

Full Length Research Paper

Voluntary counseling and testing services: Breaking resistance to access and utilization among the youths in Rakai district of Uganda

Stephen Sebudde* and Florence Nangendo

SOMA Net Africa/Social Work and Social Administration / Child Health and Development Centre Makerere University, P. O. Box 6717, Kampala, Uganda.

Accepted 28 September, 2009

Voluntary counseling and testing is important in controlling the spread of HIV, especially among adolescents. The aim is to describe the perceptions of adolescents of the best options to providing voluntary counseling and testing services to them in Rakai District Uganda. A cross-sectional descriptive study was carried out among male and female adolescents of 15 to 24 years who were selected by convenience sampling, using qualitative methods of data collection, focus group discussions, observations and in-depth/key informant interviews. Factors affecting utilization of VCT services by the adolescents include distance to the service centers, fears after testing, lack of spouse guidance, stigma attached to the VCT rooms, quality of services being provided and peer pressures. Their knowledge on the availability of VCT services in the community is adequate. The information is passed over to them through radio, media prints, health talks, relatives and friends. Providing VCT services through the mobile clinics and outreaches are much preferred by adolescent mothers to the formal structural arrangement of buildings. The traditional healers and drug shop owners could be potential providers of VCT. Dialogue should be started with the various stakeholders in providing VCT services to the adolescents in the district on the possibilities of establishing mobile service clinics and integrating the informal service providers as potential providers of the service.

Key words: Voluntary counseling and testing, access, breaking resistance.

INTRODUCTION

The study focuses on the views of the youths of 10-24 years in the Rakai District of Uganda regarding access to and use of the Voluntary Counseling and Testing Services (VCT), which is increasingly used as a strategy for reversing the HIV/AIDS pandemic. Improved health care and nutrition in Uganda have resulted in an increase of the numbers of children reaching adolescence. According to the Uganda population and housing census 2003 done by the Uganda Bureau of Statistics (UBOS) the current population of Uganda is over 20 million people, of which over 7 million are between 10-24 years or almost thirty two percent (32%) of the total population. HIV/AIDS pose as a challenge to their lives; however, voluntary counseling and testing (VCT) acts as an entry point for

providing comprehensive HIV/AIDS services.

AIDS poses one of the most serious threats to young people in poor countries. Globally, more than half of the new HIV cases occur among young women and men of 15-24 years (UNAIDS, 2000; UAC, 2000). According to the Uganda Demographic Health Survey (UDHS, 2002), it is estimated that the HIV prevalence rate among youths (15-24 years) is 3.70-5.56% among females, and 1.59-2.38% among males in Uganda. This compares with the sub-Saharan rates of 6.41-11.39% for females and 3.13-5.56% for males (UNAIDS, 2002). The females' aged 15-19 years are six times more likely to be infected than males in this age group. Early marriage and earlier onset of sexual activity for females, as well as sexual relations with older men are cited as factors predisposing young women to infection (UDHS, 2002). Studies have shown that social, cultural, and biological factors contribute to the vulnerability of girls to HIV/AIDS (Ayiga et al., 1999;

*Corresponding author. E-mail: drsebuddes@doctor.com.

Gumusiriza et al., 1996; UNAIDS, 2000).

Available data in Uganda indicate that among youths of 15-24 years, the prevalence rates have declined from 11% among males and 29% in females in 1992 to 2.5% and 12.1% respectively in 1999 (UDHS, 2002). And the general prevalence is down from 18% in 1992 to 6.5% in 2001. This decline is as a result of the open policy the Uganda government adopted in 1986 to fight HIV/AIDS. Messages of prevention were spread and people became aware of the causes of the disease. It is currently estimated that knowledge about HIV/AIDS in Uganda is almost universal (UDHS, 2002). Voluntary counseling and testing, initiated as early as 1987 when the Immune Suppressive Syndrome clinic was founded at Mulago Hospital in Kampala, had within months hundreds of clients registered for HIV counseling and testing.

Voluntary counseling and testing interventions

Since 1986, VCT has become one of the responses to the pandemic. By definition voluntary counseling and testing is a process where individuals or couples undergo counseling to enable them to make an informed choice about being tested for HIV. This decision must be entirely the choice of the individuals who must be assured of confidentiality (Ministry of Health, 2004; Boswell et al., 1999; Baggaley, 1997). The Uganda VCT policy (2004) clearly shows the benefits of VCT services. VCT can lead to use of other services including prevention and clinical management of HIV-related illnesses, tuberculosis control, psychosocial and legal support, and prevention of mother to child transmission of HIV. VCT can also be an effective behavior-change intervention. VCT offers benefits to those who test positive or negative, alleviates anxiety, increases clients' perception of their vulnerability to HIV, promotes behavior change, facilitates early referral for care and support—including access to ARV therapy—and assists in reducing stigma in the community because of the awareness on the sero-status.

The AIDS Information Centre (AIC) in Uganda was the first Non Governmental Organization (NGO) to start a VCT clinic in 1990 and in its first 11 months of operation, it served over 9,000 clients and above its target of 5,000 (AIC, 2003). The Uganda Demographic Health Survey (2002) indicates that over 70% of Ugandans are eager to know their HIV status. However, the percentage for those who actually volunteer for the test is still small: eight percent (8%) men and twelve percent (12%) women. These are mostly people with some secondary education and those living in urban areas. Married men also access the services in greater numbers compared to the unmarried. A baseline study by Baggaley and Boswell (2001) in two countries of East Africa, Uganda and Kenya showed that most of the young people who had taken a HIV test, said that they would adopt safer sexual behaviors such as abstinence, practicing monogamy, using condoms and reducing the number of sexual partners. This suggests

that VCT can be an important strategy in controlling and reversing the HIV pandemic.

Factors affecting VCT utilization among the youth

Despite the extensive availability of VCT services, utilization by the youths has been low (AIC, 2003; Boswell, 1999; Baggaley, 1997; Baggaley and Boswell, 2001; UAC, 2000). This limited use has been attributed to transport costs; hours of service, service not being youth friendly and at times lack of the necessary supplies (UDHS, 2002; AIC, 2003; UN AIDS, 2001). Patient and Neil (2004) also provided some information on the stigma attached to VCT structures and also examined the whole process. The observers within the vicinity act as the referees and begin to speculate the reasons why a person is visiting such structures. Another limitation is the feeling or response of the person- after the whole process of counseling and testing- to the results, which might be negative or positive, bringing a shock or a big grin on the face. This shows that there is still a gap in normalizing the HIV/AIDS functions within the policy framework and the existing health care systems. During a preparatory workshop prior to this study, which included district political leaders, administrators, youths and NGO representatives dealing with young people, other factors that limit access of VCT to the youths were mentioned. Among those mentioned were limited out-reach services, high transport costs to the centers and limited post test facilities which are poorly distributed in the district. Others mentioned were the few staff members available to provide counseling services and lack of laboratory facilities in most sub-counties. In an effort to promote access to HIV testing the Center for Disease Control Program in Uganda has tried to introduce community outreach programs for VCT in two districts- Tororo and Bushenyi. This aims to provide home to home voluntary counseling and testing services, which may increase access to the service for the general community. While this appears to be an innovative way of making service more accessible, it does not specifically target the youth.

Objectives of the study

This study therefore investigated what the youths in Rakai District perceive as best options for being provided with VCT services and what factors limited this access. It aimed at identifying practical ways of improving accessibility of VCT to the youths as a measure of controlling the spread of HIV/AIDS, using participatory action research. Specifically, it is aimed to identify what factors facilitate or limit access to VCT services, what alternatives are available and to describe the characteristics of the youths who seek VCT services.

This study was therefore an attempt to improve on the collaboration between researchers and practitioners as well as communities. The researchers interacted and dis-

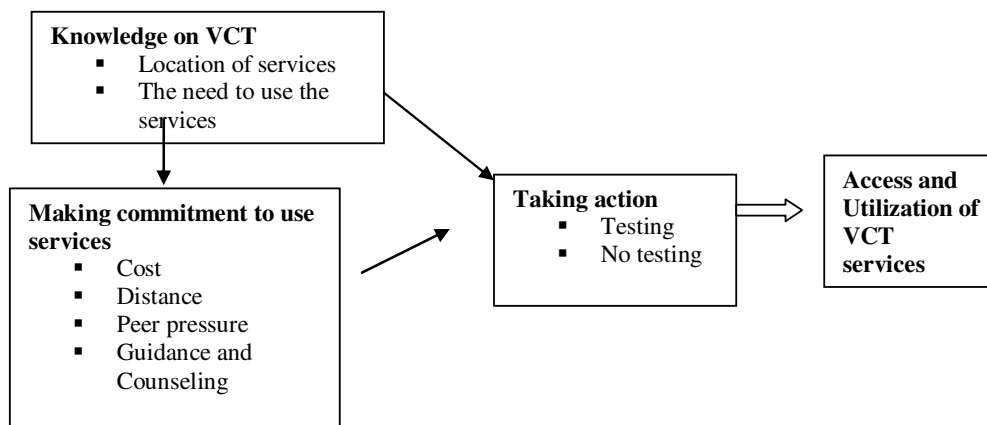


Figure 1. Conceptual model on VCT access and utilization in Rakai District.

cussed with the youths who utilize the VCT services to find out what prompts them to seek VCT services and what alternatives the youths say can be used to provide the services in order to improve accessibility and utilization. The interaction with the service providers including government staff and NGOs gave some insights on the barriers, facilitating factors and usefulness of VCT services to the youths, support systems for youth accessing and utilizing VCT. The findings shared with stakeholders would identify possible solutions to the problems of the young people accessing and utilizing VCT services.

Theoretical frame work of the study

In 1990, Catania et al. (1990) developed a theoretical model of the AIDS Risk Reduction. This model explains some of the interacting factors in limiting and promoting HIV/AIDS spread. This model can be replicated for the VCT services as one of the parameters for HIV/AIDS reduction. The interacting factors thus contribute in one way or the other to the spread of HIV/AIDS as shown in Figure 1.

It is clear from this model that knowledge on the availability of the services influences the actions taken and making commitment to change. These factors when studied may contribute to the access and increased utilization of the services.

METHODOLOGY

Research site

The study was carried out in Rakai District, which borders Masaka District to the North and northeast, Mbarara to the West and northwest and Tanzania to the South. It has an area of 4,973 sq.km and a total population of 383,501 people- 189,082 males and 194,419 females. It has 2 hospitals and 21 health centers. The District has four counties namely, Kabula, Kakuuto, Kooki and Kyotera, with a total of 21 sub-counties. There are 262 primary sch-

ools, 23 secondary schools, 1 technical institution and 1 teacher training college.

Following a stakeholder meeting that included the district political leaders, administrators, youths and representatives of NGO's working with youths at the district headquarters prior to the study, a number of suggestions were made on the study sites. Kakuuto County was selected because it has landing sites for boats with heavy cross boarder interactions. The site is where the first HIV/AIDS cases were first identified back in the 1980s (AIC, 2003). This provided an opportunity to understand how prevention worked in the population, which has been exposed for almost over 2 decades. In addition there are a number of youths who are exposed to risks of HIV, being a highly mobile group with people coming in from different parts of Uganda and Tanzania. Also, being a high-risk area, a number of interventions including VCT centers have been established. This provided the research team with ample opportunity to assess the impact of VCT services on the youths.

Kyebe sub-county was selected for the same characteristic with Kakuuto and Kyotera Town Council for its semi - urban characteristics. Again, here the sub-county being urban with open inlets puts the youth here at risk of acquiring HIV/AIDS. This provided an appropriate population in regard to youth access and utilization of VCT services.

Methods of data collection

Data collected for this study were qualitative in nature. The qualitative data collection methods were adopted because they provide the researchers an opportunity to study social interactions in a natural setting as recommended by Hollander (2004). The main issues discussed included why the youths seek VCT, how VCT has helped behavior change, what behaviors are commonly adopted, which ones are difficult to change, which ones are easy and why. What are the factors affecting access and utilization? Are there differences in rural and urban localities? The methods used to gather information included in depth interviews with various individuals and focus group meetings.

In depth interviews

These were held with twenty (20) young people from the community, fourteen (14) of who have tested and six (6) who had not, four (4) service providers, sixteen (16) teachers, one (1) hospital medical superintendent, twelve (12) adult women in the community, eight (8) adult men in the community, five (5) district administrators,

six (6) political leaders, four (4) religious leaders, three (3) traditional medicine providers and three (3) sub county leaders.

The focus group discussions

A total of two hundred and fifty (250) young people participated in twenty four (24) Focus Group Discussion (FGDs). These included male and females, in and out of school youths in almost equal numbers. In addition, 4 FGDs were conducted with community members for men and women separately, organized by sub-counties representing rural and urban distribution.

Data analysis and management

The data were analyzed using thematic and content analysis. All interviews and focus group discussions were transcribed and translated. The transcripts were then read and coded manually to identify concepts, patterns and themes. The themes developed in the analysis among which included knowledge on VCT services, factors limiting the use of the available services, and what alternatives can be explored for improving accessibility and utilization of the services by the youths. Quotes have been recorded verbatim in the text with some editing done without losing the content and ideas of the participants.

As part of improving quality, the research assistants were trained in participatory research methods, provided with detailed background to research project, aims/objectives and methodology, pre-testing the research instruments, sampling technique and good communication/interviewing technique (using role plays), for the facilitation of the numerous qualitative data collection methods. The research team had daily discussions on emerging issues and gaps in order to maximize quality in the data collection exercise

The proposal to conduct this research was first submitted to the ethical committees of the Makerere University Social Worker and Social administration and permission to conduct research at district, sub-county and village level was obtained from the appropriate administrators. The researchers also obtained introductory letters from Makerere University introducing them to the district authorities. Informed consent was sought from the participants prior to participating in the study.

FINDINGS

Knowledge on VCT services

In analyzing the data for this study, we found that most young people have knowledge and information on VCT services available. This is an indication of the amount of publicity of VCT, as a key informant shared:

“People are being sensitized every day about the advantages of VCT services and their availability. The VCT services were brought nearer (health centers) but before, people used to suffer a lot in the villages” (Key informant district administrator)

In all the focus group discussions, the youths- male and females- in rural- urban described the prints media and the radios as their main source of information on VCT services:

“We have heard about VCT services through radios,

straight talk, posters and visiting health workers (FGDs)”.

Others, especially mothers had heard about VCT services when they attended the health centers for other health issues as shared by a married youth:

“We have heard about VCT and we have been checked at the Health Centre. We got our results” (FGD Married Youth).

The students youths preferred the messages on radios and straight talk, a newspaper pullout on sexuality especially among the youth; an indication that the interaction and communication between the youths and service providers could be problematic. The services are provided in the government facilities, the key services provided being testing, and counseling. The youths were given information on behavioral change such as reducing the number of sexual partners, avoiding drinking alcohol, and seeking further counseling. Additional health education about prevention of mother to child HIV transmission and treatment of sexually transmitted diseases for those who need the services was provided.

Commitment to take actions on going for a test

Commitment to action for either to test or not is influenced by individual, community and institutional factors as the youth shared. This influence had a potential limitation to the access and utilization of VCT services.

Individual factors: Girls could seek for VCT as early as 18 years as shared during the FGDs. This is because at this age some are mothers and are sensitized about VCT services when they visit the center for antenatal care or for the treatment of their children. However, in areas where few girls attend antenatal, for example in Kakuuto, utilization of VCT was low. One key informant summarizes what motivates the female youths to seek services in the following way:

“The level of utilization of VCT is very high in females compared to males because ...when they come for ante natal care, they seek VCT, which is not the case with boys who rarely visit health centers” (PHA Kakutto Health Centre).

The boys rarely seek the VCT services because they do not attend the health centers for other reasons as women do. Some times they may be busy with survival ventures but other times they lack patience necessary to follow through with the testing as suggested by a service provider:

“The boys (male youth) rarely seek the VCT services because they tend to be busy and lack patience. At times one has to spend almost a whole

day at the VCT due to many patients” (Ki, Service provider).

The discussions further indicated that the youths thought it embarrassing, for they suspect they may be infected, given the lives they have led.

“Most youth here suspect their status to be HIV/AIDS positive because they have played live sex with widows, etc and they just don’t want to confirm their status” (KI Kakuuto health center, Kyebe sub-county).

The youths in this study, however are willing to know their health/blood status, whether negative or positive, so as to plan accordingly. They also want to have access to free drugs and plan for a career as illustrated by this story shared by Jane regarding her process of accessing and utilizing the VCT services (name has been changed to provide anonymity).

Jane wanted to know her health status so she could begin medication if found positive. Jane wanted VCT services in this area because she had hope for a job to work as a teacher in the tailoring class. Because the distance to the VCT was not too long, she could walk in case she had no money for transport. Jane was sensitized through a friend who was a member of the Drama group and had used the services already. She had developed some fear although counseled but later gained strength when going for results. Jane got her results after waiting for some four hours because of the large number of clients. Jane learnt to take care by use of condoms especially when tempted to having sex. She stopped taking alcohol because it influenced her so much into sex. Jane started planning seriously for her future. She wanted to start business in Kalisizo after getting capital. She found the environment at the VCT centre friendly and excellent especially on the side of counselors.

Fears after testing

The young people expressed fear of receiving the results as shared by a health worker, “The youths fear a lot, many who tested never came back for their results” (KI Health Worker, Kyebe). But those who are almost sure that they are infected, having lost spouses or having been involved in risky sexual behavior, the fear was minimal, almost non-existent as shared by a youth living with HIV:

“I had no fear at all [testing] because of my past movements. I enjoyed life so much at Kasensero because I was a driver of pick up –Datsun. In fact, it is for my mother and she also contributed much on my acquiring aids because may be if she had not given me a car,

I wouldn’t be positive by now” (In depth Interview with Young PHA).

Fears of the outcome deterred many youths from utilizing the VCT because of the stress related to knowing

about an imminent death, loss of economic sustenance, lack of necessary medication, which is expensive and fears as who can manage the wealth, children and parents after death. This fear was discussed during the FGD: Some people fear testing because they come as sex workers, majority have lost partners and do not have capital to start up even a small business. So they earn a living through sex trade. So if health workers come, they fear to attend because they fear to lose customers (FGD Kansensero Landing site).

Nevertheless, peers were reported to give support to each other to go for VCT services. Colleagues encourage those who have tested through social support systems.

Community factors

Transport costs: We found transport cost to be a barrier in accessing VCT services. In most cases the high transport costs is due to the long distance to the service centers and this was mentioned as a constraint mainly for the female youths as shared by a political leader:

“Utilization is low in some areas, due to the long distances to be traveled. They need “boda-boda” (motor-cycle) up to the health centers because some are weak and have no money to meet transport costs, so they decide to stay home” (KI district political leader).

Parental guidance and support: We found that parental guidance and support is crucial to access and utilization of VCT services with the young women being more restricted by their protective parents. At times the young girls fear to seek parental permission to enable them to use the services. In addition they are the care takers and have household responsibilities, leaving them no time to visit the Health Centers for the VCT services as shared by a female youth: “The parents do not care or provide guidance so the children do not know much about VCT” (FGD Female Youth Kasensero).

Institutional factors

Quality of services: Quality of services determines how much the youths will access and utilize the VCT services. In this study we found that although the majority of the health workers are trained, they are few compared to the demand. This is especially the case in outreach centers where the youths said that their morale was lowered from the long waiting, “on reaching there, one has to wait for so long, no drink available so people lose morale” (FGD female youth Kasensero). The youths said that they found the quality of counseling to be good, with confidentiality assured when filling in forms with the counselor. The counselors were described as friendly to the patients but the constraints mentioned included lack of peer educators, long waiting hours to access the services, giving

varying results as reported by a female youth: “Some hospitals give results which are varying, for example the first test is negative and the second is positive. The health workers do not tell you the truth about the results” (FGD female Youth Kasensero). Also, lack of privacy, and the environment in which the service offered being youth unfriendly because all patients (young and old) are mixed up. As a result the young people tend to shy away from the services. Another constraint mentioned was the lack of facilities particularly in areas where the youths are transient as shared by a female participant:

“Some youths are very mobile: today in Uganda and two weeks reside in Tanzania. So it would be better if they give us a day in a month when they can test us. They could tell us two weeks before the actual day of testing in order to organize ourselves” (FGD Female Youth Kasensero).

Another constraint towards quality services described was the time taken to release results. The government health facilities take a short time to release results after testing but in some non governmental projects it was revealed that it takes 2 – 3 weeks. The counselors in the government health facilities were older and offered youth friendly services and provided an environment conducive to the youths. In other non-governmental facilities there was no clear information on how the youths are accessing VCT services despite the indication that the services are being provided. The service providers, however, re-ported that, there are sometimes delay in supply of reagents, medicine which interrupts the services both with government and NGOs.

Cost of services: Cost of services largely influences the provision of services. In this study, we found that the services were not free and the cost ranged from 2500/ (1.5 US dollars) to 5,000 (2.5 Us Dollars) as shared by a male participant: “Currently, people get VCT services from Kakuuto H/C, where they pay 5,000/= for transport and this is very expensive to the majority” (FGD Males Kasensero). Other related costs such as being asked to bring one’s own stationary was reported during the FGDS, “When filling in the clients forms we are told to buy exercise books where medicine is recorded” (FGD PHA Kakuuto Health center). This discussion revealed that such services were too costly to the youths who in most cases have no source of income.

In the study, we found that there was a referral system of clients from the lower health units to hospitals for further services as needed. However, the clients were referred to the hospitals at their own transport expenses making it even more costly. Clients were mostly referred to a district hospital (Kalisizo) and at the Health Centre Level IV (Lyantonde). Sometimes they are referred to NGOs like World Vision about their concerns for economic support. The reasons why clients are referred include when reagents are unavailable at the health cen-

ter, preference to particular counselors and lack of drugs particularly the STI drugs in the lower health units. Interestingly, among the facilities visited by the study team there was no Post-Test support services, and Kasensero a historical site for AIDS, had practically no services specifically targeting HIV/AIDS control as shared by a female participant, “The last time we received an outreach was on World AIDS Day of 1999, where people participated so much” (FGD Female Youths, Kasensero).

Choices and alternatives for providing VCT services to the youths

In this study, we found some alternatives that could be used to make VCT accessible to the youth other than the mainstream health facility. These alternatives included establishing of mobile clinics in market places and the use of traditional and complementary medicine providers. These alternative sites were found to offer the youth more anonymity and privacy compared to health care facilities and hospitals.

Mobile clinics in market places: Young people mostly from market centres as well as health workers providing VCT outreach services reported a high number of youths seeking VCT services at the market places as compared to hospitals and health units. This was revealed by a key informant who said the following: “At the health centers there are few young people who attend VCT services compared to the outreaches in market places such as Bethlehem, Lwankoni and Kabira” (Medical Superintendent District Hospital, KI Clinical Officer/VCT trainer Rakai).

The health workers reported that during the outreach service, the setting was informal compared to the one in the Health Unit. Simple curtains are put in place; group counselling and mobilisation by the parish mobilizers put in place. Such an environment was perceived as promoting accessibility with no structured routine. This provides an opportunity to serve a larger population because more youths come to the markets for petty trade, purchasing domestic commodities and less mobilization is required to inform the general population about the facility. The majority of the youths during the FGDS expressed the desire to have services in such settings because confidentiality is almost always guaranteed and care providers have no chance to be biased.

Use of traditional and complementary medicine providers: Some young people and Community members mentioned the services of the traditional and complementary medicine providers as widely used especially in areas where health facilities are non-existent. The interviews with traditional healers in the area also confirmed they provide such services to the youths. These were seen to have potential in providing care and support to clients as shared by a key informant:

"We are here. People of all ages come to us with different problems and we solve them, we counsel them, we give them advice. I even go to schools to talk about HIV/AIDS. I even approached the District Director of Health Services asking his support. If I went with a person from his office, I can be listened to better. We have the potential and the interest, but we are not supported" (KI Herbalist Kyotera TC).

Policy on voluntary counseling and testing among the youths

The policy guidelines for voluntary counseling and testing 2003 gives the process of providing VCT services and the various institutional arrangements to be put in place. Under the circumstances under which HIV testing in the Uganda should be made, it spells out that only people who have attained the legal age of 18 years should consent for VCT and thus qualify to be tested. However, it provides for legal minors to be tested because of the early exposure to sex by the age of 14. On the type and location of VCT services it provides for a free standing site like market place that is not physically located in an existing healthy facility. The policy states that under such circumstances a strong referral system should be in place to support this kind of arrangement. In human resources for VCT the policy provides that a trained counselor should not see more than 6 clients a day and it should a trained counselor to provide the services. The person to perform the test should have the rank of a medical laboratory technician or a person with a diploma trained as a medical personnel. The policy recommends that VCT services being preventive they should be provided free of charge.

DISCUSSION

Knowledge on VCT

Many countries have recognized VCT services as a priority intervention for HIV/AIDS control (UAC, 2003; MOH, 2003; Jackson, 2002). Despite the fact that the majority of the youth knew about VCT, this study has demonstrated that there are still no innovative ways of disseminating the information on HIV/AIDS and particularly on VCT other than the common methods of using the print media, posters and radio programs. Some studies have shown that it is often difficult for both men and women to discuss HIV testing in general and their own HIV status in particular because of cultural and social taboos surrounding discussion of sexual issues (Baggaley et al., 1997; MOH, 2004). This can be worse among the young people where sexuality issues are never discussed openly. This calls for designing other innovative ways such as painting of big pictures on the walls of big buildings like community halls, dispensaries and shops depicting information on the adverse effects of HIV/AIDS on the young

people in particular and the need for VCT services among the young people.

Commitment to action

An interaction of individual, community and institutional factors have been found to be contributing factors to the low use of VCT services by the youths and hence influence the commitment to go for a test or not. This shows the stigma attached to the structures and the personnel who provide the services. Some of the young people still do not know the advantages of the VCT services. The stress is related to the imminent death or loss of income, the fears, and lack of support because of the costs associated with positive status. All these individual factors point in one way to the fact that there is this kind of stigma attached because as soon as the youths enter the facilities or consultation rooms it is like a condemnation and a belief that has had an exposure to the risk. This kind of environment needs to be adjusted to suite the beneficiaries of the program and their involvement in the designing process. The quality of services, particularly the time taken to release results which came out as one of the concerns, is a manifestation of the structural arrangements of bureaucratic processes, undermining the provision of VCT services. While advocating for the same day results as an attraction for accessing the services it is still a challenge in this community and hence the need to modify the procedures being followed. (UNAIDS 2000, Jackson 2002).

Alternative and choices to providing VCT services

The study results have shown that there are number of alternatives and choices which can be explored and strengthened in order to increase on the accessibility to the services. Mobile clinics in market areas are potential alternative sites. The youths found the mobility of these structures to be a source of privacy and provided anonymity as compared to the regular health units or hospitals. Structural stigmatization could be a limiting factor to accessing (Patient and Neil, 2004; Ayiga et al., 1999). This is because it puts the clients or patients in situation to disclose their conditions by virtue of their presence to such structures and personnel providing the services. The traditional and herbal medicine providers were found to be potential outlets for the provision of services where the government or NGO had been unable to. Though care must be taken to ensure these providers get the adequate training and a structure put in place for supervision. On the side of modern medicine, there are drug shops and private clinics again to meet the needs of the people in the area especially treating STI. Qualified personnels provide treatment and care in most of the health facilities. Many youths go to private clinics for services. The youths seem to feel more comfortable in these establishments and have therefore a potential for coun-

selling, education and mobilization, after which the youths can be given appropriate referrals. These approaches can be explored further through dialogue meetings with the various stakeholders and particularly involving the youth.

The policy guidelines

There is a policy on VCT which provides for guidelines to be followed. The guidelines however are silent on providing services in a youth friendly manner which needs to be looked at. This will provide a framework for the service providers on what special arrangements could be made purposely for the youths in the resource limited settings. Such arrangements may include the arrangements in the locations, facilities, the nature and type of service providers and the necessary structures to be put in place. The recommended work load for a counselor and the qualifications are limiting in them because a limited number of clients will be served on a clinic day and hence limited service utilization. Where group counseling is done a big number can be served on a particular clinic day if clearly done well. The use of peer youth educators can also be adopted by providing basic youth counseling services. This can be done by integrating the peer educators into the mainstream HIV/AIDS activities, which is an area that is lacking in the policy document.

Conclusions

In conclusion this study has demonstrated that there is adequate knowledge on the availability of VCT services in the community though still the traditional methods of disseminating and providing information to the youths are still being used. An interaction of individual, community and institutional factors were found still to be limiting the youths' access and utilization of the VCT services and hence have an influence on the commitment to take action to test or not. These factors have the possibility of adding on the overall costs of providing the services to the youths, which in most cases reduces the utilization levels. Mobile clinics and outreaches seem to be more acceptable to the young in case VCT service is to be provided to them rather than the structural arrangements in health facilities and project sites. Traditional and complementary medicine providers have an advantage of reducing on the transport costs by clients to distant service centers which in most cases have been stigmatized by the young people. The policy on VCT is still silent on providing youth friendly VCT services; thus provides a stabling block to the service providers and hence limiting access to VCT services among the youths.

This study has shown that there is a need to start a dialogue with the various stakeholders in providing VCT services to the youths, policy makers especially in regard to changing the strategy of provision and disseminating the information on VCT. The youths value anonymity and

confidentiality which seem to lack in the regular health units and hospitals. There is also a need to cut cost and provide free medicine for those who test positive. The policy revision should be made to incorporate issues providing VCT services in a youth friendly manner in order to improve on access.

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