

**THE INFLUENCE OF SPECIALIZED HIV/AIDS SITES ON FIRST
TIME CLIENTS' INITIATIVE TO SEEK VCT SERVICES: A CASE
OF NKUMBA UNIVERSITY STUDENTS, UGANDA**

Allan Bucyana

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Africa Centre for HIV/AIDS Management
Faculty of Economic and Management Sciences

Supervisor: Gary Eva

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Declaration

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Allan Bucyana

March 2011

Abstract

Although VCT has been recognized for its importance in HIV prevention and control, there are several matters of concern surrounding it that potentially limit its uptake. Clients' selective behavior in tandem with service provider and operating environment factors determine uptake of VCT service. This study sought to contribute knowledge on the influence that specialized HIV/AIDS sites have on first time clients' initiative to seek VCT services in comparison with the general health care sites. The study also analyzed factors that determine clients' preference of VCT access point.

The study was done within a student population of Nkumba University in Entebbe municipality, Uganda. A sample of students to fill the study questionnaire was selected using a simple random sampling method from a population frame established from a class identified haphazardly. Four focus group discussions were done: two of the groups participants were stratified as students' male and female groups and were selected using convenient sampling from the sampling frame. The other FGDs were done with two groups of nurse counselors – one from a general health care site while the other was from a specialized VCT site, selected purposively.

Specialized VCT sites had a higher frequency of first student clients than general health care sites. Results however indicated that though the perception of service providers' attitude and availability of trained counselors affected their choice, there was no significant difference between specialized and general VCT sites in terms of first time clients' preference. Reasons for preference of site differed. Specialized sites were preferred because they are perceived to offer better quality service owing to their concentration on VCT services, but shunned by others for lack of disguise. Conversely, respondents revealed that there is disguise at general health care sites which enhances confidentiality and anonymity thereby curbing clients' fears of being identified making it easier for first time clients to go to these sites for VCT.

Opsomming

Alhoewel vrywillige raadgewing en toetsing (VRT) erken is vir sy belangrikheid met betrekking tot MIV voorkoming en beheer, is daar verskeie kwessies daaraan verbonde wat die gebruik daarvan kan beperk. Kliënte se selektiewe gedrag saam met diensverskaffers en omgewingsfaktore bepaal die gebruik van VRT dienste. Hierdie studie het gepoog om kennis by te dra oor die invloed wat gespesialiseerde MIV/Vigs toetsingsterreine het op eerstelinge se inisiatief om VRT dienste te soek in vergelyking met algemene gesondheidssorgterreine. Die studie het ook faktore geanaliseer wat kliënte se voorkeur van VRT terreine bepaal.

Die studie is binne 'n studente populasie van Nkumba Universiteit in Entebbe Munisipaliteit, Uganda, uitgevoer. 'n Steekproef van studente om die vraelyste in te vul is geselekteer deur die eenvoudige toevalmonster metode te gebruik van 'n populasie raam geskep van 'n klas was lukraak geïdentifiseer is. Vier fokusgroepe het plaasgevind: twee waar deelnemers as manlike en vroulike studentegroepe gestratifiseer was en geselekteer deur gerieflike steekproeneming van die steekproefraam. Die ander fokusgroepe was twee groepe van verpleegster beraders – een van 'n algemene gesondheidssorgterrein en die ander van 'n gespesialiseerde VRT terrein, doelbewus geselekteer.

Gespesialiseerde VRT terreine het 'n hoër frekwensie van eersteling student-kliënte as algemene gesondheidssorgterreine. Uitslae het aangedui dat hoewel die persepsie van diensverskaffers se houdings en beskikbaarheid van opgeleide beraders hul keuse geaffekteer het, dat daar geen betekenisvolle verskil was tussen gespesialiseerde en algemene VRT terreine in terme van eerstelinge se voorkeur. Redes vir voorkeur van terrein het verskil. Gespesialiseerde terreine is verkies weens die persepsie dat hulle 'n beter kwaliteit diens lewer weens hul konsentrasie op VRT dienste, maar deur ander vermy was weens gebrek aan vermomming. Omgekeerd het respondente aan die lig gebring dat daar wel vermomming by algemene gesondheidssorg terreine is wat

vertroulikheid en anonimiteit verhoog en kliënte se vrese verminder wat dit makliker maak vir eerstelinge om na hierdie terreine vir VRT te gaan.

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Chapter one: Introduction

1.1 Background to the problem

HIV/AIDS is the worst pandemic of the present time. It is estimated that more than 42 million people are infected worldwide and that 3 million people have so far died (the Global HIV/AIDS Estimates, 2006). There is hardly a community without HIV infected persons or that has not shared the impact of the pandemic (UNAIDS, 2005).

USAID continues to support the expansion of high-quality VCT services as part of its comprehensive prevention and care strategy. USAID strives to identify and overcome barriers that inhibit demand for services, while effectively meeting the needs of those most at risk for HIV infection (USAID, March 2003).

Voluntary counseling and testing (VCT) programs stand out among HIV/AIDS innovations because of their dual role: Not only do they help clients adopt HIV preventive behaviors, but they also identify people who need HIV care. Given that many of those newly infected with HIV are young people, VCT program managers and policymakers are increasingly recognizing the importance of encouraging youth to seek HIV counseling and testing services and service providers to modifying their services to meet youth's particular needs (Horizons, 2005).

1.2 Problem formulation

Although efforts have been committed to providing anonymous testing and to protect the right to confidentiality to clients attending VCT and also to address stigma and discrimination linked to HIV/AIDS as a means to attracting more clients to consume the services, gaps still exist to scaling up VCT uptake.

In its March 2003 publication, USAID stressed that they are still striving to identify and overcome barriers that inhibit demand for VCT services in order to effectively meet the needs of those most at risk for HIV infection. A similar observation was made in the call to modify VCT services to meet youth's particular needs (Horizons, 2005). WHO/UNAIDS noted that there is no single, ideal model of VCT service delivery

because different approaches are required to reach different populations and concluded therefore that there is need to continuously review and design new approaches to VCT service delivery (WHO/UNAIDS 2001).

There is a possibility that specialized VCT sites could influence first time clients' desire to go for HIV testing because of fear of being associated or suspected to be having the disease. First time clients are prime targets for VCT because they are core to the success of HIV care, prevention and control effort and increased uptake of VCT services largely depends on this category.

1.3 Problem statement

Would first time VCT clients prefer going to general health care sites to specialized VCT sites for voluntary HIV counseling and testing services?

1.4 Formulation of hypothesis

There is a likelihood that fear of being associated with HIV/AIDS affects individuals' choice of where to go for HIV testing. The choice of which site to be visited may largely depend on individuals perception of where they can be tested with limited chance of being identified or suspected to be associated with HIV/AIDS.

1.5 Research hypothesis

1. General health clinics that offer VCT services have more first time clients initiating HIV testing than specialized HIV/AIDS clinics.
2. Fear of being associated with HIV/AIDS inhibits first time clients' initiative to go for VCT in specialized VCT sites.

1.6 Null Hypothesis

There is no relationship between fear of being associated with HIV/AIDS and the first time clients' initiative to go for HIV testing at specialized VCT sites.

1.7 Dependent and independent variables

Individuals' choice of the nature of the VCT site to go to will be the dependent variable and independent variable will consist of factors that would influence choice of which VCT site first time clients would feel most comfortable going to. The independent variable will consist of factors like fear, quality of service at the sites, location of sites, and operating environment. Other reasons that will come from respondents that influence their choice of VCT site will also form part of the independent variable. The assumption is that the factors elaborated above are likely discourage seeking VCT at specialized sites for the first time clients if they perceive them to be negative and if they are perceived positively, will favor uptake of VCT at either sites. The triggers of fear will be evaluated to assess their effect on accessing VCT. The influence of personal internal and external factors on decisions regarding VCT will also be examined.

Chapter two: Literature review

2.1 Introduction

Although VCT offers an opportunity to access care, control and prevention services to infected and affected persons and to the general community, it is not void of hindrances. This chapter shows what others have covered of the problem, gaps left and how the current study intends to fill these gaps on HIV/AIDS and VCT. The chapter reviews literature outside and within Uganda with the aim of establishing the models being applied elsewhere.

HIV and AIDS are characterized by progression without a cure, is still a mystery to the public, symptoms that scare, cause death etc. Societies relate HIV/AIDS infection to rare but severe ailments like leprosy and other misfortunes that befell the community members who were said to be cursed for their wrong deeds. These diseases like HIV/AIDS were characterized by clearly severe symptoms which often lead to physical disability and death at worst. People who suffered from such diseases were looked at as outcasts and were often isolated and unfairly discriminated against. Fear of stigma and discrimination associated with HIV/AIDS impedes efforts to scale up VCT services to an extent that people prefer keeping a distance from situations that subject them to being suspected to have the disease.

2.2 VCT as an entry point to HIV prevention and care/treatment

Voluntary counseling and testing (VCT) is an essential component of comprehensive AIDS prevention and treatment programs. VCT enables people to learn their HIV status in the most informed and supportive way possible: with counseling both before the test to educate them about HIV infection, and afterward to help them respond appropriately to the results. VCT thus serves as an entry point to services that promote health and risk reduction, with those who test negative receiving prevention counseling and those who test positive receiving referrals to prevention, care, support and treatment programs.

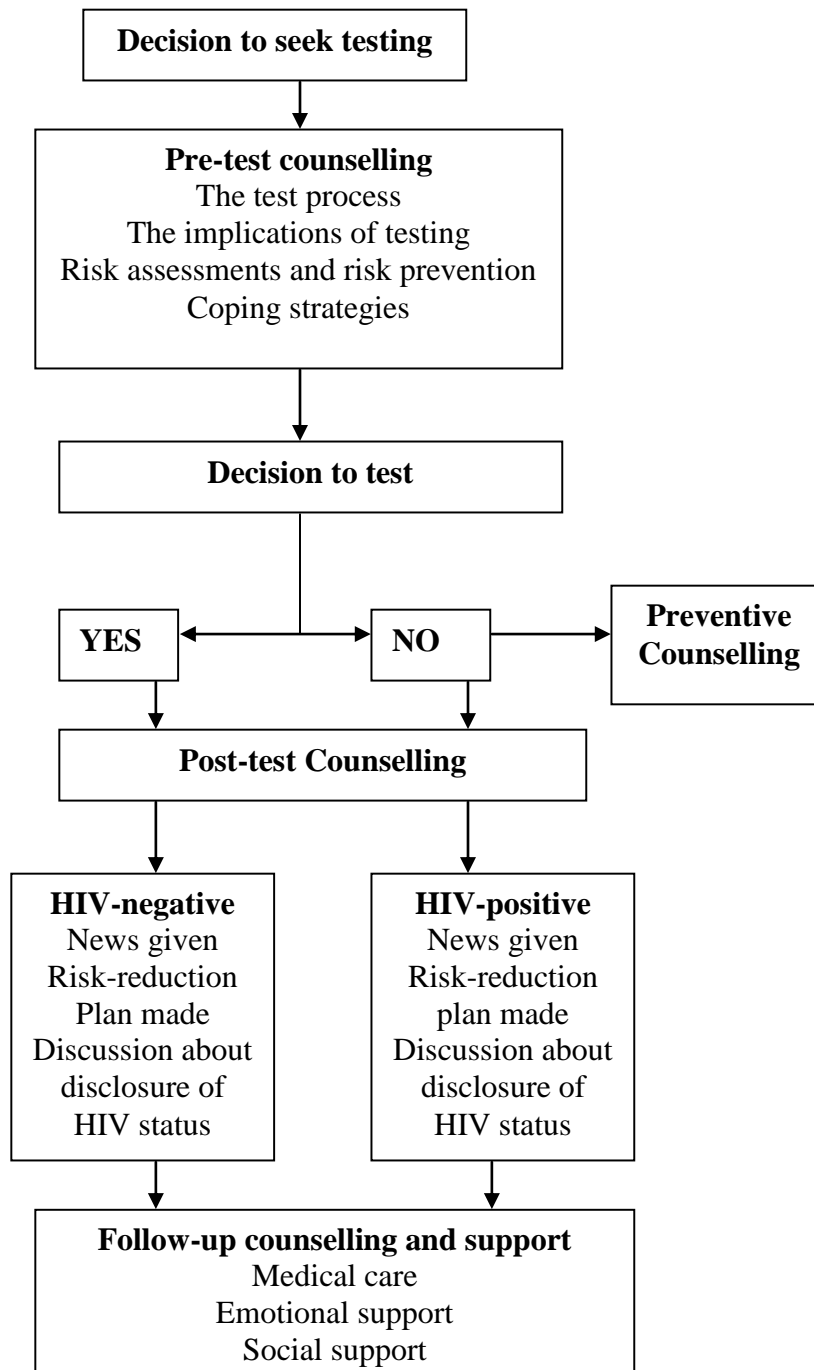
VCT also encourages and provides support for disclosing one's HIV status to sexual partners.

2.3 Demand for VCT services

In a Ugandan study of 369 young people age group between 14 to 21 years who had sought VCT, young women who decided to get tested tended to do so if they were about to be married, enjoyed their partners' support, and knew their partners were willing to pay for the service. Nearly two of every three girls said their partners encouraged them to be tested. In contrast, boys were more likely to decide on their own to be tested and to pay for testing themselves. A third of the boys said their decision to seek VCT testing was influenced by partners; a third, by friends; and another third, by no one (Finger, 2002).

THE VCT MODEL

Figure 2.1 service model



Source: Finger, 2002

In a study on factors influencing utilization of VCT services, Lukwago found that 35% of the causes of limited uptake of VCT services were due to fear of positive results (Lukwago, 2005). Also, in his experience of MARPS with VCT in Asia Pacific, Loughlin noted that slow uptake of VCT services was linked to few anonymous free sites (Loughlin, 2007).

One of the most serious barriers preventing more people from seeking VCT is fear of AIDS-related stigma, which is widespread in many countries in Africa. Many people are concerned they will become victims of discrimination and social marginalization if others find out they have been tested, whether or not the results are positive.

By implication, circumstances that may lead to suspicion of having the disease could be avoided. The relationship between VCT and HIV is enough to arouse suspicion that individuals seeking VCT are HIV positive.

2.4 Increasing demand for VCT through community awareness and creating conducive environment for clients:

Creating a broad clientele for VCT requires that members of the community be aware that the service is available, understand its value for maintaining health and feel comfortable using it. When the Lagos VCT site first opened, few clients came for services, sometimes only one or two a day. Attendance increased after radio publicity began, but the site is still not receiving as many clients as it could handle. The same is true for the SWAAN site in Kano, Nigeria (Wigley, 2004).

Ensuring privacy and confidentiality is essential to easing fears of stigmatization and thus increasing service utilization. Staffs at both sites suggest dropping the current practice of registering clients' full names in favor of nicknames or other forms of anonymous testing that are used elsewhere in Africa (Wigley, 2004:2).

Another way to overcome young clients' fears is to promote the counseling aspects of VCT rather than the HIV test, which helps relieve some of the anxiety potential clients,

may associate with testing. In Zimbabwe, the “Let’s Talk” campaign encourages young people to come to the VCT center to discuss a broad range of concerns about health and sexuality with HIV testing offered as a secondary service. This helped increase VCT attendance by young people by 34 percent in 2002 (ibid, 2004).

Three studies provide insights into what barriers young people face in terms of seeking VCT. When adolescents (ages 12 to 19) in the Mpigi District of Uganda were asked what they thought of VCT services, many of the males and females were interested in HIV testing but concerned about confidentiality, the testing process, the accuracy of test results, and the cost of VCT services (Bohmer & Kirumira, 1997).

Among surveyed youth (14 to 21 years of age) in Kenya and Uganda, 41 percent of untested youth and 38 percent of tested youth reported that they would prefer to test at a youth facility rather than at an adult facility, where they might encounter adults they knew (Horizons 2001). Untested Kenyan and Ugandan youth wanted to be sure that they saw qualified staff that used reliable testing equipment. In Zambia as well, youth stressed the need for privacy in testing (UNAIDS 2002).

In two Ugandan clinics, tested youth participating in exit interviews rated the skills and friendliness of the providers as what they liked most about the VCT service. They mentioned long waits as what they liked least, and reported that the wait as each person received their results privately was a particularly stressful time (Juma et al. 2002; Kirumira et al. 2003). Assessment of services did not differ for males and females.

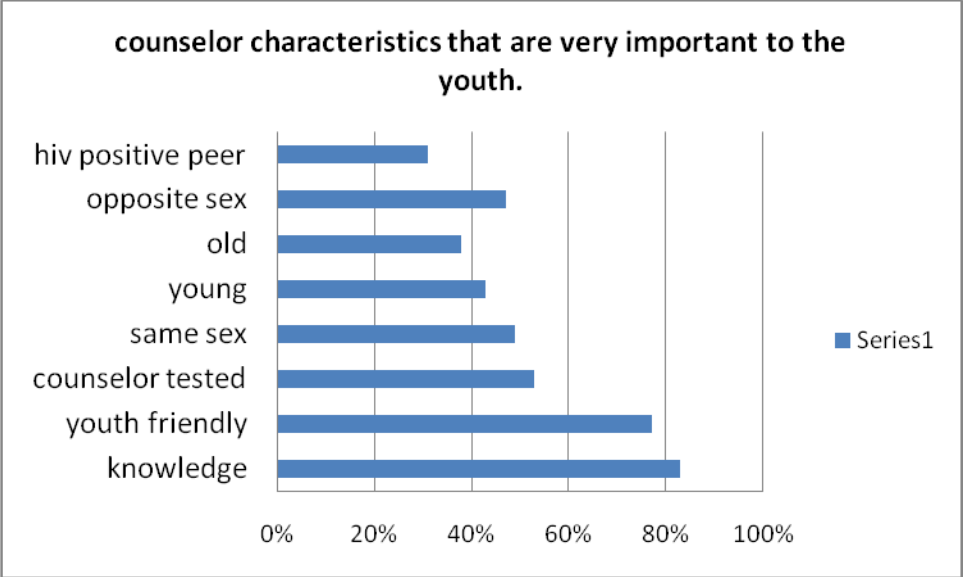
2.5 Service models that reach youth:

A WHO/UNAIDS meeting on VCT observed that there is no single, ideal model of VCT service delivery because different approaches are required to reach different populations (WHO/UNAIDS 2001). This statement is true for youth programs as well as for adult programs.

Program experience indicates that each service delivery approach will attract a slice of the population who need services. For example, in northern Thailand, VCT clinics see mostly men whose wives have already been tested as part of antenatal care (Kawichai et al. 2002). Sometimes it is hard to explain why one group uses a clinic more than another. For example, service statistics indicate that the Kara Clinic in Zambia sees more young men than young women and the AIC clinic in Uganda sees more young women than young men (McCauley, 2004:5).

Confidentiality is clearly more important than setting. Adults and young people often do not seek VCT because they fear being seen at a testing site or having health care personnel tell others that they have come to be tested. For example, 2,400 individuals in Zambia were randomly allocated to receive VCT either at the local clinic or at an alternative location such as their home. Three times as many people accepted testing at the non-clinic locations compared to the clinic location (Fylkesnes, 2000). The data indicate that a high percentage of youth were willing to be tested if they were offered testing in a private setting.

Private health practitioners provide much of the primary care that is delivered in West Africa and Asia, and youth report that their chief sources of information and services are often pharmacists, traditional healers, and nurses in private practice (Kakande, 2002). Training private health practitioners to improve VCT services for youth may be a viable strategy, yet there has been little emphasis on these methods so far (Boswell & Baggaley, 2002). Training counselors is particularly important so that they can meet varying interests of clients as the graph below illustrates.



Source: Juma et al. 2004c

Chapter three: Methodology

The chapter presents the research design, study population, sampling frame, sampling methods, sample size, data collection methods and instruments for data processing, data analysis and then the limitations to the study.

3.1 Research design

The study used both the qualitative and quantitative research design. The qualitative design was used to describe personal, organizational and other variables that are not measurable in quantitative terms. The quantitative design was used to test the hypotheses using statistical measures. Balian (1988) supported the use of both qualitative and quantitative research design arguing that there is some subjective infiltration in quantitative research that can be described using qualitative methods.

The study approach was preferred to other research methods for a particular benefit that using this methodology allows one the opportunity to carry out in-depth, face-to-face interviews, with more than one person from settings different but relevant to this research. The relevancy to this study is that data collected in this way enabled the researcher to gain insight into some of the dynamics involved within the use of General Health Care sites and the influence of specialized VCT sites on the first time clients seeking VCT services.

3.2 Study population

This research focused on students from Nkumba University in Entebbe municipality as the study population. Because the research leans on the influence of health care sites on VCT clients, it was necessary that health care providers in specialized and general health care sites also participate in the study. Nurse councilors from these categorized health care sites participated in two separate focus group discussions to share their experiences with VCT clients from tertiary institutions.

3.3 Sampling methods:

Study participants were selected using various methods of sample selection. The methods used are: Haphazard, simple random sampling, purposive, convenient and stratified sampling strategies. The reasons for methods used for sample selection are explained below.

Haphazard sampling:

Haphazard sampling method was used to select the class that provided the sampling frame at the university. Although it was possible to consider all university students in the sampling frame because the admission list is available, selecting the sample to participate in the study first and later on locating respondents from the whole university would have been very tedious, time consuming and expensive. Haphazard sampling helped to narrow down the sampling frame hence eased sampling and selection of respondents. This method was applied with limited bias because there was no likelihood of significant differences in characteristics between the sample frame of the entire university and that of the selected classes. In other words, the haphazard strategy was used to select a sampling frame that typically reflects the study population.

Simple random sampling:

Simple random sampling method was used to select respondents to whom questionnaires were administered. Students in the sample frame were listed and assigned unique numbers from 001 up to the last number, in increasing order. A corresponding number of ballot papers were marked 'yes' - For study participation and 'No' - For no participation. The number of 'yes' ballots corresponded to the sample size for the study. The ballot papers were folded such that no one can read the numbers, and then collected together into a none transparent box where all students in the sample frame were asked each to draw one ballot. The students who drew ballots indicating 'yes' were enrolled to participate in this research and were asked to complete research questionnaires. This sampling method spread chances of the whole study population size to participate in the study.

Simple random sampling method was mainly chosen for this study because the population characteristics of interest to this study appear to be homogenous across the study population. It is also relatively easier to apply and straightforward.

Purposive, stratified and convenient sampling:

Four focus group discussions were held. The first two groups comprised of male and another of female students from Nkumba University. Participants were selected from the sample frame established by haphazard sampling and from the remaining students who did not take part in filling in the questionnaire. The purpose of FGDs for these two groups was to explore if male students will have opinions different from their female counterparts regarding VCT and choice of where to access services from. Each FGD comprised of six (6) student participants selected conveniently.

Two nurse counselors FGD participants' groups were formed, one group from a clinic or hospital setting offering VCT alongside general health service and the other group from a specialized VCT site. This was done to enable a comparison of opinions from the sites in reference to the choices of first time VCT clients. Four (4) nurse counselors were recruited to take part in each of these FGDs. Recruitment involved seeking permission from the head of department where the nurse counselors worked, and seeking consent to participate in the discussions from the individual counselors. Because nurse counselors in the same setting are assumed to be a homogeneous population in terms of experiences, participants were selected according to availability-convenient sampling method. Also, purposive sampling was used to get information from those who could provide data that is comprehensive enough to gain better insight into the problem.

3.4 Sample size

The sample size was estimated from the sampling frame using the Yemane's (1967:886) formula for estimating the sample size. The sampling frame was obtained from the class records at the university. The calculated sample size of 84 students was obtained using Yemane's formula described below, and all received questionnaires.

The actual calculated sample size was 83.79, but because we cannot deal with a fraction of a person, the figure was corrected to the next whole number; 84.

$$n = \frac{N}{1+N(e)^2}$$

Where N=106, the number students present in the sample frame

e= 5%, is the sampling error/ precision level.

n=84, is the sample size

Additional to the calculated sample size were twenty (20) focus group discussion participants in all the four planned FGD categories.

3.5 Data collection methods

In the collection of data, multiple methods were used simply because no single method of data collection can guarantee 100 percent accurate data.

The methods involved use of survey and review of related literature. The survey method used a questionnaire to collect primary data while review of related literature was used to collect secondary data. Focus group discussions were also held.

3.6 Data collection instruments

3.6.1 Self-administered questionnaire (SAQ)

The SAQs – *Appendix iii* – had questions on such variables as personal and organizational profile; health care and VCT services; choice of VCT site, among others. The questionnaire primarily comprised of statements requiring the respondent to opt for one answer out of two-five choices. The Likert format of questionnaire design was used whereby respondents were required to choose between varying degrees of: yes or no, and agreement to disagreement. The respondents were encouraged to put comments alongside the statements if they felt that some of the issues raised required further explanation on their part. A pilot test of the questionnaire was conducted prior to enable

validation. Feedback was received and appropriate amendments though minor were incorporated into the questionnaire that was finally used to collect data.

3.6.2 Focus Group Discussions:

FGDs were conducted to explore a range of opinions/views regarding VCT services in specialized sites among first time clients that would otherwise not be captured using the questionnaire. A guide to the focus discussion sessions was developed together with the schedule for data collection, see *Appendix ii*.

3.7 Data processing and analysis:

3.7.1 Processing SAQ

The data collected using the self administered questionnaire was subjected to cleaning involving manually perusing the responses and using electronic database Microsoft Access to correct identified inconsistencies. It was necessary to run the error checks and data cleaning to ensure the quality of data that was later analyzed bearing in mind that the quality of data determines the plausibility of conclusions made out the that data. Chi-square test of independence table was used to test the hypothesis using Microsoft Excel. Krustal and Willis recommended use of chi square test for analyzing data collected using the likert scale method.

During data cleaning, 5% (5:84) questionnaires were completely blank hence were eliminated immediately. More 17.8% (15:84) questionnaires were grossly incomplete with over 50% of the questions not answered and were also eliminated from analysis. Out of the 84 questionnaires circulated, 64 were considered for analysis representing a response rate of 76.2%. However, though 64 questionnaires were considered during analysis, some were still missing responses in some parts. This kept the denominator varying during calculation of percentages and averages. The highest omitted response on any given question was 7 and the least was 0. The average skipped responses were approximately 4.

The data cleaning process also involve editing and coding/categorizing responses especially where respondents were required to make written statements of their views.

3.7.2 Processing FGDs:

In all the four FGDs held, a research assistant was available who voluntarily assisted me in note taking. The assistant was experienced in taking notes during FGDs. He was briefed on the purpose of the exercise and familiarized himself with FGD guide prior to commencing the discussions.

Together with the note taker, we reviewed and completed FGD notes immediately after every session to avoid losing memory of any important information. Detailed transcripts of all FGDs held were written in the participants' own words whenever possible.

Then, the transcripts were coded according to the sections outlined in the FGD guide with careful consideration of the discussants' statements and expressions/attitudes that related to the objectives of the study. Data collected was summarized and compiled per FGD category to facilitate analysis and discussion.

Chapter Four: Data Presentation and Analysis of Findings

Data collected using questionnaires was analyzed using simple descriptive statistics in Microsoft excel, while the Focus Group Discussion data was analyzed manually. Following is a presentation of the findings.

Presentation of findings from self administered questionnaire

A series of descriptive statistical analyses were done on most of the questions. Participants' responses were tallied for most of the questions to calculate frequencies and ascertain variations. Percentages were also calculated to measure the magnitude of variations. Out 84 questionnaires distributed according to the calculated sample size, only sixty four (64) were considered during analysis representing a valid response rate of 76.2%. The remaining 23.8% of responses were eliminated during data cleaning mainly due to inadequate responses.

Participants' demographics and response rate

All participants were students of Nkumba University and mainly residents around the university. A few reside outside the university community in a range of about 30km away. Only one respondent was above 40 years. The modal age was 22 years with a frequency of 18. The youngest age was 19 years while the oldest was 45 years.

Data analysis

The chi square test of a contingency table was used to evaluate the difference that exists between specialized and generalized VCT sites in service utilization by first time clients. This test was used according to the recommendation of Krustal and Willis and in regard to its suitability in analyzing Likert scale data. Responses on two questions: first on whether first time VCT clients prefer going to specialized HIV sites and second, whether they prefer going to general health sites for VCT services informed this analysis.

To determine the variation on most preferred site, a null hypothesis (Ho) was set that there is no difference in choice of VCT site for first time clients and an alternative hypothesis (Ha) that the choices vary.

Ho General site = Specialized site

Ha General site > < Specialized sites

Accordingly, the p value was used to functionally define whether the chi square test result represents a difference or not in students' preference of the two VCT service sites. The p value was obtained using the data presented in the table below.

Table 1: Site of preference for first time VCT clients

Actual values			
	Specialized site	General site	Total
Agree	34	38	72
Neutral	5	6	11
Disagree	20	17	37
Total	59	61	120
Expected values			
Agree	35.4	36.6	
Neutral	5.408	5.592	
Disagree	18.192	18.808	

Actual values represent the responses obtained from participants while the expected values are calculated from the actual values as a product of the sum of the cell column by the sum of the cell row to the sum of observations.

$P = 0.770$, collected to 3 significant figures. The computation of p value was done using Microsoft excel program with default $\alpha = 0.05$.

Results were interpreted using the rule below

If	Then
p value < α	Reject the null hypothesis

$$C^2 (2, N=120) = .523, P = .770$$

Since the p value ($p = .770$) obtained is greater than the α level ($\alpha = .05$), it fails to reject the null hypothesis. By implication, there is no observed difference between specialized and generalized sites in terms of first time VCT clients' preference for services. Using the results got, there is no assurance that general health care sites will see more of first time VCT clients than specialized VCT sites.

Trend of students seeking VCT services

When students we asked whether they had attended VCT before, thirty eight (38) student respondents had attended VCT while twenty five (25) had never. Of the thirty eight respondents who had attended VCT before, 17 students stated that they got services from health units nearest to their homes while 15 went further away from home. There were 5 missed responses.

Site preferences and reasons thereof

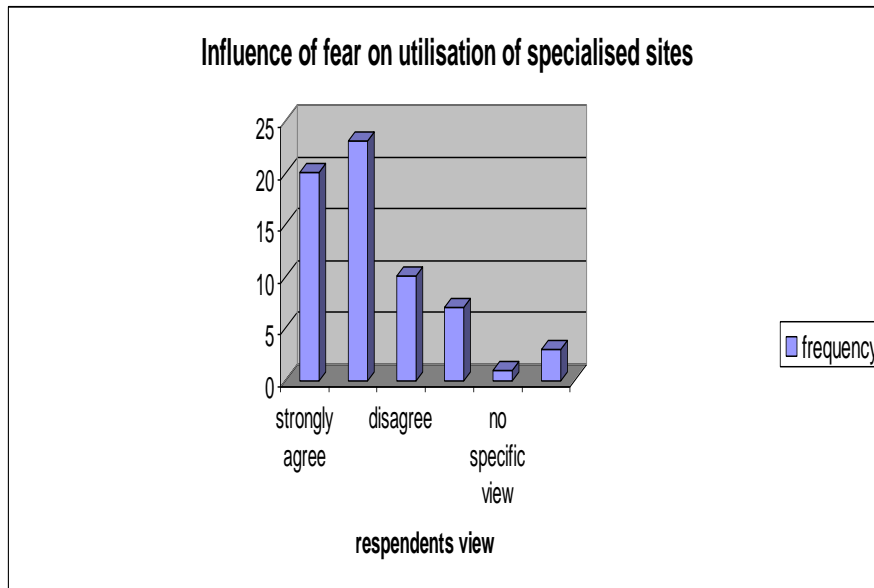
Students expressed their preference for specialized VCT sites to general health care sites with a ratio of 36,61%: 23,39% respectively. Reasons given were mainly due to perceived quality of service and availability of students/youth friendly programs. They highlighted that since specialized VCT sites are specifically for HIV related VCT, all people there have a common cause, and therefore, there is reduced stigma and fear of one being associated with HIV/AIDS. This is further informed by the response rate of 24, 42% supporting the view that fear of being perceived to be HIV positive would influence the choice of site to go to and 33, 58% refuting it.

The **table** below indicates findings on whether fear of being associated with HVI/AIDS is the major cause as to why most people do not go to specialized for VCT services.

	<i>frequency</i>	<i>percentage</i>	<i>valid percent</i>	<i>cumulative %</i>
strongly agree	20	31	33	33

Agree	23	36	38	71
disagree	10	16	16	87
strongly disagree	7	11	11	98
no specific view	1	2	2	100
missing	3	5		
Total	64	101	100	

Note: The valid percentage was calculated with the omission of missing responses.



Influence of disguise on VCT uptake

The study collected data on perception of disguise at a VCT site in regard to specialized and general health care sites. Twenty seven (27,45%) revealed that general health service sites disguise ones purpose for visiting the site. The remaining 55% however did not agree to this position. When asked whether the disguise would encourage uptake of VCT at the general health care site, the response was closely related to the previous one with 25,42% and 35,58% agreeing and disagreeing to the statement respectively. Additionally, 18,31% were of the opinion that lack of disguise at a specialized VCT site would discourage them from seeking VCT service at this site whereas 40,69% of respondents were opposed to this view.

Presentation of findings from focus group discussions:

Focus group discussions were conducted to illicit information on VCT uptake with a particular focus on site of choice for first time VCT clients. Comparisons were often made between general health care sites and specialized sites to identify the most favorable site for first time clients and assess possible reasons for the choice.

Four separate focus group discussions were conducted each targeting a specific category. The four categories represented were male students (n=5), female students (n=6), nurse counselors from general health care site (n=4) and lastly nurse counselors from specialized VCT site (n=5). Student subgroups had an average age of 23 years while the nurse counselors had a disparity in average age: counselors from the general health care site had an average age of 41 years compared with 30 years for counselors from the specialized VCT site.

Table Summarizing FGD participants’ composition:

	Students		Nurse counselors	
Participants category	Male group	Female group	General health site	Specialized VCT site
number	5	6	4	5
Ave.age	23	23	41	30
Education level	tertiary	Tertiary	tertiary	tertiary

All participants were educated up to tertiary level at least. One counselor from the specialized site had a Masters’ degree in counseling psychology.

Discussion sessions with students were conducted at the university in a lecture room. The session with nurse counselors from general health care site was held at one of the participant’s home and for the specialized VCT site; the discussion took place in a counseling rooms arranged by participants at their site. All sessions were conducted at

the time and location agreed upon by participants and they lasted an average of 50 minutes.

The FGD findings are presented in the order of ‘topic and responses’ format according to the FGD question guide.

1. Do you think specialized VCT sites and general health care sites offer different levels of comfort to clients?

Female and male students did not differ in their responses. They revealed that comfort varies from one individual to another. They also highlighted that individuals offering the service contribute significantly to comfort to clients satisfaction. A male participant said that most specialized VCT sites have a conducive environment for VCT because they are designed to suit a particular purpose unlike general health care sites. Other participants in the male group affirmed to this position adding that confidentiality and fear and stigma issues guide the set up premises. Female students views did not have a contrasting observation.

Nurse counselors’ opinion was that most students, especially first time clients are interested in hidden identity because they do not want to be associated with HIV/AIDS.

2. Comparing general health care sites and specialized VCT sites, where do you think students would prefer going to for VCT service and why?

The majority nurse counselors maintained that most youth students access a VCT service from private clinics first. One nurse counselor who also part-times in a private clinic stated “students often go to specialized sites for second or successive tests to confirm test results obtained from private clinics.”

Both students groups revealed that private clinics are preferred. A female student who dissented from her peers view said that “I do not care where I go for VCT;

what I need is good service.” Other participants expressed doubt in this statement and her colleague responded that she was ‘one in a thousand’.

3. Do think there is any kind of embarrassment or stigma about going for a VCT appointment? Consider a student’s perspective.

Student discussants generally shared the position that when they go for VCT, older people take them to be sexually active hence at risk of HIV/AIDS yet they are not expected to indulge in sex activities at their age and time.

Nurse counselors from specialized sites noted that student clients feel stigmatized because of self prejudice. They added that students know that they are not supposed to be linking with HIV/AIDS at their age unless if there is suspicion that they contracted the virus at birth. They mentioned that stigmatizing situations call for no justification. A youthful counselor blamed our culture that alienates young/youth from discussing sex issues as the main source of stigma.

A counselor from general health care site posed a question: why should a young student be worried about HIV testing if not sexually active in a country where more than 85% HIV infection is due heterosexual sex? Another participant responded that stigma does not result from the path of the virus to the body. They alluded stigma to students who simply feel that VCT sites are a wrong place for them.

4. What are the major fears or concerns regarding VCT? Are there any issues that are influenced by the nature of site: considering general or specialized VCT site from a student’s standpoint.

The main concerns that cut across all groups were that specialized sites have better waiting areas than general sites. The commonality of purpose at specialized sites eases students’ tension. A student female participant said that since it is a common pool, every aspect is shared whether good or bad. All groups were not sure whether

the duration would vary from site to site but they observed that students always want “quick fix serve” as a certain discussant put it.

5. Students are often not at ease mixing with adults at VCT sites. What is your view on this? Would the nature of site make a difference?

According to nurse counselors from general sites, every individual knows his/her purpose for visiting the site therefore, students are often not bothered by mixing with adults. Both student groups held a similar opinion. Specialized site nurses said that there is a youth friendly corner at their site that was setup after realizing that that youth including young student were not comfort mixing with adults.

Chapter Five: Discussion of findings:

This study attempted to assess the influence of specialized VCT sites on first time clients in comparison with general health care sites. Evaluation of first time student clients' preference for the two categories of VCT sites did not show significant variation on a chi square test of independent table. Results of the focus group discussions also indicated that no category of VCT site had an obvious advantage over another with respect to preference by first time clients.

Although general health care sites favored students seeking VCT services mainly because of perceived disguise of purpose of visits, they were criticized for not providing student friendly environment to encourage consumption of their services. In the same vein, specialized VCT sites which have the advantage of a conducive environment, perceived superior quality services and offering youth friendly services do not seem to attract more student clients than general sites. Results indicate that lack of disguise at these sites and fear of being associated with HIV/AIDS because one is seen at VCT site in part limit first time students uptake of services.

Results of this study relate to the conclusions in the WHO/UNAIDS 2001 report that there is no single ideal model for VCT service delivery because different approaches are required to reach different populations. As noted in focus group discussion, individuals have different drivers for the choices they make. Specialized VCT sites showed higher frequency of students who preferred having VCT services from their sites than general health care sites. The fact that the difference was not significant suggests that general sites also have a good level of preference as well. Therefore, to iron out limitations of increased uptake of VCT services, there are improvements that need to be done on either category of site taking into account the fears and concerns as stated above.

Fear of being associated with HIV is a prevalent condition that links with students' choice of where to attend VCT from. It is likely that settings that will provide

anonymous testing will encourage students to seek VCT services a case where general health care sites will likely be a better choice. However anonymity appears to take two dimensions. Whereas a particular site will provide anonymity that students want, it cannot offer complete protection against what people beyond the site staff perceive and say about a client seen or even suspected to have visited a VCT site. The possibility that a student will not go for VCT because of fear and perceived suspicion by outsiders irrespective of nature of site prevails.

An important aspect to note is that if an individual is not comfortable with a specialized VCT site he/she will not necessarily seek VCT services at general health care site. The reverse is true. Clients have an option not to go anywhere. This could explain why approximately 45% of all respondents have never attended VCT.

5.1 Limitations:

There is a possibility that some students did not value importance of this research an attribute that could have led to the low response rate with 23.8% failing to return the questionnaire and others skipping some important questions that would inform the findings. Inconsistencies were rectified during data cleaning to be able to maintain data integrity and reliability, hence validity of results and the confidence to generalize findings.

There was unforeseen limitation on time. Since the questionnaire was administered after lessons in a lecture theatre setting, the schedule did not favor all students' timetables. This partly explains why some questionnaires were incomplete while others were returned blank.

5.2 Conclusion and recommendations:

The nature of site does not in itself affect students' decision to go for VCT services but the setup at the site and mode of service delivery. VCT sites that provide service under conditions of anonymity, confidentiality and in youth friendly environment positively influence first time student clients to initiate VCT service this was also noted by

Loughlin (2007). It is imperative that VCT service providers adopt their service to students' needs to enable students to enjoy the service while increasing uptake of service and benefits of VCT.

Fear of being associated with HIV/AIDS is limiting turn-up of students for VCT services. There is need to provide counseling and VCT centered social marketing to student communities in order to arrest their fears. To encourage more students to seek VCT services, I would recommend larger community based programs to sensitize masses about HIV/AIDS and giving it a human face; and education about the benefits of VCT. The more communities understand dynamics of HIV/AIDS the less scare/stigma will suffice.

Private clinics are offering VCT services to a quite number of students but their role appears not to be well documented and therefore they are not appropriately supported. Research is necessary on the role of private clinics in provision of VCT services to young students and youth in general so that they can tap into public support to boost their services. Public-Private Partnerships in this regard will prove to be an essential component that will increasing the number of students making visits at VCT sites.

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Appendices:

Appendix i.

INTERVIEW SCHEDULE:			
Day	Activity	Audience	Venue
Day 1	Administer questionnaire	Nkumba University students	Nkumba University
Day 2	Focus group discussion	Female students	Group will decide
Day 3	Focus group discussion	Male students	Group will decide
Day 4	Focus group discussion	Nurse/counselor-SPS	Group will decide
Day 5	Focus group discussion	Nurse counselors-GES	Group will decide

SPS denotes Specialized VCT site

GES denotes General health care site

Note: Interviews will be done within five (5) days.

Appendix ii

Focus group discussion (FGD) question guide:

Number of discussion groups: 4

Categories of groups: 1. Male students

2. Female students

3. Nurse counselors from general health care site

4. Nurse counselors from specialized VCT sites

Duration of discussion: Averagely 50minute

Questions guide.

1. Do you think specialized VCT sites and general health care sites offer different levels of comfort to VCT clients?
2. Comparing general health care sites and specialized VCT sites, where do you think students would prefer going to for VCT services, and why?
3. Do you think there would be any kind of embarrassment or stigma about going for VCT appointment? Consider a student's perspective.
4. What are the major fears and/or concerns regarding VCT? Are there any issues that are influenced by the nature of site i.e. General or Specialized VCT site from a student's standpoint?
5. Students are often not at ease mixing with adults at VCT sites. Do you think this true? Would the nature of site make a difference?
6. Do you think there are particular merits or demerits associated with nature of VCT site that would influence students' inflow to a particular site? Elaborate considering specialized and general health care site.

Appendix iii.

RESEARCH QUESTIONNAIRE: Allan B. 14977613

This questionnaire is for the sole purpose of answering research questions for the fulfillment of thesis requirement for completing a Masters of philosophy in HIV management degree. All responses will be handled with utmost confidentiality.

A. General demographic questions:

1. Date: 2. Age in years.....
3. Place of residence.....
4. Your gender: Male Female

B. Health care and VCT services availability questions:

5. Do you go for health care at the health unit nearest to your home? Yes No
6. Does the health unit nearest to your home offer VCT services? Yes No
7. Would you go for VCT services at this site? Yes No.
8. If 7 is no, why not.....
9. If 7 is yes, what would motivate you?.....
10. Have you attended VCT before? Yes No
11. If yes, did you go to the VCT site nearest to your home? Yes No
12. If no, would you go to the VCT site nearest to your home? Yes No
13. Where do you go for health care when you fall sick?
14. Does the health unit offer VCT services related to HIV/AIDS? Yes No
15. Would you seek VCT services at this health unit? Yes No
16. If no, why not?
.....
17. What determines your choice of where to go for VCT?

Give reasons for your choice?

- i.....
- ii.....

C. Questions on factors influencing choice of a site to go to for VCT:

18. Do you sometimes feel fearful of your HIV status? Yes No

19. Does fear influence your decision to go for VCT? Yes No

20. If yes, to what extent does it influence your decision to go for VCT?

21. Do you sometimes fear being perceived to be HIV positive? Yes No

22. Does being associated with HIV+ status affect your decision to go for VCT?

Yes No

23. Given two (2) VCT sites of a similar standard but one offering general health care services including VCT and another one specializing in VCT for HIV/AIDS, which one would you prefer to go to?

General health unit specialized VCT unit

Give reasons for your choice

24. Does/would fear of being perceived to be HIV+ influence your choice in 23 above?

Yes No

25. If you had gone for HIV testing and found someone you know at the health unit, would you go ahead and test? Yes No

26. Would you mind people knowing that you tested for HIV/AIDS?

Yes No

27. General health service sites disguise ones purpose for a visit to the site.

True False

28. Would the disguise encourage you to go to a general health unit for VCT?

Yes No

29. Would lack of disguise at the specialized VCT site discourage you from seeking VCT at this site? Yes No

30. Some people do not want to be seen at VCT sites for fear of being suspected to be HIV+. Does this apply to you? Yes No

31. What situation do you feel would give utmost comfort at a VCT service site?

.....

D. CHOICE FOR VCT SITE AND THEIR REASONS:

32. Most people seeking VCT services for the first time prefer using the general sites
Strongly agree Agree Disagree Strongly disagree No specific view

33. First time clients seek VCT services from specialized sites because they are disguised
Strongly agree Agree Disagree Strongly disagree No specific view

34. Stigma is the major cause as to why first time clients seeking VCT services do not use specialized sites
Strongly agree Agree Disagree Strongly disagree No specific view

36. Fear of being associated with HIV is the major cause as to why people do not seek VCT services.
Strongly agree Agree Disagree Strongly disagree No specific view

37. Fear of being associated with HIV is the major cause as to why most people do not go to specialized sites for VCT services.
Strongly agree Agree Disagree Strongly disagree No specific view

38. Most people prefer going to sites further to their places of residence because they do not want to be seen at HIV/AIDS service sites.
Strongly agree Agree Disagree Strongly disagree No specific view

Give any views or comments that may have regarding this topic.

.....
.....
.....
.....

Thank you for your time: