

## Reflections on Social Support for HIV prevention among Youth in Mufindi and Mbulu, Tanzania

Bertha Erasto Losioki  
Department of Education  
The Mwalimu Nyerere Memorial Academy,  
Dar es Salaam, Tanzania  
[bertha.losioki@mnma.ac.tz](mailto:bertha.losioki@mnma.ac.tz) – Mobile: +225786 307431

### ABSTRACT

*Youth get involved in high risk sexual encounters and they become infected to HIV at an early age. This paper aims to assess social support for HIV prevention among youth in Mbulu and Mufindi in Tanzania. The sample consisted of 232 youth both in and out of school aged 15-35 years. Descriptive statistics was used to determine frequency, percentages and the mean scores for social support for HIV prevention among the youth. The findings show that social support provided for HIV prevention was inadequate and it differed among female and male youth in Mbulu and Mufindi respectively. There is the need to evaluate and improve the ways on which social support for HIV prevention is provided specifically among female.*

Key words: Youth, social support, HIV prevention, Tanzania

### 1.0 INTRODUCTION

Youth in Tanzania have their first sexual experience at an early age and they get involved in high risk sexual encounters (Odhiambo, 2001, TACAIDS *et al.*, 2012). According to Tolley *et al.* (2014) youth reported earlier sexual debut and STI infections. In addition, they had multiple sexual partners and lower perceived risk to HIV infection.

The pandemic was first identified in Tanzania in 1983 after the clinical diagnosis of three patients in Kagera Region. Thereafter, the pandemic continued to spread and by 1986 HIV and AIDS cases were reported in all the regions in Tanzania Mainland (URT, 2001; TACAIDS *et al.* 2005). In Tanzania, HIV infection is caused by HIV-1 subtype and the common HIV-1 subtypes are A, C, D and their recombinants (NACP, 2012). The results of HIV and AIDS and Malaria surveys which were conducted in 2007/2008 indicate that 3,165 (3.7 %) females and 843 (1.1 %) males out of 6,008 youth aged between 15 and 24 were infected with HIV and AIDS. Furthermore, the youth without any formal education were found to have higher (4 %) prevalence of HIV infection than those with secondary education (1 percent) (TACAIDS *et al.* 2008).

The results of HIV and AIDS and Malaria Indicators survey which was conducted in 2011-12 showed that the overall HIV and AIDS prevalence rate among the youth was (2 %). This prevalence rate was the same as the one measured in 2007/2008 survey. The survey results indicate further that HIV prevalence among females and males youth aged 23 -24 was (6.6%) and (2.8 %) respectively (TACAIDS *et al.* 2013; URT, 2016). Moreover a recent survey on HIV impact indicated a stabilizing epidemic where the prevalence among youth aged 15-24 years was (1.4 %). However, the survey showed that HIV prevalence among female youth aged 15-39 is more than double of that of males of the same age (TACAIDS *et al.* 2017). These findings indicate that youth are still vulnerable to HIV and AIDS and that, females are more vulnerable than males. In Mufindi and Mbulu districts the number of new clients HIV positive aged 15-34 were (2588 and 172) respectively (NACP, 2012).

Social support as used in this study refers to the provision of assistance or comfort to other people to help them cope with a variety of problems (Nugent, 2013). Social support comes from interpersonal relationships, family members, neighbours, support groups, religious and friends. Social support can be emotional such as expression of empathy, trust and caring. It can also be instrumental that is tangible aid and service. It could also be informational such as advice, suggestions and directives that assist a person to respond to personal or situational demands. It can be appraisal that is information which is useful for self – evaluation. Social support can also focus the quality such adequacy or satisfaction of the support (Duncan *et. al.* 2005; Taylor *et al.* 2004). Social support therefore, is the perception and actuality that one is cared for, has assistance available from other people, and that one is part of a supportive social network (Stice *et.al.* 2004).

Studies have shown that youth from families which are characterized by low support, high indulgence, and paternal rejection had lower self-restraint and more sexual partners. In addition, parental care and parental control are also related to adolescent sexual activity. Parental control, monitoring and supervision of the youth can reduce intercourse by restricting opportunities for sexual activity (Jacobson & Crockett, 2000).

The main source of youth social support are family members, peers, collage mates, social organizations and other related groups (Stice *et. al.* 2004). Youth with greater social support whether from family or friends, have a greater chance of resolving problems which they face. Parental support provides youth with unconditional love and care. Parents also set boundaries and regulations for the child to follow, and that helps to shape the child's social actions. In addition social support from family and friends influence the psychological well being of youth (Stice *et.al.* 2004, Leme *et.al.* 2015).

Furthermore, direct communication is another way in which parents are likely to influence sexual behaviour among the youth. The impact of parent and youth communication appears to depend on openness of the communication, a clear focus on sexual topics and the parents' values regarding sexual activity among the youth (Miller *et al.* 2001). In addition, good values may be more easily

transmitted within supportive parent–youth relationships (Dittus & Jaccard, 2000). In a study conducted in Iringa, some of the parents were not able to discuss HIV and AIDS with their children due to cultural values and taboos (Rumisha *et al.* 2006). Furthermore, parents' discussion on sexuality depends on the level of education of the parents (Wamoyi *et.al.* 2010).

This study aims to assess social support provided to the youth for the prevention against HIV infection. It seeks to find out how far support is provided to the youth in order to prevent them against HIV and AIDS infection. The study helps to identify the gaps in provision of social support among the youth, and therefore to find effective ways of equipping the youth with social support. The study will help policy makers in identifying barriers to HIV and AIDS prevention among the youth so that they (policy makers) can have informed decision making strategies in improving the situation. The study findings will, therefore, be instructive in helping the efforts of improving the life and social wellbeing of the youth who are among the vulnerable groups.

## 2.0 MATERIAL AND METHODS

The study was conducted in Mufindi districts in the Southern Highlands of Tanzania and Mbulu in the Northern part of Tanzania. Based on the 2012 National Population and Housing Census report, Mbulu had a population of 320,279 people and the average household size was 6.3 persons. Mufindi District had a population of 265,829 people and an average of 4.2 household size (URT, 2013; NBS; 2013).

Purposive sampling method was used to select two districts. Two wards were also selected purposively from each district, depending on location and accessibility. Then one village was picked purposely from each ward. In school and out of school youth were then selected randomly from each village where five respondents were picked in 12 households. Both quantitative and qualitative approaches were used. The study used questionnaire, Documentary Review and Non participant observation methods to obtain both primary and secondary data. The study used descriptive statistics to assess social support provided to the youth using frequency and percentages.

Social support provided to the youth with regard to HIV and AIDS prevention was measured by 16 variables. The variables captured information on whether youth live with the parents; parents' support on prevention of sexually transmitted infections, HIV Prevention and safer sex practices; parents' support on youth sexual behaviour and youth decisions. Social support was also captured through friends support and support from youth organisations as indicated in Figure 1.

The variable (SOCIALSUP) was computed from the summation of all variables measuring youth social support in order to determine and categorize the levels for social support provided to the youth in the study areas. Cronbach alpha coefficient for the variables used to measure social support was 0.721, which was acceptable (George and Mallery, 2003). Social support was considered to be low when the scores ranged from 0 – 6, moderate when the scores ranged from 7 - 10, and high when the scores ranged from 11 -16. Moreover, mean score for social support

provided among the youth was determined. An independent sample t test was used to determine the differences in social support provided for HIV prevention in the study areas.

### 3.0 RESULTS AND DISCUSSION

#### 3.1 Demographic characteristics of the respondents

Demographic characteristics of the youth were explained using age, marital status, education and religion of the respondents as indicated in Table 1.

**Table 1: Demographic characteristics of the youth**

	Mbulu (N=118)			Mufindi (N=114)		
	mean	min	max	mean	min	max
<b>Age of youth</b>	23±4.125	15	35	23±6.404	15	35
<b>Education level</b>	<b>n</b>	<b>%</b>		<b>n</b>	<b>%</b>	
Primary education	54	45.8		60	52.6	
Secondary education	48	40.7		39	34.2	
High school education	10	8.5		5	4.4	
Diploma education	3	2.5		6	5.3	
Graduate	3	2.5		4	3.5	
<b>Marital Status</b>						
Married, living with spouse	18	15.3		23	20.2	
Married, spouse lives elsewhere	1	.8		7	6.1	
Not married, but living with a partner	10	8.5		16	14.0	
Not married	89	75.4		64	56.1	
Widowed	0	.0		4	3.5	
<b>Religious affiliation</b>						
Lutheran	26	11.2		23	9.9	
Catholic	66	28.4		57	24.6	
Moslem	17	7.3		14	6.0	
Pentecost	9	7.6		13	11.4	
Other	0	.0		7	6.1	

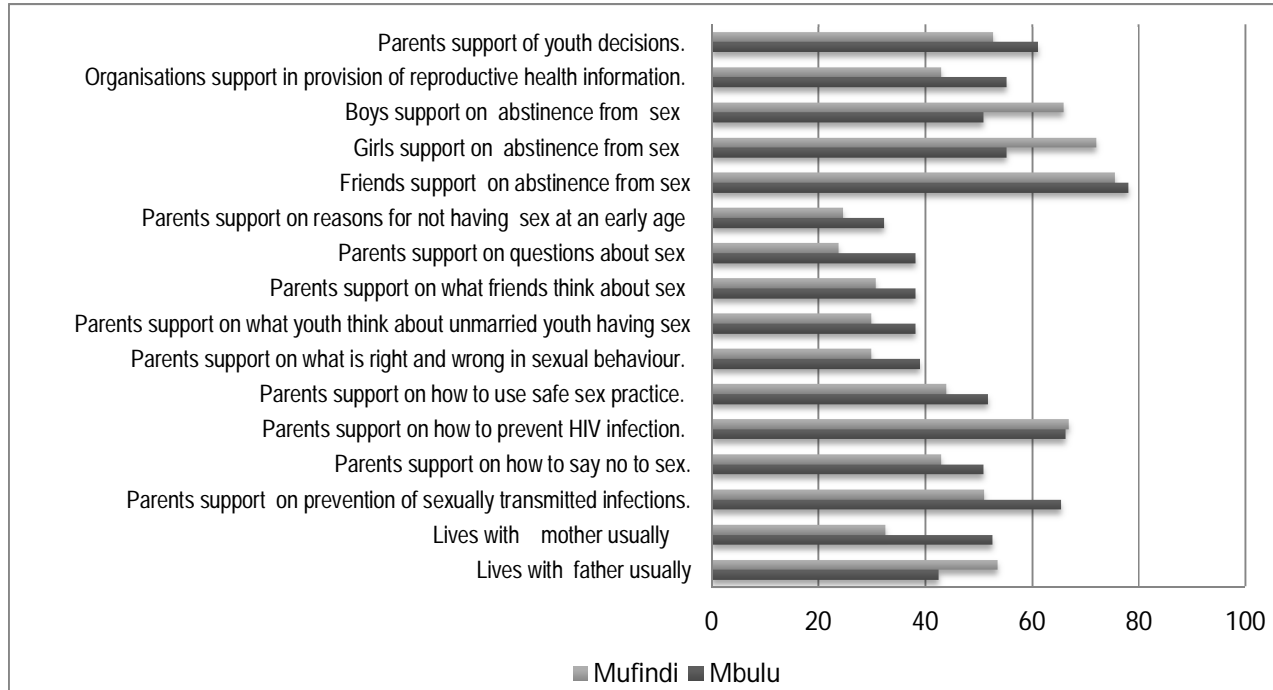
The findings show that youth age ranged from 15 years to 35 years. In addition nearly half (49.2 %) and (47.4 %) of youth in Mbulu and Mufindi respectively were males. Moreover, half (50.8 %) and (52.6 %) of youth in Mbulu and Mufindi respectively were females. The results show that (45.8 %) of youth in Mbulu had primary school education while (52.6 %) of youth had the same level of education in Mufindi. Furthermore, three quarter (75.4 %) and more than half (56 %) of youth in Mufindi and Mbulu respectively were unmarried. In addition (3.5 %) of youth in Mufindi were widowed.

The results also show a slight difference in the attainment of secondary education. The study found that (40.7 %) of youth had secondary education while (8.5 %) of youth had high school education in

Mbulu. The same trend was noted in Mufindi where (34.2 %) of the youth had secondary education while less than (10 %) of the youth had high school education. These results suggest that youth had lower educational attainment in higher education levels in the two study areas.

**3.2 Social support for HIV prevention among Youth**

The findings in Figure 1 show that a half of the youth in the study areas lived with either father or mother.



**Figure 1: Social Support for HIV and AIDS Prevention among youth**

Furthermore, the results in figure 1 show that (65 %) of the youth in Mbulu and Mufindi respectively had parents support on matters regarding to HIV prevention. In addition, the results show that more than (75 %) of the youth in the study areas had support from their friends regarding abstinence from sex. However the results suggest that not all the youth were supportive because other youth were influenced by their friends to engage into sexual activity before marriage and at an early age. These results suggest that there were youth who had inadequate support from their parents on the same. Moreover, parents’ support to the youth in making decisions appeared to be moderate, since a half of the youth obtained that support from their parents. This implies that there are cultural barriers that constrain parents from providing information and support to the youth on issues regarding sexuality including HIV and AIDS prevention. Other studies on topics related to sexuality such as HIV and AIDS, condoms use and abstinence found that communication between parents and the youth on such topics was generally low (Rumisha *et al.* 2006; Bastine *et al.* 2011 ). The findings therefore reveal lack of effective communication between parents and their children on sensitive aspects such as sex and sexuality. It can therefore be argued that not all parents were able to provide proper guidance and support to the youth with regard to reproductive information and HIV prevention.

The findings in Figure 1 also show that the support which youth obtained from organisations that provide reproductive health information to the youth was inadequate since only half (55.1 %) of the youth in Mbulu had received that support whereas less than a half (42.9 %) of the youth had received that support in Mufindi. Furthermore, the study found through observation that reproductive health information and services were provided at the PMTC (Preventing Mother-to-Child Transmission Centre) moreover, the place was found to be crowded with women attending clinic and other adults obtaining health services. Similar findings were reported by other studies which reveal that young people often have inadequate access to health and social support services. This is partly because specific needs of adolescents and young people are often overlooked during the development of national policies and budget allocations (Nkya *et. al* 2006).

Regarding as to whether or not the services were user friendly to the youth, it was observed that reproductive health services which were available were for all the people and were mainly obtained from government hospitals and health centres. Evidence shows that adolescents and young people are less likely to be vulnerable to HIV and AIDS and other STIs when they are offered relevant information, skills, and services in an enabling and protective environment. Furthermore parents who spend more time supervising their children have children who engage in less risky behaviour (Gottlieb, 2000).

The findings further show that female youth in the study areas appeared to have low social support on HIV and AIDS prevention as opposed to male youth. Table 2 gives the details.

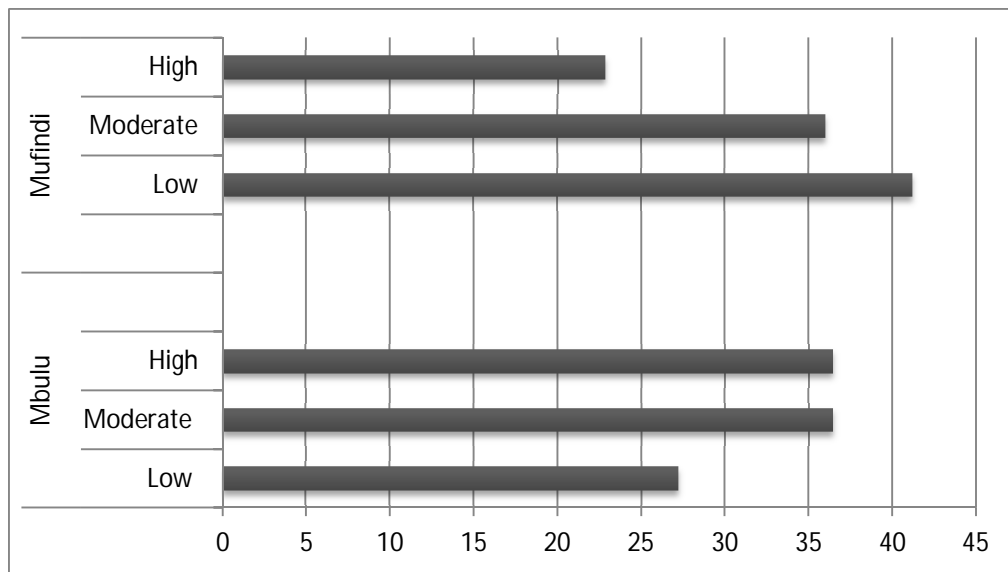
**Table 2: Social Support on HIV and AIDS Prevention by sex**

	Mbulu (N=118)				Mufindi (N=114)			
	Mean	Std. Dev	Min	Max	Mean	Std. Dev	Min	Max
<b>Male</b>	8.944	3.504	1.0	15	7.489	3.374	1.0	14.0
<b>Female</b>	8.709	3.578	1.0	16.0	7.185	3.325	1.0	14.0

The results in Table 2 show that male youth in the study areas had more support for HIV and AIDS prevention as compared to female youth ( $M=8.94$ ,  $SD=3.50$ ) and ( $M=7.49$ ,  $SD=3.37$ ) in Mbulu and Mufindi respectively. Moreover, female youth in the two study areas appeared to be disadvantaged with regards to social support provided to them for HIV prevention compared to male youth. The mean scores for social support provided for HIV prevention among female were ( $M=8.71$ ,  $SD=3.58$ ) and ( $M=7.19$ ,  $SD=3.33$ ) in Mbulu and Mufindi respectively. These results suggest that among other reasons, inadequate social support on HIV prevention among female youth was a contributing factor to female youth vulnerability to HIV and AIDS infection. Consistent with previous studies, gender continued to be a key aspect for HIV and AIDS infection. This could be attributed to the fact that

female often have limited access to sexual health information and services because of a misguided fear that it will encourage promiscuity among female. Furthermore, young women are particularly at high risk for becoming infected because gendered power relations limit women from making appropriate choices about when to get initiated into sexual activity, to use condoms and to obtain and share information (Burgard and Lee-Rife 2008). In addition, girls tend to find more support from close friends than classmates, parents or teachers. On the other hand boys find more support from all (Shan *et. al.* 2014; Camara *et. al.* 2013).

Furthermore, the findings show that social support levels for HIV prevention differed in the study areas. The results suggest that youth in Mufindi had low social support compared to the youth in Mbulu. Figure 2 shows social support levels in the study areas.



**Figure 2: Social Support for HIV and AIDS Prevention among youth**

The results in Figure 2 show that social support level for HIV prevention appears to be low among youth in Mufindi (41 %) compared to the youth in Mbulu (27 %). Furthermore social support seems to be high among youth in Mbulu compared to youth in Mufindi (36 %) and (22 %) respectively. Equally important, the results show that social support provided to the youth for HIV prevention differed significantly in the study areas as indicated in Table 3.

**Table 3 Independent sample t test Social Support for HIV Prevention**

		Levene's Test for Equality of Variances		t-test for Equality of Means				
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference
TSOCIALSP	Equal variances assumed	1.195	.275	3.158	208	.002*	1.49896	.47458

The results obtained through an independent sample *t* test show a statistically significant difference between the youth in Mbulu and Mufindi in relation to social support provided for HIV prevention ( $t=3.158$ ,  $p$  value 0.002). The findings suggest that the support and services for HIV prevention are inadequate among youth. This call for improvement of social support services for HIV prevention among the youth. Access to adequate social support is considered to be important for health life. Furthermore, social support can improve self efficacy, psychological adjustment and coping with upsetting events (Lyyra & Heikkinen, 2000).

#### 4.0 CONCLUSION AND RECOMMENDATIONS

The study concludes that male youth in the two study areas had more support for HIV prevention than was the case with their female counterparts. This suggests that female were at higher risk of infections than were male youth. Equally important, the findings reveal that social support level was higher in Mbulu than it was in Mufindi. The study findings supported the studies that confirmed that youth who have limited parents support tended to experience behavioural, social and economic challenges which increase their risks to HIV and STI's infection. The study also found that the youth with lower levels of social support were more likely to engage in sexual-risk behaviours. The findings further suggest that perhaps male youth were more open in seeking for support from their peer and health providers than was the case with female youth who might be shy and reserved due culture and traditional backgrounds.

The study also revealed that there were no specific youth organizations that provided reproductive health information to the youth in the study areas. The study showed that reproductive health services for all the people were mainly obtained in government hospitals and health centres. Moreover, the services provided in the study areas were not user friendly to the youth and therefore the youth were not reluctant in seeking for reproductive health services. More efforts are needed to ensure that social support is available to youth so as to prevent them from HIV infection.

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