; n=112); every facility should have a special room only for young people (71.8%; n=104); VCT services should be provided at youth centres (85.5%; n=124), mobile VCT clinics (64.2%; n=93), and schools (64.8%; n=94). Most respondents from the rural (72.7%; n=32) and semi-urban areas (77.8%; n=35) preferred VCT services to be rendered by mobile clinics, because this would enhance their perceptions of privacy and confidentiality as the health workers from the mobile clinics would not be living in the young people's areas.

Conclusions in terms of the health belief model's major tenets

These conclusions will be summarised according to the HBM's major tenets, namely perceived susceptibility, perceived severity, perceived benefits, perceived barriers, cues to actions and self-efficiency.

Perceived susceptibility

Almost all (93.1%; n=135) respondents perceived themselves to be susceptible to HIV/AIDS as they used VCT services to determine their status, and 60.7% (n=74) of the respondents realised their susceptibility to HIV/AIDS due to indulging in sexual activities.

Perceived severity

All respondents had utilised VCT services, and 77.9% (n=113) did so independently. These actions indicated that the young people knew about the severity of HIV/AIDS.

Perceived benefits

These young respondents realised the benefits of using VCT services. Knowing their HIV status, 70.7% (n=58) reportedly changed their behaviours and abstained from sex or used condoms.

Perceived barriers

Reportedly many young people did not use VCT services because they feared learning that they were HIV+ve, according to 88.9% (n=129) respondents. Other barriers included that the young people feared the health care workers would not treat their HIV results confidentially (61.4%; n=89), VCT sites' closeness to their homes (65.6%; n=95), and long waiting times (77.2%; n=112).

Cues to action

The respondents indicated that the following aspects would serve as cues to action, enabling more young people to utilise VCT services in Malawi: clean attractive VCT sites ensuring privacy and having short waiting periods with friendly young people as service providers.

Self-efficiency

More information about VCT, supplied by young VCT providers coupled with more discussions with their peers about VCT, would enable more young people in Malawi to make informed decisions about their utilisation of the VCT services.

LIMITATIONS OF THE STUDY

- The limitations that were identified during the course of the study included that:
- The research results might be limited by including three sites only in the study and the fact that the sample was relatively small (n=145). However, the sample comprised young people from three regions of Malawi representing urban, semi-urban and rural residential areas.
- The researchers initially planned to use a larger sample, but it was difficult to identify respondents who met the inclusion criteria. This was due to the difficulty of finding young people who had utilised VCT services, since getting tested remains a sensitive issue in Malawi. Young people, especially girls, who had been tested were not coming forward easily, consequently a long time was required to obtain the sample size of 145.
- All the respondents in this study had attended school hence the results might not be generalisable to illiterate young people in Malawi.
- The convenience (snowball) sampling technique used in this study could not ensure randomly selected respondents. Consequently the results can not be generalised beyond the study's respondents.

RECOMMENDATIONS FOR IMPROVING ACCESS TO VCT SERVICES BY YOUNG PEOPLE IN MALAWI

The recommendations that may enhance the access to VCT services by young people in Malawi based on the research results are the following:

Involvement of young people

Young people should be actively involved in the provision of VCT information and services to their peers at all levels, including community, health facility, youth centres, as well as in the development of policies based on the needs of Malawi's youth. Young people who had attended VCT services should be encouraged to become motivators and role models to their peers, including both HIV positive and negative youths. Statistics of young people who were tested and who were found to be HIV negative should be widely disseminated to encourage more young people to report for VCT to know their own status.

Information on VCT services

Information on VCT services should reach youths through a variety of media services with a special focus on the use of peer educators, radio broadcasts, and schools. Youth clubs should use well-trained young people to provide VCT information.

Youth-friendly VCT services

Existing health services should be made more youth-friendly by ensuring that special rooms are available at health facilities for VCT services for young people. VCT service providers should be trained to make their services attractive to young people. The health training curriculum of service providers should incorporate training in the provision of youth-friendly health services.

Accessibility of VCT services

Mobile VCT services should be rendered, especially in the rural and semi-urban areas to enhance access to young people where VCT services are not provided in health centres. This would be an interim measure while improving the provision of the VCT services in the health centres. Young people should have a choice of where they would like to be tested; necessitating various models of providing VCT services. Wherever resources are made available by government or non-governmental organisations, youth centres should be constructed and VCT services should be a priority. Government should ensure that all Malawi's public health facilities provide VCT services

Parental involvement

Parental involvement in the provision of sexual and reproductive health and HIV information to their children should be strengthened by empowering parents with knowledge and skills. This could be done by making parents aware of VCT and their role in providing sexual and reproductive health as well as HIV information to their children.

RECOMMENDATIONS FOR FURTHER RESEARCH

- The findings of this suggest that future researchers could:
- duplicate this study in other geographical areas prior to the generalisation of these research results to other young populations
- duplicate the same study targeting young people who had never attended school
- investigate the role that parents could play to motivate their children to be tested
- describe young people's perceptions towards VCT services rendered in health facilities compared to those of youth centres and mobile services
- test interventions that could be applied to improve the accessibility of VCT services for illiterate youths
- do cohort studies of the impact of VCT on behavioural changes among young people
- do qualitative research to obtain more in-depth information on the young people's lived experiences of using VCT services
- identify life skills required by young people to nurture a sexually responsible lifestyle.

CONCLUDING REMARKS

The importance of enabling young people to access VCT services in Malawi cannot be overemphasised in the struggle against Malawi's increased prevalence of HIV/AIDS. Not only will the young people themselves benefit by VCT, but also their children, friends, families and communities. "The HIV/AIDS epidemic presents special challenges and new frontiers for public health interventions and research. In the current situation where absolute cure for the disease is not available and where infection results in eventual death, reducing the spread of HIV/AIDS through prevention must be the focus of our efforts ... An understanding of adolescents ... is essential for designing and implementing HIV/AIDS prevention programs" (Buseh, Glass, McElmurry, Mkhabela

& Sukati 2002:533). VCT remains a cornerstone of effective HIV/AIDS preventive programmes (UNAIDS 2001:1).

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